



Protection of Conscience Project

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Submission to the College of Physicians and Surgeons of Ontario

Re: *CPSO Interim Guidance on Physician-Assisted Death*
10 January, 2016

Abstract

Virtually all of what is proposed in *Interim Guidance on Physician-Assisted Death* (IGPAD) is satisfactory, requiring only clarifications to avoid misunderstanding and appropriate warnings concerning the continuing effects of criminal law.

The College has no basis to proceed against physicians who refuse to do anything that would entail complicity in homicide or suicide, including “effective referral,” because they believe that a patient does not fit the criteria specified by *Carter*. College policies and expectations are of no force and effect to the extent that they are inconsistent with criminal prohibitions.

Proposals about respect for patients, access to services, and providing information are acceptable, subject to some clarifications and limitations with respect to offering the option of suicide. Simple and uncontroversial recommendations are offered to avoid problems associated with failed assisted suicide and euthanasia attempts, and in urgent situations.

However, the requirement for “effective referral” is completely unacceptable. It is ludicrous to assert that the reasoning that underpins the law on criminal complicity and culpability, civil liability and the College policy that prohibits referral for Female Genital Cutting can be dismissed as legally irrelevant to the exercise and protection of fundamental freedoms of conscience and religion.

The College cannot justify a demand for “effective referral” on the grounds that it cannot be understood to involve morally significant complicity in killing patients or helping them to commit suicide, nor can it be justified as a reasonable limitation on fundamental freedom.

The only apparent basis for the College’s demand for effective referral is that it has decided what the Supreme Court of Canada did not decide: that euthanasia and assisted suicide in circumstances defined by *Carter* are morally/ethically acceptable. College officials seem to consider the College justified in using force - the force of law - to compel dissenting physicians to conform to their moral/ethical views.

This is not a reasonable limitation of freedom but a reprehensible attack on them. It is a paradigmatic example of the authoritarian suppression of freedom of conscience and religion and a serious violation of human dignity. Examples of alternative acceptable policies demonstrate that access to assisted suicide and euthanasia can be ensured without suppressing freedom of conscience and religion.

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I. Outline of the submission

- I.1 The Project does not take a position on the acceptability of euthanasia and physician-assisted suicide. For this reason, much of the draft *Interim Guidance on Physician-Assisted Death* (IGPAD) is outside the scope of this submission.
- I.2 From the perspective of freedom of conscience, virtually all of what is proposed in IGPAD is satisfactory, requiring only clarifications to avoid misunderstanding and appropriate warnings concerning the continuing effects of criminal law.
- I.3 The first issue raised concerns conflicts that can adversely impact patients, families and objecting health care providers in two different situations: in failed assisted suicide and euthanasia attempts, and in urgent situations. Simple and uncontroversial recommendations are offered to avoid these problems. (Part II)
- I.4 The submission next points out the legal effect of *Carter v. Canada* with respect to the law on homicide, suicide, parties to offences, counselling offences and conspiracy, and that counselling (recommending) suicide remains a criminal offence. In some circumstances this will limit the power of the College to enforce demands for physician participation. (Part III)
- I.5 Part IV considers the draft policy's proposals about respect for patients, access to services, and providing information. The proposals are acceptable, subject to some clarifications and limitations with respect to offering the option of suicide.
- I.6 IGPAD requires that physicians who, for reasons of conscience, are unwilling to kill patients or help them commit suicide, must, nonetheless, find someone willing to do so. It also threatens to punish physicians who refuse to become parties to homicide and suicide. This unacceptable demand, now the subject of a lawsuit against the College, is the primary focus of this submission. It is addressed in Parts V and VI.
- I.7 Examples of acceptable alternative policies are offered in Part VII.

II. Avoiding foreseeable conflicts

II.1 Failed assisted suicide and euthanasia

- II.1.1 According to the draft, the patient must "understand and appreciate the certainty of death upon taking or having the physician administer lethal medication." In fact, euthanasia and assisted suicide drugs do not always cause death as expected.¹ 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.
- II.1.2 A 2014 survey of Canadian Medical Association members indicated that more physicians were willing to participate in assisted suicide (27%) than euthanasia (20%).^{2,3,4,5}
- II.1.3 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.

- II.1.4 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.
- II.1.5 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.
- II.1.6 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.

II.2 Urgent situations

- II.2.1 The College policy on *Professional Obligations and Human Rights* (POHR) conflicts with the draft Interim Guidance document. IGPAD insists that "effective referral" for euthanasia and assisted suicide must be "timely," and that patients must not be exposed to adverse clinical outcomes by delay. However, POHR states 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.⁶ This appears to assume that, since the procedures require extensive preliminary consultation and preparation before they can be authorized, they can never be urgently required.
- II.2.2 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.⁷ 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.⁸
- II.2.3 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.⁹
- II.2.4 Under the terms of the *Carter* ruling and the draft policy, 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 the patient to ask for immediate relief from pain or suffering by euthanasia or assisted suicide.

II.2.5 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.

II.3 Project recommendations

II.3.1 Physicians should not undertake to provide assisted suicide unless they are also willing to provide euthanasia.

II.3.2 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.

II.3.3 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*.)

II.3.4 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.

II.3.5 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.

II.3.6 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.

II.3.7 The second responsible physician must be continuously available to act in the place of the primary responsible physician.

III. IGPAD and criminal law

III.1 The draft policy states:

On [6 February, 2016], subject to any prohibitions or restrictions that may be imposed in future legislation or policy, physicians will be legally permitted to assist competent adults who are suffering intolerably from grievous and irremediable medical conditions to end their lives. (Lines 17-20)

III.2 While this statement is accurate as far as it goes, it fails to correctly assess the legal effect of *Carter v. Canada* with respect to the law on homicide, suicide, parties to offences, counselling offences and conspiracy and fails to acknowledge that counselling (recommending) suicide remains a criminal offence.

III.3 The implications of the continuing offence of counselling suicide will be discussed in relation to IGPAD's expectation that objecting physicians must provide patients with advice on "all options," though the point is obviously of concern to all physicians.

III.4 *Carter* did not entirely strike down murder and assisted suicide laws, and it left the law against counselling suicide intact. Physicians can be charged for murder, manslaughter, or administering a noxious substance if they fail to follow the *Carter* guidelines (Appendix A2.6); if they recommend suicide to patients they can be charged for counselling suicide (Appendix A2.5). Moreover, *Carter* did not touch laws on parties to offences, counselling offences and conspiracy, which apply to the College's policy on "effective referral." (Appendix A2.7)

III.5 In view of this, the College has no basis to proceed against any physician who, having the opinion that a patient does not fit one of the criteria specified by *Carter*, refuses to do anything that would entail complicity in homicide or suicide, including "effective referral." College policies and expectations are of no force and effect to the extent that they are inconsistent with criminal prohibitions.

IV. IGPAD on respect, access, notification and providing information

IV.1 Treat patients respectfully; do not impede access

IV.1.1 The draft policy requires that physicians who refuse to provide euthanasia or assisted suicide must treat patients respectfully. The experience of the Project is that patients are normally treated respectfully by objecting physicians, though refusal itself is sometimes misunderstood or deliberately misconstrued as a disrespectful act.

IV.1.2 To 'impede access' is unacceptable, if it is understood to mean some positive act of interference, such as discouraging other health care providers from seeing the patient, or to some wrongful act, like a refusal to release medical records that are the property of the patient.

IV.1.3 On the other hand, physicians who simply refuse to help patients find someone willing to kill them or help them commit suicide are no more impeding patients than colleagues who who refuse to help patients find someone willing to provide virginity certificates or sell organs.

IV.2 Notification of objections

IV.2.1 The expectation that physicians will personally advise patient of their objections is entirely in keeping with the intentions of objecting physicians made known to the Project.

IV.2.2 That objections are in all cases "due to personal and not clinical reasons" is a mistaken assumption. Objecting physicians may have both clinical and ethical/moral objections to providing euthanasia and assisted suicide. Where both reasons exist, it is appropriate to inform the patient of both. Indeed: to withhold clinical reasons would seem to violate the requirements of informed medical decision-making.

IV.3 Providing information

IV.3.1 In the Project's experience, objecting physicians are willing to provide information necessary to enable informed medical decision making, so the expectation that they will provide information on all treatment options, including euthanasia and assisted suicide, should not be problematic. However, two qualifications are in order.

- IV.3.2 First: counselling (recommending) suicide remains a criminal offence. Although it may be appropriate for physicians to discuss assisted suicide in response to a patient's request or enquiries, physicians cannot be expected to "offer the option" of assisted suicide outside the context of a patient-led discussion. Further: even in that arguably legal context, a physician may be reluctant to discuss the option of assisted suicide if there is some reason to fear that the patient might thus be prompted to commit suicide independently.
- IV.3.3 Second: while information necessary to enable informed medical decision-making must be provided, the point at which that information ought to be provided must be left to the discretion of individual physicians based on their knowledge of and interaction with their patients.
- IV.3.4 Physicians may believe that it would sometimes be harmful or even abusive to gratuitously offer assisted suicide and euthanasia as treatment options: the case of a patient just blinded or paralysed by an industrial accident comes to mind.
- IV.3.5 It may sometimes be at least insensitive to offer assisted suicide and euthanasia as treatment options: for example, upon a diagnosis of dementia, congestive heart failure, chronic obstructive pulmonary disease, stroke, or major depressive disorder, all of which would qualify as irremediable medical conditions under the terms of the *Carter* ruling.

V. Freedom of conscience

V.1 IGPAD and "effective referral"

- V.1.1 The draft policy requires physicians who refuse to kill patients or help them commit suicide arrange for them to be killed or assisted in suicide by a willing colleague by means of an "effective referral," as defined in *Professional Obligations and Human Rights*.
- V.1.2 The policy also demands that the referral must be "timely," so that patients will not experience "adverse clinical outcomes" before being killed.
- V.1.3 Since the College reasonably foresees that the number of physicians willing to kill patients or help them commit suicide "may be limited," it "expects physicians to make reasonable efforts" to an keep up-to-date list of physicians willing to provide lethal injections and prescriptions. This deliberate planning demonstrates and emphasizes the complicity in homicide and suicide that many objecting physicians wish to avoid.
- V.1.4 While this particular requirement applies to all physicians, the College makes a point of imposing it in the section of the draft policy dealing with conscientious objection. Moreover, the College imposes no obligation on physicians willing to kill patients or help them commit suicide to identify themselves in order to make the services more accessible.
- V.1.5 The differential treatment of objecting and non-objecting physicians by exclusively imposing an offensive requirement on the former is strongly suggestive of an illicitly discriminatory attitude toward objecting physicians.

V.2 “Effective referral” and criminal law

- V.2.1 The College policy requiring “effective referral” is unacceptable to many conscientious objectors because they believe that it makes them unacceptably complicit in homicide and suicide. The validity of this position can be verified by considering the effect of a policy of “effective referral” absent the *Carter* decision.
- V.2.2 But for the *Carter* decision, providing an “effective referral” for euthanasia or assisted suicide would expose physicians to prosecution as parties to murder or assisted suicide, or conspiracy to commit murder or assisted suicide (Appendix A2.6-A2.7). It would, in addition, make objecting physicians parties to wrongdoing according to their moral/ethical/religious beliefs. Identical reasoning leads to identical conclusions about moral and criminal responsibility.
- V.2.3 Given the *Carter* decision, providing an “effective referral” for euthanasia and assisted suicide *in accordance* with the *Carter* criteria remains serious wrongdoing from the perspective of many objecting physicians and health care workers, but it is not a criminal offence *because killing patients or helping them commit suicide à la Carter is not a criminal offence*, not because the reasoning about criminal complicity has changed or has been invalidated.
- V.2.4 The *Carter* decision changed the law on murder and assisted suicide by making exemptions in defined circumstances, but it did not change the reasoning that underpins the law on parties to offences. The reasoning that supports the law against aiding or abetting murder is exactly the same reasoning used by physicians and health care providers who would refuse to provide “effective referral” for euthanasia. It is, moreover, reasoning that the College accepts and applies in other contexts:
- Under the Canadian *Criminal Code*, the performance of FGC/M is considered to be aggravated assault; anyone who aids, abets or counsels such assault is considered to be a party to the offense; . . .
- Physicians must not perform any FGC/M procedures. Further, physicians must not refer patients to any person for the performance of FGC/M procedures.
- The performance of, or referral for, FGC/M procedures by a physician will be regarded by the College as professional misconduct.¹⁰
- V.2.5 Since *Carter* does not invalidate the reasoning leading to the conclusion that effective referral involves criminal culpability, and the same reasoning leads to the conclusion that effective referral involves moral culpability, nothing in *Carter* impugns the conclusion of physicians who, applying this reasoning, refuse to provide effective referrals because they refuse to be complicit in homicide and suicide - or female genital cutting.

V.3 Legal vs. ethical/moral evaluation of euthanasia, assisted suicide

- V.3.1 Further, while *Carter* means that euthanasia and assisted suicide in the circumstances defined by the Court are no longer criminal offences, the ruling does not affect the validity of moral/ethical/religious beliefs that it is is gravely wrong to kill patients or

- help them to commit suicide, even in those circumstances.
- V.3.2 Notwithstanding the appellants' occasionally extravagant claims,¹¹ evidence at trial did not demonstrate the ethical or moral acceptability of euthanasia or assisted suicide.¹² It was not an issue in the appeal,¹³ and the Supreme Court of Canada was unconcerned with the question.¹⁴ Thus, nothing in *Carter* suggests that objecting physicians are mistaken in believing that killing patients or helping them to commit suicide is gravely wrong, even in the circumstances defined by the Court (Appendix "B").
- V.3.3 On the contrary, the Supreme Court of Canada acknowledged continuing moral/ethical opposition to *providing or participating* in euthanasia and assisted suicide,¹⁵ that the need to accommodate objecting health care providers.¹⁶
- V.4 The College position: "error has no rights"**
- V.4.1 The *Canadian Charter of Rights and Freedoms* is not interpreted in a legal vacuum. It would be ludicrous to assert that the reasoning that underpins the law on criminal complicity and culpability, civil liability and the College policy that prohibits referral for female genital cutting can be dismissed as legally irrelevant to the exercise and protection of fundamental freedoms of conscience and religion. That would arbitrarily disconnect the *Charter* from the corpus of Canadian law. The College is thus precluded from justifying a demand for "effective referral" on the grounds that it cannot be understood to involve morally significant complicity in killing patients or helping them to commit suicide.
- V.4.2 Moreover, the nature of what the College demands - morally significant complicity in homicide and suicide - precludes justification of the policy on the grounds that forcing objecting physicians to arrange for the killing of patients by someone else is a reasonable limitation of their fundamental freedoms that can be demonstrably justified in a free and democratic society.
- V.4.3 The only apparent basis for the College's demand for effective referral is an assertion of its own authority to make binding dogmatic decisions, together with the claim that error has no rights.
- V.4.4 That is: College officials appear to have decided what the Supreme Court of Canada did not decide: that euthanasia and assisted suicide in circumstances defined by *Carter* are morally/ethically acceptable, rather than simply legally permissible (Appendix A3). College officials seem to consider the College justified in using force - the force of law - to compel dissenting physicians to conform to their moral/ethical views.
- V.4.5 The requirement for "effective referral" in IGPAD is a paradigmatic example of the authoritarian suppression of freedom of conscience and religion by those in positions of power, cloaked by a pretence of moral neutrality.

VI. Project response

VI.1 Previous submissions

VI.1.1 The Protection of Conscience Project's 2014 submission to the College concerning *Physicians and the Human Rights Code* remains relevant:

. . .it is incoherent to include a duty to do what one believes to be wrong in a code of ethics, the very purpose of which is to encourage physicians to act ethically and avoid wrongdoing. . .

There is a significant difference between preventing people from seeking perfection by doing the good that they wish to do and destroying their integrity by forcing them to do the evil that they abhor.

As a general rule, it is fundamentally unjust and offensive to force people to support, facilitate or participate in what they perceive to be wrongful acts; the more serious the wrongdoing, the graver the injustice and offence. It is a policy fundamentally opposed to civic friendship, which grounds and sustains political community and provides the strongest motive for justice. It is inconsistent with the best traditions and aspirations of liberal democracy. And it is dangerous, since it instills attitudes more suited to totalitarian regimes than to the demands of responsible freedom.

VI.1.2 In 2015, the Project warned against the requirement for “effective referral” in *Professional Obligations and Human Rights*.

A Council member who approves *Professional Obligations and Human Rights* will thereby approve the principle that a learned or privileged class, a profession or state institution can legitimately compel people to do what they believe to be wrong - even gravely wrong - even murder - and punish them if they refuse.

VI.1.3 These warnings were ignored. College Council uncritically adopted the policy of “effective referral.”

VI.1.4 As the Project predicted, College officials now want the power to compel physicians to kill patients or arrange for them to be killed - and punish them if they refuse. It is doubtful that any argument is likely to prevail against this authoritarian mindset. When argument fails, stories may help.

VI.2 Making freedom easy - or impossible

VI.2.1 Dr. Sigmund Rascher attended the Luftwaffe's Institute for Aviation Medicine in Munich for a medical course in May, 1941. He wrote to Reichsfuehrer SS Heinrich Himmler, asking if “professional criminals” or “feeble minded” persons could be made available as test subjects for high altitude research.¹⁷ Himmler agreed to provide “asocial individuals and criminals who deserve only to die” to serve as test subjects,¹⁸ and approved the use of Dachau for the project in July.¹⁹ He was concerned that physicians or researchers from the Luftwaffe or Institute for Aviation Medicine would attempt to take credit for the research, so he insisted that Rascher, an SS physician with no expertise in aviation medicine²⁰, participate in all experiments involving human

subjects.²¹

VI.2.2 Subsequently, Institute director Weltz met Dr. Siegfried Ruff, Dr. Wolfgang Romberg and Dr. Rascher at the institute to discuss the planned experiments. According to Ruff, the plan was to use concentration camp inmates condemned to death, whose sentences would be commuted to life imprisonment. He did not consider the experiments immoral, “especially in war time.”²² At least 200 experiments were conducted by Rascher and Romberg in Dachau from March to May, 1942,²³ during which 70 to 80 of the test subjects died.²⁴

VI.2.3 Later, Rascher and his colleagues in Dachau embarked on a series of “freezing experiments” that ultimately involved 300 inmates, 70-80 of whom died.²⁵ It appears that the experiments met with resistance, and Himmler asked Rascher to personally report on the experiments to Luftwaffe Inspector General Erhard Milch in the hope that “the difficulties, based mainly on religious objections . . . could be eliminated.”

The difficulties are still the same now as before. In these “Christian medical circles” the standpoint is being taken that it goes without saying that a young German aviator should be allowed to risk his life but that the life of a criminal . . . is too sacred for this purpose and one should not stain oneself with this guilt. . . It will take at least ten years before we can get such narrow-mindedness out of our people.²⁶

VI.2.4 With this summary of the “high altitude” experiments in Dachau in mind, return now to Institute for Aviation Medicine in late 1941 or early 1942, when Institute director Dr. Weltz approached Dr. Wolfgang Lutz about assisting with the Dachau experiments. Dr. Lutz, the son of an Austrian general practitioner,²⁷ was an internal medicine specialist, a Luftwaffe physician who had joined the Institute in 1940.²⁸

VI.2.5 According to Dr. Lutz, he was asked by Weltz if he was willing to participate in “high altitude research on human beings in the Dachau concentration camp.”²⁹ Dr. Lutz said that he understood that the research was intended to save the lives of soldiers, and that the test subjects would be criminals who had been condemned to death, but who had the opportunity to be pardoned if they participated in the experiments.³⁰

VI.2.6 Dr. Lutz declined, later testifying that he did not consider himself “robust enough to conduct such experiments.”³¹ When asked on cross-examination to explain what he meant, he said, “It is even difficult to experiment upon a dog which looks at you and which seems to have some kind of a soul; it is even difficult to do that with a dog.”^{32, 33}

VI.2.7 What is of interest here is not that Lutz declined to participate, nor his reasons, which did not amount to conscientious objection. What is of interest is the approach taken by Dr. Weltz.



Lutz: Weltz, in the way in which he formulated the question, let it be seen that he expected that we would refuse. He called us in and he asked us "Do you want to conduct these experiments in Dachau?" And he continued to me: "Mr. Lutz, I do not believe that you want to do that because I know you are rather religious." These were his exact words, so that he neither forced us or urged

us to agree. Rather, on the contrary, he made refusal easy for us.”³⁴

- VI.2.8 Nazi Germany: the director of a Luftwaffe medical institute, suspecting (incorrectly, it seems) that the subordinate physician might have religious scruples about the Dachau experiments supported by Heinrich Himmler, “made refusal easy.”
- VI.2.9 Nazi Germany: no *Universal Declaration of Human Rights*, no *Charter of Rights and Freedoms*, just the Fuehrer Principle - yet, sensitive to moral scruples, Dr. Weltz “made refusal easy.”
- VI.2.10 But physicians who don’t want to be involved in killing patients will not find refusal made easy in Ontario. On the contrary: College officials want to make it impossible.
- VI.2.11 This is not a reasonable limitation of fundamental freedoms, but a reprehensible attack on them. It is a serious violation of human dignity. And it is profoundly dangerous. If the state can demand that citizens must be parties to killing other people and threaten to punish them or discriminate against them if they refuse, what can it not demand?

VII. Alternative acceptable policies

- VII.1 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 from physicians who receive requests for euthanasia or assisted suicide.³⁵
- VII.2 Subject to the Project’s recommendations (which largely mirror those in this submission),³⁶ the *Draft Statement on Physician Assisted Dying* (October, 2015) from the College of Physicians and Surgeons of Manitoba³⁷ is generally satisfactory.
- VII.3 In Appendix “C” the Project offers an example of a freedom of conscience policy that can be applied to all services or procedures, including euthanasia and assisted suicide.

VIII. Conclusion

- VIII.1 From the perspective of freedom of conscience, virtually all of what is proposed in IGPAD is satisfactory, requiring only clarifications to avoid misunderstanding and appropriate warnings about the continuing effects of criminal law.
- VIII.2 The single element of IGPAD that is completely unacceptable is the demand for “effective referral.” This and previous submissions from the Project have addressed this. The examples of alternative acceptable policies demonstrate that access to assisted suicide and euthanasia can be ensured without suppressing freedom of conscience and religion.

Notes

1. 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.
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(<http://www.edsonleader.com/2015/02/12/doctor-is-hoping-feds-will-guide-on-assisted-suicid>)

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(<http://www.1310news.com/2015/02/13/medical-professionals-try-to-answer-burning-questions-on-doctor-assisted-death/>) Accessed 2015-07-04.
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(<http://news.nationalpost.com/news/canada/how-far-should-a-doctor-go-mds-say-they-need-clarity-on-supreme-courts-assisted-suicide-ruling>) Accessed 2015-07-04.
6. "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.
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8. 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>).
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(<http://www.consciencelaws.org/background/procedures/assist009-005.aspx#076>)
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10. College of Physicians and Surgeons of Ontario, Policy Statement #2-11, *Female Genital Cutting (Mutilation)* (Updated September, 2011)
([http://www.cpso.on.ca/Policies-Publications/Policy/Female-Genital-Cutting-\(Mutilation\)](http://www.cpso.on.ca/Policies-Publications/Policy/Female-Genital-Cutting-(Mutilation)))
Accessed 2016-01-05.
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Supreme Court of Canada, Webcast of the Hearing on 2014-10-15, 35591, *Lee Carter, et al. v. Attorney General of Canada, et al* (British Columbia) (Civil) (By Leave). *Joseph Arvay, Oral Submission*, 101:25 | 491:20 to 102:01 | 491:20
(http://www.scc-csc.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 2015-06-28

12. The trajectory of the case was determined by the trial judge's belief that suicide can be a rational and moral/ethical act, which led her to conclude that assisted suicide and euthanasia could be ethical. These moral/ethical conclusions became the assumptions underlying the judge's explanation of the purpose of the law, but they originated in the judge's personal views, not derived from the evidence. See Murphy S. "Legalizing therapeutic homicide and assisted suicide: A tour of *Carter v. Canada*," Part VI.1
(http://www.consciencelaws.org/law/commentary/legal073-001.aspx#VI.1_Finding_of_discrimination) *Protection of Conscience Project*.

13. *Carter v. Canada (Attorney General)*, 2015 SCC 5, para. 40. (Hereinafter "Carter")
(<https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/14637/index.do>) Accessed 2015-06-27.

14. *Carter*, para. 1-4

15. *Carter*, para. 130-131

16. *Carter*, para. 132

17. Letter from Dr. Sigmund Rascher to Reichsfuehrer SS, 15 May, 1941. (Letter to Heinrich Himmler concerning the high altitude experiments. Harvard Law School Library Item No. 30)
(http://nuremberg.law.harvard.edu/php/pflip.php?caseid=HLSL_NMT01&docnum=30&num_pages=1&startpage=1&title=Letter+to+Heinrich+Himmler+concerning+the+high+altitude+experiments.&color_setting=C) Accessed 2016-01-07

18. Letter from Heinrich Himmler to Erhard Milch, November, 1942. (Letter to Erhard Milch concerning the high altitude and freezing experiments. Harvard Law School Library Item No. 65).
(http://nuremberg.law.harvard.edu/php/pflip.php?caseid=HLSL_NMT01&docnum=65&num_pages=2&startpage=1&title=Letter+to+Erhard+Milch+concerning+the+high+altitude+and+freezing+experiments.&color_setting=C) Accessed 2016-01-07.

19. Brandt REH, Affidavit. (Affidavit concerning the high altitude experiments at Dachau. Harvard Law School Library Item No. 29).
(http://nuremberg.law.harvard.edu/php/pflip.php?caseid=HLSL_NMT01&docnum=29&num_pages=4&startpage=1&title=Affidavit+concerning+the+high+altitude+experiments+at+Dachau.&color_setting=C) Accessed 2016-01-07

20. Ebbinghaus A. "Introduction to the Trial's History." In *The Nuremberg Medical Trial 1946/47: Transcripts, Material of the Prosecution and Defense, Related Documents. Guide*

to the Microfiche Edition. Compiled by Johannes Elzschig and Michael Walter, (Hereinafter “Ebbinghaus”), p. 58

21. Brandt REH, Affidavit. (Affidavit concerning the high altitude experiments at Dachau. Harvard Law School Library Item No. 29).
(http://nuremberg.law.harvard.edu/php/pflip.php?caseid=HLSL_NMT01&docnum=29&numpages=4&startpage=1&title=Affidavit+concerning+the+high+altitude+experiments+at+Dachau.&color_setting=C) Accessed 2016-01-07

22. Ruff S. Affidavit, 18 October, 1946. (Affidavits concerning the high altitude experiments at Dachau. Harvard Law School Library Item No. 28).
(http://nuremberg.law.harvard.edu/php/pflip.php?caseid=HLSL_NMT01&docnum=28&numpages=4&startpage=1&title=Affidavits+concerning+the+high+altitude+experiments+at+Dachau.&color_setting=C) Accessed 2016-01-07

23. Rascher S. Secret Report, 11 May, 1942 (Munich). (Secret Report. Harvard Law School Library Item No. 48).
(http://nuremberg.law.harvard.edu/php/pflip.php?caseid=HLSL_NMT01&docnum=48&numpages=2&startpage=1&title=Secret+Report.&color_setting=C) Accessed 2016-01-07

24. *Ebbinghaus*, p. 58, citing Transcript p. 1698.

25. *Ebbinghaus*, p. 15

26. Letter from Heinrich Himmler to Erhard Milch, November, 1942. (Letter to Erhard Milch concerning the high altitude and freezing experiments. Harvard Law School Library Item No. 65).
(http://nuremberg.law.harvard.edu/php/pflip.php?caseid=HLSL_NMT01&docnum=65&numpages=2&startpage=1&title=Letter+to+Erhard+Milch+concerning+the+high+altitude+and+freezing+experiments.&color_setting=C) Accessed 2016-01-07.

27. Waters V. “Wolfgang Lutz Obituary.” *The Guardian*, 30 November, 2010.
(<http://www.theguardian.com/theguardian/2010/nov/30/wolfgang-lutz-obituary>) Accessed 2016-01-08

28. Official Transcript of the American Military Tribunal in the matter of the United States of America, against Karl Brandt, et al., defendants, sitting at Nurnberg, Germany, on 12 December 1946, 0930-1630, Justice Beals, presiding. (Hereinafter “Transcript”) p. 267-268
(http://nuremberg.law.harvard.edu/NurTranscript/TranscriptPages/306_267.html)(http://nuremberg.law.harvard.edu/NurTranscript/TranscriptPages/307_268.html) Accessed 2016-02-07

29. *Transcript*, p. 268
(http://nuremberg.law.harvard.edu/NurTranscript/TranscriptPages/307_268.html) Accessed 2016-02-07

30. *Transcript*, p. 277
(http://nuremberg.law.harvard.edu/NurTranscript/TranscriptPages/316_277.html) p. 294
(http://nuremberg.law.harvard.edu/NurTranscript/TranscriptPages/333_294.html)

31. *Transcript*, p. 269-270
(http://nuremberg.law.harvard.edu/NurTranscript/TranscriptPages/308_269.html)(http://nuremberg.law.harvard.edu/NurTranscript/TranscriptPages/309_270.html)
32. It does not appear that he actually explained this to Weltz. When asked in cross-examination if Weltz knew this, he said only that Weltz knew that he had rejected involvement. *Transcript*, p. 302.
(http://nuremberg.law.harvard.edu/NurTranscript/TranscriptPages/341_302.html)
33. Weltz was charged with war crimes and crimes against humanity. Testifying in his own defence, said that he had discussed the Dachau experiments “rhetorically” with Lutz but was surprised to learn that he did not think himself “robust” enough to participate. Neumann A. “Wolfgang Lutz: Die höhenphysiologischen Experimente im Konzentrationslager Dachau 1942 und deren Auswirkungen auf seine Biographie” (“Wolfgang Lutz: The altitude physiological experiments in the Dachau concentration camp in 1942 and their impact on his biography.”) *Inaugural Dissertation for Earning a Doctorate in Medicine of the Faculty of Medicine at the University of Giessen*, 2013
(http://geb.uni-giessen.de/geb/volltexte/2014/11008/pdf/NeumannAndrea_2014_04_28.pdf) Accessed 2016-01-07.
34. *Transcript*, p. 282
(http://nuremberg.law.harvard.edu/NurTranscript/TranscriptPages/321_282.html) Accessed 2016-01-07
35. College of Family Physicians of Canada, *A Guide for Reflection on Ethical Issues Concerning Assisted Suicide and Voluntary Euthanasia* (September, 2015)
(http://www.cfpc.ca/uploadedFiles/Health_Policy/_PDFs/GuideforEuthanasia_EN_Final.pdf) Accessed 2015-10-30.
36. Protection of Conscience Project, “Submission to the College of Physicians and Surgeons of Manitoba Re: Draft Statement on Physician Assisted Dying (15 October, 2015).” (10 November, 2015)
(<http://www.consciencelaws.org/publications/submissions/submissions-021-001-carter-cpsm.aspx>)
37. College of Physicians and Surgeons of Manitoba *Draft Statement on Physician Assisted Dying* (October, 2015)
(<http://www.conscience.laws.org/archive/documents/cpsm/2015-10-15-cpsm-pad.pdf>)

Appendix "A"

Supreme Court of Canada.

Carter v. Canada (Attorney General), 2015 SCC 5

A1. Carter criteria for euthanasia and physician assisted suicide

- A1.1 In February, 2015, the Supreme Court of Canada struck down the criminal law to the extent that it prohibits physician assisted suicide and euthanasia in circumstances defined by the Court.¹
- A1.2 The ruling requires that physician assisted suicide and euthanasia be limited to competent adults who clearly consent to the procedure.² The use of the present tense suggests that consent cannot be established by an advance directive or provided by a substitute medical decision maker if the patient is otherwise unable to express valid consent.³
- A1.3 According to Carter, the condition need not be terminal, but the patient must have “a grievous and irremediable medical condition (including an illness, disease or disability).”⁴ The word "including" used here means that assisted suicide and euthanasia may be provided not only for "illness, disease or disability," but for other medical conditions - frailty, for example.⁵
- A1.4 While the Court notes that "minor medical conditions" would not qualify⁶ and that the medical condition must be "grievous," these are vague terms. Moreover, the Court does not specify whether it is the patient or the physician who determines that a condition is grievous. The medical condition must be "irremediable"; in oral argument, the appellants suggested this could be understood as "incurable."⁷ However, the Court further states that individuals are entitled to refuse any treatments they find unacceptable,⁸ so the ruling actually means that even treatable and curable medical conditions can be considered irremediable and incurable if the patient refuses treatment.
- A1.5 Mental illness is a medical condition, and some kinds of mental illness are thought not to affect decisional capacity or competence. In passing, the Court remarks that the parameters they would propose in the reasons would not apply to "persons with psychiatric disorders."⁹ However, the parameters actually laid out do not explicitly exclude mental illness, so, on this point, the ruling is ambiguous.
- A1.6 Finally, the medical condition must cause "enduring suffering that is intolerable to the individual."¹⁰ The Court does not specify that the suffering must be physical. Since it acknowledges the distinction between physical and psychological suffering¹¹ and pain and suffering,¹² the reference to intolerable suffering can be understood to mean both. Although the ruling does not say so, it is generally understood that suffering is subjectively assessed by the individual experiencing it.

A2. Carter and the criminal law

- A2.1 If all of these criteria are met, a physician who kills a patient or helps him commit suicide cannot be charged for murder or assisted suicide or any other offence. However,

Carter did not entirely strike down murder and assisted suicide laws. They were invalidated only to the extent that they prevent homicide and assisted suicide by physicians adhering to the Court's guidelines.

- A2.2 In the absence of legislation, the appropriate historical reference point for understanding the legal effect of *Carter* is the period between the 1938 case of *R. v. Bourne* and Canada's 1969 abortion law reform. *Bourne* was an English case that established a defence for physicians who provided abortions deemed necessary to preserve the life of the mother.¹³
- A2.3 Though this condition was broadly construed, physicians were still liable to prosecution if the abortion were shown not to be required for that purpose. In 1967, CMA representatives told a parliamentary committee that "uncertainty about transgression of the law" was one of the reasons the Association supported reform of the abortion law.¹⁴ Physicians wanted more than a defence to a charge. They wanted positive assurance that they would not be prosecuted.
- A2.4 That assurance came when the Supreme Court of Canada struck down the abortion law entirely in the *Morgentaler* case. Physicians cannot be charged for providing abortions no matter what the circumstances.
- A2.5 However, even with legislation - but particularly without it - it is difficult to see how physicians who are parties to homicide and suicide can entirely avoid some "uncertainty about transgression of the law." In the first place, the law against counselling suicide still stands [241(a) *Criminal Code*], so, while physicians may assist with suicide under the *Carter* guidelines, they can be charged if they recommend it.
- A2.6 Second, as a matter of public policy, complete immunity from prosecution for murder or manslaughter can be safely guaranteed only for public executioners acting in the course of their duties. Thus, while the *Carter* ruling means that the state cannot prevent qualified patients from obtaining therapeutic homicide and suicide from physicians, it also means that physicians who fail to follow the *Carter* guidelines can be charged for first or second degree murder,^{15,16} or manslaughter,¹⁷ or administering a noxious substance.¹⁸
- A2.7 Further, in such cases it would be a crime to conspire with the physician,¹⁹ to do or omit to do anything for the purpose of aiding the physician,²⁰ to abet the physician,²¹ or to counsel, procure, solicit or incite a physician to violate the *Carter* guidelines,²² even if a patient is not ultimately killed.²³ Thus, anyone who deliberately participates in or facilitates euthanasia or assisted suicide by "effective referral" or similar means is liable to be charged unless the act is exempted by *Carter* from prosecution.
- A2.8 The ruling itself is limited to the constitutional validity of the criminal law. It does not impose a legal duty on the state or upon anyone else to pay for euthanasia or assisted suicide or to provide or participate in them.

A3. *Carter* and freedom of conscience and religion

- A3.1 That is essentially what the judges themselves acknowledge in *Carter*.

In our view, nothing in the declaration of invalidity which we

propose to issue would compel physicians to provide assistance in dying. The declaration simply renders the criminal prohibition invalid. What follows is in the hands of the physicians' colleges, Parliament, and the provincial legislatures (para. 132). (Emphasis added)

A3.2 Note that the Court here referred to "physicians" (plural), not "a physician" (singular). This passage indicates 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. The statement is limited to providing - doing the killing or providing the lethal prescription.

A3.3 However, the Court included the broader term - participation - as it continued:

. . . we note - as did Beetz J. in addressing the topic of physician participation in abortion in *R. v. 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). In making this observation, we do not wish to pre-empt the legislative and regulatory response to this judgment. Rather, we underline that the Charter rights of patients and physicians will need to be reconciled (para. 132). (Emphasis added)

A3.4 To suggest that this reconciliation is to be accomplished by forcing unwilling physicians to become parties to homicide and suicide is inconsistent with the comments of Justice Beetz in *Morgentaler*, cited with approval by the full bench of the Court in *Carter*:

Nothing in the *Criminal Code* obliges the board of an eligible hospital to appoint therapeutic abortion committees. Indeed, a board is entitled to refuse . . . in a hospital that would otherwise qualify to perform abortions, and boards often do so in Canada. Given that the decision to appoint a committee is, in part, one of conscience, and, in some cases, one which affects religious beliefs, a law cannot force a board to appoint a committee any more than it could force a physician to perform an abortion.²⁴ (Emphasis added)

A3.5 Note that Justice Beetz, while distinguishing between appointing a committee and performing an abortion, nonetheless considered both acts to involve judgements of conscience and religious belief, and the legal suppression of one to be the equivalent of the legal suppression of the other.

A3.6 Therapeutic abortion committees did not provide abortions. In fact, members of therapeutic abortion committees were prohibited from doing so.²⁵ The committees facilitated abortions by authorizing them. The refusal of boards to approve the formation of such committees was a refusal to become part of (participate in) a chain of causation culminating in abortion, even if not every case brought to a committee resulted in abortion.

A3.7 Thus, Justice Beetz' comments, affirmed by *Carter*, are authority for the proposition that the state is not only precluded from forcing individuals or institutions to provide

- morally contested procedures, but also precluded from forcing them to participate indirectly by referral or other forms of causal facilitation.
- A3.8 At the very least, this passage indicates that the suppression or restriction of freedom of conscience or religion by compelling indirect participation in a morally contested procedure is legally equivalent to compelling direct participation, a conclusion wholly consonant with the law on criminal responsibility and civil liability. The same constitutional standard applies, whether the state means to force unwilling physicians to kill patients themselves, or to force them to arrange for patients to be killed by someone else.
- A3.9 Put another way, compelling indirect participation in a morally contested act is not a constitutionally valid ‘solution’ for the ‘problem’ that arises from being unable to compel direct participation.
- A3.10 The Court’s statement that “the *Charter* rights of patients and physicians will need to be reconciled” is not, as some seem to think, a warrant for the suppression of freedom of conscience and religion among health care workers.
- A3.11 The *Charter* right of patients clearly established by *Carter* is a legal right not to be impeded or obstructed by the state in seeking euthanasia and assisted suicide in accordance with the Court’s guidelines from willing physicians, except to the extent that impediments or obstructions can be demonstrably justified in a free and democratic society.
- A3.12 The *Charter* right of physicians clearly established by *Carter* is their legal right not to be impeded or obstructed by the state in providing euthanasia and assisted suicide in accordance with the Court’s guidelines, except to the extent that impediments or obstructions can be demonstrably justified in a free and democratic society.
- A3.13 Any additional rights claims are derived by reading into the ruling what the judges either did not address, or purposefully and expressly left out.

Notes

1. *Carter v. Canada* (Attorney General), 2015 SCC 5, para. 132. (Hereinafter “Carter”) (<https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/14637/index.do>) Accessed 2015-06-27.
2. *Carter*, para. 4, 127, 147
3. This interpretation has been adopted by others. The College of Physicians and Surgeons of Alberta recently released a policy on euthanasia and assisted suicide that states, “PAD cannot be provided to patients who lack the capacity to make the decision, including when consent can only be provided by an alternate decision maker, is known by patient wishes or is provided through a personal directive.” (Emphasis in the original). College of Physicians and Surgeons of Alberta, Physician Assisted Death (December, 2015) (<http://www.cpsa.ca/standardspractice/advice-to-the-profession/pad/>) Accessed 2015-12-18
4. *Carter*, para. 4, 127, 147

5. Cimon M. "Frailty Is a Medical Condition, Not an Inevitable Result of Aging (Op-Ed)." *Livescience*, 29 November, 2013.
(<http://www.livescience.com/41602-frailty-is-medical-condition.html>) Accessed 2015-06-28.
6. *Carter*, para. 111
7. "We are limiting our case to people whose condition is irremediable, or incurable if you want to use that language, because it, assisted dying should only be allowed in the most serious cases. And not just because somebody wants to. It's because their condition is not going to get any better." Supreme Court of Canada, Webcast of the Hearing on 2014-10-15, 35591, *Lee Carter, et al. v. Attorney General of Canada, et al (British Columbia) (Civil) (By Leave)*. Joseph Arvay, Oral Submission, 113:35/491:20 - 114:50/491:20
(http://www.scc-csc.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 2015-06-28
8. *Carter*, para. 127
9. *Carter*, para. 111
10. *Carter*, para. 4, 127, 147
11. *Carter*, para 40 , 64
12. *Carter*, para. 68
13. *R. v Bourne* (1939) 1KB 687
14. "'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
15. *Criminal Code* (R.S.C., 1985, c. C-46) (Hereinafter "CC"), Section 229
(<http://laws-lois.justice.gc.ca/eng/acts/c-46/page-114.html>); Section 231(1)
(<http://laws-lois.justice.gc.ca/eng/acts/c-46/page-115.html>) (Accessed 2014-07-25)
16. CC, Section 229 (<http://laws-lois.justice.gc.ca/eng/acts/c-46/page-114.html>); Section 231(7) (<http://laws-lois.justice.gc.ca/eng/acts/c-46/page-115.html>) (Accessed 2014-07-25)
17. CC, Section 232(1) (<http://laws-lois.justice.gc.ca/eng/acts/c-46/page-116.html>) (Accessed 2014-07-25)

18. CC, Section 245. (<http://laws-lois.justice.gc.ca/eng/acts/c-46/page-119.html>) (Accessed 2014-07-25)
19. CC, Section 465. (<http://laws-lois.justice.gc.ca/eng/acts/c-46/page-225.html>)(Accessed 2014-07-25)
20. CC, Section 21(b). (<http://laws-lois.justice.gc.ca/eng/acts/c-46/page-6.html>)(Accessed 2014-07-25)
21. CC, Section 21(c). (<http://laws-lois.justice.gc.ca/eng/acts/c-46/page-6.html>) (Accessed 2014-07-25)
22. CC, Section 22 (<http://laws-lois.justice.gc.ca/eng/acts/c-46/page-6.html>)(Accessed 2014-07-25)
23. CC, Section 464. (<http://laws-lois.justice.gc.ca/eng/acts/c-46/page-224.html>) (Accessed 2014-07-25)
24. *R. v. Morgentaler* (1988) 1 S.C.R.95-96 (Supreme Court of Canada) (<http://scc-csc.lexum.com/scc-csc/scc-csc/en/item/288/index.do>) Accessed 2015-06-28.
25. CC, Section 287(4)a. (<http://laws-lois.justice.gc.ca/eng/acts/C-46/page-152.html?texthighlight=abortion#s-287.>) Accessed 2015-06-27

Appendix “B”

***Carter* in the Trial Court. Part VII: A Judicial Soliloquy on Ethics**

B1. A note of caution

- B1.1 Part VII of the trial court judgement in *Carter* illustrates the difference between the role of a scholar and the role of a judge: between an investigative and deliberative process that can be followed by parliamentary subcommittees or royal commissions and the process followed in a trial conducted on adversarial principles. As the Christian Legal Fellowship observed, a trial judge “does not have the benefit of the wide-ranging consultations that are available to government.”¹
- B1.2 A judge is not a scholar who has the freedom and the obligation to go beyond evidence that is ready to hand in order to identify all issues raised by a problem and locate all evidence that may be relevant to resolving it. A judge is largely confined to the issues as defined by the pleadings and to the evidence presented by the parties, which is selected by them according to their respective interests.
- B1.3 One of the strengths of judicial office is this demanding specificity that can bring a bright light to bear on dark doings, or bring into focus something not readily seen without the assistance of a judge’s lens, be it microscopic or telescopic. However, this restricted focus and dependence on the evidence “as presented” becomes a handicap when a wide angle lens is needed, and when the evidence “as presented” is selected, shaped and limited by the interests and practical judgement of the parties in conflict.
- B1.4 Part VII of the judgement, in which the trial court judge tried to make sense of the evidence “as presented,” seems to reflect this limitation.

B2. The questions addressed in Part VII

- B2.1 In Part VII of the judgement, Madam Justice Smith posed three questions:
1. whether or not it would ever be ethical - not legal- for a physician to provide assisted suicide or euthanasia at the request of a competent, informed patient;²
 2. whether or not current end of life practices are *ethically* distinguishable from physician-assisted suicide and euthanasia;³
 3. whether or not the law attempts to uphold a conception of morality inconsistent with social consensus.⁴
- B2.2 The reason for this exercise is unclear.
- B2.3 Madam Justice Smith asserted that the question before her was constitutional, not legal or ethical, adding that the realms of ethics, law and constitutionality “tend to converge even though they do not wholly coincide.”⁵ However, she did not explain why a legal challenge to the constitutionality of the law against assisted suicide is not a legal question. And if the question before her was *not* ethical, one may reasonably ask why she embarked upon a lengthy discussion of ethics. Her explanation that the law and medical practice are shaped by ethical principles⁶ was not germane in the circumstances

of the case before her, in which ethical principles and/or their application were either in dispute or in conflict.

- B2.4 Moreover, Madam Justice Smith did not confine herself to the ethical question she proposed to answer. Instead, in Part VII she seemed to wander through the evidence, perhaps attempting to synthesize disparate and incomplete evidentiary materials and arguments provided by the parties in conflict.

B3. Plaintiffs' claim shapes and limits the analysis

- B3.1 It seems that the judge's opinion that "the ethics of *physician*-assisted death are relevant to, although certainly not determinative of, the assessment of the constitutional issues in this case,"⁷ originated in the plaintiffs' claim, which was specifically for *physician* assisted suicide and euthanasia.
- B3.2 However, the law then forbade *anyone* - not just physicians - from assisting in suicide or therapeutic homicide. If there was an ethical question central to constitutional issues, it was the ethics of assisted suicide and therapeutic homicide by *anyone* - not just physicians. Of course, to begin there would have complicated the case enormously, since it would have been difficult to avoid questions about how suicide and homicide are consistent with the high value the law and society assign to human life, be it described in terms like "the sanctity of life" or "the inviolability principle" or "fundamental value."
- B3.3 The plaintiffs chose to begin with *physician*-assisted suicide and euthanasia,⁸ thus avoiding these logically prior ethical questions, and Madam Justice Smith did the same when she expressly accepted this framework for her analysis.⁹ Thus, Part VII of the trial court judgement includes one strand of discussion that addresses a central question identified by the judge: "whether or not it is ethical for physicians to provide such assistance."¹⁰

B4. Ethics: which one?

- B4.1 Madam Justice Smith did not acknowledge the first and most obvious difficulty that had to be faced in answering that question: identifying the ethical or moral standard to be applied. Since physicians provide assisted suicide and therapeutic homicide in Belgium and the Netherlands, it would seem that either they are acting unethically, or that Canadian physicians are acting unethically by refusing to do so. Alternatively, a moral or ethical relativist would likely assert that medical ethics are cultural or social constructs with no transcendent significance, so that we should expect that different countries may have different ethics.
- B4.2 Here, the law itself is of no assistance. The judge recognized that what is ethical or moral may not be legal, and what is legal may not be moral or ethical,¹¹ a proposition with which St Augustine, St. Thomas Aquinas and Martin Luther King Jr. (among others) would agree.¹² But these men accepted that proposition because they recognized a transcendent or objective standard to which human law ought to conform, while *Carter* was presented, argued and decided as if such a standard does not exist or is irrelevant.

- B4.3 Instead, in Part VII, the judge tried to establish a common standard by searching for ethical consensus. This is not surprising, since seeking common ground is a legitimate and important conflict resolution strategy, and a civil trial can be understood as a formal conflict resolution process. Thus, the judge frequently referred to what she identified as common ground, points of agreement, and what is “accepted.”¹³
- B4.4 However, the search for common ground in *Carter* was confined to the sources recommended to the judge by the parties, and her review of these sources was largely circumscribed by their submissions and arguments.

B5. Medical ethics

B5.1 Ethics and the willingness of physicians

- B5.1.1 In her search for consensus in medical ethics, the sources relied upon by the judge included the opinions of physicians, medical associations and ethicists, and current end-of-life practices.
- B5.1.2 Thus, the judge asked if Canadian physicians “would be willing to assist patients” with suicide and euthanasia if the law were changed.¹⁴ She concluded that there were “experienced and reputable Canadian physicians” who were “unchallenged with respect to their standing in the medical community or their understanding of and respect for medical ethics” who were willing to provide assisted suicide and euthanasia.¹⁵
- B5.1.3 But exactly the same thing could have been said of the German physicians and leaders of the German medical profession who supported the Nazi euthanasia programme and medical atrocities of the Nazi regime.¹⁶ And she ignored the fact that there were also “experienced and reputable Canadian physicians” who were “unchallenged with respect to their standing in the medical community or their understanding of and respect for medical ethics” who were not willing to provide assisted suicide and euthanasia. The willingness of reputable physicians to provide assisted suicide and therapeutic homicide hardly demonstrates that the services are ethical.
- B5.1.4 After all, some physicians are willing to have sex with consenting patients, but Canadian professional and regulatory authorities are generally clear that it is always unethical for a physician to do so, even though it is not against the law.¹⁷ This is also the case in the Netherlands. The Royal Dutch Medical Association forbids physicians to have sex with patients who consent,¹⁸ though it allows physicians to kill patients who consent.¹⁹ In the United Kingdom, on the other hand, physicians must neither have sex with patients nor kill them or help them to kill themselves, their consent notwithstanding.²⁰
- B5.1.5 Certainly, these comparisons would have raised interesting ethical questions about different understandings of physician-patient relationships and consent,²¹ had any of the parties chosen to bring them forward. However, it appears that the willingness of physicians to have sex with patients is treated as a problem to be solved rather than an ethical justification for physician-patient sex, so it is not clear how the willingness of physicians to kill patients or help them commit suicide can be presumed to provide ethical justification for physician-assisted suicide and therapeutic homicide.

B5.2 Ethics and the positions of medical associations

B5.2.1 It appears that neither defendants nor plaintiffs provided an adequate survey of the policies of medical associations or physician regulators on assisted suicide and euthanasia, but offered a sampling of policies from different organizations. The selection illustrated only that there were differing views, while the judge acknowledged that the “official” position of an association on assisted suicide and euthanasia did not necessarily represent the views of all of the members of a profession.²²

B5.3 Ethics and the opinions of ethicists

B5.3.1 Predictably, the ethicists called by the plaintiffs differed from those called by the defendants about the ethics of physician-assisted suicide and euthanasia.²³

B5.3.2 For the plaintiffs, Dr. Marcia Angell, Professor Margaret Battin and Dr. Upshur justified physician-assisted suicide and euthanasia primarily by appeals to patient autonomy.²⁴ Defendant witness Professor Koch responded that one can hardly claim to be acting autonomously while demanding that society support and assist with suicide.²⁵

B5.3.3 For the defendant governments, Prof. John Keown asserted that “any intentional taking of life is unethical and should not be permitted,” a statement that would presumably include suicide, though this point was not pursued. He insisted that the inviolability of human life was at the heart of both law and medical practice. He opposed physician-assisted suicide and euthanasia because of his belief in the sanctity of life, and because he believed that the practices cannot be controlled if legalized.²⁶

B5.4 Ethics and current end-of-life practices

B5.4.1 Ethicists and other witnesses also discussed current end-of-life practices. Dr. Gerrit Kimsma of the Netherlands argued that assisted suicide and euthanasia are consistent with the goals of medicine and already occurring in fact, though “under a veil of confusion, ambiguity and lack of truth/disclosure.”²⁷

B5.4.2 However, the judge found that the law had deterred all but a very few Canadian physicians from providing assisted suicide and euthanasia.²⁸ The evidence, she said, suggested that Canadian physicians provided assisted suicide or euthanasia in only “a very small number of instances.”²⁹

B5.4.3 The withdrawal of life support or treatment was of particular interest to Madam Justice Smith because 90% of patients die “following the withdrawal of some form of life support, most commonly the withdrawal of medical ventilation, dialysis or inotrope medications.”³⁰

B5.4.4 With respect to end-of-life practices generally, Madam Justice Smith identified the pivotal principle of informed consent, which (she said) rest on the foundational concept of individual autonomy. Medical procedures cannot be undertaken or sustained without the continuing informed consent of a competent patient, who is entitled to refuse treatment even if death will result. In the case of non-competent patients whose wishes are not known, “medical decisions will be made in the patient’s best interests.” Patients can make their wishes known by means of advance directives, and such directives must be respected if the patient is incapacitated. Alternatively, decisions about withdrawal

or refusal of treatment can be made by legally recognized third parties.³¹ Madam Justice Smith held that the law concerning the right of physicians to withdraw or refuse treatment despite the objections of third-party decision-makers was uncertain.³²

B5.4.5 However, much that is necessary to understand the ethical issues and controversies associated with end-of-life practices was absent from Part VII, particularly with reference to palliative sedation. Thus, while the judge's explanation of the *law* of informed consent was satisfactory, as was her explanation of the *law* concerning withdrawal and refusal of treatment,³³ her discussion of the *ethics* of end-of-life decision-making was seriously deficient.³⁴

B5.4.6 The deficiency was especially problematic because Madam Justice Smith also attempted to answer another question: whether or not current end of life practices could be ethically distinguished from physician-assisted suicide and euthanasia.³⁵ One of the plaintiffs' central claims was that there is no ethical distinction.³⁶ (See B8.3)

B6. Ethics of society

B6.1 A second strand of discussion in Part VII, occasionally spliced into the discussion of medical ethics, was whether or not there was an ethical or moral consensus on the subject of assisted suicide and therapeutic homicide outside the medical profession. This, too, originated in the plaintiffs' claim, since they asserted that the law was invalid if its purpose was "to uphold a particular religious conception of morality" that was unsupported by social consensus in Canada.³⁷

B6.2 Ethics and public opinion

B6.2.1 The reliability of public opinion polls as an indicator of ethical consensus was disputed.³⁸ British Columbia urged that consensus should be recognized in a plurality of sources: "in the refusal of successive governments and Parliaments to legalize assisted dying," in the fact that "the overwhelming majority of Western democracies" forbid assisted suicide and euthanasia, in a comprehensive report from the Canadian Senate, and in laws and judicial rulings that are unspecified in the judgement.³⁹

B6.2.2 The judge ultimately cited an opinion poll showing a majority of Canadians "are supportive of physician-assisted death in some circumstances."⁴⁰ This was an inaccurate description of the poll, which referred to "euthanasia," not "physician-assisted death." Moreover, the poll posed the question without reference to circumstances and without defining "euthanasia."⁴¹

B6.2.3 A poll of this type was of no value in assessing the ethical content or ethical significance of the opinions of respondents. While the judge noted that public opinion polls (in general) "provide some indication as to societal values overall,"⁴² she failed to explain how this particular poll could reasonably contribute to the ethical evaluation she attempted in Part VII.

B6.3 Ethics and public committees

B6.3.1 The judge noted that the 1995 Special Senate Committee Report was the result of a 14 month enquiry that heard evidence from witnesses across the country and received hundreds of letters and briefs, but added that the report was not unanimous on the

subject of assisted suicide and euthanasia.⁴³

B6.3.2 She appeared to give equal weight to subsequent reports produced by committees of the Royal Society of Canada (RSC) and the Quebec National Assembly (QNA), both of which unanimously recommended legalization of assisted suicide and euthanasia.⁴⁴

B6.3.3 Quite apart from challenges that might be made concerning the comprehensiveness of the reports, the reference to the RSC and QNA reports in the ruling might be questioned for three reasons.

- First: five of the six authors of the RSC report favoured at least voluntary euthanasia before joining the RSC panel,⁴⁵ and the report was alleged to present a biased (largely legal) argument.⁴⁶
- Second: three authors of the RSC report were plaintiff witnesses at trial, and one helped to instruct plaintiff witnesses.⁴⁷
- Third: the recommendations of the QNA committee report were reported to have contradicted the majority of submissions received by the committee.⁴⁸

B6.3.4 However, Madam Justice Smith did not treat the reports as evidence of a consensus that assisted suicide and euthanasia are ethical. Instead, she relied upon them only to demonstrate a *lack* of social consensus. She contrasted the majority and minority Senate Committee positions,⁴⁹ and the recommendations of the RSC and QNA reports with the adverse response of Parliament in 2010.⁵⁰

B.6.4 Ethics and prosecution policies

B6.4.1 In considering Crown Counsel policy governing prosecution of assisted suicide in British Columbia,⁵¹ Madam Justice Smith noted that the policy appeared to recognize that the public interest may not always require prosecution of assisted suicide or euthanasia, even if there is a strong likelihood of conviction. She found this conceivably supportive of legalization of the procedures.⁵² She failed to acknowledge that public interest may not always require the prosecution of assault, but that has never been proposed as justification for legalizing assault.

B6.4.2 Further, she completely ignored the prosecution policy of the United Kingdom, which was also part of the evidentiary record⁵³ and directly relevant to the subjects considered in Part VII. According to the English policy, if there is sufficient evidence to support a charge, there is a *greater* public interest in prosecuting physicians, healthcare workers and others who assist in the suicide of someone in their care than in prosecuting those who are *not* in positions of authority.⁵⁴ Madam Justice Smith's silence concerning this evidence is inexplicable.

B7. Summary of the ethical debate

B7.1 Madam Justice Smith correctly noted agreement that palliative care is not always effective, and, more commonly, often not accessible.⁵⁵

B7.2 She also stated that there was no disagreement about the facts related in Part VII concerning "existing clinical end-of-life practices and the understood legal and ethical justification for them."⁵⁶ Given her incomplete treatment of the subject, her conclusion

is highly questionable.³⁴

- B7.3 The judge asserted that there was “little dispute” that principles of autonomy, compassion and non-abandonment “play a central role in the formation of medical ethics” and that the principle “do no harm” was of continuing importance for physicians.⁵⁷ This was correct, but insufficient.
- B7.4 In the first place, this comment implied that “medical ethics” is a monolithic entity, which suggests that the judge was unaware that there are distinct traditions of medical ethics that are not always in agreement on all points.
- B7.5 Moreover, autonomy, compassion, non-abandonment and non-maleficence are not the only principles that shape medical ethics, and there are ongoing disputes about the application of these principles. For example: the principle of non-abandonment is generally accepted, but that it could be applied (as suggested by Professor Battin) to compel an objecting physician to facilitate assisted suicide⁵⁸ would be sharply contested. The judge’s failure to appreciate this was illustrated by her casual dismissal of references in the evidence and in submissions to conscientious objection by physicians.⁵⁹
- B7.6 Finally, Madam Justice Smith acknowledged (without explaining) controversies associated with palliative sedation and the withdrawal of food and fluids from patients unable to give informed consent, but deemed them irrelevant to the claims made by the plaintiffs.⁶⁰

B8. Conclusions about the ethical debate.

- B8.1 The judge provided succinct and useful summaries of the arguments for and against legalizing assisted suicide and euthanasia before drawing conclusions about the ethical debate.⁶¹ She then arranged her conclusions under three headings.

B8.2 Would Canadian physicians provide the services?

- B8.2.1 Ultimately, the exploration of the willingness of physicians to provide assisted suicide or euthanasia revealed only what ought to have been obvious from the pleadings: that some were willing to kill patients or help them commit suicide, others not. The judge’s conclusion that some “experienced and reputable physicians” would be willing to do so resolved nothing with respect to the ethics of the practices, for the obvious reason that similarly experienced and reputable physicians opposed them.

B8.3 Does current medical practice with respect to end-of-life care make distinctions that are ethically defensible?

- B8.3.1 Much of this section of the ruling concerned peripheral legal issues⁶² and a re-statement of the ethical arguments of the plaintiffs and defendants.⁶³
- B8.3.2 The subject of intention as an ethically significant element in decision-making was introduced,⁶⁴ but the judge did not pursue it because, in her view, the focus of the Supreme Court of Canada’s discussion of intention in *Rodriguez* was law, not ethics.⁶⁵ It does not seem to have occurred to her that intention might nonetheless be relevant to her consideration of the ethics of end-of-life care. Nor did she explain why she thought that intention can provide the basis of a valid distinction in law⁶⁶ but not in ethics.

B8.3.3 In any case, Madam Justice Smith offered the following summary of her study:

The evidence shows that within the medical and bioethical community the question still remains open whether an ethical distinction is maintainable between withholding or withdrawing life-sustaining treatment and palliative sedation on the one hand, and physician-assisted death on the other.⁶⁷

B8.3.4 Consistent with this, in summarizing the ruling, she stated that “currently accepted practices bear similarities to physician-assisted death, but opinions differ as to whether they are ethically on a different footing.”⁶⁸ This plainly conceded that she could not answer the question she posed (B8.3) by reference to the evidence from “the medical and bioethical community.”

B8.3.5 However, the judge then contradicted herself. Immediately after declaring the question still open, she claimed that “[t]he preponderance of the evidence from ethicists is that there is no ethical distinction between physician-assisted death and other end-of-life practices whose outcome is highly likely to be death,” adding that she found this view “persuasive.”⁶⁹ Further, she observed that a number of defendant and plaintiff witnesses were doubtful about the distinction,⁷⁰ and that she found it difficult to make a distinction in individual cases.⁷¹ Such doubts and difficulties (possibly exacerbated by avoiding consideration of intention) did not reconcile the contradiction between declaring the question “open” and then deciding it on the basis of conflicting opinions.

B8.3.6 Ultimately, Madam Justice Smith’s conclusion about the ethical relationship between current end-of-life practices and physician-assisted suicide and euthanasia was inconclusive at best, and, at worst, incoherent.

B8.4 Does the law attempt to uphold a conception of morality inconsistent with the consensus in Canadian society?

B8.4.1 Madam Justice Smith asserted that there appeared to be a “strong consensus that currently legal end-of-life practices are ethical.”⁷² While this conclusion may be open to question in some respects, and the judge commented on it in her summary of the ruling,⁷³ it did not enter into the reasoning offered to support her decision to strike down the law.⁷⁴

B8.4.2 The judge’s belief that consensus about end-of-life practices was ultimately based on the “value of individual autonomy” was a hazardous oversimplification. Personal autonomy is arguably the most highly prized legal principle in Canada, and in dominant theories of bioethics it is frequently the value that trumps all others. However, other ethical traditions give priority to other principles, like the sanctity of life or human dignity.⁷⁵ Practitioners from these traditions may share in a consensus about a particular end-of-life practice, but their agreement may not be based on the concept of autonomy.

B8.4.3 In attempting to identify the key difference of opinion that frustrates ethical consensus, Madam Justice Smith concluded that there was really no difference of opinion about the value of human life. “[N]o one questions that the preservation of human life has a very high value in our society,” she wrote. “Rather, the difference of opinion is about whether the preservation of human life is an absolute value, subject to no exceptions.”⁷⁶

- B8.4.4 With respect, this statement was a caricature of the position of the principal opponents of assisted suicide and therapeutic homicide. They do not hold that human life must be preserved at all costs. Madam Justice Smith acknowledged that the Christian Legal Fellowship had explicitly repudiated this view in its submission.⁷⁷ It appears that the judge's interest here was not on "cost" but on "exceptions." That is, she may simply have meant, "Granted that the preservation of human life has very high value, when can we make an exception and kill someone?"
- B8.4.5 Rephrasing the question in this way accounts for the judge's reference in the next paragraph to the "deprivation account of the badness of death" offered by Professor Sumner. "[W]hat makes death such a bad thing in the normal case," he says, "is what it takes away from us - the continuation of a life worth living."⁷⁸ It follows that if a life is not worth living, assisted suicide or euthanasia could be a good for that person.
- B8.4.6 In any case, Madam Justice Smith did not address the difference of opinion she purported to identify by way of caricature, or Professor Sumner's provocative ethical reflections. In fact, neither seems to be related directly to the judge's eventual conclusions in Part VII, though perhaps they reveal something of her personal outlook.
- B8.4.7 Instead, the judge emphasized differences of opinion among medical associations, individual physicians and politicians,⁷⁹ among panels, committees, parliaments and senates,⁸⁰ and among professional ethicists and medical practitioners.⁸¹ Consistent with these differences, she concluded that there is no "clear societal consensus" about assisted suicide or euthanasia in the case of competent adults who are "grievously ill and suffering symptoms that cannot be alleviated."⁸²
- B8.4.8 In addition, however, Madam Justice Smith purported to discover a "strong consensus" supporting the view that if physician assisted suicide were ever ethical, it would only be in strictly limited circumstances.⁸³ This is like claiming a strong consensus that, *if* violence against women were ever to be ethical, it would only be in strictly limited circumstances.
- B8.4.9 But there is no consensus that violence against women could ever be ethical, there is no consensus that euthanasia and assisted suicide could ever be ethical. A significant number of people and a number of religious groups absolutely reject the judge's "if." Madam Justice Smith's "strong consensus" was a rhetorical conjuring trick used to make these people and groups disappear. In effect, the judge adopted the pretense that they do not exist, or dismissed their views as irrelevant to the formation of a consensus.
- B8.4.10 In the end, Madam Justice Smith simply did not answer the question she posed; she did not say whether or not the law attempts to uphold a conception of morality inconsistent with social consensus.

B9. Carter Part VII: in brief

B9.1 Unanswered questions

B9.1.1 In Part VII of the judgement, Madam Justice Smith was unable to answer three questions she posed:

- whether or not it would ever be ethical for a physician to provide assisted suicide

or euthanasia at the request of a competent, informed patient;

- whether or not current end of life practices are *ethically* distinguishable from physician-assisted suicide and euthanasia;
- whether or not the law attempts to uphold a conception of morality inconsistent with social consensus.

B9.2 Meaningless findings

- B9.2.1 The judge's finding that "experienced and reputable Canadian physicians" are willing to provide assisted suicide and euthanasia disclosed nothing about the ethics of the procedures.
- B9.2.2 The purported "strong consensus" about assisted suicide "if" it were ethical was a fabrication constructed by excluding those who absolutely rejected the suggestion that it could ever be ethical.

B9.3 Inconclusiveness

- B9.3.1 Madam Justice Smith was unable to identify an ethical consensus concerning assisted suicide and euthanasia among professional associations, physicians, ethicists, public committees and the public as a whole.
- B9.3.2 The judge was unable to determine whether or not current end-of-life practices could be ethically distinguished from assisted suicide and euthanasia.

B9.4 Neglected evidence

- B9.4.1 Madam Justice Smith reviewed British Columbia's prosecution policy, but inexplicably failed to consider the prosecution policy of the United Kingdom, which spoke to issues dealt with in Part VII.

B9.5 Deficient review of end-of-life decision-making

- B9.5.1 Much that is necessary to understand the ethical issues and controversies associated with end-of-life practices was lacking in Part VII, particularly with reference to palliative sedation.
- B9.5.2 Despite prompting by the Christian Legal Foundation,⁸⁴ the judge did not explain why intention cannot be a valid element in ethical decision-making at the end of life.

B10. On appeal to the Supreme Court of Canada

- B10.1 An appeal does not involve a re-trial of a case. An appellate court considers the evidence heard by the trial judge (the facts), including inferences or conclusions that the trial judge draws from the evidence. It also considers the trial judge's interpretation of the law when applying it to the evidence in order to reach a conclusion.
- B10.2 If the appeal concerns a point of law, the "standard of review" is correctness; the appellate court can replace the trial judge's findings with its own if there is an error in law. If the appeal concerns the facts, or questions of mixed fact and law, the appellate court will not overturn the lower court ruling unless the trial judge has made a "palpable and overriding error."⁸⁵ This means only that the evidence at trial is capable of

supporting the trial judge's conclusions. It does not mean that the appellate judges would reach the same conclusions had they tried the case themselves. It does not even mean that the trial judge's conclusions are objectively correct.

- B10.3 This can be illustrated by applying the standard of review for judicial fact-finding to the first report of Columbus that he had reached Asia. His conclusion was not a "palpable and overriding error" according to the evidence 'on the record' in 1492. The error became "palpable" only after evidence that had been left out became available.
- B10.4 In this respect, Madam Justice Smith's conclusion that there is no ethical distinction between euthanasia and withdrawal or refusal of care was analogous to Columbus' conclusion that there was no geographical distinction between Cuba and China. Both were "evidence-based" conclusions, but both left out evidence that was capable of undermining them.
- B10.5 A further consideration is that not everything in a trial court ruling is relevant for the purpose of appeal. For example: though Madam Justice Smith's conclusion about the significance of prosecutorial discretion was arrived at by tendentious reasoning and cherry-picked evidence (B6.4), this was irrelevant on appeal because she did not rely upon it to reach the conclusion that the prohibition of euthanasia and physician assisted suicide was unconstitutional. The same applies to the balance of Part VII of the judgement.
- B10.6 The Supreme Court of Canada thus had little to say about Madam Justice Smith's judicial soliloquy on ethics. In outlining the judicial history of the case, the judges briefly and uncritically summarized her findings and mentioned the fabricated "strong consensus" about the theoretical ethical acceptability of euthanasia and assisted suicide (B8.4.8-B8.4.9)⁸⁶ Later, when considering whether or not it was appropriate to overrule *Rodriguez*, the Court reviewed the differences between *Rodriguez* and *Carter*, including "[T]he matrix of legislative and social facts."

The majority in *Rodriguez* relied on evidence of (1) the widespread acceptance of a moral or ethical distinction between passive and active euthanasia (pp. 605-7); (2) the lack of any "halfway measure" that could protect the vulnerable (pp. 613-14); and (3) the "substantial consensus" in Western countries that a blanket prohibition is necessary to protect against the slippery slope (pp. 601-6 and 613). The record before the trial judge in this case contained evidence that, *if* accepted, was *capable* of undermining each of these conclusions.⁸⁷ (Emphasis added)

- B10.7 The conditional reference to the evidence in the trial record (*if* accepted, was *capable*) reflects adherence to the standard of review. The Supreme Court could not say that the trial judge had made a "palpable and overriding error."
- B10.8 With respect to the first point, which concerns the ethical acceptability of euthanasia, this was inconsequential. The trial judge's ethical musings about euthanasia and assisted suicide were irrelevant to her ruling, the ethical or moral acceptability of the procedures was not an issue in the appeal,⁸⁸ and the Supreme Court of Canada was

unconcerned with the question.⁸⁹ The Court did, however, acknowledge the existence of moral opposition to killing patients and helping them commit suicide,⁹⁰ and the need to accommodate objecting health care providers.⁹¹

Notes

1. *Carter v. Canada, Christian Legal Fellowship's Written Submissions*, para. 85 (<http://www.consciencelaws.org/archive/documents/Carter/2011-12-01-submission-plaintiffs.pdf>) Accessed 2012-07-27
2. *Carter v. Canada*, para. 161-162, 183, 316
3. *Carter v. Canada*, para. 186, 318
4. *Carter v. Canada*, para. 177, 318
5. *Carter v. Canada*, para. 173
6. *Carter v. Canada*, para. 165
7. *Carter v. Canada*, para. 173. Emphasis added.
8. *Carter v. Canada*, para. 175. See Original Notice of Claim, Part 2, para. 1-3. This refers to the liberty interests of others who wish to help someone obtain “*physician-assisted dying services*,” not suicide *per se*. (*Original Notice of Claim*, Part 3, para. 12-14)
9. *Carter v. Canada*, para. 175
10. *Carter v. Canada*, para. 164
11. *Carter v. Canada*, para. 173
12. St. Augustine, *On the Free Choice of the Will (De Libero Arbitrio Voluntatis)*, Book I,V. Indianapolis-New York: Bobbs-Merrill, 1964, p. 11; St. Thomas Aquinas, *Summa Theologica*, II.I.96.4 (<http://www.newadvent.org/summa/2096.htm>) Accessed 2012-07-10; King, Martin Luther, *Letter from Birmingham Jail*, 16 April, 1963. http://www.africa.upenn.edu/Articles_Gen/Letter_Birmingham.html (Accessed 2012-07-10)
13. *Carter v. Canada*, para. 163, 200, 234, 236, 300, 303-306, 308-309, 311, 322, 349. Such reference also occur outside Part VII: para.5, 8, 492, 1198, 1336, 1369.
14. *Carter v. Canada*, para. 318
15. *Carter v. Canada*, para. 319, 344. They are identified in para. 254.
16. “Germany’s medical association has adopted a declaration apologizing for sadistic experiments and other actions of doctors under the Nazis. . . The medical association says “these crimes were not the actions of individual doctors but involved leading members of the medical community” and should be taken as a warning for the future.” German medical association apologizes for Nazi-era crimes committed by doctors. *Associated Press*, 25 May,

2012.

(<http://www.foxnews.com/world/2012/05/25/german-doctors-apologize-for-nazi-era-crimes>)
Accessed 2012-07-23. See also Lifton, Robert Jay, *The Nazi Doctors: Medical Killing and the Psychology of Genocide*. United States: Basic Books, 1986, p.33-35.

17. For example, “The nature of a fiduciary relationship makes a consensual sexual relationship between physician and patient impossible.” College of Physicians and Surgeons of British Columbia, Professional Standards and Guidelines: *Sexual Boundaries in the Physician-Patient Relationship* (October, 2009)
(<https://www.cpsbc.ca/files/u6/Sexual-Boundaries-in-the-Patient-Physician-Relationship.pdf>)
Accessed 2012-07-10

18. Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst (KNMG), *Seksueel contact tussen arts en patiënt: Het mag niet, het mag nooit*. [Royal Dutch Medical Association, *Sexual contact between doctor and patient: It should not be, it should never be.*](2000)
(<http://knmg.artsennet.nl/Publicaties/KNMGpublicatie/Seksueel-contact-tussen-arts-en-patient-het-mag-niet-het-mag-nooit-2000.htm>) Accessed 2012-07-10

19. Royal Dutch Medical Association, *The Role of the Physician in the Voluntary Termination of Life* (30 August, 2011)
(<http://knmg.artsennet.nl/Publicaties/KNMGpublicatie/Position-paper-The-role-of-the-physician-in-the-voluntary-termination-of-life-2011.htm>) Accessed 2012-07-12

20. General Medical Council, *Maintaining Boundaries: Guidance for Doctors*. (November, 2006) (http://www.gmc-uk.org/guidance/ethical_guidance/maintaining_boundaries.asp)
Accessed 2012-07-19; Hunt, Liz, “Sex with patients remains taboo. BMA conference: Doctors take steps to repair their tarnished image.” *The Independent*, 28 June, 1996
(<http://www.independent.co.uk/news/sex-with-patients-remains-taboo-1339111.html>)
Accessed 2012-07-19

21. Barilan, Y Michael, *Of Doctor-Patient Sex and Assisted Suicide* IMAJ 5:460-463. June, 2003. (<http://www.ima.org.il/imag/ar03ju-23.pdf>) Accessed 2012-07-10

22. *Carter v. Canada*, para. 274-277

23. *Carter v. Canada*, para. 233. Plaintiff witnesses: Prof. Wayne Sumner; Dr. Marcia Angell; Prof. Margaret Battin; Dr. Upshur; Dr. Gerritt Kimsma. Defendant witnesses: Prof. John Keown; Prof. Thomas Koch; Dr. Bereza.

24. *Carter v. Canada*, para. 238-242

25. *Carter v. Canada*, para. 246-247

26. *Carter v. Canada*, para. 244

27. *Carter v. Canada*, para. 243

28. *Carter v. Canada*, para. 203-204, 680.
29. *Carter v. Canada*, para. 1370.
30. *Carter v. Canada*, para. 185
31. *Carter v. Canada*, para. 207-223.
32. *Carter v. Canada*, para. 227-230.
33. *Carter v. Canada*, para. 231.
34. The deficiencies are discussed in detail in Murphy S., “Legalizing therapeutic homicide and assisted suicide: A tour of *Carter v. Canada*. Appendix ‘C’ - *Carter* Part VII: Postscript.” *Protection of Conscience Project* (<http://www.consciencelaws.org/law/commentary/legal073-004.aspx>)
35. *Carter v. Canada*, para. 318, 320
36. *Carter v. Canada*, para. 163, 176; 186, 234-237, 321-322
37. *Carter v. Canada*, para. 177
38. *Carter v. Canada*, para. 278-284, 286-287
39. *Carter v. Canada*, para. 285
40. *Carter v. Canada*, para. 347
41. *Carter v. Canada*, para. 280
42. *Carter v. Canada*, para. 347
43. *Carter v. Canada*, para. 288-292
44. *Carter v. Canada*, para. 295-296, 298
45. Prof. Sheila McLean, Prof. Jocelyn Downie, Prof. Ross Upshur, Prof. Johannes J.M. van Delden, Prof. Udo Schuklenk
46. *Carter v. Canada*, para. 123. The witnesses were Prof. Ross Upshur, Prof. Johannes J.M. van Delden and Prof. Udo Schuklenk. Prof. Jocelyn Downie instructed plaintiff witnesses.
47. *Carter v. Canada*, para. 124
48. Couture, Linda, *Results of public hearings held by The Select Committee on dying with dignity in Quebec: Briefs submitted*. (15 November, 2011) (http://www.vivredignite.com/en/docs/positon_csmd_nov15_11.pdf) Accessed 2012-07-22
49. *Carter v. Canada*, para. 290-292, 346

50. *Carter v. Canada*, para. 346
51. *Carter v. Canada*, para. 300-307.
52. *Carter v. Canada*, para. 355.
53. *Carter v. Canada*, para. 299.
54. Director of Public Prosecutions, *Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide*. February, 2010, para. 43.14 (http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.html) Accessed 2012-07-13
55. *Carter v. Canada*, para. 309; 190-193
56. *Carter v. Canada*, para. 309
57. *Carter v. Canada*, para. 310
58. *Carter v. Canada*, para. 239
59. *Carter v. Canada*, para. 311. Her comment also demonstrates she shaping and limiting power of the pleadings, which exclude consideration of others whose interests might be affected by the judgement.
60. *Carter v. Canada*, para. 312-313
61. *Carter v. Canada*, para. 314-315
62. *Carter v. Canada*, para. 326-333
63. *Carter v. Canada*, para. 321-323
64. *Carter v. Canada*, para. 324-325
65. *Carter v. Canada*, para. 330
66. *Carter v. Canada*, para. 929
67. *Carter v. Canada*, para. 334
68. *Carter v. Canada*, para. 5
69. *Carter v. Canada*, para. 335
70. *Carter v. Canada*, para. 336-337
71. *Carter v. Canada*, para. 338
72. *Carter v. Canada*, para. 340, 357

73. *Carter v. Canada*, para. 5
74. *Carter v. Canada*, para. 8-10, 15-18
75. Sachedina, Abdulaziz, *Islamic Biomedical Ethics: Principles and Application*. Oxford: University Press, 2009, p. 166
76. *Carter v. Canada*, para. 350
77. *Carter v. Canada*, para. 171
78. *Carter v. Canada*, para. 351
79. *Carter v. Canada*, para. 343
80. *Carter v. Canada*, para. 345-346
81. *Carter v. Canada*, para. 348
82. *Carter v. Canada*, para. 358. See also para. 6, 7
83. *Carter v. Canada*, para. 342, 358
84. *Carter v. Canada, Christian Legal Fellowship's Written Submissions*, para. 41, 44-45 (<http://www.consciencelaws.org/archive/documents/Carter/2011-12-01-submission-plaintiffs.pdf>) Accessed 2012-07-27
85. *Housen v. Nikolaisen*, [2002] 2 S.C.R. 235, 2002 SCC 33 (<http://scc-csc.lexum.com/scc-csc/scc-csc/en/item/1972/index.do>) Accessed 2016-01-05
86. *Carter v. Canada (Attorney General)*, 2015 SCC 5 (Hereinafter "*Carter*, SCC"), para. 23-24 (<https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/14637/index.do>) Accessed 2015-06-27.
87. *Carter*, SCC, para. 47
88. *Carter*, SCC, para. 40
89. *Carter*, SCC, para. 1-4
90. *Carter*, SCC, para. 130-131
91. *Carter*, SCC, para. 132

Appendix “C”

Physician Exercise of Freedom of Conscience and Religion

C1. Introduction

C1.1 To minimize inconvenience to patients and avoid conflict, physicians should develop a plan to meet the requirements of Parts C2 and C3 for services they are unwilling to provide for reasons of conscience or religion.

C2. Providing information to patients

C2.1 This Part highlights points of particular interest within the context of the exercise of freedom of conscience. It is not an exhaustive treatment of the subject of informed consent.

C2.2 In exercising freedom of conscience and religion, physicians must provide patients with sufficient and timely information to make them aware of relevant treatment options so that they can make informed decisions about accepting or refusing medical treatment and care.

- CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) I.4¹
- Canadian Medical Association *Code of Ethics* (2004) para. 21²
- Canadian Medical Protective Association, *Consent: A guide for Canadian physicians* (4th ed) (May, 2006): Disclosure of information; Standard of disclosure.³
- Canadian Medical Association, *Principles-based Recommendations for a Canadian Approach to Assisted Dying* (2015) Section 1.2,⁴ 5.2⁵

C2.3 Sufficient information is that which a reasonable patient in the place of the patient would want to have, including diagnosis, prognosis and a balanced explanation of the benefits, burdens and risks associated with each option.

- CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) I.7⁶
- Canadian Medical Association *Code of Ethics* (2004) para. 21²
- Canadian Medical Protective Association, *Consent: A guide for Canadian physicians* (4th ed) (May, 2006): Standard of disclosure; Some practical considerations.⁷
- Canadian Medical Association, *Principles-based Recommendations for a Canadian Approach to Assisted Dying* (2015) Section 1.2,⁴ 5.2⁵

C2.4 Information is timely if it is provided as soon as it will be of benefit to the patient. Timely information will enable interventions based on informed decisions that are most likely to cure or mitigate the patient’s medical condition, prevent it from developing further, or avoid interventions involving greater burdens or risks to the patient.

- C2.5 Relevant treatment options include all legal and clinically appropriate procedures, services or treatments that may have a therapeutic benefit for the patient, whether or not they are publicly funded, including the option of no treatment or treatments other than those recommended by the physician.
- Canadian Medical Association *Code of Ethics* (2004) para. 23⁸
 - Canadian Medical Protective Association, *Consent: A guide for Canadian physicians* (4th ed) (May, 2006): Standard of disclosure; Some practical considerations.⁷
- C2.6 Physicians whose medical opinion concerning treatment options is not consistent with the general view of the medical profession must disclose this to the patient.
- Canadian Medical Association *Code of Ethics* (2004) para.45⁹
- C2.7 The information provided must be responsive to the needs of the patient, and communicated respectfully and in a way likely to be understood by the patient. Physicians must answer a patient's questions to the best of their ability.
- CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) I.4¹
 - Canadian Medical Association *Code of Ethics* (2004) para. 21,² 22¹⁰
 - Canadian Medical Protective Association, *Consent: A guide for Canadian physicians* (4th ed) (May, 2006): Standard of disclosure; Some practical considerations - (3)¹¹
 - Canadian Medical Association, *Principles-based Recommendations for a Canadian Approach to Assisted Dying* (2015) Foundational Principle (6)¹² (10)¹³
- C2.8 Physicians who are unable or unwilling to comply with these requirements must promptly arrange for a patient to be seen by another physician or health care worker who can do so.

C3. Exercising freedom of conscience or religion

- C3.1 In exercising freedom of conscience and religion, physicians must adhere to the requirements of Part C2 (Providing information to patients).
- C3.2 In general, and when providing information to facilitate informed decision making, physicians must give reasonable notice to patients of religious, ethical or other conscientious convictions that influence their recommendations or practice or prevent them from providing certain procedures or services. Physicians must also give reasonable notice to patients if their views change.
- CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) I.16¹⁴
 - Canadian Medical Association *Code of Ethics* (2004) para. 12,¹⁵ 21²
- C3.3 Notice is reasonable if it is given as soon as it would be apparent to a reasonable and prudent person that a conflict is likely to arise concerning treatments or services the physician declines to provide, erring on the side of sooner rather than later. In many

- cases - but not all - this may be prior to accepting someone as a patient, or when a patient is accepted.
- C3.4 In complying with these requirements, physicians should limit discussion related to their religious, ethical or moral convictions to what is relevant to the patient's care and treatment, reasonably necessary for providing an explanation, and responsive to the patient's questions and concerns.
- C3.5 Physicians who decline to recommend or provide services or procedures for reasons of conscience or religion must advise affected patients that they may seek the services elsewhere, and provide information about how to find other service providers. Should the patient do so, physicians must, upon request, transfer the care of the patient or patient records to the physician or health care provider chosen by the patient.
- (CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) II.10¹⁶
 - Canadian Medical Association *Code of Ethics* (2004) para. 21²
 - Canadian Medical Association, *Principles-based Recommendations for a Canadian Approach to Assisted Dying* (2015) Section 5.2⁵
- C3.6 Alternatively, in response to a patient request, physicians may respond in one of the following ways, consistent with their moral, ethical or religious convictions:
- a) by arranging for a transfer of care to another physician able to provide the service; or
 - b) by providing a formal referral to someone able to provide the service; or
 - c) by providing contact information for someone able to provide the service; or
 - d) by providing contact information for an agency or organization that will refer the patient to a service provider; or
 - e) by providing contact information for an agency or organization that provides information the patient may use to contact a service provider; or
 - f) by providing non-directive, non-selective information that will facilitate patient contact with other physicians, health care workers or sources of information about the services being sought by the patient.
- (CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) II.10¹⁶
 - Canadian Medical Association, *Principles-based Recommendations for a Canadian Approach to Assisted Dying* (2015) Section 5.2⁵
- C3.7 A physician's response under C3.5 or C3.6 must be timely. Timely responses will enable interventions based on informed decisions that are most likely to cure or mitigate the patient's medical condition, prevent it from developing further, or avoid interventions involving greater burdens or risks to the patient.
- C3.8 In acting pursuant to C3.5 or C3.6, physicians must continue to provide other treatment or care until a transfer of care is effected, unless the physician and patient agree to other arrangements.

- CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) I.16,¹⁴ II.11¹⁷
 - Canadian Medical Association *Code of Ethics* (2004) para. 19,¹⁸ 21²
- C3.9 Physicians unwilling or unable to comply with these requirements must promptly arrange for a patient to be seen by another physician or health care worker who can do so.
- C3.10 Physicians who provide medical services in a health care facility must give reasonable notice to a medical administrator of the facility if religious, ethical or other conscientious convictions prevent them from providing certain procedures or services, and those procedures or services are or are likely to be provided in the facility. In many cases - but not all - this may be when the physician begins to provide medical services at the facility.
- C4. Reminder: treatments in emergencies**
- C4.1 Physicians must provide medical treatment that is within their competence when a patient is likely to die or suffer grave injury if the treatment is not immediately provided, or immediately arrange for the patient to be seen by someone competent to provide the necessary treatment.
- Canadian Medical Association *Code of Ethics* (2004) para. 18¹⁹
- C4.2 Physicians who fail to provide or arrange for medical treatment in such circumstances may be liable for negligence or malpractice.

Notes:

1. *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) (Canadian Medical Association, Canadian Healthcare Association, Canadian Nurses' Association, Catholic Health Association of Canada) "I.1 Open communication, within the confines of privacy and confidentiality, is also required. All those involved in decision-making should be encouraged to express their points of view, and these views should be respectfully considered. Care providers should ensure that they understand the needs, values and preferences of the person receiving care. To avoid misunderstanding or confusion, they should make their communications direct, clear and consistent. They should verify that the person receiving care understands the information being conveyed: silence should not be assumed to indicate agreement. The person receiving care should be provided with the necessary support, time and opportunity to participate fully in discussions regarding care."

(<http://www.consciencelaws.org/background/policy/associations-001.aspx>)

2. Canadian Medical Association *Code of Ethics* (2004): "21. Provide your patients with the information they need to make informed decisions about their medical care, and answer their questions to the best of your ability."

(<http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf>) Accessed 2015-09-22

3. Canadian Medical Protective Association, *Consent: A guide for Canadian physicians* (4th ed) (May, 2006)

(<https://www.cmpa-acpm.ca/-/consent-a-guide-for-canadian-physicians#disclosure>) Accessed 2015-09-15

4. Canadian Medical Association, *Principles-based Recommendations for a Canadian Approach to Assisted Dying* (2016) “Section 1.2: The attending physician must disclose to the patient information regarding their health status, diagnosis, prognosis, the certainty of death upon taking the lethal medication, and alternatives, including comfort care, palliative and hospice care, and pain and symptom control.”

(https://www.cma.ca/Assets/assets-library/document/en/advocacy/cma-framework_assisted-dying_final-jan2016.pdf) Accessed 2016-01-09

5. Canadian Medical Association, *Principles-based Recommendations for a Canadian Approach to Assisted Dying* (2016) “Section 5.2: . . . physicians are expected to provide the patient with complete information on all options available to them, including assisted dying, and advise the patient on how they can access any separate central information, counseling, and referral service.”

(https://www.cma.ca/Assets/assets-library/document/en/advocacy/cma-framework_assisted-dying_final-jan2016.pdf) Accessed 2016-01-09

6. *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) (Canadian Medical Association, Canadian Healthcare Association, Canadian Nurses’ Association, Catholic Health Association of Canada) “I.7 Informed decision-making requires that the person receiving care or his or her proxy be given all information and support necessary for assessing the available options for care, including the potential benefits and risks of the proposed course of action and of the alternatives, including palliative care.”

(<http://www.consciencelaws.org/background/policy/associations-001.aspx>)

7. Canadian Medical Protective Association, *Consent: A guide for Canadian physicians* (4th ed) (May, 2006): Standard of disclosure; Some practical considerations.

(<https://www.cmpa-acpm.ca/-/consent-a-guide-for-canadian-physicians#practical>) Accessed 2016-01-09

8. Canadian Medical Association *Code of Ethics* (2004): “23. Recommend only those diagnostic and therapeutic services that you consider to be beneficial to your patient or to others. . . .” (<http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf>) Accessed 2015-09-22

9. Canadian Medical Association *Code of Ethics* (2004): “45. Recognize a responsibility to give generally held opinions of the profession when interpreting scientific knowledge to the public; when presenting an opinion that is contrary to the generally held opinion of the profession, so indicate.” (<http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf>) Accessed 2015-09-22

10. Canadian Medical Association *Code of Ethics* (2004): “22. Make every reasonable effort to communicate with your patients in such a way that information exchanged is understood.” (<http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf>) Accessed 2015-09-22

11. Canadian Medical Protective Association, *Consent: A guide for Canadian physicians* (4th ed) (May, 2006): Standard of disclosure; Some practical considerations. “3. A physician must answer any specific questions posed by the patient as to the risks involved in the proposed treatment. Always the patient must be given the opportunity to ask questions.” (<https://www.cmpa-acpm.ca/-/consent-a-guide-for-canadian-physicians#practical>) Accessed 2016-01-09
12. Canadian Medical Association, *Principles-based Recommendations for a Canadian Approach to Assisted Dying* (2015) “Foundational Principle (6) Dignity: All patients, their family members or significant others should be treated with dignity and respect at all times, including throughout the entire process of care at the end of life.” “Foundational Principle (https://www.cma.ca/Assets/assets-library/document/en/advocacy/cma-framework_assisted-dying_final-jan2016.pdf) Accessed 2016-01-09
13. Canadian Medical Association, *Principles-based Recommendations for a Canadian Approach to Assisted Dying* (2015) “Foundational Principle (10) Mutual respect: There should be mutual respect between the patient making the request and the physician who must decide whether or not to perform assisted dying. A request for assisted dying is only possible in a meaningful physician-patient relationship where both participants recognize the gravity of such a request. . . .” (https://www.cma.ca/Assets/assets-library/document/en/advocacy/cma-framework_assisted-dying_final-jan2016.pdf) Accessed 2016-01-09
14. *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) (Canadian Medical Association, Canadian Healthcare Association, Canadian Nurses’ Association, Catholic Health Association of Canada) “I.16 . . . Health care providers should declare in advance their inability to participate in procedures that are contrary to their professional or moral values. . . .” (<http://www.consciencelaws.org/background/policy/associations-001.aspx>)
15. Canadian Medical Association *Code of Ethics* (2004): “12. Inform your patient when your personal values would influence the recommendation or practice of any medical procedure that the patient needs or wants.” (<http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf>) Accessed 2015-09-22
16. *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) (Canadian Medical Association, Canadian Healthcare Association, Canadian Nurses’ Association, Catholic Health Association of Canada) “II.10 If the person receiving care or his or her proxy is dissatisfied with the decision, and another care provider, facility or agency is prepared to accommodate the person's needs and preferences, provide the opportunity for transfer.” (<http://www.consciencelaws.org/background/policy/associations-001.aspx>)
17. *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) (Canadian Medical Association, Canadian Healthcare Association, Canadian Nurses’ Association, Catholic Health Association of Canada) “II.11 If a health care provider cannot support the decision that prevails as a matter

of professional judgement or personal morality, allow him or her to withdraw without reprisal from participation in carrying out the decision, after ensuring that the person receiving care is not at risk of harm or abandonment.”

(<http://www.consciencelaws.org/background/policy/associations-001.aspx>)

18. Canadian Medical Association *Code of Ethics* (2004): “19. Having accepted professional responsibility for a patient, continue to provide services until they are no longer required or wanted; until another suitable physician has assumed responsibility for the patient; or until the patient has been given reasonable notice that you intend to terminate the relationship.”
(<http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf>) Accessed 2015-09-22

19. Canadian Medical Association *Code of Ethics* (2004): "18. Provide whatever appropriate assistance you can to any person with an urgent need for medical care. "
(<http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf>) Accessed 2015-09-22