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Submission to the College of Physicians and Surgeons of Alberta

Re: *Informed Consent (Draft)*

28 October, 2015

Abstract

The Project finds the proposed policy on conscientious objection generally satisfactory. Pursuant to *Moral or Religious Beliefs Affecting Medical Care,* it distinguishes between providing information (required) and facilitating access to morally contested procedure (not required). This preserves physician freedom of conscience and religion without interfering with patient access to services. The wisdom of this approach has become particularly obvious since the *Carter* ruling.

It is also clear that refusal according to the terms of the policy does not constitute abandonment, which is entirely satisfactory. The policy prudently puts physicians in the position of responding to patient requests for euthanasia or assisted suicide rather than requiring the procedures to be presented as options.

The claim that the provision of euthanasia and assisted suicide is a *Charter* right is excessive. The ruling provides physicians with an exemption from prosecution for murder and assisted suicide in the specific circumstances contemplated in the judgement. It does not require the state or "the medical profession as a whole" to provide these services.

The policy limits the role of physicians to establishing the existence of an irremediable medical condition, leaving the patient to decide all questions related to the existence and nature of suffering. It envisages the provision of euthanasia and assisted suicide address suffering caused by "depression" or a "psychiatric or psychological disorder." These provisions illustrate the importance of particularly robust protection of conscience policies and laws.

This submission makes recommendations concerning three issues not addressed by the policy that have implications for physician freedom of conscience.

The first is the possibility of failed euthanasia/assisted suicide attempts that incapacitate a patient. This also raises questions about a physician's contractual responsibility and criminal liability with respect to killing an incompetent patient.

The second is the possibility that unexpected deterioration in a patient's condition may occur before a scheduled euthanasia or assisted suicide procedure. In the absence of the responsible physician, this may precipitate demands that objecting physicians or health care workers kill the patient.

The third is the possibility of discrimination against medical school applicants, medical students and physicians who refuse to provide or facilitate euthanasia for reasons of conscience.

In addition, this submission recommends that demeaning statements directed at objecting physicians should be deleted or moved to the general section on informed consent and made applicable to all physicians in all circumstances. In addition, the terms "legally permissible" and "publicly-funded" should be deleted because they are gratuitous as well as misleading.

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I. Introduction

I.1 The Protection of Conscience Project is a non-profit, non-denominational initiative that advocates for freedom of conscience among health care workers. It does not take a position on the acceptability of morally contested procedures. Comments and recommendations concerning the draft standard of practice Informed Consent (including Appendix "A" - The Special Case of Physician Assisted Dying) are limited to issues directly or indirectly related to the protection of physician freedom of conscience.

II. Outline of this submission

II.1 The Project finds the proposed policy on conscientious objection generally satisfactory, while taking issue with demeaning statements directed at objecting physicians (Part III).

II.2 The Project takes issue with the claim of rights advanced in the document and its references to public funding (Part IV).

II.3 Observations are made concerning the document's treatment of the *Carter* criterion of suffering, and the inclusion of chronic depression as grounds for euthanasia and assisted suicide (Part V).

II.4 Observations are also made with respect to the practical and possible legal consequences of failed euthanasia/assisted suicide procedures (Part VI).

II.5 The need to take additional steps to ensure freedom of conscience for objecting physicians and health care workers in urgent situations is discussed in Part VII.

II.6 A number of recommendations are made concerning the obligations of physicians who provide euthanasia and assisted suicide (Part VIII). The recommendations are intended to minimize the likelihood of conflicts of conscience among other physicians and health care workers.

III. Conscientious objection

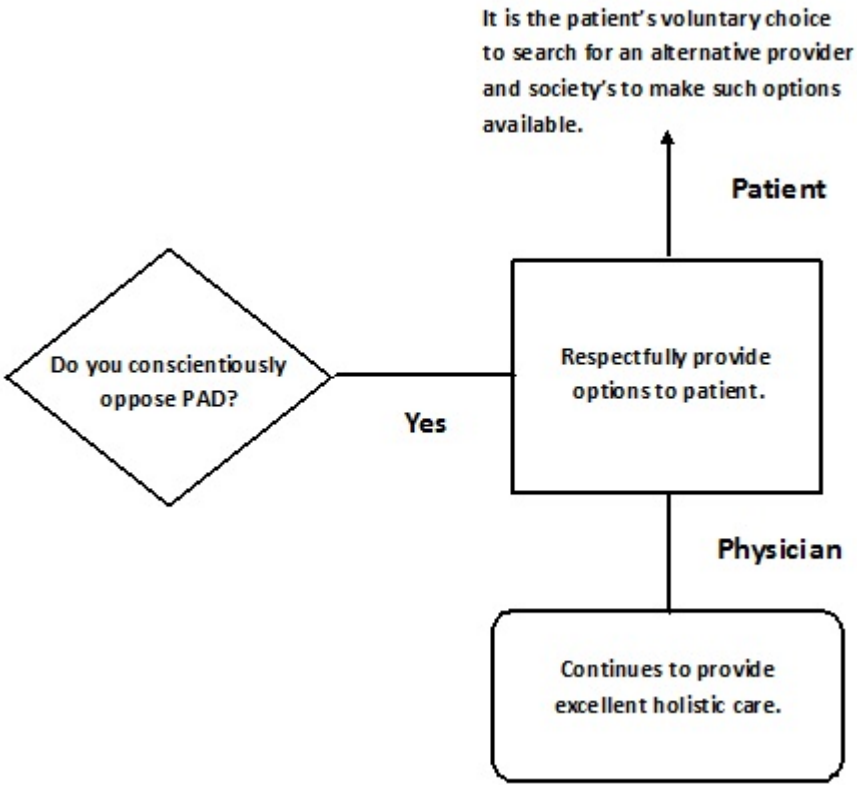
III.1 From the Project perspective, the critical parts of the policy are the following statements, numbered here for ease of reference in this submission:

> 1) Physicians may decline to provide PAD if doing so would violate their freedom of conscience, as per the CPSA standard of practice *Moral or Religious Beliefs Affecting Medical Care*.
>
> 2) The physician is expected to provide sufficient information and resources to enable the patient to make his/her own informed choice and access all options for

care, even if providing such information conflicts with the physician's deeply held and considered moral or religious beliefs.

3) This means arranging timely access to another physician or resource or offering the patient information and advice about all medical options available.

III.2 These statements are supplemented by a decision flow chart:



III.3 Statement (1): *Moral or Religious Beliefs Affecting Medical Care*

III.3.1 The reference to *Moral or Religious Beliefs Affecting Medical Care* in statement (1) is important. The key provision in that document states:

> When moral or religious beliefs prevent a physician from providing or offering access to information about a legally available medical or surgical treatment or service, that physician must ensure that the patient who seeks such advice or medical care is offered timely access to another physician or resource that will provide accurate information about all available medical options.[1]

III.3.2 This document originated in the revision of CPSA *Standards of Practice* in 2008. The

original draft *Standards* included a section concerning the termination of pregnancy. The Registrar of the College stated:

> Most respondents take exception with the draft, believing that the College will require physicians to refer patients for termination of pregnancy, or at the very least to be compliant in arranging a patient's abortion, contrary to the physician's personal beliefs. This is not true. . . .
>
> . . . The College's current policy (in place for the past decade) states:
>
> > While recognizing the varied personal convictions of physicians it must still be the responsibility of physicians to ensure that pregnant women who come to them for medical care are provided with or are offered access to information or assistance to enable them to make informed decisions on all available options for their pregnancies including termination.
>
> The points I wish to make are these: A Standard of Practice on this subject will not change the obligations of physicians that have been accepted by this College since 1991. The words are a little different, but the intent is not, as the principles underlying the standard have not changed over the past 20 years. (Emphasis in the original)[2]

III.3.3 The section concerning termination of pregnancy was deleted from the final version of the *Standards* and the policy *Moral or Religious Beliefs Affecting Medical Care* adopted. The development and wording of the policy make clear that it is intended to ensure that a patient has all of the information necessary to make an informed decision about treatment options. It does not imply that objecting physicians have a duty to facilitate morally contested procedures like abortion or contraception by referral or other means.

III.3.4 *Moral or Religious Beliefs Affecting Medical Care* effectively distinguishes between providing information necessary for medical decision-making (required) and facilitating access to morally contested procedure (not required). This preserves physician freedom of conscience and religion, but it does not interfere with patient access to services. This is demonstrated by the fact that there is no evidence that anyone in the province of Alberta has ever been unable to access health care as a result of conscientious objection by a physician.

III.3.5 The wisdom of the approach taken in *Moral or Religious Beliefs Affecting Medical Care* has become particularly obvious since the *Carter* ruling.

III.4 Statement (2): Providing information

III.4.1 In the Project's experience, physicians who object to a procedure or service do not

normally object to providing the kind of information required in statement (2), particularly in response to a patient request.

III.4.2 The draft policy does not impose a requirement that physicians offer patients the options of euthanasia or assisted suicide. This is prudent, for two reasons.

III.4.3 First: even physicians willing to provide or refer for the procedures might sometimes consider it harmful or even abusive to offer them as "options": the case of a patient just blinded or paralysed by an industrial accident comes to mind.

III.4.4 Second: the *Carter* decision did not strike down the law against counselling suicide [241(a) *Criminal Code*], so the gratuitous suggestion of physician assisted suicide even to patient who meets the *Carter* criteria may expose physicians to criminal prosecution.

III.5 Statement (3): Arranging access OR offering information

III.5.1 The options offered in statement (3), supplemented by the explanatory flow chart, are consistent with the approach taken in *Moral or Religious Beliefs Affecting Medical Care.* Physicians who object to euthanasia or assisted suicide for reasons of conscience are obliged to facilitate the exercise of informed medical decision making, but they are not obliged to facilitate the procedures. This is entirely satisfactory.

III.6 Abandonment

III.6.1 The draft document states that a physician who declines to provide euthanasia or assisted suicide for reasons of conscience "must not abandon a patient who makes this request." Activists often attempt to coerce physicians who refuse to provide or facilitate a service or treatment for reasons of conscience by accusing them of patient abandonment. However, it is clear that refusal according to the terms of the policy does not constitute abandonment. This is entirely satisfactory.

III.7 Demeaning statements

III.7.1 The draft document states that a physician who declines to provide euthanasia or assisted suicide for reasons of conscience must "treat the patient with dignity and respect." This is a salutary reminder, but the draft document goes further:

> Physicians must not provide false, misleading, intentionally confusing, coercive or materially incomplete information, and the physician's communication and behaviour must not be demeaning to the patient or to the patient's beliefs, lifestyle choices or values.

III.7.2 This additional paragraph implies that physicians who act in accordance with their moral convictions by refusing to do something they believe to be wrong are likely to lie or

deceive patients or denigrate them. The statement arguably demeans such physicians or their beliefs, lifestyle choices or values.

III.7.3 The tone of the paragraph reflects its origin. It has been taken almost *verbatim*, without attribution, from a proposed policy drafted by the Conscience Research Group (CRG).[3] This group intends to compel physicians and other health care workers to do what they believe to be wrong, such as facilitating euthanasia. Most of the principles enunciated in the draft document have also been copied from the CRG's proposed policy. One of the authors of the CRG's proposed policy, Professor Jocelyn Downie, is a member of the Provincial/Territorial Expert Advisory Group on Physician-Assisted Dying.

III.7.4 If College Council believes, nonetheless, that the paragraph is appropriate, it should be moved to the general section on informed consent and applied to *all* physicians with respect to *all* consent discussions with patients about *all* procedures, since *all* physicians act in accordance with their moral convictions, including those who *provide* morally contested procedures. Its presence in the section on conscientious objection gives the appearance of unacceptable prejudice, particularly against religious believers.

III.7.5 Even if the paragraph is moved to the general section on informed consent, some caveats are in order.

III.7.6 Objecting physicians or health care workers who are explaining their own position to patients may make statements to the effect that they do not consider euthanasia and assisted suicide to be forms of medical treatment or palliative care. In the course of such conversations, they may also ethically distinguish between withdrawal/refusal of treatment and killing patients or helping them to kill themselves. Euthanasia/assisted suicide activists may take exception to statements or explanations of this kind, calling them "false, misleading, intentionally confusing, coercive." Such complaints must be dismissed as unacceptable attempts to suppress contrary views.

III.7.7 It is reasonable to believe that the communication of an objecting physician's position will cause patients to infer (correctly) the beliefs of the physician concerning euthanasia and assisted suicide. Patients may thus believe that the physician is 'demeaning' their "beliefs, lifestyle choices or values," even if the physician's views pertain to the morality of the procedures rather than the personal culpability of the patient. The policy should not be used to punish objecting physicians simply because a patient has been upset by the expression of views contrary to his own.

III.8 Discrimination against objecting physicians, medical school applicants and students

III.8.1 The policy does not address the issue of discrimination against medical school applicants, medical students and physicians who refuse to provide or facilitate euthanasia for reasons

of conscience.

IV. Rights claim, public funding

IV.1 Rights claim

IV.1.1 The draft document states that the *Carter* ruling "establishes physician-assisted death (PAD) as a *Charter* right."

IV.1.2 This claim is excessive. The ruling provides physicians with an exemption from prosecution for murder and assisted suicide in the specific circumstances contemplated in the judgement. It prevents the state from prohibiting assisted suicide or euthanasia in such circumstances, but it does not require the state or "the medical profession as a whole" to provide these services.

IV.1.3 The text of the ruling states, "nothing in the declaration of invalidity which we propose to issue would compel *physicians* to provide assistance in dying." (Emphasis added) The Court here referred to "physicians" (plural), not "a physician" (singular). This suggests that striking down the criminal prohibition did not, in the Court's view, create any obligation on the part of physicians (individually *or collectively*) to provide assisted suicide or euthanasia, although individuals or groups might undertake to do so voluntarily.

IV.1.4 Unlike the Supreme Court's 1988 *Morgentaler* decision, which struck down the abortion law entirely, the *Carter* decision did not invalidate murder and assisted suicide laws altogether, but only to the extent that the laws prevent homicide and assisted suicide by physicians in accordance with the guidelines laid down by the Court.

IV.1.5 Thus, a physician accused of failing to follow the *Carter* guidelines is still liable to be charged for murder or assisted suicide, just as, prior to 1969, physicians who provided an abortion under guidelines based on the case of *R. v. Bourne*[4] were liable to be charged if the abortion was not necessary to preserve the life of the mother.[5]

IV.2 "*legally permissible and publicly funded* health services"

IV.2.1 The principles concerning the College's advice on physician assisted suicide and euthanasia include the following:

> The medical profession as a whole has an obligation to ensure people have access to the *legally permissible* and *publicly-funded* health services. (Emphasis added)
>
> Physicians have an obligation not to interfere with or obstruct the public's access to *legally permissible* and *publicly-funded* health services. (Emphasis added)

IV.2.2 These statements were taken almost *verbatim*, without attribution, from the policy proposed by the CRG (III.7.3).[6]

IV.2.3 Neither individual physicians nor the medical profession as a whole have an obligation to ensure that people have access to *illegal* health services. Any actual obligation can refer only to *legal* services.

IV.2.4 Many kinds of elective surgery are *not* publicly funded. Diabetic supplies like insulin needles or pumps may not be publicly funded or may be publicly funded only after payment of an annual deductible. The fact that a health service is or is not "publicly-funded" has nothing to do with whether or not individual physicians or the medical profession as a whole have an obligation to ensure that people have access to it.

IV.2.5 Physicians may not interfere with or obstruct a patient's right to access legally permissible services *whether or not* they are health services and *whether or not* they are publicly funded.

IV.2.6 "Public funding" provides a benefit for a patient, but it confers no privileged status on a procedure, nor does "public funding" establish definitively that a procedure is morally or ethically acceptable, any more than "public funding" can establish that a war is justified.

IV.2.7 The descriptors "legally permissible" and "publicly-funded" are intended in the CRG policy to provide a rhetorical pretext for the suppression of freedom of conscience. Since the College's draft document is not intended to suppress freedom of conscience, the terms "legally permissible" and "publicly-funded" should be deleted because they are gratuitous as well as misleading.

V. Suffering, chronic depression and euthanasia/assisted suicide

V.1 Suffering

V.1.1 One of the requirements for exemption from criminal prosecution under the terms of the *Carter* ruling is that the patient be experiencing "suffering that is intolerable to the individual."

V.1.2 "Intolerable suffering" is an entirely subjective phenomenon. With respect to those opposed to assisted suicide and euthanasia, Joseph Arvay, counsel for the appellants, told the Supreme Court of Canada that "it is wrong, indeed, it is arrogant . . . to impose their views of what suffering is acceptable and tolerable for others, because suffering is a very personal, subjective and contextual concept."

> For some, the suffering will be purely physical, as a result of their medical condition. For others, it will be a combination of physical, psychological,

psychosocial, which may be a function of both their medical condition and their own sense of what it means to lead a dignified life.[7]

V.1.3 In view of this and the text of the ruling, it was to be expected that evaluation of suffering would be problematic, and that establishing the *de facto* existence of intolerable suffering as a legal criterion for providing assisted suicide and euthanasia would ultimately prove to be impossible. This may be why the policy limits the role of physicians to establishing the existence of an irremediable medical condition, leaving the patient to decide all questions related to the existence and nature of suffering.

V.1.4 In doing so, however, the policy sets one of the legal criteria that physicians must ensure are met outside the purview of physicians, despite the fact that the Supreme Court made the existence of intolerable suffering one of the criterion that must be met to qualify for exemption from prosecution for murder and assisted suicide.

V.1.5 It would thus not be unreasonable for physicians to insist that they must somehow be satisfied that a patient is experiencing intolerable suffering, particularly since, if a physician were charged for murder, the patient would not be available to testify. This applies equally to physicians who object to the procedures and those who do not. How this might be consistently done is an open question.

V.2 Euthanasia/assisted suicide for chronic depression, psychiatric or psychological disorders

V.2.1 The policy envisages the provision of euthanasia and assisted suicide to put an end to suffering caused by "depression" or a "psychiatric or psychological disorder," on the condition that physicians establish that the depression or disorder is not "causing" impaired judgement.

V.2.2 This is consistent with an exchange between Mr. Justice Lebel and Mr. Arvay during the Supreme Court hearing emphasized that "suffering" could be either physical or psychological:

> Lebel: And your test is, essentially, about someone who is undergoing intense suffering . . .
>
> Arvay: Yes.
>
> Lebel: Psychological or physical. . .
>
> Arvay: Yes. And there is no dispute in the record, by the way. Dr. Chochinov, who was one of Canada's main witnesses, was very strong about how horrible psychological suffering is and equal to if not exceeds physical suffering.[8]

V.2.3 The policy permits euthanasia and assisted suicide in such cases if an "additional assessment" confirms that "the illness itself does not impair the patient's ability to make and informed and reasoned decision." Thus, the College appears to have adopted the position laid before the Supreme Court by Sheila Tucker, the appellants' co-counsel, who stated that the evidence indicated that someone who has "major depressive disorder" (clinical depression) can "still be competent as a medical decision maker."

> What the further question was, if you are to make the further judgement about whether or not, even though you're competent, the major depressive disorder is influencing your decision about wanting to end your life, that that's a very fine judgement. And so, the recommended answer to her from the witness, and which she agreed with, was, it's too fine of a judgement. Simply exclude people who are *actively* suffering from major depressive disorder. . . because you cannot rely on their decision. . . But that's a very high threshold . . . of major depressive disorder, and she also said, because it's expressed in the context of *actively* suffering. She said such people should be treated, with a course of medication for major depressive disorder, and if they could recover enough to reliably make the decision because they weren't *actively* suffering it to the same degree, then they should be allowed to make the decision.[9]

V.2.4 On the other hand, the Court remarked, in passing, that the parameters they would propose would not apply to "persons with psychiatric disorders." (para. 111) The parameters actually laid out do not explicitly exclude mental illness, so, on this point, the ruling is ambiguous. It appears from the text of the draft policy that the College has elected to resolve the ambiguity in favour of providing euthanasia and assisted suicide for the mentally ill.

V.2.5 However, the broader the criteria for assisted suicide and euthanasia, the greater the likelihood of conflicts of conscience among physicians and health care workers. Killing patients or helping them commit suicide because they are suffering from depression or psychiatric or psychological disorders is particularly contentious. Among physicians responding to a Canadian Medical Association survey after the Carter ruling, while 29% indicated that they were willing to "consider" providing either assisted suicide or euthanasia (the question did not distinguish between them), the number dropped to about 6% when the reason for doing so was "purely psychological suffering."[10]

V.3 Summary

V.3.1 The policy provisions concerning suffering and euthanasia and assisted suicide for depression or psychological or psychiatric disorders underscores the importance of maintaining robust protection of conscience policies and laws for physicians and other

health care workers.

VI. Failed assisted suicide and euthanasia

VI.1 Introduction

VI.1.1 According to the draft, the patient must be informed of the "risks of taking the prescribed medication" and the "probable outcome/result of taking the medication." It is not clear that this includes discussion about the possibility that the drugs may not kill the patient.

VI.1.2 Euthanasia and assisted suicide drugs do not always cause death as expected.[11] It is for this reason that Quebec euthanasia kits are to include two courses of medication.[12]

VI.1.3 Discussion with patients should include discussion of options available in the event that a lethal injection or prescribed drug does not kill the patient, and the patient should be asked to provide direction on this point.

VI.1.4 As will be seen presently, this issue has implications for the advice given in the draft document concerning "ongoing capacity," and it also appears to have legal implications with respect to a physician's criminal responsibility and is related to protection of physician freedom of conscience.

VI.2 Willingness of physicians to provide assisted suicide vs. euthanasia

VI.2.1 A 2014 survey of Canadian Medical Association members indicated that more physicians were willing to participate in assisted suicide (27%) than euthanasia (20%).[13,14,15,16,]

VI.2.2 However, a physician who agrees to help a patient commit suicide would seem to have accepted an obligation to do something that will result in the patient's death, and to do it according to accepted standards. This obligation seems implicit in the agreement.

VI.2.3 In the case of a failed physician-assisted suicide that incapacitates a patient, it is likely that the responsible physician will be expected to fulfil his commitment to help bring about the death of the patient by providing a lethal injection or finding someone willing to do so. The expectation would be stronger if the patient had sought assisted suicide to avoid the kind of incapacitation caused by the failed suicide attempt.

VI.2.4 Here the issue of physicians willing to assist in suicide but unwilling to provide euthanasia becomes acute. Those willing to assist with suicide but not euthanasia may be reluctant or unwilling to ask another colleague to kill the patient. Moreover, the *Carter* ruling limits the provision of euthanasia to competent patients. Thus, to ask physicians to kill a patient who has been rendered incompetent by a colleague's failed attempt would seem to expose them to prosecution for first degree murder or, at least, assisted suicide.

VI.2.5 In addition, the draft document appears to rule out euthanasia if a patient is incapacitated but not killed by an assisted suicide or euthanasia attempt.

> **9. Ongoing capacity**
>
> A patient must maintain mental capacity for PAD to proceed. If at any time during the progression of the patient's condition, the patient loses the mental capacity to rescind his/her decision, PAD ceases to be an option.

VII. Urgent situations

VII.1 Some authorities have stated that a physician's obligation to provide treatment urgently needed to prevent imminent harm to patients does not extend to providing assisted suicide or euthanasia.[17] This presumes that, since the procedures require extensive preliminary consultation and preparation before they can be authorized, they can never be urgently required. The silence of the draft document on this point suggests a similar presumption in Alberta.

VII.2 That presumption is challenged by testimony taken by the Quebec legislative committee studying what later became the province's euthanasia law (*An Act Respecting End of Life Care*). Representatives of the College of Pharmacists of Quebec agreed that the provision of euthanasia would not seem to involve "the same urgency" as other kinds of procedures, and that arrangements could normally be made to accommodate conscientious objection by pharmacists because the decision could be anticipated.[18] However, they also stated that situations may evolve more quickly than expected, and that (for example) palliative sedation might be urgently requested as a result of respiratory distress precipitated by sudden bleeding.[19]

VII.3 The pharmacist representatives distinguished between making a decision that euthanasia or assisted suicide should be provided - a decision which might take days or weeks - and a decision that a drug should be urgently provided to deal with an unanticipated and critical development in a patient's condition.[20]

VII.4 Under the terms of the *Carter* ruling and the draft document, it is possible that a responsible physician might agree to provide euthanasia or assisted suicide on a given date and time, to accommodate (for example) the desire of geographically distant family members to be present at the patient's death. Between the time that decision is made and the appointed time, however, a sudden deterioration of the patient's condition may cause him to ask for immediate relief from pain or suffering by euthanasia or assisted suicide.

VII.5 No problem will arise if the responsible physician is immediately available to fulfil the request. However, there is likely to be a problem if the responsible physician is absent or

unavailable, and other physicians willing to kill the patient or assist in suicide cannot be conveniently found. This situation is more likely to arise if the originally appointed time for euthanasia/assisted suicide is some days later than the decision to provide the procedure.

VIII. Recommendations

VIII.1 The section of the policy dealing with conscientious objection is satisfactory with respect to the expectation that objecting physicians will provide patients with sufficient information to permit informed medical decision making, while making it clear that they are not obliged to facilitate euthanasia or assisted suicide. It does not, however, address the issue of discrimination against medical school applicants, medical students and physicians who refuse to provide or facilitate euthanasia for reasons of conscience.

VIII.2 The issues raised in Parts IV and V suggest that it is important to ensure robust protection of conscience provisions in policy and law.

VIII.3 Part VI and VII demonstrate a need to include in the policy some additional guidance in order to avoid conflicts of conscience and concerns about criminal responsibility in particularly difficult circumstances, and to avoid conflicts of conscience among health care workers who may be involved in other aspects of the care or treatment of a patient.

VIII.4 The following recommendations address these concerns. To avoid ambiguity, the term "responsible physician" is used in this part to mean a physician who has agreed to assist with the patient's suicide or provide euthanasia, distinct from (for example) a family physician who has declined to do so, but who continues to be responsible for other aspects of patient care in accordance with section 14 of the draft document (Conscientious objection).

1) Discrimination

No discrimination should be directed against applicants for medical school or doctors who do not perform, assist with or facilitate euthanasia or assisted suicide. Respect for freedom of conscience in this area must be stressed, particularly for doctors training in general practice, palliative care and anesthesia.

2) Obligations of responsible physicians

a) Physicians should not undertake to provide assisted suicide unless they are also willing to provide euthanasia.

b) In all cases, the responsible physician should, as part of the informed consent discussion preliminary to decision making, advise the patient of the possibility

that the drugs might not cause death and discuss the options available.

c) Immediately prior to administering or providing the lethal medication, the responsible physician should obtain written direction from the patient as to what action should be taken if the prescribed or administered drugs fail to cause death. (NB. In the case of patients incapacitated by failed euthanasia/assisted suicide, it is not known if this would be legally sufficient to invoke the exemption from prosecution provided by *Carter*.)

d) The responsible physician should personally administer the lethal drug or be personally present when it is ingested, and remain with the patient until death ensues.

e) A responsible physician who has agreed to provide euthanasia or assisted suicide must be continuously available to do so from the time the agreement is made to the time that the procedure is performed, unless the patient withdraws the request.

f) A responsible physician who has agreed to provide euthanasia or assisted suicide must also arrange for a second responsible physician to provide the procedure in the event that he is unable to be continuously present or is unable to act.

g) The second responsible physician must be continuously available to act in the place of the primary responsible physician.

Notes

1. College of Physicians and Surgeons of Alberta, *Moral or Religious Beliefs Affecting Medical Care*. (http://www.cpsa.ca/standardspractice/moral-or-religious-beliefs-affecting-medical-care/) Accessed 2015-10-20.

2. "Registrar's Report: Draft standard for termination of pregnancy." *The Messenger*, April, 2009, p. 3 (http://www.cpsa.ab.ca/Libraries/Res_Messenger/M150.pdf) Accessed 2015-02-12

3. Compare: "Physicians must not provide false, misleading, intentionally confusing, coercive, or materially incomplete information to their patients" (College draft document) and ". . . physicians must not communicate or otherwise behave in a manner that is demeaning to the patient or to the patient's beliefs, lifestyle, choices, or values." (Downie J. McLeod C. Shaw J. "Moving Forward with a Clear Conscience: A Model Conscientious Objection Policy for Canadian Colleges of Physicians and Surgeons." *Health Law Review*, 21:3, 2013) (hereinafter "Downie *et al*") (http://carolynmcleod.com/wp-content/uploads/2014/05/04_Downie-McLeod-Shaw.pdf) Accessed 2015-02-24.

4. *R. v. Bourne* (1939) 1KB 687

5. This was one of the reasons offered by the Canadian Medical Association for its recommendation to legalize abortion. "'We don't like being lawbreakers,' Dr. Aitken told the committee in partial explanation of the C.M.A's motivation in supporting the move to expunge the *Criminal Code's* prohibition of abortion. Dr. Gray commented that while he knew of no doctor having been prosecuted for performing an abortion openly in a hospital, there was still the uncertainty about transgression of the law. Dr. Cannell reported there were 262 therapeutic abortions performed in Canadian hospitals between 1954 and 1965." Waring G. "Report from Ottawa." *CMAJ* Nov. 11, 1967, vol. 97, 1233

6. Compare: "The Canadian medical profession as a whole has an obligation to ensure that people have access to the provision of legally permissible and publicly funded health services" (College draft document) and "Physicians have an obligation not to interfere with or obstruct people's access to legally permissible and publicly funded health services." (Downie *et al*).

7. Supreme Court of Canada, 35591, Lee Carter, et al. v. Attorney General of Canada, et al.(British Columbia) (Civil) (By Leave) Webcast of the Hearing on 2014-10-15: *Oral submission of Joseph Arvay* (hereinafter "Arvay"), 76:17/491:20 to 77:13/491:20 (http://www.scc-csc.gc.ca/case-dossier/info/webcastview-webdiffusionvue-eng.aspx?cas=35591&urlen=http%3a%2f%2fwww4.insinc.com%2fibc%2fmp%2fmd%2fopen_protected%2fc%2f486%2f1938%2f201410150500wv150en%2c001&urlfr=http%3a%2f%2fwww4.insinc.com%2fibc%2fmp%2fmd%2fopen_protected%2fc%2f486%2f1940%2f201410150500wv150en%2c001&date=2014-10-15) Accessed 2015-10-28.

8. *Arvay*, 90:09/491:20 to 90:38/491:20

9. Supreme Court of Canada, 35591, Lee Carter, et al. v. Attorney General of Canada, et al.(British Columbia) (Civil) (By Leave) Webcast of the Hearing on 2014-10-15: *Oral submission of Sheila M. Tucker*, 144:35/491:20 to 145:59/491:20 (http://www.scc-csc.gc.ca/case-dossier/info/webcastview-webdiffusionvue-eng.aspx?cas=35591&urlen=http%3a%2f%2fwww4.insinc.com%2fibc%2fmp%2fmd%2fopen_protected%2fc%2f486%2f1938%2f201410150500wv150en%2c001&urlfr=http%3a%2f%2fwww4.insinc.com%2fibc%2fmp%2fmd%2fopen_protected%2fc%2f486%2f1940%2f201410150500wv150en%2c001&date=2014-10-15) Accessed 2015-10-28.

10. Canadian Medical Association Annual General Council 2015, *Education session 2: Setting the context for a principles-based approach to assisted dying in Canada*. Webcast-.15:23 - 15:39 (https://webcasts.welcome2theshow.com/cma2015/setting) (Accessed 2015-10-23)

11. Groenewoud JH, van der Heide A. Onwuteaka-Philipsen BD Willems DL van der Maas PJ, van der wal G., "Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands." *N Engl J Med* 2000; 342:551-556 February 24, 2000

12. Ubelacker S. "Quebec MDs to get euthanasia guide to prepare for legalized assisted death: Unclear whether other provinces and territories will adopt a similar practice."*The Canadian Press*, 1 September, 2015 (http://www.cbc.ca/news/canada/montreal/quebec-mds-to-get-euthanasia-guide-to-prepare-for-legalized-assisted-death-1.3212081) Accessed 2015-09-03.

13. Moore E. "Doctor is hoping feds will guide on assisted suicide legislation." *Edson Leader*, 12 February, 2015. (http://www.edsonleader.com/2015/02/12/doctor-is-hoping-feds-will-guide-on-assisted-suicide-legislation) Accessed 2015-07-16.

14. Rich, P. "Physician perspective on end-of-life issues fully aired." *Canadian Medical Association*, 19 August, 2014 (https://www.cma.ca/En/Pages/Physician-perspective-on-end-of-life-issues-fully-aired.aspx) Accessed 2015-06-22

15. Ubelacker S. "Medical professionals try to answer burning questions on doctor-assisted death." *Associated Press*, 13 February, 2015 (http://www.1310news.com/2015/02/13/medical-professionals-try-to-answer-burning-questions-on-doctor-assisted-death/) Accessed 2015-07-04

16. Kirkey S. "How far should a doctor go? MDs say they 'need clarity' on Supreme Court's assisted suicide ruling." *National Post*, 23 February, 2015 (http://news.nationalpost.com/news/canada/how-far-should-a-doctor-go-mds-say-they-need-clarity-on-supreme-courts-assisted-suicide-ruling) 2015-07-04

17. "A request for physician assisted death will not be considered an emergency in the context of this policy, and is therefore not a service or intervention that physicians will be required to provide, contrary to their conscience or religion." College of Physicians and Surgeons of Ontario, *Professional Obligations and Human Rights: Frequently Asked Questions*. (http://www.cpso.on.ca/CPSO/media/documents/Policies/Policy-Items/Human-Rights-FAQ.pdf?ext=.pdf) Accessed 2015-10-17

18. Consultations & hearings on Quebec Bill 52, *College of Pharmacists of Quebec: Dianne Lamarre, Manon Lambert*. Tuesday 17 September 2013 - Vol. 43 no. 34, T#49, T#58 (http://www.consciencelaws.org/background/procedures/assist009-005.aspx#049; http://www.consciencelaws.org/background/procedures/assist009-005.aspx#058)

19. Consultations & hearings on Quebec Bill 52, *College of Pharmacists of Quebec: Dianne Lamarre, Manon Lambert*. Tuesday 17 September 2013 - Vol. 43 no. 34, T#33 (http://www.consciencelaws.org/background/procedures/assist009-005.aspx#033)

20. Consultations & hearings on Quebec Bill 52, *College of Pharmacists of Quebec: Dianne Lamarre, Manon Lambert*. Tuesday 17 September 2013 - Vol. 43 no. 34, T#76, T#87, T#88 (http://www.consciencelaws.org/background/procedures/assist009-005.aspx#076)

(http://www.consciencelaws.org/background/procedures/assist009-005.aspx#087)
(http://www.consciencelaws.org/background/procedures/assist009-005.aspx#088)