Conscientious refusal to provide medically-assisted dying

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Medical assistance in dying (MAiD) became legal in Canada in June 2016. Since that time many health care practitioners and health care institutions have undertaken to provide it, and thousands of Canadians have taken advantage of it. At the same time, a significant number of both practitioners and institutions have refused provision of MAiD for various reasons, including conscience-based objections to it. These conscientious refusals to provide MAiD are my topic.

There are two related topics I will *not* be discussing: whether MAiD can, under appropriate conditions, be ethically justified and whether it should, under these conditions, be legally available. I have dealt with both of these questions at length elsewhere and do not plan to reopen them here.[1] In Canada the MAiD law is here to stay and enjoys widespread public support; any future changes to it will almost certainly be in the direction of loosening or expanding its eligibility criteria. The debate has therefore moved on to collateral issues, including patient access to MAiD and conscientious refusal to provide it. These issues play out as well in other jurisdictions but I will also not be discussing any of them, since I know and care much less about them. My focus in what follows will be firmly on the situation in Canada.

I begin with the case of practitioners and then go on to consider institutions.

1. Health care practitioners

To begin, it will be useful to settle on a working definition of conscientious refusal. In general, we can say that it consists in someone refusing to do something on the ground that doing it would be contrary to their conscience.[2] In the specific context of health care, a practitioner (a

[1] Sumner 2011.
[2] The classic context for conscientious refusal is compulsory military service; see, e.g., Rawls 1971, 368ff.

physician, nurse, or pharmacist) engages in an act of conscientious refusal when they (1) refuse to provide a good or service that is legal and professionally accepted and that falls within the scope of their professional competence, and (2) justify their refusal by claiming that it is an act of conscience or is conscience-based.[3]

As Mark Wicclair has pointed out, 'conscience' can mean many things in many settings.[4] For the present purpose I will follow him in identifying a person's conscience with their core moral beliefs:

> Core moral beliefs are an agent's fundamental moral beliefs. They comprise the subset of an agent's moral beliefs that matter most to the agent. They are integral to an agent's understanding of who she is (i.e. her self-conception or identity). Accordingly, acting contrary to core moral beliefs is perceived by the agent as an act of self-betrayal.[5]

It follows that an agent's refusal to provide a good or service is conscientious just in case (1) the agent has a core set of moral beliefs, (2) providing the good or service would be incompatible with those beliefs; and (3) the agent's refusal is based on those beliefs.[6]

The legal right of health care practitioners to refuse to provide MAiD is effectively settled in Canada. In *Carter v Canada*—the 2015 decision that resulted in MAiD becoming legal— the Supreme Court addressed the issue of conscientious refusal without pronouncing on it:

> In our view, nothing in the declaration of invalidity which we propose to issue would compel physicians to provide assistance in dying. The declaration simply renders the criminal prohibition invalid. What follows is in the hands of the physicians' colleges, Parliament, and the provincial legislatures. However, we note ... that a physician's decision to participate in assisted dying is a matter of conscience and, in some cases, of religious belief.... In making this observation, we do not wish to pre-empt the legislative

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[3]Adapted from Wicclair 2011, 1.
[4]*Ibid.*, 1ff.
[5]*Ibid.*, 4-5.
[6]Adapted from *Ibid.*, 5.

and regulatory response to this judgment. Rather, we underline that the *Charter* rights of patients and physicians will need to be reconciled.[7]

When the Court referred here to "the *Charter* rights of patients" what it had primarily in mind was their s. 7 right to "life, liberty, and security of the person"—the right that served as the constitutional basis for their decision in *Carter*. It is fair, I think, to read that right as entailing not just the absence of a legal prohibition of MAiD (as embodied in the two sections of the *Criminal Code* the Court found to be invalid) but also effective access to MAiD on the part of eligible patients, since the former without the latter would be nugatory.[8] The effect of the *Carter* decision was to remove a legal barrier to MAiD. As a result, MAiD now has the same legal and professional status in Canada as any other medical service, and eligible patients have the same affirmative right to it as cardiac patients in need of bypass surgery or cancer patients in need of chemotherapy.[9]

What the Court meant by the *Charter* rights of physicians was presumably their s. 2(a) right to "freedom of conscience and religion". These rights can conflict when an eligible patient requests MAiD from a qualified practitioner who then declines to provide it on the ground that doing so would be incompatible with their core moral beliefs. The Court declined to spell out what "reconciling" the rights of patients and physicians might involve, though it did seem to be gesturing toward striking some kind of balance between them.

The first step toward finding this balance was taken by Parliament in Bill C-14, which became law in June 2016.[10] The Preamble to C-14 notes that "nothing in this Act affects the guarantee of freedom of conscience and religion". S. 241.2(9) then follows up by stating that

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[7]*Carter v Canada (Attorney General)*, (2015) 1 S.C.R. 331 at para 132.
[8]See, for instance, *The Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario*, 2018 ONSC 579 (henceforth, *CMDS* 2018) at para 195; *Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario*, 2019 ONCA 393 (henceforth, *CMDS* 2019) at para 166.
[9]My thanks to Philip Shadd for pointing out the need for clarification on this point.
[10]Bill C-14, *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, SC 2016.

"For greater certainty, nothing in this section compels an individual to provide or assist in providing medical assistance in dying". Note that in at least one important respect this stipulation is broader than would be suggested by the Supreme Court's treatment of the issue, since it applies not only to physicians but more broadly to "individuals". This shift was necessitated by the fact that C-14 authorized nurse practitioners to provide MAiD, and also authorized pharmacists to dispense the medication to be administered to patients under the terms of the Act.[11]

This section of C-14 does not exempt practitioners from being legally compelled to provide or assist in providing MAiD.[12] It merely says that nothing in the federal law so compels them. It is in any case not clear how the law could have compelled them, since the regulation of medical services lies within provincial/territorial jurisdiction. The question of what practitioners may, or may not, be compelled to do will ultimately be determined not by Parliament but by the provincial/territorial legislatures and regulators.[13] While C-14 does not, and cannot, settle this issue, it does operate as a strong reminder that any position taken by these bodies must be *Charter*-compliant. As it happens, every provincial jurisdiction in Canada has elected to allow objecting practitioners to refuse to provide (or assist in providing) MAiD, even if their refusal will impede access to the procedure by patients who fully satisfy the eligibility criteria for it.[14] This opt-out provision does not appear to be so much a reconciling or balancing of the rights of patients and practitioners as a wholesale surrender of the former to the latter. If practitioners

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[11]Notwithstanding this broader focus, most of the discussion to follow will focus on the duties of physicians, since they are the primary providers of MAiD. However, the analogous issues for nurses and pharmacists will also be addressed, where appropriate.
[12]I owe this point to Richard Moon.
[13]Other bodies, such as professional associations and advocacy organizations, may also have rules, guidelines, or principles regarding conscientious refusal in general and refusal of MAiD in particular. See Shaw and Downie 2014, 35–6. For convenience, and relevance, I am limiting myself to bodies with powers of enforcement.
[14]For instance, Manitoba's Bill 34, *The Medical Assistance in Dying (Protection for Health Professionals and Others) Act*, passed in November 2017, stipulates that "a professional regulatory body must not make a regulation, by-law, rule or standard that requires a member of the regulated profession to provide or aid in the provision of medical assistance in dying".

refuse to provide MAiD, on grounds of conscience, then eligible patients will have no effective access to the procedure. What, then, has become of their rights?

A partial answer to this question will point out that, as a matter of fact, not all practitioners, or maybe even most, will be conscientious refusers. Canada is fortunate to have a robust cohort of physicians and nurse practitioners who have committed to providing MAiD to eligible patients, though they are distributed unevenly across the country, with shortages of willing providers in some areas. Since thousands of Canadians have managed to access the procedure since the passage of C-14 in 2016, it is fair to say that their rights have not been nullified by widespread conscientious refusal. This is fine as far as it goes, but it is still only a partial answer, since patients' access can be significantly impeded if their request for MAiD is refused by the practitioner who is already responsible for their care. Under the terms of C-14 a patient can be eligible for MAiD only if they have a "grievous and irremediable medical condition" that is causing them "enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable". In that vulnerable condition a seriously sick patient is requesting from their health care practitioner a form of treatment that is legal and professionally recognized, that they are fully eligible to receive, and that they regard as their best option under their circumstances—and the practitioner is refusing to provide it. That hardly seems consistent with effective access.

The rest of the answer to the question hangs on what refusing practitioners *may* be compelled to do on behalf of their patients. The only provincial legislature to have spoken directly to this issue is Quebec. Under the terms of Bill 52, passed by the National Assembly in June 2014, a physician who refuses MAiD to an eligible patient must forward the patient's request to their health care institution or local health authority, who will then have the responsibility "to find another physician willing to deal with the request in accordance with" the eligibility criteria.[15] The legislation therefore requires that a practitioner who conscientiously

[15]Bill 52, *An Act respecting end-of-life care*, 1st Sess, 41st Leg, Quebec, 2013 (assented to 10 June 2014), RSQ c S-32.0001, s. 30.

refuses to provide MAiD must still take active steps to facilitate or enable the patient's access to the procedure.

In Ontario the necessary steps have been spelled out not by the legislature but by the College of Physicians and Surgeons of Ontario (CPSO). The College states that it "recognizes that physicians have the right to limit the health services they provide for reasons of conscience or religion. However, physicians' freedom of conscience and religion must be balanced against the right of existing and potential patients to access care."[16] In order to achieve this balance it stipulates that "physicians who decline to provide MAID due to a conscientious objection...**must** not abandon the patient and **must** provide the patient with an effective referral".[17] It then spells out what is required by an effective referral: "Physicians make an effective referral when they take positive action to ensure the patient is connected in a timely manner to a non-objecting, available, and accessible physician, other-health-care professional, or agency that provides the service or connects the patient directly with a health-care professional who does."[18] As with the Quebec legislation, therefore, the CPSO's rules require objecting practitioners to actively enable access to MAiD for their eligible patients.

At least in Ontario, essentially the same requirement also applies to the two other groups of practitioners involved in the provision of MAiD: nurses (including nurse practitioners) and pharmacists. The College of Nurses of Ontario states that "nurses who conscientiously object must transfer the care of a client who has made a request for medical assistance in dying to another nurse or health care provider who will address the client's needs".[19] Likewise the

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[16]https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Professional-Obligations-and-Human-Rights/Advice-to-the-Profession-Professional-Obligations. Last accessed 21/03/20.
[17]https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Medical-Assistance-in-Dying, s. 11. Last accessed 21/03/20. Emphasis in original.
[18]https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Professional-Obligations-and-Human-Rights/Advice-to-the-Profession-Professional-Obligations. Last accessed 21/03/20. Policies regarding referral are not uniform in medical regulatory bodies across the country. However, some other provinces do require an "effective transfer of care". See, e.g., Nova Scotia: https://cpsns.ns.ca/wp-content/uploads/2016/06/Medical-Assistance-in-Dying-Standard.pdf. Last accessed 04/0520.
[19]https://www.cno.org/globalassets/docs/prac/41056-guidance-on-nurses-roles-in-maid.pdf. Last accessed 21/03/20.

Ontario College of Pharmacists: "In circumstances where a pharmacist declines to assist in MAiD on the basis of a conscientious objection, he or she must provide the patient with an effective referral to a non-objecting alternate provider where the patient can receive the desired services in a timely manner."[20]

It was, however, the CPSO policy for physicians that came to be challenged on grounds of conscience. The Christian Medical and Dental Society (CMDS) is an organization of practitioners who object to providing MAiD on moral or religious grounds. More to the point, they also object to referring patients to practitioners who will provide MAiD:

> Referral is as problematic as actually performing the controverted procedure. In a referral, the physician is essentially recommending that the procedure needs to be done and expects that the physician who receives the referral will do it. This is morally equivalent to doing the action.[21]

The CMDS accordingly launched a constitutional challenge of the validity of the CPSO's "effective referral" requirement in the Ontario Divisional Court. The case was heard in June 2017 and a decision rendered in January 2018.[22]

The CMDS's principal argument in the case (though not their only one) was that requiring objecting physicians to provide an "effective referral" was an unjustified infringement of their *Charter* right to freedom of conscience and religion. Providing such a referral, they argued, would make them complicit in an act they believed to be immoral. In a nutshell, the Court agreed with the applicants that the CPSO requirement infringed their freedom of religion but disagreed that the infringement was unjustified. In deciding whether the infringement was "demonstrably justified in a free and democratic society" (under the terms of s. 1 of the *Charter*) the Court applied the Oakes tests.[23] The justices interpreted "the essential purpose of the

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[20]https://www.ocpinfo.com/library/practice-related/download/PhysicianAssistedDeath.pdf. Last accessed 21/03/20.
[21]Letter from the CMDS to the CPSO, 5 August 2014.
[22]*CMDS* 2018.
[23]*R. v. Oakes*, (1986) 1 S.C.R. 103.

effective referral requirements...to be the facilitation of patient access to health care services, and in particular, the facilitation of equitable access to such services",[24] a purpose which they found to be "pressing and substantial". Moving on, they then found that the CPSO policy met the 'rational connection' and 'minimal impairment' tests. The outcome of the challenge then turned on the final test of proportionality, which required balancing the benefits of the policy against its costs. The benefits consisted in securing timely access for patients to needed health care services. The costs were the burdens on objecting physicians, including the 'moral distress' of being constrained to do something that they regard as morally wrong, and the potential need to alter their medical specialty in order to avoid such distress. The Court concluded that "the positive effects associated with the effective referral requirements of the Policies are significant, while the impact on the Individual Applicants, while not trivial, does not extend to deprivation of the ability to practice medicine in Ontario although it may require an accommodation on their part".[25] It therefore upheld the constitutionality of the CPSO policy. The Ontario Court of Appeal reached the same conclusion, essentially agreeing with the reasoning of the lower court.[26]

If exemption from the duty to provide MAiD was a victory for the objecting practitioners, imposition of the duty to refer was a victory for the patients. As far as the law is concerned, the appropriate balance has been struck between the rights of the two parties. The outcome is a classic compromise in which eligible patients' access to MAiD is impeded (but not denied) while objecting practitioners are required to enable provision of MAiD (but not provide it). To many this has seemed a fair tradeoff.[27] In Canada there is a robust public consensus favouring it among the various expert groups who have recommended terms and conditions for legal access to MAiD.[28] Despite this strong support, however, it is not clear that it is ethically stable.

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[24] *CMDS* 2018 at para 146.
[25] *CMDS* 2018 at para 212.
[26] *CMDS* 2019. As far as I am aware, this decision has not been appealed.
[27] It once so seemed to me: Sumner 2011, 173. The compromise view is defended at length in Wicclair 2011, ch. 3, though he does not consider the particular case of MAiD.
[28] The Royal Society of Canada Expert Panel Report, *End-of-Life Decision Making*, p. 62: https://rsc-src.ca/sites/default/files/RSCEndofLifeReport2011_EN_Formatted_FINAL.pdf; The Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying, *Final Report*, pp. 43-5:

To see why, it will help to take a closer look at the process of patient access to MAiD.[29] The pathway begins either with an inquiry from the patient or with the patient's condition reaching the point at which MAiD becomes a possible alternative. The practitioner responsible for the patient's care then provides information both about MAiD and about all other available treatment and care options. The next step is a request from the patient to proceed, which necessitates an assessment of eligibility. If the patient is found to meet the eligibility criteria then they must complete and sign a formal written request. A separate assessment must then be conducted by an independent second practitioner. If there is agreement that the patient is eligible then a plan will be developed for the administration of MAiD in consultation with the patient and with other members of the care team (including the pharmacist), and also (assuming patient consent) with family/caregivers. Finally, MAiD is administered, after the patient is offered a final opportunity to withdraw the request.

Conscientiously objecting practitioners are expected to step off the pathway at the first step, by explaining to the patient that they do not provide MAiD and arranging an effective referral. So it seems to follow that every further step on the pathway would constitute either assisting the provision of MAiD or actually providing it. Instead of either assisting or providing, the objecting practitioner is enabling both actions by referring their patient to a "willing provider".[30] It should be obvious what a slender ethical reed this is. From the objecting practitioner's point of view, it would be wrong to either assess a patient for MAiD or administer MAiD to the patient. It is easy to see why it will also appear wrong to enable others to carry out these same actions.

http://www.health.gov.on.ca/en/news/bulletin/2015/docs/eagreport_20151214_en.pdf; The Report of the Special Joint Committee on Physician-Assisted Dying, *Medical Assistance in Dying: A Patient-Centred Approach*, pp. 25-6:
https://www.parl.ca/Content/Committee/421/PDAM/Reports/RP8120006/pdamrp01/pdamrp01-e.pdf.

[29] See, e.g., https://www.ontariofamilyphysicians.ca/files/maid-handbook-0-2-2018-august-2.pdf. Last accessed 22/03/20.

[30] For its part, the CPSO is definitive on this point: "For clarity, the College does not consider providing the patient with an 'effective referral' as 'assisting' in providing medical assistance is dying." https://mentalhealthandassisteddeath.files.wordpress.com/2017/04/college-of-physicians-and-surgeons-of-ontario-policy-statement-4-16-maid.pdf, p. 5. Last accessed 22/03/20.

The CMDS claimed that referring a patient to a willing provider for MAiD is "morally equivalent" to providing MAiD. That claim appears to rest on an ethical principle which we will just call Moral Equivalence (ME):

> ME: If it is wrong to do something, then it is equally wrong to knowingly enable someone else to do it.

That principle, however, seems problematic. Suppose that you offer me a considerable sum of money to murder your sworn enemy. Not being in that line of work, I decline, but I also refer you to someone who might be willing to take it on. As a result of my referral, the murder is duly carried out. What I have done in knowingly enabling the murder is morally serious, but it is less serious than it would have been for me to actually commit it. These differing degrees of seriousness appear in the criminal law, which defines various principal offences (murder, assault, fraud, etc.) and then defines secondary offences on them (conspiring, counseling, inciting, aiding, abetting, being an accessory, etc.). In at least some cases (though not all) these secondary offences, while they may be serious, carry a lesser penalty. In ethics ME comes up against the traditional Doctrine of Doing and Allowing, which holds that allowing a wrong to be committed is less bad than committing the very same wrong.[31] Enabling an action, of course, manifests somewhat greater agential involvement in it than merely allowing it to happen, but it still seems that, at least in general, enabling another agent to commit a wrong is less serious than actually committing it. If so, then the moral equivalence claim is too strong.

However, to make its point about referrals the CMDS might not need a claim this strong. A weaker claim might do as well, applying a principle we could call Moral Transmission (MT):

> MT: If it is wrong to do something, then it is also wrong to knowingly enable someone else to do it.

The enabling does not have to be *equally* wrong; it may be enough for it just to be wrong. In its weaker form the claim seems very plausible. In the foregoing scenario it was wrong of me to

[31] The Doctrine is not uncontroversial; see, e.g., the entry on "Doing vs. Allowing Harm" in the *Stanford Encyclopedia of Philosophy*: https://plato.stanford.edu/entries/doing-allowing/#CiteWork.

refer you to a contract killer because I was thereby knowingly enabling a murder. More to the present point, if it would be wrong for a physician to provide MAiD (as the CMDS believes) then it would also be wrong for them to knowingly enable another physician to provide MAiD (by referring a patient to that other). Maybe not just as wrong, but still wrong. And if it is wrong to compel a physician to provide MAiD against the dictates of their conscience then it is also wrong to compel them to enable another physician to provide it (by requiring an effective referral). Maybe not just as wrong, but still wrong.

So there does seem to be some ethical support for the contention by CMDS that requiring an effective referral for MAiD infringes their freedom of conscience or religion by compelling them to be complicit in the commission of (what they regard as) a grave wrong. Playing any role whatever in the patient pathway to MAiD, even one as comparatively minimal as providing a referral, will constitute complicity and will therefore be (in their view) a wrong. This much of their position the courts agreed with. But it is not enough to make a conclusive case against the effective referral requirement, since it does not take into account the counterweight of patients' right of access to MAiD. And here the difference in seriousness between providing MAiD and enabling it may make a difference. In the contest between physicians' right of conscience and patients' right of access, the former might prevail on providing but the courts have determined that the latter wins on enabling.[32] This could make sense if the patients' right is thought of as a constant which is outweighed by the objecting physician's right not to be compelled to provide MAiD but outweighs the physician's right not to be compelled to enable its provision. And that in turn can make sense only if committing (what one considers to be) a wrong is considered to be more serious than enabling it. So the CMDS does need its moral equivalence claim after all. But that claim, as we have seen, is implausible.[33]

[32]To my knowledge, the exemption for practitioners from a duty to provide MAiD has never been tested in Canadian courts.

[33]How much does this matter? Isn't it enough that objecting practitioners *believe* that enabling a wrong is just as bad as committing it, and would therefore be equally distressed by either? Does their belief also have to be justified, or at least reasonable? I address these questions (which I owe to Udo Schuklenk) below, pp. 14-15.

So far, the balance that has been struck between physicians' right of conscience and patients' right of access seems stable. But middle grounds are notoriously susceptible to challenges on two fronts. The claim by the CMDS was basically of this form:

> If it is wrong to compel physicians to provide MAiD, against the dictates of their conscience, then it is also wrong to compel them to refer their patients to a willing provider.

However, as every undergraduate student of propositional logic knows, this conditional is equivalent to another one:

> If it is not wrong to compel physicians to refer their patients to a willing provider, against the dictates of their conscience, then it is also not wrong to compel them to provide MAiD.

The CMDS relied on the first conditional, but dissenting voices have preferred the second. What the two sides share is rejection of the compromise position; they both contend that, where physicians' conscience rights are concerned, committing and enabling should be treated symmetrically. So there seem to be three views in play:[34]

(1) No duty to provide or refer.

(2) No duty to provide, but a duty to refer (the compromise position).

(3) Duty to provide.

The views that reject the compromise are alike in being absolutist: conscientious refusal with respect to MAiD is either always or never permissible. We have seen how difficult it is for the CMDS to defend option (1). Now let us see whether option (3) might fare better.[35]

We are now at the heart of the matter of conscientious refusal by practitioners: if they are qualified to provide MAiD, do they have the right to refuse on the ground that MAiD is incompatible with their core moral beliefs? In pursuing an answer to this question we should

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[34]Cf. Wicclair 2011, ch. 2.

[35]This position has been defended by Rhodes 2006; Savulescu 2006; Savulescu and Schuklenk 2017; Schuklenk and Smalling 2017; Mathison 2019.

begin by getting a potential distraction out of the way. Sometimes the critics of conscientious refusal suggest that policies allowing it specially favour health care practitioners with religious beliefs.[36] It may be that most practitioners who object to MAiD do so on religious grounds (the challenge to the CPSO policy on effective referral was, after all, brought by the *Christian* Medical Dental Association). More specifically, many objecting practitioners will be following the dictates of the Catholic Church, which condemns (physician-administered) MAiD as morally equivalent to murder. But it would be a mistake to assume that all moral objections to MAiD are faith-based. Strictly secular arguments against the practice have been voiced for more than a half-century,[37] and philosophers in the Catholic tradition continue to try to make their case against MAiD on the basis of reason rather than faith.[38] Just as there is no reason to assume that moral objections to MAiD must be faith-based, there is also no reason to give such objections greater legal protection than should be accorded to secular ones.[39] The fact that moral convictions are religiously based does not make them deeper or more central to a person's self-identity than convictions held without benefit of the divine, nor does it make them more costly to abandon or betray.[40]

So in what follows we will, as much as possible, ignore religion and assume that all moral objections to MAiD are on an equal footing.[41] We will also assume that these objections

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[36]"I suspect it isn't unfair to note that these protections in the real world are nothing other than protections for Christian doctors who are unwilling to deliver services they would be obliged to deliver to patients who are legally entitled to receive these services, were it not for their religiously motivated objections....Conscience clauses today are by and large a concession of special rights to Christian healthcare professionals, at least in secular Western democracies." (Schuklenk 2015, ii) Cf. Savulescu and Schuklenk 2017.
[37]See, e.g., Kamisar 1958.
[38]See, e.g., Finnis 1995.
[39]"Sometimes religious values are considered special. However, to treat religious values differently from secular moral values is to discriminate unfairly against the secular, a practice not uncommon in medical ethics. Other values can be as closely held and as central to conceptions of the good life as religious values." (Savulescu 2006, 295) It is worth noting that s. 2(a) of the *Charter* explicitly protects freedom of conscience as well as of religion.
[40]Leiter 2013.
[41]For an argument that faith-based objections merit less accommodation than secular ones, see Weinstock 2014. However, Weinstock does not regard faith-based views as moral (13).

can be *genuine*: that is, that they can form part of, or derive from, a practitioner's core moral beliefs and so partially define their self-identity. Being compelled to act against such beliefs is likely to be experienced as acute 'moral distress' (guilt, shame, or remorse) and as a loss of moral integrity. For most of us the sense that we are being true to ourselves—to our core values—is an important underpinning of our self-respect. So it would be a mistake to think that the price paid by an objecting physician for being compelled to provide MAiD to an eligible patient would be inconsequential. The point is worth emphasizing because the lazy way to build a case against conscientious refusal in health care is to trivialize the cost to objecting physicians of either betraying their own core moral values or seeking work in a specialty better aligned with their convictions. I don't think we should do that. As noted earlier, the Divisional Court did not find the burden on objecting physicians to be trivial; instead, it found that the cost to eligible patients of impeded access to MAiD was greater.[42] But the issue there was just referral for MAiD, not provision of it. If it is costly to objecting physicians to refer, surely it would be even more costly to them to provide. We must not forget that.

There is, however, an important issue here that merits some attention. Besides being genuine or sincere, should conscientious objections also have to satisfy any further conditions in order to be worthy of respect (that is, to be given some moral weight against patient interests)?[43] Seemingly so, since moral beliefs can be both sincerely held and completely bizarre. Mark Wicclair gives the example of a physician who refuses to prescribe painkillers, on the ground that pain is a sign of moral defect and those who suffer it deserve to do so.[44] Furthermore, medical services can be refused on grounds that are discriminatory, as when assisted reproductive technologies are denied to single women or lesbians.[45] These moral convictions do not merit respect, however sincerely held they might be. Perhaps we should then go the distance and require that the conviction in question be *justified* or *correct*, so that the procedure believed to be

[42] *CMDS* 2018, at paras 114 and 205-212.
[43] For an argument that only genuineness matters, see Meyers and Woods 2007.
[44] Wicclair 2000, 216.
[45] Kantymir and McLeod 2014, 17–18.

wrong must *really be* wrong. This fits some cases well: for instance, the universal conviction that doctors are justified in refusing complicity in torture, just because torture is such an obvious evil. However, this requirement seems too demanding, since it leaves no room for reasonable disagreement about the justifiability of medical practices. (It would also be difficult—I would say impossible—to satisfy for objections to MAiD). So perhaps it is enough that the objection be *reasonable* (under some appropriate conception of reasonableness).[46] I am going to sidestep this question, which would merit investigation in a broader inquiry into conscientious refusal in health care, or conscientious refusal in general. For my present purposes, I will just assume that moral objections to MAiD can be reasonable as well as genuine, and therefore worthy of respect.[47]

However this may be, the conscience costs to practitioners do not settle the matter. The costs to eligible patients of access to MAiD delayed or denied are serious as well. We also need to remind ourselves of their plight. In order to be eligible for MAiD a patient must be diagnosed with a medical condition that is grievous and irremediable. The most common presenting condition is cancer, but patients also qualify with other illnesses: neurodegenerative disorders, cardiac disease, chronic obstructive pulmonary disease, etc. In addition, they must be experiencing intolerable physical or mental suffering as a result of their condition—suffering that cannot be relieved by any means they find acceptable. Besides pain, intractable physical symptoms can include shortness of breath, dizziness, persistent nausea, weakness, uncontrollable itching, incontinence, and the like. These can be bad enough, but most patients who request MAiD report being more distressed by psychological or 'existential' conditions such as loss of dignity, loss of ability to do the things that gave their life meaning, and loss of autonomy or

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[46]Advocates of this position include Card 2007; Card 2014; Kantymir and McLeod 2014; Liberman 2017; Zolf 2019. However, they differ in their criteria of reasonableness.
[47]I stand by my earlier argument that the CMDS position—that providing an effective referral is morally equivalent to providing MAiD—will fail an appropriate reasonableness test. However, the weaker position—that if the latter is wrong then so is the former—would pass it.

decision-making control.[48] They are also overwhelmingly elderly: in Canada more than three-quarters of requesting patients are over 65, with an average age of 73.[49] So we are dealing here with an extremely vulnerable population who are old, sick, suffering, and facing death, and whose need for the service they are requesting is urgent. Any delay in accessing that service occasioned by a refusing practitioner will likely result in the patient enduring further, and completely avoidable, suffering.[50]

Clearly conscientious refusal by practitioners will sometimes result in delays. Not always: sometimes it will be possible to refer the patient to a willing nearby provider who can take over the file quickly. (This relatively happy scenario, of course, underlines the necessity of refusing practitioners providing their patients with an effective referral.) But there will be cases of patients in rural or remote areas who will have no ready access to a willing provider. The CPSO policy on effective referrals stipulates that the referral must be to "another physician, health-care provider, or agency who is non-objecting, *accessible* and *available* to the patient" (emphasis added). Further:

> The referral must be made in a timely manner, so that the patient will not experience an adverse clinical outcome due to a delayed referral. A patient would be considered to suffer an adverse outcome due to a delay if their untreated pain or suffering is prolonged, their clinical condition deteriorates, or the delay results in the patient no longer being able to access care (e.g., for time sensitive matters such as emergency contraception, an abortion or when a patient wishes to explore medical assistance in dying).[51]

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[48]https://www.deathwithdignity.org/oregon-death-with-dignity-act-annual-reports/. Last accessed 27/03/20.
[49]https://www.canada.ca/content/dam/hc-sc/documents/services/publications/health-system-services/medical-assistance-dying-interim-report-april-2019/medical-assistance-dying-interim-report-april-2019-eng.pdf. Last accessed 29/03/20.
[50]Under the terms of Bill C-14 patients approved for MAiD had to endure a waiting period of at least 10 days before the procedure could be administered. Bill C-7, introduced in March 2020, proposes to eliminate this waiting period, at least for patients whose natural death is deemed to be "reasonably foreseeable".
[51]https://d3n8a8pro7vhmx.cloudfront.net/dwdcanada/pages/651/attachments/original/1468439148/CPSO-PAD-Effective-Referral-FactSheet.pdf?1468439148. Last accessed 28/03/20.

So we have established that the stakes are high on both sides. Furthermore, both sides can claim a *Charter* right on their behalf: for practitioners freedom of conscience or religion, for patients life, liberty and security of the person. We already know that, at least as far as the courts are concerned, the patients win when the issue is conscientious refusal to provide an effective referral for MAiD. But who wins when the issue is refusal to "provide or assist in providing" MAiD? From the fact that patient need trumps refusal to refer we cannot simply assume that it also trumps refusal to assist or provide, since the conscience costs of the latter are likely to be higher than those of the former. Nonetheless, it is not difficult to build a case that the need for MAiD on the part of eligible patients is so grave and so urgent that here too conscience must give way.

The critics of conscientious refusal rest their case partly on the seriousness of patient need for MAiD. But they also make a quite different argument based on an asymmetry between the two parties: practitioners have voluntarily placed themselves in this situation of conflict between their conscience and patient need, by choosing to practice in an area in which the conflict can arise, whereas patients have not. The position articulated by Savulescu and Schuklenk emphasizes this point:

> Doctors must put patients' interests ahead of their own integrity. They must ensure that legal, beneficial, desired services are provided, if not by them, then by others. If this leads to feelings of guilty remorse or them dropping out of the profession, so be it. As professionals, doctors have to take responsibility for their feelings. There is an oversupply of people wishing to be doctors. The place to debate issues of contraception, abortion and euthanasia is at the societal level, not the bedside, once these procedures are legal and a part of medical practice.[52]

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[52]Savulescu and Schuklenk 2017, 164. Cf. Savulescu 2006, 295: "...people have to take on certain commitments in order to become a doctor. They are a part of being a doctor.... To be a doctor is to be willing and able to offer appropriate medical interventions that are legal, beneficial, desired by the patient, and a part of a just healthcare system." See also Schuklenk and Smalling 2017; Mathison 2019. For the contrary view, see Cowley 2016, 361–2.

In other words: if you are not prepared to provide MAiD don't go into a field of practice in which you may be called upon to do so. And if you are already in such a field, and wish to maintain your moral integrity, then find another specialty or subspecialty in which this predicament will not arise for you. As the Divisional Court observed, "the potential for a conflict between a physician's religious practice and the [CPSO] Policies, and any resulting psychological concern, results from a conscious choice of the physician to practice in circumstances in which such a conflict could arise".[53] While the Court was adjudicating the policy of requiring objecting practitioners to provide an effective referral for MAiD, the same point could be made about a policy of requiring them to provide MAiD.

The point is well taken. Health care practitioners choose their own core moral convictions and they choose the area(s) of health care in which they wish to practise. Patients do not choose to be in a condition in which they will qualify for MAiD. The burden on practitioners of ensuring that their convictions do not impede their ability to deliver needed services to patients is for them to bear. It is unfair to expect patients to pay the price of practitioners' convictions by having their access to these services impeded. By the time a patient requests MAiD it is too late to protect one's moral integrity by refusing to provide it. The time for that exercise of conscience was earlier, when entering the profession or entering that field of practice.

While this position is, I think, defensible, it may seem a little harsh and cavalier. It did not seem so to the Court. The CMDS argued that the burden on objecting physicians of having to relocate to another field of practice would be considerable, perhaps requiring extensive retraining. The Court was not convinced, pointing out that for many physicians—those practising in a hospital, clinic, or family practice group—there may be ways of accommodating their conscientious objections without requiring them to transfer to a new specialty or subspecialty.[54] For those not so fortunate, the burden may indeed be greater. However, even in this case "such burdens do not deprive objecting physicians of their ability to carry on the

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[53] *CMDS* 2018, at para 208.
[54] *CMDS* 2018, at para 205.

practice of medicine in Ontario in accordance with their beliefs. The deleterious effects of the Policies, while not trivial, are less serious than an effective exclusion from the practice of medicine."[55]

The point the Court made about ways of accommodating conscientious objections is important. Nowadays much health care is delivered by practice groups, comprising both physicians and nurses. For some of these groups (for instance, those with a palliative care specialty), MAiD may well fall within the scope of their clinical practice. Since it is a controversial procedure, it is likely that some practitioners in the group will object to providing it, and possibly also to assisting in it (e.g., by conducting assessments of patient eligibility). In that case, as long as the group contains a critical mass of willing assessors and providers, the group practice may be able to tolerate not burdening objecting members with these responsibilities.

This model of accommodation is not merely hypothetical but is in place in some hospital-based programs. The University Health Network in Toronto has adopted what it calls a "three-team model" for the delivery of MAiD.[56] The clinical team, responsible for the first stages of response to a patient inquiry about MAiD, consists of "all health care providers involved in usual care for the patient". The assessment and intervention teams, which handle all further steps in the pathway, including assessment and provision, "are constituted entirely of physicians and nurse practitioners who have volunteered to participate." This approach, those reporting on it say, "has largely circumvented the anticipated problem of conscientious objection". A similar three-stage process has been developed at the Temmy Latner Centre for Palliative Care (Mount Sinai Hospital, Toronto), a home-based palliative care program that elected to integrate provision of MAiD into its practice, once it became legal.[57] The Centre comprises clinicians who are willing to provide MAiD, others who are willing to assess but not provide, and a group of

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[55] *Ibid.*, at para 209.
[56] Li, et al. 2017. Cf. Loggers, et al. 2013.
[57] Wales, et al. 2018.

conscientious objectors who will neither assess nor provide. At every stage (from inquiry through assessment to provision) the patient is put in the care of a practitioner who is comfortable with taking them through the necessary steps.

In Canada MAiD is administered not only by specialists, who are likely to be clinic- or hospital-based, but also by family physicians and nurse practitioners. However, much primary health care, at least in Ontario, is provided by multidisciplinary family health teams. My family physician belongs to such a practice group. When MAiD was legalized in Canada patients were urged to 'have the conversation' with their family practitioner. When I raised the question with my physician he told me that he would not be offering this service himself but, should I seek it, he would connect me with a member of the practice group who was a willing provider. My physician's decision not to be a provider was not conscience-based; he supported the legalization of MAiD but had decided not to pursue the necessary training to offer it. But it would have been no different had he been a conscientious refuser. The point is that the group practice would have afforded him accommodation of his refusal while fully meeting the needs of patients.

Nurses will normally be working in practice groups in hospitals or clinics where MAiD is administered. Conscientiously objecting nurses are required to provide routine care to patients who are seeking MAiD but not to participate in the procedure itself, at least as long as there are non-objecting colleagues available for this purpose. If a nurse announces an objection to such participation, it should be possible in most hospitals and clinics to accommodate that objection without compromising patient care. The same will be true for pharmacists working with colleagues who can cover for their conscientious refusal to fill prescriptions for the medication(s) used in MAiD.

As the Court acknowledged, this solution will not be available to sole practitioners, whether they are physicians, nurse practitioners, nurses, or pharmacists. For them the model of 'reasonable accommodation' of moral or religious beliefs may not be applicable. Where accommodation of objecting practitioners is possible, without compromising institutional

functioning or patient care, then it can be reasonable to afford it to them.[58] But where it is not, and where a process of referral would result in an "adverse outcome" for the patient due to a delay, then the objecting practitioner will simply have to set conscience aside and do what is right for their patient. Any objecting practitioner who wishes to avoid this outcome will have a strong incentive to find and join a group clinical practice in which their beliefs can be accommodated. Better still, the problem could be avoided at an earlier stage if medical educators would alert their students not to seek careers in specialties in which their conscientious objections would limit the services they would be willing to provide. Future practitioners who object to abortion would be well advised not to aim at obstetrics/gynecology; likewise, those who object to MAiD should steer well clear of family practice, oncology, and palliative care. The best way to solve the problem of the conflict between practitioner conscience and patient need is to prevent it from arising in the first place. However, once the conflict has arisen, then, as the Court put it: "to the extent there remains any conflict between patient rights and physician rights that cannot be reconciled...,the former must govern".[59]

Time for a recap. Earlier we identified three competing views on conscientious refusal to provide (or assist in providing) MAiD. Two of these views were absolutist: practitioners have a duty to provide or they have no duty either to provide or refer. The other was the compromise: no duty to provide, but a duty to refer. I observed at the time that the compromise position is ethically unstable, since it will come under pressure from both of the absolutist views. The compromise survived the pressure from the one side: no duty to provide or refer (the CMDS position). But it is much less clear that it can survive a challenge from the other side. The need for MAiD on the part of eligible patients may be sufficiently serious and urgent to outweigh the conscience costs to objecting practitioners of providing MAiD to them, as well as of referring

[58]Cf. Weinstock 2014, 12: A practitioner's "claim to be exempted from delivering legal medical services that are generally thought to be medically appropriate cannot jeopardize the ability of a person to receive such services, nor should it jeopardize the functioning of the healthcare institution to which the dissenter belongs."

[59]*CMDS* 2018, at para 210; affirmed in *CMDS* 2019, at para 187.

them to willing providers. Furthermore, it seems unfair to place the burden of conscience on patients rather than on practitioners who choose both their core moral convictions and their field of practice. So it seems that, by process of elimination, the absolutist duty-to-provide view wins.

Not so fast. The model of reasonable accommodation of conscientious objection provides a fourth option. Unlike the absolutist view, on this model whether an objecting practitioner has a duty to provide (or assist in providing) MAiD would be context-dependent. If embedded in a practice group that could provide adequate cover for their conscientious refusal without compromising patient access, a practitioner could be excused from responsibility for active participation in the provision of MAiD. But if not, then the duty to provide would remain in place.[60] Unlike the absolutist position, this option takes a more nuanced form:

> (4) Duty to provide, except when accommodation of refusal is possible without unduly burdening other practitioners or adversely affecting patient care.

The objecting practitioner would assume the burden of ensuring that they fall within the limits of the exception clause.

Reasonable accommodation of refusal differs from requiring an effective referral in an important respect: under the former, arrangements are made so that the patient at no stage actually encounters a refusal (unless found to be ineligible). However, I want to make it clear that on this model objecting practitioners do not have a right (either moral or legal) to accommodation of their refusal, nor do practice groups have a duty to provide it.[61] It is important to clarify this, since some contexts of reasonable accommodation (for instance, those that involve modifying work places for persons with disabilities) will implicate such a right and such a duty. Instead, I am suggesting that where a practice group can accommodate an objecting practitioner without unduly burdening other members of the group or adversely affecting patient access to

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[60] Mark Wicclair defends a similar position (though he is not discussing the case of MAiD): Wicclair 2011, 102.

[61] Thanks to Udo Schuklenk for pointing out the need for clarification on this point.

MAiD, doing so would be considerate and collegial, but not obligatory.[62] It would be up to the practice group, or institution, to determine when the burden on willing providers would be undue and when patient access to MAiD would be adversely affected. Should they choose not to accommodate, the objecting practitioner could not claim unjust treatment. Reasonable accommodation offers an objecting practitioner an exemption from the default presumption, which is the duty to provide. In this context, it is not a right but a privilege.

One advantage of approaching conscientious refusal in health care through the model of reasonable accommodation is that it enables us to draw on experience from other contexts in which the model has also been applied. In the broadest sense 'reasonable accommodation' refers to adjustments made in a group setting—such as a work place or educational institution—to allow full participation by those with particular needs, without jeopardizing the functioning of the group. It has been most commonly invoked on behalf of persons with disabilities whose opportunity to participate fully in the group enterprise would be significantly impaired were the adjustments (e.g., to access or to the arrangement of physical space) not made. In these cases it can be argued that refusal to accommodate would constitute discrimination on the prohibited ground of disability. However, the model has also been applied in cases in which the condition requiring accommodation is not involuntary (as in the case of a disability) but freely chosen (as in the case of religious belief or cultural affiliation).

Perhaps the clearest such cases are ones in which the rules of an institution restrict the religious practice of some of its members. This was the issue in the 1995 Federal Court of Canada decision in *Grant*, which upheld the 1990 decision by the RCMP to allow Sikh officers to wear a turban in place of the usual stetson.[63] The issue of accommodation of religious practice was also adjudicated, this time by the Supreme Court, in *Multani* (2006).[64] In this case a public school authority prohibited a Sikh student from wearing a kirpan to school on the ground that it

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[62]I am assuming that both of these conditions are satisfied in the two instances I cited earlier at the University Health Network and Mount Sinai Hospital.
[63]*Grant v. Canada (Attorney General)* (T.D.), 1995 1 F.C. 158.
[64]*Multani v. Commission scolaire Marguerite-Bourgeoys*, 2006 SCC 6.

was a weapon and therefore a threat to public safety. The Court found that the safety of the school would not be significantly compromised if the student were allowed to wear the kirpan (sewn into his clothes), thus that the prohibition was an unjustified restriction of his right to freedom of conscience and religion. The two cases are somewhat different, since in *Multani* the Court ruled that the school authority was required to accommodate the religious practice, while in *Grant* the decision permitted, though it did not require, the RCMP to do so. Other examples come readily to mind—for example, accommodating the religious holidays of non-Christian employees or students.[65]

Requiring objecting health care practitioners to provide (or assist in providing) MAiD does not restrict their religious practice (if indeed they are religious). Instead, it requires them to do something that offends their deeply held moral beliefs. There have been other such cases in Canada. Some have involved businesses that refused to offer their services to same-sex couples: a print shop in one case,[66] a bed and breakfast in another.[67] These claims for accommodation of conscience failed because the policies in question were ruled to constitute discrimination on a prohibited ground.

We move a little closer to the health care context with the cases of civil marriage commissioners who have objected to performing marriages for same-sex couples. As in the case of MAiD, we must assume that the moral objections of such commissioners are deeply held and sincere; the objecting commissioners regard same-sex marriage as an evil to which they wish not to contribute.[68] Nonetheless, in several instances Canadian tribunals and courts have held that provinces can require their marriage commissioners to officiate at such ceremonies, effectively

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[65]Most recently, of course, we have the example of Quebec's Bill 21, which denies reasonable accommodation to members of certain professions who wish to wear religious symbols, such as hijabs, while on the job.
[66]*Brockie v. Ontario (Human Rights Commission)*, 2002 OJ No. 2375.
[67]*Eadie v. Riverbend Bed and Breakfast (no. 2)*, 2012 BCHRT 247.
[68]I leave open the question whether their objection can be defended as reasonable.

denying them the right to conscientious refusal.[69] The tribunals/courts have framed these issues as a conflict between religious freedom and equality and have consistently found in favour of the latter. They have reached this conclusion even though the objecting commissioners argued that their moral/religious beliefs could be accommodated without tangible impact on access to services by same-sex couples, since these couples could readily find another commissioner to solemnize their marriages. This arrangement, favoured by the objecting commissioners, would be analogous to the compromise view (no duty to provide/duty to refer) for health care practitioners and MAiD.

In its decision the Saskatchewan Court of Appeal raised the possibility of a different means of accommodating the objecting commissioners: a 'single point of entry' system whereby couples would seek the services they need through a central office, rather than contacting commissioners directly. In such a system, the beliefs of commissioners could be accommodated 'behind the scenes', while also ensuring that couples didn't have to deal with the sting of rejection based on their sexual orientation. The objecting commissioners could be excused from officiating at same-sex marriages without any impairment of access to services by same-sex couples, or indeed any awareness by the couples of the commissioners' objections. This arrangement would be an analogue to the practice group model among health care practitioners, in which patients seeking MAiD are routinely directed to non-objecting practitioners. The same arrangement is managed in some provinces by 'patient navigator' models.[70]

These analogies between the situations of marriage commissioners and health care practitioners are not perfect. For one thing, the former, but not the latter, act as agents of the

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[69]See, e.g., the following rulings in Saskatchewan: *Nichols v. Dept. of Justice, Government of Saskatchewan*, Oct. 25, 2006 (Sask. HRT); *Nichols v MJ and the Sask. HRC*, 2009 SKQB 299; *Re Marriage Commissioners Appointed Under the Marriage Act*, 2011 SKCA 3. I am indebted to the discussions of these and other cases by Richard Moon in Moon 2016; Moon 2018.

[70]Alberta's health care phone line (811) provides such a model for MAiD (and every other health care need). Patients can call in and be directed to a willing provider: https://www.albertahealthservices.ca/findhealth/service.aspx?Id=1001957&facilityId=1011654. Last accessed 04/05/20.
See also Nova Scotia: http://www.nshealth.ca/about-us/medical-assistance-dying. Last accessed 04/05/20.

state and may for that reason have a particular duty not to allow their private moral beliefs to interfere with the delivery of their services. But there is one important point of similarity between them. Under provincial legislation marriage commissioners have a monopoly on the solemnization of civil marriages, while under federal legislation physicians and nurse practitioners have a monopoly on the provision of MAiD. In any case, the important point is that in both instances a group practice arrangement may offer a reasonable accommodation of the moral beliefs of conscientiously refusing individuals without overburdening colleagues or impairing access to the services offered by the group. Where such arrangements are possible for the delivery of MAiD they appear to offer the kind of reconciliation of *Charter* rights that the Supreme Court said was needed. Where they are not, then eligible patients' right of access to MAiD must prevail and conscientiously objecting practitioners may justifiably be compelled to provide it.

2. Health care institutions

More than half of the Canadians who have so far opted for MAiD have had the procedure administered in a health care institution: in most cases a hospital, but sometimes a long-term care facility or a hospice.[71] Many such facilities across the country offer MAiD as one of their services, but many others refuse to do so. Unlike practitioners, health care institutions are mentioned neither in the *Carter* decision nor in Bill C-14. But as in the case of practitioners, the question whether objecting institutions can be compelled to provide MAiD is entirely up to the provinces, who are responsible for the delivery of health care. With one conspicuous exception, provincial jurisdictions have chosen to allow at least some institutions to refuse to provide those services, including MAiD, to which they object.

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[71] https://www.canada.ca/content/dam/hc-sc/documents/services/publications/health-system-services/medical-assistance-dying-interim-report-april-2019/medical-assistance-dying-interim-report-april-2019-eng.pdf. Last accessed 20/04/20.

The exception is Quebec. Under the terms of Bill 52, passed by the National Assembly in June 2014, all hospitals and long-term care facilities in Quebec, including those that are religiously affiliated, must offer end-of-life care which, for the purpose of the Act, includes MAiD.[72] Palliative care hospices, by contrast, are not required to provide MAiD, though many have opted to do so.

In the other provinces (as in Quebec) most objecting institutions are faith-based. Some provinces have reached agreements with such institutions that they will not be compelled to provide services that conflict with their religious affiliation. British Columbia, for instance, signed a Master Agreement in March 1995 with the Denominational Health Care Facilities Association, which comprised various religious organizations owning and operating health care facilities in the province.[73] Under the terms of that agreement, regional health authorities, who are responsible for the funding of these facilities, will not require them to offer services that "would threaten...[their] religious mission, viability, or existence".[74] The agreement predated the legalization of MAiD and would at the time have applied to such legal medical services as emergency contraception, sterilization, and abortion. However, it would be safe to conjecture that MAiD would be equally objectionable to the member religious organizations of the Association. Agreements of this sort were also signed in Alberta, Saskatchewan, Manitoba, and New Brunswick.

Pre-MAiD, Ontario had similar arrangements in place with religiously-affiliated institutions, allowing them to opt out of providing such services as abortion. When MAiD became legal, however, the province elected to provide some degree of statutory protection for objecting institutions. In December 2016, just six months after the federal MAiD law came into

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[72] Bill 52, *An Act respecting end-of-life care*, 1st Sess, 41st Leg, Quebec, 2013 (assented to 10 June 2014), RSQ c S-32.0001. Ss. 3(3), 8. Nova Scotia and Newfoundland are exceptions in a different way for hospitals. Neither have hospitals that are not owned by the province. And no provincially-owned institutions are allowed to opt out of providing MAiD.

[73] Since renamed the Denominational Health Association: https://www.denominationalhealth.ca/. Last accessed 13/04/20.

[74] http://docs.openinfo.gov.bc.ca/Response_Package_HTH-2017-71745.pdf. S. 7.2(c).

effect, the Ontario Legislature passed Bill 41, the ironically titled “Patients First Act”.[75] One of its many provisions authorizes a local health integration network (LHIN) to “issue operational or policy directives to a health service provider to which it provides funding where the network considers it to be in the public interest to do so” and makes compliance with such a directive mandatory.[76] Presumably, a LHIN could consider it to be in the public interest that a particular health service provider offer MAiD. However, the authorization comes with a significant restriction: “A directive shall not unjustifiably as determined under section 1 of the *Canadian Charter of Rights and Freedoms* require a health service provider that is a religious organization to provide a service that is contrary to the religion related to the organization.”[77] Later sections of the Act assign the same authority to the Minister of Health and impose the same limitation on that authority.[78]

Bill 41 conveniently packs together virtually every factor relevant to deciding whether objecting health care institutions should be compelled to offer MAiD among their services. So let’s start to unpack them. The apparent intent of these sections of the Act is to afford institutions some degree of immunity against directives from health authorities that they offer medical services to which they object. But not all institutions are afforded this immunity—just those with a religious affiliation. The B.C. Master Agreement likewise applies only to religiously affiliated health care facilities. It would be easy to assume that all such facilities are Catholic, since the Church’s opposition to emergency contraception, sterilization, abortion, gender reassignment surgery, and MAiD is well known. And indeed most are, in B.C., Ontario, and across the country. The Catholic Health Alliance of Canada (CHAC) comprises twelve

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[75]Bill 41, *An Act to amend various Acts in the interests of patient-centred care*, SO 2016. https://www.ola.org/sites/default/files/node-files/bill/document/pdf/2016/2016-12/bill---text-41-2-en-b041ra.pdf
[76]S. 20.2 (1),(5).
[77]S. 20.2 (4). This provision was brought forward from the *Local Health System Integration Act, 2006, SO 2006, c. 4*, S. 26(2)(f): https://www.ontario.ca/laws/statute/s06004. But in the earlier Act it applied only to directives relating to the integration of health services. In Bill 41 it applies to all operational and policy directives, including directives to provide MAiD.
[78]S. 46 (2) 8.1 (1), (2).

"sponsor organizations" (congregations or dioceses) across the country that provide affiliation for approximately one hundred health care institutions: hospitals, community health centres, nursing homes, and long-term care facilities. All of these organizations subscribe to the *Health Ethics Guide* published by the CHAC, which includes, *inter alia*, the following directives:

> 87. Treatment decisions for the person receiving care are never to include actions or omissions that intentionally cause death (euthanasia)....
>
> 88. Intentionally causing one's own death (suicide), or directly assisting in such an action (assisted suicide), is morally wrong.[79]

One of the CHAC's sponsor organizations is The Catholic Health Sponsors of Ontario, with over twenty member institutions including such major facilities as St. Joseph's Health Centre and St. Michael's Hospital in Toronto. The CHSO is on record as stating that "we will not provide the medical service of physician assisted death in our institutions nor will we directly or explicitly refer a patient to receive this same medical procedure".[80]

While Catholic facilities may form the largest group of objecting faith-based institutions, they are far from the only ones. Three of Winnipeg's major hospitals refuse to offer MAiD: two of them (St. Boniface and Misericordia) are Catholic, while the other (Concordia) is Mennonite. The Toronto Grace Health Centre, whose palliative care services do not include MAiD, is affiliated with the Salvation Army. The religious organizations included in the 1995 B.C. Master Agreement include some twelve Christian denominations, from Anglican to United Church, as well as an Orthodox Jewish denomination. Collectively, they own and operate about fifty facilities in the province, providing over 7,800 beds and suites. Faith-based institutions, it is safe to say, play a major role in the delivery of health care across Canada. Their refusal to provide MAiD is likely, therefore, to have a serious impact on patient access to the service.

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[79]Catholic Health Alliance of Canada 2012, 66.

[80]https://chco.ca/en/catholic-health-sponsors-of-ontario-response-to-physician-assisted-death/. Last accessed 13/04/20.

It would be a mistake, however, to assume that all institutional refusal in this country is faith-based. The Irene Thomas Hospice in Ladner, B.C., is operated by the Delta Hospice Society, a non-denominational organization. As of December 2019 the hospice has refused to allow MAiD on its premises, a stance that places it in opposition to the Fraser Health Authority that provides the public funding for the facility. The Authority has ordered the hospice to change its policy or risk losing its funding. While the hospice has no overt religious affiliation, religion may still be playing a role in the background. In September 2019 the then board of directors of the hospice voted to allow MAiD. In response, opponents of that decision organized a membership drive that was supported by local churches. The augmented membership then voted to install a new 'pro-life' board which reversed the earlier decision and banned MAiD.

There are, however, many other cases in which the refusal to provide MAiD by a secular hospice is entirely on (what we may call) philosophical rather than religious grounds. Nipissing Serenity Hospice, in North Bay, Ontario, opened its doors in January 2020. Its board of directors refuses to allow MAiD to be provided on the ground that it is incompatible with the goals of hospice palliative care. In this the board is following the lead of the Canadian Hospice Palliative Care Association and the Canadian Society of Palliative Care Physicians, who issued a joint statement that "MAiD is not part of the practice of hospice palliative care".[81] While many hospices across the country do allow MAiD on their premises, many others subscribe to this position. I have argued elsewhere that the position is deeply misguided,[82] and it certainly does not represent the views of all palliative care physicians, but it has taken root in at least some strictly secular hospice facilities.

Unlike the case of faith-based institutions, the provinces have unfettered authority to direct that MAiD be offered at secular facilities (although in practice they have been reluctant to exercise that authority). But that brings us to an important question. Bill 41 and the various

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[81]https://www.cspcp.ca/wp-content/uploads/2019/11/CHPCA-and-CSPCP-Statement-on-HPC-and-MAiD-Final.pdf. Last accessed 14/04/20.
[82]Sumner 2011, 198–9.

provincial agreements all provide special immunity to religiously affiliated institutions. Why this bias in favour of religion? It may just be based once again on the mistaken assumption, discussed earlier, that religiously inspired moral values are somehow deeper or more worthy of respect than secular ones. (That assumption would be even harder to defend for institutions than it was for individuals.) Or it may reflect the long history of involvement by religious denominations in the founding, ownership, and operation of health care institutions. But there may also be something else going on, which brings us to the next element of Bill 41: its reference to the *Charter*.

At least at first glance, the mention of the *Charter* seems odd. Both the Minister of Health and the various regional health authorities (LHINs) in Ontario are state actors, whose directives would therefore be subject to *Charter* limits. So what is the point of stating explicitly that they may not issue a directive to a faith-based health care institution that would contravene the *Charter*? Perhaps the clue lies in the fact that such a directive may not be unjustifiable "as determined under section 1" of the *Charter*. The normal role of s. 1 is to determine whether breaches of rights enumerated elsewhere in the *Charter* are "demonstrably justified in a free and democratic society". So the suspicion might be that a directive to a faith-based institution that it provide a medical service—such as MAiD—to which it objects might be a breach of one of the institution's *Charter* rights. Which one? Presumably the s. 2(a) right to "freedom of conscience and religion". Any health care institution could, in principle, plead the right to freedom of conscience.[83] But only faith-based institutions could claim the right to freedom of religion. So perhaps s. 1 comes into play here due to the suspicion that directing a faith-based institution to provide a service that contravenes the tenets of its affiliated religious organization might constitute a denial of its freedom of religion.

The s. 2(a) rights belong in the first instance to individuals. Can they also apply to institutions? As a matter of law, this is not a question I am qualified to answer. As far as I am

[83] We will consider later whether institutions, as well as individuals, can have conscientious objections to MAiD.

aware, the issue has never been adjudicated in the Canadian courts. The closest approach by the Supreme Court of which I am aware was in their 2015 *Loyola High School* decision.[84] That case involved, not a health care institution, but a Jesuit high school. In their concurring opinion, McLachlin C.J. and Rothstein and Moldaver JJ. addressed the question whether the school might qualify for s. 2(a) protection of freedom of religion:

> [100] On the submissions before us, and given the collective aspect of religious freedom long established in our jurisprudence, we conclude that an organization meets the requirements for s. 2(a) protection if (1) it is constituted primarily for religious purposes, and (2) its operation accords with these religious purposes.
>
> [101] The precise scope of these requirements may require clarification in future cases which test their boundaries, but it is evident that Loyola falls within their ambit. It is a non-profit religious corporation constituted for the purpose of offering a Jesuit education to children within Quebec's Catholic religious community. It has operated for over a century in accordance with this religious educational purpose.

As far as I am aware "the precise scope of these requirements" has never received any further clarification from the courts. Furthermore, the status of the requirements themselves is unclear, since the opinion of these three justices did not constitute the judgement of the Court. Nonetheless, we are free to speculate whether a faith-based health care institution might satisfy the requirements. It is difficult to see how it could meet the first requirement, since presumably health care institutions are constituted primarily for the purpose of delivering health care, and not for any religious purpose.[85]

However this may be, the actual effect of the *Charter* reference is to underline the fact that the immunity accorded by Bill 41 to objecting faith-based health care institutions is qualified and defeasible. This was already true for the agreements that various provinces entered into with

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[84] *Loyola High School v. Quebec (Attorney General)*, 2015, 1 S.C.R. 613.

[85] It is instructive that the relevant sections of Bill 41 cover directives to "a health service provider that is a religious organization". It is doubtful that any faith-based health care institution qualifies as a religious organization, as opposed to an organization affiliated to a religious body.

religiously affiliated organizations and facilities. Under the terms of the B.C. Master Agreement, a regional health authority may issue a directive to a faith-based facility "which, if implemented, would threaten the religious mission, viability or existence of the ... facility" as long as the directive is "reasonable" (as determined by an independent review panel). The agreement does not spell out what would qualify as a reasonable directive, but it is easy to suppose that a strong public interest argument would be required. Such an argument could be made, for instance, if a community's only hospital were faith-based, so that eligible patients seeking MAiD would have no ready access to the service. There are many communities, both in B.C. and across the country, in exactly that situation. It is not hard to imagine a strong public interest case being made for requiring these institutions to offer MAiD among their medical services.

In fact, we don't have to imagine it. St. Martha's Regional Hospital, in Antigonish, Nova Scotia, was a Catholic facility owned and operated by the Sisters of St. Martha. When the province took over ownership of the hospital in 1996 it signed a mission assurance agreement with the order that the facility's Catholic identity and values would be preserved. The agreement explicitly prohibited both abortion and "assisting suicide" from being offered in the hospital. However, in 2019 the Nova Scotia Health Authority decided to require the facility to offer MAiD, in part on the ground that otherwise eligible patients in the Antigonish area would have no reasonable access to the service.[86]

In Ontario, under the terms of Bill 41, a LHIN or the Minister may direct a religiously affiliated institution to provide a service "that is contrary to the religion related to the organization" as long as the directive is not unjustifiable as determined by s. 1 of the *Charter*. Whether such a directive could be given a s. 1 justification would have to be determined on a case-by-case basis. Under the terms of the Act the mere fact that the directive would be in the public interest would not suffice. But if we imagine a scenario where a community's only

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[86]Under current policy in Newfoundland and Labrador, faith-based institutions are allowed to opt out of offering MAiD, but patients in those facilities are permitted to request the service and if the MAiD team determines that a transfer to another site would cause undue suffering then the facility must provide space where it can be administered.

hospital is faith-based, it seems reasonable to think that the public interest argument could be strong enough to satisfy the *Oakes* tests.[87] The purpose of the directive—to ensure access to MAiD for community residents—could readily be defended as "pressing and substantial" and the directive would be rationally connected to that purpose. Whether it minimally impaired the institution's values and mission would depend on whether some alternative arrangement could provide at least roughly equivalent access. Assuming success at all these steps, the verdict would come down to proportionality between the burden on the institution and the needs of the patients. It would be no surprise if the latter prevailed at this stage.[88]

When considering the conflict between the religious identity of objecting institutions and access to MAiD, the obvious parallel is with abortion. After abortion became legal in Canada, following the *Morgentaler* decision in 1988, issues of access to the procedure for women persisted for decades. Some provinces refused to fund abortions, others would not licence abortion clinics to operate, and one province (Prince Edward Island) had no abortion facility whatever until 2017. All of these restrictions of access imposed serious burdens on women who were seeking to terminate their pregnancies and often had to travel long distances, or pay out of pocket, in order to be able to do so. While the continuing barriers to accessing abortion are bad enough, the barriers to accessing MAiD are even worse. To put it bluntly, women of fertility age are more mobile than sick and dying patients. If an eligible patient has no local access to MAiD, because their only community hospital refuses to provide it, then travel to another location to receive the service will be at best onerous and at worst simply infeasible.

We come now to the final element in these sections of Bill 41, and possibly the most significant. The Act covers directives from a LHIN, or from the Minister, to "a health service provider *to which it provides funding*". Health care institutions in Canada may be publicly or privately owned, but virtually all of them are publicly funded. In Ontario, as in most provinces,

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[87]In Ontario the towns of Pembroke, Elliott Lake, and Mattawa are served only by faith-based hospitals.
[88]If the Minister did reach the conclusion, in a particular instance, that a directive to a faith-based institution to offer MAiD was justifiable under s. 1, the institution could, of course, challenge it in court.

the funding flows from the Health Ministry through the regional health authorities to the institutions. For most hospitals public funding makes up 85-100% of their operating budget. Though most of them are privately owned not-for-profit corporations, the fact that they are publicly funded is presumably what gives the government the right to issue "operational or policy directives" to them, including directives telling them which health care services they are expected to provide. So why should that not be *all of them*, including MAiD?

Actually, that's oversimple. There can be many legitimate reasons for a particular facility not to offer a particular procedure among its medical services. Philip and Joshua Shadd have suggested the following:[89]

> • *Expertise*. ...[H]ealth centres, whether due to size or geography or otherwise, may lack personnel with the expertise needed for a particular procedure.
>
> • *Institutional capacity*. Health centres may lack the physical infrastructure, medical technology, or financial resources for a particular procedure.
>
> • *Institutional specialization*. Even where a health centre could offer a wider range of services, it may nonetheless choose to concentrate its resources on certain treatments or conditions, complementing other centres that specialize elsewhere.
>
> • *Demand*. Sometimes a health centre may not offer a procedure because there is little or no demand for it in its particular context.

These factors may all be relevant in some cases, but it is questionable whether they can serve to justify not offering MAiD. In most provinces MAiD assessors and providers will travel to any institution to provide their services. They bring their own supplies and expertise; all the facility has to do is let them in the door and provide them with appropriate space.[90] In any case, even if there can be legitimate reasons for a particular facility not to include MAiD among its services,

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[89]Shadd and Shadd 2019, 210–11. Shadd and Shadd also suggest that a facility can have another legitimate reason applicable to MAiD: "*Moral principle*. A health centre might find a procedure accepted by the wider medical community nonetheless morally objectionable..." (*ibid*., 212) For my response, see Sumner 2019.

[90]I owe this important point to Jocelyn Downie.

simple refusal, on moral or religious grounds, is not one of them. In this case an objecting institution is declining to offer this service not on grounds of expertise, capacity, specialization, or lack of demand, but because it considers MAiD to be morally wrong or inconsistent with its religious affiliation. In effect, it is saying "We have the expertise and the capacity to provide MAiD, we recognize that end-of-life care is one of our areas of specialization, and we anticipate demand for it, but we nonetheless refuse to provide it". It is easy to understand why a regional health authority might reply: "We are paying you to provide health care services, there is a need for this service, and that is not a legitimate reason for you not to provide it. If you do not wish to offer MAiD you have the option of declining public funding of your services." This is exactly what the Fraser Health Authority has said to the Delta Hospice Society, which operates the Irene Thomas Hospice. In fact, the Hospice Society does not even have to forego all of its public funding in order to maintain its stance on MAiD. Under B.C. policy, if the level of funding falls below 50% of the hospice's operating budget then it will be free to make its own decision whether to offer MAiD. It just cannot both accept full funding and refuse to provide this service.[91] In Ontario hospitals are accountable for funding through annual service accountability agreements with LHINs. These agreements stipulate service, financial, and performance outcomes to be achieved by hospitals. As long as the terms of the agreement could survive *Charter* scrutiny, they could require religiously-affiliated hospitals to offer MAiD as a condition of their funding.[92]

I turn now to an important issue thus far neglected. My topic—conscientious refusal by health care institutions—presupposes that refusal by these institutions can be *conscientious*, thus that they can have a conscience. But can they? Can any institution be said to have a conscience?

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[91]The facility has now lost its funding: https://infotel.ca/newsitem/bc-hospice-loses-funding-after-refusing-to-provide-assistance-in-dying/it70692. Last accessed 04/05/20.

[92]Philip and Joshua Shadd argue that it doesn't matter whether a religiously-affiliated facility is publicly or privately funded (Shadd and Shadd 2019, 213), but they do so by rejecting this contractual model between health authorities and the institutions they fund.

Sometimes it is argued that "bricks and mortar cannot have a conscience".[93] But that is too quick: institutions are not identical with their physical plant. Certainly institutions cannot have a conscience under some of the conceptions of conscience delineated by Mark Wicclair.[94] They cannot, for instance, possess a special mental faculty capable of discerning moral truth. But that is not the conception I am working with here. Instead, I am identifying a person's conscience with their core moral beliefs. Now institutions are not (natural) persons and it may be a stretch to say that they can have beliefs. But the conception can be readily broadened a little, to say that an *agent*'s conscience consists of their core moral *values*. So how do institutions fare under this slightly more expansive definition? It is a commonplace to attribute agency to any organization that has a decision-making structure with a body authorized to act for, or on behalf of, the organization as a whole. Thus we have no difficulty understanding what it means for a hospital to do something—such as refusing to offer MAiD. We assume that this was a decision reached by the body authorized to make such decisions—probably its board of directors—and as such it stands as a decision *by the hospital*. Furthermore, the authoritative decision-making body for the hospital can adopt a set of values guiding its provision of medical services, embodied in a mission statement or some such document. The hundred or so Catholic health care institutions in this country who subscribe to the principles in the *Health Ethics Guide* published by the Catholic Health Alliance of Canada have adopted those principles as (at least part of) their core values. And since at least many of the principles seem moral in character, these institutions can fairly be said to have a set of core moral values. If this is what it means to have a conscience (which I am supposing it is), then secular health care institutions can easily qualify as well.[95]

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[93]Jonathan Reggier, "Faith-based health facilities shouldn't prolong patient suffering", *Policy Options*, December 18, 2017. https://policyoptions.irpp.org/magazines/december-2017/faith-based-health-facilities-shouldnt-prolong-patient-suffering/. Last accessed 04/05/20.
[94]Wicclair 2011, 1ff. For Wicclair's own treatment of this issue, see pp. 148ff.
[95]In suggesting that institutions can be said to have a conscience, I am not assuming that they can thereby qualify for conscience rights under s. 2(a) of the *Charter*. That is a separate question which I am not qualified to answer.

It is worth noting in passing that institutional refusal to offer MAiD need not be defended on grounds of conscience. Philip and Joshua Shadd have proposed "changing the conversation" on this issue, reframing refusal as an exercise not primarily of conscience but of the institutional right of self-governance.[96] They claim that hospitals have such a right and that it includes the right to decide not to offer MAiD. The first conjunct in this claim seems right: hospitals are, at least within limits, self-governing corporations. The second conjunct is, of course, the present point of contention. I have argued elsewhere that Shadd and Shadd do not strengthen their defence of institutional refusal by grounding it in the right of self-governance rather than conscience, and may indeed weaken it.[97] So I will henceforth ignore this strategic option and instead assume that institutional refusal is best characterized as conscientious.

I have argued earlier that objecting health care practitioners can justifiably be compelled to assist in and provide MAiD, unless they practise in a setting in which their objection can be accommodated without impairing patient access. The crux of that argument was that the burdens on patients of denied or delayed access to MAiD are disproportionately greater than the costs to practitioners of being compelled to act contrary to their conscience. If these are indeed the key factors in the moral calculus, then it is much easier to show that institutions, including faith-based institutions, should not be allowed to opt out of providing MAiD on conscientious grounds.[98]

On the one hand, institutions cannot suffer any of the personal costs of betrayal of conscience: guilt, remorse, shame, erosion of integrity, loss of self-esteem, etc. Institutions

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[96]Shadd and Shadd 2019.

[97]Sumner 2019.

[98]See Wicclair 2011, 147ff. Wicclair does not discuss the special case of MAiD, though he does address a closely analogous issue (withdrawal of artificial nutrition and hydration) at pp. 158-62. The Special Joint Committee on Physician-Assisted Dying, which was willing to permit conscientious refusal by practitioners, drew the line at refusal by publicly-funded institutions, including those that are faith-based: *Medical Assistance in Dying: A Patient-Centred Approach*, 26-7. https://www.parl.ca/Content/Committee/421/PDAM/Reports/RP8120006/pdamrp01/pdamrp01-e.pdf. By contrast, in its *Final Report* (46-7) the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying recommended requiring only non-faith-based institutions to offer MAiD. http://www.health.gov.on.ca/en/news/bulletin/2015/docs/eagreport_20151214_en.pdf.

cannot experience these feelings because institutions have no feelings. Moral distress can be bad for individuals, but it cannot be bad for institutions. Some staff members of the institution, or even some patients resident in it, may be distressed that MAiD will be provided on its premises. But we need to keep in mind that, while the institution may have a religious affiliation, many of its staff and patients will not share that affiliation and also will not subscribe to the institution's faith-based mission statement. In a Catholic hospital, for instance, there may be many medical and nursing staff quite willing to assist in and provide MAiD, as well as patients who want and need it. This intersection of supply and demand is blocked by the hospital's refusal to allow MAiD on its premises. Leaving medical and nursing staff aside, some members of the institution's board of directors may likewise be distressed that they are being compelled to violate some of the tenets of their adopted religious mission.[99] However, like hospital staff, they are not identical to the institution, and any distress they experience is not experienced by the institution. In any case, if they believe that providing MAiD is a grave wrong then they have the option of resigning. The board as a whole also has the option of severing its religious affiliation.

On the other hand, the impact on patient access to MAiD is much greater for institutional refusal than it is for refusal by individual practitioners. I have already mentioned earlier the burdens on eligible patients who are seeking MAiD but whose only local hospital is faith-based. While that is bad enough, it is not the worst case. As noted above, patients who are already being cared for in an objecting hospital may decide to seek MAiD, only to be informed that in order to access it they will have to be moved to another facility.[100] When a practitioner refuses to provide MAiD but an effective referral is possible, the transfer of care to a willing provider may happen with little or no inconvenience to the patient. But it is a very different matter to transfer a

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[99]I am focusing on faith-based institutions here, but I mean the argument to apply equally to facilities whose objection to MAiD is 'philosophical' rather than religious.

[100]Some objecting institutions publicly state that they will not provide MAiD, but others do not. In that case, a patient may not learn of the hospital's policy until initiating an inquiry about the procedure. Furthermore, Ontario's Bill 84, passed in May 2017, protects institutions that wish to conceal this information from Freedom of Information requests. https://www.ola.org/sites/default/files/node-files/bill/document/pdf/2017/2017-05/bill---text-41-2-en-b084ra_e.pdf.

seriously ill patient to another institution. Recall that in order to qualify for MAiD a patient must have a grievous and irremediable medical condition that is causing them intolerable suffering. Transporting someone in this condition out of their care facility will be at best traumatic and at worst horrendous. And it has been horrendous in some highly publicized cases:

Doreen Nowicki. In May 2017 Ms. Nowicki was a patient in palliative care at the Edmonton General Continuing Care Centre operated by Covenant Health, a publicly-funded Catholic organization. She had amyotrophic lateral sclerosis (ALS) and her health had deteriorated to the point where she could neither walk nor speak and could barely eat. When she decided to pursue a medically-assisted death the management of the facility initially made an exception to their policy and gave permission for Ms. Nowicki's assessment to be carried out on the premises. However, an hour before her first assessment Ms. Nowicki's family learned that management had changed their mind and she would now have to leave the property for her assessment. Her daughters had to wheel her off the property to benches on a busy Edmonton street so that she could keep her appointment with the assessor. She was too distraught to complete the assessment. She was eventually able to access MAiD and died at another care facility.[101]

Cheppidura Gopalkrishna. An 88-year-old also with ALS, Mr. Gopalkrishna was resident in Misericordia Health Centre, a Catholic hospital in Winnipeg. In May 2017 he asked the hospital to forward his request for MAiD to the provincial committee that assesses patients for eligibility. The hospital provided no assistance with this request and then delayed transfer of his medical records to the committee for several months. Mr. Gopalkrishna finally received an assessment in October 2017, for which the hospital required that he be moved off-site.[102]

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[101] https://www.cbc.ca/news/canada/edmonton/edmonton-alberta-covenant-health-medically-assisted-death-1.4875394. Last accessed 17/04/20.

[102] https://www.cbc.ca/news/canada/manitoba/misericordia-assisted-dying-maid-1.4371796; https://www.cbc.ca/news/canada/manitoba/winnipeg-man-assisted-death-assessment-1.4377321. Last accessed 02/05/20.

Horst Saffarek. Until it closed as an acute-care facility in October 2017, St. Joseph's General Hospital, a Catholic institution, was the only public hospital in Comox, British Columbia. Before its closure it refused to provide MAiD for Mr. Saffarek, who then had to be moved to another facility in Nanaimo, B.C. Mr. Saffarek's health declined after the transfer and he died before being able to access MAiD.[103]

Ian Shearer. Mr. Shearer, 84 years old, was dying a painful death in the palliative care ward of St. Paul's Hospital in Vancouver, B.C., suffering from spinal stenosis, heart disease, kidney failure, and sepsis, when MAiD became legal in Canada in June 2016. When he sought to use the law to end his suffering, the Catholic institution refused his request. Mr. Shearer had to be transferred to Vancouver General Hospital to access MAiD, a four-kilometer ambulance ride that his daughter said left him in agony.[104] At least Mr. Shearer, like Ms. Nowicki, was eventually able to receive the service he had requested. Others, like Mr. Saffarek, have been less fortunate.

Anonymous. In September 2016 a patient at Hotel-Dieu Grace Hospital in Windsor, Ontario was approved for MAiD but then told that the procedure could not be carried out on the hospital's premises. Hospital administrators attempted to arrange a transfer to Windsor Regional Hospital but were refused on the ground that Windsor Regional offers MAiD only to its own patients. After Hotel-Dieu then failed to find any alternative setting where MAiD could be provided, the patient withdrew their request and died in the hospital's care.[105]

These are particularly outrageous incidents and we should not assume that every transfer from an objecting institution goes as badly as they did. On the other hand, the sheer number of

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[103]https://www.cbc.ca/radio/thecurrent/the-current-for-january-11-2018-1.4481312/should-catholic-hospitals-have-to-provide-access-to-medically-assisted-dying-1.4482372. Last accessed 17/04/20.
[104]https://nationalpost.com/news/canada/b-c-man-faced-excruciating-transfer-after-catholic-hospital-refused-assisted-death-request. Last accessed 17/04/20.
[105]https://windsorstar.com/columnists/jarvis-searching-along-the-401-for-a-place-to-die. Last accessed 17/04/20.

such transfers seems to make it inevitable that tragedies will occur. Most provinces do not record, or at least do not publicize, figures on this process. But Alberta does, among its data on MAiD in the province. Its report reveals that from the time MAiD was legalized in June 2016 through the end of 2019, 125 patients were transferred from objecting institutions in order to receive MAiD, 109 from faith-based facilities and the rest from secular ones.[106] If we extrapolate these figures across the country, then a great many sick and dying patients are being forced to leave their facility in order to access a legal medical service that they need and want. That just seems cruel, both to the patients themselves and to their families.

3. Conclusions

My conclusion concerning conscientious refusal by practitioners was that it could, and should, be tolerated, but only where it could be accommodated in practice groups without unduly burdening willing providers or adversely affecting patient access. My conclusion about refusal by institutions is less compromising. In this case the cost to vulnerable patients of MAiD being delayed or denied is much greater and the burdens of conscience (if we may call them that) to institutions are insignificant. Since it cannot be accommodated without seriously impairing both patient access and patient well-being, refusal by publicly-funded health care institutions to offer MAiD must be completely disallowed.

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[106]https://www.albertahealthservices.ca/info/Page14930.aspx. Last accessed 17/04/20.

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