CHRISTIAN LEGAL FELLOWSHIP | ALLIANCE DES CHRÉTIENS EN DROIT

January 15, 2024

Submissions of the Christian Legal Fellowship re:
The College of Physicians and Surgeons of Alberta's (CPSA)
proposed changes to the *Conscientious Objection* standard

Christian Legal Fellowship (CLF) appreciates this opportunity to participate in the CPSA's consultations on its *Conscientious Objection* standard.

By way of background, CLF is a national association of over 700 lawyers, law students, and jurists, representing more than 40 Christian denominations, with chapters in Alberta. As an association of religious legal professionals, CLF has developed unique expertise in religious and conscientious freedoms and the accommodation of the exercise of those freedoms 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, and CLF lawyers and members have published peer-reviewed articles on these and related subjects.[1]

There is much to be said on the role of professional regulators in Canada's MAID regime; however, we have limited these submissions to our concerns with the possibility that the CPSA's revised policy may require physicians to participate in MAID through a mandatory referral process or similar form of active facilitation.[2] We note that, since the draft revised policy was released, the CPSA has announced that "[b]ased on initial feedback received, the term 'effective referral' will be removed from the Conscientious Objection standard" and that, those who offer feedback during this process "will be consulted again during the re-consultation phase and see additional edits before final approval." We acknowledge and appreciate this response, and look forward to the opportunity to provide further feedback on any additional edits.

Until then, we wish to offer the following input on why we would be concerned with a process – whether it be described as an "effective referral" or something else – which requires physicians to take positive action to actively facilitate the act of intentionally terminating a patient's life.[3] CLF is deeply concerned that, in the context of Bill C-7's expanded MAID regime, this would fail to respect the fundamental human rights of objecting physicians and marginalized patient groups – particularly Canadians with disabilities who seek care from those who agree with them that death is not a medical solution for disability-related suffering.

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[1] See, for example, Derek Ross and Deina Warren, "The Importance of Conscience as an Independent Protection" in J Kotalik and D.W. Shannon (eds), *Medical Assistance in Dying (MAID) in Canada,* The International Library of Bioethics, vol 104. Springer, Cham.

[2] Though our submissions are written with the expansion of MAID as the issue of context, our concerns also have application to other issues or procedures to which doctors may have a clinically-informed and evidence-based conscientious objection.

[3] We also recognize that such a process may no longer be contemplated, and we look forward to further information regarding same.

1) **Mandating referrals for MAID fails to accommodate those whose consciences preclude them from aiding in intentionally causing the death of patients.**

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, a patient's life.[4] MAID is permitted only as a strictly defined exception to the *Criminal Code*'s prohibition on homicide and assisted suicide.[5] MAID is, for legal purposes, the act of inflicting death upon another person with their consent.[6] For many physicians, this is not "medicine" at all.[7] 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".[8] The decriminalization of MAID – now even for patients who are not dying, and possibly in March 2024 for those with mental disorders as their sole underlying condition – does not undermine the legitimacy of these ethical concerns.

For many healthcare professionals, taking positive action for the express purpose of aiding a patient in terminating his or her own life (*e.g.*, an effective referral) is morally equivalent to *performing* MAID. The ethical significance of such referrals is recognized by the Canadian Medical Association[9] and the World Medical Association.[10]

Facilitating the death of another person is a serious matter – one which can have profoundly negative impacts on objecting physicians' psychological well-being.[11] Whatever one's views on the desirability of decriminalizing MAID, the reality of this burden should elicit high degrees of empathy and respect for those whose professional consciences prevent their complicity in this controversial, and only recently *permissible*, practice.

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

[5] The *Criminal Code* carves out a special regime for "medical assistance is 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)).

[6] *Criminal Code*, s. 227(4).

[7] 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/>.

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

[9] 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>.

[10] 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/>.

[11] 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."

The extraordinary nature of a request to terminate human life justifies accommodating physicians by preventing their coerced participation in MAID through mandatory 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.

2) The Canadian Charter of Rights and Freedoms does not "require" objecting physicians to provide mandatory referrals for MAID.

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. 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 have contested, as discussed further below), the Charter has never been interpreted to *require* such a policy.

The Ontario court decisions in *CMDS v CPSO* 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 provincial regulator 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.

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 referrals for MAID. Both meaningful accommodation and equitable access are achievable in Alberta. We strongly urge the CPSA to maintain an approach consistent with most other Canadian and international jurisdictions in *forgoing* mandatory referrals, at least for the extraordinary act of intentionally ending human lives, and especially in cases where a patient is not even dying.

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

CLF is concerned that requiring physicians to actively facilitate MAID would effectively exclude, from many areas of medicine, those with a 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.[12] This further incentivizes competent and conscientious practitioners to

[12] 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 requires that patients give "serious consideration" to these other means (*Criminal Code,* s. 241.2(3.1)(h)).

move elsewhere, impoverishing Alberta's healthcare to the detriment of the public and the 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.[13]

The CPSA should also be mindful of the risk of creating a monoculture on the issue of MAID within the 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 if only those physicians and nurses who essentially support MAID are permitted to work in palliative and other areas of care. Mandating referrals or active facilitation risks eliminating the legitimate diversity of professional ethical views on this subject, thereby reducing the representativeness of Alberta'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 by members of Indigenous, religious, and other marginalized communities, and felt most acutely by patients with disabilities, who already face the enormous challenge of regularly confronting systemic ableism.[14] 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] Bill C-7's expansion of MAID for disability-related suffering has already increased the fear 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 a medically administered death is not an appropriate "treatment" for non-life-threatening conditions 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 accommodation of conscientious objectors would thereby strengthen the representativeness of Alberta's medical profession by fostering greater inclusivity and accessibility to healthcare for marginalized Albertans.

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[13] See note 11, *supra*.

[14] See, for example, the concerns expressed in the submissions of the British Columbia Aboriginal Network on Disability Society, Council of Canadians with Disabilities, DisAbled Women's Network Canada, Inclusion Canada, and Vulnerable Persons Standard to the Human Rights Committee to the UN Human Rights Committee (21 May, 2021), online: < https://archdisabilitylaw.ca/submission-to-un-human-rights-committee-re-canadas-medical-assistance-in-dying-law/ >.

[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 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.

[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>.

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 mandatory referrals for controversial procedures such as MAID would diminish the expertise, representativeness, and overall quality of healthcare in Alberta.

4) The constitutionality of mandatory 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 *both* physicians and patients).[17]

The *CMDS v CPSO* case was decided in a specific factual and legal context. 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 a few months' 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".

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*.[18] Those court decisions only considered whether the effective referral requirements were a proportionate means to achieving equitable access to MAID in a legislative context where MAID was limited to 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,[19] fundamentally changes this calculus and requires a fresh Charter analysis.

Especially in light of these statutory changes, CLF urges the CPSA to reconsider the detrimental effects that forcing physicians to participate in the MAID process may have on the profession, on vulnerable patients, particularly from marginalized groups, and on the public generally.

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[17] *Carter v. Canada (Attorney General)*, [2015] 1 S.C.R. 331 at para 132.
[18] *Carter v. Canada (Attorney General)*, [2015] 1 S.C.R. 331 at para 47.
[19] See note 12, *supra.*