Ewan C. Goligher MD PhD FRCPC
Internal Medicine and Critical Care
University Health Network

The Standing Committee on Justice and Human Rights
Attn: Mike MacPherson, Committee Clerk
House of Commons
131 Queen St., 6-07
Ottawa ON K1A 0A6

May 2, 2016

Re: Bill C-14, Case for Protection of Conscience Rights

Dear Honourable Members of Parliament:

I am writing as a concerned physician who conscientiously objects to physician-assisted death to request that you include provisions in Bill C-14 to protect the conscience rights of Canadian citizens who work as healthcare professionals. Some have argued that patients' legal entitlement to accessing assisted death trumps the ethical concerns of some doctors and nurses. As an academic physician specializing in internal medicine and intensive care medicine I frequently care for patients at the end of life, and having carefully considered the relevant ethical and philosophical issues, I conclude that conscientious objection to assisted death merits robust legal protection. Given that some physician regulatory bodies have already indicated that effective referrals for assisted death will be mandatory, parliamentary intervention is required to uphold freedom of conscience as guaranteed in the Charter of Rights and Freedoms.

Conscientious objection is reasonable and merits respect given the following considerations.

1. Doctors should provide PAD only if it is both legal and ethical
The Supreme Court has ruled that PAD ought not to be legally prohibited, but it cannot define whether it is ethical for doctors to intentionally cause death. In their decision on the legality of PAD, the Supreme Court Justices stated that "nothing in this decision would compel physicians to provide assistance in dying." The Justices recognize that we need not automatically accept that PAD is ethical in the wake of this sweeping change in law.

2. Assisted death is ethical only if certain insupportable philosophical assumptions are accepted.
First, in contending that death is better than life for some patients, advocates for PAD assume some notion of what it is like to be dead. Yet the medical profession has no idea what it is like to be dead. All beliefs about the afterlife (including the belief that there is no afterlife) are metaphysical (quasi-religious) beliefs which cannot be confirmed or refuted by scientific medical evidence. Medical care must be based on evidence and observation, and doctors should not be forced to practice medicine based on untestable quasi-religious assumptions.

Second, PAD advocates assume that respect for the patient's wishes, rather than respect for the patient as a whole, is the foundational value of medical ethics. Respect for the patient's wishes is unquestionably part of respecting the patient, but valuing these wishes above the patient herself would prevent doctors from ever refusing any patient request, even if it would clearly harm her health. The long-accepted firm foundation for medical ethics (including the duty to respect the patient's wishes) is the incalculable intrinsic objective worth of the patient. Intentionally causing death would require us to render valueless that which is of essential value: the patient.

Intensivist, Mount Sinai Hospital & University Health Network
Mount Sinai Hospital, 600 University Ave., Room 18-206, Toronto ON, M5G 1X5
ewan.goligher@mail.utoronto.ca Tel: 416.86.8449

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In sum, given the tenuous assumptions underpinning the case for PAD, doctors need not accept that PAD is ethical.

3. Providing an effective referral makes physicians complicit in another physician's actions
If a father were to request that his daughter undergo circumcision (i.e. genital mutilation), and I deliberately provided an effective referral to a willing physician, I would be complicit in an extremely grievous breach of medical ethics. This scenario is not ethically identical to PAD but it effectively illustrates the moral and ethical responsibility attached to an effective referral. This moral responsibility is recognized in law: doctors are legally liable for referring a patient for a procedure that is forbidden by law, even if requested by the patient (as was the case for PAD until now). Knowingly referring a patient to a physician willing to cause the patient's death makes doctors complicit in that death. Therefore, reason and conscience prevent us from accepting the claim that PAD is ethical, we ought not to provide referrals for PAD.

4. The Charter right of Freedom of Conscience applies to healthcare professionals
Some argue that doctors cannot claim the Charter right of Freedom of Conscience because we willingly accept responsibilities and duties that limit our freedom when we commit to care for the patient. Accordingly, doctors are duty-bound to deliberately cause death upon the patient's voluntary request. This argument is successful only if PAD is ethical: the commitment to care does not extend to providing unethical care. Doctors are duty-bound to ensure that their patient's suffering is relieved by all effective means available. Whether this commitment entails a duty to cause death is a controversial moral question contingent upon certain philosophical assumptions. Those who insist upon a duty to refer for PAD impose their personal ethical beliefs and assumptions upon others. The freedom of individuals to decide this issue and to act in accordance with one's deeply held moral beliefs is precisely what the Charter right of Freedom of Conscience protects.

5. Respect for conscientious objection promotes good medical care
Even given the assumption that PAD is ethical, robust respect for conscientious objection is still ultimately good for patients. Patients entrust themselves to their doctors, and doctors must be worthy of this trust. The doctor's moral integrity—a commitment to acting in accordance with moral norms—is foundational to his/her trustworthiness. Suppressing conscientious objection prizes moral conformity over moral integrity and systematically teaches physicians to suppress their basic moral intuitions in favour of constantly evolving social conventions. It also teaches the profession to be less sympathetic of and tolerant toward patients' diverse moral beliefs. Thus, robust respect for conscientious objection should be viewed as an important public good that upholds the quality of medical care. [This claim has been convincingly argued in one of the world's most influential medical journals, see White and Brody, JAMA 2011:305(17):1804-1805].

6. Respect for conscientious objection will not meaningfully obstruct access to physician-assisted death?
Making referrals mandatory does not immediately guarantee access as PAD will not be routinely provided by any particular medical specialty and many in the medical community do not know physicians willing to accept such referrals. Conscientious objectors have proposed simple solutions allowing patients to refer themselves for PAD. As an objector, I plan to transfer my hospitalized patients to a different attending physician (an act qualitatively different than an effective referral) to avoid unduly obstructing access. Carefully considered policy frameworks for providing PAD can show robust respect for conscientious objection while enabling universal patient access.

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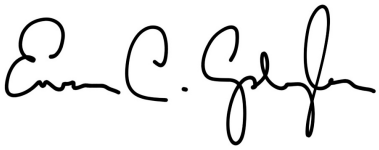
These considerations support our claim that it is reasonable to object to providing either assisted death or an effective referral for the same. Given this reasonable position and the evidence that regulatory bodies are not universally prepared to respect conscientious objection in this matter, I urge you to enact protections in law for the substantial minority of Canadian doctors and nurses who, for the sake of our unswerving commitment to the value of our patients, cannot participate in deliberately taking a life.

Thank you for your time and consideration.

Yours sincerely,



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