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Legalization of Assisted Suicide and Euthanasia: Foundational Issues and Implications

*Sean Murphy**

ABSTRACT

This paper takes a general approach by examining foundational issues, and the primary focus is on a single jurisdiction: Canada. It outlines the current legal criteria for euthanasia and assisted suicide in Canada, identifying differences in criteria for the procedures set by the Supreme Court of Canada, Quebec's unique provincial euthanasia law, and the Criminal Code.

Commentary drawing from anecdotal reports from eight dissenting physicians offers some insight into their experience since legalization of the procedures. Material from the public record provides additional context, and the commentary is informed by difficulties that have arisen in relation to morally contested procedures. The experience of dissenting physicians is affected by a number of variables, including cultural and social dynamics, differing beliefs, differing moral and social sensitivity and individual personalities. Four sources of stress are identified: the demand for collaboration in killing, the prospect of punishment, the continuing need to distinguish between cooperation and collaboration, and concern for their patients. Particular concerns of palliative care physicians are discussed, as well as concerns shared by other dissenting physicians.

*A detailed review of the moral underpinnings of the trial court decision in *Carter v. Canada* demonstrates that morality precedes and drives law. From this it is argued that a judge will either assume or construct a moral justification that supports a decision, even if this is not explicitly articulated in legal reasoning. These assertions are tested against the ruling of the Irish High Court in *Fleming v. Ireland &**

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Ors, which came to radically different conclusions about the risks presented by legalization of assisted suicide and euthanasia.

An extensive discussion distinguishes the obligation to kill from the more familiar authorization or justification of killing. An obligation to kill can be based upon a contract model of obligation, a social contract (professional) model, and a fiduciary model, each with increasingly serious consequences. To allow the state to enforce an obligation to kill under any of the three models is subversive of life, liberty and security of the person, even before issues of freedom of conscience and religion are considered. In addition, the implications of an obligation to kill suggest that, in the long term, assisted-suicide-only regimes are likely to be unstable.

Legislative developments demonstrate that the government of Canada supports totalitarian claims seeking total domination of will and intellect in moral decision-making, even in matters of life and death. The ground for this was prepared by demands that dissenting physicians should be forced to refer for abortion and contraception, which established popular support for the erroneous and incoherent principle that there can be a moral duty to do what one believes to be wrong.

The Carter ruling formally ratified a new establishment orthodoxy, according to which refusing to at least collaborate in killing in circumstances defined by Carter is unacceptable. This new orthodoxy can be expected to operate at a foundational level, exerting a significant influence that may not be immediately obvious. A defense of freedom of conscience and religion must take this into account.

In particular, the medico-legal establishment sees the exercise of freedom of conscience and religion through the dogmatic lens of the new orthodoxy. Dissenting physicians are viewed as heretics threatening an establishment theory of social contract. This is dogmatic moral imperialism, and not less so because the dogmatists are not ecclesiastical theorists and functionaries. It should be identified as such.

Again, foundational moral beliefs shape jurisprudence. Judges should be challenged to candidly acknowledge and precisely articulate the philosophical or moral premises underpinning their positions. Similarly, what lies at the root of current controversies about freedom of conscience and religion is fundamental disagreement about the nature of the human person. Thus, judges should clearly acknowledge the credal concept of the human person that informs the evaluation of evidence and legal reasoning.

Finally, freedom of conscience is exercised in two different ways. The first is by pursuing some good that one thinks should be done; call this perfective freedom of conscience, because the pursuit of the good as one understands it is thought to be perfective of the human person. The second is refusing to do what one believes to be wrong; call this preservative freedom of conscience, or preservative of personal integrity.

No polity could long exist without restrictions of some sort on human acts, so some limitation of perfective freedom of conscience is not unexpected. On the other hand, suppressing preservative freedom of conscience by compelling people to serve ends they find morally abhorrent reduces them to a form of servitude that cannot be reconciled with principles of equality. It is inconsistent with the best traditions and aspirations of liberal democracy, since it instils attitudes more suited to totalitarian regimes than to the demands of responsible freedom. It arguably imposes upon them a particularly odious form of involuntary servitude, which is all but forbidden by the Thirteenth Amendment to the Constitution of the United States.

This does not mean that no restriction can ever be placed on preservative freedom of conscience. It does mean, however, that if the restriction can be justified at all, it will only be as a last resort and only in the most exceptional circumstances.

I. INTRODUCTION

This paper reflects upon some of the implications of the legalization of assisted suicide and euthanasia. Consistent with the Project's mandate, this paper's focus is on physicians who object to the procedures for reasons of conscience or religion, and on the broader implications for law and fundamental freedoms. While legalization of the procedures also affects nurses and other health care workers, it is appropriate to begin with physicians because it is legalization of physician-assisted suicide and physician-administered euthanasia that is most frequently advocated.

The physicians who are the focus of this paper are referred to throughout as dissenters rather than objectors. Certainly, they have religious or conscientious objections to euthanasia and assisted suicide, but, generally speaking that is because they dissent from a new orthodoxy espoused by establishment high priests who have a considerable following.

A. Problems of the Approach

In considering the implications of the legalization of assisted suicide and euthanasia, this paper takes a general approach by examining foundational issues, and the primary focus is on a single jurisdiction. This mitigates some of the factors affecting the validity of empirical research and systematic comparisons across jurisdictions: methodology, the nature and scope of legalization, jurisprudential traditions, and cultural and social differences. However, these difficulties are acknowledged here because they cannot be entirely avoided.

1. Methodology

The implications of the legalization of assisted suicide and euthanasia might be revealed by studying what has happened in jurisdictions where it has been legalized. In theory, legalization should produce measurable results that can be studied over time to provide empirical findings about changes attributable to it. It will be seen, however, that people—including judges—can cite the same data to justify diametrically opposite conclusions.

Further, important data may be lacking for the period prior to legalization so that it may be extremely difficult—even impossible—to empirically establish the existence, nature and extent of a change. For example, the Canadian Medical Association conducted surveys of physician attitudes about euthanasia and assisted suicide prior to, and soon after, the Supreme Court of Canada decision that approved the practices. However, these were of doubtful empirical value so that, even if scientific surveys are done in the future, comparisons are unlikely to yield findings of significant value. In addition, commentators like Professor Margaret Somerville argue that some important kinds of changes are not easily measured.

“The problem,” she says, “is that many of the serious risks and harms of legalized physician-assisted suicide and euthanasia, at levels other than that of the individual, are not physical risks and harms but metaphysical ones (to values, beliefs, attitudes, norms and so on) that are not necessarily assessable through empirical research, especially the metaphysical harms that will occur in the future.”¹

1. MARGARET SOMERVILLE, *BIRD ON AN ETHICS WIRE: BATTLES ABOUT VALUES IN THE CULTURE WARS* 132 (Mc-Gill-Queen’s University Press 2015) [hereinafter *Somerville, Bird*].

This is related to another methodological problem: that the implications of legalization (whatever they might be) may not be evident during the period of study. This is certainly the case in Canada, where euthanasia and assisted suicide first became legally available only within the last year.

2. Nature of legalization

Legalization is not a uniform process. It can be triggered by judicial fiat (Canada), through referendum or citizen initiative (Washington and Oregon), and by a public policy of non-prosecution, which ultimately leads to legislation (Netherlands). Legalization can also occur directly by legislative action (Quebec, California, and Vermont), but these proceedings may differ among jurisdictions with respect to public and professional input, balance, transparency, and thoroughness. The implications of legalization will depend, in part, upon the manner in which it is achieved.

3. Scope of legalization

Some jurisdictions distinguish between euthanasia and assisted suicide, and allow both (Canada); some distinguish between them, but allow only one or the other (Quebec allows only euthanasia; American states allow only assisted suicide); some allow both (the Netherlands). In addition, criteria for the procedures vary among jurisdictions and can change with time, and different jurisdictions have different rules about who can provide the services, and different procedural requirements.

4. Jurisprudential considerations

Different constitutional traditions are likely to exert influence on the understanding of law and the development of jurisprudence, particularly in relation to human rights, all having implications for consequences flowing from legalization of the procedures.

5. Cultural and social differences

Finally, legalization always occurs within a specific cultural and social framework. Some jurisdictions are relatively homogenous in ethnicity, religion, language, and customs, while others are notably

diverse. Some jurisdictions are culturally and socially similar to each other, while quite different from others. Implications for families and society may vary considerably within a culturally and socially heterogeneous jurisdiction, as well as between jurisdictions.

II. EUTHANASIA AND ASSISTED SUICIDE IN CANADA

A. Legal Background

Sue Rodriguez was 41 years old when diagnosed with amyotrophic lateral sclerosis (ALS or Lou Gehrig's Disease) in 1991. She wanted a physician to assist her to commit suicide, but assisted suicide was illegal. She launched a constitutional challenge that was heard by the Supreme Court of Canada in 1993. By a 5-4 decision the Court ruled that the law prohibiting assisted suicide did not violate the *Canadian Charter of Rights and Freedoms*.²

Seeking to reverse the *Rodriguez* decision, in 2011 the British Columbia Civil Liberties Association and others filed what became the landmark case of *Carter v. Canada (Attorney General)*. The plaintiffs specifically wanted *physician* assisted suicide and *physician* administered euthanasia because, they claimed, these were medical treatments. Medical treatments, they argued, fell under provincial health care jurisdiction and could not be prohibited by the federal government in the Criminal Code. They sought euthanasia and assisted suicide for any grievously and irremediably ill patient, not just for the terminally ill.³

In 2014, ten days after a British Columbia Supreme Court judge had ruled in favour of the plaintiffs in *Carter*,⁴ the Quebec government passed the *Act Respecting End of Life Care* (ARELC), declaring that eligible patients have a *right* to "end-of life-care" including euthanasia. It authorized euthanasia by physicians, but not assisted suicide.⁵

Euthanasia under the terms of the Quebec law amounted to first-degree murder under Canada's Criminal Code, a federal statute, but

2. *Rodriguez v. B.C.*, [1993] 3 S.C.R. 519 (Can.).

3. *In the Supreme Court of British Columbia Notice of Civil Claim*, B.C. CIVIL LIBERTIES ASS'N (Apr. 26, 2011), <https://bccla.org/wp-content/uploads/2012/03/20110426-BCCL A-Legal-Case-Carter-et-al.pdf>.

4. *Carter v. Canada*, [2012] BCSC 886 (Can.).

5. *An Act Respecting End-of-Life Care*, S.C. 2013, c. 52 (Can.) (Original text and text as passed by the Quebec National Assembly, 5 June, 2014) [hereinafter *ARELC*].

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Canadian provinces have constitutional jurisdiction to administer the criminal law. Quebec's attorney general promised immunity from prosecution for physicians who complied with ARELC. The federal government did not intervene. While traditional political concerns about Quebec nationalism were likely a factor, the Quebec law did not take effect until December 2015. This was long after the pending ruling by the Supreme Court of Canada in *Carter*, and also after the federal election. It made legal and political sense to take no action at least until after the ruling.

On February 6th, 2015, the nine Supreme Court justices unanimously ruled in *Carter* that physicians should be allowed to provide euthanasia or assisted suicide in some circumstances.⁶ They suspended the ruling for a year to give governments and the medical profession a chance to enact new laws and regulations. The Court later granted a four-month extension of the suspension. However, it also allowed euthanasia to proceed during that time in Quebec, under its provincial statute, and authorized superior courts elsewhere to grant euthanasia or assisted suicide requests in accordance with the *Carter* ruling.⁷ In June 2016, Parliament passed an amendment to the Criminal Code to implement the *Carter* decision.

B. Criteria for Euthanasia/Assisted Suicide

It might be said that Canada actually has three sources of laws governing euthanasia and assisted suicide: the Supreme Court ruling in *Carter*, the Quebec euthanasia law, and the Criminal Code. The only thing that everyone agrees upon is that the *Carter* ruling is the standard that other laws have to meet. The following summary is limited to an outline of the basic criteria established by each.

1. Carter

The *Carter* ruling requires that physicians be allowed to provide euthanasia or assisted suicide:

- for competent adults who clearly consent,
- who have a grievous and irremediable medical condition,
- including illness, disease, or disability,

6. *Carter v. Canada*, [2015] S.C.R. 331 (Can.).

7. *Carter v. Canada*, [2016] S.C.R. 13 (Can.).

- that causes enduring and intolerable physical or psychological suffering,
- that cannot be relieved by means acceptable to the individual.

The Court did not rule out allowing euthanasia or assisted suicide in other situations. That is yet to be decided by Parliament or by further litigation.⁸

2. *Quebec*

The Quebec law is more restrictive than *Carter* because it allows only euthanasia, and only for someone “at the end of life”⁹ who is in an “advanced state of irreversible decline in capability.”¹⁰ Otherwise, it is essentially the same as *Carter*.

3. *Criminal Code*

The Criminal Code is more permissive than *Carter* in one respect. It allows both physicians and nurse practitioners to provide the end of life services.¹¹

It is more specific than *Carter* because it requires that candidates be at least 18 years old. This is consistent with *Carter’s* requirement that the candidates be adults.

Candidates must also be eligible for government health insurance, a provision intended to prevent suicide tourism. The Court was silent on this issue.

However, the Criminal Code adds three criteria not found in *Carter*.

First: the illness, disease or disability must be incurable.

Second: the candidate must be in an advanced state of irreversible decline in capability, a provision borrowed from the Quebec law.

Third: the natural death of the candidate must be reasonably foreseeable, though no timeline is required. This is similar to the Quebec law.¹²

8. *See Carter*, [2015] S.C.R. 331 at ¶ 127.

9. *ARELC*, *supra* note 5, § 26(3).

10. *ARELC*, *supra* note 5, § 26(5).

11. The Criminal Code authorizes nurse practitioners to provide euthanasia and assisted suicide, but they can do so only if permitted by provincial regulations or policies.

12. An Act to amend the Criminal Code and to make related amendments to other Acts

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The B.C. Civil Liberties Association has filed a lawsuit alleging that these provisions are unconstitutional.¹³

C. The Current Situation

While the federal government has jurisdiction in criminal law, provinces have jurisdiction in health care and the regulation of health care professions. Quebec law allows physicians to provide only euthanasia; elsewhere, subject to provincial regulations, physicians and nurse practitioners may provide either assisted suicide or euthanasia. Religiously affiliated hospitals are incorporated into the state health care system on terms which seem to have largely respected their denominational integrity. Now they face increasingly strident demands that they be forced to provide the procedures.¹⁴

Provincial medical regulators are called Colleges of Physicians and Surgeons. The College of Physicians and Surgeons in Ontario demands effective referral by dissenting physicians for all morally contested procedures, including euthanasia and assisted suicide.¹⁵

An effective referral means a referral made in good faith, to a non-objecting, available, and accessible physician, other health-care professional, or agency. The referral must be made in a timely manner to allow patients to access care. Patients must not be exposed to adverse clinical outcomes due to a delayed referral.¹⁶

Two lawsuits have been filed against the Ontario College as a result.¹⁷ The College in Nova Scotia makes a similar demand under the

(medical assistance in dying), S.C. 2016, C-14 (Can.).

13. See Julia Lamb & B.C. Civil Liberties Ass'n, *In The Supreme Court of British Columbia Notice of Civil Claim*, B.C. CIVIL LIBERTIES ASS'N (June 27, 2016), <https://bccla.org/wp-content/uploads/2016/06/2016-06-27-Notice-of-Civil-Claim-1.pdf>.

14. See Paula Simons, *If Covenant Health won't obey law, it shouldn't get public funds to run public hospitals*, EDMONTON J. (Feb. 12, 2016), <http://edmontonjournal.com/opinion/columnists/paula-simons-if-covenant-health-wont-obey-law-it-shouldnt-get-public-funds-to-run-public-hospitals> [hereinafter Simons].

15. *Policy Statement #4-16, Medical Assistance in Dying*, COLL. OF PHYSICIANS AND SURGEONS OF ONTARIO (June 2016) <http://www.cpso.on.ca/Policies-Publications/Policy/Medical-Assistance-in-Dying> [hereinafter CPSO-MAID].

16. *Policy Statement #2-15, Professional Obligations and Human Rights*, COLL. OF PHYSICIANS AND SURGEONS OF ONTARIO, (March 2015) <http://www.cpso.on.ca/policies-publications/policy/professional-obligations-and-human-rights> [hereinafter CPSO-POHR].

17. See Christian Medical and Dental Society of Canada et al., *Ontario Superior Court of Justice Notice of Application*, THE PROTECTION OF CONSCIENCE PROJECT (Mar. 20, 2015), <http://consciencelaws.org/archive/documents/cpso/2015-03-20-cmds-notice.pdf>; see also Coalition for HealthCARE and Conscience, *Ontario physicians oppose referrals for assisted suicide, seek judicial review of CPSO requirement*, THE PROTECTION OF CONSCIENCE

rubric of an effective transfer of care.¹⁸ The *Code of Ethics* of the Collège des Médecins du Québec requires dissenting physicians to refer for services they decline to provide.¹⁹ The Quebec euthanasia law alludes to this²⁰ but also allows a physician who refuses to provide euthanasia for reasons of conscience to notify a designated administrator, who then becomes responsible for finding a willing practitioner.²¹

D. Drawing the Line Between Co-operation and Collaboration

Other regulators have adopted the following approach for all morally contested services, including euthanasia and assisted suicide:²²

- Dissenting physicians are expected to provide information needed for informed medical decision making, such as prognosis, treatments or procedures available, benefits and burdens of treatment, etc. A physician unwilling to provide this kind of information is required to refer the patient to someone who will. This referral is for information, not for the morally contested service.
- If need be, dissenting physicians are expected to advise patients how they can find other physicians or health care providers.
- While most policies do not say so explicitly, dissenting physicians are not expected to make an effective referral for a morally contested service.

This is generally accepted by dissenting physicians. They are willing to cooperate to enable a patient to make informed decisions

PROJECT (June 20, 2016), <http://consciencelaws.org/blog/?p=6913>.

18. *Professional Standard Regarding Medical Assistance in Dying*, C. OF PHYSICIANS & SURGEONS OF NOVA SCOTIA (June 22, 2016), <http://www.cpsns.ns.ca/DesktopModules/Bring2mind/DMX/Download.aspx?PortalId=0&TabId=129&EntryId=284>.

19. Code of Ethics of Physicians, R.S.Q., c C-26 (Can.) (the section does not explicitly require effective referral, but the official gloss provided by the College makes clear that is intended); Legal, Ethical and Organizational Aspects of Medical Practice in Quebec, *Personal Convictions: Conscientious Objection*, ALDO-QUEBEC, <http://aldo.cmq.org/en/Grands-Themes/ConvictionsPerso/ObjectConsc.aspx> (last visited Nov. 2, 2016).

20. *ARELC* § 50.

21. *Id.* at § 31.

22. See *Policy and Position Statements*, PROTECTION OF CONSCIENCE PROJECT, <http://consciencelaws.org/background/policy001.aspx#REGULATORS> (last visited Apr. 8, 2017).

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and find other physicians, but they refuse to collaborate in what they consider to be wrongdoing.

III. EXPERIENCE OF DISSENTING PHYSICIANS

Anecdotal reports from eight dissenting Canadian physicians provide some insight into the experience of physicians who object to participation in homicide and suicide since the new laws came into effect. While obviously limited, the reports are instructive, particularly when combined with information from public sources and informed by the experience of dissenting physicians concerning other morally contested procedures. This section of the paper was returned to the contributing physicians for comment to ensure accuracy and protection of their privacy. Responses were positive; no revisions were required.

A report from one dissenter suggests that implementing an assisted suicide and euthanasia regime can be managed without trampling fundamental freedoms:

I have not heard of or experienced any marginalization or pressure with regards to conscientious objection. In fact, there is almost unanimous support for the protection of conscience rights from the people I have met at work and through conversations with others about their contexts. Even the most pro-euthanasia colleagues that I have met are clear that they want to protect dissenters from becoming complicit in the act.

I would say that the efforts to remove protections for conscientious dissenters do not represent the general thought of the majority of health care providers. There are thousands of conscientious dissenters in the health care system in Canada and if they are not protected there will be a massive exodus out of the health care system. Our system is not capable of sustaining such a loss.²³

Unfortunately, this experience is far from universal. As this paper was being prepared for publication, a committee of the Ontario legislature heard an oncologist describe what is happening at one of Toronto's major hospitals:

At my institution, physicians are being bullied into accepting the role of the most responsible physician for MAID patients. This forces these physicians to be legally responsible for the MAID act,

23. Personal communication of Physician D and the author (Sept. 9, 2016) [hereinafter Physician D].

even when that goes against their conscience or religious beliefs. It gets worse: At one of our staff meetings, a psychiatrist stood up and announced that any physician who didn't actively support MAID should not be working at our hospital. . .

There's a horrendous stress level at our hospital. Physicians are afraid to speak up. Physicians are afraid that they will lose their jobs if they say anything. Even just speaking to my colleagues about this, we use alternative email addresses and we speak in code. We feel sometimes like we're in some sort of dystopian novel.²⁴

It will be seen from what follows that the experience of dissenting physicians where assisted suicide or euthanasia is legal depends upon a number of variables and is the product of stress from a number of sources.

A. Variables

1. Scope of legalization and legal protection

First, the scope of legalization and the extent of protection afforded by conscience legislation is significant. Legal expectations in an assisted suicide regime may be less challenging than in jurisdictions where only physician-administered euthanasia is allowed. Adequate protection of conscience measures may or may not exist, or may vary in effectiveness.

2. Cultural and social dynamics

Second, while the law is important, its effects may be mitigated or eclipsed by cultural and social dynamics. As one physician observed, "The language of the law does not transpose directly into the practice environment. In reality, patients and colleagues have a much greater impact on the practice environment than the law."²⁵

24. Committee Documents: Standing Committee on Finance and Economic Affairs - 2017-Mar-23 - Bill 84, Medical Assistance in Dying Statute Law Amendment Act (Mar. 23, 2017), http://www.ontla.on.ca/web/committee-proceedings/committee_transcripts_details.do?Date=2017-03-23&ParlCommID=8997&BillID=4460&Business=&locale=en&DocumentID=31834#P1025_246018.

25. Personal communication of Physician E and the author (Aug. 25, 2016) [hereinafter Physician E].

3. Differing beliefs

Third, dissenting physicians are motivated by different religious, moral, or philosophical traditions. Even physicians of the same religious persuasion or who apply the same moral or ethical principles may not reach the same conclusions when faced with conflicts of conscience.

4. Differing moral and social sensitivity

Fourth, people differ in moral and social sensitivity. Their experience of moral distress varies in intensity, as does their response to it, and they are not equally attuned to the communication of approval or disapproval by others. What causes acute distress in one person may be overlooked by someone else.

5. Differing dispositions

Finally, people differ also in natural dispositions. When faced with a moral challenge, their instinctive responses are likely to lie on a continuum between fight and flight. In uncertain situations, when no course of action recommends itself, stress is likely to build. This will have a corrosive effect and may, in a crisis, generate explosive reactions.

A. Sources of Stress

While it is obvious that the legalization of assisted suicide and euthanasia is stressful for physicians who object to the procedures for reasons of conscience, it is necessary to identify the actual sources of stress to appreciate their situation. There appear to be four, all operating simultaneously.

1. The demand for collaboration in killing

No jurisdiction requires dissenting physicians to personally kill patients or help them commit suicide—yet. Thus, the first source of stress for dissenters is not a demand that they kill patients, but that they arrange for a patient to be killed by someone else by making an effective referral.²⁶ The demand itself, perceived as fundamentally

26. See Udo Schuklenk et al., *The Royal Society of Canada Expert Panel: End-of-Life*

unjust and evil, generates moral indignation, even outrage. “The role of physician as healer has been perverted, with expectations placed upon us physicians that are diametrically opposed to the values and motivations of why I entered into the practice of medicine.”²⁷

However, professional and social environments are decidedly hostile to the expression of moral disapproval of euthanasia; a pretense of neutrality makes cool, detached, non-judgemental discourse normative. Dissenters are often constrained to contain and redirect their natural indignation, with varying degrees of difficulty and success, and this generates internal pressures.

2. *The prospect of punishment*

The second source of stress for dissenters is the ever-present prospect they will be punished or disadvantaged for refusing to collaborate in killing, even forced out of medical practice. This, too, may provoke moral indignation. “[W]hen society makes it impossible for me to continue, with expectations that cannot be ethically and practically met, I may need to stop practicing, not because I want to, but because an intolerant society has demanded it to be so.”²⁸

More important, it causes ongoing uncertainty and insecurity, naturally tending to the development of hypervigilance, defensive strategies and worst-case scenario planning. Fear of retaliation or harassment may explain why 55 of 804 physician signatories to the *Declaration of the Physicians Alliance Against Euthanasia* did not want their names published.²⁹ This concern has made it necessary, in this paper, to redact material contributed by dissenting physicians to ensure that they cannot be identified.

Decision Making, ROYAL SOC’Y OF CAN. 62, 69, 101 (Nov. 2011), http://rsc-src.ca/sites/default/files/pdf/RSCEndofLifeReport2011_EN_Formatted_FINAL.pdf [hereinafter Royal Society]; see also Jocelyn Downie et al., *Moving Forward with a Clear Conscience: A Model Conscientious Objection Policy for Canadian Colleges of Physicians and Surgeons*, 21 HEALTH L. REV 28 (2013) [hereinafter Downie et. al.]; see generally CPSO-MAID, *supra* note 15.

27. Personal communication of Physician A and the author (Aug. 9, 2016) [hereinafter Physician A].

28. *Id.*

29. *Founding Physicians and First Signatories of the Physicians Alliance Against Euthanasia Declaration*, PHYSICIANS’ ALLIANCE AGAINST EUTHANASIA, <http://collectifmedecins.org/en/declaration/signatories/> (last visited Sept. 25, 2016).

333] *Legalization of Assisted Suicide and Euthanasia**3. The need to distinguish between cooperation and collaboration*

Facing the possibility of discipline and even the loss of livelihood, dissenters struggle to find a balance that will satisfy Caesar so that they can continue in practice without compromising their personal integrity. Thus, the third stressor is the continuing need to distinguish between co-operation and collaboration: to discern when morally acceptable or excusable cooperation becomes unacceptable collaboration. This is particularly burdensome, since the distinction is not always easily made, and the consequences are particularly grave.

Here, there is an additional and painful complication: dissenting physicians who are unanimous in rejecting euthanasia and assisted suicide may differ among themselves on this most sensitive and difficult point. This is evident in the different responses of dissenting physicians to Quebec's legal requirement that they notify an administrator (DPS) when they refuse to provide euthanasia for a patient, so that the administrator can find someone willing to do so.

Acceptable: This is not a direct referral, nor is it an effective referral. The DPS is mandated to know of all significant conflicts between a physician and a patient, and this is no exception. In fact, our particular DPS has been very understanding of our position and has offered support to physicians who are involved in these cases.³⁰

Not acceptable: This form of collaboration in killing a patient, with all due respect, is not the ultimate compromise. It is an obligation to collaborate—which can be experienced by a physician as complicity in an act he considers to be harmful to his patient, irrelevant whether the act is criminal or not (the crime evoked here only compounds the insult of the obligation).³¹

4. Concern for their patients

Finally, convinced, as they are, that euthanasia and assisted suicide are grave and destructive evils, dissenters are perpetually bur-

30. Physician D, *supra* note 23.

31. Marc Beauchamp, *Physicians: Quebec "solution" is collaboration in killing, not an "elegant" compromise*, THE PROTECTION OF CONSCIENCE PROJECT (Feb. 15, 2016), <http://consciencelaws.org/blog/?p=6456>.

dened with concern for their patients, for whose welfare they feel especially responsible. This can be thrown back in their faces as disrespectful paternalism, unwelcome moralizing, and unacceptable interference with patient autonomy.

Trying as this is, what is worse is the fear that failing to find the right words, failing to hit the right note, or a mistake in judgement might contribute to the killing of a patient. Here the ever-present problem of distinguishing between cooperation and collaboration is particularly acute.

There is a further point:

My first responsibility is to the patient, and what's best for the patient. And what I'm realizing is, because of inadequate end-of-life services, and there are cases that I could discuss, it might be the best thing for a person to have euthanasia, because of the lack of palliative care services. And that realization makes me angry.³²

All of the preceding variables and stressors should be kept in mind when considering the implications of legalizing assisted suicide or euthanasia for dissenting physicians.

A. Effects of Legalizing Assisted Suicide/Euthanasia on Dissenting Physicians

Legalization is commonly preceded by extensive public debate, whether generated by legislative hearings or court proceedings. If earlier attempts at legalization have been unsuccessful—as they often are—those opposed to euthanasia may be confident that the latest efforts will also fail. Dissenting physicians are likely to be shocked when, contrary to their expectations, the law is changed. “I never believed it would come into effect. I was in big denial, things were relatively easy.”³³

When the law changes, more shocks may be in store. In 2005, *National Post* journalist Charles Lewis found his editors doubtful that attempts to legalize euthanasia/assisted suicide were newsworthy. Ten years later, just after the Supreme Court of Canada ruled in *Carter*, he said, “suddenly, everybody I know is in favour of euthanasia.”³⁴

32. Personal communication of Physician B and the author (Aug. 8, 2016) [hereinafter Physician B].

33. *Id.*

34. Margaret Somerville & Charles Lewis, *Where to now, Saint Peter?*, CONVIVIUM

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Some dissenting physicians were just as surprised—and alarmed and demoralized—to discover that opposition to euthanasia among their colleagues dissolved with the change in the law, and the widespread resistance they had anticipated did not materialize.³⁵

1. Palliative care physicians

Legalization of assisted suicide and euthanasia has more serious implications for some specialties than others, notably palliative care. It has begun to affect the concept of accompaniment, which has been central to the practice of palliative care from the beginning.

Accompaniment in the tradition of palliative care can be described as “a human solidarity pact,” in which physicians and caregivers “[accompany] patients through all the symptoms and stages of their disease.”³⁶ In this sense, it has nothing to do with euthanasia or assisted suicide, nor is it simply an expression of the ethical duty of non-abandonment, which does not imply nearly as much.

However, the concept is being stretched, notably in Belgium, where what is termed “the caring practice of ‘euthanasia accompaniment’ (*euthanasiebegeleiding*) is part of the daily work of palliative care professionals” because the practice of euthanasia has become embedded in palliative care. Refusal to participate in the patient’s journey to euthanasia is now characterized by some Belgian palliative care specialists—including a Jesuit priest—as abandonment, even if a physician who withdraws refers a patient to a willing colleague outside the palliative network.³⁷ A prominent Belgian Catholic priest-theologian who has been providing such accompaniment for about five years has just published a book on the subject.³⁸

These developments are contentious outside of Belgium, the Palliative Care Federation of Flanders being described as either a heretic or innovative outlier, depending on one’s point of view.³⁹ No doubt,

(Apr. 1, 2015), <http://www.conviviummagazine.ca/article/4441/where-to-now-saint-peter>.

35. Physician E, *supra* note 25.

36. Canadian Cancer Soc’y Pub. Issues Dep’t, *Palliative Care... Caring for Life*, CANADIAN CANCER SOC’Y 3 (2014), available at <https://www.cancer.ca/~media/cancer.ca/QC/get%20involved/take%20action/Advocacy/Palliative-care-2015.pdf>.

37. Paul Berghe et. al., *Assisted dying—the current situation in Flanders: euthanasia embedded in palliative care*, 20 EUR. J. OF PALLIATIVE CARE 6, 266–72 (2013).

38. See GABRIEL RINGLET, *VOUS ME COUCHEREZ NU SUR LA TERRE NUE: L’ACCOMPAGNEMENT SPIRITUEL JUSQU’À L’EUTHANASIE (LIE ME DOWN NAKED ON THE BARE EARTH: SPIRITUAL ACCOMPANIMENT TO EUTHANASIA)* (Albin Michel 2015).

39. Jan L. Bernheim et. al., *Questions and Answers on the Belgian Model of Integral*

one of the issues is that the rate of euthanasia and life-ending acts without explicit request has been found to be higher in Belgian in-patient palliative care units than in hospitals or nursing homes, and euthanasia is more likely after spiritual care has been provided than when it has not.⁴⁰

In any case, some dissenting palliative care physicians are disturbed by the possibility that, in the longer term, a changed concept of accompaniment will transform palliative care at its roots, making it difficult for them to continue in practice. In the meantime, the introduction of euthanasia and assisted suicide has had more immediate effects.

Then the law came into effect, and everything changed. It's like a very different situation, and I'm coming across this every day . . . And it's always a case-by-case situation. It's always like that in palliative . . . but I realize now what the implications are, when it's case-by-case where euthanasia is an option as prescribed by the law.⁴¹

In palliative care in Quebec, one excellent palliative care physician has compared her daily life under this law to living in a war zone. You never know when a death request is going to land on you. You can't be giving hope to dying patients in one room and euthanizing them in the next. Another doctor retired early the day the law came into effect for this reason.⁴²

[W]e have noted that patients who want access to medical aid in dying become very resistant to the provision of Palliative Care. They reject our multidisciplinary approach to whole-patient well-being, opting instead for this "easy" way out.⁴³

2. Capacity assessments

Under the current law, patients must be competent (have legal

End-of-Life Care: Experiment? Prototype?: "Eu-Euthanasia": The Close Historical, and Evidently Synergistic, Relationship Between Palliative Care and Euthanasia in Belgium: An Interview With a Doctor Involved in the Early Development of Both and Two of His Successors, J. OF BIOETHICAL INQUIRY, 507, 514 (2014).

40. Lieve Van den Block et. al., *Euthanasia and other end of life decisions and care provided in final three months of life: nationwide retrospective study in Belgium*, b2772 BRIT. MED. J. 339 (2009).

41. Physician B, *supra* note 31.

42. *Standing Comm. on Justice and Human Rights*, 42nd Parliament, 1st Sess., Meeting No. 13 (2016) (statement of Dr. Catherine Ferrier, President, Physicians Alliance against Euthanasia), available at <https://openparliament.ca/committees/justice/42-1/13/dr-catherine-ferrier-1/>.

43. Physician D, *supra* note 23.

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capacity for medical decision making) when they request assisted suicide or euthanasia, and must be competent when it is performed. The ability of physicians to perform capacity assessments is disputed, particularly in the case of palliative care patients. On the one hand, it is argued that assessing patient competence for euthanasia requires significant expertise that is not necessarily present for the majority of physicians.⁴⁴ On the other, plaintiffs in the *Carter* case convinced the trial court judge that obtaining informed consent presented no more difficulty in the case of assisted suicide and euthanasia than in seeking or refusing medical treatment.⁴⁵ It is instructive to set these different viewpoints side by side:

The decision to have medical aid in dying requires significant “meta” thought and reflection. It is more complex than even a decision about level of care, antibiotic treatment for pneumonia, or blood pressure pills. It is even at a different level than the choice to take chemotherapy or not.

Dr. Ganzini, a geriatric psychiatrist and Professor of psychiatry and medicine, disputes the assertion that the decision to end one’s life is necessarily cognitively demanding. Dr. Ganzini cites the decision whether to undergo a neurosurgical procedure as an example of a cognitively demanding one, since the risks, benefits, and various trade-offs between short-term and long-term gains can be very complex and challenging to understand.

All of our patients are vulnerable, many of them have concomitant psychiatric disorders, and almost all of them are demoralized to a certain extent that is normal in the context of a life-threatening illness. These

In contrast, she says, the risks and benefits of a lethal prescription are straightforward and not cognitively complex. The risk is that the prescription might not work; the benefit is that the patient’s life will end at a

44. *Id.*

45. *Carter v. Canada*, [2012] BCSC 866, ¶831 (Can.).

issues make the determination of competence very difficult *because of the gravity of deciding to end one's own life.*⁴⁶ (emphasis added)

time of her choosing.⁴⁷

The italicized passages demonstrate that different underlying philosophical or ethical views about life and life-ending acts can significantly affect one's views about the existence and nature of risk. The risk perceived by Physician D is that the patient might die. On the other hand, the risk perceived by Dr. Ganzini is that the patient might live (at least, for a time). A life-or-death decision has, for Physician D, a completely different significance than it has for Dr. Ganzini. This issue cannot be avoided in capacity assessments. One physician who does many capacity assessments explains that each assessment is made within the context of the kind of decision-making contemplated. It is influenced by the risks involved in the decision, life-or-death consequences calling for the highest level of capacity.⁴⁸ A patient who might be considered competent to decide whether to take a daily aspirin might not be considered competent to make a decision about a neurosurgical procedure. Similarly, Canadian Psychiatric Association President Dr. K. Sonu Gaind explained that the kind of capacity assessment used in therapy based on the recovery model is not appropriate for euthanasia or assisted suicide.

He says that in the recovery model, "patients want to be able to make their own decisions, even if [those decisions] are mistakes. The idea is that they want to learn from their mistakes. In the case of this particular decision, you can't learn from it if it's a mistake."⁴⁹

Rigorous capacity assessment is particularly important for dissenting palliative care physicians "who are especially sensitive to the risk of allowing medical aid in dying in a case where the person was

46. Physician D, *supra* note 23.

47. *Carter*, [2012] BCSC 866, ¶775 (emphasis added).

48. Physician H, explanation offered at meeting in the presence of the author, Oct. 10, 2015.

49. Special Joint Comm. on Physician-Assisted Dying, 42nd Parliament, 1st Sess., Meeting No. 6 (2016) (statement of Dr. K. Sonu Gaind), *available at* <http://www.parl.gc.ca/HousePublications/Publication.aspx?Language=e&Mode=1&Parl=42&Ses=1&DocId=8075735#Int-8772921> (last visited Apr. 8, 2017).

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not truly competent to decide.”⁵⁰ The stress caused by this possibility is exacerbated if there is concern that those doing capacity assessments for euthanasia and assisted suicide share Dr. Ganzini’s bias in favor of the procedures.⁵¹

2. *Dissenting physicians generally*

The possibility that a formal complaint may be made for refusing to provide or facilitate euthanasia or assisted suicide is a source of continuing stress. Complaints can be made by a patient or a patient’s family to immediate supervisors, to hospital authorities, to medical regulators and to human rights commissions, which, in some cases, are notoriously hostile to physician freedom of conscience and religion.⁵²

To preserve my own sanity under the stress that this uncertainty and constant threat can cause . . . I will need to practice my craft with the knowledge that I may lose everything that I’ve worked so hard to become as a healer for the sick.

[L]osing my license to practice would essentially eliminate any further possibility of working in [province].⁵³

One physician, hearing that the regional health authority might expect the collaboration of physicians with euthanasia and assisted suicide of their patients in the local hospital, decided to give up hospital privileges should that come to pass.⁵⁴

Some are closing their practices to new patients to reduce the risk that they will encounter someone likely to ask for euthanasia or assisted suicide, or who will respond to refusal by making a formal complaint to state authorities.⁵⁵ The mutual trust that is supposed to

50. Physician D, *supra* note 23.

51. Physician E, *supra* note 24.

52. For example, in 2008 the Ontario Human Rights Commission told the College of Physicians and Surgeons of Ontario that physicians must essentially check their personal views at the door in providing medical care. *Submission of the Ontario Human Rights Commission to the College of Physicians and Surgeons of Ontario Regarding the draft policy, “Physicians and the Ontario Human Rights Code”*, ONT. HUMAN RIGHTS COMM’N, <http://www.ohrc.on.ca/en/submission-ontario-human-rights-commission-college-physicians-and-surgeons-ontario-regarding-draft-0> (last visited Apr. 8, 2016).

53. Physician A, *supra* note 26.

54. Personal Communication of Physician F and the author (Oct. 09, 2016) [hereinafter Physician F].

55. Personal Communication of Physician C and the author (July 30, 2016) [hereinafter Physician C].

exist in a physician-patient relationship is being displaced by distrust.⁵⁶

Even so, dissenting physicians may also make extra efforts to establish a bond of trust with patients that may serve both patient and physician well if a conflict arises.

I intend to build up trust and respect in any doctor patient relationship and continue to be pleasant, helpful and go the extra distance to build goodwill for the day someone asks me for help in MAID, and I will do what I usually do, get to the bottom of the request, and problem solve around that request.⁵⁷

In response to the demand for effective referral by the College of Physicians and Surgeons of Ontario, one physician decided to leave medical practice.

I refuse to let anyone or any organization dictate my moral code. . . I have practiced full scope family medicine, including palliative care for the past 37 years and solely palliative care for the past 3 years. I have no wish to stop. But I will not be told that I must go against my moral conscience to provide standard of care.⁵⁸

A physician in another province suggested outright defiance: “[W]e should make them take our licenses, not retire.”⁵⁹

Dissenting physicians in institutions work within a matrix of policies that may or may not be satisfactory; notwithstanding claims (sincere or disingenuous) that they are respectful of freedom of conscience and religion.

[I]f I am required to abide by all [institutional] policies, including this most recent objectionable one, I may no longer be able to work at this [institution]. [L]osing my current job [would] not [be] so bad. I can always set up my own private practice outside the [institution] . . . If I am forced out of necessity to leave the practice of medicine, I may try to get into another area related to my field . . .⁶⁰

Transferring to a different institution, or to a different kind of institution is a viable strategy in some cases. A denominational institu-

56. Physician A, *supra* note 26; Physician C, *supra* note 55.

57. Physician C, *supra* note 55.

58. Letter from Nancy L. Naylor, Physician, responding to Stephen J. Genuis SJ, Clinical Professor, U. Alta. (Apr. 17, 2016), in *Emerging Assault on Freedom of Conscience*, 62 CAN. FAM. PHYSICIAN 293 (2016) (responding to Commentary).

59. Personal Communication of Physician G and the author (Apr. 17, 2016), [hereinafter Physician G].

60. Physician A, *supra* note 26.

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tion may provide a safe haven for dissenting physicians in some jurisdictions. Alternatively, dissenters might find a position in institutions caring for those legally ineligible for euthanasia or assisted suicide—a hospital for children and adolescents, for example.⁶¹ The latter strategy may provide only temporary protection, given the pressure to make the procedures available to such groups.

*D. Particular Problems**1. Inflicting death to control death*

Public campaigns and court cases leading to the legalization of euthanasia and assisted suicide have always emphasized hard cases. “When they were preparing the field, getting ready for the implementation of the law, training always focused on nightmare scenario: patients in agony, intractable pain, etc.”⁶²

What some dissenting physicians have observed in reality is quite different—the killing of patients who are not in pain or whose pain is adequately controlled; who do not, upon enquiry, report that they are suffering, and who could have lived for weeks or months longer had they not been lethally injected.⁶³ In such cases, a dissenting physician may conclude that the real purpose of euthanasia and assisted suicide is to control death by inflicting death.⁶⁴

Particularly in these situations, when maintaining a pretence of complete normality and equanimity is likely to be especially difficult, it is natural to become preoccupied with other duties that allow interaction to be minimized or avoided. In the end, dissenting physicians may be left with feelings of guilt for having somehow failed the patient or the patient’s family.⁶⁵ On the other hand, if they successfully manage the pretence of normality and continue interactions with patients, family and colleagues, they might well be left with feelings of guilt for having contributed to the patient’s death.

2. Cooperation vs. collaboration

The account of one physician highlights the distinction between

61. Physician E, *supra* note 24.

62. *Id.*

63. Physicians B, *supra* note 31; Physician E, *supra* note 24.

64. Physicians B, *supra* note 31.

65. *Id.*

law and practice environments:

To have an office beside the room where euthanasia is done is like being a collaborator. The law allows conscientious objection, but the environment makes him a collaborator—part of the system that is making euthanasia happen. One can collaborate, or one can go away. There are no other options.⁶⁶

This also illustrates how moral reasoning and individual sensitivity affect the impact of legalization on dissenting physicians. Other dissenters might be able to work in this environment, not feeling implicated by what they consider to be their mere presence. In contrast, this physician feels like a clerk in a concentration camp: an active contributor to an immoral system, even if not directly involved in killing. This reaction merits closer examination.

S.S. guard Oskar Gröning was a clerk in a concentration camp—Auschwitz. He was convicted in 2015 as an accomplice to the murder of 300,000 Hungarian Jews, though he had never been directly involved in killing anyone. At first glance this lends credibility to Physician E's analogy.

However, the judge did not find that Gröning had merely been present at Auschwitz. Gröning was convicted because his role at the camp, minor though it was, had directly contributed to the smooth running of an extremely efficient machine of death and deception. He had been an integral cog in the machine of the Auschwitz extermination apparatus.⁶⁷

Unlike Gröning, Physician E is not working in a facility dedicated exclusively to murder, nor do his/her duties or interaction with patients contribute to or support euthanasia, as Gröning's work undoubtedly contributed to genocide. Yet Physician E's tone of voice and emotion make clear that his/her reference to a clerk in a concentration camp is not merely a rhetorical flourish or polemical ploy.

What is the reason for this conviction?

A hint comes from his/her reaction to an associate who argues that palliative care physicians are obliged to support and affirm a patient's choice of euthanasia because such accompaniment is fundamental to the essence of good palliative care. As we have seen, this is a contentious and debatable claim, and Physician E could certainly

66. Physician E, *supra* note 24.

67. Kate Connolly, *Accountant of Auschwitz jailed for the murder of 300,000 Jews*, THE GUARDIAN (July 15, 2015, 1:25 PM), <https://www.theguardian.com/world/2015/jul/15/accountant-oskar-groning-auschwitz-jailed-for-the-of-300000-jews>.

argue the point. Instead, he/she feels he/she can no longer speak with the associate.

This reaction seems consistent with Physician E's sense that he/she is no longer welcome in the new practice environment. "It has quickly become normal to kill other people, and in this environment the realistic options are to provide the treatment or leave [I]t is necessary to retire from patients and from the group."⁶⁸

Faced with colleagues celebrating a successful lethal infusion, for example, professional etiquette and social convention forbid the expression of moral disapproval of euthanasia. Even if disapproval is expressed respectfully, doing so persistently would likely result in discipline for disruptive behavior.⁶⁹ This may explain why Physician E feels that he/she can no longer speak with the associate who is advocating Belgian-style euthanasia accompaniment.

One can collaborate, or one can go away. There are no other options.

One piece of the puzzle is still missing. Physician E is unable to express disapproval of euthanasia in the practice environment, but does nothing to contribute to it. He or she simply continues to treat and care for his or her patients. How can this constitute collaboration with homicide? Is this not mere presence?

The missing piece of the puzzle is in plain view and has already been mentioned: it is the pretence of non-judgementalism that forbids the expression of moral disapproval of euthanasia.

Notice the *pretence* of non-judgementalism. In reality, the expression of moral disapproval is *not* forbidden in the practice environment. On the contrary, it is *expected*, notably in the face of offensive remarks about race, ethnicity, religion, sexual orientation, age, physical appearance, or socioeconomic or educational status;⁷⁰ it may even be *required*.⁷¹ The expression of moral disapproval in the face of perceived wrongdoing is normative, not exceptional.

68. Physician E, *supra* note 24.

69. "Disruptive behaviour is demonstrated when inappropriate conduct, whether in words or action, interferes with, or has the potential to interfere with, quality health care delivery." C. OF PHYSICIANS & SURGEONS OF ONT., GUIDEBOOK FOR MANAGING DISRUPTIVE PHYSICIAN BEHAVIOUR 5-7 (2008), *available at*, http://www.cpso.on.ca/CPSO/media/upload/edfiles/policies/policies/Disruptive_Behaviour_Guidebook.pdf.

70. *The Are You an ALLY? Campaign*, MOUNTSINAI.ON.CA, http://www.mountsinai.on.ca/about_us/human-rights/ally/allyhttp://www.mountsinai.on.ca/about_us/human-rights/ally (last visited Apr. 8, 2017).

71. ONT. HUMAN RIGHTS COMM'N, HUMAN RIGHTS AT WORK — THIRD EDITION, pt. III (2008), *available at*, <http://www.ohrc.on.ca/en/human-rights-work-2008-third-edition>.

However, where euthanasia or assisted suicide are delivered as medical treatment, the assumption that they *are* morally acceptable cannot be openly challenged. Racism can be openly challenged, but not deliberate homicide. Hence, dissenting physicians are obliged to dissemble, to maintain the appearance of complete normality and equanimity as arrangements are made to kill people, and while people are being killed down the hall. In these circumstances, that someone should feel that he/she is a collaborator—a part of the system—is not surprising.

This might be better appreciated if one imagines a situation in which a physician, sensitive to racism, finds himself in a practice environment in which racism is normative, moral disapproval of racism forbidden, and he is expected to act as if nothing is amiss. Imagine, as well, that the full weight of the state, the profession and public opinion supports such a status quo. It would not be surprising if, like Physician E, he was to conclude that continuing to work in such an environment is a form of collaboration, and felt the need to leave.

IV. MORALITY AND THE LAW

Turning from the particular experiences of dissenting physicians to foundational issues, it is important to recognize that law is aimed at accomplishing or protecting what is thought to be good and avoiding what is thought to be evil. Thus, morality precedes and drives law, and the law enforces and teaches the morality that informs it.⁷² This is exemplified by the trial court decision in *Carter v. Canada*.

A. *Carter v. Canada*

The *Carter* case began in 2011. The plaintiffs claimed that the laws prohibiting physician assisted suicide and euthanasia were unconstitutional because they violated equality rights (Section 15 rights)⁷³ and rights to life, liberty, and security of the person (Section 7 rights).⁷⁴

72. In this paper, morality is shorthand for moral philosophy, and synonymous with ethics.

73. Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982, *being* Schedule B to the Canada Act, 1982, c 11 (U.K.). Section 15(1): “Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.”

74. *Id.* Section 1: “The Canadian Charter of Rights and Freedoms guarantees the rights

*B. Legal Reasoning**1. Equality rights*

With respect to equality claims (Section 15), British Columbia Supreme Court Madam Justice Smith observed that the law did not prevent able-bodied people from committing suicide in order to relieve themselves of the burden of pain or suffering. In contrast, she said, disabled people may not be able to commit suicide without assistance, and were thus forced to endure pain or suffering.⁷⁵ She decided that the law, though neutral on its face, disproportionately affected disabled people,⁷⁶ thus creating a distinction based on physical disability that was discriminatory.⁷⁷

With the finding of illicit discrimination, the burden of proof shifted to the defendant governments to demonstrate that nothing short of absolute prohibition could achieve the purpose of the law. This was narrowly construed as the protection of vulnerable people in moments of weakness from being induced to commit suicide.⁷⁸ The defendants had to prove that there was no viable alternative to absolute prohibition that would less seriously infringe the plaintiffs' rights.⁷⁹ This was precisely what the defendants did claim.⁸⁰

However, the assertion that only a blanket prohibition could be effective rested on the premise that even one wrongful death was too many:⁸¹ that safeguards could be considered effective only if they absolutely eliminated any possibility of error. Madam Justice Smith rejected this zero-tolerance standard.⁸² Instead, having narrowly construed the purpose of the law, she accepted the plaintiffs' argument that it could not possibly be to prevent *all* wrongful deaths, because wrongful deaths could occur as a result of accepted but unregulated end-of-life practices like refusing or withdrawing treatment.⁸³

and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.”

75. *Carter v. Canada*, [2012] BCSC 866, ¶¶ 1039, 1050, 1064.

76. *Id.* ¶¶ 1032, 1036.

77. *Id.* ¶¶ 1156, 1159, 1161.

78. *Id.* at ¶¶ 926, 1184.

79. *Id.* at ¶¶ 1172, 1232.

80. *Id.* at ¶ 359.

81. *Id.* at ¶¶ 1192–96, 1230, 1236, 1349, 1351. The term wrongful death was rejected by the judge, but for the sake of convenience, she used it in the ruling nonetheless. *Id.* ¶¶ 755–58.

82. *Id.* at ¶ 1353.

83. *Id.* at ¶¶ 435, 1198–99, 1230–31, 1237, 1240.

Combined with the narrow construction of the purpose of the law, rejection of the zero-tolerance standard was fatal to the defendants' case. Their witnesses produced evidence of risk, and the judge was willing to accept that evidence,⁸⁴ but the problem was judicially defined as one of managing or reducing risk, not eliminating it altogether.⁸⁵ Thus, Madam Justice Smith ruled that the defendant governments had failed to prove that the protection of vulnerable persons in moments of weakness could not be achieved by means less drastic than absolute prohibition, such as a stringently limited, carefully monitored system of exceptions.⁸⁶

2. Life, liberty and security of the person

Turning to life, liberty, and security of the person (Section 7), Madam Justice Smith agreed that the right to life is engaged only when there is a threat of death,⁸⁷ but added (apparently as a kind of extension of that principle) that the prohibition of assisted suicide has the effect of shortening the lives of persons who fear that they will become unable to commit suicide later, and therefore take their lives at an earlier date than would otherwise be necessary.⁸⁸

With the infringement of Section 7 rights established, the onus shifted to the defendant governments to prove that the legislation was not overbroad.⁸⁹ Once more, given the narrowly construed purpose of the law and risk management approach, they failed.⁹⁰ By concluding that the absolute prohibition was overbroad, the judge again affirmed that the purpose of the law could be served by "a system with properly designed and administered safeguards."⁹¹ While it was not necessary in view of her finding on overbreadth, the judge went on to rule that the adverse effects of the law were grossly disproportionate to its limited purpose.⁹²

The Supreme Court of Canada affirmed the trial court judge's conclusion that the existing law violated rights to life, liberty, and se-

84. *E.g.*, *id.* at ¶¶ 653, 815.

85. *Id.* at ¶ 1240.

86. *Id.* at ¶ 1243.

87. *Id.* at ¶ 1320.

88. *Id.* at ¶¶ 17, 1322.

89. *Id.* at ¶ 1339.

90. *Id.* at ¶¶ 1362–63, 1371.

91. *Id.* at ¶ 1367.

92. *Id.* at ¶¶ 1372, 1378.

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curity of the person (Section 7) because it was overbroad. It declined to rule on her finding that it was grossly disproportionate and violated equality rights (Section 15).⁹³

With summary of the legal reasoning in hand, we now consider the moral reasoning that determined the trajectory and outcome of the case.

A. *The Morality Preceding and Driving Carter*

1. *Part VII: judicial dicta*

The trial judge's reasoning in *Carter* began with the fact that neither suicide nor attempted suicide was illegal.⁹⁴ In Part VII of her ruling, she reviewed the "ethical debate" about assisted suicide⁹⁵ to address the question of 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.⁹⁶

Her review of ethical issues was unsatisfactory because what was necessary to understand them and controversies associated with end-of-life practices was lacking.⁹⁷ Nonetheless, 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 the "arguments" for this view "persuasive."⁹⁸ Similarly, she was persuaded by "the arguments" that there was no ethical distinction between suicide and assisted suicide in the circumstances contemplated by the plaintiffs' application.⁹⁹ Whatever merit the judge found in the arguments, the evidence, on her own account, did not support such findings. The evidence consisted of a sampling of conflicting ethical opinions provided by parties to a contentious suit and the expression of doubts and difficulties by some of the witnesses.¹⁰⁰ It ac-

93. *Carter v. Canada*, [2015] S.C.R. 331, ¶¶ 56, 90, 93.

94. *Carter*, [2012] BCSC 866, ¶¶ 102–07.

95. *See id.* at ¶¶ 161–358.

96. *Id.* at ¶¶ 161–62, 183, 316.

97. For a detailed critique, see Sean Murphy, *Legalizing Therapeutic Homicide and Assisted Suicide: A Tour of Carter v. Canada*, PROTECTION OF CONSCIENCE PROJECT, <http://www.consciencelaws.org/law/commentary/legal073-001.aspx> (last visited Apr. 8, 2017).

98. *Carter*, [2012] BCSC 866, ¶ 335 (emphasis added); *Id.* ¶ 1336 (referring to this view as "the preponderant ethical opinion.").

99. *Id.* at ¶ 339 (emphasis added).

100. *Id.* at ¶¶ 336–38.

tually demonstrated what the judge herself admitted: “[T]he 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.”¹⁰¹

Madam Justice Smith’s reference to a “preponderance of evidence” was a misapplication of an evidentiary rule developed for other purposes. The “preponderance of evidence” or “balance of probabilities” rule pertains to findings of contested facts in civil litigation, not to the evaluation of contested ethical beliefs. A judge cannot properly make a finding of fact to the effect that ethical position A is correct and ethical position B is not: that, for example, capital punishment is ethical, and those who think otherwise are mistaken.

Further, the binary system of reasoning and rules about standards and burdens of proof that are sufficient for the purposes of a common law civil proceeding¹⁰² fall short of what is normative in other disciplines. For example, “more likely than not” or 51% probability is sufficient to prove facts required for judicial decision-making in civil litigation,¹⁰³ but not for medical decision-making.¹⁰⁴

What is noteworthy is that nothing in Part VII materially contributed to the judge’s finding that the law prohibiting physician assisted suicide/euthanasia was unconstitutional.¹⁰⁵ The whole of Part VII is best described as the “considered enunciations of the judge’s opinion on [points] not arising for decision” that went beyond what was necessary for the decision:¹⁰⁶ the classic definition of “dicta.”¹⁰⁷ Nonetheless, Part VII is important because it provides evidence of the moral falsehood the judge used in the construction of the judgement.

101. *Id.* at ¶ 334.

102. *In Re B (Children)* [2008] UKHL 35, [2008] 2 FLR 141 (appeal taken from Eng.), available at <http://www.publications.parliament.uk/pa/ld200708/ldjudgmt/jd080611/child-1.htm>.

103. *McIver v. Power*, 1998 CanLII 4858 (Can. P.E.I. S.C.), ¶ 5, available at <https://www.canlii.org/en/pe/pesctd/doc/1998/1998canlii4858/1998canlii4858.html>.

104. *Snell v. Farell*, [1990] 2 S.C.R. 311 (Can.) (“Medical experts ordinarily determine causation in terms of certainties whereas a lesser standard is demanded by the law.”).

105. This is apparent in the summary of the judgement when the judge introduced her ruling. See *Carter*, [2012] BCSC 866, ¶¶ 3–18.

106. MACKAY OF CLASHFERN, HALSBURY’S LAWS OF ENGLAND (Helen Halvey & David Hay eds., 5th ed. 2009).

107. “Obiter dicta” and “judicial dicta.” The former are often described as the “passing remarks” of a judge. Part VII of *Carter*, expressing additional considered opinions, falls within the latter category.

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This rested on her belief that suicide could be morally acceptable—not that it *always* is, but that it *can* be.¹⁰⁸ The logically prior discussion of the morality of suicide was avoided because the plaintiffs had brought a case for *assisted* suicide and euthanasia (thus assuming the acceptability of suicide). Madam Justice Smith expressly adopted this approach in her analysis.¹⁰⁹ None of the defendants or interveners contested that assumption,¹¹⁰ even to the limited extent of arguing that the morality of suicide cannot be established without reference to some moral framework.¹¹¹

The judge believed that suicide could be moral if it resulted from a “sound, rational and well reasoned” decision by someone not suffering from clinical depression, mental illness, substance abuse, trauma or similar psychosocial factors.¹¹² The latter she appears to have classed as “traditionally-defined suicide,”¹¹³ – “suicide arising out of mental illness or transitory sadness.”¹¹⁴ She believed that suicide could be rational¹¹⁵ and appears to have accepted the view of Professor Margaret Battin that it would be rational to choose suicide in order to avoid serious future evils.¹¹⁶

3. *From suicide to assisted suicide*

The belief that suicide can be moral implies that *assisted* suicide can be moral. Thus, the judge said that where suicide is moral, the distinction between suicide and assisted suicide “vanishes” when “the

108. *Carter*, [2012] BCSC 866, ¶ 339. The judge uses the term “ethical,” not “moral,” and more frequently employs the former, but she treats them as synonyms when addressing the question, “Does the law attempt to uphold a conception of morality inconsistent with the consensus in Canadian society?”; *id.* at ¶¶ 340–58.

109. *Id.* ¶¶ 175, 180–81.

110. The nearest approach to a challenge appears to have come from Canada, which asserted that “suicide is not a fundamental social institution,” and emphasized that “suicide is not condoned, let alone recognized as a legal right.” *Id.* ¶¶ 1146–47. However, it also argued that disabled people were not disadvantaged by the prohibition of assisted suicide because they could still commit suicide “by refusing treatment, hydration or nutrition” which implied that suicide could be considered advantageous. *Id.* ¶ 1049.

111. MARGARET SOMERVILLE, *DEATH TALK: THE CASE AGAINST EUTHANASIA & AND PHYSICIAN-ASSISTED SUICIDE* 103 (2001).

112. *Carter*, [2012] BCSC 866, ¶ 813–14.

113. *Id.* at ¶¶ 812, 827, 833.

114. *Id.* at ¶ 1262.

115. *Id.* at ¶ 339.

116. *Id.* at ¶ 842.

patient's decision for suicide is entirely rational and autonomous, it is in the patient's best interest, and the patient has made an informed request for assistance."¹¹⁷

Further, moral conduct is associated with the protection or pursuit of the good. Thus, a belief that suicide can be moral naturally invites the conclusion that it can be beneficial: "in the patient's best interest." The plaintiffs asserted that suicide can be in the best interest of a patient if it prevents or avoids needless suffering.¹¹⁸ Indeed, the basis of their case was that the prohibition of assisted suicide denied them a good to which they were entitled, and to which others had access.

Quite apart from burdens of proof in law, this effectively shifted the rhetorical burden of proof to those opposed to assisted suicide. It put them in the position of having to argue that people should not be allowed access to something that could be moral and beneficial.¹¹⁹

4. *From assisted suicide to euthanasia*

In circumstances in which suicide and assisted suicide are moral, if the person seeking suicide is unable to perform the lethal act even with assistance, euthanasia in response to a request from that person would seem to be moral.¹²⁰ This moral equivalence was arguably implicit in the term "assisted dying," which, in the ruling, includes both assisted suicide and voluntary euthanasia.¹²¹ Thus, beginning with the premise that suicide can be moral and beneficial, the judge concluded that assisted suicide and euthanasia can be moral and beneficial. Why, then, should assisted suicide and euthanasia be prohibited by law?

5. *Purpose of the law*

Consistent with her belief that suicide could be a moral act, the judge concluded that the purpose of the law was not to prevent sui-

117. *Id.* at ¶ 339; *See id.* ¶ 237 (quoting Professor Wayne Sumner).

118. *Id.* at ¶ 234 (quoting Professor Wayne Sumner).

119. This may explain, in part, why Professor Margaret Somerville, upon reading the judgement, was left with "a strong impression that [the judge] is far from neutral about physician-assisted suicide and euthanasia" and that she favoured the interventions in some cases. Somerville, *Bird*, *supra* note 1, at 120.

120. *Carter*, [2012] BCSC 866 ¶¶ 234–36 (quoting Professor Wayne Sumner); *Id.* at ¶ 242 (quoting Dr. Upshur).

121. *Id.* at ¶¶ 23, 39.

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cide by absolutely everyone for any reason. Per the judge, the sole purpose of the law against assisted suicide was to prevent suicides by vulnerable people who, in a moment of weakness, might succumb to suggestions or pressures by others.¹²² The ruling seems to have assumed that the law against consensual homicide served the same purpose. The narrow construction of the purpose of the law illustrated common ground among the parties to the case.¹²³

6. *Morality and risk*

This chain of reasoning can be broken between suicide and assisted suicide. Even if suicide *per se* can be moral, it can be argued that assisted suicide is a different kind of act because “it is action not by a person on herself but by one person upon another.”¹²⁴ Based on this distinction, it can be argued that, whatever the moral status of suicide, assisted suicide is immoral if it entails harm for others or society not entailed by suicide *per se*. It can also be argued that assisted suicide is immoral if it entails the *risk* of harm for others or society. In either case, however, proof of harm or risk is required to sustain these moral arguments, and it is also necessary to establish at what point the risk or harm becomes morally unacceptable.

This was the approach taken by the defendant governments and interveners, and this was the focus of much of the evidence and argument. However, the parties argued as if only points of law and legal principle were relevant. None appear to have recognized the intuitive and implicit moral assumptions and reasoning that informed the arguments.

The *Carter* trial court decision demonstrates that when serious moral issues are in play (as they are when the subject is killing people or helping them to commit suicide), a judge will either assume or construct a moral justification that supports a decision.

The justification is like the falsework used to support a masonry arch while stones are being laid. The falsework is removed when the arch is complete, becoming invisible, as it were, though implied in the outline of the stonework that remains.

122. *Id.* at ¶¶ 16, 926, 1116, 1126, 1166, 1184–85, 1187–88, 1190, 1199, 1348, 1362. On this point, the judge purported to follow *Rodriguez*, but *Rodriguez* can yield a broader interpretation.

123. *Id.* at ¶¶ 237, 339, 1124, 1136, 1185, 1190, 1362.

124. *Id.* at ¶ 237 (quoting Professor Wayne Sumner).

Similarly, moral beliefs that provide the falsework necessary for the construction of a judicial decision may be overlooked or even denied because they lie outside the spectrum of elements identifiable as *ratio* in common law. Nonetheless, the moral falsework essential to the construction of a ruling may be implied in it and discernable as *dicta* in the text.

B. Carter and Fleming v. Ireland & Ors

Some support for this proposition is found in *Fleming v. Ireland & Ors*, a decision of the High Court of Ireland in which the judges considered and declined to follow the *Carter* trial court decision, even though they had before them much of the same evidence and arguments of the same kind.¹²⁵

Fleming can be distinguished from *Carter* in a number of respects, including the differences between Canadian and Irish jurisprudence on proportionality,¹²⁶ claims and counterclaims as presented,¹²⁷ the quality of evidence provided by defendant witnesses¹²⁸ and the acuity of government counsel, at least as reflected in the written judgements.¹²⁹ Nonetheless, the Irish court made a number of striking statements that reflect underlying moral views about suicide notably different from *Carter*. The Court in *Fleming* stated: “It is nevertheless idle to suggest that even the intentional taking of another’s life—even if this is consensual—or actively assisting them so to do does not have objective moral dimensions.”¹³⁰ In the same paragraph, instead of assuming that suicide could be a moral act or a benefit, the Court referred to “*obvious and self-evident* considerations” against legalization of assisted suicide, including “detering suicide and *anything that smacks of the ‘normalisation’* of suicide.”¹³¹

The Irish court also strongly and repeatedly emphasized that “there is an enormous and defining difference” between physician-assisted suicide and discontinuing medical treatment to allow a patient to die a natural death.¹³²

125. *Fleming v. Ireland & Ors* [2013] IEHC 2 (Ir.).

126. *Id.* at ¶¶ 87, 90.

127. *Id.* at ¶¶ 6, 9.

128. *Id.* at ¶¶ 34–47.

129. *Id.* at ¶¶ 30–33.

130. *Id.* at ¶ 69.

131. *Id.* (emphasis added).

132. *Id.* at ¶ 93; see *id.* at ¶¶ 53, 55.

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Considering much of the same evidence heard by Madame Justice Smith about Belgium, the Netherlands and Switzerland, as well as her discussion of the evidence, the Court rejected her conclusions.¹³³ Of particular interest, the Irish court stressed the importance of maintaining an attitude unfavourable to assisted suicide, and disapproved of popular and official lack of concern about potentially non-voluntary homicide where euthanasia is allowed.¹³⁴ All of this indicates a moral outlook decidedly unsuited to constructing a legal ruling favourable to euthanasia.

It appears that the Irish judges and Madame Justice Smith came to radically different conclusions about the risks presented by legalization of assisted suicide and euthanasia because their moral beliefs affected their evaluation of evidence and the conclusions drawn from it.

V. THE OBLIGATION TO KILL

A. *Canadian Medical Association Approves Euthanasia, Assisted Suicide*

Until the end of 2014, the Canadian Medical Association (“CMA”) opposed the participation of physicians in euthanasia and assisted suicide. In 2014 and 2015, as the *Carter* case was making its way through the courts and after, the CMA consulted its members about euthanasia and assisted suicide.¹³⁵

The most plausible rendering of the results indicates that the great majority of physicians—from 63% to 78%—were opposed to both euthanasia and assisted suicide, and that support for the procedures among favourably disposed physicians was highly volatile, depending heavily upon the diagnosis, the condition of the patient and

133. *Id.* at ¶ 104.

134. *Id.* at ¶ 67.

135. The CMA had about 81,000 members in 2014 and 2015. Five thousand members (6.2%) were surveyed in 2014. This was supplemented by town hall meetings with the public and member-only meetings held across the country. In 2015, on-line surveys were completed by about 1407 members (about 1.7%) and 372 members (about 0.5%). 595 members registered for an on-line member dialogue, but only 150 actually contributed to the discussion. CAN. MED. ASSOC., END-OF-LIFE CARE: A NATIONAL DIALOGUE 1 (June 2014), available at <https://www.cma.ca/Assets/assets-library/document/en/advocacy/end-of-life-care-report-e.pdf>; CAN. MED. ASSOC., END-OF-LIFE CARE: A NATIONAL DIALOGUE: *CMA MEMBER CONSULTATION REPORT 1–2* (July 2014), available at <https://www.cma.ca/Assets/assets-library/document/en/advocacy/Englishreportfinal.pdf>.

the rigour of the regulatory regime; significantly fewer physicians were willing to provide euthanasia than assisted suicide.¹³⁶

Nonetheless, in 2014 the CMA Board of Directors decided to position the Association to take a leading role in implementing the new regime should the Supreme Court strike down the law against the procedures.¹³⁷

The Board secured support from the CMA membership for a position of neutrality,¹³⁸ which it drew to the attention of the Supreme Court of Canada in its intervention in *Carter*.¹³⁹ It then reversed the policy against physician participation in euthanasia and assisted suicide, recognizing both as end of life care. The new policy does not limit the procedures to the terminally ill or those with uncontrollable pain, nor does it exclude euthanasia for minors, the incompetent, or the mentally ill.¹⁴⁰ The sole limiting criterion recognized is that set by law. It affirmed the CMA's support for patients' access to the full spectrum of end of life care that is legal in Canada—whatever that might turn out to be.

The new policy was announced more than a month *before* the Supreme Court ruled in *Carter*—probably with the reasonable expectation that the judges would read it before the ruling¹⁴¹—which they

136. SEAN MURPHY, A UNIQUELY CANADIAN APPROACH TO FREEDOM OF CONSCIENCE: *EXPERTS RECOMMEND COERCION TO ENSURE DELIVERY OF EUTHANASIA AND ASSISTED SUICIDE* 46–61 (2016), available at <http://www.consciencelaws.org/law/commentary/legal073-012-004.aspx>.

137. J. Blackmer & L.H. Francescutti, *Canadian Medical Association Perspectives on End-of-Life in Canada*, 14 HEALTHCAREPAPERS 17, 17–20 (2014) [hereinafter Blackmer-Francescutti]; Simpson Aff. ¶ 10, June 5, 2014, *Carter v. Canada*, [2015] 1 S.C.R. 331 (Can.), available at <https://www.cma.ca/Assets/assets-library/document/en/advocacy/EOL/Supreme-Court-Affidavit-Carter-Case.pdf> [hereinafter Simpson Affidavit]; Sheryl Ubelacker, *Doctors ready for Supreme Court decision on assisted suicide*, CTV NEWS (Feb. 5, 2015), <http://www.ctvnews.ca/health/doctors-ready-for-supreme-court-decision-on-assisted-suicide-1.2223268>.

138. CAN. MED. ASSOC., 147TH GENERAL COUNCIL DELEGATES MOTIONS: END-OF-LIFE CARE: *MOTION DM 5–6* (2014), available at <https://www.cma.ca/Assets/assets-library/document/en/GC/Delegate-Motions-end-of-life.pdf>; Pat Rich, *Physician perspective on end-of-life issues fully aired*, CANADIAN MEDICAL ASSOCIATION (Aug. 19, 2014), <https://www.cma.ca/En/Pages/Physician-perspective-on-end-of-life-issues-fully-aired.aspx>.

139. Factum of Interviewer Can. Med. Ass. ¶¶ 27–28, Aug. 27, 2014, *Carter*, [2015] 1 S.C.R., available at <http://www.consciencelaws.org/archive/documents/carter/2014-08-27-cma-factum.pdf>.

140. *CMA Policy: Euthanasia and Assisted Death (Update 2014)*, CANADIAN MEDICAL ASSOCIATION (2014), https://www.cma.ca/Assets/assets-library/document/en/advocacy/EOL/CMA_Policy_Euthanasia_Assisted%20Death_PD15-02-e.pdf.

141. Simpson Affidavit, *supra* note 137, ¶¶ 19–20.

did.¹⁴² By doing all of this, the Board of Directors effectively wrote a blank cheque for the Supreme Court to legalize euthanasia and assisted suicide on any terms acceptable to the judges.

After the *Carter* ruling, CMA officials expressed surprise and concern that it was much broader than they had anticipated.¹⁴³ In fact, the legal eligibility criteria set by the Court were more restrictive than CMA policy. If CMA officials did not get exactly what they wished for in the *Carter* decision—and, perhaps, more than they bargained for—they nonetheless got exactly what they had worked for.

The full implications of the CMAs change of policy were not appreciated at the time, even by those involved in bringing it about. The new policy is not one of neutrality. Instead, it acknowledges homicide and suicide to be acceptable forms of medical treatment. Only with developments made possible by the *Carter* ruling did the long-term consequences of the policy change begin to come into view. These are best considered within the context of the imposition of an obligation to kill.

B. One Person's Right is Another Person's Obligation

Writing a few months before the CMA revised its policy on euthanasia and assisted suicide, CMA officials reflected on what such a revision might mean.

“One person’s right is another person’s obligation, and sometimes a great burden,” they wrote. “And in this case, a patient’s right to assisted dying becomes the physician’s obligation to take that patient’s life”—a prospect that terrified many physicians.¹⁴⁴ They were terrified because homicide has traditionally been understood to be an act of grave moral significance, even if killing *per se* does not necessarily entail an adverse moral or ethical judgement.¹⁴⁵

It might be suggested that a collective obligation to kill could be

142. *Carter*, [2015] 1 S.C.R. at 37.

143. John Geddes, *Interview: The CMAs president on assisted dying: Dr. Chris Simpson calls for a process to set new rules*, MACLEANS (Feb. 6, 2015) [hereinafter Geddes], <http://www.macleans.ca/politics/ottawa/interview-the-cmas-president-on-assisted-dying/> [hereinafter Geddes]; Nicolas Santi, *From Courtroom to Bedside - A Discussion with Dr. Jeff Blackmer on the Implications of Carter v. Canada and Physician-Assisted Death*, 5 UOJM 1, 1–3 (2015), available at <https://uottawa.scholarsportal.info/ojs/index.php/uojm-jmuo/article/view/1276/1270>.

144. Blackmer-Francescutti, *supra* note 137.

145. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 176 (7th ed., 2013).

imposed upon and discharged by the medical profession as a whole without imposing an obligation to kill upon individual practitioners, particularly those terror-struck by the prospect.¹⁴⁶ However, only if at least one practitioner has an obligation can the medical profession be said to have a collective obligation, so this approach neither negates an obligation to kill nor guarantees that it will not be imposed upon individual members. Indeed, a *Model Conscientious Objection Policy* for medical regulators proposed by a group of Canadian academics asserts that the “medical profession as a whole” is obliged “to ensure . . . the provision of legally permissible and publicly funded health services,” yet would force dissenting physicians to provide morally contested services if non-dissenting colleagues are not readily available.¹⁴⁷

An obligation to kill seems implicit in the rights language used by euthanasia and assisted suicide activists,¹⁴⁸ and the media,¹⁴⁹ and the Quebec euthanasia law.¹⁵⁰ It is implied in assertions by ethicists and others that failure to kill patients or help them commit suicide amounts to unethical abandonment of patients.¹⁵¹

On the other hand, Joseph Arvay, counsel for the appellants in *Carter*, assured the Supreme Court of Canada that “no one is suggesting that a physician who has a religious objection to assisting a patient with his or her death must do so.”¹⁵² He subsequently

146. One such model has been proposed by Holly Fernandez Lynch, who advocates for a bifurcated model of medical professionalism in which the whole is recognized as greater than the sum of its parts. HOLLY FERNANDEZ-LYNCH, CONFLICTS OF CONSCIENCE IN HEALTH CARE: AN INSTITUTIONAL COMPROMISE 10 (2008) [hereinafter CONFLICTS].

147. Downie et al., *supra* note 25, at 30.

148. *Assisted Dying is a Right*, DYING WITH DIGNITY CANADA, http://www.dyingwithdignity.ca/assisted_dying_is_a_right (last visited Apr. 8, 2016).

149. Sean Fine, *Supreme Court rules that Canadians have a right to doctor assisted suicide*, THE GLOBE & MAIL (Feb. 6, 2015, 5:29 AM), <http://www.theglobeandmail.com/news/national/supreme-court-rules-on-doctor-assisted-suicide/article22828437/>.

150. Section 4 of Quebec’s *Act Respecting End of Life Care* states, “Every person whose condition requires it has the right to receive end-of-life care, subject to the specific requirements established by this Act.” Subsections 3(3) and 3(6) clarify that this includes euthanasia (medical aid in dying). *ARELC*, *supra* note 5, at 6.

151. *Carter v. Canada*, [2012] 287 C.C.C. 3d 1 (Can. B.C. S.C.), ¶¶ 239–40; Marcia Angell & Edward Lowenstein, *Letter re: Redefining Physicians’ Role in Assisted Dying*, 368 N. ENG. J. MED. 485, 485–86 (2013), available at <http://www.nejm.org/doi/full/10.1056/NEJMc1209798.3>.

152. Webcast of Arvay Oral Submission 74:45/491:20 – 75:05/491:20, Oct. 15, 2014, *Carter v. Canada* [2015] 1 S.C.R. 5 (Can.), available at http://www.scc-csc.ca/case-dossier/info/webcastview-webdiffusionvue-eng.aspx?cas=35591&urlen=http%3a%2f%2fwww4.insinc.com%2fibe%2fmp%2fmd%2fopen_protected%2fc%2f486%2f1938%2f201410150500ww150en%2c01&urlfr=http%3a%2f%2fwww4.insinc.com%2fibe%2fmp%2fmd%2fopen_protected%2fc%2

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acknowledged before the Court that *Carter* “wasn’t a positive rights case,”¹⁵³ which suggests that, at best, a “right” to euthanasia or assisted suicide based upon *Carter* is simply a right not to be prevented from obtaining the services from a willing physician, entailing no obligation on the part of anyone else beyond a duty not to obstruct an eligible candidate.

Consistent with this, the Supreme Court itself, in ruling in favour of physician assisted suicide and euthanasia, stated that “nothing in the declaration of invalidity which we propose to issue would compel physicians to *provide* assistance in dying,” noting “that a physician’s decision to participate in assisted dying is a matter of conscience and, in some cases, of religious belief.”¹⁵⁴

The use of “physicians” (plural) in the first assertion and “physician” (singular) in the second, together with the alternative terms “provide” and “participate” suggests that *Carter* imposes no duty to kill upon either the profession as a whole or upon individual physicians. It merely authorizes (willing) physicians to provide euthanasia and assisted suicide in the circumstances described by the Court. Similarly, the amendment to the Criminal Code authorizing euthanasia and assisted suicide includes the statement, “nothing in this section compels an individual to provide or assist in providing medical assistance in dying.”¹⁵⁵

Nonetheless, it will be seen that prominent Canadian academics claim that physicians have an obligation to arrange for patients to be killed and even to kill patients in circumstances defined by law. Unfortunately, it does not appear that the nature of these claims is sufficiently appreciated, probably because the obligation to kill is almost never identified as such in the media and professional literature. The 2014 reference to it by CMA officials was a notable exception.

f486%2f1940%2f201410150500wv150en%2c001&date=2014-10-15.

153. Webcast of Arvay Oral Submission 167:15/205:09 – 167:48/205:09, Jan. 11, 2016, *Carter*, [2015] 1 S.C.R., available at http://www.scc-csc.ca/case-dossier/info/webcastview-webdiffusionvue-eng.aspx?cas=35591&urlen=http%3a%2f%2fwww4.insinc.com%2fbc%2fmp%2fnd%2fopen_protected%2fc%2f486%2f1938%2f201601110500wv150en%2c001&urlfr=http%3a%2f%2fwww4.insinc.com%2fbc%2fmp%2fnd%2fopen_protected%2fc%2f486%2f1940%2f201601110500wv150en%2c001&date=2016-01-11.

154. However, the Court concluded its comment on this point cautioning that it did not intend to pre-empt the role of legislators and regulators, emphasizing that the rights of patients and physicians will need to be reconciled. *Carter*, [2015] 1 S.C.R., ¶ 132 (emphasis added).

155. An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying), CRIM. CODE § 241.2(9), R.S.C. 1985, c. C-46 (Can.). S.C. 2016, c 3, 241.2(9) (Can.), available at <http://www.parl.gc.ca/HousePublications/Publication.aspx?Language=E&Mode=1&DocId=8384014>.

1. The nature of an obligation to kill

An *obligation* to kill must be distinguished from an *authorization* to kill or a *justification* of killing. Soldiers and police are legally authorized to kill, and anyone may be legally *justified* in killing in self-defence. But neither the *authority* to kill nor legal *justifications* for killing amount to an *obligation* to kill. It is often on the contrary: for example, a police constable who administers a coup-de-grâce to a wounded bank robber is liable to be charged for murder. There is no obligation to kill even in military combat; deliberately killing disabled enemies is a crime.¹⁵⁶

Since an obligation to kill is not imposed even upon people whose duties may entail killing, the imposition of an obligation to kill upon *physicians* appears to be unique and extraordinary, but not unprecedented. An obligation to kill was formerly imposed on public executioners. The essence of the obligation was captured by Blackstone: “[I]f, upon judgment to be hanged by the neck till he is dead, the criminal be not thoroughly killed, but revives, the sheriff must hang him again.”¹⁵⁷

That is what an obligation to kill would require of attending physicians should assisted suicide or euthanasia drugs not cause death as expected.¹⁵⁸ They would be expected to take steps to ensure that the patient is “thoroughly killed.” It thus seems likely that euthanasia will be wanted at least as a backup for failed assisted suicide, just as abortion is wanted as a backup for failed contraception.¹⁵⁹ An obligation to ensure the patient is “thoroughly killed” and the use of euthanasia as a backup for failed physician assisted suicide are reflected in professional guidelines, most notably in the Netherlands, but also in Quebec.

156. Oliver Moore, *Former Canadian army officer accused of murder speaks out*, THE GLOBE & MAIL (Sept. 4, 2012), <http://www.theglobeandmail.com/news/national/former-canadian-army-officer-accused-of-murder-speaks-out/article4518314/>.

157. WILLIAM BLACKSTONE, COMMENTARIES ON THE LAWS OF ENGLAND 406 (10th ed., 1795), *citing* 2 Hal. P.C. 412, 2 Hawk. P.C. 463.

158. Johanna H. Groenewoudet. et. al., *Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands*, 342 N. ENG. J. MED. 551, 551–56 (2000).

159. *Abortion a necessary option: advocate*, TVNZ (Oct. 18, 2010), <http://tvnz.co.nz/health-news/abortion-necessary-option-advocate-3839309>; *Planned Parenthood v. Casey*, 505 U.S. 833, 856 (1992).

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Dutch guidelines acknowledge that assisted suicide is not a “preferred method” of causing the death of the patient because it may take several hours¹⁶⁰ and complications can arise. If death does not occur within an agreed-upon time (a maximum of two hours), physicians are to provide a lethal infusion.¹⁶¹ It appears that an average of thirty-six cases reported annually in the Netherlands involve failed or unduly prolonged assisted suicides backed up by euthanasia.¹⁶²

In Quebec, where only physician-administered euthanasia is allowed, Quebec’s law requires physicians providing euthanasia to remain with the patient until death ensues, which at least implies an obligation to ensure that it does.¹⁶³ The obligation to kill is more explicitly stated in professional guidelines, which emphasize the attending physicians’ responsibility “to ensure a respectful death, quick and free of suffering.”¹⁶⁴

3. *“Assisted suicide only” regimes*

Where both assisted suicide and euthanasia are legal, as in the Netherlands, a commitment to collaborate in suicide blends seamlessly into an obligation to kill; the attending physician can fulfil his obligation by lethally injecting the patient.¹⁶⁵ In Canada, where the law requires that a patient be competent at the time lethal medication

160. KNMG/KNMP, GUIDELINES FOR THE PRACTICE OF EUTHANASIA AND PHYSICIAN—ASSISTED SUICIDE 13 (2012), available at https://www.google.ca/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwiO0a_G19PPAhVC0WMKHW9mASAQFggeMAA&url=https%3A%2F%2Fwww.knmg.nl%2Fweb%2Ffile%3Fuuid%3D6dd97d29-f731-4c43-9bf0-9d155bc7bdd2%26owner%3D5c945405-d6ca-4deb-aa16-7af2088aa173%26contentid%3D224%26elementid%3D127002&usq=AFQjCNGXGj-UBUVMSK_WIMa4Y8TkpHPdEQ [hereinafter KNMG/KNMP].

161. *Id.* at 17–18.

162. Sean Murphy, *Euthanasia reported in Netherlands: statistics compiled from the Regional Euthanasia Review Committees’ Annual Reports*, PROT. OF CONSCIENCE PROJECT (Sept. 19, 2016), <http://consciencelaws.org/archive/documents/Statistics/euthanasia-netherlands.xlsx>.

163. *ARELC*, *supra* note 5, § 30.

164. COLLÈGE DES MÉDECINS DU QUÉBEC, ORDRE DES PHARMACIENS DU QUÉBEC, ORDRE DES INFIRMIÈRES DU QUÉBEC, MEDICAL AID IN DYING: 11/2015 PRACTICE GUIDELINES (Nov. 2015) [hereinafter MEDICAL AID IN DYING].

165. In the Netherlands, assisted suicide and euthanasia can be provided to an incompetent patient who, when competent, made a written request for the procedures. TERMINATION OF LIFE ON REQUEST AND ASSISTED SUICIDE (REVIEW PROCEDURES) ACT, art. 2, ¶2, *reprinted in* 9 ETHICAL PERSP. 176, 176–81 (2002). There are no references to patient consent, capacity or competence in the KNMG/KNMP, *supra* note 160.

is administered,¹⁶⁶ the situation is less certain. Lethally injecting a patient incapacitated by unsuccessful physician-assisted suicide or euthanasia might be permitted as part of a single act of “medical assistance in dying.” However, that would not be possible in Oregon, Washington, Vermont, and California, where assisted suicide is legal but euthanasia is not.

This suggests that the stability of an “assisted-suicide-only” regime may depend, in part, upon the efficacy of assisted suicide drugs, the statistical probability of failure increasing with the number of assisted suicides. Media attention on a failed attempted suicide would likely generate pressure to legalize euthanasia, it being argued that the acceptance of an obligation to kill is implicit in a physician’s commitment to assist in suicide.

C. Imposing an Obligation to Kill

Three models of obligation can be used to explain or justify the imposition of an obligation to kill.

1. The contract model

As the Canadian experience demonstrates, a statute or court ruling that authorizes assisted suicide and/or euthanasia need not impose an obligation to kill on either individual physicians or on the medical profession as a whole. However, individual physicians may voluntarily accept such an obligation: implicitly, when they agree to assist with suicide, or explicitly, when they agree to provide euthanasia. In the case of a failed attempt, the principles of basic contract law could be invoked to enforce the obligation they have voluntarily accepted: to ensure a respectful death, quick and free of suffering.

The imposition of an obligation to kill based on its voluntary acceptance by a physician does not bind the profession as a whole. Further, a physician’s need for training, drugs, equipment and, perhaps, the assistance of others, does not require the imposition of an obligation upon others to collaborate in killing. Others can, like a physician, voluntarily accept such responsibilities.

166. Physicians or nurse practitioners must “immediately before providing the medical assistance in dying, give the person an opportunity to withdraw their request and ensure that the person gives express consent to receive medical assistance in dying.” CRIM. CODE § 241.2(3)(h), R.S.C. 1985, c C-46 (Can.).

2. *The social contract (professional) model*

Social contract theory is often used to explain the concept of medical professionalism,¹⁶⁷ even by those seeking compromises that afford maximum protection for freedom of conscience.¹⁶⁸

According to this theory, society gives medical professionals a monopoly on the provision of certain services (and, perhaps, other perquisites like wealth or social status), in return for which it expects physicians, putting the interests of their patients ahead of their own, to ensure the delivery of those services.¹⁶⁹ This is typically described as a duty of self-sacrifice.¹⁷⁰ Professional self-sacrifice in the interests of the patient is extended to include the sacrifice of personal integrity.¹⁷¹

In 2011, Professor Udo Schuklenk and five other academics argued that physicians unwilling to kill patients or help them commit suicide should be forced to refer them to colleagues willing to do so, justifying this with an appeal to patient autonomy.¹⁷² Writing soon after the *Carter* decision, expressing dissatisfaction with the notion of referral, he applied social contract theory:

Doctors are first and foremost providers of health care services. Society has every right to determine what kinds of services they ought to deliver.¹⁷³

167. *Medical professionalism*, CANADIAN MEDICAL ASSOCIATION, <https://www.cma.ca/En/Pages/medical-professionalism.aspx> (last visited Apr. 8, 2016); ABIM Found., ACP-ASIM Found. & Eur. Fed'n of Internal Med., *Medical Professionalism in the New Millennium: A Physician Charter*, 136 ANNALS OF INTERNAL MED. 243, 243–46 (2002); William M. Sullivan, *Medicine under threat: professionalism and professional identity*, 162 CMAJ 673, 673–75 (2000); C. OF PHYSICIANS AND SURGEONS OF ONT., THE PRACTICE GUIDE: MEDICAL PROFESSIONALISM AND COLLEGE POLICIES (2007) [hereinafter CPSO-PRACTICE GUIDE], available at http://www.cpso.on.ca/CPSO/media/documents/Policies/Policy-Items/PracticeGuideSept07_nolinks.pdf. [hereinafter CPSO-PRACTICE GUIDE].

168. Conflicts, *supra* note 146.

169. *Id.* at 10, 46, 69–70, 79, 86, 132, 214.

170. Julie D. Cantor, *Conscientious Objection Gone Awry—Restoring Selfless Professionalism in Medicine*, 360 N. ENG. J. MED. 1484, 1484–85 (2009).

171. Udo Schuklenk, *Doctors Have no Right to Refuse Medical Assistance in Dying, Abortion or Contraception.*, BIOETHICS ISSN 0269-9702 doi:10.1111/bioe.12288 VOL. 31 NO. 3 (2016) [hereinafter Savulescu-Schuklenk].

172. Udo Schuklenk et. al., *End-of-Life Decision-Making in Canada: The Report by of the Royal Society of Canada Expert Panel on End-of-Life Decision-Making*, BIOETHICS ISSN 0269-9702, VOL. 25, NO. S1, 62, 69, 101 (Nov. 2011) [hereinafter *Royal Society*].

173. Udo Schuklenk, *Conscientious objection in medicine: Private ideological convictions must not supersede public service obligations*, UDO SCHUKLENK'S ETHX BLOG (Mar. 26, 2015), <http://ethxblog.blogspot.ca/2015/03/conscientious-objection-in-medicine.html>.

In 2016, Professor Schuklenk joined a geography professor in advancing an obligation to kill based on social contract, assuming a professional obligation to put patient's interests (not even qualified as *best* interests) first.¹⁷⁴ In response to criticism, he and Professor Julian Savulescu defended this position at length.¹⁷⁵

Ottawa law professor Amir Attaran insists that physicians are “duty-bound” to provide euthanasia or assisted suicide in circumstances defined by the *Carter* decision.¹⁷⁶ He believes that an obligation to kill should be derived from “ethics and the social contract inherent to Canada’s publicly funded healthcare system,” for which “secularism is the only feasible social contract”—and, presumably, the only acceptable source of ethics.¹⁷⁷

More likely the courts would rule that a doctor, having obtained from society the monopoly power to prescribe barbiturates within his or her clinical judgment, in turn owes it to society to ensure that each of his or her patients legitimately needing those drugs gets access—including to die. Or in other words: the doctor’s fiduciary duty matters to the *Charter* question.¹⁷⁸

While he refers here and elsewhere to fiduciary duties, it appears that, by “fiduciary duty,” he means no more than what is meant by Professors Schuklenk and Savulescu: a duty to serve a patient’s interest *simpliciter* by the delivery of requested legal medical services according to “rules of professional conduct.”¹⁷⁹

In any case, Professor Attaran argues that physicians cannot refuse to provide services on grounds prohibited by human rights legislation. Those who are “grievously, irremediably ill” are, he says, “disabled,” and disability is a prohibited ground of discrimination.¹⁸⁰ Professor Attaran claims that, having undertaken to provide medical treatment to the public, physicians who refuse to kill patients or help

174. Udo Schuklenk, *Why medical professionals have no moral claim to conscientious objection accommodation in liberal democracies*, J. MED. ETHICS (2016), doi 10.1136/medethics-2016-103560.

175. Savulescu-Schuklenk, *supra* note 171.

176. Amir Attaran, *Doctors can’t refuse to help a patient die — no matter what they say*, IPOLITICS (Nov. 13, 2015), <http://ipolitics.ca/2015/11/13/doctors-cant-refuse-to-help-a-patient-die-no-matter-what-they-say/> [hereinafter Attaran, IPOLITICS].

177. Amir Attaran, *Commentary: The Limits of Conscientious and Religious Objection to Physician-Assisted Dying after the Supreme Court’s Decision in Carter v. Canada*, 36 Health L. Can. 86, 94–95 (emphasis added) [hereinafter Attaran, *Limits*] (emphasis added).

178. *Id.* at 95.

179. *Id.* at 90.

180. *Id.* at 94.

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them commit suicide are engaging in invidious discrimination; he calls them “bigots.”¹⁸¹

While this attack is directed at dissenting physicians, they are, to some extent, protected by a constitutional guarantee of fundamental freedoms: not so physicians willing to provide euthanasia and assisted suicide. About half of them would provide the services only for the terminally ill, and very few would provide the services for purely psychological suffering.¹⁸² Leaving Professor Attaran’s broad claims aside, they may discover that if they provide euthanasia or assisted suicide to anyone, they must provide euthanasia or assisted suicide to everyone: that if they kill patients who are suffering from terminal illness, they cannot refuse to kill patients who are suffering from mental illness.¹⁸³

The euthanasia and assisted suicide policy of College of Physicians and Surgeons of Nova Scotia appears to reflect the social contract (professional) model in imposing an obligation on dissenting physicians to collaborate in killing. They are required to initiate an “effective transfer of care” to a non-dissenting physician to ensure “equitable access” to services, patient autonomy and dignity, an “appropriate balance” between physician freedom of conscience and religion and patient’s rights, and legality.¹⁸⁴

3. *The fiduciary model*

Supporters of euthanasia and assisted suicide often explain the obligation to kill as a fiduciary duty arising from the physician-patient relationship. This was explained by counsel for the Canadian Medical Association during the intervention in *Carter* at the Supreme Court of Canada.

“The first principle of medicine” is a physician’s “duty to secure

181. Attaran, *iPOLITICS*, *supra*, note 176; Attaran, *Limits*, *supra*, note 177.

182. CAN. MED. ASS’N, *Annual General Council 2015, Education session 2: Setting the context for a principles-based approach to assisted dying in Canada*, Webcast, 15:23–15:39, <https://webcasts.welcome2theshow.com/cma2015/setting> (last visited Dec. 29, 2015).

183. *Potter v. Korn*, [1995] B.C.C.H.R.D.; *Korn v. Potter*, [1996] B.C.J. No. 692, 134 D.L.R. (4th) 437 (B.C.S.C.); *SCOCAL, North Coast Women’s Care Medical Group v. San Diego Superior Court*, 44 Cal. 4th 1145, 189 P.3d 959, 81 Cal. Rptr. 3d 708, *available at* <http://scocal.stanford.edu/opinion/north-coast-womens-care-medical-group-v-san-diego-superior-court-33046> (last visited Apr. 8, 2017).

184. C. OF PHYSICIANS & AND SURGEONS OF N. S., *PROFESSIONAL STANDARD REGARDING MED. ASSISTANCE IN DYING*, (June 22, 2016), *available at* <http://www.cpsns.ns.ca/DesktopModules/Bring2mind/DMX/Download.aspx?PortalId=0&TabId=129&EntryId=284>.

patient well being,” and the traditional view has been that “the cornerstone” of this principle is “[t]he duty to preserve life.”

But the concept of patient well-being is capable of an interpretation which encompasses the patient’s right to choose death, where the alternative is certain suffering, a choice which is also supported by the concept of patient autonomy. Thus, going back to first principles, the two approaches are each possible.¹⁸⁵

In later reversing its policy against euthanasia and assisted suicide, the CMA officially adopted the second approach: that being killed or helped to commit suicide can be in a patient’s best interest. This also grounds a duty to cause death in a manner that ensures “a respectful death, quick and free of suffering.”¹⁸⁶ However, this has more serious implications.

The principle that it can be in someone’s best interest to be killed or helped to commit suicide has serious consequences for all physicians because it implies that all physicians, simply by virtue of being physicians, may have an obligation kill. Moreover, since providing requested medical treatment is the norm and refusing it the exception that requires justification, the CMA’s recognition of homicide and assisted suicide as forms of medical treatment has reversed the customary moral onus for *all* physicians, not just for dissenters. Assuming the legal criteria are met, killing becomes the norm: it is *refusing* to kill patients that now requires justification.

While CMA policy insists that dissenting physicians should not be forced to participate in or provide assisted suicide or euthanasia, it adds that “there should be no undue delay” in providing such “end of life care” to patients.¹⁸⁷ Consistent with this, in defending dissenting physicians against demands that they provide effective referrals for euthanasia, CMA officials offered a largely pragmatic argument: that access to the services would not be a problem, since only “a very

185. *Carter v. Canada*, Supreme Court of Canada, (Oct. 15, 2015), Webcast of Hearing: Oral Submission of Harry Underwood (Counsel for the Canadian Medical Association) 227:29/491:20 - [228:32/491:20] (http://www.scc-csc.gc.ca/case-dossier/info/webcast-view-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/) (last visited Apr. 8, 2017); Special Joint Comm. on Physician-Assisted Dying, 42nd Parliament, 1st Sess., Meeting No. 6 (2016) (statement of Dr. K. Sonu Gaind), *available at* <http://www.parl.gc.ca/HousePublications/Publication.aspx?Language=e&Mode=1&Parl=42&Ses=1&DocId=8075735#Int-8772921>.

186. *MEDICAL AID IN DYING*, *supra* note 164.

187. *CMA Policy*, *supra* note 137.

small percentage” of physicians find referral “categorically, morally unacceptable,” and about 24,000 physicians were willing to participate.¹⁸⁸ This implies that the exercise of physician freedom of conscience is conditional upon timely patient access to the services.

The College of Physicians and Surgeons of Ontario (CPSO) was the first state medical regulator in Canada to impose an obligation upon dissenting physicians to arrange for homicide and suicide.¹⁸⁹ The CPSO justifies this by citing the fiduciary obligations of physicians, claiming that effective referral is necessary “to protect patient’s best interests and to ensure that existing patients, or those seeking to become patients, are not abandoned.”¹⁹⁰ It also relies on social contract (professional) arguments.¹⁹¹

These public affirmations that it can be in someone’s best interest to be killed or helped to commit suicide, ratified by the Supreme Court of Canada and affirmed by legislation, have ramifications that go far beyond the medical profession. Being killed or helped to commit suicide are now seen to be benefits, at least in the circumstances defined by law. That being the case, a society that extols beneficence can be expected to extend access to those benefits as widely as possible.

This largely explains why, within a year of the ruling, a provincial-territorial group of experts recommended that legislation should expand the *Carter* criteria so that euthanasia and assisted suicide could be provided to adolescents and children,¹⁹² to incompetent people who had made advanced directives,¹⁹³ and as therapy for mental illness.¹⁹⁴ By the time parliamentary hearings were held a few months later, the recommendations—which had come to be called *Carter-plus*—were receiving vociferous support from some groups and many individuals, and a commitment to consider *Carter-plus* was

188. Special Joint Comm. on Physician-Assisted Dying, 42nd Parliament, 1st Sess., Meeting No. 6 (2016) (statements of Dr. Jeff Blackmer and Dr. Cindy Forbes), available at http://www.consciencelaws.org/background/procedures/assist014-001.aspx#Canadian_Medical_Association. CMA representatives also stated that demanding referral respects the conscience of some physicians, but not of others.

189. CPSO-MAID, *supra* note 15.

190. CPSO-POHR, *supra* note 16; see also ARELC, *supra* note 5.

191. CPSO-MAID, *supra* note 15; CPSO-PRACTICE GUIDE, *supra* note 167.

192. PROVINCIAL-TERRITORIAL EXPERT ADVISORY GRP. ON PHYSICIAN-ASSISTED DYING, FINAL REP., RECOMMENDATION 17, 29–34 (Nov. 30, 2015) [hereinafter REPORT].

193. *Id.*, Rec. 12 at 29–31.

194. *Id.*, Rec. 18 & 20 at 7, 15, 34, 36–37.

written into new law.¹⁹⁵

D. The Role of the State in Enforcing an Obligation to Kill

Both euthanasia and assisted suicide necessarily involve acts by people other than the patient. Among other things, this means that conflicts concerning the existence and discharge of an obligation to kill are inevitable, and that they will have to be adjudicated by the state. Should the state enforce an obligation to kill under any of the three models of obligation outlined above?

1. Enforcing a contractual obligation to kill

The enforcement of a contractual obligation to kill, voluntarily accepted, would not seem to have adverse consequences for freedom of conscience or religion, even if the state is involved in enforcing it, because enforcement would be directed only against physicians who had agreed to provide euthanasia or assisted suicide, not on dissenting physicians.

Presumably the role of the medical profession and medical regulators would involve ensuring that physicians who provide euthanasia and assisted suicide are competent¹⁹⁶ and conform to the requirements of the law, issuing guidelines and directives for this purpose, and taking disciplinary or remedial action when necessary.

Failing to provide the services as promised could be dealt with by civil actions for breach of contract, while damages for negligence or breach of contract might be awarded if a physician failed “to ensure a respectful death, quick and free of suffering.”¹⁹⁷

However, a difficulty might arise if a physician contracted to provide euthanasia or assisted suicide and later had a moral change of

195. An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying), S.C. 2016 C 14 (Can.), available at <http://www.parl.gc.ca/HousePublications/Publication.aspx?Language=E&Mode=1&DocId=8384014>.

196. The methods used for physician-assisted suicide and euthanasia are not difficult to master. Dr. Ellen Wiebe of Vancouver, discussing her performance of the first judicially authorized euthanasia in Canada, said that she had spent time with experienced providers in the Netherlands and Oregon, and reading what was available about Quebec protocols. She noted that some physician training programmes were being planned that would be “useful and helpful” but that no special training was required: “I don’t think that is what we’ll need.” B.C. Pharmacy Ass’n, Webinar, *Physician Assisted Dying: How pharmacists & physicians can work together*, (Mar. 10, 2016, 6:00 PM–7:00 PM Pacific Time).

197. MEDICAL AID IN DYING, *supra* note 164.

heart, perhaps as a result of reflection and experience. In many cases the problem might be resolved by providing timely notice to the patient, but this may not always be possible. Should the state, in such a case, suppress freedom of conscience or religion and enforce the obligation to kill by requiring performance of the contract?

Holocaust historian Saul Friedlander has something to say about state involvement in euthanasia and assisted suicide. Friedlander insists that the Nazi killing operation aimed at eliminating “life unworthy of life” had nothing to do with euthanasia, as the term is commonly understood: “the act of painlessly putting to death a person suffering from a terminal and incurable disease.”¹⁹⁸

While the *Carter* decision allows more than this, Friedlander’s definition of euthanasia approximates the thrust of the ruling. Nonetheless, “whatever one’s position on either abortion or assisted suicide,” he says, “comparisons with Nazi killing operations do not illuminate today’s discussion.”¹⁹⁹

It seems to me, however, that one general lesson can be applied. Government programs launched by the Nazi regime to exclude and kill clearly show that there are private spheres of human life where no state interest is sufficiently compelling to justify intervention. Only the individual directly affected, and possibly his or her closest relatives, should make such intimate decisions. True, individuals might err, but even mistakes by millions of private citizens about their bodies or their lives are far less open to abuse than are judgments legislated by the state and imposed by its agents.²⁰⁰

Understood in the sense intended by Professor Friedlander, this observation seems to support what might be called a “pro-choice” view: that the state should not intervene to prevent assisted suicide or euthanasia when such procedures are provided as a result of the voluntary choices of individuals. Even if those choices are objectively problematic, he argues, greater harm is likely to result if the state intervenes to prevent them.

Certainly, those opposed to assisted suicide and euthanasia would dispute this. Nonetheless, even without engaging claims of freedom of conscience and religion, Professor Friedlander’s insight provides an entirely adequate and pragmatic response to claims that the state

198. HENRY FRIEDLANDER, *THE ORIGINS OF NAZI GENOCIDE* xxi (CHAPEL HILL & LONDON: UNIV. OF N. C. PRESS 1995).

199. *Id.*

200. *Id.* at xxii.

should intervene, not to *prevent*, nor merely to *authorize*, but to *compel* some people to kill or collaborate in killing others. Enforcement of contractual arrangements for euthanasia and assisted suicide should stop short of enforcing an obligation to kill. It is simply too dangerous.

2. Enforcing a social contract (professional) obligation to kill

Social contract arguments, precisely because they are intended to achieve the compliance of whole professions or groups of people, even at the expense of personal integrity, are structurally supportive of programmes of organized, widespread killing, and subversive of individual resistance. This is particularly evident when euthanasia activists, by changing the meaning of fundamental terms like “benefit,” “harm,” and “best interests,” transform codes of ethics into ideological weapons and use them for ethical cleansing by repression and exclusion of dissenters. Quite apart from concerns about freedom of conscience and religion, Professor Friedlander’s insight has even greater force when the state is asked to enforce an obligation to kill based on social contract professionalism.

3. Enforcing a fiduciary obligation to kill

A fiduciary is required to act in the best interests of the beneficiary. However, generally speaking, physicians do not consider procedures to which they object for reasons of conscience to be in the best interests of their patients. That is certainly the case with euthanasia and assisted suicide.

Nonetheless, the current approach of the medico-legal establishment favours a definition provided solely by the patient, assisted by the advice and recommendations of the physician. Thus, the CPSO claims that a dissenting physician has a fiduciary duty to kill a patient or arrange for the killing if the patient ultimately decides that being killed is in his best interest.²⁰¹

201. CPSO-POHR *supra*, note 16: “The fiduciary nature of the physician-patient relationship requires that physicians act in their patients’ best interests.” There are repeated references to fiduciary duty in later sections, including the section on Conscience or Religious Beliefs. The policy also requires physicians to provide “care” that conflicts with their beliefs in an emergency, if others cannot do so. Both “emergency” and “care” are undefined. “Care” now necessarily includes euthanasia and assisted suicide. CPSO-MAID, *supra*: “The fiduciary nature of the physician-patient relationship requires that physicians prioritize patient interests. In doing so, physicians must strive to create and foster an environment in which the rights, dignity,

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This, however, violates a fiduciary's duty not to act under the dictation of another²⁰²—even the dictation of a beneficiary,²⁰³ and renders the concept of fiduciarity superfluous. If what is in a patient's "best interest" is defined exclusively by the patient, and the role of the physician is ultimately to provide whatever the patient has decided to be in his best interest, one does not need a theory of fiduciarity to describe the physician-patient relationship; one needs only a theory of servitude. The claim that a dissenting physician "abandons" a patient by refusing to do what he considers to be contrary to the patient's best interest enforces involuntary servitude, not fiduciary duty. This remains true even if, in cases where the physician and patient disagree, some third party is called upon to decide what counts as a patient's "best interests."

To have the state serve as the third party in the case of euthanasia or assisted suicide would be worse. It would be equally destructive of the concept of fiduciarity, and it would give the state the power to determine that it is in one's best interest to be killed, and to ensure that it happens. From the perspective suggested by Professor Friedlander, enforcing an obligation to kill based on fiduciary duty would be far more dangerous than enforcing an obligation to kill based on social contract professionalism.

Finally, when killing is seen as an act of compassion, refusing to kill is seen as cruel,²⁰⁴ even sadistic. Ultimately, killing someone ceases to be the greatest evil; refusing to kill can be worse. Such attitudes, allowed or encouraged to flourish, provide powerful emotional fuel

and autonomy of all patients are respected." CPSO-MAID also characterizes refusal to provide an effective referral for euthanasia as patient abandonment, which is considered a breach of fiduciary duty. The policy directs objecting physicians to adhere to CPSO-POHR, which, as noted above, includes a requirement to provide "care" in emergencies. On the other hand, CPSO-MAID states: "The federal legislation does not compel physicians to provide or assist in providing medical assistance in dying. For clarity, the College does not consider providing the patient with an 'effective referral' as 'assisting' in providing medical assistance in dying." This does not quite amount to a repudiation of an obligation to provide euthanasia in an "emergency."

202. Law Commission (United Kingdom), *Consultation Paper No. 215: Fiduciary Duties of Investment Intermediaries*, (2013), p. 85, http://www.lawcom.gov.uk/wp-content/uploads/2015/03/cp215_fiduciary_duties.pdf (last visited Mar. 18, 2017).

203. **Error! Main Document Only.** Law Commission (United Kingdom), Report No. 350, *Fiduciary Duties of Investment Intermediaries*. Williams Lea Group for HM Stationery Office (2014) p. 48, para. 3.53, citing *Selby v Bowie* (1863) 8 LT 372 and *Re Brockbank* [1948] Ch 206, http://www.lawcom.gov.uk/wp-content/uploads/2015/03/lc350_fiduciary_duties.pdf, (last visited Mar. 18, 2017).

204. The alleged "cruelty" of refusing to provide euthanasia or assisted suicide was noted five times in the trial court judgement and affirmed in the first paragraph of the Supreme Court of Canada decision. *Carter v. Canada*, [2012] BCSC 866, ¶¶ 258, 810, 1044, 1047, 1070.

for self-righteous crusades against dissenters. History demonstrates that it is in no one's best interest to place the power of the state at the service of such zealotry.

E. Summary

All of this suggests that, while the state may attempt to regulate and even facilitate assisted suicide and euthanasia, the state should not be permitted to enforce an obligation to kill or to collaborate in killing, and should not permit any entity or person to enforce such obligations. This conclusion is entirely consistent with Professor Friedlander's observations and with the position of civil liberties advocates, who have traditionally recognized the need to protect citizens against the exercise of oppressive and potentially deadly state power. Expressed in currently favored legal terms, to allow the state to enforce or support the enforcement of an obligation to kill would ultimately be subversive of rights to life, liberty and security of the person—to say nothing of freedom of conscience and religion.

VI. TOTALITARIAN CLAIMS

A. Recommendations to Force Participation in Homicide and Suicide

Parliamentary committee hearings and debates were held from January to June 2016 concerning amendments to the Criminal Code to implement the *Carter* decision.

In 2016, a joint parliamentary committee recommended that, "at a minimum," a policy of effective referral be imposed upon dissenting physicians. It also recommended that all publicly funded facilities, including denominational institutions, be compelled to provide euthanasia and assisted suicide, not merely to allow the services or arrange for them to be provided elsewhere. These recommendations could only be implemented by provincial governments, which have primary constitutional jurisdiction over human rights and the regulation of health care professions and hospitals, so the committee urged the federal government to work with provincial governments to achieve these goals.²⁰⁵

205. SPECIAL JOINT COMM. ON PHYSICIAN ASSISTED DYING, MEDICAL ASSISTANCE IN DYING: A PATIENT-CENTRED APPROACH, RECOMMENDATION 10, 26; RECOMMENDATION 11 27 (Feb. 2016), available at <http://consciencelaws.org/archive/documents/2016-02-25-PDAM-Rpt01-bookmarked.pdf>.

333] *Legalization of Assisted Suicide and Euthanasia**B. Attempts to Secure Legislative Protection for Freedom of Conscience*

Opposition members of parliament and senators proposed or supported protection of conscience amendments to Bill C-14, introduced by the government to revise the Criminal Code to conform to the *Carter* decision.²⁰⁶ However, the government argued that the constitutional division of powers between federal and provincial governments would make a protection of conscience clause in the Criminal Code unconstitutional.²⁰⁷

While this was true, it was also true that the federal government had exclusive criminal law jurisdiction over the subject matter of Bill C-14—homicide and suicide. The government could have made it a crime to force someone to be a party to homicide or suicide. That would not have prevented the provision of euthanasia or assisted suicide by willing practitioners, nor trespassed in provincial jurisdiction. However, it would have established that, as a matter of law and national public policy, no one could be compelled to become a party to homicide or suicide, or punished or disadvantaged for refusing to do so. The importance of such a provision was clear in view of the recommendations of the joint committee, and the well-known fact that the College of Physicians and Surgeons of Ontario planned to compel physicians to arrange for homicide and suicide through effective referral.

At the Justice Committee hearings on the proposed law, the Minister of Justice was asked twice, point blank, if that could be done. The Deputy Minister of Justice was asked the same question. Both

206. House of Commons Debates, 42nd Parliament, 1st Sess., Meeting No. 55, 1005–1315 (May 13, 2016), available at <http://www.parl.gc.ca/HousePublications/Publication.aspx?Language=E&Mode=1&Parl=42&Ses=1&DocId=8263399&File=0>; House of Commons Debates, 42nd Parliament, 1st Sess., Meeting No. 57, 1535–1750 (May 17, 2016), available at <http://www.parl.gc.ca/HousePublications/Publication.aspx?Language=E&Mode=1&Parl=42&Ses=1&DocId=8284973&File=0>; House of Commons Debates, 42nd Parliament, 1st Sess. Meeting No. 57, 1005–1225 (May 20, 2016), available at <http://www.parl.gc.ca/HousePublications/Publication.aspx?Language=E&Mode=1&Parl=42&Ses=1&DocId=8298112&File=0>; Vote No 61, 42nd Parliament, 1st Session, Sitting No. 57, 17 May, 2016 (<http://www.parl.gc.ca/HouseChamberBusiness/ChamberVoteDetail.aspx?Language=E&Mode=1&Parl=42&Ses=1&Vote=61&GroupBy=party&FltrParl=42&FltrSes=1>) (last visited Apr. 8, 2017).

207. Hon. Jody Wilson-Raybould, Minister of Justice, House of Commons Debates, 42nd Parliament, 1st Sess., Seating No. 55, 1040–45 (May 13, 2016), available at <http://www.parl.gc.ca/HousePublications/Publication.aspx?Language=E&Mode=1&Parl=42&Ses=1&DocId=8263399&File=0>.

evaded the questions.²⁰⁸ An amendment of exactly this kind²⁰⁹ was rejected in the Senate because it would “make an offence out of something that is currently part of the practice of medicine,” it would interfere in provincial jurisdiction, and because federal-provincial discussions were said to be resolving the issue.²¹⁰

In the end, the Liberal majority government allowed only revisions to the preamble, which, in Canadian law, counts for almost nothing. Only a single substantive section was added to the law:

241.2(9) For greater certainty, nothing in this section compels an individual to provide or assist in providing medical assistance in dying.²¹¹

C. Canadian Government Deliberately Supports Totalitarian Claims

And that is true. Nothing in the Criminal Code compels individuals or institutions to kill people or help them commit suicide. But nothing in the Criminal Code prevents such compulsion. Indeed: the College of Physicians and Surgeons of Ontario subsequently affirmed that its policy of “effective referral” was consistent with the Criminal Code.²¹²

The federal government knew full well that physicians were be-

208. Standing Comm. on Justice and Human Rights, House of Commons, Parliament of Canada: Meeting No. 10, Philpott, Jane (Minister of Health), Oral Submission, Edited Video Transcript: *Minister of Justice Jody Wilson-Raybould responding to Iqra Khalid and the Chair*, (May 2, 2016), available at <http://www.consciencelaws.org/background/procedures/assist016-002b.aspx#Philpott>; Standing Comm. on Justice and Human Rights, House of Commons, Parliament of Canada: Meeting No. 10, (May 2, 2016), Department of Health and Department of Justice, Oral Submission, Edited Video Transcript: *Deputy Minister William F. Pentney, responding to Ted Falk and Mark Warawa*, (May 2, 2016), available at <http://www.consciencelaws.org/background/procedures/assist016-002a.aspx#Department>.

209. Unfortunately, it used the term *medical aid in dying* rather than *homicide* and *suicide*. “No person shall compel an individual or organization to provide or assist in providing medical assistance in dying or to provide a referral for medical in dying.” Debates of the Senate, 42nd Parliament 1st Sess., Vol. 150, Issue 46, (June 9, 2016), available at http://www.parl.gc.ca/Content/Sen/Chamber/421/Debates/046db_2016-06-09-e.htm?#35.

210. Senator Serge Joyal was a member of the joint senate-commons committee that had made these recommendations. In speaking against the amendment, he cited and briefly paraphrased the policies of Colleges of Physicians and Surgeons across the country, including Ontario’s requirement for “effective referral,” claiming that none of them had been challenged as being contrary to freedom of conscience. This was obviously an erroneous assertion. Debates of the Senate, 42nd Parliament 1st Sess., Vol. 150, Issue 46, (June 9, 2016), available at http://www.parl.gc.ca/Content/Sen/Chamber/421/Debates/046db_2016-06-09-e.htm? (last visited Apr. 8, 2017).

211. Criminal Code (R.S.C., 1985, c. C-46), (<http://laws-lois.justice.gc.ca/eng/acts/C-46/page-54.html#docCont>) (last visited Apr. 8, 2017).

212. CPSO-MAID, *supra* note 15.

ing ordered to be parties to homicide and suicide, it had the power to prevent it, and it was repeatedly asked to do so. It steadfastly refused. This omission was deliberate, and this omission is significant.

It demonstrates that the government of Canada and its supporters deem it acceptable to force dissenting physicians, “at a minimum,” to arrange for their patients to be killed or helped to kill themselves.²¹³ They deem it acceptable to force all publicly funded health care institutions—including denominational institutions—to kill patients in their care or help them commit suicide.²¹⁴ The government of Canada considers all of this acceptable because it could have prevented it, but deliberately chose to enable it by wilfully refusing to prohibit compulsory participation in homicide and suicide.

Killing is not surprising. Even murder is not surprising. But to claim that the state, or a learned or privileged class or profession, can legitimately compel unwilling souls to collaborate in inflicting death upon another person, and justly punish them if they refuse—such claims are extraordinary, and extremely dangerous.

In Hannah Arendt’s terms, these are totalitarian claims. They seek total domination of will and intellect in moral decision-making, even in matters of life and death.²¹⁵ Such claims would have been completely unacceptable in Canada only two generations ago.

Why are they now supported by the government of Canada and prominent members of the academic and medico-legal establishments?

There may be a number of plausible answers to this question, but one of them is offered in Part 4: morality precedes and drives law. Arguments now made in support of these totalitarian demands were first developed in relation to abortion and contraception. Attacks on physicians refusing to provide or refer for abortion and contraception were a dress rehearsal for attacks now being made for refusing to provide or participate in homicide and suicide, because both policies are supported by the same erroneous and incoherent principle: that some authority can impose a moral duty to do what one believes to be wrong, or that the acceptance of such a duty can be made a condition

213. SPECIAL JOINT COMM. ON PHYSICIAN ASSISTED DYING, MEDICAL ASSISTED DYING: A PATIENT-CENTRED APPROACH, RECOMMENDATION 10, 26 (Feb. 2016) [hereinafter PDAM Report], *available at* <http://www.consciencelaws.org/archive/documents/2016-02-25-PDAM-Rpt01-bookmarked.pdf>.

214. *Id.* See also, Rec. 11 at 27.

215. HANNAH ARENDT, *THE ORIGINS OF TOTALITARIANISM*, 310, 311, 323, 326, 336, 339, 371, 392, 404–05, (Orlando: Harcourt, Inc., 1985).

membership in a profession.²¹⁶ It is not an accident that Professor Jocelyn Downie, one of the foremost advocates of compulsory “effective referral” for abortion and contraception, is also one of the foremost advocates of compulsory referral for euthanasia and assisted suicide.²¹⁷

VII. DEFENDING FUNDAMENTAL FREEDOMS

A. *A New Establishment Orthodoxy*

It is noteworthy that the CMA Board’s approval of euthanasia and assisted suicide did not generate a backlash from CMA members, most of whom were opposed to both. In part, this might be explained by the fact that the change occurred over the Christmas season, and the announcement in early January made it seem that the Board had adopted a policy of neutrality consistent with the motion approved by the General Council.²¹⁸

The key factor, however, was that the legal, political and social landscape changed four weeks later when the *Carter* decision was released. All attention was immediately directed to its implementation. Criticism of the policy change would have been considered an irrelevant and unwelcome distraction. As unhappy as they might have been with the new euthanasia policy, dissenting physicians had nothing to gain by criticizing the CMA Board of Directors. On the contrary, they needed the support of the Board and their colleagues.

Most important, the decision placed the Supreme Court’s seal of approval on the new policy, which was cited in the ruling and consistent with it. Support for euthanasia and assisted suicide in all walks of life became associated with the authority of the Supreme Court and the *Charter of Rights and Freedoms*. Attempts to reverse, revise or resist laws or policies supportive of the procedures have since been characterized by *Carter* enthusiasts not only as reactionary, but as an

216. Sean T. Murphy, *No More Christian Doctors: Crusade Against NFP Only Physicians*, PROTECTION OF CONSCIENCE PROJECT, <http://www.consciencelaws.org/background/procedures/birth002.aspx> (last visited Apr. 8, 2017).

217. In 2006, Professor Downie claimed that there was a legal and professional obligation to refer for abortion. Rodgers S. Downie J. Abortion: Ensuring Access. *CMAJ* July 4, 2006 vol. 175 no. 1 doi: 10.1503/cmaj.060548] <http://www.cmaj.ca/content/175/1/9.full> (last visited Apr. 8, 2017). She later made the same claim about euthanasia and assisted suicide. [hereinafter Royal Society].

218. Pat Rich, *CMA updates assisted dying policy* (Jan. 9, 2016), <https://www.cma.ca/En/Pages/cma-updates-assisted-dying-policy.aspx>.

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assault on constitutional rights, on the authority of the Court and on the rule of law.²¹⁹

Thus, the *Carter* ruling formally ratified a new establishment orthodoxy, according to which refusing to at least collaborate in killing in circumstances defined by *Carter* is unacceptable. The most radical implications of the new orthodoxy only began to come into focus after the decision, when it finally became possible to dismiss mere collaboration as insufficient, and to demand that physicians must kill patients themselves. Part 4 indicates that this new orthodoxy can be expected to operate at a foundational level, exerting a significant influence that may not be immediately obvious. On the other hand, it may also manifest itself publicly as concern about something called the problem of unregulated conscientious objection.²²⁰

1. *Dogmatic moral imperialism*

What this actually means is that many citizens in responsible positions refuse to do what they believe to be gravely wrong—and that this is a problem. In 2010, the Council of Europe was urged to address this problem by requiring citizens who intend to make moral decisions to register with the state, prove to state regulators that they are sincere, and notify employers and others of their intentions.²²¹ We do not take this approach to conflicts arising from the exercise of other fundamental freedoms. We do not typically describe dissemination of pornography or racist ideas as demonstrating “the problem of unregulated speech.” We do not require citizens to satisfy state committees of their sincerity before granting them permission to exercise freedom of association. We register sex offenders, not citizens who plan to exercise freedom of expression.

The so-called “problem of unregulated conscientious objection”

219. B.C. CIVIL LIBERTIES ASS'N, MEDIA RELEASE: BCCLA REACTS TO PASSAGE OF ASSISTED DYING BILL THAT IT CALLS “UNCONSTITUTIONAL.” (June 17 2016), available at <https://bccla.org/news/2016/06/media-release-bccla-reacts-to-passage-of-assisted-dying-bill-th-at-it-calls-unconstitutional/>; Paula Simons, *WHEN ASSISTED DYING TAKES A BACK SEAT TO RELIGION*, CALGARY HERALD (Sep. 29, 2016), <https://www.pressreader.com/canada/calgary-herald/20160929/281543700414376>.

220. See generally Sean Murphy, *The problem of unregulated conscientious objection*, PROTECTION OF CONSCIENCE PROJECT (Aug. 19, 2013), <http://www.consciencelaws.org/background/procedures/execution001.aspx>.

221. See *Submission to the Parliamentary Assembly of the Council of Europe Re: Women's access to lawful medical care: the problem of unregulated use of conscientious objection*, PROTECTION OF CONSCIENCE PROJECT (Oct. 6, 2010), <http://www.consciencelaws.org/publications/submissions/submissions-010.aspx>.

is actually the exercise of freedom of conscience and religion seen through the dogmatic lens of the new orthodoxy. Once upon a time, dissenters were seen as heretics threatening a divinely appointed social order. Now, dissenting physicians are seen as heretics threatening an establishment theory of social contract. This is dogmatic moral imperialism, even if the dogmatists are not ecclesiastical theorists and functionaries. It should be identified as such.

2. *Morality and law*

The moral underpinning for European legal systems was provided largely by acculturated Judeo-Christian religious traditions that persisted in the Europe and the European diaspora until the mid-twentieth century, when the validity of such “traditional morality” or “shared values” was called into question. The questioners, however, while disputing the nature and content of the morality that ought to inform the law, did not dispute the need for something of the kind.

H.L.A. Hart, criticizing Lord Devlin’s *The Enforcement of Morals*, acknowledged that moral consensus, “on certain matters” was essential.²²² Ronald Dworkin did not dispute Lord Devlin’s idea that “morality counts.”²²³ On the contrary, he insisted that judges rulings are informed by a moral vision of some kind, and developed his own ideas about what that moral vision should be.²²⁴ The growing influence of ethics and bioethics on law and public policy in the late twentieth century, described by Margaret Somerville,²²⁵ appears to reflect an intuitive insight that Judeo-Christian concepts foundational to law could not simply be rejected, but had to be replaced with something else.

The trial court ruling in *Carter* demonstrates that foundational moral beliefs shape jurisprudence, yet none of the parties supporting the law addressed the morality of suicide.²²⁶ This was probably because they reasonably anticipated that moral argumentation would be ill-received, ineffective and possibly damaging to their interests in a

222. See RICHARD A. WASSERSTROM, *MORALITY AND THE LAW* 52 (Wadsworth Publishing Co., 1971).

223. *Id.* at 69.

224. See Noah Feldman, *Dworkin’s death deprives Scalia of his moral foil*, BLOOMBERG VIEW (Feb. 14, 2013, 6:39 PM), <https://www.bloomberg.com/view/articles/2013-02-14/dworkin-s-death-deprives-scalia-of-his-moral-foil>.

225. Somerville, *Bird supra* note 1, at 232–35.

226. See *Carter v. Canada*, [2012] BCSC 886 (Can.).

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judicial environment informed by secularism and moral pluralism. However, the failure to address the morality of suicide did not produce a morally neutral judicial forum. It simply allowed the belief that suicide can be moral to set the parameters for argument and adjudication.

When foundational moral beliefs are in issue, Mr. Justice David M. Brown of the Ontario Superior Court of Justice suggests that judges should be challenged to candidly acknowledge and precisely articulate the philosophical or moral premises underpinning their positions.²²⁷

3. *The person is central*

It is equally important for counsel to put in issue the anthropology that underlies moral reasoning. Reasoning from different beliefs about what man is and what is good for him leads to different moral or ethical conclusions. Is lethally injecting a patient harmful, or beneficial? Is it medical treatment, or not?

Such questions cannot be answered without reference to the nature of the human person.

A credal concept of the human person determines not only what counts as harm, but how one approaches every moral or ethical problem, not only in medicine,²²⁸ but also in law. This, perhaps, is why basing an obligation to kill upon fiduciary duty is not only destructive of the concept of fiduciarity, but exponentially more dangerous than basing it upon principles of contract law.

Change the credal concept of the human person, and the *meaning* of the law will change, even if the *wording* of the law remains unchanged. What lies at the root of current controversies about freedom of conscience and religion is fundamental disagreement about the nature of the human person. Here, too, judges should clearly acknowledge the credal concept of the human person that informs

227. See David M. Brown, *The Courts' Spectacles: Some Reflections on the Relationship between Law and Religion in Charter Analysis: Reasonable Accommodation and Role of the State: A Democratic Challenge*, PROTECTION OF CONSCIENCE PROJECT (Sept. 24, 2008), <http://www.consciencelaws.org/law/commentary/legal046.aspx#001>.

228. See Sean Murphy, Freedom of Conscience and the Needs of the Patient, Presentation at the Obstetrics and Gynaecology Conference in Banff, Alberta (Nov. 9–12, 2001), available at <http://www.consciencelaws.org/Examining-Conscience-Ethical/Ethical23.html>; See Sean Murphy, *Service or Servitude: Reflections on Freedom of Conscience for Health Care Workers*, PROTECTION OF CONSCIENCE PROJECT (Nov. 4, 2004), <http://www.consciencelaws.org/Examining-Conscience-Ethical/Ethical48.html>.

their evaluation of evidence and legal reasoning, particularly when they intend to suppress other views in favor of their own.

B. Freedom of Conscience

1. Distinctions: perfective and preservative freedom of conscience

A credal concept of the human person is implicit in the observation of Madame Justice Bertha Wilson of the Supreme Court of Canada that, “an emphasis on individual conscience and individual judgment . . . lies at the heart of our democratic political tradition.”²²⁹ Nonetheless, judges and legislators who purport to “balance” conflicting rights claims by limiting freedom of conscience, often fail to make a critical distinction.

Freedom of conscience is exercised in two different ways. The first is by pursuing some good that one thinks should be done; call this perfective freedom of conscience, because the pursuit of the good as one understands it is thought to be perfective of the human person. The second is refusing to do what one believes to be wrong; call this preservative freedom of conscience—preservative of personal integrity.

2. Limiting perfective freedom of conscience

By its nature, perfective freedom of conscience demands much more of society than preservative freedom of conscience, so that limitations are likely to be imposed on it by preventing someone from doing some good that he believes ought to be done. Such limitations may interfere with some of the aspirations of citizens or their pursuit of moral perfection. They are not necessarily inconsistent with democratic freedom or human dignity. Certainly, restrictions may go too far; they might fail to demonstrate sufficient understanding and respect for human freedom and dignity, even if they do not subvert them entirely. But no polity could long exist without restrictions of some sort on human acts, so some limitation of perfective freedom of conscience is not unexpected.

Limiting perfective freedom of conscience may do people some wrong; that is why democratic regimes have been increasingly in-

229. See *R. v. Morgentaler* [1988] 1 S.C.R. 30, 165 (Can.) [hereinafter *Morgentaler*], available at <http://scc-csc.lexum.com/scc-csc/scc-csc/en/item/288/index.do>.

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clined to err on the side of freedom, demanding that restrictions on freedom of conscience must be demonstrably necessary, narrowly framed, and strictly construed. But if it does them some wrong, it does not necessarily do them an injury.

3. *Limiting preservative freedom of conscience*

Restricting preservative freedom of conscience is very different. Demanding the submission of physicians' intellect, will, and conscience in order to force them to serve as means to achieve ends chosen by others reduces them to the status of tools: mere things. Precisely because he believed that segregation relegated persons "to the status of things," Dr. Martin Luther King Jr. condemned it as "morally wrong and sinful."²³⁰ Similar observations have been made by others.²³¹

This was lucidly expressed by Madame Justice Wilson. She insisted that an individual must never be treated as a means to an end—especially an end chosen by someone else, or by the state. She rejected the idea that the state should endorse and enforce "one conscientiously-held view at the expense of another," for that is "to deny freedom of conscience to some, to treat them as means to an end, to deprive them . . . of their 'essential humanity'."²³²

Thus, to force people to do something they believe to be wrong is always an assault on their personal dignity and essential humanity because it reduces them to a form of servitude that cannot be reconciled with principles of equality. It is inconsistent with the best traditions and aspirations of liberal democracy, since it instils attitudes more suited to totalitarian regimes than to the demands of responsible freedom.

Here it may be significant that the Thirteenth Amendment to the Constitution of the United States virtually abolished not just slavery,

230. See Martin Luther King, Jr., LETTER FROM BIRMINGHAM JAIL (Apr. 16, 1963), available at https://www.africa.upenn.edu/Articles_Gen/Letter_Birmingham.html.

231. See Immanuel Kant, *Fundamental Principles of the Metaphysic of Morals*, http://www.gutenberg.org/ebooks/5682?msg=welcome_stranger (last visited Oct. 9, 2008), quoted in *Immanuel Kant (1724-1804) Metaphysics*, THE INTERNET ENCYCLOPEDIA OF PHILOSOPHY, <http://www.iep.utm.edu/kantmeta/> (last visited Oct 9, 2008); See C.E.M. JOAD, GUIDE TO THE PHILOSOPHY OF MORALS AND POLITICS 803 (London: Gollancz Ltd., 1938), quoted in *Morgentaler*, *supra* note 229, at 178.; KAROL WOJTYLA, LOVE AND RESPONSIBILITY 27 (San Francisco: Ignatius Press, 1993).; see TZVETAN TODOROV, FACING THE EXTREME: MORAL LIFE IN THE CONCENTRATION CAMPS 165 (London: Phoenix Books, 2000).

232. See *Morgentaler*, *supra* note 229, at 178–79.

but “involuntary servitude,” a historical practice associated with slavery.²³³ Surely, to compel people to serve ends they find morally abhorrent is to treat them as things to be used for ends chosen by others, thus imposing upon them a particularly odious form of involuntary servitude.

This does not mean that no restriction can ever be placed on preservative freedom of conscience. It does mean, however, that if the restriction can be justified at all, it will only be as a last resort and only in the most exceptional circumstances.²³⁴

233. U.S. CONST. amend. XIII.

234. Sean Murphy & Stephen J. Genius, *Freedom of conscience in health care: distinctions and limits*, 10 *BIOETHICAL INQUIRY* 347 (2013), available at <http://link.springer.com/article/10.1007/s11673-013-9451-x>.