Ambiguity of Faith and Reason: Exploring the Challenges of Conscientious Objection and the Provision of Effective Referrals for Medical Assistance in Dying among Christian Physicians in Ontario

Mackenzie Street, H.B.S.W.

Faculty of Social Work, Lakehead University

A thesis submitted to the Faculty of Graduate Studies in partial fulfillment of the requirements of the Master of Social Work Degree

Acknowledgements

Throughout the writing of this thesis, I have received a lot of support and guidance that I would like to make note of.

I would first like to thank my supervisor, Dr. Ravi Gokani, who supported and challenged me through this process to grow both as a writer and an academic. I know these skills will serve me well moving forward in my professional career and I thank you for that.

I would also like to thank my committee members, Dr. Kathy Kortes-Miller and Dr. Elaine Wiersma who I have also had the pleasure of learning from in the classroom setting. Your knowledge base and passion for the field of gerontology is something that I greatly admire.

Next, I would like to thank recent graduate from the Master of Social Work program at Lakehead University, Breanna Sweers, who generously provided guidance as I learned to navigate the many application processes throughout this journey.

I would also like to thank both my friends and family who supported and encouraged me not only to pursue this opportunity but to persevere through the difficult moments.

Lastly, I would like to extend a very sincere thank you to my husband, Tyler. I could not have achieved this without your unconditional love and support. The last two years have not been easy, but I thank you for your patience, your words of encouragement, and your willingness to take on this adventure with me.

Abstract

This paper explores the tensions experienced by Christian physicians in Ontario as they navigate the Effective Referral Requirement. Physicians in Ontario are currently required by law to provide an effective referral should they conscientiously object to Medical Assistance in Dying, also referred to as MAiD (CPSO, 2015). This paper will consider the relationship Christian physicians in Ontario have with the Effective Referral Requirement and the ways in which they manage their competing values within their profession and their faith. Ultimately this paper will aim to answer the following research question, "How do Christian Physicians in Ontario understand the tension between their professional and religious obligations when considering MAiD?". To answer this question structured-qualitative interviews were conducted with eight physicians who a.) identify as Christian, b.) are in a position to receive requests for MAiD, and c.) practice medicine within Ontario with a license. Thematic analysis was used to analyze the interview data. Participants suggested several alternatives that they feel would adequately address their concerns with the Effective Referral Requirement such as the implementation of a self-referral system and changing the requirement from providing a referral to requiring the provision of a phone number to patients instead.

Contents

Introduction……………………………………………………………………………………..…5

Literature Review……………………………………………………………………….…....5

A Brief History of Medical Assistance in Dying in Canada..…………………………….…6

Medical Assistance in Dying and Christianity……………………………………….….9

Christianity and Other Bioethical Issues……………………………………………....20

Methodology…………………………………………………………………………………..26

Methodological Approach………..……………………………………………….…..27

Participant Recruitment.…….……………………………………………………….…..29

Data Collection………………………………………………………………………..29

Analysis…………………………………………………………………………..….…30

Findings…………………………………………………………………………………..…32

Discussion and Implications………………………………………………………………..…46

Implications for Literature...47

Implications for Policy…………………………………………….…………………..…49

A Role for Social Work and the Effective Referral Requirement……………………….54

Implications for Current and Future Practice as a Physician…..55

Limitations…………………………………………………………………………..…56

Conclusion…………………………………………………………………………….…57

Introduction

As with most changes in medical legislation, there has been much debate and deliberation surrounding the legalization of Medical Assistance in Dying (MAiD) in Canada. One prominent source of opposition has been and continues to be those of Christian faith. A key reason for arguments rooted in Christian Faith is because of their belief in the sanctity of life. This is the belief that all lives are valuable, sacred, and in turn should be protected (Jackson & Keown, 2011). Following the legalization of MAiD in Canada, further debate continues as Christian Physicians in Ontario express their dissatisfaction with a policy that requires them to provide a medical referral for patients who wish to access MAiD should they [the physician] conscientiously object. The policy in question is the Effective Referral Requirement (CPSO, 2015). The purpose of this thesis is to provide additional insight into both the religious and professional tensions experienced by Christian physicians when exploring their personal experiences and understandings of current Effective Referral Requirement in Ontario. The word tension was chosen with care, and I feel that it fits appropriately given that there are very vocal Christian organizations that have historically exhibited push back to other bioethical issues such as abortion and stem cell research. Within this thesis tension is defined as the presence of mental, emotional, or nervous strain (Stedman, 2005). As can be observed in the following literature review, I have reviewed many articles that allude to such tension as well.

Before reviewing the accounts of a sample of physicians from across Ontario I will review five things: (a) relevant definitions and terminology, (b) a brief history of MAiD in Canada, (c) the legalization of MAiD in Canada, (d) MAiD and Christianity, and (e) MAiD and other issues of conscience, namely, abortion, stem cell research, and suicide. The articles discussed within section (b) through (e) were selected through a deductive process in which

relevant articles were gathered and later pruned of those who were only loosely related to the above-named topics leaving only those which were closely related to each topic. An excel spread sheet was kept to organize this process.

Relevant Definitions and Terminology

Before reviewing the literature there are a few clarifications of terminology that may be helpful. Prior to the use of the term Medical Assistance in Dying in Canada, and you will see throughout the literature review in other countries, terms such as 'assisted suicide' and 'euthanasia' were more commonly used. Even within these two terms there are several subcategories which may be of importance to note. The first is 'assisted suicide' which is where an individual takes their own life with the assistance of a second party (Dumsay, 2021). When the individual assisting is a physician, this is known as 'physician assisted suicide'. Euthanasia is the intentional ending of life, often to end pain or suffering.

Further distinction is often made between 'passive' and 'active' euthanasia. The nuance of passive euthanasia is not germane to MAiD. Active euthanasia, however, is when measures are taken to end someone's life outside of natural causes such as a lethal injection administered by a physician at the request of the patient. This would be considered voluntary active euthanasia. (Dumsay, 2021).

For the purpose of this paper the term Medical Assistance in Dying will be used in abbreviated form, MAiD, however throughout the literature review the terms used by each author will be honoured accordingly.

A Brief History of Medical Assistance in Dying in Canada

The aim of this section is to review the events leading up to the legalization of MAiD in Canada as it provides relevant context needed to best understand the topic of this thesis. The legalization of MAiD quickly became not only a debate of medical legislation but one rooted deeply in individual conscience, issues of human rights, as well as bioethical standards of practice within the field of medicine. Within this portion of the literature review I will review generally: (1) the events leading up the passing of Bill C-14, (2) the passing of Bill C-14 and later Bill C-7, (3) the concept of conscientious objection, and (4) the Effective Referral Requirement in Ontario.

Leading up to the Passing of Bill C-14

There are two prominent court cases that each played a role in the legalization of MAiD in Canada involving the following individuals: Sue Rodriguez, Gloria Taylor, and Kay Carter. Sue Rodriguez of Vancouver, British Columbia was diagnosed with Amyotrophic lateral sclerosis (ALS) in August 1991 and was the first to pursue the legalization of assisted suicide in 1993. Rodriguez was, however, unsuccessful following a ruling of five to four by the Supreme Court of Canada (Rodrigues v. British Columbia, 1993). Gloria Taylor of Castlegar, British Columbia who was also diagnosed with ALS in 2009 continued to pursue the legalization of assisted suicide by joining the British Columbia Civil Liberties Association (BCCLA) death with dignity lawsuit as a plaintiff in 2011 (Pullman, 2020). This lawsuit began with two family members of Kay Carter of Vancouver, British Columbia who was also diagnosed with ALS. Carter traveled to Zurich, Switzerland to pursue a medically assisted death as this was not accessible to her in Canada at the time. The court ruled unanimously on February 6th, 2015, in favor of the BCCLA accompanied by Taylor and Carter (Pullman, 2020). The advocacy of

Rodriguez, and continued efforts of Taylor and Carter are often referenced when discussing the journey to the legalization of MAiD in Canada.

The Passing of Bill C-14 and Bill C-7

MAiD was officially decriminalized on June 16th, 2016, through the passing of Bill C-14 (Parliament of Canada, 2016). Under this legislation those who wish to access MAiD must meet the following criteria: (1) be eligible for health services funded by the Canadian Government; (2) be 18 years of age and capable to make independent health care decisions; (3) have a grievous and irremediable medical condition; (4) make a voluntary request for MAiD without external pressure; (5) and have the ability to provide informed consent following the review of all other means to address their suffering (Parliament of Canada, 2016). I want to acknowledge the shifting landscape and moving target that is MAiD legislation given that a new Bill was passed following the completion of my study. On March 17th, 2021, during the writing of this thesis, Bill C-7 was passed which resulted in changes to the eligibility criteria (Parliament of Canada, 2021). This legislation expanded the eligibility criteria to no longer require that an individual's death be reasonably foreseeable but had no direct impact on conscientious objection. Although Bill C-7 is the most recent and present acting piece of legislation that dictates MAiD eligibility it is important to note that my research began, and data collection was completed prior to the passing of this bill therefore my findings remain relevant despite this change in legislation. Conducting this study again with Bill C-7 in place could possibly produce different results.

Conscientious Objection

Since the legalization of Medical Assistance in Dying (MAiD) in Canada in 2016, much research has been conducted exploring its implications within the field of medicine. Most of

these studies have explored more generally the relationship between MAiD and quality of life for patients/care recipients while also considering the practical implications for care providers such as nurses, nurse practitioners, and physicians. This in turn has led to further policy implementation regarding conscientious objection. Conscientious objection is an “objection to complying with a specific standard or practice” (Lamb, 2016).

To be clear, the legalization of MAiD did not introduce the concept of conscientious objection to the field of medicine. The term was first used by religious groups as early as 1661 when referring to men who did not want to enlist in military services on religious grounds (Moskos & Chambers, 1993). Other highly controversial topics such as stem cell research and abortion have also elicited discussions of conscience and moral tension (Hurlbut, 2006; Smith, 2010; Stettner & Douville, 2016). Conscientious objection has since then been used further in healthcare when referring to one’s right to object to medical procedures and practices that are not consistent with one’s religious beliefs. In the context of MAiD, physicians may choose to conscientiously object should their religious beliefs prohibit participation in MAiD. This includes but is not limited to the beliefs of Christians.

Effective Referral Requirement in Ontario

As of 2015, the College of Physicians and Surgeons of Ontario (CPSO) decided that should physicians in Ontario wish to exercise their right to conscientiously object they are required by law to provide an Effective Referral for the inquiring patient to another physician who can facilitate this request (CPSO, 2015). An Effective Referral is by definition “a referral made in good faith, to a non-objecting, available, and accessible physician, nurse practitioner or agency,” and “the referral must be made in a timely manner to allow the patient to access medical assistance in dying. Patients must not be exposed to adverse clinical outcomes due to

delayed referrals." (CPSO, 2015). This policy aims to respect the rights of professionals who conscientiously object to the provision of MAiD but also to ensure accessibility to MAiD for patients who wish to access it. Following implementation of the Effective Referral Requirement, "tensons flared in the Province of Ontario" as many objecting physicians felt that this new policy was coercive and unethical (Carpenter & Vivas, 2020, p.1). When reviewing the literature, it is evident that the issue of an Effective Referral due to conscientious objection to MAiD emerges strongly at the intersection of Christianity and MAiD. This intersection is the focus of my study and I now turn to the review of the relevant academic literature.

Medical Assistance in Dying and Christianity

The literature at the intersection of MAiD and Christianity can be categorized in two: - literature published prior to the legalization of MAiD and literature published after the legalization of MAiD. I will review the literature in this order as I move through the following section.

MAiD and Christianity Prior to Legalization

Prior to the legalization of MAiD in Canada assisting someone to end their life was more commonly referred to as physician assisted suicide. In 1992 the Christian Medical and Dental Society (CMDS) released an ethical statement addressing their thoughts pertaining to physician assisted suicide. One of the prominent points made by the CMDS was that "human life is a gift from God and is sacred because it bears God's image" to which they follow with a clear statement that they "oppose active intervention with the intent to produce death for the relief of pain, suffering, or economic considerations, or for the convenience of patient, family, or society" (CMDS, 1993).

One of the earliest academic articles, in this area, and an opposing view to the CMDS, was written and published in 1995 by Paul Badham, theology and religious studies professor at the University of Wales. Badham (1995) stated “it would be entirely appropriate for a believing and practising Christian patient to request the termination of his or her life, and equally appropriate for a believing and practicing Christian doctor to accede to such a request” (p. 1). Badham (1995) further denoted that although he strongly believed in the use of palliative medicine and hospice care, until it can be further developed, there remains a place for assisted deaths (p. 2). He provided several Biblical references justifying his stance such as Ecclesiasticus 41:2 which states, “O death how welcome is your sentence to one who is in need and is failing in strength, very old and distracted over everything; to one who is contrary and has lost patience” and Ecclesiasticus 30:17 which states, “death is better than a miserable life, and eternal rest than chronic sickness”. Overall, Badham believed that death was not something to be avoided at all costs but to be embraced in appropriate circumstances, and that an assisted death could be viewed as acceptable through Christian eyes for the reasons stated above. Badham’s interpretation however was not commonly shared which is evident from the next three publications addressing Christianity and assisted suicide published in 1998. (Engelhardt, 1998; Kaczer, 1998; O’Mathuna & Amundsen, 1998).

The first of these publications was by Tristram Engelhardt (1998), a philosopher and prominent voice in the field of bioethics. Engelhardt argued that the aim of physician assisted suicide was to address “post-traditional Christian and secular concerns with self-determination, control, [and] dignity” (p. 1). By contrast, when viewing physician assisted suicide in the context of traditional Christianity it should be sternly condemned (Engelhardt, 1998). He further implies that arguments formulated outside of faith are misguided in nature and that to understand

physician-assisted suicide in its entirety one must take on a Christian life (Englehardt, 1998). He believed that the Christian understanding of death goes far beyond the secular understanding that is based solely on human knowledge as the Christian understanding is rooted in spiritual knowledge (Englehardt, 1998). He referenced John 14:6, “Jesus answered, I am the way the truth and the life. No one comes to the father except through me.” (pg.148). This verse from the Bible highlights that those of Christian faith attribute significant authority to Jesus Christ and God. Further it alludes to the belief that there is a life after death and in order to gain access to this after-life that one must adhere to the specific guidelines passed down from God through Jesus and other key players in the Bible.

Following Engelhardt’s publication was one by Christopher Kaczor, philosophy professor at Marymount University, who shared a similar understanding of physician assisted suicide. Kaczor (1998) also alludes to the same conclusion that physician assisted suicide is an act that is morally unjust given the traditional teaching of the Christian church while also acknowledging that, “among Christians there is no single view that they share” (p. 196).

The final publication addressing physician assisted suicide and Christianity in 1998 was *Historical and Biblical References in Physician Assisted Suicide Court Opinions* by Donald O’Mathuna and Darrel Amundsen. This article addresses several Biblical references utilized in two judicial opinions on physician assisted suicide in the United States of America. The authors believed that “understanding the theological and historical perspectives of Christianity remains important in discussions of public policy on suicide and euthanasia” (p. 474) and they aim to address what they believe to be “distorted understandings” (p. 474) of Biblical references in court.

The first court case referenced is Hobbins v. Attorney General, in which Judge Richard C. Kaufman addressed Michigan's law proscribing assisted suicide (Hobbins v. Attorney General, 1994). The authors do not contest Kaufman's initial argument that Greek and Roman law did not prohibit either abortion or suicide; however, where the authors feel there has been a misrepresentation is where Kaufman drew the conclusion that there is significant support within Christianity that alludes to the approval of suicide or euthanasia. Kaufman gives five instances of suicide in the Bible that were not explicitly condemned. However, O'Mathuna & Amundsen challenge this position and state that there are not five but seven instances of suicide throughout the Bible. Where they depart from Kaufman's interpretation is that although these acts are not explicitly condemned, when they are considered alongside the commandment "Thou shalt not kill," (Exodus 20:13), it appears clear that these acts are not condoned despite not being explicitly condemned (O'Mathuna & Amundsen, 1998).

The second court case referenced by O'Mathuna and Amundsen is Compassion in Dying v. Washington, in which Judge Reinhardt addressed the history of Christian attitudes towards suicide while conducting his Ninth Circuit Court of Appeals. The authors critique was that Reinhardt did not thoroughly review early accounts of Christian attitudes towards suicide and euthanasia when he presented his statement that, "The early Christians saw death as an escape from the tribulations of a fallen existence and as the doorway to heaven" (Compassion in Dying v. Washington, 1995).

O'Mathuna and Amundsen highlight that in both cases I just discussed, the judges suggested that suicide and euthanasia are not explicitly condemned in the Bible. Moreover, they highlight that this rationale could be problematic as it would also imply that many other acts that are currently viewed as unethical such as prostitution and rape could be considered ethical using

explicit prohibitive statements present in the Bible as the measuring stick (O'Mathuna & Amundsen, 1998).

In conclusion, the authors make the final argument that, "there is not a scintilla of evidence that the preferential position that Christianity gave to the sick included an expedited final exit" given that although "the Bible does not explicitly condemn suicide, it nowhere explicitly condones it either" (O'Mathuna & Amundsen, 1998, p. 495). Following the review of this publication, various arguments have been made based on subjective interpretations and implied meaning of Biblical scripture.

Etienne de Villiers' 2002 publication continued to explore the views of two contrasting Christian theologians: Gilbert Meilaender and Harry Kuitert. The first, Gilbert Meilaender, expressed firm objection to euthanasia and medically assisted suicide but believed the refusal of treatment to be ethical given that it is not necessarily with the sole intent to cause death (Meilaender, 1996 as cited in De Villiers, 2002). In contrast, Harry Kuitert stated that he supported euthanasia, medically assisted suicide, and refusal of treatment regardless of intention based on his unique interpretation of the commandment "Though shalt not kill" and his belief in individual autonomy. Kuitert suggested that "this command should not be interpreted as an absolute prohibition of all killing, but as a prohibition of unjustified killing" (Kuitert, 1993 as cited in De Villiers, 2002). From these two perspectives De Villiers denoted that there is reason to believe that issues such as euthanasia, medically assisted suicide, and refusal of treatment cannot simply be evaluated through a single lens. He implies that both ethical debate among those of Christian faith as well as individual internal debate related to one's personal stance exists. He further highlights that differences in personal stance exist among Christians and room should be made for these viewpoints when creating policy.

Similarly in 2003, Corinna Delkeskamp-Hayes further addressed the concern of policy surrounding physician assisted suicide but on the basis of maintaining a relationship between Christianity and the secular world. She acknowledged that euthanasia and physician assisted suicide are becoming increasingly more accepted within the public secular sphere despite significant pushback from the Christian community (Delkeskamp-Hayes, 2003). Interestingly, within Delkesamp-Hayes paper there were two suggested approaches posed by Christian voices for decreasing the demand for euthanasia and physician assisted suicide; (1) increasing accessibility of palliative care resources and (2) legalizing euthanasia and physician assisted suicide so that it can be regulated. The second point is further articulated in the following quote: “an evil that is practiced in secret is better controlled when rendered transparent, even if that rendering involves legally permitting the evil” (p. 166).

Although this argument may at first glance appear in favor of physician assisted suicide it still deems this act as “evil”. This argument furthermore carries undertones of permissiveness rather than genuine support. Delkeskamp-Hayes further denotes that it is not the right of the government to define policy addressing issues such as euthanasia and physician assisted suicide. His reason for this is that he believes human rights are of Christian heritage given that Christians have had significant involvement providing social service, and therefore policies such as this should be defined by the church.

The last known publication prior to the legalization of MAiD was published in 2004 by David McKenzie, titled *Church, State, and Physician-Assisted Suicide.* In this publication McKenzie first examines the history of Christian attitudes towards suicide to which he concludes that the general disapproval of suicide previously expressed by those of Christian faith has translated into today’s lingering opposition to physician assisted suicide. Reference is made to

O'Mathuna and Amundsen's publication further highlighting the ambiguous use of Biblical references when examining the validity of Biblically based arguments in support of euthanasia and assisted suicide. It is evident to me that throughout this article Biblical references are highly contextual and often interpreted in various ways. O'Mathuna and Amundsen (2002) rely heavily on the argument that, "the Bible does not explicitly condemn those who commit suicide" (p. 478). In response to this argument McKenzie states that, "pointing out that the Bible does not condemn suicide is not the same thing as saying that it condones the practice" (McKenzie, pg. 801).

Following McKenzie's 2004 article there appears to be an eight-year gap in academic discussion at the intersection of MAiD and Christianity. One possible explanation for this gap could be related to the conviction and sentencing of Dr. Jack Kevorkian. Dr. Kevorkian assisted individuals who wished to end their lives to do so through lethal injection even though it was deemed illegal to do so (People v Kevorkian, 1999). In 1998 he was convicted on two separate accounts of second-degree murder and in 1999 was sentenced to 10 -15 years in prison (People v Kevorkian, 1999). As is evident when reviewing the literature at the intersection of euthanasia and Christianity, there was a slight influx in publications in 1998. One might wonder whether this could be related to the prominence of the ethical debate surrounding assisted suicide in the American judicial system at the time. The decrease in publications between 2004 and 2016 could indicate that Christian scholars, naturally opposed to Dr. Kevorkian's practice, no longer saw an need for further moral debate. Similarly, a resurgence of publications in 2016 could be related to the legalization of MAiD in Canada

MAiD and Christianity Following Legalization

The divisions created by differing opinions on euthanasia and physician assisted suicide did not dissipate following the legalization of MAiD. Significant push back from those of Christian faith remained evident. There are five articles exploring the intersection of MAiD and Christianity that were published following the legalization of MAiD in 2016 that I would like to use to explore these divisions and their rationale further.

The first article was published by David Albert Jones in 2016. Jones further examines the view presented by Paul Badham, namely, that there is a justification for Christian support of MAiD (Badham, 1998). Although Jones refers to Badham's support for legalizing assisted suicide as "a voice crying in the wilderness" (pg.332), he goes on to highlight several bishops and archbishops who expressed support for Badham's view in 2014 (Jones, 2016).

Jones goes on to review the viewpoints of other scholars such as William Inge, a Christian eugenicist, who was said to be one of the first and most vocal Christian advocates for euthanasia. Jones (2016) describes Inge's argument as problematic, yet given that Inge strongly believed that "if nature is not allowed to take her own way of eliminating failures, rationale [sic] must take its place" (Inge, 1909). To be clear, Inge is suggesting that those born with disabilities would be adequate candidates for euthanasia as he views their differing abilities as imperfections to be eliminated. This attitude was also expressed by several other scholars and bishops as Christian justification for euthanasia while rationalizing its use for those born with disabilities (Inge, 1909). In conclusion, Jones states that there is a clear demonstration of Christian support for assisted dying in the past, but upon closer examination, he expressed concerns regarding the problematic attitudes towards individuals with disabilities imbedded in their rationale.

The second publication in 2016 explores considerations made in the beginning stages of policy writing addressing religious or conscientious objections to the provision of MAiD

(Christie, Sloan, Dahlgren, & Koning, 2016). Significant difficulty is outlined when considering the conflicting duties of one who wishes to conscientiously object to MAiD. The conflict outlined in the article is a result of the following two values often held by conscientious objectors: 1) one must respect the patient's right to life, liberty and security of the person, and 2) everyone has the right to freedom of religion or conscience. (p. 2). The authors suggest that these two values are mutually exclusive and cannot be achieved simultaneously given that they are based on moral absolutes. Within the discussion the authors highlight further the possibility not only for values to conflict between patient and conscientious objector but also that a conflict might also exist within the conscientious objector themselves (Christie et al., 2016). In conclusion the authors emphasizes that one must account for the competing duties of the conscientious objector and consider "whether the duty to respect one's conscience or religion supersedes the duty to respect the patient's right to life" (Christie et al., 2016, p. 1).

In 2018, Mark J. Cherry published an article entitled *Physician-Assisted Suicide and Voluntary Euthanasia: How Not to Die as a Christian.* Cherry emphasizes the traditional Christian belief that murder, and self-murder are to be prohibited as participating in such acts would have significant spiritual implications such as individual spiritual harm, referencing 1 Corinthians 3:17: "Surely you know that you are God's temple, where the Spirit of God dwells. Anyone who destroys God's temple will himself be destroyed by God, because the temple of God is holy; and you are that temple". As a result, Cherry expresses strong opposition to the legalization of MAiD and feels that institutions such as the hospital have replaced the Church and have become a prominent location for individuals to sort out problems related to suffering, dying, and death (Cherry, 2018). He uses the word "shallow" to describe the idea of "dying with dignity" from his understanding of traditional Christianity. In conclusion, Cherry advocates for

improved palliative care and indicates that in order to die well as a Christian, time is needed for prayer, confession, and repentance in conjunction with careful religious planning and spiritual support (Cherry, 2018).

Alternatively, in his article *Physician Assistance in Dying: An Option for Christians?* Published in 2021*,* Lloyd Steffen suggests "natural law provides an ethics resource that can be used to defend limited instances of physician-assisted suicide within a framework of Christian moral theology" (Steffen, 2021, p. 246). Within this framework he suggests that there are instances where one good may conflict with another and in the case of physician-assisted suicide life being one good and extending care for others to alleviate suffering as another good. He suggests that within the moral framework of Christianity a held value is to love one another and therefore assisting to relive suffering through physician-assisted suicide could be justified (Steffen, 2021). He does however clarify that using this rationale does not suggest that physician-assisted suicide is always justifiable in the same way that it cannot be absolutely condemned. He suggests that support for physician-assisted suicide remains circumstantial and careful moral consideration should be given to whether all possibilities for meaningful life have been explored (Steffen, 2021).

The last article I will highlight was published by Daniel P. Sulmasy, director of the Kennedy Institute of Ethics at George Town University. Sulmasy explores further a Christian ethical perspective of MAiD in his article published in 2021 entitled *Physician-Assisted Suicide and Euthanasia: Theological and Ethical Responses.* Within this article he questions whether Christian patients and health care providers can justify the use of Physician Assisted Suicide or Euthanasia in a way that is compatible with their faith. He references Lloyd Steffen (2021), who as previously discussed, presents a Christian defense for Physician Assisted Suicide on the

grounds of natural law. Sulmasy then responds to a common critique of Physician Assisted Suicide that some believe there to be no difference between dying by Physician Assisted Suicide or dying by withdrawal of life sustaining measures (Sulmasy, 2021). Sulmasy draws out what he believes these differences to be by suggesting that Physician Assisted Suicide is an intentional act whereas the latter is accepting an inevitable fate (Sulmasy, 2021). He clearly states that "it is permissible to accept one's inevitable death from disease but never permissible to bring one's own death on oneself" (Sulmasy, 2021, p. 225).

To summarize, the literature at the intersection of MAiD and Christianity both prior to and following the legalization of MAiD shows that interpretations of traditional Christian teachings vary among scholars as do their opinions on the possibility for a Christian justification for MAiD. Most of the articles reviewed here condemn MAiD, while a select few demonstrate support for it. The reasons for condemning MAiD include the Christian belief in the "sanctity of life", Biblical references to teachings and injunctions, such as "do not kill" and "love your neighbour as yourself", and lastly the belief that only God has the governing authority over life and death. Justifications presented in favor of MAiD highlighted that the Bible does not explicitly condemn MAiD and, in some cases, suggests that death should be welcomed as it is more favorable than suffering. This variability in moral positioning is not something that is novel among Christian scholars when considering bioethical issues. As a result, I will briefly consider other bioethical issues – suicide, abortion, and stem cell research – to make some useful comparisons before outlining the details of the current study.

Christianity and other Bioethical Issues

Although the following bioethical issues might seem strikingly different from MAiD, and indeed they are, they share with MAiD some important similarities. The most obvious similarity

is that they are all bioethical issues that have resulted in significant debate of which strong Christian opposition has been apparent. But when looking at them more closely, there are striking similarities directly relevant to the MAiD debate, including (1) the argument from the sanctity of life; (2) the right to autonomy; and (3) the varied use of biblical references. Thus, it is helpful to review the ways in which these arguments have been applied to other bioethical issues as that might provide some insight into the ways they figure in the MAiD debate.

Christianity and Suicide

For instance, suicide, and any act of self-harm, has historically been strongly condemned among those of Christian faith (Cooley, 2020). Depending on the moral or philosophical lens one uses MAiD too could be considered an act of self-harm and therefore also be viewed similarly to suicide. As previously referenced when discussing the intersection of MAiD and Christianity, there are several common Biblical references that arise in the suicide debate such as Exodus 20:13 which states "Thou shall not kill" and 1 Corinthians 3:17 which reads, "if anyone destroys God's temple, God will destroy that person; for God's temple is sacred, and you together are that temple". (O'Mathuna & Amundsen, 1998). These portions of scripture reference expectations related to the treatment of self and others when considering the taking of life. Exodus 20:13 explicitly forbids taking a life whereas Corinthians 3:17 contextualizes it by indicating that there are ramifications when one does not respect their body as a temple in which God dwells.

Similar to O'Mathuna and Amundsen (1998), Glen Shewchuk, Master of Arts (Theology) graduate, also examined Biblical references to suicide in the context of assisted suicide (Shewchuk, 2021). Shewchuk highlights several instances of suicide in the Bible including Saul's amour bearer (1 Sam. 31:5), Ahithophel (2 Sam. 17:23), Zimri (1 Kings 16:18-19), and Judas (Matthew 27:5). This author further denotes that suicide based on these accounts was a

result of sin and disobedience to God, therefore, is not something that should be encouraged or endorsed (Shewchuk, 2021). When considering these Biblical accounts within the MAiD debate one may also denote that MAiD is not something that is condoned within Christianity. Reviewing the Biblical interpretations of suicide accounts, from the perspective of this author suggests that Christian involvement in MAiD would also not be encouraged.

MAiD and suicide both involve an individual wishing to end their life. A primary difference is that MAiD hastens death for those who have a irremediable medical condition, is a medical intervention, and often provides loved ones with the opportunity to be involved in decision making in addition to medical personnel (Parliament of Canada, 2016; Brody, 1995). Alternatively, those who wish to die and are considering suicide often don't actually wish to die, often die violent deaths, are misunderstood and do not enter the medical system (Giner, Jaussent, Olie, Beziat, Guillaume, Baca-Garcia, Lopez-Castroman, & Courtet, 2014).

Regardless, these two topics have been highly debated and share similar moral and ethical considerations with respect for Christian opposition. The most prominent similarity between Christian arguments against suicide that is also mirrored in the MAiD debate is the Christian belief in sanctity of life. That all life is precious and should not be intentionally destroyed.

Christianity and Abortion

The second bioethical issue is abortion. Here there are three articles that I would like to highlight. The first was written by Shannon Stettner and Bruce Douville in 2016 entitled, *"In the Image and Likeness of God: Christianity and Public Opinion on Abortion in the Globe and Mail during the 1960s".* This article aims to explore Christian stances pertaining to the legalization and morality of abortion while emphasizing that religion has historically played a significant role

in political discourse. They highlight that abortion has been strongly opposed by those of Christian faith and viewed as sinful to which some go as far as to equate it with murder (McLaren & McLaren, 1997 as cited in Stettner & Douville, 2016). Prominent arguments highlighted throughout this paper that have also been used in opposition of MAiD are (a) that human beings are created in the image of God, (b) that life is sacred, and (c) that no one has the right to destroy life (Cooper, 1961 as cited in Stettner & Douville, 2016). Stettner and Douville conclude by suggesting that the 1960s and following the legalization of abortion in Canada, Christian authority decreased and was a pivotal moment in Canadian history. One could wonder whether the same may have occurred following the legalization of MAiD.

In 2018, Michael Jones and John Molinari continued to explore the abortion debate further in their work entitled, *"Christianity, Epistemic Peer Disagreement, and the Abortion Debate"*. An interesting point made within the article is that even those within the same tradition have disagreed on the issue of abortion. Simply belonging to the same tradition does not necessarily result in identical views on a bioethical issue such as abortion, as was also evident when reviewing the literature surrounding MAiD and Christianity. These authors further outlined that differing opinions among Christians is often a result of individualized interpretations of Biblical passages. To support this point, they share a passage which has been used to argue both pro-choice and pro-life positions (Exodus 21:22-25). Similarly, as was evident when reviewing Biblical arguments presented in court both for and against euthanasia, O'Mathuna and Amundsen (1998) highlight Biblical references are often subjective interpretations where some focus on the implied meaning and others focus on the literal semantics of what is written.

The final article I will review is one published by Rohini Hensman in 2020 entitled, *"Christianity and Abortion Rights"*. This article addresses continued discussions surrounding

abortion in the 21st century. Concerns regarding ones right to autonomy and choice, specifically from a feminist perspective and the repercussions associated with revoking these rights from women. The argument of right to autonomy and choice is also prominent in discussions surrounding MAiD access. The author presents uncertainty around the validity of Christian authority when it comes to providing direction on the morality of abortion stating that the Bible does not make mention of abortion or prohibit abortion. Similar arguments have been made for euthanasia and in turn MAiD--that the Bible does not explicitly condemn these acts (O'Mathuna & Amundsen, 1998). They also highlight that within a single denomination, their stance on abortion may change from year to year as leadership changes because their stance is strongly influenced by values held by their governing leadership. Stance variability is also evident when reviewing literature addressing Christianity and MAiD even among those in leadership positions (De Villiers, 2002). As the reader can see there are many similar arguments presented when comparing the literature at the intersection of MAiD and Christianity with the literature at the intersection of Christianity and abortion.

The most prominent commonality between conversations surrounding Christian bioethics, MAiD, and abortion is that of autonomy and sanctity of life. In the case of abortion, the argument of autonomy has been used to defend both the mothers in their choices to access abortion as well as to defend the fetus and their inability to exercise their right to autonomy. When considering MAiD, the argument of autonomy has been presented in support of patients who wish to access MAiD. It has also been used by physician who wish to exercise their right to abstain from MAiD involvement. The sanctity of life argument, however, only appears in arguments against the provision of MAiD, never as a justification for support.

Christianity and Stem Cell Research

A more recent example of bioethical debate among science and religion is that of stem cell research. In 2006, William B. Hurlbut published *Science, Religion, and the Politics of Stem Cells*. In this publication he asks an important question that may also be translatable to the conversation of MAiD and Christianity, "What is the source of our moral principles and how do we govern amid a plurality of perspectives?". He also emphasizes the importance of dialogue between those representatives of a religious perspective and those of a political perspective. Hurlbut concludes by anticipating that stem cell research would not be the last advancement in biotechnology to result in moral dilemma and conflict.

In 2010, Alexander Thomas T. Smith explored the perceived issue of stem cell research and Christianity highlighting the issues of human rights. He highlights a common Christian argument expressing opposition to stem cell research that stem cell research promotes the destruction of life. Whereas those in favor of stem cell research often of secular persuasion emphasized that it is "society's 'moral obligation' to help those suffering from debilitating illnesses" and stem cell research aspired to achieve this. Similar to the findings of the research surrounding Christian attitudes towards suicide this author also identifies that those of Christian faith that may know someone personally who has a terminal illness demonstrated support for stem cell research. Smith highlights how moral debate of stem cell research has resulted in significant division between those of Christian faith and the secular community despite both sharing a desire to advocate for the right to life.

Christian arguments in opposition of stem cell research were further explored by Mircea Leabu in his publication titled, *Christianity and Bioethics, Seeking Arguments for Stem Cell Research in Genesis.* The author acknowledges the Biblical authority given to the book of Genesis when those of Christian faith analyze whether an action can be deemed good and evil

(Leabu, 2012). He goes on to highlight five commonly expressed Christian concerns related to stem cell research: (1) The issue of personhood or respect for autonomy; (2) protection of life (particularity with respect to fetal stem cells); (3) vulnerability, i.e, the weak should be protected and the potential for life should not be wasted; (4) one should not "play God"; and (5) permitting stem cell research would trivialize the dignity and worth of human life (Leabu, 2012). Interestingly, many if not all of these justifications have also been utilised to support arguments against MAiD. The reason for highlighting these arguments is that points two, three, and five share elements of the sanctity of life debate and could be used in opposition of MAiD. Point one is such that could be used in support of MAiD and point four is one that I have not yet explored in this review; "Playing God". What is meant by this is that only God has governing authority over life and death. Therefore, when looking through a Christian lens, the use of abortion or MAiD would be seen as acting on God's behalf and is not acceptable.

The last article I will review is one published in 2017 titled, *Religion and the public ethics of stem cell research: Attitudes in Europe, Canada and the United States* (Allum, et al., 2017). The authors highlight the complexity of defining one's understanding of new developments in health care and its deeper relation to individual morals when they state that, "The reception of new technologies by the public is linked to judgements about risks and benefits, but it is also based on ethical issues and general ideas about "how we want to live", and this is particularly the case for sensitive technologies in the life sciences" (Allum et al., 2017, p. 1). More specifically they highlight a predominant difference between secular and religious belief; 'sanctity of life' versus 'quality of life' (Allum et al., 2017). In the context of stem cell research those who hold the position that emphasis need be placed on sanctity of life, feel that the embryo utilized in stem cell research is a human life therefore possessing the right to life.

Alternatively, those who possess the stance that quality of life should be prioritized argue that it is of utmost importance that suffering be alleviated through the fabrication of cures for serious diseases through the use of stem cell research. The comparison drawn here between the religious belief in "sanctity of life" and the proposed secular belief in "quality of life" is very relevant to MAiD. Also present both within the moral discussions surrounding stem cell research and MAiD are the issues of autonomy and "Playing God" which were also evident within discussions surrounding abortion.

The three elements reviewed in this section were: (1) Christianity and suicide, (2) Christianity and abortion, and (3) Christianity and stem cell research. The reason for reviewing these topics is that they all historically have had significant pushback from those of Christian faith. Similar arguments trail through each topic that also have emerged within the MAiD debate such as the issue of autonomy, sanctity of life, and "Playing God". In reviewing the arguments in opposition to these bioethical issues similar faith-based rationales have emerged in more recent arguments related to MAiD.

Methodology

Research Question and Self in Research

As previously identified, the purpose of this research was to provide additional insight into the tensions experienced by Christian physicians when exploring their personal experiences and understandings of current Effective Referral Requirement in Ontario. Given the literature discussed above that outlines the tension that have historically surrounded adjacent topics such as physician assisted suicide and euthanasia, as well as the bioethical issues of suicide, abortion, stem cell research, I wanted to explore this more deeply in relation to MAiD. Throughout my studies I have always had a keen interest in the study of end of life and the relationship it has

with spirituality and religion. At present I work in the health care field as a social worker and have observed first-hand the complexity of religious beliefs and service provision. Given this, within my role as MSW student I wanted to consider the potentially complex relationship between religious beliefs and professional obligations that may exist for service providers such as physicians who identify as Christian. Accordingly, my research question is, “How do Christian Physicians in Ontario understand the tension between their professional and religious obligations when considering MAiD?”.

Methodological Approach

In conducting this research, following consultation with my thesis supervisor, I chose to utilize the methodology of Exploratory-Descriptive Qualitative (EDQ) research. The reason I chose this methodological approach is because I like that this methodology aims to acquire a better understanding of phenomenon about which little is known, while minimizing the power imbalance that often exists between researcher and participant (Hunter, McCallum, & Howes, 2019). EDQ serves as a way to conduct research in the field of social science in a systematic and purposive way (Hunter et al., 2019). As a student researcher, this approach allowed ample freedom to explore a topic such as this, more generally while also beginning to learn more about the nuances of methodological application in research.

More specifically this methodological approach is guided by six key philosophical underpinnings of which five were adopted when conducting this research. I would like to highlight there in particular. Firstly, EDQ is an inductive process that “describes a picture of the phenomenon that is being studied and can add to knowledge and develop a conceptual and/or theoretical framework” (Bradshaw et al., 2017, p. 2). Similarly, this research describes the tensions experienced by Christian physicians as they attempt to navigate the current Effective

Referral Requirement in Ontario, and I grouped these tensions together to provide a picture of the phenomenon in question. The fourth underpinning is that the researcher is active within the research process (Bradshaw et al., 2017). EDQ allows room for the researcher to share their own personal experiences with participants while conducting interviews. The way in which this may have been achieved in my research is that my personal faith identity was shared with the research participants in discussion; however, my personal stance or interpretations were not. The last underpinning present within my research that is shared by the EDQ research methodology is that it took an emic stance. By this what is meant is that the research begins from an "insider view". In this case the view observed is that of several Christian Physicians from Ontario, further analysis takes place from these responses (Bradshaw et al., 2017). One of the EDQ underpinning that was not fulfilled in conducting this research was that it was not conducted in a natural setting. This unfortunately could not be achieved due to the COVID-19 pandemic which will be outlined further in the limitations section of this work and did not take away from the study.

In conclusion, the reason I chose this methodological approach is that the collaborative nature of it provided the freedom for participants to share the intricate details of their experiences given that the aim of my research was to explore subjective experiences of Christian Physicians. More specifically, EDQ has been recognized for its practical application to healthcare research (Hunter et al., 2019). Overall, the objectives and structure of this methodology were well suited to my research given that little is known about the way Christian Physicians understand the tension between their professional and religious obligations when considering MAiD.

Participant Recruitment

The participants eligible to participate in the study were those who were licensed physicians in Ontario who (a) identified as Christian, (b) were in a position where they may

receive a request for MAiD and (c) were actively practicing medicine within Ontario. Initially, the way I obtained the sample for this study was through purposeful sampling followed by additional snowball sampling. There were eight participants recruited. Due to the Covid-19 pandemic and the related stress on the health care system many physicians expressed interested however declined participation at time of recruitment due to their professional responsibilities. Specific gender identification and age was not gathered however there appeared to be an even biological distribution of males and females ranging from roughly 30 to 60 years of age. Participant experience ranged from just completing their years in medical school and residency to those who identified being near the end of their career and considering retirement. As for their medical specialties 50 percent practiced in the field of anesthetics, 25 percent were general practitioners, and 25 percent practiced in the field of palliative care. Each participant identified their denomination of which none identified similarly. With this being said, I would like to acknowledge that although I have used the term "Christian" generally throughout this thesis it is important to note that beliefs differ by denomination. One uniform definition of "Christianity" is near impossible to curate especially within the confines of this thesis given that participant denominations were so diverse. Lastly, no two participants resided in the same city. Participant location ranged broadly across Ontario.

Some participants were recruited purposefully through a Christian organization in Ontario. An information letter was provided to the organization to assist with participant recruitment. This letter outlined the purpose of the study, required participant demographics, and researcher contact information. The information letter also indicated that all transcripts and audio recordings will be stored in a locked cabinet in my supervisor, Dr. Gokani's office for 5 years following which all physical research material will be disposed of through confidential shredding

and all electronic materials will be removed from the encrypted hard drive on which they are stored. Other participants were recruited via snowball sampling. Following each interview, additional participants were suggested by current participants. Interviews were conducted between May 2020 and September 2020. The average interview length was 50 minutes with a range of 40 to 75 minutes. As outlined in the information letter provided, participants were welcome to withdraw from the study at any time and could choose not to answer a question if they did not wish to answer it. Following completion of writing this report writer made effort to contact the recruitment organization to do a member check to ensure participants were comfortable with the presentation of the data. No response was received.

Data Collection

Structured interviews were utilized in data collection. Subsequent peripheral questions were asked following each response to obtain clarity or further context. The reason I chose to utilize structured interviews was the increase comparability when reviewing participant responses and reduce bias (Patton, 2014). The interview questions were broken down into two key categories (Appendix A). The first category of questions aimed to highlight Tensions related to professional obligations" at which time participants were asked questions such as, "Are there any aspects of your role as physician that are more challenging as a result of your position on MAiD?" and "Do you feel that the Effective Referral Requirement adequately protects you as a Christian physician and your right to conscientiously object?". The second category of questions aimed to highlight "Tensions related to religious obligations" at which time participants were asked questions such as, "Have you ever experienced tension or discrimination within your religious community related to your position on MAiD?" and "Did you experience any moral tension or faith questioning when defining you stance surrounding MAiD?". Due to the COVID-

19 pandemic, all interviews were conducted either via telephone or Zoom audio as public health restrictions did not allow for in-person interviews in Ontario. With this being said, there was no opportunity to build rapport with participants prior to each interview. All interviews were recorded and transcribed verbatim. Interviews were conducted in a private office to ensure participant confidentiality. The limitations of virtual data collection will be explored further in detail later in this paper. In order to obtain consent, the consent letter was read to the participants following which they were asked to express verbally their consent (see appendix D). A copy of the consent form was provided to each participant through email and further clarification was provided as needed. The consent form provided detailed information about the research process and outlined that given the small sample size, participants were made aware that confidentiality cannot be guaranteed however all efforts were made to try to ensure confidentiality. Before interviews were conducted, I obtained approval from the Research Ethics Board (see *appendix B*).

Analysis

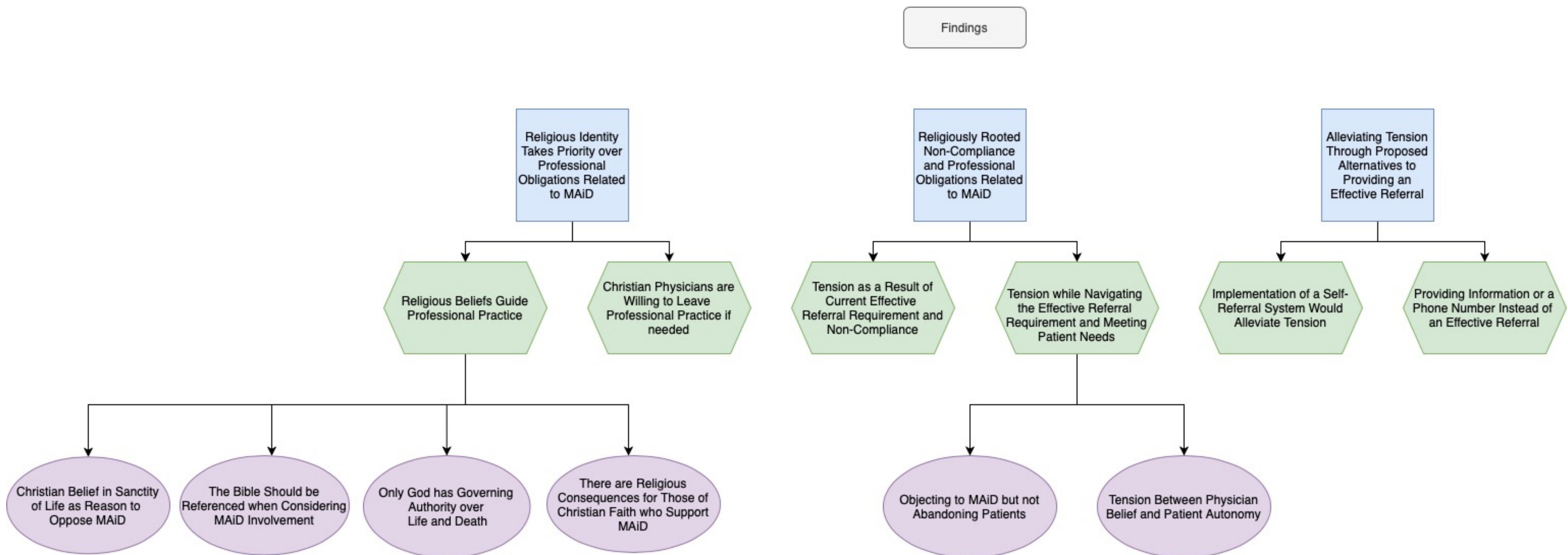
The data from this study were analyzed using Thematic Analysis which in short is a method used to find themes and patterns within qualitative data (Braun & Clarke, 2015). This method is comprised of six steps that I followed closely in creating this report. The six steps identified by Braun and Clarke (2006, p. 87) are as follows; (1) familiarizing yourself with the data, (2) generating initial codes, (3) searching for themes, (4) reviewing themes, (5) defining and naming themes, and (6) producing the report.

As is consistent with Braun and Clarke (2015), prior to beginning any categorization or searching for themes I read through each transcribed interview transcript twice to familiarize myself with the data. This also provided me an opportunity to remove any duplicate or filler

words that did not hold inherent meaning. In an effort to maintain confidentiality, at this time I also removed all identifying information from the data such as names, professional titles, locations, and organization names.

During a third read though of the transcripts I began to make codes (ie., similar words or phrases) that highlighted any tensions felt by Christian Physicians and the meanings each participant attributed to them. Once each interview transcript was coded all codes were then manually entered into an Excel spreadsheet and organized into several themes and subsequent subthemes which will be discussed in detail next. Clear definitions and names were curated with the help of my supervisor to ensure clarity and objectivity. Once these definitions and names were deemed satisfactory, I began to organize these findings within this final report below. Below you will also find a visual chart (Figure 1. Themes and Subthemes: Tensions felt by Christian physicians related to MAiD and the Effective Referral Requirement) constructed for theme and subtheme clarity.

Figure 1. Themes and Subthemes: Tensions felt by Christian physicians related to MAiD and the Effective Referral Requirement



Findings

After analyzing the interviews of eight Christian physicians it was very clear that tension did exist between their professional practice and religious beliefs in a variety of ways. It was evident that they were not always able to clearly identify whether the tension they felt was a result of their professional practice or religious beliefs. Despite this, tension between these two domains was quite evident throughout their responses. Participants attributed these tensions to the current Effective Referral Requirement legislation. Three main themes emerged following the analysis of the data: (1) religious identity takes priority over professional obligations related to MAiD; (2) religiously rooted non-compliance and professional obligations related to MAiD; and (3) alleviating tension through proposed alternatives to providing an Effective Referral.

Religious Identity Takes Priority over Professional Obligations Related to MAiD

The first theme was that although all the physicians within the study acknowledged that they had responsibilities as physicians, they indicated that they identified as Christian first and as a physician second. Therefore, should a situation arise within their professional practice which requires them to act in such a way that was not consistent with their faith, they would act in a way that was consistent with their faith and regardless of whether that aligned with their professional duty. Two sub-themes emerged as participants articulated this point. The first is that their religious beliefs guide their professional practice, including: (1) the Christian belief in the sanctity of life as a reason to oppose MAiD as a physician, (2) the Bible should be referenced when considering MAiD involvement, (3) only God has authority over life and death, (4) and there are consequences for those of Christian faith who support MAiD. The second is that Christian physicians are willing to leave professional practice if needed.

Religious Beliefs Guide Professional Practice

All eight of the participants identified that they aimed to ensure that the decisions they made within their professional practices were always reflective of their religious beliefs especially in relation to MAiD. One participant further described this when they stated, “I think my… my personal views are highly influenced by my own religious beliefs and trumped… trump my professional obligation in my stance [surrounding MAiD]” (P1). Another clearly stated, “And at the end of the day, I firmly believe that I am a person of faith first and a physician second” (P3). Another participant shared a similar sentiment with secular comparison in the following response:

> My Christian commitment informs my understanding of what my professional obligation ought to be. So, it's not so much that as a religious person I have a conflict between my religious beliefs and my professional obligations, and someone else who… a secular person doesn't live with that tension. It… rather we just have different understanding of professional obligations as a consequence of different underlying metaphysical and ethical concepts. (P6)

It was remarkably clear through discussion with all participants that when considering any professional action, their religious beliefs played a prominent role in the way they conducted themselves professionally. There were four specific religious beliefs that support his general theme of religious beliefs guiding professional practice; (1) Christian belief in sanctity of life as reason to oppose MAiD, (2) the Bible should be referenced when considering MAiD involvement, (3) only God has governing authority over life and death, and (4) there are divine consequences for those of Christian faith who support MAiD.

Christian Belief in the Sanctity of Life as Reason to Oppose MAiD.

This theme further speaks to the way religious beliefs were identified by participants to guide professional practice as a physician. More specifically it refers to the tension participants experienced because of limitations within their ability to perform professional duties related to MAiD because of their religious beliefs. As identified by all participants, a core religious belief they held was that all lives are sacred and holy which means all life should be protected as it has inherent value and worth. This is also referred to as the "sanctity of life argument".

One participant alluded to this when they stated, "From my Christian perspective, every life is extremely valuable, and MAiD does not account for that" (P7). Another participant expressed this more vividly in the following quote:

I think my primary motive here [to abstain from MAiD] is certainly faith based. I believe in the sanctity of life and that my role as a physician is to support health and wellness. (P5)

Participants expressed that this belief did not allow them to support or participate in the provision of MAiD. Although there were not a lot of explicit quotes where sanctity of life was directly referenced undertones of the sanctity of life argument were evident throughout. Therefore, I have elected to include this theme.

The Bible Should be Referenced when Considering MAiD Involvement.

Through discussion, all participants either provided direct reference to verses within the Bible they believed were relevant to MAiD or paraphrased and explained their interpretations of these pieces of scripture. More specifically they suggested that the Bible should be used as a tool to guide professional actions and support to their opposition to MAiD participation. One participant cited, "when it comes to MAiD...I think it's pretty clear from the biblical point of view, at least to me, that it's wrong" (P4). Another participant drew this point out further using additional Biblical references that they interpreted to oppose MAiD:

> I have been accused perhaps of being a little bit black and white, but to me do not kill, not murder, is very clear. One can talk about love your neighbor as yourself and see the loving thing to do as providing medical assistance in dying. But I feel like the ending of a life, that the scriptures teach us, is life is inherently valuable? Stamped with the image of the creator and that murder is disallowed. I feel like it's quite clear. So, to me, I don't see anything in scripture that would point me towards being involved in MAiD but rather the opposite. (P5).

When reviewing the scripture cited throughout the data, directly and indirectly, the verses that were referenced most frequently were Exodus 20:13 and Matthew 22:39. “Thou shalt not kill” (Exodus 20:13), was cited by eight of the nine participants in addition to “Love your neighbor as yourself” (Matthew 22:39), which was referenced by four of the eight participants. In most cases these verses were not cited directly rather paraphrased or inherently suggested.

Only God has Governing Authority over Life and Death.

In addition to providing Biblical references six of the eight participants explained that a core Christian belief is that only God can give and take away life and therefore within their professional practice they were not able to participate in MAiD. One participant alluded to this when they stated, “God numbers our days, not physicians” (P2). Additionally, another participant also suggested that physicians do not hold the authority to take away life:

> I don't believe that we have the authority to take it [life] away, neither for ourselves, nor for others. And I feel very strongly that is well detailed in the Bible, but to pull out verse and chapter that I haven't done yet. (P3)

One participant provided further insight, drawing connection between the Bible and the concept of God’s authority as it pertains to taking of life when they stated:

> I mean there's scriptures that say you know do not kill. That's one of the 10 commandments. There are scriptures that say, it's God speaking, saying it's up to me to decide when the end of your life is. I forget where that reference is now. Isaiah or Psalms? You know there's a sovereignty of God, which is obviously evident throughout scripture. He's the giver of life. Life is so precious. I mean he died for us to redeem us. I mean, he thinks it's [life is] pretty precious. (P4).

It was made very clear by all participants that because of their religious belief in the higher authority of God that participating in MAiD was not something they could do. One participant further stated, “I also don't think we have the right to play God necessarily and end someone's life” (P1). When exploring this same point with another participant the comparison of ending a life and extending a life through medical intervention was discussed. When asked whether using medical intervention to extend a life could also be considered “playing God” this participant’s response was:

> No, actually I don't think [providing medical intervention to extend a life is ‘playing God’] so because eating is a life sustaining measure, exercise is a life sustaining measure, the things that God gave us for pleasure and that God gave us for sustenance, you know to pursue those is not wrong. So, I don't believe that medical therapies that [aim to extend a life], I don't believe that's playing God. I believe that those are things that God has given us to live as fully as we can in the situation that the world is in. But actively ending a life, you know there are very clear ordinances on that in the Bible and that’s why I feel that's [MAiD is] morally wrong, but I don't feel that it's morally wrong to not to pursue a therapy that's available even if it would extend life. (P3).

There are Divine Consequences for those of Christian Faith who Support MAiD.

Not only did participants identify that because of their religious belief they believed that God has the ultimate authority over life, but six of the eight participants also identified that there are consequences for those of Christian faith who go against this authority and support MAiD. Through discussion participants clarified that because of the consequences associated with disregarding the authority of God, as long as they acted in such a way that was consistent with their religious beliefs, tension did not exist between themselves and their faith. However, there remained the potential for tension between themselves and their professional practice. One participant suggested that they feared they may not gain entrance to Heaven after death should they support MAiD, while another expressed the fear that they could be excommunicated from their church if they participated in the facilitation of MAiD without repentance:

> Right now, if I were to decide to be fine with that [MAiD], I don't think they [the church] would kick me out if I started practicing MAiD, I'd probably get, I would be under church discipline, I think. If I were to actually practice MAiD I would be under church discipline and probably be excommunicated if I didn't repent. (P8).

Another participant further described participation in MAiD as sinful in the following quote:

> Taking of life, intentional taking of life is a pretty fundamental for lack of a better word, a sin or wrongdoing, I think it's pretty fundamental and you'd either have to deny the infallibility of the word of God or come right against the traditional teaching of the church, which people do but I don't see it for myself. (P4)

Although participants identified that they did not explicitly experience tension so long as they abided by their religious beliefs, an underlying tension appeared to be evident with respect to avoiding divine consequence for participating in MAiD.

Christian Physicians are Willing to Leave Professional Practice if Needed

As previously identified, all eight participants expressed that they felt tension because of the current Effective Referral Requirement, to which they further indicated that they had not and would not provide an Effective Referral despite legal requirement. Of these eight participants five identified that they prioritized their faith so much so that they would leave their practice as a physician in Ontario or all together if it was the only way to abstain from participation in MAiD. One participant highlighted this when they said they "became a physician to glorify God and to serve him. And if my license is gone here [in Ontario] then I trust that God has somewhere else for me to work and if not, that will be okay too" (P8). Another participant shared a similar sentiment when they stated:

> I don't feel like I question my faith I feel like I question my ability to be a physician in this role as a Christian with my beliefs. For me it's not a faith question, it's a profession question and the rope would break on the profession side, not on the faith. (P3).

All eight participants expressed deeply that they hoped the current Effective Referral Requirement in Ontario would change in such a way that they would no longer be legally required to provide referrals for MAiD. Tension was undoubtedly evident in respect to their fear of professional reprimand for their past choices not to adhere to this policy so much so that as you can see, by the quotes presented, they have considered leaving their practice as a last resort.

Religiously Rooted Non-Compliance and Professional Obligations Related to MAiD

There are two ways that participants identified feeling tension related to their choice not to comply with the current Effective Referral Requirement: (1) tensions as a result of current Effective Referral Requirement and non-compliance, and (2) tension while navigating the Effective Referral Requirement and meeting patient needs. Both of these tensions were deeply rooted in their religious beliefs but the way these tensions are felt differs. The first tension existed between the participants and the policy specifically whereas the second is more

interpersonal in nature, which they described as existing between themselves and their patients. These differences will be drawn out further in the following sections.

Tensions as a Result of Current Effective Referral Requirement and Non-Compliance.

All eight participants expressed that they felt tension as a result of the current Effective Referral Requirement, indicating that they had not and would not provide an effective referral despite legal requirement[1]. This tension was largely as a result of their belief in the sanctity of life. One physician stated, “I'm willing to give them [the patients] the information of how they can access that [MAiD] if that's something they choose to access, but I'm not going to directly facilitate it through referral” (P2). Another physician more directly noted, “I think legally we are responsible for that [providing an effective referral] now according to government but that’s something I just won’t do” (P1).

A more nuanced point made by one of the participants was related specifically to the semantics of the current Effective Referral Requirement. More specifically referencing the historical significance of a medical referral which will be further described in the quote below:

> I think that the policy is poorly worded. Poorly described. Completely unnecessary. Driven by an agenda. College agenda. And completely out of keeping with historical standard of practice in this province. The effective referral language needs to be dropped because the whole historic precedent of how it started is very clearly not tolerant of conscience and historically a referral in medical terms is an endorsement of a service, but you don't make a referral if you think it’s [the procedure or service being requested] bad. (P4).

[1] Current policy requires physicians unable to facilitate MAiD due to conscientious objection, practicing in the province of Ontario, to provide a referral to a non-objecting physician who can accommodate the patient’s request (CPSO, 2015)

According to this physician providing an effective referral implied endorsement which ultimately is making the statement that the physician providing the referral believed that the patient would benefit from accessing MAiD. For instance, one participant elaborated, “I'm justified in denying my patients request [for MAiD] because I do not feel they will be benefited by acquiescing to it [MAiD]. So, I do not feel like [providing an effective referral is] actually my professional responsibility” (P5). Another participant echoed this when they said, “a medical referral should never be done for something that one thinks is unethical, ever under any circumstances” (P7).

Due to this non-compliance with the Effective Referral Requirement many participants expressed that they feared professional reprimand or job loss as expressed in the following quote:

> As a Christian physician I do worry about both getting in trouble with the college and having my license taken away from me because of my conscience. I hope that they won't discipline any conscientious objectors but all it takes is them wanting to make a scapegoat of someone like someone getting on the wrong side of the CPSO and I don't doubt they'll do it [reprimand a physician]. (P2).

Another physician said, “I always keep [losing my job] in the background as a possibility. I would say I am not fearful to the extent that it dominates my mind, but I never discount the possibility that things may change such that I can't retain my position” (P6). Similarly, another physician referenced job loss when they said, “There's always a tension because of the college’s position [on MAiD and effective referrals], you wonder, will this be the thing that means I don't have a license anymore?” (P5).

Tension while navigating the Effective Referral Requirement and meeting patient needs

All participants went one step further to say that not only do they feel tension because of their non-compliance but they also feel tension as a result of the professional obligations they felt they had to their patients. All participants identified that they felt tension as they navigated the Effective Referral Requirement with patients due to their desire to fulfill all patients' needs and requests while also adhering to their religious beliefs. Tensions arose when the requests of patients differed from the religious beliefs held by the physician. Participants identified several reasons why navigating the Effective Referral Requirement with patients has resulted in tension which will be explained in the following two sub-themes: (1) objecting to MAiD but not abandoning patients and (2) tension between physician belief and patient autonomy.

Objecting to MAiD but not abandoning patients.

Six of the eight participants identified that they fear they will be labelled as "abandoning" their patients for exercising their objection to both MAiD and the Effective Referral Requirement. Tension was said to be evident as they attempted to find ways to provide their patients' some form of service connection for MAiD despite their desire to completely abstain from involvement with MAiD. More specifically, one of the participants identified that they felt that they did not have the right to block their patients' access to MAiD and owed them some level of direct involvement to ensure they were connected with the services they desired. This, of course, resulted in tension as the actions required to support their patients in their pursuit of MAiD, such as directly facilitating MAiD or providing an effective referral, are actions that the physician morally objected to. This tension is evident in the following participant quote: "from a professional perspective, I never want to be accused of [abandoning patients], so it's the question of how do I, with care and compassion, also stick to my morals" (P2). Another participant presented with additional uncertainty on how to manage the tension associated with receiving a

request for MAiD/providing an effective referral when they stated, “I want to be sure that I was being fair to my patients and not abrogating my responsibility towards them, but that and I was being obedient to God's word” (P3). One participant provided insight into the way in which they have navigated this tension:

> [After receiving a request for MAiD] I wanted to be sure that I wasn't abrogating my responsibility [to the patient] and so that's why to me giving them the telephone number [to telehealth] was morally okay because telehealth is a general service you can call and ask about your child’s fever, you can call and say whatever, or you can call and say, hey I want MAiD. And then they would connect you with the MAiD telephone service. So, to me, because it was hands…at arm's length. I felt it was morally okay. (P4).

It was strikingly evident among the physicians who participated in the study that although they all shared similar positions on MAiD, which they attributed to their faith, their professional comfort levels varied significantly. They did not identify a uniform way of addressing this tension.

Tension between physician belief and patient autonomy.

Although participants expressed concerns that they would be viewed as abandoning their patients as a result of their objection to MAiD involvement, they identified that a larger concern of theirs was that patients may choose to access MAiD despite their [the physician’s] belief that this is wrong. All the participants within the study acknowledged that patients still had the right to autonomy. By this they meant that patients had the right to make their own personal health care decisions pertaining to the medical interventions they received. This resulted in tension for physicians when their values and beliefs about the best medical intervention differed from the beliefs held by the patient. In this case, this difference may lead the patient to choose to continue

to pursue MAiD. In response to this tension one physician noted, “We can only give people advice and the treatment we think that would be the best thing for them based on what we know, and they have to make the choice whether to act on that. We have to allow the patient to make that decision” (P8). Another also stated, “I may not agree with my patient’s choice to pursue MAiD, but I recognize the fact that people have free choice” (P2). These participants clearly identified that despite their personal opposition to MAiD patients may still choose to support MAiD and the physician’s role in this situation is to have utilized their professional knowledge and expertise to assist patients to make their decisions. The tension in this situation may have been overt in nature when discussing medical options with patients but it was also suggested by participants that this tension was more often felt internally as the physician grappled with the possibility that despite advice or information provided, that patient may still choose to access MAiD.

Alleviating Tension through Proposed Alternatives to Providing an Effective Referral

The third and final theme that arose following analysis of the data was that all eight participants felt that the Effective Referral Requirement was unnecessary, following which they identified other ways in which people could access MAiD that did not require an effective referral or direct involvement from a conscientious objector. One of the participants clearly identified this when they stated that “there's always a tension because of the college’s position [on MAiD and effective referrals]. There are definitely ways around this that doesn’t [sic] need to directly involve us [conscientious objectors]” (P8)

There were two common alternatives to the current Effective Referral Requirement suggested: (1) implementation of a self-referral system and (2) providing information or a phone number instead of an effective referral. Participants further expressed that should either of these

alternatives come to fruition that it would help alleviate a significant amount of tension they have felt in their current practice.

Implementation of a Self-Referral System Would Alleviate Tension

Five of the eight participants expressed that a self-referral system would alleviate a significant amount of tension among physicians who contentiously object to MAiD. They identified that they did not feel that the current Effective Referral Requirement allowed for them to fully exercise their right to contentiously object whereas a self-referral system would better accommodate this right. One participant stated that:

> Implementation of a self-referral system would show that there's… there's ways around providing an effective referral, and I would like to see the college acknowledge that and say, hey we're about protecting patient's rights, but we also recognize that physicians have rights to conscience. (P2).

More specifically, one participant suggested that the self-referral system should be modeled similarly to the process to access abortion in the following quote:

> It would be very easy for organizations like Dying with Dignity, or the people who practice euthanasia to advertise, to have specific clinics. You know, just like the abortion clinics all over the province. Where people can self-refer and be assessed for abortion without requiring effective referral. A self-referral mechanism would be very easy to run and would adequately accommodate the concerns [regarding access and physician rights]. (P6).

Although not all participants specifically referenced the implementation of a Self-Referral System, they all offered some form of alternative to the current Effective Referral

Requirement and did not strictly suggest the policy be removed without providing other means for patients to access MAiD.

Providing Information or a Phone Number instead of an Effective Referral

Of the eight participants interviewed seven of them indicated that instead of providing an effective referral they would be willing to provide patients wishing to access MAiD with information regarding the process or a phone number they could call to explore the process further. Some expressed this with great certainty as they have already opted for this alternative instead of providing an effective referral as one participant stated, “I'm willing to give them [patients] the information of how they can access that [MAiD] if that's something they choose to access, but I'm absolutely not going to and have not directly facilitated it through referral” (P2). Some were more hesitant stating they felt they would be making a moral compromise by providing information or a phone number to patients as the following participant stated:

“I guess in my mind giving people information about how they could access something [MAiD] without me writing a letter I can…I can kind of come to terms with that but deep within my core it… it still makes me feel rather uncomfortable. I feel like I’m still kind of compromising my morals to do that though” (P8).

Although several alternatives were proposed by all participants there did not appear to be one uniform solution that all participants agreed would adequately address their desire to be relinquished entirely from involvement with MAiD while also ensuring adequate access for patients.

Discussion and Implications

The aim of this study was to gain a better understanding of how Christian physicians in Ontario understand the tension they feel while considering MAiD and more specifically as they

navigate the Effective Referral Requirement in Ontario. Following review of the findings it was evident that tension clearly exists and is felt by Christian physicians in a variety of ways. More specifically I identified three major areas of tension: (1) religious identity takes priority over professional obligations related to MAiD, (2) religiously rooted non-compliance and professional obligations related to MAiD, and (3) alleviating tension through proposed alternatives to providing an effective referral.

In this discussion I would like to further consider four things: (1) implications of my findings for the literature on MAiD and Christianity, (2) the potential implications of my findings for MAiD/ the Effective Referral Requirement, (3) the role for social work and the Effective Referral Requirement, and (4) the implications for current and future practice as a physician.

Implications for the Literature

First and foremost, I am not aware of any studies that specifically explored the topic of MAiD and conscientious objection in Ontario while also working to gain a better understanding of the tensions felt by Christian physicians. Most of the studies reviewed did not explicitly explore policy implications but instead highlighted support and opposition for MAiD more generally. Despite this, following review of the data it does appear that this study contributes more broadly to the literature about Christian attitudes towards MAiD and the complexity of the issue of conscientious objection.

Although some scholars such as Paul Badham (1995) and Harry Kuitert (1993) suggested a Christian case for supporting MAiD in their publications all eight participants in this study presented responses that were more consistent with Englehardt (1998), Kaczor (1998), and Delkeskamp-Hayes (2003), all of whom expressed disapproval towards MAiD and its previous

counterparts such as euthanasia and physician assisted suicide. More specifically the participants in this study proposed several identical arguments for their opposition to those presented by the above-named scholars. Firstly, similar to Englehardt (1998), six of the eight participants also identified that their opposition to MAiD is largely because they believe that only God has governing authority over life and death. Secondly, although all participants were united in opposition to MAiD, the reasons they provided were all slightly unique which supports Kaczor's (1998) statement that there is no single unified view on this topic among those of Christian faith aside from their shared oppositional stances to MAiD. Most participants clearly identified that they do not support MAiD and why, and although generally they shared a similar view surrounding MAiD and the provision of effective referrals their justifications and comfort levels varied significantly. Lastly, participants expressed many concerns regarding current policy surrounding MAiD and effective referrals. Delkeskamp-Hayes' (2003) proposed that by increasing accessibility of palliative care resources that the demand for physician assisted suicide might decrease. This same antidote was also mentioned many times by participants of this study but in respect to decreasing requests for MAiD which in turn would lessen the demand for effective referrals from those who conscientiously object to MAiD. Participants of this study identified that although they would prefer MAiD not to be legal, they respect their patient's right to choose MAiD should they wish. In supporting their patient's right to choose MAiD, they clarify that this should not be confused for supporting MAiD but, similar to Delkeskamp-Hayes, they have adopted an attitude of permissiveness in order to cope with an act they do not agree with morally.

Furthermore, many similarities may be drawn between the findings of my study and the work of Christie, Sloan, Dahlgren, & Koning (2016). Their publication identifies that there are

many factors and considerations involved in asserting a conscientious objection to MAiD. Their study also identified that simply asserting a conscientious objection does not acknowledge the possible conflicting duties within the persona of the conscientious objector. What is meant by this is that expressing one's desire to conscientiously object is not simply saying no, it is a very complex internal moral debate. The conscientious objector must weigh the consequences associated with their decision and how it may affect their patients. Accordingly, all of the participants in the study identified some degree of internal conflict with respect to remain consistent with their faith, their fear of job loss, and their desire to adequately provide care to their patients. If anything, this study serves as additional support to Christie et al. (2016) but also suggests that there may be more than two competing duties. Both of these studies have still yet to address whether one duty may hold priority and should be respected. This was briefly explored as several participants in my study suggested that they feel the current Effective Referral Requirement clearly prioritizes patients and does not give equal consideration for their right to freedom of religion. Future research might give more consideration to this latter point.

Implications for Policy

Something that was quite interesting following review of the data is that although all the participants advocated that the Effective Referral Requirement should be removed, they all offered alternative solutions that they identified would adequately relieve some or all of the tension they felt as a result of this policy. None of the physicians expressed the desire to completely block patient access to MAiD and recognized that should the Effective Referral Requirement be removed something would have to replace it to ensure patient access to MAiD. More importantly, I would like to give consideration to these proposed alternatives and the ways they could be beneficial to policy as well as the limitations they may have.

The two most prominent proposed alternatives that physicians offered to replace the current Effective Referral Requirement were: (1) the creation of a self-referral system and (2) changing the requirement from providing a referral to providing information or a telephone number for patients to call. Although these two alternatives ultimately aim to achieve the same goal, less physician involvement while ensuring access to MAiD for those who wish to access it, they are strikingly different from one another and should be considering individually. My goal in the following section is to consider briefly what the implementation of each of these alternatives may look like as well as the pros and cons to utilizing each.

Five of the eight participants suggested the implementation of a self-referral system to replace the Effective Referral Requirement in Ontario. Hypothesizing what this may look like however is unnecessary as the option for self-referral already exists in Ontario. In 2017, the Ministry of Health and Long-Term Care launched the Care Coordination Service (CCS) which aims to "help patients and clinicians access information and supports for medical assistance in dying and other end-of-life options" (Weiss, 2017). When a patient phones the CCS, they can connect them with a physician who can complete an eligibility assessment and MAiD, should they meet the criteria. One participant demonstrated that they were aware of this self-referral system and identified that they anticipate issues may arise should this system no longer be available.

When considering the position of those who conscientiously object it does seem evident that they could find themselves in a rather precarious position should the provincial government no longer fund the CCS and default to ensuring access to MAiD solely through the Effective Referral Requirement. An argument could also be made that with the CCS fully operational the Effective Referral Requirement is ultimately unnecessary. It appears unclear why the Effective

Referral Requirement remains with such a system in place that facilitates access to MAiD without the involvement of a conscientious objector. However, consideration should also be given to those wishing to access MAiD and how they may be affected; eliminating the Effective Referral Requirement may not have an immediate negative effect but should this policy no longer exist, and funding be removed from the CCS, eliminating the self-referral system as well, patients could be left in a vulnerable position, unable to easily access MAiD with no legal framework to protect their right to access MAiD. Without the Effective Referral Requirement and the self-referral system it could be very difficult for patients to access MAiD if their physician conscientiously objects to MAiD and does not have any legal obligation to assist with system navigation or service connection.

With only one participant referencing the current self-referral system available through the CCS it is unclear whether the other seven participants were unaware that this service exists or whether they may have reservations about providing this information to their patients. The phone number for the CCS is publicly available and easily accessed. One might wonder whether these physicians did mention the self-referral system currently available through the CCS as they feel providing that information still constitutes as involvement with MAiD. Following review of the CCS self-referral process it appears this option facilitates an opportunity for very little involvement on the part of the conscientious objector. Some responsibility should be taken by myself, the researcher, as I was unaware of the current self-referral system as well and had I know about it I could have explored this more explicitly in the interviews. Based on other participants quotes that expressed discomfort with providing patients with MAiD information this could be a possibility which brings us to the next proposed alternative.

As identified in the findings, seven of the eight participants suggested that they would be willing to provide a patient wishing to access MAiD a phone number to call for more information instead of providing an effective referral. Most were confident in this response whereas some were hesitant. Those that were hesitant indicated that although it would be more desirable than providing an effective referral that they would still feel some degree of discomfort. Some participants clearly identified that they felt that providing a phone number to a patient still constituted as involvement with MAiD whereas the other six felt that they were removed enough from the process that providing a phone number would be morally okay. Providing a phone number may feel further removed from the MAiD process and this could be why they feel it is moral okay versus providing a referral. Semantics aside, following the provision of a referral a patient still may not qualify for the MAiD process or may choose not to continue on with the process after receiving all of the information so in that sense providing a phone number or providing a referral could arguably be seen as similar.

This point raises the question as to whether eliminating the Effective Referral Requirement as suggested by all eight participants, would adequately address the tensions they feel as there was no unanimously agreed upon alternative. Also evident is that although all eight participants did not support MAiD, they had varying comfort levels pertaining to their level of involvement. More specifically their definitions of what constitutes involvement varied. Given that only one participant expressed discomfort with providing a phone number it is unclear whether there is a significant demographic difference that sets them apart. Exploring this further may provide further insight into why comfort levels, as they pertain to MAiD involvement, may vary among those who do not support MAiD. Within this study all participants belonged to

different denominations so additional comparisons could not be drawn from that, but future considerations could be given to denominational differences.

This study did not bring to light an ideal solution to alleviate tension for Christian Physicians practicing in Ontario. However, it was clear that participants were unhappy with the current Effective Referral Requirement and did not feel that it adequately protects their religious freedoms. Consideration should be given to whether the Effective Referral Requirement is achieving what it was set out to achieve. All eight participants disclosed that they have not ever provided an effective referral and are not willing to provide any moving forward. Although the intent of this policy is to ensure that patients have access to MAiD it may not be achieving this if those who conscientiously object are not willing to provide a referral. If the policy were utilized as intended patient access would not be a concern; however, an argument could be made that it does not adequately accommodate religious freedoms as it still requires some involvement on the part of the conscientious objector. Is the current Effective Referral Requirement favoring patients? The policy intent is to provide distance between MAiD and those who conscientiously object. Participants identified that they do not feel this policy adequately achieves this for two reasons: (1) some participants identified providing an effective referral as indirect involvement, and (2) others viewed providing an effective referral as endorsement for MAiD. The reason they feel it is endorsement is because, as previously stated, historically a medical referral means that the physician providing the referral thinks that the patient would benefit from a specific serve and therefore is referring them onward to receive that service. One may argue that this could be an easy fix, a simple semantic revision of the policy by removing the word referral given its historical medical meaning of endorsement. If revision was made to the policy wording but the policy still required some form of action from a conscientious objector, it may still be viewed as

indirect involvement which in turn would not address all stakeholder concerns. There does not appear to be an obvious solution to ensure all policy stakeholders feel that their rights and freedoms are adequately accommodated.

A role for social work and the Effective Referral Requirement

Although at first glance a direct role for social work may not appear evident when considering the tensions felt by Christian physicians and the Effective Referral Requirement there does seem to be a continued need for social work involvement. Social work is well known for providing advocacy and support for those who may find themselves in vulnerable situations. In the case of not only Christian physicians but their patients as well, the Effective Referral Requirement seems to have put them both in places of vulnerability. As expressed by the Christian physicians who participated in this study, they feel significant tension as a result of the Effective Referral Requirement and the associated expectations to participate in the provision of MAiD even if in an indirect way. In conducting this research, it was not only my goal to fulfill the requirements for my Masters of Social Work thesis but it was my hope to advocate for further policy analysis. My strategy was to provide a platform for Christian physicians to further explore the tensions they feel and share their insights with others who may not otherwise take the time to acquire a more thorough understanding of the nuances associated with the tensions they feel. With this being said, Christian physicians are not the only individuals who may be negatively impacted by the Effective Referral Requirement.

Strong consideration should also be given to how patients are being impacted by both the policy as well as how they are being affected by policy non-compliance. Advocating for unheard voices such as patients wishing to access MAiD is definitely an area where social work could assist. Although this study did not directly explore the ways in which patient’s feel MAiD access

could be improved it did shed light on holes that exist despite the Effective Referral Requirement due to physicians unwilling to provide a referral regardless of legal requirement to do so. Social work may not always have a direct role in the MAiD process but advocating for policy change and vulnerable populations is a way in which social work can and should continue to be involved with MAiD and the current Effective Referral Requirement. Perhaps some of the challenges proposed by the participants within in this study could also be experienced by social work due to the fact that historically there is strong Christian representation within the field of social work (Hodge, 2002). Taking this into considerations, the role for social work may complicated by faith similarly to the tensions expressed by the participants of this study as the navigate their roles in relation to the Effective Referral Requirement in Ontario.

Implications for Current and Future Practice as a Physician

Following review of the data it is evident that tension exists surrounding the Effective Referral Requirement and how it may affect future practice. Five participants indicated that they feel so strongly about abstaining from any MAiD involvement that they are willing to leave the profession if that was the only way they could do so. Given that this is a significant concern for Christian Physicians already practicing one may wonder whether this is also a concern for those currently studying to become a physician or those considering the profession. One could argue that due diligence should be given on behalf of all schools of medicine to ensure any physician considering working in end-of-life care is aware of the possibility of encountering bioethical issues such as MAiD provision. There are other professions within the field of medicine that require similar skill sets that are not legally required to have any MAiD involvement direct or indirect. Future research might consider examining how much consideration is given by those

who conscientiously object to MAiD prior to beginning their academic journey now knowing that a legal requirement of physicians in Ontario is to provide an effective referral.

With that being said there appear to be many fields of medicine that would likely have very minimal involvement with the MAiD process and therefore providing an effective referral would rarely be required. There does remain the possibility to receive a request in any field, but some specialties may be further removed from this process. Additionally, an unwillingness to provide an effective referral despite legal requirement is blocking patient access and disregarding a patient's right to autonomous choice. If one's skills set appears to be best matched to work in end-of-life care and they conscientiously object to MAiD careful consideration should be given on behalf of the physician to patient rights, autonomy, and how they might navigate these situations to ensure adequate continuity of care.

Limitations

Several limitations were evident within this study that are important to make note of. The first and arguably most prominent limitation was that this study was conducted during the COVID-19 pandemic and several modifications had to be made to remain consistent with COVID-19 restriction protocol. Unfortunately, interviews were not able to be conducted in-person and were conducted over the phone or Zoom audio. In some cases, some context or additional emphasis may have been lost given that non-verbal cues or gestures could not be observed by the interviewer. Secondly, there were some limitations evident more specifically related to the sample of participants. The sample size for this study was relatively small and all gathered from within a single organization that does not support MAiD. The sample size may have also been negatively affected by the COVID-19 pandemic given the significant strain COVID-19 put on the medical system, possibly limiting physician availability to participate in

this study. That brings us to the third and final limitation I would like to address: sample diversity. Although the sample was relatively diverse in several categories such as age, field of practice, and Christian denomination there remained room for additional diversity more specifically related to the participants stance on MAiD. All participants of this study clearly expressed that they do not support MAiD. Hearing responses from Christian physicians who are more lenient or in support of MAiD may have provided a more robust understanding of the different ways the Effective Referral Requirement has been received and navigated by Christian physicians.

Conclusion

This study began by revising the events leading up to the legalization of MAiD and the many differing views presented by Christian scholars. Although the literature is predominantly saturated with views in opposition to MAiD some Christian arguments remained in support of it. Considerations were also given to the bioethical issues such as suicide, abortion, and stem cell research in relation to how they were received by those of Christian faith. It seems similar arguments and justifications have also been mapped onto discussions surrounding MAiD both in the literature and by participants within this study.

Following review of the findings it appears evident that Christian physicians do feel tension surrounding MAiD. It is my hope that this research may inspire other students and academics to continue to look more closely at MAiD policy, more specifically the Effective Referral Requirement and its implications for service providers as well as services users. Balancing one's right to conscience and a patient's right to access is very complex. It is important that all effort is given to ensure neither are intentionally nor unintentionally compromised as a result of policy. Current policy appears to ensure patient right to access and

yet following review of participant responses, it is also evident that some tension is felt by participants related to the level of involvement still required by conscientious objectors outlined within the Effective Referral Requirement.

This research also explored several alternatives proposed by participants and how these alternatives may or may not adequately address the tension felt by those who conscientiously object to MAiD. No finite solution was identified and that was not the purpose. The purpose was to dive deeper and gain a better understanding of how Christian Physicians understand the tension between their professional and religious obligations when considering MAiD, to which I think it has done. In doing so, it is my hope that it may provide additional insights that may assist in formulating future policy that meets the needs of all stakeholders given the ambiguous relationship that exists between faith and reason.

References

Allum, N., Allansdottir, A., Gaskell, G., Hampel, J., Jackson, J., Moldovan, A., ... & Stoneman, P. (2017). Religion and the public ethics of stem-cell research: attitudes in Europe, Canada and the United States. *PloS one*, *12*(4), e0176274.

Badham, P. (1995). Should Christians accept the validity of voluntary euthanasia?. *Studies in Christian ethics*, *8*(2), 1-12.

Bereza, E. (1994). The private and public deaths of Sue Rodriguez. *McGill LJ*, *39*, 719.

Bible, H. New International Version. (1984). International Bible Society. *All Rights Reserved. Grand Rapids: Zondervan Publishing House*.

Bill C-7: *An Act to Amend the Criminal Code (Medical Assistance in Dying).* (2021). Royal Assent March 17th, 2021, 43rd Parliament, 2nd Session. Retrieved from the Parliament of Canada website: https://parl.ca/DocumentViewer/en/43-2/bill/C-7/royal-assent

Bill C-14: *Medical Assistance in Dying.* (2016). 3rd Reading May 31, 2016, 42nd Parliament, 1st Session. Retrieved from the Parliament of Canada website: https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/third-reading

Bradshaw, C., Atkinson, S., & Doody, O. (2017). Employing a qualitative description approach in health care research. Global qualitative nursing research, 4, 2333393617742282.

Brody, H. (1995). Physician-Assisted Suicide: Family Issues. *Michigan Family Review*, *1*(1).

Carpenter, T., & Vivas, L. (2020). Ethical arguments against coercing provider participation in MAiD (medical assistance in dying) in Ontario, Canada. *BMC Medical Ethics*, *21*(1), 1-5.

Clarke, V., Braun, V., & Hayfield, N. (2015). Thematic analysis. *Qualitative psychology: A practical guide to research methods*, *222*, 248.

Compassion in Dying *v.* State of Washington, 49 F.3d 586 (9th Cir. 1995).

Cooley, D. R. (2020). Was Jesus an assisted suicide?. *Ethics, medicine and public health*, *14*, 100514.

Cherry, M. J. (2018). Physician-assisted suicide and voluntary euthanasia: How not to die as a Christian.

Christian medical & (and) dental society. (1993) Ethical statement: Physician-assisted suicide Issues in Law & Medicine, 8(4), 553-554.

Christie, T., Sloan, J., Dahlgren, D., & Koning, F. (2016). Medical assistance in dying in Canada: an ethical analysis of conscientious and religious objections. *BioéthiqueOnline*, *5*.

CPSO. (2015, March 1). *Professional obligations and human rights*. Retrieved March 25, 2022, from https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Professional-Obligations-and-Human-Rights

Delkeskamp-Hayes, C. (2003). Euthanasia, Physician Assisted Suicide, and Christianity's Positive Relationship to the World. *Christian bioethics*, *9*(2), 163-185.

De Villiers, E. (2002). Euthanasia and assisted suicide: A Christian ethical perspective. *Acta Theologica*, *2002*(Supplement 3), 35-47.

Dumsay, T. (2021). *Assisted Suicide in Canada: Moral, Legal, and Policy Considerations*. UBC Press.

Engelhardt, H. T. (1998). Physician-assisted suicide reconsidered: dying as a Christian in a post-Christian age. *Christian bioethics*, *4*(2), 143-167.

Giner, L., Jaussent, I., Olie, E., Beziat, S., Guillaume, S., Baca-Garcia, E., ... & Courtet, P. (2014). Violent and serious suicide attempters: one step closer to suicide?. *The Journal of clinical psychiatry*, *75*(3), 22230.

Hensman, R. (2020). Christianity and Abortion Rights. *Feminist Dissent*, (5), 155-182.

Hodge, D. R. (2002). Does social work oppress evangelical Christians? A "new class" analysis of society and social work. *Social Work*, *47*(4), 401-414.

Hobbins *v.* Attorney General, 518 N.W.2d 487, 205 Mich. App. 194 (Ct. App. 1994).

Hunter, D., McCallum, J., & Howes, D. (2019). Defining exploratory-descriptive qualitative (EDQ) research and considering its application to healthcare. *Journal of Nursing and Health Care*, *4*(1).

Hurlbut, W. B. (2006). Science, religion, and the politics of stem cells. *social research*, 819-834.

Inge, W. R., (1909). Some Moral Aspects of Eugenics*, Eugenics Review,* 1(1), 26–36.

Jackson, E., & Keown, J. (2011). *Debating euthanasia*. Bloomsbury Publishing.

Jones, D. A. (2016). Apostles of suicide: Theological precedent for Christian support of 'assisted dying'. *Studies in Christian Ethics*, *29*(3), 331-338.

Jones, M. S., & Molinari Jr, J. B. (2018). Christianity, Epistemic Peer Disagreement, and the Abortion Debate. *Journal for the Study of Religions and Ideologies*, *17*(49), 32-45.

Kaczor, C. (1998). Faith and reason and physician-assisted suicide. *Christian bioethics*, *4*(2), 183-201.

Kuitert, H. M. (1993). Mag er een eind komen aan het bittere einde. *Baarn: Ten Have*.

Lamb, C. (2016). Conscientious objection: Understanding the right of conscience in health and healthcare practice. *The New Bioethics*, *22*(1), 33-44.

Leabu, M. (2012). Christianity and bioethics. Seeking arguments for stem cell research in Genesis. *Journal for the Study of Religions and Ideologies*, *11*(31), 72-87.

McKenzie, D. (2004). Church, state, and physician-assisted suicide. *J. Church & St.*, *46*, 787.

Meilaender, G., (1996). Bioethics: A primer for Christians. Cambridge, MI: William B.

Moskos, C. C., & Chambers II, J. W. (Eds.). (1993). *The new conscientious objection: from sacred to secular resistance*. Oxford University Press.

O'Mathuna, D. P., & Amundsen, D. W. (1998). Historical and Biblical references in physician-assisted suicide court opinions. *Notre Dame JL Ethics & Pub. Pol'y*, *12*, 473.

Patton, M. Q. (2014). *Qualitative research & evaluation methods: Integrating theory and practice*. Sage publications.

People *v.* Kevorkian, 639 N.W.2d 291, 248 Mich. App. 373 (Ct. App. 1999).

Pullman, D. (2020). In a Familiar Voice: The Dominant Role of Women in Shaping Canadian Policy on Medical Assistance in Dying. *Canadian Journal of Bioethics/Revue canadienne de bioéthique*, *3*(3), 11-20.

Rodriguez *v.* British Columbia (Attorney General), [1993] 3 S.C.R. 519

Smith, A. T. T., (2010). Faith, science and the political imagination: moderate Republicans and the politics of embryonic stem cell research. *The Sociological Review*, *58*(4), 623-637.

Stedman, T. L. (Ed.). (2005). *Stedman's medical dictionary for the health professions and nursing*. Lippincott Williams & Wilkins.

Stettner, S., & Douville, B. (2016). “In the Image and Likeness of God”: Christianity and Public Opinion on Abortion in The Globe and Mail during the 1960s. *Journal of Canadian Studies*, *50*(1), 179-213.

Weiss, E. (2017) *Room for improvement in Ontario's Maid Care Coordination Service*. Healthy Debate. Retrieved March 25, 2022, from https://healthydebate.ca/2017/08/topic/medical-assistance-in-dying/

Young, R. (2013). 'Debating the Morality and Legality of Medically Assisted Dying'. Critical Notice of Emily Jackson and John Keown, Debating Euthanasia. Oxford: Hart Publishing, 2012. *Criminal Law and Philosophy*, *7*(1), 151-160.

Appendix

Appendix A

955 Oliver Road
Thunder Bay, ON, P7B 5E1
School of Social Work

INTERVIEW QUESTIONS

Research Question: How do Christian Physicians in Ontario understand the tension between their professional and religious obligations when considering MAiD?

Introductory Questions

1. What denomination of Christianity do you belong to?
2. Does your denomination support MAiD?
3. What is your position on MAiD?
4. Why is this your stance/position?
5. Have you ever received a request for MAiD?
6. Have you ever exercised your right to contentiously object?

Tensions Related to Professional Obligations

7. Are there any aspects of your role as physician that are more challenging as a result of your position on MAiD?
8. Can you think of a situation in your professional environment where you felt tension? (Pulled in one direction in leu of your professional values and pulled in another direction in leu of your religious values?)
9. Have you ever been in conflict with another physician or health care professional regarding a MAiD referral?
10. Do you feel that the effective referral policy adequately protects you as a Christian physician and your right to conscientiously object?

11. Do you feel that there are any policy changes that could be made that would both protect your right to conscientiously object as well as ensure continuity of care for those wishing to access MAiD?
12. Is there a specific situation in which you would support MAiD despite your position on MAiD?

Tensions Related to Religious Obligations

13. Is your position on MAiD something you have openly disclosed or shared with members of your religious community?
14. Did you consult within another member of your religious community when defining your position on MAiD?
15. Have you ever experienced tension or discrimination within your religious community related to your position on MAiD?
16. Did you experience any moral tension or faith questioning when defining your stance surrounding MAiD?
17. Is there anything within your religious understanding or interpretation that would permit you to support MAiD?

Final question

18. Do you ever experience tension between your religious position on MAiD and your professional position on MAiD?

Thank you for taking the time today to meet with me and answer these questions.

- Are there any other Christian physicians that you know that may be interested in participating in this study?
    - If so, how would they prefer to be contacted?
    - If you do not feel comfortable sharing their contact information you are welcome to share this information letter along with the graduate student researcher, contact information for them to inquire.

Appendix B

Research Ethics Board
t: (807) 343-8283
research@lakeheadu.ca

April 15, 2021

Principal Investigator: Dr. Ravi Gokani
Co-Investigator: Ms. Mackenzie Street
Health and Behavioural Sciences\School of Social Work
Lakehead University

Dear Dr. Gokani and Mackenzie:

Re: Romeo File No: 1468549
Granting Agency: N/A
Agency Reference #: N/A

On behalf of the Research Ethics Board, I am pleased to grant ethical approval to your research project titled, "Ambiguity of Faith and Reason: Exploring the Challenges of Conscientious Objection and the Provision of Effective Referrals for Medical Assistance in Dying among Christian Physicians in Ontario".

Ethics approval is valid until April 15, 2022. Please submit a Request for Renewal to the Office of Research Services via the Romeo Research Portal by March 15, 2022 if your research involving human participants will continue for longer than one year. A Final Report must be submitted promptly upon completion of the project. Access the Romeo Research Portal by logging into myInfo at:

https://erpwp.lakeheadu.ca/

During the course of the study, any modifications to the protocol or forms must not be initiated without prior written approval from the REB. You must promptly notify the REB of any adverse events that may occur.

Best wishes for a successful research project.

Sincerely,

Dr. Kristin Burnett
Chair, Research Ethics Board

/sw

955 Oliver Road, Thunder Bay, ON, Canada, P7B 5E1 | lakeheadu.ca

Appendix C

955 Oliver Road
Thunder Bay, ON, P&B 5E1
School of Social Work

Exploring the Challenges of Conscientious Objection and the Provision of Effective Referrals for Medical Assistance in Dying among Christian Physicians in Ontario

INFORMATION LETTER

Dear Potential Participant:

You are being invited to participate in a Master of Social Work thesis project study exploring the challenges of conscientious objection and the provision of effective referrals for MAiD among Christian physicians in Ontario by answering the question, "How do Christian Physicians in Ontario understand the tension between their professional and religious obligations when considering MAiD?".

Taking part in this study is voluntary. Before you decide whether or not you would like to take part in this study, please read this letter carefully to understand what is involved. After you have read the letter, please ask any questions you may have.

Purpose

The main purpose of the research is to gain a better understanding the challenges that may arise as a Christian physician when considering your role expectations as a professional as well as a member of a religious community.

What information will be collected?

Researchers will ask you questions about how you as a Christian physician have responded when presented with a request for MAiD and any challenges that may have arisen.
These questions will be in the form of an interview.

What is requested of me as a participant?

The nature of your participation is similar to a conversation. The interview will last about 45-60 minutes and will be facilitated via Zoom or phone as per the participants choice.

What are my rights as a participant?

Please be assured that you are under no obligation to participate and may withdraw at any time without prejudice to pre-existing entitlements.

What are the risks and benefits?

There are no foreseeable risks to your participation in this project. One potential benefit is that you will have the opportunity to contribute to knowledge surrounding MAiD policy and potentially assist in improving current practices.

How will my confidentiality be maintained?

Although absolute confidentiality is impossible, the researcher will make all efforts to remove identifying information in light of the small sample size. When we record the interview and then transcribe or convert the audio recording to text, we also eliminate personal identifying things you might have said. The only people with access to the audio recordings and transcribed data are research team members.

What will my data be used for?
The data will help further the understanding of the unique challenges faced by Christian physicians in relation to MAiD policies and procedures and therefore the main purpose would be to gather this information in an effort to contribute to current knowledge surrounding MAiD policies and their implications. The findings will be prepared to be presented in academic fora, such as conferences and the Canadian Association of Social Work Education's student publication competition.

Where will my data be stored?
All data, including audio, transcriptions, and cumulative data, will be stored by the researcher on a password-protected hard drive in a locked file cabinet in a locked office at Lakehead University in the School of Social Work. Data must be stored for a minimum of 5 years following completion of the project.

How can I receive a copy of the research results?
Please contact the lead graduate student researcher at mrst@lakeheadu.ca after October 2021 for a summary of the results.

What if I want to withdraw from the study?
You are able to withdraw from the study at any time. To withdraw, simply tell the researcher by email that you wish to withdraw. Please see contact information below.

What if I know someone who would also like to participate in the study?
If there is someone you know that may also want to participate in the study, you are welcome to share this information letter along with the graduate student researcher contact information for them to inquire.

Researcher/Supervisor contact information:
You may contact the graduate student researcher at mrst@lakeheadu.ca or the graduate student supervisor at ravi.gokani@lakeheadu.ca.

Research Ethics Board review and approval:
The research study has been reviewed and approved by the Lakehead University Research Ethics Board. If you have any questions related to the ethics of the research and would like to speak to someone outside of the research team, please contact Sue Wright at the Research Ethics Board at 807-343-8282 or research@lakeheadu.ca.

Appendix D

955 Oliver Road
Thunder Bay, ON, P&B 5E1
School of Social Work

CONSENT FORM – Verbal Consent

The following consent form is to be reviewed collaboratively between researcher and participant.

PARTICIPANT CONSENT:

I understand that by participating, I agree to the following:

- I have read and understood the information contained in the Information Letter
- I agree to participate
- I understand the risks and benefits to the study
- I understand that I am a volunteer and can withdraw from the study at any time and may choose not to answer any question
- I understand that the data will be securely stored for a minimum period of 5 years following completion of the research project
- I understand that the research findings will be made available upon my request
- I understand that the researchers will make all efforts to remove identifying information however confidentiality cannot be guaranteed in light of the small sample size of this study
- All of my questions have been answered

By consenting to participate, I have not waived any rights to legal recourse in the event of research related harm.

The following is to be completed by the researcher:

Participant Name: ______________________________

Date: ______________________________

Consent reviewed and verbally obtained: ___ Yes ___ No