S.C.C. No. 35591

IN THE SUPREME COURT OF CANADA
(ON APPEAL FROM THE COURT OF APPEAL FOR BRITISH COLUMBIA)

BETWEEN:

LEE CARTER, HOLLIS JOHNSON, DR. WILLIAM SHOICHET, THE BRITISH COLUMBIA CIVIL LIBERTIES ASSOCIATION and GLORIA TAYLOR

Appellants

- and -

ATTORNEY GENERAL OF CANADA
and ATTORNEY GENERAL OF BRITISH COLUMBIA

Respondents

- and –

ATTORNEY GENERAL OF ONTARIO, ATTORNEY GENERAL OF QUEBEC, ALLIANCE OF PEOPLE WITH DISABILITIES WHO ARE SUPPORTIVE OF LEGAL ASSISTED DYING SOCIETY, ASSOCIATION FOR REFORMED POLITICAL ACTION CANADA, THE CANADIAN CIVIL LIBERTIES ASSOCIATION, THE CANADIAN HIV/AIDS LEGAL NETWORK AND THE HIV & AIDS LEGAL CLINIC ONTARIO, THE CANADIAN MEDICAL ASSOCIATION, THE CANADIAN UNITARIAN COUNCIL, THE CATHOLIC CIVIL RIGHTS LEAGUE, THE FAITH AND FREEDOM ALLIANCE AND THE PROTECTION OF CONSCIENCE PROJECT, THE CATHOLIC HEALTH ALLIANCE OF CANADA, THE CHRISTIAN LEGAL FELLOWSHIP, THE CHRISTIAN MEDICAL AND DENTAL SOCIETY OF CANADA, THE CANADIAN FEDERATION OF CATHOLIC PHYSICIANS' SOCIETIES, THE COLLECTIF DES MÉDECINS CONTRE L'EUTHANASIE, THE COUNCIL OF CANADIANS WITH DISABILITIES AND THE CANADIAN SOCIETY FOR COMMUNITY LIVING, THE CRIMINAL LAWYERS' ASSOCIATION (ONTARIO), DYING WITH DIGNITY, THE EVANGELICAL FELLOWSHIP OF CANADA, THE FAREWELL FOUNDATION FOR THE RIGHT TO DIE and THE ASSOCIATION QUÉBÉCOISE POUR LE DROIT DE MOURIR DANS LA DIGNITÉ, and THE EUTHANASIA PREVENTION COALITION AND THE EUTHANASIA PREVENTION COALITION – BRITISH COLUMBIA

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Part I: Overview of Argument

1. The policy of the Canadian Medical Association (the "CMA") on euthanasia and assisted suicide[1] forms part of the trial record.[2] The policy was debated at successive annual meetings of the CMA's members in 2013 and 2014, resulting in its amendment. In 2013, new definitions were added to clarify key terminology used. In August 2014, a motion was passed by delegates to CMA's General Council, and affirmed by the CMA Board of Directors, supporting the right of all physicians, within the bounds of existing legislation, to follow their conscience when deciding whether or not to provide medical aid in dying.[3] The policy will be amended as a consequence.

2. It is anticipated that the policy, once amended, will continue to reflect the ethical principles for physicians to consider in choosing whether or not to participate in medical aid in dying.

3. The statement of support for matters of conscience now exists alongside the statement in the CMA policy that "Canadian physicians should not participate in euthanasia or assisted suicide." As long as such practices remain illegal, the CMA believes that physicians should not participate in medical aid in dying. If the law were to change, the CMA would support its members who elect to follow their conscience.

4. A portion of the CMA's membership believes that patients should be free to choose medical aid in dying as a matter of autonomy. Other voices highlight that participation would undermine long-established ethical principles applicable to the practice of medicine. Amidst this

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[1] CMA Policy: Euthanasia and Assisted Suicide (Update 2014), https://www.cma.ca/Assets/assets-library/document/en/about-us/PD14-06.pdf#search=assisted%20death.

[2] *Carter v. Canada (Attorney General)*, 2012 BCSC 886, paragraphs 6 and 274.

[3] Resolutions adopted at the 147th Annual Meeting of the Canadian Medical Association, Aug. 18-20, 2014: https://www.cma.ca/Assets/assets-library/document/en/advocacy/Final-Resolutions-GC-2014-end-of-life-care.pdf.

diversity of views, however, there is a unifying theme: one of respect for the alternative perspective. This element was highlighted in the policy motion coming out of the CMA's August 2014 General Council meeting.

5. The CMA accepts that the decision of whether or not medical aid in dying should be allowed as a matter of law is for lawmakers, not medical doctors, to determine. The policy itself acknowledges, uniquely among CMA policies in this respect, that "[i]t is the prerogative of society to decide whether the laws dealing with euthanasia and assisted suicide should be changed."

6. As the national voice of physicians across the country, the CMA intervenes in this appeal desiring to assist the Court by providing its perspective on the rationale for the diverse views expressed by its membership, and to highlight practical considerations that must be assessed if the law were to change.

Part II: Statement of Argument

A. The CMA's policy on euthanasia and assisted suicide

7. The CMA's policy on euthanasia and assisted suicide[4] was adopted in 2007, replacing and consolidating two previous CMA policies[5], and has been amended twice since then as noted above.

8. In an effort to promote broad public and member discussion, in the first half of 2014 the CMA hosted a series of town hall meetings across Canada on end of life care issues. Members of the public and the profession were able to attend the town halls in person, or post comments

[4] CMA Policy: Euthanasia and Assisted Suicide (Update 2014): https://www.cma.ca/Assets/assets-library/document/en/about-us/PD14-06.pdf#search=assisted%20death.
[5] *Physician Assisted Death 1995* and *Euthanasia and Assisted Suicide (1998).*

online, to provide their perspectives and opinions on, *inter alia*, euthanasia and physician-assisted suicide.[6]

9. The CMA adopts policies in order to inform the organization's advocacy efforts, and to provide physician members with an understanding of the views and opinions of their national representative organization and to reflect the views of its membership. The CMA's policies are not meant to mandate a standard of care for members or to override an individual physician's conscience.

10. The CMA recognizes that many of its policies are referenced by other health care groups and the courts, as well as the provincial and territorial medical regulatory authorities.

11. In general, those CMA members who oppose medical aid in dying do so because of the derogation from established medical ethical principles and clinical practices that would result. Those who support medical aid in dying do so because of the equally established principles of considering patient well-being and patient autonomy. The policy in its current form reflects these various considerations.

12. Physicians have a tremendous amount of compassion and concern for patients who are suffering near the end of their lives, and strive to improve their patients' quality of life for the remainder of their lives. Physicians are trained to be healers. For most Canadian physicians, the question is not a simple matter of balancing between patient autonomy and professional standards, but goes much deeper, to the very core of what it means to be a medical professional.

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[6] The CMA published two reports coming out of the end of life care town halls – a public report in June 2014 and a CMA members' report in July 2014 – both of which can be found on the CMA's website.

13. One rationale for the position in opposition to physician participation is that euthanasia and assisted suicide would have, as the policy states, "unpredictable effects on the practice of medicine" as well as the physician-patient relationship.[7]

14. At the same time, the policy recognizes the principle of patient autonomy, and the fact that it is a competing consideration. It cites several articles from the CMA Code of Ethics[8] that emphasize the importance of patient well-being and autonomy.[9] Physicians are advised to "consider first the well-being of your patient."

15. Opposition to participation is found in statements from the World Medical Association and various national medical associations akin to the CMA.[10] In jurisdictions where medical aid in dying has been legalized, the practice is considered "ethically sound ...and part of end of life care" by the national medical association in the Netherlands and the Belgian association has not published any policy.[11]

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[7] CMA Policy: Euthanasia and Assisted Suicide (Update 2014): https://www.cma.ca/Assets/assets-library/document/en/about-us/PD14-06.pdf#search=assisted%20death.

[8] For example, "Provide your patients with the information they need to make informed decisions about their medical care, and answer their questions to the best of your ability"; "Respect the right of a competent patient to accept or reject any medical care recommended"; and "Ascertain wherever possible and recognize your patient's wishes about the initiation, continuation or cessation of life-sustaining treatment."

[9] The concept of patient autonomy is usually associated with allowing or at least enabling patients to make their own decisions about which health care treatments they will or will not receive, or incorporating their point of view into assessments of the appropriateness and effectiveness of treatment options. See: Entwistle, VA., Carter, SM., Cribb, A. & McCaffery, K. (2010). 'Supporting patient autonomy: The importance of clinician-patient relationships'. *Journal of General Internal Medicine*, vol 25, no. 7, pp. 741-745; and Sullivan MD. "The new subjective medicine: taking the patient's point of view on health care and health". *Soc Sci Med* 56:1595-1604, 2003.

[10] World Medical Association Statement on Physician-Assisted Dying. Adopted by the 44th World Medical Assembly, Marbella, Spain, September 1992 and editorially revised by the 170th WMA Council Session, Divonne-les-Bains, France, May 2005: http://www.wma.net/en/30publications/10policies/p13/. British Medical Association. *What is the current BMA policy on assisted dying?* http://bma.org.uk/practical-support-at-work/ethics/bma-policy-assisted-dying. Australian Medical Association. *Position Statement on the Role of the Medical Practitioner in End of Life Care 2007*, section 10: https://ama.com.au/position-statement/role-medical-practitioner-end-life-care-2007. American Medical Association's Opinion 2.211 – Physician-Assisted Suicide: http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2211.page?.

[11] KNMG. Euthanasia in the Netherlands. Available at: http://knmg.artsennet.nl/Dossiers-9/Dossiers-thematrefwoord/Levenseinde/Euthanasia-in-the-Netherlands-1.htm.

16. It is acknowledged that just moral and ethical arguments form the basis of arguments that both support and deny assisted death. The CMA accepts that, in the face of such diverse opinion, based on individuals' consciences, it would not be appropriate for it to seek to impose or advocate for a single standard for the medical profession.

17. In any event, the CMA accepts that the decision as to the lawfulness of the current prohibition on medical aid in dying is for patients and their elected representatives as lawmakers to determine, not physicians.

B. The implications of a change in the law

18. The CMA and its members have practical and procedural concerns to bring to the Court for reflection with respect to the legalization of medical aid in dying and the implications for medical practice. Three such implications are addressed below.

1. Palliative care

19. One question and element highlighted in CMA policy formulation is the role of palliative care and whether adequate public access is a precondition to changing the law. The CMA acknowledges that the desire to access medical aid in dying is predicated, at least in part, on the inadequacy or inability of palliative care to address a patient's needs in particular circumstances. The policy currently recognizes that adequate palliative care is a prerequisite to the legalization of medical aid in dying. That is because patients should never have to choose death because of unbearable pain which can, in fact, be treated, but the treatment cannot, in reality, be accessed.

20. However, even if palliative care were readily available and effective, there would likely be some patients who would still opt for medical aid in dying over palliative care. Moreover, it

seems wrong to deny grievously ill patients the option of medical aid in dying simply because of systemic inadequacies in the delivery of palliative care.

21. The public and the medical profession lack current, specific and non-anecdotal information as to the availability of adequate palliative care across Canada. Notwithstanding this lack of rigorous data, concerns are often expressed.[12] As Justice Smith held at trial, "High quality palliative care is far from universally available in Canada."[13] The policy itself provides that "[e]fforts to broaden the availability of palliative care in Canada should be intensified."

22. Canada has no national strategy to ensure the delivery of a uniformly high standard of palliative care across the country. Similarly, there are no national uniform standards which direct when and how palliative care is to be provided and by which physicians. At the CMA's annual meeting in August 2014, motions were passed as policy affirming that (i) all health care providers should have access to referral for palliative care services and expertise, (ii) a strategy should be developed for advance care planning, palliative and end of life care in all provinces and territories, and (iii) the CMA will engage in physician human resource planning to develop an appropriate strategy to ensure the delivery of quality palliative care throughout Canada.[14]

23. Regardless of the outcome of this appeal, the Canadian public and the medical profession must unite in insisting upon the dedication of appropriate resources to overcome the deficiencies identified above. Palliative care will continue to be a focus of the CMA's future policy development.

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[12] The Senate of Canada: the Honourable Sharon Carstairs, *Raising the Bar: A Roadmap for the Future of Palliative Care in Canada*, June 2010, http://www.chpca.net/media/7859/Raising_the_Bar_June_2010.pdf, pages 12 and 16.
[13] *Carter v. Canada (Attorney General)*, 2012 BCSC 886, paragraph 192.
[14] Resolutions adopted at the 147th Annual Meeting of the Canadian Medical Association, Aug. 18-20, 2014: https://www.cma.ca/Assets/assets-library/document/en/advocacy/Final-Resolutions-GC-2014-end-of-life-care.pdf

2. Concerns over safeguards

24. The trial judge placed great reliance on the ability of physicians to assess the competency of patients requesting medical aid in dying and the voluntariness of their wishes.[15] The CMA submits that the challenges physicians will face in making these assessments have been understated, especially in the end of life care context where the consequences of decisions are particularly grave and in a public medical system in which resource constraints are a pressing issue.[16]

25. The CMA submits that these assessments will involve significant new responsibilities that warrant comprehensive study by and with physicians for the following reasons:

a) Patients must be afforded a full right of informed consent, but the ordinary context in which a physician obtains the patient's informed consent would not apply since the intervention would be initiated not by the physician's recommendation but by the patient's request and since the patient's decision may turn more than usually is the case upon considerations apart from the expected efficacy of the treatment.

b) A patient may be subject to influences which the patient is motivated not to disclose to his or her physician and which may be very difficult to detect.

c) Such important decisions are best made following careful discussions between physician and patient, well in advance, concerning the patient's end of life wishes generally. The CMA and its provincial and territorial medical association colleagues note that these types of discussions do not now routinely occur, and that when they do, patients' assessments of their goals can and do evolve over the course of their illness.[17]

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[15] *Carter v. Canada (Attorney General)*, 2012 BCSC 886, paragraphs 883, 1240 and 1367.
[16] *Chaoulli v. Quebec (Attorney General)*, [2005] 1 SCR 791, paragraphs 173 and 221-222.
[17] The Policy urges that "a Canadian study of medical decision making during dying" be undertaken. It explains that "relatively little" is known about "the frequency of various medical decisions made near the end of life, how these

d) It may be very difficult to assess competency and voluntariness in some patients (for example, the very old, the very ill and the depressed) and in some settings (for example, the emergency room and the intensive care unit) where there may not be an established physician-patient relationship.

e) Institutional supports are lacking, including recognition in provincial fee schedules of the time that is required for meetings with patients and their families.

3. Protections for physicians

26. The CMA submits that, if the law were to change, any regime of medical aid in dying must legally protect those physicians who choose to participate from criminal, civil or disciplinary proceedings or sanctions.

27. In addition, if the law were to change, no physician should be compelled to participate in or provide medical aid in dying to a patient, either at all, because the physician conscientiously objects to medical aid in dying, or in individual cases, in which the physician makes a clinical assessment that the patient's decision is contrary to the patient's best interests. Notably, no jurisdiction that has legalized medical aid in dying compels physician participation.[18] If the

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decisions are made and the satisfaction of patients, families, physicians and other caregivers with the decision-making process and outcomes." See also the Ontario Medical Association, 'Ontario Doctors Launch End of Life Care Plan'. Available at: https://www.oma.org/resources/documents/eolcstrategyframework.pdf.

[18] **Quebec**: Bill 52, *An Act respecting end-of-life care*, 1st Sess, 41st Leg, Quebec, 2014 cl 50 (assented to 10 June 2014), SQ 2014, c2; **Netherlands**: *Termination of Life on Request and Assisted Suicide (Review Procedures) Act* (2002) http://www.euthanasiecommissie.nl/Images/Wet%20toetsing%20levensbeeindiging%20op%20verzoek%20en%20hulp%20bij%20zelfdoding%20Engels_tcm52-36287.pdf; **Switzerland**: *Suiss Criminal Code*, Book Two : Specific Provisions, Title One : Offences against Life and Limb, Article 115 (1942). http://www.admin.ch/opc/en/classified-compilation/19370083/index.html; **Belgium**: *Loi relative à l'euthanasie*, Chapitre 6, article 14 (2002) http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&table_name=loi&cn=2002052837; **Luxembourg**: *Loi du 16 mars 2009 sur l'euthanasie et l'assistance au suicide*, Chapitre 7, article 15 (2009). http://www.legilux.public.lu/leg/a/archives/2009/0046/a046.pdf#page=7; **Washington**: *The Washington Death with Dignity Act*, RCW, 70 §70.245.190 (2009). http://apps.leg.wa.gov/RCW/default.aspx?cite=70.245.190; **Oregon**: *The Oregon Death with Dignity Act*, ORS, 127 §127.885 4.01 (1997). http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/statute.pdf; **Vermont**: *An act relating to patient choice and control at the end of life*, VSA, 113 § 5285 (a) (2013).

attending physician declines to participate, every jurisdiction that has legalized medical aid in dying has adopted a process for eligible patients to be transferred to a participating physician.[19]

28. While the Court cannot and should not set out a comprehensive regime, the CMA submits that it can indicate that a practicable legislative regime for medical aid in dying must legally protect those physicians who choose to provide this new intervention to their patients, as well as those who do not.

Part III: Submissions regarding remedy

29. If the law is changed, the CMA would ask this Court to adopt a remedy that would preserve the autonomy and constitutional rights of patients and their health care providers. To that end, the CMA asks the Court to adopt a remedy akin to what Justice Smith ordered at the trial level: suspending the effect of a declaration for one year from the date of any decision and instituting a process for individual exemptions such as that afforded to the late Ms. Taylor.

Part IV: Submissions regarding costs

30. The CMA seeks no costs and asks that none be awarded against it.

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http://www.leg.state.vt.us/docs/2014/Acts/ACT039.pdf; **New-Mexico**: *Morris v New-Mexico* (2014); and **Montana**: *Baxter v Montana*, 482 LEXIS at 59 (2008).

[19] Canadian Medical Association, *Schedule A: Legal Status of Physician-Assisted Dying (PAD) in Jurisdictions with Legislation,* https://www.cma.ca/Assets/assets-library/document/en/advocacy/EOL/Legal-status-physician-assisted-death-jurisdictions-legislation.pdf#search=schedule%20A%3A%20legal%20status%20of%20physician%2Dassisted%20death, page 3.

Part V: Request for oral argument

31. The CMA requests permission to make fifteen minutes of oral argument at the hearing of this appeal.

ALL OF WHICH IS RESPECTFULLY SUBMITTED, this 27th day of August, 2014.

H. Underwood Jessica Prince PER: Jean Nelson

Harry Underwood Jessica Prince Jean Nelson

Part VI: Table of Authorities

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2. *Chaoulli v. Quebec (Attorney General)*, [2005] 1 SCR 791

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13. Ontario Medcial Association'Ontario Doctors Launch End of Life Care Plan'. Available at: https://www.oma.org/resources/documents/eolcstrategyframework.pdf.

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16. Switzerland: Suiss Criminal Code, Book Two : Specific Provisions, Title One : Offences against Life and Limb, Article 115 (1942). http://www.admin.ch/opc/en/classified-compilation/19370083/index.html

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