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Submission to the College of Physicians and Surgeons of Manitoba

Re: *Draft Statement on Physician Assisted Dying*

10 November, 2015

Abstract

The Project finds the proposed policy concerning the exercise of physician freedom of conscience generally satisfactory. Unfortunately, in its current form, the proposed policy could be understood to mean that objecting physicians cannot or should not discuss euthanasia and assisted suicide with patients. This is inconsistent with recent advice from the College of Family Physicians, and it inadvertently introduces bias against objecting physicians. However, this can easily be corrected by rewording the draft to bring it more closely into line with existing College policy on moral or religious beliefs.

The draft does not clearly indicate that patients must be advised about the possibility that the drugs may not cause death as expected. The patient should be asked to provide direction as to what the physician should do in the event of incapacitation by failed physician-assisted suicide or euthanasia. This situation would be particularly problematic for physicians willing to assist with suicide but not provide euthanasia. The killing of an incapacitated patient in such circumstances may be legally questionable even within the terms of the Carter ruling. At a minimum, the Project suggests that physicians should not undertake to provide assisted suicide unless they are also willing to provide euthanasia.

The proposed policy seems to envisage the possibility of delegation of aspects of the lethal act to other physicians or health care workers. This increases the likelihood of conflicts of conscience, particularly in urgent situations. While it seems unlikely that physicians will be expected to provide euthanasia and assisted suicide on an urgent basis, there is evidence that this expectation could develop when there is a delay between final approval and the provision of the procedures. Among other things, the Project recommends that the responsible physician should personally administer the lethal drug or be personally present when it is ingested, remain with the patient until death ensues, and be continuously available for this purpose once the procedure has been approved.

This submission also recommends that the policy should include provisions to protect physicians, applicants for medical school and medical students from

discrimination.

The Project's view is that if the draft policy is revised in accordance with its recommendations, the result will be entirely satisfactory from the perspective of ensuring protection of conscience for physicians, without impeding patient access to euthanasia and assisted suicide.

Finally, it is unlikely that the College will encounter procedures more contentious than euthanasia and assisted suicide. If the revisions proposed in this submission are accepted, the Project suggests that the part of the policy dealing with physician freedom of conscience could be adopted as a standard policy applicable to all morally contested procedures and services. This would very likely make it unnecessary for the College to revisit the issue of physician freedom of conscience every time social and technological developments give rise to new morally contested procedures.

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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 *Draft Statement on Physician Assisted Dying* (15 October, 2015) 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 concerning the exercise of physician freedom of conscience generally satisfactory, recommending revision of one element to correct inadvertent bias against objecting physicians (Part III).

II.2 The practical and possible legal consequences of failed euthanasia/assisted suicide procedures are discussed Part IV.

II.3 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 V.

II.4 The importance of protecting physicians, applicants for medical school and medical students from discrimination is noted in Part VI.

II.5 A number of recommendations are made in Part VII to address the issues raised in this submission. The recommendations are intended to minimize the likelihood of conflicts of conscience among other physicians and health care workers.

II.6 In Part VIII, the Project suggests that the part of the policy developed by the College to address physician freedom of conscience in relation to assisted suicide and euthanasia could be adopted as a standard policy applicable to all morally contested procedures and services if the recommendations in this submission are accepted.

III. Freedom of conscience

III.1 From the Project perspective, the critical part of the proposed policy is Part I, reproduced here:

> **I. Minimum Requirements of All Physicians**
>
> A. Physicians must not impede patients' access to physician assisted dying or impose their moral or religious beliefs about physician assisted dying on patients.
>
> B. A physician who elects not to provide or participate in physician assisted dying for any reason is not required to provide it or participate in it or to refer the patient to a physician who will provide

physician assisted dying to the patient.

C. When a physician receives a request from a patient to provide or participate in providing physician assisted dying to that patient or to be referred to another physician who will, if that physician elects not to provide or participate in providing physician assisted dying to the patient that physician must:

1. disclose his/her objection to providing or participating in physician assisted dying to the patient; and

2. provide the patient with timely access to another member or resource[2] that will provide accurate information about physician assisted dying[3]; and

3. continue to provide care unrelated to physician assisted dying to the patient until that physician's services are no longer required or wanted by the patient or until another suitable physician has assumed responsibility for the patient; and

4. make available the patient's chart and relevant information (i.e., diagnosis, pathology, treatment and consults) to the physician(s) providing physician assisted dying to the patient when authorized by the patient to do so; and

5. provide a copy of this Statement to the patient.

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2. Resources may include but are not limited to other health care providers, counsellors and publicly available resources for physician assisted dying.

3. CPSM Statement 181 *Members Moral or Religious Beliefs not to Affect Medical Care*

III.2 Paragraph "I.A" - entirely satisfactory

III.2.1 In view of paragraphs "I.B" and "I.C," the expectation in "I.A" cannot be understood to mean that the exercise of freedom of conscience in accordance with this policy amounts to imposing moral or religious beliefs or impeding patients' access to services. This is entirely satisfactory.

III.3 Paragraph "I.B" - entirely satisfactory

III.3.1 Paragraph "I.B" is entirely satisfactory because it recognizes that the issue of complicity arises not just with respect to providing a procedure, but also with respect to indirect forms of participation, including referral.

III.3.2 This is consistent with the distinction made in the factum of the Canadian Medical Association in its intervention in the *Carter* case at the Supreme Court of Canada when it insisted that the law should protect both physicians providing the procedures and those who do not (para. 28).

> [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.(para. 27) (Emphasis added)[1]

III.3.3 It is also consistent with the distinction made by the Supreme Court in the *Carter* ruling:

> In our view, nothing in the declaration of invalidity which we propose to issue would compel physicians to *provide* assistance in dying . . . we note - as did Beetz J. in addressing the topic of physician *participation* in abortion in *Morgentaler* - that a physician's decision to *participate* in assisted dying is a matter of conscience and, in some cases, of religious belief (pp. 95-96). (Emphasis added)[2]

III.3.4 Finally, the provision is consistent with guidelines just released by the College of Family Physicians of Canada:

> . . .the right to freedom of conscience in law and ethics normally extends to an individual's right to limit cooperation with others in a practice that he or she objects to on ethical grounds. This is pertinent to the degree of involvement that a physician judges to be ethically acceptable in responding to a patient's request for assisted suicide or euthanasia. Such involvement might range from providing information to the patient on how to end his or her life, to prescribing medication or administering medication, to referring or transferring the care of the patient to another physician or third party. In general, the more essential and direct the cooperation is in bringing about an outcome to which that physician objects on the grounds of conscience, the more complicit the physician would be in it.[3]

III.4 Paragraph "I.C" - generally satisfactory

III.4.1 The proposed policy presumes that a request for euthanasia or physician assisted suicide will come from the patient. It does not impose a requirement that physicians offer patients the options of euthanasia or assisted suicide. This is prudent, for two reasons.

> a) 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.
>
> b) 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.4.2 In the Project's experience, physicians who object to providing morally contested

procedures do not normally object to providing information about them that a patient needs in order to make informed decisions. Moreover, the Project's experience is that objecting physicians are particularly sensitive to and anxious to respond to the difficult circumstances that may cause patients to request euthanasia or physician assisted suicide. In this regard, the suggestions made in recent guidance from the College of Family Physicians of Canada indicate the kind of response that should be presumed and encouraged.[4]

III.4.3 However, in its current form, the proposed policy could create the impression that objecting physicians cannot or should not discuss euthanasia and assisted suicide with patients. This is an erroneous conclusion that should be corrected (see III.4.4).

III.4.4 Inadvertent bias against objecting physicians

III.4.4.1 Paragraph I.C2 states that physicians who, for reasons of conscience, refuse to provide, participate in or refer for euthanasia and assisted suicide must "provide the patient with timely access to another member or resource that will provide accurate information about physician assisted dying." This statement implies that such physicians are not capable of providing accurate information about these procedures, and, further, that only physicians who support euthanasia and assisted suicide are capable of doing so.

III.4.4.2 The underlying presumption here seems to be that physicians who support assisted suicide and euthanasia are trustworthy sources of information about the procedures, but physicians opposed to euthanasia and assisted suicide are not. This is inaccurate, unfair and biased. Leaving aside legal issues, it is unlikely that a physician opposed to female genital mutilation would, by reason of that opposition, be considered an unreliable source of information about the procedure.

III.4.4.3 However, the fact that this paragraph cites CPSM Statement 181, *Members Moral or Religious Beliefs not to Affect Medical Care*, suggests that the bias in the draft document is inadvertent. The relevant section of Statement 181 states:

> If the moral or religious beliefs of a member *prevent him or her from providing or offering access to information about a legally available medical treatment or procedure*, the member must ensure that the patient who seeks that advice or medical care is offered timely access to another member or resource that will provide accurate information about all available medical options.[5] (Emphasis added)

III.4.4.4 This statement correctly recognizes that moral or religious beliefs do not necessarily prevent physicians from providing accurate information about procedures to which they object. Only if physicians' beliefs preclude the provision of information are they expected

to direct the patient to other sources of information.

III.4.4.5 The bias in paragraph I.C2 can be corrected in one of two ways:

a) by incorporating a more substantial rendering of the above section of Statement 181: for example -

> 2. Provide all information necessary to facilitate informed decision-making by the patient. If the moral or religious beliefs of a member prevent him or her from providing or offering access to information about physician assisted dying,[3] provide the patient with timely access to another member or resource[2] that will provide accurate information about all available medical options.

b) by adopting a more comprehensive statement: for example -

> 2. Provide all information necessary to facilitate informed decision-making by the patient. Advise patients that they may approach other physicians, health care providers or sources if they wish to obtain euthanasia or assisted suicide. In response to a patient request, provide information about how to contact other physicians, health care providers or sources of information. If the moral or religious beliefs of a member prevent him or her from providing or offering access to information about physician assisted dying,[3] provide the patient with timely access to another member or resource[2] that will provide accurate information about all available medical options.

III.4.4.6 Either of these proposed revisions may more accurately reflect what the current draft was actually meant to express.

III.5 Summary

III.5.1 CPSM Statement 181, *Members Moral or Religious Beliefs not to Affect Medical Care*, requires objecting physicians to ensure that patients have information necessary for informed decision-making, but does not require them to facilitate access to morally contested procedure by referral. This distinction preserves physician freedom of conscience and religion, but it does not impede access to services. The wisdom of this approach has become particularly obvious since the *Carter* ruling.

IV. Failed assisted suicide and euthanasia

IV.1 Introduction

VI.1.1 According to the draft, the patient must be informed of "the potential risks and complications associated with taking the lethal medication." It is not clear that this

includes discussion about the possibility that the drugs may not kill the patient.

IV.1.2 The proposed policy requires the physician who is to provide or administer the lethal medication to "be readily available to care for the patient" from the time the medication is provided or administered "until the patient is declared dead by a physician." However, it does not require the responsible physician to personally administer or provide the lethal medication or to remain until death ensues. This suggests the possibility of delegation of aspects of the lethal act to other physicians or health care workers, which increases the likelihood of conflicts of conscience.

IV.1.3 Further, euthanasia and assisted suicide drugs do not always cause death as expected.[6] It is for this reason that Quebec euthanasia kits are to include two courses of medication.[7]

IV.1.4 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.

IV.1.5 As will be seen presently, this issue appears to have legal implications with respect to a physician's criminal responsibility, and also implications for physician freedom of conscience.

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

IV.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%).[8,9,10,11,]

IV.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.

IV.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.

IV.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.

IV.2.5 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. Even the legal position of an administering physician faced with a patient incapacitated by the first course of medication seems doubtful.

V. Urgent situations

V.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.[12] 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 Manitoba.

V.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.[13] 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.[14]

V.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.[15]

V.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.

V.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.

VI. Discrimination against objecting physicians, medical school applicants and students

VI.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. This can be addressed by adopting a provision derived from the current Canadian Medical Association policy, *Induced Abortion*:[16]

> No discrimination should be directed against applicants for medical school or doctors who refuse to 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.

VI.2 This proposal, while intended to protect freedom of conscience, would also function as an additional safeguard against abuses that even the successful appellants in the Carter case are keen to avoid. In his oral submission, Mr. Arvay, counsel for the appellants, stated:

> [I]t is also an irrefutable truth, borne out by the evidence in this case from all sides, that all doctors believe it is their professional and ethical duty to do no harm, which means, in almost every case, that they will want to help their patients live, not die. And it's for the very reason that we advocate only physician assisted dying and not any kind of assisted dying, because we know physicians will be reluctant gatekeepers, and only agree to it as a last resort.[17]17

VI.3 The proposed revision would help to ensure that physicians can remain the reluctant gatekeepers that Mr. Arvay wishes them to be.

VII. Recommendations

VII.1 Paragraphs "I.A" and "I.B" of the proposed policy are entirely satisfactory.

VII.2 The provisions of "I.C" of the proposed policy are generally satisfactory. However, for the reasons given in Part III.4 of this submission, paragraph "I.C2" should be revised to correct what appears to be inadvertent bias.

VII.3 The policy should address the issue of discrimination against medical school applicants, medical students and physicians who refuse to provide or facilitate euthanasia for reasons of conscience.

VII.4 Part IV and V of this submission 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.

VII.5 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 patients 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.

A) Discrimination

1. A policy to the following effect should be included:

> No discrimination should be directed against applicants for medical school or doctors who refuse to 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.

B) Providing information

2. Paragraph I.C2 should be revised in the manner indicated in III.4.4.5. Either:

> 2. Provide all information necessary to facilitate informed decision-making by the patient. If the moral or religious beliefs of a member prevent him or her from providing or offering access to information about physician assisted dying, provide the patient with timely access to another member or resource that will provide accurate information about all available medical options.

or:

> 2. Provide all information necessary to facilitate informed decision-making by the patient. Advise patients that they may approach other physicians, health care providers or sources if they wish to obtain euthanasia or assisted suicide. In response to a patient request, provide information about how to contact other physicians, health care providers or sources of information. If the moral or religious beliefs of a member prevent him or her from providing or offering access to information about physician assisted dying, provide the patient with timely access to another member or resource that will provide accurate information about all available medical options.

C) Obligations of responsible physicians

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

4) 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.

5) 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.)

6) 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.

7) 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.

8) 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.

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

VIII. Closing remarks

VIII.1 The Project's view is that if the draft policy is revised in accordance with these recommendations, the result will be entirely satisfactory from the perspective of ensuring protection of conscience for physicians without impeding patient access to euthanasia and assisted suicide.

VIII.2 It is unlikely that the College is likely to encounter morally contested procedures more contentious than euthanasia and assisted suicide.

VIII.3 If revised in accordance with the recommendations under VII.5 (A) and (B), Part I of the draft policy could be adopted as a standard policy applicable to all morally contested procedures and services. This would very likely make it unnecessary for the College to revisit the issue of physician freedom of conscience every time social and technological developments give rise to new morally contested procedures.

Notes

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

2. *Carter v. Canada (Attorney General)*, 2015 SCC 5, 132 (https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/14637/index.do) Accessed 2015-10-30.

3. College of Family Physicians of Canada, *A Guide for Reflection on Ethical Issues Concerning Assisted Suicide and Voluntary Euthanasia* (September, 2015) (Hereinafter "CFPC Guide") p. 4 (http://www.cfpc.ca/uploadedFiles/Health_Policy/_PDFs/Guidefor Euthanasia_EN_FInal.pdf) Accessed 2015-10-30.

4. *CFCP Guide*, p. 5

5. College of Physicians and Surgeons of Manitoba, Statement No. 181: *Members Moral or Religious Beliefs not to Affect Medica Care* (Effect 1 May, 2014) (http://cpsm.mb.ca/cjj39alckF30a/wp-content/uploads/st181.pdf) Accessed 2015-10-30.

6. 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

7. 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.

8. 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.

9. 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

10. 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

11. 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

12. "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

13. 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)

14. 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)

15. 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)

16. Canadian Medical Association, *Induced Abortion* (1988)(http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD88-06.pdf) Accessed 2010-10-30.

17. 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, (81:09/491:20 - 82:12/491:20) (http://www.scc-csc.gc.ca/case-dossier/info/webcastview-webdiffusionvue-eng.aspx?cas=35591&urlen=http://www4.insinc.com/ibc/mp/md/open_protected/c/486/1938/201410150500wv150en,001&urlfr=http://www4.insinc.com/ibc/mp/md/open_protected/c/486/1940/201410150500wv150en,001&date=2014-10-15) Accessed 2015-06-26.