

May 14, 2021

**Submissions of the Christian Legal Fellowship re:
The College of Physicians and Surgeons of Ontario's (CPSO) policies concerning
Medical Assistance in Dying and *Professional Obligations and Human Rights***

Christian Legal Fellowship (CLF) appreciates this opportunity to participate in the CPSO's consultations on its *Medical Assistance in Dying* (MAID) and *Professional Obligations and Human Rights* (POHR) policies.

By way of background, CLF is a national association of over 700 lawyers, law students, and jurists, representing more than 40 Christian denominations. As an association of religious legal professionals, CLF possesses a unique expertise in religious and conscientious freedoms and their accommodation in a pluralist society. CLF participated as an intervener in the *Carter* and *Truchon* cases, as well as the *CMDs v CPSO* cases in Ontario.

There is much to be said on the role of professional regulators in Canada's MAID regime; however, we've limited these submissions to our concerns with the CPSO's current policies mandating effective referrals for MAID. CLF is deeply concerned that, in the context of Bill C-7's expanded MAID regime, these policies unduly violate the fundamental human rights of objecting physicians and marginalized patient groups – particularly Canadians with disabilities who seek care from those who agree that MAID is never an appropriate medical solution for disability-related suffering.

1) The CPSO's current approach fails to accommodate those whose consciences preclude them from aiding the death of patients.

Canada is a profoundly pluralist nation both in fact and in law.¹ It is well established that the full inclusion of our multicultural and multireligious citizenry in public life depends upon society's meaningful accommodation of diverse ethical viewpoints – religiously informed or otherwise.² Such inclusion via the accommodation of difference is at the very heart of the equality protections found in Canada's Constitution and human rights law.

¹ Deep diversity of belief is the inevitable by-product of the freedoms of conscience and religion; however, our political order is also self-consciously committed to the "preservation and enhancement of the multicultural heritage of Canadians" (section 27 of the *Canadian Charter of Rights and Freedoms*).

² As the Supreme Court of Canada has emphasized, state authorities must preserve "a neutral public space that is free of discrimination and in which true freedom to believe or not to believe is enjoyed by everyone equally, given that everyone is valued equally. [...] neutral public space free from coercion, pressure and judgment on the part of public authorities in matters of spirituality is intended to protect every person's freedom and dignity. The neutrality of the public space therefore helps preserve and promote the multicultural nature of Canadian society enshrined in s. 27 of the *Canadian Charter*. Section 27 requires that the state's duty of neutrality be interpreted not only in a manner consistent with the protective objectives of the *Canadian Charter*, but also with a view to promoting and enhancing diversity." *Mouvement laïque québécois v. Saguenay (City)*, [2015] 2 S.C.R. 3 at para 74.

We are deeply concerned, therefore, that the CPSO's interpretation of accommodation in the context of religious or conscientious objections results in one of the least accommodating regimes in the world. For many physicians, the CPSO's current MAID policy provides no meaningful accommodation at all. Particularly in the context of MAID, mandatory effective referral policies fail to adequately recognize two crucial facts:

First, MAID is categorically distinct from any other act a healthcare professional may perform; it is the *only* act wherein a caregiver intentionally terminates, or aids in terminating, his or her patient's life.³ MAID is permitted only as a strictly defined exception to the *Criminal Code*'s prohibition on assisted suicide.⁴ MAID is, for legal purposes, the act of inflicting death upon another person with their consent.⁵ For many physicians, this is not "medicine" at all.⁶ As Justice Smith affirmed in the trial judgment in *Carter*: "thoughtful and well-motivated people can and have come to different conclusions about whether physician-assisted death can be ethically justifiable"; she further recognized that, for some physicians, it is "ethically inconceivable" to ever participate in "intentionally ending the life of a patient".⁷ The decriminalization of MAID – now even for patients who are not dying – does not undermine the legitimacy of these ethical concerns.

Second, for many healthcare providers, taking positive action to place a patient in the hands of another for the express purpose of aiding that patient in terminating his or her own life (*i.e.*, an effective referral) is morally equivalent to *performing* MAID. The ethical significance of such referrals is recognized by the Ontario Medical Association,⁸ the World Medical Association,⁹ and even the CPSO itself, which prohibits referrals for harmful procedures like FGM.¹⁰ Moral culpability of this kind is also recognized in Canadian law through party offenses, whereby one who *aids* in a criminal act shares legal responsibility with the primary perpetrator of the offense.¹¹

³ Abortion may also fall into this category when not intended to save the mother's life, but to terminate the life of the unborn child.

⁴ The *Criminal Code* carves out a special regime for "medical assistance in dying" as an exemption to the offences of culpable homicide (s. 222), aiding a person to die by suicide (s. 241(1)(b)), and administering a noxious thing (s. 245(1)).

⁵ *Criminal Code*, s. 227(4).

⁶ The World Medical Association is "firmly opposed to euthanasia and physician-assisted suicide". See "WMA Declaration on Euthanasia and Physician-Assisted Suicide" (Adopted by the 70th WMA General Assembly, October 2019), online: <<https://www.wma.net/policies-post/declaration-on-euthanasia-and-physician-assisted-suicide/>>.

⁷ *Carter v. Canada (Attorney General)*, 2012 BCSC 886 at paras 310, 343.

⁸ The Canadian Medical Association's position is that "physicians must be able to follow their conscience without discrimination when deciding whether or not to provide or participate in assistance in dying", including whether to refer a patient to someone who will provide MAID. See CMA Policy, "Medical Assistance in Dying" (2017), online: <<https://policybase.cma.ca/documents/policypdf/PD17-03.pdf>>.

⁹ The World Medical Association's position is that no physician should be obliged to provide a referral for assisted suicide or euthanasia: "WMA Declaration on Euthanasia and Physician-Assisted Suicide" (Adopted by the 70th WMA General Assembly, October 2019), online: <<https://www.wma.net/policies-post/declaration-on-euthanasia-and-physician-assisted-suicide/>>.

¹⁰ The CPSO's policy re *Female Genital Cutting (Mutilation)* states that physicians "**must not** perform or refer patients to any person for the performance of any [FGM] procedures" (emphasis in original), online: <<https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Female-Genital-Cutting-Mutilation>>.

¹¹ Section 21 of the *Criminal Code* states: "21. (1) Every one is a party to an offence who (a) actually commits it; (b) does or omits to do anything for the purpose of aiding any person to commit it; or (c) abets any person in committing it. (2) Where two or more persons form an intention in common to carry out an unlawful purpose and to assist each other therein and any one of them, in carrying out the common purpose, commits an offence, each of them who knew or ought to have known that the commission of the offence would be a probable consequence of carrying out the common purpose is a party to that offence."

The healthcare professional who facilitates, directly or indirectly, the death of his or her patient bears the moral and emotional responsibility of doing so long after the patient is gone. This is a serious matter with demonstrable and profoundly negative impacts on objecting physicians' psychological well-being.¹² Whatever one's views on the desirability of decriminalizing MAID, the reality of this burden should elicit high degrees of empathy and respect for professionals whose consciences prevent their complicity in this controversial, and only recently *permissible*, practice.

The extraordinary nature of a request to terminate human life justifies accommodating physicians by preventing their coerced participation in MAID through mandatory effective referrals. Moreover, such accommodation would help preserve and enhance diversity within the medical profession by keeping the door open for all competent candidates, regardless of their religion or creed. Conversely, the CPSO's current policy effectively alienates conscientious and qualified Ontario physicians from areas of medicine in which MAID requests might arise.

2) The Charter does not require objecting physicians to provide mandatory effective referrals for MAID.

Access to MAID may be less immediate in certain cases than some desire. However, one must bear in mind the extraordinary nature of the procedure requested. Exempting conscientious objectors from referring for MAID is ethically justifiable on the basis of the unique and lasting burden that taking a human life can impose on the responsible actors. The administrator of MAID, not the patient, ultimately bears this burden. It is inequitable to impose that burden on a professional against his or her will.

It is also important to note that while the Charter may have been interpreted to *permit* the imposition of mandatory effective referrals (a position we contest below), nothing in the Charter *requires* such a policy. The Ontario court decisions in the *CMDS v CPSO* cases never settled what the Charter *requires* in reconciling patient access with physicians' conscience rights.

First, the Ontario decisions only indicated mandatory referrals were *one* acceptable approach to reconciling physicians' and patients' rights – not necessarily the *only* one. The Divisional Court recognized that other provincial authorities have adopted policies that do not mandate effective referrals and are “arguably less restrictive of physicians' religious and conscientious freedom” (para. 174). Importantly, the court did not suggest those policies were unconstitutional. Rather, the court decided that the CPSO should be afforded some “leeway” in making its own “informed decisions about complex policy issues regarding the professional obligations of physicians” (para. 174).

The Ontario courts simply concluded the mandatory referral policy fell “within the range of reasonable alternatives for addressing physicians' conscientious and religious objections” (Div Ct, para 177, C.A., para 158). In other words, the Charter *allows* effective referrals, in a specific context, but does not *mandate* them, and different approaches could also be Charter compliant.

¹² See, e.g., Michael Quinlan, “When the State Requires Doctors to Act Against their Conscience: The Religious Freedom Implications of the Referral and the Direction Obligations of Health Practitioners in Victoria and New South Wales”, (2017) 2016:4 B.Y.U. L. Rev. 1237, at 1271: “Health practitioners who consistently act against their conscience can also become desensitized to it. They are at greater risk of developing indifference to patients and ‘doubling’ or ‘compartmentalization,’ leading to a weakened ability to make the types of ethical decisions critical for health practitioners.”

That the majority of jurisdictions now permitting MAID do so while maintaining robust conscience protections demonstrates that neither equitable access nor the Charter *requires* mandatory effective referrals for MAID. Both meaningful accommodation and equitable access are achievable in Ontario. We strongly urge the CPSO to join these Canadian and international jurisdictions in forgoing mandatory effective referrals, at least for the extraordinary act of intentionally ending human lives, and especially in cases where a patient is nowhere near death.

3) Discouraging the conscientious practice of medicine diminishes the quality of healthcare for both physicians and patients

CLF is concerned that current CPSO policies effectively alienate physicians from all or part of the profession in Ontario, based on their conscientious objection to administering death in response to suffering – including, under Bill C-7, suffering that is non-life threatening and could potentially be addressed by other means.¹³ This further incentivizes competent and conscientious practitioners to move elsewhere, impoverishing Ontarian healthcare to the detriment of the public and medical profession.

Medical professionals are expected to practice conscientiously, and there is a cost to preventing them from doing so. CLF is among those who believe that the public is best served by ensuring physicians are not forced to violate their ethical framework, which invites burnout from moral distress, desensitized consciences, and forced departures from practice that only exacerbate doctor shortages and health care delays.¹⁴

The CPSO should also be mindful of the risk of creating a monoculture on the issue of MAID within the Ontario healthcare system. Many Canadians cherish the opportunity to entrust their healthcare to professionals who share their ethical framework on fundamental life issues. Many would be distraught to know that only those physicians and nurses who support MAID are permitted to work in palliative and other areas of care. Mandating effective referrals risks eliminating the legitimate diversity of professional ethical views on this subject, thereby reducing the representativeness of Ontario’s medical profession in these areas relative to the public it is entrusted to serve.

CLF is concerned that this lack of representation will be felt most acutely by patients with disabilities, who already face the enormous challenge of regularly confronting systemic ableism. During the Bill C-7 hearings, Canadians with disabilities shared their traumatic experiences of having to overcome ableist stereotypes and presumptions to access even the most basic healthcare interventions.¹⁵ The recent expansion of MAID for disability-related suffering has already increased the fear and

¹³ Bill C-7 does not require patients to exhaust or even try other “reasonable and available” medical means to relieve their suffering; rather, it only that they patients give “serious consideration” to these other means.

¹⁴ See note 12, *supra*.

¹⁵ See, for instance, Roger Foley, “Evidence: Tuesday, November 10, 2020”, Standing Committee on Justice and Human Rights, Number 006, 43rd Parl, 2nd Sess at 1111-1116. In another case, a young woman had to confront a physician’s ableist presumptions about her quality of life and repeatedly insist that she wanted oxygen to help her breathe. While breathing supports would be standard procedure, this young woman identified that “[a]ll the doctors seemed to see was a disabled woman alone, sick, tired, and probably tired of living.” See: Taylor Hyatt, “Evidence: Tuesday, November 10, 2020”, Standing Committee on Justice and Human Rights, Number 006, 43rd Parl, 2nd Sess at 1226 and 1228.

trepidation such persons experience in seeking out care.¹⁶ Policies that effectively exclude conscientious objectors and enforce a monoculture in key practice areas work to further exacerbate these fears.

Physicians who hold the ethical conviction that MAID is never an appropriate “treatment” for non-life-threatening disabilities are uniquely equipped to support and reassure Canadians with disabilities who feel targeted and unsafe in a system that all too often fails to adequately support them. The CPSO’s accommodation of conscientious objectors will thereby strengthen the representativeness of Ontario’s medical profession by fostering greater inclusivity and accessibility to healthcare for marginalized Ontarians.

Medical conscience is informed by clinical – not just personal – considerations

CLF is concerned that the CPSO policies appear to assume that a physician’s conscientious objection to MAID can only be for personal – and never *clinical* – reasons. The policies require a physician to inform patients that a conscientious decision “is due to personal and not clinical reasons”. This narrow approach leaves no room for the possibility that a physician may take the position – informed by their professional experience and expertise – that certain services (even legal ones) are *never* clinically indicated, such as MAID for mental illness, for example.¹⁷ The CPSO policies should recognize that a physician may decline to participate in MAID not just for personal/moral reasons, but also *ethical* reasons, as the College of Physicians and Surgeons of Newfoundland and Labrador does, for example.¹⁸

Characterizing professional conscience as purely “personal” and never “clinical” is not only a false dichotomy, but also a dangerous one, because it extricates ethical considerations from clinical practice. As CLF argued in the *CMDS v CPSO* litigation, this is an impossible divide:

[A]s the [Ontario] Court of Appeal has recognized, “ethical considerations form an essential part of medical decision-making”. Any exercise of professional judgment is inherently and necessarily holistic; it integrates clinical experience, education, and — critically — a morally-informed ethical framework. All ethical decisions are informed by one’s moral philosophy. Such beliefs will likely develop over time, being challenged or confirmed by factors such as clinical experience, but they remain relevant, rational and required elements of professional decision-making. **Attempts to bifurcate the “moral” from the “clinical” undermine the very idea of professional judgment, which necessarily integrates both elements. Such**

¹⁶ As one witness explained to the Standing Committee on Justice and Human Rights: “Knowing that those caring for you consider death to be a possible (or even favorable) treatment option, rips away any feelings of security and trust that may have been left.” See: Elizabeth Mack, Brief, Standing Committee on Justice and Human Rights (27 November 2020), online: <<https://www.ourcommons.ca/Content/Committee/432/JUST/Brief/BR10949827/br-external/MackElizabeth-e.pdf>>. See also the concerns expressed by 147 disability rights organizations and allies about Bill C-7 in an open letter online: <<http://www.vps-npv.ca/stopc7>>.

¹⁷ Even where physicians are given a “gatekeeping” role in connection with a particular service, “they remain bound by their own ethics and codes of conduct” and may decline to participate entirely (such as in providing medical marijuana, for example). See *R v. Mernagh*, 2013 ONCA 67 at para 88 (per Doherty J.A.).

¹⁸ See College of Physicians and Surgeons of Newfoundland and Labrador, “Standards of Practice: Medical Assistance in Dying” at para 6.2, online: <<https://www.cpsnl.ca/web/files/2017-Mar-11%20-%20MAID.pdf>>.

integration is foundational to a professional’s integrity, which is a fundamental quality and essential element in all professional relationships.¹⁹

CLF urges the CPSO to re-examine its approach, and to reject blanket assumptions or stereotypes about the nature of conscientious objection. There should be no suggestion that a physician’s decision to limit health-care services, other than for reasons of clinical competence, could only be the result of “discriminatory bias or prejudice”.²⁰ There is a third way – which must be respected – wherein physicians *can* practice according to both medical standards *and* their clinically-informed ethical framework.

Ultimately, the public interest is best served by respecting an appropriate degree of ethical diversity within the medical profession, *while also* providing a centralized government service that can connect patients seeking these services to physicians willing to provide them. However, insisting on effective referrals for controversial procedures such as MAID will diminish the expertise, representativeness, and overall quality of healthcare in Ontario.

4) The constitutionality of mandatory effective referrals for MAID remains an open question that is likely to arise again with the passage of Bill C-7

The *CMDS v CPSO* decision was never appealed to the Supreme Court of Canada, and thus Canada’s high court has not weighed in on this issue beyond its earlier comments in *Carter* (*i.e.*, that any MAID regime must reconcile the rights of physicians and patients²¹).

The *CMDS v CPSO* case was decided in a specific factual and legal context.²² For example, the courts declined to address whether effective referrals violate freedom of conscience; they focussed exclusively on freedom of religion. Whether the effective referral policies violate physicians’ freedom of conscience, therefore, remains to be decided. The Court of Appeal also dismissed the physicians’ section 15 religious equality claim on the assumption that physicians could easily “transition to other areas of medicine in which these issues of faith or conscience are less likely to arise, if at all” (para 94). After Bill C-7’s passage, however, MAID is permitted more widely, including for those whose deaths are *not* “reasonably foreseeable” and potentially, in two years’ time, for those whose sole underlying condition is a mental illness. As a result, there are now significantly fewer areas of medicine in which these issues of conscience are “less likely to arise”.

¹⁹ Factum of the Interveners The Evangelical Fellowship of Canada, The Assembly of Catholic Bishops of Ontario, and The Christian Legal Fellowship in *CMDS v CPSO* (Court of Appeal file no. C65397) at para 15 (references omitted, emphasis added) quoting *Flora v. Ontario Health Insurance Plan*, 2008 ONCA 537 at para 75.

²⁰ The CPSO questionnaire asks respondents their opinion on whether physicians who limit the health-care services they provide “must communicate this information in a clear and straightforward manner to ensure that potential or existing patients understand that their decision is **based on an actual lack of clinical competence rather than discriminatory bias or prejudice**” (emphasis added). This is also the approach required by the current *POHR* policy.

²¹ *Carter v. Canada (Attorney General)*, [2015] 1 S.C.R. 331 at para 132.

²² Even in *CPSO v CMDS*, the ONCA noted that non-compliance with the effective referral Policies would not, in itself, necessarily constitute an “act of professional misconduct” – rather, the Policies represent “expectations of physicians’ behaviour” and can be used as evidence of professional standards in support of an allegation of professional misconduct. In other words, each case will need to be decided within its own context and on the basis of its own facts. The CPSO decision should not be interpreted as condoning a blanket, “one-size-fits-all”, automatic imposition of an effective referral requirement in all cases.

Indeed, the courts' analysis in *CPSO v CMDs* was specific to the federal MAID regime in place at that time (Bill C-14), which has now been fundamentally changed by Bill C-7's removal of MAID from the end-of-life context. In our view, these and other changes to Canada's MAID laws exacerbate the concerns set out above and substantively alter the "matrix of legislative and social facts" that were before the courts in *CMDS v CPSO*.²³ Those decisions rested entirely on whether the effective referral requirements were a proportionate means to achieving equitable access to MAID for patients whose natural deaths were "reasonably foreseeable". Forcing physicians to aid in the termination of patients who are not only *not dying*, but whose condition may also be treatable through alternate means,²⁴ fundamentally changes this calculus and requires a fresh Charter analysis.

Especially in light of these statutory changes, CLF urges the CPSO to reconsider the detrimental effects its current policies may have on the profession and the public generally. The demonstrable cost of continuing the mandatory effective referral policy for MAID far outweighs any speculative benefits that could be achieved for healthcare in Ontario.

Closing thoughts

Canadian law delegates the extraordinarily difficult tasks of assessing – and now implementing – patients' life and death decisions to physicians. Most physicians did not ask for this role; rather, it was thrust on them to satisfy decisionmakers that adequate safeguards (including conscientiously-informed medical ethics) were in place. If Canadians cannot trust *all* physicians to abide by their consciences respectfully and responsibly, then why are we asking them to be the sole performers of such procedures in the first place? Physicians have been made gatekeepers to absolve *the public's* conscience. In thrusting this responsibility upon physicians, the CPSO policies must, at the very least, respect *the physician's* conscience too.

²³ *Carter v. Canada (Attorney General)*, [2015] 1 S.C.R. 331 at para 47.

²⁴ Bill C-7 does not require patients to exhaust or even undergo other means to relieve their suffering – only that they give "serious consideration" to them.