Good news and bad news

Presentation to the Catholic Physicians' Guild of Vancouver

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Introduction

Thank you for inviting me to speak this evening. I have never been asked to give a three hour presentation to a group of physicians. You will be relieved to know that I have not been asked to do that tonight.

Those of you who saw the BC Catholic headline may have been expecting a "lecture on medical ethics," but, thanks to Dr. Bright's introduction, you now know that I am an administrator, not an ethicist, and that my topic is freedom of conscience in health care.

Protection of Conscience Project

The Protection of Conscience Project will be 15 years old this December. Although a meeting sponsored by the Catholic Physicians Guild provided the impetus for its formation, the Project is a non-denominational initiative, not a Catholic enterprise. Thus, if I mention the Catholic Church or Catholic teaching tonight, it will be as an outsider, as it were, though an outsider with inside information.

One more thing: the Project does not take a position on the acceptability of morally contested procedures like abortion, contraception or euthanasia: not even on torture. The focus is exclusively on freedom of conscience.

Context

The context for my presentation is provided by the passage of the Quebec euthanasia law[1] and the pending decision in *Carter v. Canada* in the Supreme Court.[2] Physicians are now confronted by the prospect that laws against euthanasia and physician assisted suicide will be struck down or changed. If that happens, what does the future hold for Catholic physicians and others who share your beliefs?

Will you be forced to participate in suicide or euthanasia?

If you refuse, will you be disadvantaged, discriminated against, disciplined, sued or fired?

Will you be forced out of your specialty or profession, or forced to emigrate if you wish to continue in it?

What about those who come after you? If you avoid all of these difficulties,

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will they?

In sum, will freedom of conscience and religion for health care workers be protected if assisted suicide and euthanasia are legalized?

These questions and the issues and problems they raise have been largely avoided or glossed over.

They have been avoided by *opponents* of assisted suicide and euthanasia because, understandably, they don't want to compromise their central message: don't do it.

They have been *glossed over* by *advocates* of assisted suicide and euthanasia because they are afraid that support for legalization may evaporate if people think that unwilling physicians will be forced to kill patients. Instead, they adopt a reassuring posture of respect for freedom of conscience and tolerance for opposing views.

I will suggest tonight that we have reached the point at which these questions and the problems they bring with them can no longer be avoided, nor can they be glossed over with saccharine promises of respect and tolerance.

Carter v. Canada

The common law that came to Canada from England recognized that suicide can be deliberately chosen by someone who is of sound mind, but viewed such acts as always immoral and contrary to reason.[3] Deliberate choice was understood to make suicide more wrongful, not less. Consistent with this tradition, many people - Catholic physicians among them - continue to believe that suicide, while not blameworthy if it results from mental or emotional disorder, is immoral or unethical if deliberately chosen, should always be prevented, and should never, ever be encouraged or assisted.

However, the ruling of Madame Justice Smith in *Carter v. Canada* was based on a radically different fundamental premise. She held that suicide is *not* always wrong: that it *can*, in some circumstances, be a rational and moral act.[4] In other words, she believed that it can sometimes be a good thing to commit suicide. Logically, if it is good to commit suicide in some circumstances, it must, *in* those circumstances, be good to *assist* with suicide.[5]

Granted this, it must *also* be a good thing, *in* those circumstances, to do *for* someone like Gloria Taylor what she *wants* to do but is unable to do: to end her life - to kill her. Thus, the judge's reasoning moved logically from approving suicide, to approving assisted suicide, and then to approving euthanasia.

According to Madame Justice Smith, the purpose of the law is not to prevent *all* suicides or all assisted suicides. The sole purpose of the law is to protect vulnerable people, who, in moments of weakness, might be tempted to kill themselves without sufficient reason and reflection.[6] Having established this, she framed the key questions.

Can vulnerable people be adequately protected only by the absolute prohibition of assisted suicide?

Or is there a less drastic alternative that can achieve the same goal?

The burden was on the defendant governments to prove that vulnerable people cannot not be protected by anything less than absolute prohibition.[7] They produced evidence of risk, which the

judge accepted.[8] However, the effect of this evidence was significantly diminished because the judge defined the goal as one of managing or reducing risk - not eliminating it altogether.[9] She concluded that the risks could be reduced to acceptable levels.[10]

I suggest that her belief that suicide could sometimes be a good thing led her to adopt the policy of risk management. I suggest she would not have been so inclined in the case of something she believed to be always gravely immoral. For example, if the subject were sexual assault, I doubt that she would recommend risk reduction rather than risk elimination. I don't think she would attempt to calculate an acceptable level of risk for rape.

For these reasons, I suggest that the trial court ruling in *Carter* hinged entirely upon the foundational premise that killing oneself can sometimes be a good thing. The premise was not challenged during the trial. Instead, the defence of the law depended largely upon utilitarian arguments about the ineffectiveness of safeguards, the risks to vulnerable people and slippery slopes.

Now, I don't mean to denigrate those who did their best to defend the law. In the first place, I am tackling this from a different perspective. Moreover, the defendant governments probably believed - with good reason - that moral arguments would be abruptly dismissed, with contempt or condescension. However, keeping silent about morality does not produce a morally neutral judicial forum. It simply allows the judge's moral beliefs to set the parameters for argument and adjudication.

This applies not only in courtrooms, but in the public square.

This was illustrated during CBC's *Cross Country Checkup* following the *Carter* decision.[11] Most of those who opposed the ruling argued, as the defendant governments did at trial, that assisted suicide and euthanasia should not be legalized because that would endanger vulnerable people.

But when asked if they would deprive Gloria Taylor of the right to physician-assisted suicide, every one of them avoided the question. Not one said that she should be denied help to kill herself.

They had argued against legalizing assisted suicide solely because of the risk that vulnerable people would be exploited, and no safeguards could adequately protect them. But Gloria Taylor could not plausibly be described as a vulnerable and exploited person in need of protection, so they could not explain why, in her case, assisted suicide should not be permitted.

And if they could offer no reason to deny it to her, upon what basis would they deny it to others similarly situated? And what reason would they have to refuse to help her kill herself?

Had they argued from the outset against suicide and euthanasia on moral, philosophical or religious grounds (though not excluding others), they might have been able to answer differently. But, like the government defendants, they did not do so, and were placed in a very awkward spot by the interviewer.

As you might be by a patient if the law is changed. In the case of conscientious objection, silence about one's moral, religious or philosophical beliefs is impossible.

Rights claims

Once suicide, assisted suicide and euthanasia are understood to be benefits, it is possible to assert that one has a right to them, at least in defined circumstances. The Quebec euthanasia law purports to enact such a right,[12] and the BC Civil Liberties Association and others claim such a right in *Carter*.[13] Such claims imply that, in some circumstances, physicians have a legal or professional obligation to kill a patient or to help a patient kill himself.

A statement by new CMA President, Dr. Chris Simpson, can be understood to support that view. Responding to a suggestion that someone other than physicians should provide euthanasia and assisted suicide, he said, "I don't think we want to be reneging on our responsibilities to serve our patients."[14]

That is the language of obligation.

The obligation to kill

I want to dwell for a moment on the obligation to kill, but I should first clarify my use of the term. I use "killing" in the sense explained by Beauchamp and Childress in the *Principles of Biomedical Ethics*:

> The term killing does not necessarily entail a wrongful act or a crime, and the rule 'Do not kill' is not an absolute rule. Standard justifications of killing, such as killing in self-defense, killing to rescue a person endangered by another persons' wrongful acts, and killing by misadventure. . . prevent us from prejudging an action as wrong merely because it is killing.[15]

With that out of the way, I want to focus on the obligation to kill because I don't think the nature of the obligation is sufficiently appreciated. An *obligation* to kill must be distinguished from an *authorization* to kill or a *justification* of killing.

Soldiers and police are legally *authorized* to kill, and all of us may be legally *justified* in killing in self-defence. But neither the *authority* to kill nor legal *justifications* for killing amount to an *obligation* to kill. If the first shot merely wounds a bank robber, a policeman is not entitled to administer a coup-de-grâce. There is no obligation to kill even in military combat; deliberately killing disabled enemies is a crime.[16]

Once we realize that an obligation to kill is not imposed even upon people whose duties may entail killing, we can recognize that imposing an obligation to kill upon *physicians* would be unique and extraordinary.

But it is not unprecedented.

An obligation to kill was formerly imposed on public executioners. The essence of that obligation was captured by Blackstone's explanation that "if, upon judgment to be hanged by the neck till he is dead, the criminal be not thoroughly killed, but revives, the sheriff must hang him again."[17]

That is what an obligation to kill would require of a physician. If a lethal injection failed to kill a patient, a physician would have to inject the patient again to ensure that he is "thoroughly killed."

This is implied in the Quebec euthanasia law, which requires a physician who administers a lethal substance to remain with the patient "until death ensues."[18]

It would thus seem to be difficult to legalize physician-assisted suicide without also legalizing euthanasia.

Let's suppose a patient seeks assisted suicide to avoid being incapacitated by a progressive illness. A physician provides the lethal drug. The patient takes it, but doesn't die. Instead, the drug causes precisely the kind of incapacitation that the patient wanted to avoid. It could be argued that the physician who contracted to help the patient kill himself is obliged to fulfil the terms of the contract: to make sure that a patient who survives assisted suicide is "thoroughly killed" by euthanasia. It seems likely that euthanasia will be wanted at least as a backup for failed assisted suicide, as abortion is wanted as a backup for failed contraception.[19]

Good news

Now, my reference to public executioners may be thought inappropriate. I'll grant that it may cause discomfort, but I think it is instructive with respect to the nature of the obligation to kill. But Catholic physicians and others who share your beliefs are looking for assurance that they will not be expected to kill patients if the Supreme Court strikes down the law. On this point, there is good news and bad news.

The good news begins with some statistics. These are only approximations, but they will do for present purposes. (See Appendix "A")

Belgium

Euthanasia has been legal in Belgium since 2002, but the number of physicians directly involved is quite low: I estimate a maximum of 0.62% to 2.3% of all Belgian doctors. The actual number of physicians directly involved could be much lower. For example, one physician killed 28 patients in about ten years,[20] which, in official statistics, would be reflected as the work of 28 physicians, not one.

Netherlands

In the Netherlands, physicians may provide both euthanasia and assisted suicide. Dutch General practitioners are the main providers: over 28% of GP's were directly involved in 2011. But, of all Dutch physicians, it seems that a maximum of 9% to 12% have been directly involved in reported euthanasia.

Taking the opposite view, this indicates that over 80% of Dutch GP's and 88% to 98% of Belgian and Dutch physicians overall are not directly involved in killing patients. This estimate seems so high as to be improbable, until we look at the numbers from Oregon and Washington.

Oregon and Washington

In Oregon, where assisted suicide has been legal since 1997, between 0.38% to 0.62% of the state's active registered physicians wrote prescriptions for lethal medication between 2002 and 2013. The state of Washington legalized assisted suicide in 2009. The number of Washington physicians

prescribing lethal medications has increased steadily since then : from 0.21% to 0.34% of licensed physicians.

I repeat that these are only approximations, but I believe that they demonstrate that if you refuse to kill patients or assist in consultations leading to euthanasia or assisted suicide, your practices will reflect the professional norm. From your perspective, I think that is good news.

We find more good news by turning once more to *Carter* and the Quebec euthanasia law.

Carter v. Canada

In her ruling in *Carter*, Madame Justice Smith noted that the plaintiffs did not assert that physicians should be compelled to provide euthanasia or assist in suicide.[21] Lawyer Joseph Arvay opposed the Project's intervention in the *Carter* appeal because his clients had never argued that physicians should be forced to kill patients,[22] and, in his oral submission, said, "[N]o one is suggesting that a physician who has a religious objection to assisting a patient with his or her death must do so."[23]

Quebec euthanasia law

Quebec intervened in the *Carter* appeal to advocate for its euthanasia law. When asked about the law's protection for conscientious objectors, Quebec's lawyer said the law "allows a doctor to refuse to administer aid in dying" and that physicians would "never [be] compelled to act against their conscience."[24] The Quebec Association for the Right to Die with Dignity had previously assured Quebec legislators that it had no intention of forcing physicians to provide euthanasia.[25]

Canadian Medical Association

Finally, the Canadian Medical Association's intervention in *Carter* referred to the motion supporting "the right of all physicians. . . to follow their consciences when deciding whether or *not*" to provide assisted suicide or euthanasia.[26] The CMA insisted that the law should protect both physicians providing the procedures and those who do not.[27]

> [N]o physician should be compelled to participate in or provide medical aid in dying to a patient, either at all, because the physician conscientiously objects . . . or in individual cases, in which the physician makes a clinical assessment that the patient's decision is contrary to the patient's best interests.[28]

There you have it. If you refuse to kill patients for reasons of conscience, your refusal be consistent with the practice of an overwhelming majority of physicians. Moreover, you have the solemn promises of euthanasia activists and the Quebec government, made publicly before a legislative committee and the Supreme Court of Canada, that you will never be forced to do so. Finally, you have the support of the Canadian Medical Association, underwritten by their intervention in *Carter*.

There you have the good news.

The bad news

On the one hand, the Quebec government and the plaintiffs in the *Carter* case are asking the Supreme Court to declare that patients have a constitutional right to physician assisted suicide and euthanasia. On the other, we know that most physicians do not kill their patients or help them kill

themselves.

This has the makings of a first class train wreck.

If the Supreme Court strikes down the law, how can the Quebec government, Mr. Arvay and the BC Civil Liberties Association ensure that patients will be able to access euthanasia and assisted suicide without breaking their promise that objecting physicians will not have to kill patients?

The answer is that they will keep their promises - to the letter.

Mandatory referral implicit in *Carter*

You will not have to kill. That will not be expected. But you will be expected to cooperate. If, for reasons of conscience or religion, you won't kill a patient or help him to kill himself, you will not have to. All you will have to do is help the patient find someone who will. They promised that you would not have to kill. They did not promise that you would not have to find someone else to do it. This has been in the cards from the beginning. That's why the Project joined the Catholic Civil Rights League and Faith and Freedom Alliance as an intervener in *Carter*.

An obligation to at least facilitate euthanasia and assisted suicide was implicit in Mr. Arvay's factum.[29] It was implicit in his notice of claim[30] and in the testimony of his witness, Professor Margaret Battin. She implied that a physician's refusal to provide assisted suicide or euthanasia would amount to unethical abandonment of patients.[31] Mr. Arvay introduced into evidence[32] a report by a Royal Society panel of experts. It stated that if religious or moral conscience prevents health professionals from killing patients or assisting in suicide, "they are duty bound to refer their patients to a health care professional who will."[33] One of the authors of the report was Professor Jocelyn Downie of Dalhousie University. Professor Downie helped prepare Mr. Arvay's expert witnesses for the trial.[34]

Mandatory referral implicit in Quebec euthanasia law

An undetermined number of physicians who don't want to kill patients or assist with suicide may, in fact, be willing to refer patients to colleagues who will. The Protection of Conscience Project won't hear from them. But many physicians will not be willing to refer patients because they believe that helping to arrange a killing makes them a participant in it. This was very succinctly explained by the President and Director General of Quebec's Collège des médecins, Dr. Charles Bernard. He said,

> [I]f you have a conscientious objection and it is you who must undertake to find someone who will do it, at this time, your conscientious objection is [nullified]. It is as if you did it anyway. / [Original French] Parce que, si on a une objection de conscience puis c'est nous qui doive faire la démarche pour trouver la personne qui va le faire, à ce moment-là , notre objection de conscience ne s'applique plus. C'est comme si on le faisait quand même. [35]

This is a striking admission, because it is an indictment of Dr. Bernard's own *Code of Ethics*. The Collège des médecins *Code of Ethics* requires that physicians unwilling to provide a service for reasons of conscience "offer to help the patient find another physician."[36]

Quebec's euthanasia law allows physicians to refuse to kill patients, but adds that they "must

nevertheless ensure that continuity of care . . . *in accordance with their code of ethics*"[37] - and that demands referral.

This is what Quebec's lawyer left out when he told the Supreme Court that physicians would "never [be] compelled to act against their conscience." The Project's lawyer drew the contradiction to the attention of the Court, using it as an example of "precisely the sort of thinking that, in our submission, ought to be protected against."[38]

Canadian Medical Association and mandatory referral

Much more could be said on that score, but let's look more closely at the Canadian Medical Association's intervention. The Association's factum stated, "[N]o physician should be compelled to participate in or provide" the services. Surely this means that the CMA will support physicians who refuse to help patients find someone to kill them.

Not necessarily. The devil is in the footnotes.

The factum states that "no jurisdiction that has legalized medical aid in dying compels physician participation."[39]

However, the footnote to this comment includes a citation of the Quebec euthanasia law, which, as we have just seen, is less than satisfactory. The factum continues:

> If the attending physician declines to participate, every jurisdiction that has legalized medical aid in dying has adopted a process for eligible patients to be transferred to a participating physician.[40]

Here the footnote cites an addendum, "Schedule A," part of a package prepared for the August AGM.[41] Schedule A states that objecting physicians in Washington, Vermont, Oregon, Belgium, and Luxembourg "have a duty to transfer patient care to another physician who can fulfil the request."[42]

This is erroneous, misleading and troubling.

It is erroneous because the law in Vermont says nothing of the sort: in fact, says nothing at all about this.[43]

It is misleading because it could be taken to mean that the objecting physician has a duty to initiate the transfer to a willing colleague. This is not required in any of the jurisdictions listed. All that is required is that objecting physicians transfer the patient's medical records as requested by the patient.[44]

So, erroneous and misleading.

It is troubling for two reasons

First: the error and slant in the presentation favours the view that failure to initiate a referral or transfer for euthanasia constitutes patient abandonment.

Second: I have had access to a document that indicates that this is the view of influential CMA staffers.

I will not be more specific because I do not burn my sources, but I do not think that sloppy research

and clumsy draftsmanship adequately account for the wording of Schedule A.

More direct evidence is available in the Association's oral submission. This referred only to the need to avoid "overriding the consciences of those who object to *performing*" euthanasia or assisted suicide and to respect "the choice of those who do not wish to *perform* the practice."[45]

These statements certainly do not engender confidence that the Canadian Medical Association will support physicians who refuse to help patients find someone to kill them.

So what did the CMA mean when it said "no physician should be compelled to participate in or provide" euthanasia or assisted suicide?

I don't know. It all depends upon what the Association means by "participate." I'm not a member of the CMA, but, if I were, I would make it my business to find out.

What the future holds

Now, if the Supreme Court strikes down the law, an undetermined number of physicians and health care workers will eventually begin to kill patients, in the belief that what they were doing is not only legal, but morally acceptable. In a sense, this would not be remarkable, because that sort of thing has happened in the past, and it is happening now, in Belgium, the Netherlands and Luxembourg, for example.

Nonetheless, many physicians and health care workers will, despite the ruling, continue to consider euthanasia to be (morally) planned and deliberate homicide. They will likely refuse to kill patients and refuse to encourage or facilitate the killing of patients by counselling, referral or other means.

And then the Collège des médecins du Québec, the Royal Society of Canada, Professor Downie, and the BC Civil Liberties Association and others will play the mandatory referral card. They will demand that health care professionals be *compelled* to facilitate the killing of patients by referral and other means.

How can I be sure of this?

Because some of them are already making these demands, and all of them have been rehearsing this play for years. The last full-scale dress rehearsal was in Ottawa. Three of your colleagues played starring roles.

Dress rehearsal in Ottawa

The play opened in January, when a 25 year old woman was unable to get a prescription for birth control pills at an Ottawa walk-in clinic. The physician on duty was a Catholic with an NFP only practice. The receptionist gave the woman a letter explaining that he did not prescribe or refer for contraceptives for reasons of "medical judgment as well as professional ethical concerns and religious values." She obtained the prescription at a clinic two minutes away.[46]

The physician was not forced to do something contrary to his medical judgement and religious beliefs, and the young woman obtained birth control pills by driving around the block. In more tolerant times and places this might have been considered a successful compromise. In this case, it sparked a witch hunt. Two more NFP only physicians - both Catholics - were discovered lurking in

the nation's capital.

The three NFP only physicians account for 0.076% of about 4,000 physicians practising in the Ottawa area,[47] so at least potentially, 99.9% of Ottawa area physicians are willing to prescribe contraceptives.

Nonetheless, a venomous feeding frenzy erupted on Facebook. News that three out of 4,000 area physicians did not prescribe The Pill made headlines.[48] It was front page news and a public scandal that three Ottawa physicians would not recommend, facilitate or do what they believed to be immoral, unethical, or harmful. Consulted by an *Ottawa Citizen* columnist, officials from the CMA and the CPSO seemed unsure about whether or not there is room for that kind of integrity in the medical profession.[49] A few days later, a reporter with the *Medical Post* expressed doubt that it was even legal.[50] It eventually became the subject of a province-wide CBC Radio programme.[51]

This was a wildly disproportionate response to news that a young woman had to drive around the block to get birth control pills.

Why do I call this a rehearsal for confrontations about assisted suicide and euthanasia?

A duty to refer patients to be killed

Because the arguments said to justify compelling objecting physicians to provide or refer for contraception and abortion are the same arguments used to try to compel objecting physicians to provide or facilitate euthanasia and assisted suicide. I won't attempt to cover them tonight, but I will give you a single example that demonstrates the connection.

In 2006 Jocelyn Downie was one of two law professors who wrote a guest editorial in the *Canadian Medical Association Journal* claiming that physicians who refuse to provide abortions for reasons of conscience had an ethical and legal obligation to refer patients to someone who would.[52] Five years later she was a member of the "expert panel" of the Royal Society of Canada that, as we have seen, recommended that health care professionals who object to killing patients should be compelled to refer patients to someone who would.[53] The experts argued that, *because* it is agreed that we can compel objecting health care professionals to refer for "reproductive health services," we are justified in forcing them to refer for euthanasia.[54]

Jocelyn Downie and Daniel Weinstock, another member of the Royal Society expert panel, are members of the faculty[55] of the "Conscience Research Group."[56] This is a quarter-million dollar Canadian Institutes of Health Research (CIHR) funded project.[57] It is headed by Professor Carolyn McLeod and supported by a research assistant and seven graduate students. A central goal of the group is to entrench in medical practice a duty to refer for or otherwise facilitate contraception, abortion and other "reproductive health" services. From the perspective of many objecting physicians, this amounts to imposing a duty to do what they believe to be wrong.

But that is just what the Conscience Research Group and others propose: that the state or a profession can impose upon physicians a duty to do what they believe to be wrong - even if it is killing someone - even if they believe it to be murder - and that they should be punished if they

refuse.

Killing is not surprising; even murder is not surprising. But to hold that the state or a profession can, in justice, compel an unwilling soul to commit or even to facilitate what he sees as murder, and justly punish or penalize him for refusing to do so - to make that claim is extraordinary, and extraordinarily dangerous. For if the state or a profession can require me to kill someone else - even if I am convinced that doing so is murder - what can it *not* require?

Conclusion

How can we possibly have arrived at this point?

By first convincing people that contraception is a good thing, and that physicians should be made to prescribe or refer for contraception.

By then convincing them that abortion is a good thing, and that physicians should be made to perform or refer for abortion.

Finally, as Madame Justice Smith has demonstrated, by convincing people that suicide, then assisted suicide, and then euthanasia are good things, and that physicians should be made to provide or refer for them.

Convince people that X is a good thing - whatever X might be - and the rest will follow - especially if X offers power, sex or relief from suffering.

When laws governing abortion and contraception became less restrictive almost fifty years ago, the kind of attacks now being made on physicians and other health care workers who decline to provide or facilitate the services was beyond imagining. No one would then have anticipated that the more liberal society they thought they were building would generate the vituperative intolerance now evident in Ontario.

So how can we know what the future holds for Catholic physicians and others who share your beliefs if the Supreme Court legalizes assisted suicide and euthanasia?

You might ask your three Ottawa colleagues.

And then you might read G.K. Chesterton's *Ballad of the White Horse.*

Closing

I again thank you for inviting me to speak tonight.

If my presentation has not been quite what you were expecting, I hope that you will at least be able to thank Dr. Bright for referring a pleasant 61 year old gentleman to you for consultation.

Appendix "A"

A1. Belgium

The Belgian Act on Euthanasia of May 28th, 2002

Euthanasia was legalized in Belgium in 2002. The following statistics refer only to reported euthanasia cases. The statistics here indicate the maximum number of physicians involved in reported cases each year, not the actual number of physicians participating.

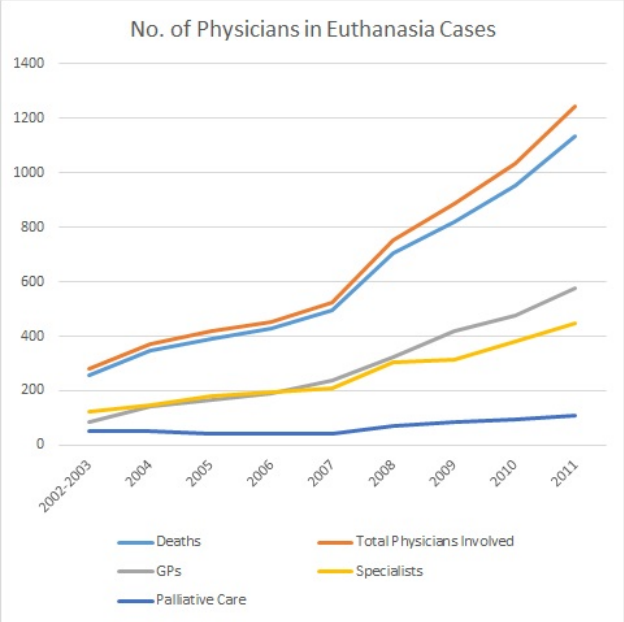
		1st. Consultant				2nd Consultant		Totals		
Year	**Deaths**	**A**	**B**	**C**	**D**	**E**	**F**	**1st**	**2nd**	**1st & 2nd**
2002-03	259	51	84	124	0	15	7	259	22	281
2004	349	53	143	147	6	10	14	349	24	373
2005	393	42	166	183	2	18	9	393	27	420
2006	429	43	190	195	1	15	11	429	26	455
2007	495	43	238	211	3	19	9	495	28	523
2008	704	71	326	307	0	38	11	704	49	753
2009	822	85	420	315	2	41	26	822	67	889
2010	953	97	475	381	0	55	25	953	80	1033
2011	1133	109	575	449	0	78	36	1133	114	1247

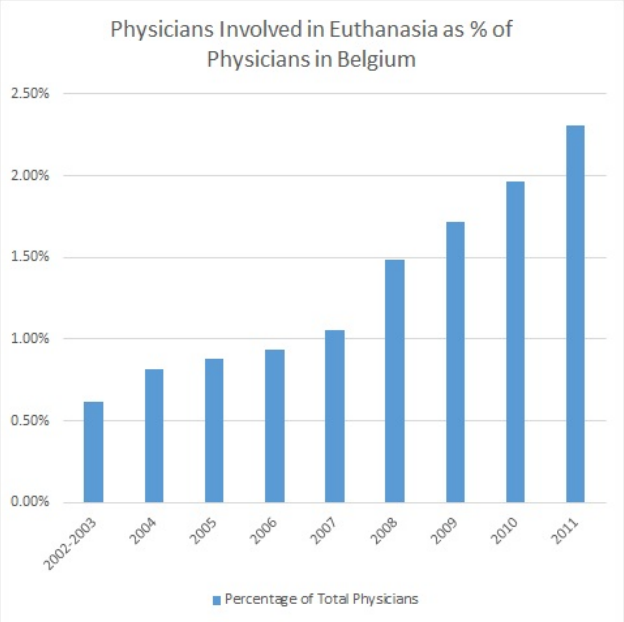
A: Palliative Care | B: General Practitioners | C: Specialists | D: Unspecified
E: Psychiatrist | F: Specialist

Sources: Commission Fédérale de Contrôle et d'Évaluation de l'Euthanasie Annual Reports

Year	Deaths	Physicians Involved	Physicians/ 100,000	Population	Est. Total No. Physicians	% of Total
2002-03	259	281	437.3	10355844	45286	0.62%
2004	349	373	441.3	10396421	45879	0.81%
2005	393	420	458.4	10445852	47884	0.88%
2006	429	455	462.7	10511382	48636	0.94%
2007	495	523	469	10584534	49641	1.05%
2008	704	753	474.7	10666866	50636	1.49%
2009	822	889	480.9	10753080	51712	1.72%
2010	953	1033	485.5	10839905	52628	1.96%
2011	1133	1247	491.1	11000638	54024	2.31%

Sources: Commission Fédérale de Contrôle et d'Évaluation de l'Euthanasie Annual Reports; Eurostat: Licensed Physicians Per 100,000 Inhabitants; Eurostat: Population on 1 January- Belgium


No. of Physicians in Euthanasia Cases
1400
1200
1000
800
600
400
200
0
2002-2003
2004
2005
2006
2007
2008
2009
2010
2011
Deaths
Total Physicians Involved
GPs
Specialists
Palliative Care


Physicians Involved in Euthanasia as % of Physicians in Belgium
2.50%
2.00%
1.50%
1.00%
0.50%
0.00%
2002-2003
2004
2005
2006
2007
2008
2009
2010
2011
Percentage of Total Physicians

A2. Netherlands

Termination of Life on Request and Assisted Suicide (Review Procedures) Act

Euthanasia and assisted suicide were legalized in the Netherlands in 2002. The following statistics refer only to reported euthanasia and assisted suicide cases. The statistics here indicate the maximum number of physicians involved in reported cases each year, not the actual number of physicians participating.

	Euthanasia & A. Suicide Deaths				Attending Physician				
Year	**Total**	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**Total**
2002	1882								
2003	1815	1626	148	41					
2004	1886	1714	141	31	1646	188	52	0	1886
2005	1933	1765	143	25	1697	170	66	0	1933
2006	1923	1765	132	26	1692	151	80	0	1923
2007	2120	1923	167	30	1886	157	76	1	2120
2008	2331	2146	152	33	2083	152	91	5	2331
2009	2636	2443	156	37	2356	184	87	10	2637
2010	3136	2910	182	44	2819	193	115	9	3136
2011	3695	3446	196	53	3329	212	139	15	3695
2012	4188	3965	185	38	3777	171	166	74	4188

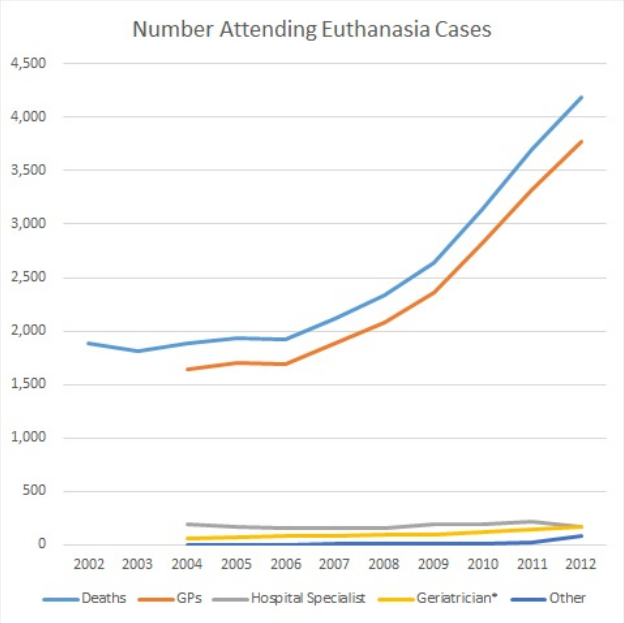
A: Euthanasia | B: Assisted Suicide | C: Combined Euthanasia & Assisted Suicide

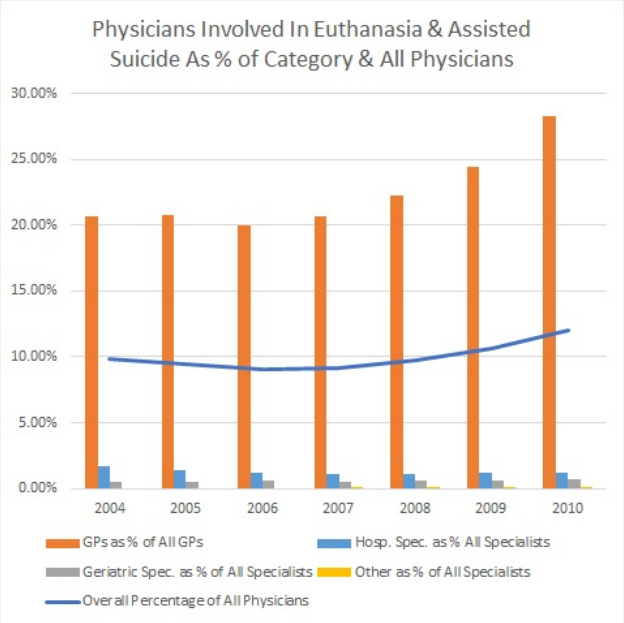
D: General Practitioner | E: Hospital Specialist | F: Geriatrician* | G: Other
***Includes physicians working in nursing homes.**

Sources: Regional Euthanasia Review Committees Annual Reports.

		Total in Netherlands per Category			Percentage of Totals, Categories & Overall No. Physicians				
Year	**Deaths**	**A**	**B**	**C**	**D**	**E**	**E**	**G**	**% Overall**
2004	1886	7960	11275	19235	20.68%	1.67%	0.46%	0.00%	9.81%
2005	1933	8165	12305	20470	20.78%	1.38%	0.54%	0.00%	9.44%
2006	1923	8450	12850	21300	20.02%	1.18%	0.62%	0.00%	9.03%
2007	2120	9130	14080	23210	20.66%	1.12%	0.54%	0.01%	9.13%
2008	2331	9350	14485	23835	22.28%	1.05%	0.63%	0.03%	9.78%
2009	2636	9660	15020	24680	24.39%	1.23%	0.58%	0.07%	10.68%
2010	3136	9960	16055	26015	28.30%	1.20%	0.72%	0.06%	12.05%

		Total in Netherlands per Category			Percentage of Totals, Categories & Overall No. Physicians				
Year	Deaths	A	B	C	D	E	E	G	% Overall
A: General Practitioners | B: Medical Specialists | C: Physicians **D: % of General Practitioners | E: % Hospital Specialists | F: % Geriatricians | G: % Other**									
Note: percentages of hospital and geriatric specialists and "other" is relative to the total number of medical specialists. Overall percentage is in relation to the total number of physicians.									
Sources: Regional Euthanasia Review Committees Annual Reports; Statistics Netherlands: Health, lifestyle, health care use and supply, causes of death; from 1900. Subjects: Care Supply, Health Professions. (Accessed 2014-07-16)									





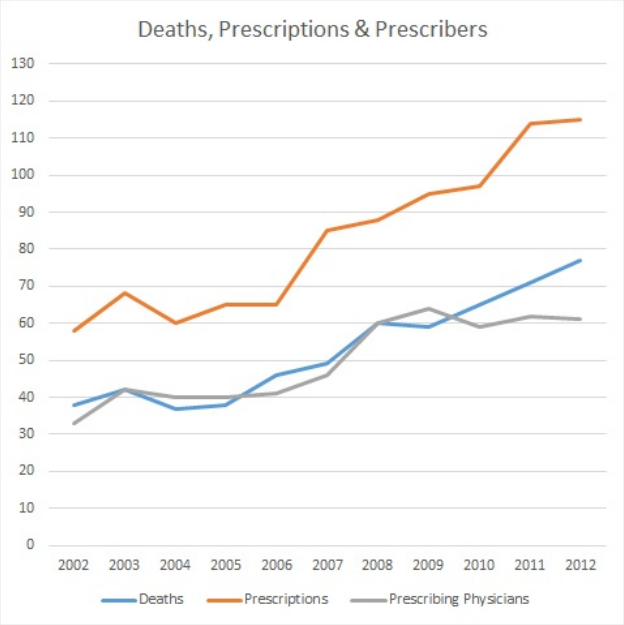
A3. Oregon

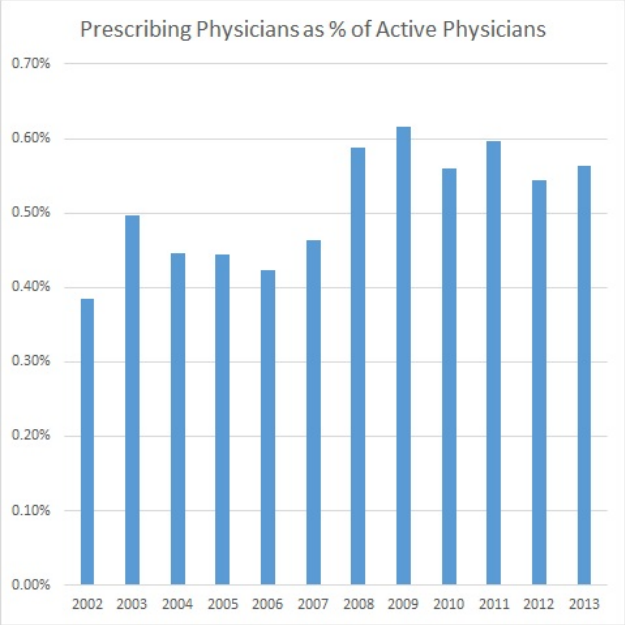
Death With Dignity Act: Physician Prescribers

Physician assisted suicide was legalized in Oregon in 1997.

Year	Deaths	Prescriptions	Prescribing Physicians	Active MDs	% of Active MDs
2002	38	58	33	8596	0.38%
2003	42	68	42	8469	0.50%
2004	37	60	40	8986	0.45%
2005	38	65	40	8997	0.44%
2006	46	65	41	9691	0.42%
2007	49	85	46	9915	0.46%
2008	60	88	60	10211	0.59%
2009	59	95	64	10389	0.62%
2010	65	97	59	10546	0.56%
2011	71	114	62	10389	0.60%
2012	77	115	61	11203	0.54%
2013	71	122	62	11005	0.56%

Sources: Oregon Public Health Division, 2013 Death with Dignity Act Report: Prescription History; Oregon Medical Board Reports.





A4. Washington State

Death With Dignity Act: Physician Prescribers, Pharmacist Dispensers

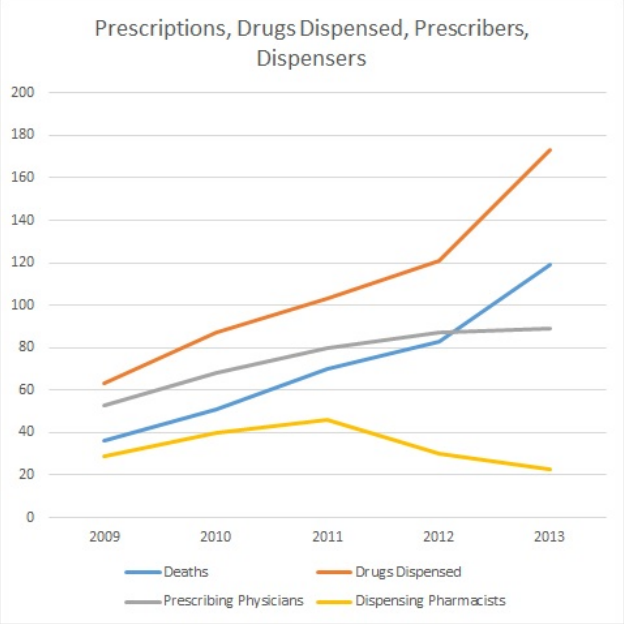
Physician assisted suicide was legalized in the state of Washington in 2009.

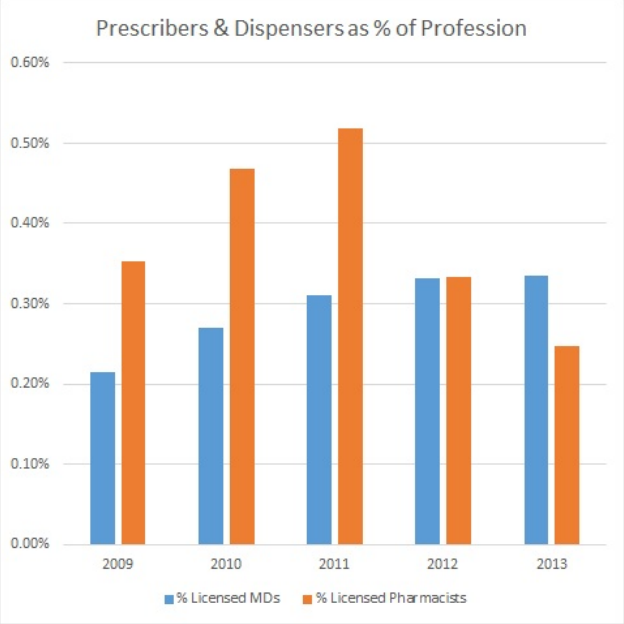
Year	Deaths	A	B	C	D	E	% Licensed MDs	%Licensed Pharmacists
2009	36	63	53	29	24670	8216	0.21%	0.35%
2010	51	87	68	40	25135	8556	0.27%	0.47%
2011	70	103	80	46	25783	8861	0.31%	0.52%
2012	83	121	87	30	26167	8983	0.33%	0.33%
2013	119	173	89	23	26536	9289	0.34%	0.25%

A: Drugs Dispensed | B: Prescribing Physicians | C: Dispensing Pharmacists |

D: Licensed Mds | E: Licensed Pharmacists

Sources: Washington State Department of Health, Death With dignity Act Reports; Washington State Department of Health, Health Systems Quality Assurance, Health Professions Discipline and Regulatory Activities (2009-2011 Biennial Report); Washington State Department of Health, Health Systems Quality Assurance Division, 2011-2013 Uniform Disciplinary Act Biennial Report.





Notes

1. Bill 52, *An Act respecting end-of-life care.* (http://www.consciencelaws.org/background/procedures/assist009-041.aspx) Hereinafter "ARELC."

2. *Lee Carter, et al. v. Attorney General of Canada, et al.* Supreme Court of Canada, Case 35591. (http://www.scc-csc.gc.ca/case-dossier/info/sum-som-eng.aspx?cas=35591) Accessed 2014-11-24

3. "The party must be of years of discretion, and in his senses, else it is no crime. But this excuse ought not to be strained to that length, to which our coroner's juries are apt to carry it, viz. that the very act of suicide is an evidence of insanity; as if every man, who acts contrary to reason, had no reason at all: for the same argument would prove every other criminal non compos, as well as the self-murderer. The law very rationally judges that every melancholy or hypochondriac fit does not deprive a man of the capacity of discerning right from wrong; which is necessary, as was observed in a former chapter, to form a legal excuse." Blackstone, William, *Commentaries on the Laws of England* (12th ed), Vol. IV. London: A. Strahan and W. Woodfall, 1795, p. 188-189.

4. *Carter v. Canada (Attorney General)* 2012 BCSC 886. Supreme Court of British Columbia, 15 June, 2012. Vancouver, British Columbia. (Hereinafter "*Carter v. Canada*") para. 339 (http://www.courts.gov.bc.ca/jdb-txt/SC/12/08/2012BCSC0886cor1.htm) Accessed 2014-11-24. The qualifications "rationally and morally"are implicit in the reasoning but not stated. The judge uses the term "ethical," not "moral," and more frequently employs the former, but she treats them as synonyms when addressing the question, "Does the law attempt to uphold a conception of morality inconsistent with the consensus in Canadian society?" (para. 340-358) Moreover, witnesses on both sides do not typically distinguish between ethical and moral issues. See, for example, Dr. Shoichet (plaintiffs) at para. 75, Prof. Sumner (plaintiffs) at para. 237, Dr. Bereza (defendants) at para. 248, Dr. Preston (plaintiffs) at para. 262. The judge defines ethics as "a discipline consisting of rational inquiry into questions of right and wrong" and frames the question accordingly: " whether it is right, or wrong, to assist persons who request assistance in ending their lives and, if it is right to do so, in what circumstances." *Carter v. Canada*, para. 164. Most would see in this passage no way to distinguish between ethics and moral philosophy.

5. Murphy S. "Legalizing therapeutic homicide and assisted suicide: A tour of *Carter v. Canada*."- VI.1- Finding of "discrimination." *Protection of Conscience Project.* (http://www.consciencelaws.org/law/commentary/legal073-001.aspx#VI.1_Finding_of_discrimination)

6. *Carter v. Canada*, para. 16, 926, 1116, 1126, 1166, 1184-1185, 1187-1188, 1190, 1199, 1348, 1362

7. *Carter v. Canada*, para. 1172, 1348

8. For example, *Carter v. Canada*, para. 653, 815

9. *Carter v. Canada*, para. 1240

10. *Carter v. Canada*, para. 1243, 1283

11. CBC Radio, *Cross Country Checkup*, 24 June, 2012. (http://podcast.cbc.ca/mp3/podcasts/checkup_20120624_66105.mp3/) Accessed 2012-06-28

12. Section 4 of ARELC states that eligible patients have a right to "end-of life-care," which includes euthanasia and palliative care. (https://www.canlii.org/en/qc/laws/stat/rsq-c-s-32.0001/latest/rsq-c-s-32.0001.html)

13. *In the BCSC, Amended Notice of Civil Claim*, Part 1, para. 64(c), Part 3, para. 5-7, 9-11 (http://www.consciencelaws.org/archive/documents/carter/2011-08-15-noticeofclaim02.pdf); *In the SCC on appeal from the BCCA, Factum of the Appellants*, para. 4, 123, 162-164, 182(e).(http://bccla.org/wp-content/uploads/2012/12/2014-05-13-Appellants-Factum.pdf) Accessed 2014-10-14

14. Kirkey S. "Doctor-assisted death appropriate only after all other choices exhausted, CMA president says." *canada.com*, 26 August, 2014 (http://o.canada.com/news/national/doctor-assisted-death-appropriate-only-after-all-other-choices-exhausted-cma-president-says) Accessed 2014-10-06.

15. Beauchamp TL, Childress JF, *Principles of Biomedical Ethics* (7th ed.) New York: Oxford University Press, 2013, p. 176

16. Moore, O. "Former Canadian army officer accused of murder speaks out." *Globe and Mail*, 4 September, 2012. (http://www.theglobeandmail.com/news/national/former-canadian-army-officer-accused-of-murder-speaks-out/article4518314/) Accessed 2014-08-14.

17. Blackstone, W. *Commentaries on the Laws of England* (12th ed.), Vol. 4. London: Strahan & Woodfall, 1795, p. 405. Citing 2 Hal. P.C. 412, 2 Hawk. P.C. 463

18. ARELC, section 30 (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#030)

19. Ann Furedi the chief executive of the British Pregnancy Advisory Service, told New Zealanders that abortion is required as a part of family planning programmes because contraception is not always effective. She noted that abortion rates do not drop when more effective means of contraception are available because women are no longer willing to tolerate the consequences of contraceptive failure. *Abortion a necessary option: advocate*. 18 October, 2010, TVNZ. (http://tvnz.co.nz/health-news/abortion-necessary-option-advocate-3839309) Accessed 2014-02-15. Over twenty years ago, the U.S. Supreme Court stated that "for two

decades of economic and social developments, people have organized intimate relationships and made choices that define their views of themselves and their places in society, in reliance on the availability of abortion in the event that contraception should fail. The ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives." *Planned Parenthood of Southeastern Pa. v. Casey* - 505 U.S. 833 (1992), p. 856 (http://supreme.justia.com/cases/federal/us/505/833/case.html) Accessed 2014-02-15.

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21. *Carter v. Canada*, para. 311. (http://www.consciencelaws.org/archive/documents/carter/2012-06-15-Carter-v-canada.pdf)

22. In the SCC on appeal from the BCCA, *Appellants' Response to Motions to Intervene*, 20 June, 2014, para. 5(c) (http://www.consciencelaws.org/archive/documents/carter/2014-06-20-response-to-interventions.pdf)

23. Murphy S. "Re: Joint intervention in Carter v. Canada-Selections from oral submissions." Supreme Court of Canada, 15 October, 2014. Joseph Arvay, Q.C. (Counsel for the Appellants). *Protection of Conscience Project.* (http://consciencelaws.org/law/commentary/legal073-009.aspx#Joseph_Arvay)

24. Murphy S. "Re: Joint intervention in Carter v. Canada-Selections from oral submissions." Supreme Court of Canada, 15 October, 2014. Jean-Yves Bernard (Counsel for the Attorney General of Quebec) *Protection of Conscience Project.* (http://www.consciencelaws.org/law/commentary/legal073-009.aspx#Jean-Yves_Bernard)

25. *Consultations*, Wednesday, 25 September 2013 - Vol. 43 no. 38: Quebec Association for the Right to Die with Dignity (Hélène Bolduc, Dr. Marcel Boisvert, Dr. Georges L'Espérance), T#107 (http://www.consciencelaws.org/background/procedures/assist009-018.aspx#107)

26. In the SCC on appeal from the BCCA, *Factum of the Intervener, The Canadian Medical Association*, para. 3 (http://www.consciencelaws.org/archive/documents/carter/2014-08-27-cma-factum.pdf)

27. In the SCC on appeal from the BCCA, *Factum of the Intervener, The Canadian Medical Association*, para. 28 (http://www.consciencelaws.org./archive/documents/carter/2014-08-27-cma-factum.pdf)

28. In the SCC on appeal from the BCCA, *Factum of the Intervener, The Canadian Medical Association*, para. 27 (http://www.consciencelaws.org./archive/documents/carter/2014-08-27-cma-factum.pdf)

29. In the SCC on appeal from the BCCA, *Factum of the Appellants* (13 May, 2014) para. 4, 123, 162-164 (http://bccla.org/wp-content/uploads/2012/12/2014-05-13-Appellants-Factum.pdf) Accessed 2014-10-14

30. In the BCSC, *Amended Notice of Civil Claim*, Part 1, para. 55, 64(c); Part 3, para. 9-11, 18. (http://www.consciencelaws.org/archive/documents/carter/2011-08-15-noticeofclaim02.pdf)

31. *Carter v. Canada*, para. 239-240. Others have made the same claim: see Angell M., Lowenstein E. "Letter re: Redefining Physicians' Role in Assisted Dying." *N Engl J Med* 2013; 368:485-486 January 31, 2013 DOI: 10.1056/NEJMc1209798 (http://www.nejm.org/doi/full/10.1056/NEJMc1209798) Accessed 2014-11-25.

32. *Carter v. Canada*, para. 120-130

33. Schuklenk U, van Delden J.J.M, Downie J, McLean S, Upshur R, Weinstock D. *Report of the Royal Society of Canada Expert Panel on End-of-Life Decision Makin*g (November, 2011) p. 70
(http://rsc-src.ca/sites/default/files/pdf/RSCEndofLifeReport2011_EN_Formatted_FINAL.pdf) Accessed 2014-02-23.

34. *Carter v. Canada*, para. 124

35. *Consultations*, Tuesday 17 September 2013 - Vol. 43 no. 34: Collège des médecins du Québec, (Dr. Charles Bernard, Dr. Yves Robert, Dr. Michelle Marchand) T#154 (http://www.consciencelaws.org/background/procedures/assist009-001.aspx#154)

36. Collège des médecins du Québec, *Code of Ethics of Physicians*, para. 24 (http://www.cmq.org/en/Public/Profil/Commun/AProposOrdre/\u126 ~/media/Files/ReglementsANG/cmqcodedeontoan.ashx?61323) (Accessed 2013-06-23)

37. ARELC, Section 50, (http://www.consciencelaws.org/background/procedures/assist009-041.aspx)

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(http://consciencelaws.org/law/commentary/legal073-009.aspx#Robert_W._Staley)

39. In the SCC on appeal from the BCCA, *Factum of the Intervener, The Canadian Medical Association*, para. 27
(http://www.consciencelaws.org./archive/documents/carter/2014-08-27-cma-factum.pdf)

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(http://www.consciencelaws.org./archive/documents/carter/2014-08-27-cma-factum.pdf)

41. Canadian Medical Association, *Reports to the General Council*. CMA 147th Annual General Meeting, August 17-20, 2014.
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(http://consciencelaws.org/archive/documents/carter/2014-08-27-cma-schedule-a.pdf)

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Accessed 2014-11-20

44. Belgium: "At the request of the patient or the person taken in confidence, the physician who refuses to perform euthanasia must communicate the patient's medical record to the physician designated by the patient or person taken in confidence."
(http://www.consciencelaws.org/law/laws/belgium.aspx)

Luxembourg: A physician who refuses to comply with a request for euthanasia or assisted suicide is required, at the request of the patient or support person, to communicate the patient's medical record to the doctor appointed by him or by the support person.
(http://www.consciencelaws.org/law/laws/luxembourg.aspx)

Washington: If a health care provider is unable or unwilling to carry out a patient's request under this chapter, and the patient transfers his or her care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the patient's relevant medical records to the new health care provider. (http://www.consciencelaws.org/law/laws/usa-washington.aspx)

Oregon: If a health care provider is unable or unwilling to carry out a patient's request under ORS 127.800 to 127.897, and the patient transfers his or her care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the patient's relevant medical records to the new health care provider.
(http://www.consciencelaws.org/law/laws/usa-oregon.aspx)

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(http://www.consciencelaws.org/law/commentary/legal073-009.aspx#Harry_Underwood)

46. Murphy S. "NO MORE CHRISTIAN DOCTORS." *Protection of Conscience Project*, March, 2014 (http://www.consciencelaws.org/background/procedures/birth002.aspx)

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nguage=E&p_session_id=2018158) Accessed 2014-11-25