Protection of Conscience Project
www.consciencelaws.org

ADVISORY BOARD
J. Budziszewski, PhD
Professor, Departments of Government & Philosophy, University of Texas, (Austin) USA

Shimon Glick, MD
Professor (emeritus, active) Faculty of Health Sciences, Ben Gurion University of the Negev, Beer Sheva, Israel

Mary Neal, PhD
Senior Lecturer in Law, University of Strathclyde, Glasgow, Scotland

David S. Oderberg, PhD,
Dept. of Philosophy, University of Reading, England

Abdulaziz Sachedina,PhD
Dept. of Religious Studies, University of Virginia, Charlottesville, Virginia, USA

Roger Trigg, MA, DPhilSenior Research Fellow,
Ian Ramsey Centre for Science and Religion, University of Oxford, England

PROJECT TEAM

Human Rights Specialist
Rocco Mimmo, LLB, LLMAmbrose Centre for Religious Liberty, Sydney, Australia

Administrator
Sean Murphy

Submission to Canadian Regulatory Authorities and Ministers of Health

Re: Health Canada's *Model Practice Standard for Medical Assistance in Dying (MAID)* (March, 2023)

Executive Summary

Preliminary observations

The Canadian federal department of health has issued a *Model Practice Standard* for euthanasia and assisted suicide (EAS) (commonly referred to in Canada as "Medical Assistance in Dying" or "MAID"). From March, 2024 it will apply to the provision of EAS for mental disorders alone. For constitutional reasons, the Standard has no legal effect except to the extent that provincial professional regulators adopt its provisions. However, it articulates state expectations in relation to lawfully killing people that are intended to override the moral/ethical convictions of individuals.

The ruling of the Supreme Court of Canada ordering legalization of EAS in defined circumstances does not undermine the legitimacy and reasonable plausibility of moral/ethical/religious beliefs that it is gravely wrong and/or contrary to good medical practice to deliberately kill people or assist in suicide — even if the law approves. Acting upon this belief should not be a reason for the state to penalize practitioners or exclude someone from health care practice. However, adopting the Standard would have that effect.

Killing people continues to be a deeply controversial subject, but the Standard attempts to erase the controversy by an authoritarian exercise of moral partisanship. It assumes the default position that practitioners have a moral duty to facilitate the killing of their patients, and it enlists the power of the state to impose this contested premise systemically. Regulators are thus encouraged to suppress unceded moral/ethical positions — and freedom of conscience — just as European colonists applied a false and enlarged notion of *terra nullius* to take control of unceded indigenous lands. That is the focus of this submission, which concentrates on Parts 5 and 6 of the Standard.

Involvement and participation

The Standard suggests that involvement with EAS is inescapable but participation is optional. The concepts of *involvement* and *participation* are critical in ethical/moral deliberation, becoming acute in deliberation about involvement or participation in killing people. Nonetheless, the terms are undefined in the Standard, and the attributed meanings are not clearly distinguished in the text. Further, kinds of involvement the Standard requires — notably effective referral and effective transfer of care — may be

Pub: 2023 Jul 17
Rev: 2023 Nov 27

reasonably classed as morally charged participation or entail serious moral/ethical responsibility that practitioners may find unacceptable. While the Standard affirms the relevance of ethical norms espoused by the Canadian Medical Association (CMA) and other professional groups, its demand for effective referral contradicts the longstanding position of the CMA and its current policy on EAS.

Unaddressed legal issues

The Standard acknowledges that the exercise of freedom of conscience by practitioners produces a range of responses, some willing to provide EAS in some circumstances but not in others. However, it does not address legal criticism to the effect that this amounts to discrimination on the basis of disability, nor the accompanying claim that practitioners cannot escape the obligation to personally provide EAS by making an effective referral: that referral would itself be evidence of unlawful discrimination.

Legal and ethical goalposts have been shifting steadily to expand access to EAS in Canada. The likelihood of conflicts of conscience increases as exemptions allowing EAS increase. However, the Standard does not recognize this, and, moreover, is unduly restrictive in its explanation of current exemption criteria.

Practitioners and patients

Irremediability of a medical condition is a key criterion established by the Supreme Court of Canada for exempting practitioners from prosecution for providing EAS. Some argue that practitioners must determine irremediability; others insist that patients can determine irremediabilty by refusing treatment. The Standard maintains that patients cannot compel practitioners to provide EAS by refusing potentially effective interventions, but fails to provide a rationale supporting this position. It asserts that determination of irremediability should be negotiated by practitioners and patients, but dodges the problem of what should be done if they disagree.

By revisiting the *Carter* decision this submission provides the missing rationale and addresses the problem of practitioner/patient disagreement. In sum, practitioners are responsible for determining irremediability, and their determination cannot be overridden by patient refusal to accept potentially efficacious treatments. Patients in these cases may continue to look for a practitioner who may find they meet the exemption criteria, but cannot expect assistance from practitioners who believe that they do not. Further, practitioners who believe that a patient does not meet the legal exemption criteria are constrained from doing anything to further a request for it. Regulators have no basis to proceed against them, and would seem to commit the offence of counselling were they to advise practitioners or attempt to persuade or coerce them to provide effective referrals or effective transfers of care.

Compulsory assistance

The Standard states that physicians and nurse practitioners must not be compelled to "prescribe or administer substances" for the purpose of EAS, but it does not prevent them and other health care workers from being compelled *to assist* in providing EAS. Demands for compulsory assistance are most likely to arise in situations characterized as emergencies. Requests for active assistance in providing EAS in such situations are now treated as emergencies by mainstream actors in Canada's

public healthcare system. Hence, the Standard's silence on this point is troubling.

It is also revealing. If one believes that the state must not compel unwilling individuals to assist in lawfully killing other people, nor allow such compulsion, one would expect the Standard to make clear that no one can compelled under any circumstances to assist in providing EAS. The absence of such a statement indicates that Canada's national government supports coercion of unwilling health care workers to assist in killing their patients. Provincial governments and professional regulators should clearly reject this position by prohibiting coerced participation in EAS.

Cooperation vs. collaboration

The logic underlying the law on criminal complicity is applied to moral complicity by practitioners who refuse to collaborate in EAS. They refuse to take positive action that establishes a causal connection to or is supportive of killing their patients. They reasonably hold that such action would make them complicit in killing their patients, which they hold to be gravely wrong and/or contrary to good medical practice. On the other hand, they are generally willing to cooperate with patients by providing information for informed medical decision-making, enabling them to connect with other health care practitioners and continuing to provide treatment and care unrelated to EAS.

This willingness to cooperate (but not to collaborate) — if understood and honoured — makes it possible to accommodate practitioners and patients. Unfortunately, the Standard's authoritarian moral partisanship precludes admission that practitioners can be legitimately concerned about complicity in killing other people. Hence, the Standard erroneously suggests that effective referral and effective transfer of care (as defined) are ethically/morally interchangeable, and — more important — it fails to recognize the possibility of a compromise in an alternative that it suggests but does not develop.

Recognizing an alternative

The undeveloped alternative suggested by the Standard is "taking positive action" to connect a patient to an "agency, program, office responsible patient navigation" that can connect the patient to EAS providers. Subject to important caveats, this may prove to be a generally satisfactory method of accommodating objecting practitioners. In order to avoid confusion and mistrust, it should *not* be identified or described as "effective referral," which has accumulated too much baggage.

This submission presents the alternative in a form clearly distinguished by name and modified to enable accommodation likely to be generally satisfactory to objecting practitioners. It identifies unacceptable arrangements (Provincial-Territorial Expert Advisory Group EAS delivery system; MAiD Care Coordination Services) that would push objecting practitioners beyond cooperation to collaboration. It distinguishes these from acceptable arrangements (the CMA model; Alberta Health Link; Health Connect Ontario).

Suggesting EAS

The Standard trades on principles of informed consent to force practitioners to suggest EAS to patients who have expressed no interest in it simply because the patient might be "eligible" for it. This is most evident in the requirement that practitioners explore patients' views about euthanasia

and assisted suicide in order to determine whether or not to present them as potential treatment options. The exploration itself would effectively present the procedures as options, just as a practitioner's exploration of a patient's views about having a sexual relationship with him could hardly fail to be understood as the presentation of an option.

Practitioners cannot be expected to characterize what they believe to be an unethical/immoral practice as a normal or acceptable treatment, especially since they often judge practices to be unethical/immoral because they consider them actually or potentially harmful. On the other hand, they are required and willing to provide information necessary to enable patients to make informed medical decisions, including information about procedures or services they refuse to provide or recommend.

Regulatory adaptation

Appendix "C" provides a regulatory adaptation of Parts 5 and 6 of the Standard reflecting the observations and recommendations in this submission.

TABLE OF CONTENTS

Introduction

Health Canada, a Canadian federal government department, has issued a *Model Practice Standard* ["the Standard"] for providing euthanasia and assisted suicide [EAS] (commonly referred to in Canada as "Medical Assistance in Dying" or "MAID") [1] and a companion document, *Advice to the Profession*.[2] The development of these documents by the MAID Practice Standards Task Group ["Task Group"] is explained in a *Background Document*.[3] The Standard is intended to apply to the provision of EAS in all cases, including EAS for mental disorders alone when this becomes legal in March, 2024.[4]

Federal jurisdiction in relation to these procedures is confined to establishing exemptions and related modifications in criminal law governing homicide and suicide, subject to the decision of the Supreme Court of Canada in *Carter v. Canada (Attorney General)*.[5] Euthanasia and assisted suicide provided in accordance with the criminal law are considered health care in Canada, the regulation of which is within the constitutional jurisdiction of provincial governments. Hence, the Standard has no legal effect except to the extent that provincial professional regulators adopt its provisions in "authoritative and binding regulatory standards."[6] Nonetheless, publication and endorsement of the Standard and related documents by Health Canada demonstrate approbation by the Canadian government. Hence, the Standard should be understood to articulate state expectations and demands in relation to lawfully killing people that are intended to override the moral/ethical convictions of individuals.

The Protection of Conscience Project does not take a position on the acceptability of EAS. The Project's interest is confined to issues related to the exercise of freedom of conscience by practitioners who refuse to do what they believe to be unethical or immoral. The focus here is on Parts 5 and 6 of the Standard. While this submission necessarily entails discussion of legal issues,

---

[1] Health Canada, "Model Practice Standard for Medical Assistance in Dying (MAID)" (27 March, 2023), Health Canada (website), online: <https://www.canada.ca/content/dam/hc-sc/documents/services/medical-assistance-dying/model-practice-standard/model-practice-standard.pdf> [*Model Standard*].

[2] Health Canada, "Advice to the Profession: Medical Assistance in Dying (MAID)" (27 March, 2023), Health Canada (website), online: <https://www.canada.ca/content/dam/hc-sc/documents/services/medical-assistance-dying/advice-profession/advice-profession.pdf> [*Advice*].

[3] Health Canada, "Background Document: The Work of the Medical Assistance in Dying (MAID) Practice Standards Task Group" (March, 2023: modified 17 April, 2023), Health Canada (website), online: <https://www.canada.ca/content/dam/hc-sc/documents/services/medical-assistance-dying/background-document-work-practice-standards-task-group/background-document-work-practice-standards-task-group.pdf> [*Task Group Background*].

[4] *Model Standard*, *supra* note 1 at 4, para 2.

[5] *Carter v Canada (Attorney General)*, 2015 SCC 5, [2015] 1 SCR 331, online: <https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/14637/index.do> [*Carter SCC*].

[6] *Task Group Background*, *supra* note 3 at 9.

the Project does not provide legal advice. Practitioners should consult legal counsel before acting upon discussion or arguments advanced.

I. Preliminary observations

Law and morality/ethics

I.1 The *Carter* decision changed the law by exempting physicians from prosecution for murder and assisted suicide in defined circumstances. In amending the *Criminal Code*, Parliament extended the exemption to include nurse practitioners.[7] Subject to the Court's guidelines, the *Charter* right of patients clearly established by the decision is a legal right not to be impeded or obstructed by the state in seeking euthanasia and assisted suicide from willing practitioners; that of practitioners, a legal right not to be impeded or obstructed by the state in providing euthanasia and assisted suicide. Any additional rights claims adverse to practitioner freedom of conscience are derived by reading into the ruling what the judges either did not address, or purposefully and expressly left out.[8]

I.2 Notwithstanding occasionally extravagant claims made by the appellants in *Carter*,[9] evidence at trial did not demonstrate the ethical or moral acceptability of euthanasia or assisted suicide.[10] It was not an issue in the appeal,[11] and the Supreme Court of Canada was unconcerned with the question.[12] On the contrary, the Court acknowledged continuing moral/ethical opposition to providing or participating in the procedures.[13] Thus, *Carter* does not undermine the legitimacy and

---

[7] *Criminal Code*, RSC 1985, c C-46 (18 October, 2022), Government of Canada, Justice Laws (website), online: <https://laws-lois.justice.gc.ca/eng/acts/c-46/> at s 241.1(a).

[8] Sean Murphy, "Supreme Court of Canada orders legalization of physician assisted suicide and euthanasia: Physicians unwilling to kill already face demands that they find someone who will" (31 January, 2016), *Protection of Conscience Project* (website), online: <https://www.consciencelaws.org/law/commentary/legal073-010.aspx>.

[9] In his oral submission, Joseph Arvay referred to the ethical distinction between euthanasia and withdrawing or withholding treatment, describing it as "the Rubicon." "We asked the trial judge to cross that Rubicon. And she did, based on evidence of ethicists and philosophers and physicians and practitioners, and she said there is no ethical distinction . . .". *Carter SCC*, *supra* note 5 (Oral argument, Appellant), Supreme Court of Canada (SCC), "Webcast of the Hearing on 2014-10-15" (22 January, 2018), online: SCC <https://www.scc-csc.ca/case-dossier/info/webcastview-webdiffusionvue-eng.aspx?cas=35591&id=2014%2f2014-10-15--35591&date=2014-10-15&fp=n&audio=n> [*Carter SCC webcast*] at 00:39:53 to 00:40:31.

[10] *Carter v. Canada (Attorney General)* 2012 BCSC 886, online: <https://bccla.org/wp-content/uploads/2012/06/Carter-v-Canada-AG-2012-BCSC-886.pdf> [*Carter BCSC*] at para 5–7. The trajectory of the case was determined by the trial judge's belief that suicide can be a rational and moral/ethical act, which led her to conclude that assisted suicide and euthanasia could be ethical. This became the assumption underlying the judge's explanation of the purpose of the law, but was not derived from the evidence. See *Carter BCSC* at para 339, 812–814, 842, 827, 1262 and Sean Murphy, "Legalizing therapeutic homicide and assisted suicide: A tour of Carter v. Canada" (12 April, 2017), *Protection of Conscience Project* (website), online: <https://consciencelaws.org/law/commentary/legal073-001.aspx> at Part VI.2, VI.5.

[11] *Carter SCC*, *supra* note 5 at para 40.

[12] *Ibid,* para 1-4.

[13] *Ibid*, para 130-132.

reasonable plausibility of moral/ethical/religious beliefs that it is gravely wrong or contrary to good medical practice — in principle or in particular cases — to deliberately kill people or help them to commit suicide — even if the law approves. Acting upon this belief should not be a reason for the state to penalize practitioners or exclude someone from health care practice. However, adopting the Standard would have that effect.

I.3 On a practical note, excluding people unwilling to collaborate in killing patients from health care practice also has implications for patient safety. Joseph Arvay, chief counsel for the *Carter* plaintiffs, lauded physician's unwillingness to harm their patients as an outstanding virtue that made them ideal euthanasia practitioners. "[I]t is an irrefutable truth," he told the Supreme Court of Canada, "that all doctors believe it is their professional and ethical duty to do no harm."

> Which means, in almost every case, that they will want to help their patients live, not die. It is for the very reason that we advocate only physician assisted dying and not any kind of assisted dying because we know physicians will be reluctant gatekeepers, and only agree to it as a last resort.[14]

Excluding people unwilling to collaborate in killing their patients from health care practice would thus seem to weaken what one of Canada's most prominent EAS advocates described as the most fundamental patient safeguard.

I.4 Killing people continues to be a deeply controversial subject, but the Standard attempts to erase the controversy by an authoritarian exercise of moral partisanship. It assumes the default position that practitioners have a moral duty to facilitate the killing of their patients. The pretence that this has been definitively settled becomes a premise made possible and made dangerous by enlisting the power of the state to impose it systemically through social, political and regulatory structures. The Standard thus encourages regulators to suppress unceded moral/ethical positions — and freedom of conscience — just as European colonists applied a false and enlarged notion of *terra nullius* (supported until recently by judicial deference) to take control of unceded indigenous lands in Australia and elsewhere.[15] That is the focus of this submission.

Inescapable involvement: optional (?) participation

I.5 The Standard is intended "to set the professional expectations of [practitioners] who *are involved* with MAID"[16] while imposing responsibilities on practitioners unable or unwilling to *participate*.[17] This suggests that involvement with euthanasia and assisted suicide is inescapable, but participation (as presented in the Standard) is optional.

---

[14] *SCC Carter webcast*, *supra* note 7 at 00:20:02 to 00:20:40.

[15] Margaret Beazley, "2021 Michael O'Dea Oration" (Memorial lecture delivered virtually at the National School of Law and Business, University of Notre Dame Australia, 20 October 2021) at para 7–8, 13, 15, 20.

[16] *Model Standard, supra* note 1at 2.1.2, emphasis added.

[17] *Ibid* at 5.2, emphasis added.

I.6 The concepts of *involvement* and *participation* are critical in ethical/moral deliberation, becoming acute in deliberation about involvement or participation in killing people. Nonetheless, the terms are undefined in the Standard and the meanings it attributes to them are not clearly distinguished in the text. It appears that, by participation, the Standard means

- personally making a request for EAS or an EAS assessment,[18]
- personally (or directly, actively assisting in) providing a lethal injection or a prescription for lethal substances,[19]
- personally (or directly, actively assisting in) assessing global EAS eligibility,[18] (but not specialist assessments of capacity, prognosis, etc., even if essential to establish eligibility).[20]

I.7 While these forms of participation entail serious moral/ethical responsibility, other kinds of involvement required by the Standard — notably effective referral and effective transfer of care — may be reasonably classed as morally charged participation or entail serious moral/ethical responsibility that practitioners may find unacceptable.[21] Thus, while the Standard states that it should be read in conjunction with relevant ethical statements and that practitioners "should respect existing ethical norms," including the *Canadian Medical Association Code of Ethics*,[22,23] it will be seen that, on the critical issue of referral, the Standard contradicts the position of the Canadian Medical Association.

Shifting legal and ethical goalposts

I.8 From the beginning, legal and ethical goalposts have been shifting steadily to expand access to EAS.[24,25] A comparison of the criteria for exemption in *Carter* with the *Criminal Code* and the explanations provided by the Standard and related documents indicate that further expansion is likely (See Appendix "A"). Specifically:

- the *Criminal Code* limits the exemption to illness, disease or disability, which is narrower than what *Carter* defined and unlikely to be sustained in the long term;

---

[18] *Ibid* at 5.2.2.

[19] *Ibid*. See generally 7.1 and 7.3 (for physician regulators allowing trainee participation), 7.1 and 7.2 (for physician regulators that do not allow trainee participation) and 7.1 (for nursing regulators).

[20] *Ibid* at 10.3.7.4.

[21] *Ibid* at 5.2.1.

[22] *Ibid* at 4, para 6.

[23] *Ibid* at 10.3.3.

[24] Sean Murphy, "Redefining the Practice of Medicine Euthanasia in Quebec: An Act Respecting End-of-Life Care" (28 October, 2015) at Part 3: Evolution or Slippery Slope?, *Protection of Conscience Project* (website), online: <https://www.consciencelaws.org/law/commentary/legal068-003.aspx>.

[25] Thomas Laberge, "Quebec government adopts law to expand medical aid in dying" (7 June, 2023), *The Montreal Gazette*, online: <https://montrealgazette.com/news/quebec/quebec-government-adopts-law-to-expand-medical-aid-in-dying>.

- beginning in March, 2024, to include neurodevelopmental or neurocognitive disorders (e.g. "dementias, autism, spectrum disorders, or intellectual disabilities").

Formulation of regulatory standards must take into account the fact that the likelihood of conflicts of conscience increases as exemptions allowing EAS increase.

Response continuum

I.9 The Standard acknowledges that the exercise of freedom of conscience by practitioners produces a range of responses to euthanasia and assisted suicide.[26] Some oppose the procedures in principle in all cases, while others oppose only practitioner involvement. Some will provide or facilitate EAS for some reasons (eg., terminal illness) but not others (eg., mental disorder). Practitioners generally willing to provide the service may be unwilling to do so in specific cases.

I.10 The Standard does not address legal criticism of the response continuum based on human rights law. It is argued that providing EAS service for some legally eligible patients (those with terminal cancer) but not for others (beginning March, 2024, those with only a mental disorder) is differential treatment that discriminates on the basis of disability. If that is so, it would seem that practitioners who provide EAS service to *someone* cannot refuse to provide it to *anyone*. Further, it is argued that (except for reasons of competence) practitioners cannot escape the obligation to personally provide EAS by making an effective referral; on the contrary, referral would be evidence of unlawful discrimination.[27]

Healthcare professional associations

I.11 The Standard defines "health professional association,"[28] but the terms actually used in the text are "professional association"[29] and "healthcare professional association."[30] Presumably the terms used in the text should be understood to reflect the definition of health professional association, which encompasses professional associations formed by practitioners who adhere to particular philosophical or religious traditions. Happily, this broad definition is consistent the Supreme Court of Canada's unanimous view that a secular public square (or profession) "is inclusive of people of religious belief and that they therefore should have equality under the law and be placed at no disadvantage as against non-religious believers."[31]

---

[26] *Model Standard*, *supra* note 1 at 6, footnote 8.

[27] Amir Attaran, "The Limits of Conscientious and Religious Objection to Physician-Assisted Dying after the Supreme Court's https://www.consciencelaws.org/law/commentary/legal073-010.aspx.Decision in Carter v. Canada" (2016) 36:1 Health Law Can. 2016 Feb;36(3):86, online: <https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2741748.

[28] *Model Standard, supra* note 1 at 22.

[29] *Ibid* at 4, para 7.

[30] *Ibid* at 21, "Clinical Practice Guidelines".

[31] Iain T. Benson "Seeing Through the Secular Illusion" (2013) 54 (Supplement 4) Nederduitse Gereformeerde Teologiese Tydskrif (Dutch Reformed Theological J) 12-29, online: <http://ojs.reformedjournals.co.za/index.php/ngtt/article/download/573/965> citing *Chamberlain v. Surrey School*

II. Irremediability, incurability and irreversibility

II.1 That a patient must suffer from a medical condition that is "grievous and irremediable" are two of the primary exemption criteria set by the *Carter* decision.[32] The Standard and Advice to the Profession document adopt the *Criminal Code's* definition of the phrase in which the concepts of incurability and irreversibility (of decline) are central.[33,34]

II.2 The Standard and Advice to the Profession document also make clear that incurability and irreversibility are established by a practitioner's considered opinion alone,[35,36] and that, when effective interventions are accessible "in a reasonable timeframe," patients "cannot refuse all or most interventions and automatically render themselves incurable/ in an advanced state of irreversible decline" in order to obtain EAS.[37] This appears to reflect comments by the co-chair of the Canadian Psychiatric Association's MAID Working Group, who told a parliamentary committee in 2022 that patients who refuse treatments for mental illness"without good reason" are "unlikely to have met the eligibility criterion for incurable."[38] On the other hand, Task Group member Jocelyn Downie had previously advised a parliamentary committee that the criterion of irremediability may ultimately be determined by the patient's treatment decisions.[39]

II.3 The explanation offered by the Standard attempts to straddle the two positions. It states that a practitioner's opinion as to incurability and irreversibility must be arrived at "by the clinician and person together exploring the recognized, available, and potentially effective interventions in light of

---

District No. 36 [2002] 4 S.C.R. 710 (SCC) at para 137, online: <http://scc-csc.lexum.com/scc-csc/scc-csc/en/item/2030/index.do?r=AAAAAQALIm1hbmRhdG9yeSIAAAAAAAAB>.

[32] *Carter SCC*, *supra* note 5 at para 127.

[33] *Model Standard*, *supra* note 1 at 9.1.5.

[34] *Advice*, *supra* note 2 at 4, question 2.

[35] *Model Standard*, *supra* note 1 at 9.1.5.

[36] *Advice*, *supra* note 2 at 4: question 3(a) and 5: question 4.

[37] *Ibid* at 4: question 3(b), at 5: question 4; at 13: question 13(c)

[38] House of Commons, Special Joint Committee on Medical Assistance in Dying, *No. 009: Evidence* (26 May, 2022) (Cochairs: Marc Garneau & Yonah Martin) online: <https://parl.ca/Content/Committee/441/AMAD/Evidence/EV11816254/AMADEV09-E.PDF#page=14> [*SJMAID 009*] at 12 (Dr. Alison Freeland).

[39] Parliament of Canada, Special Joint Committee on Physician Assisted Dying, *Meeting No. 7: Evidence* (28 January, 2016) (Cochairs: Kelvin Kenneth Ogilvie & Robert Oliphant), online: <https://parl.ca/Content/Committee/421/PDAM/Evidence/EV8077830/PDAMEV07-E.PDF#page=16> at 14 (Jocelyne Downie).

the person's overall state of health, beliefs, values and goals of care."[40]

II.4 Advice to the Profession simply repeats the Standard passages *verbatim*,[41] as if what should be done when patient and practitioner disagree were self-evident. It is not. The Standard and accompanying documents sidestep rather than address this issue, as Task Group Chair Dr. Mona Gupta did when she told a parliamentary committee that a finding of irremediability should be negotiated by practitioners and patients.[42]

II.5 The Standard and supporting documents maintain that patients cannot refuse potentially effective interventions and thus compel practitioners to find that they meet the criteria for practitioner exemption from prosecution, but fail to provide a rationale supporting this position. The Standard suggests that patients and practitioners should negotiate irremediability and irreversibility, but dodges the issue of what should be done if they disagree.

II.6 The Project agrees with the Standard that patients cannot refuse potentially effective interventions in order to force practitioners to provide EAS. This submission offers a principled argument to support that position and also addresses the issue of practitioner/patient disagreement.

Revisiting *Carter*

II.7 The phrase "grievous and irremediable" was coined by the plaintiffs in *Carter*. They defined grievous and irremediable medical conditions as being "without remedy, *as determined by* reference to treatment options acceptable to the person" (emphasis added), causing intolerable suffering that "cannot be alleviated by any medical treatment acceptable to that person."[43] The trial court judge adopted these elements in her ruling,[44] thus making the irremediability of a medical condition something ultimately determined by the patient. On this point the Supreme Court of Canada took a different approach. It ruled that the laws against murder and assisted suicide do not apply to physicians providing EAS to a competent adult who

> [127] . . . (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition. "Irremediable", it should be added, does not require the patient to undertake treatments that are not acceptable to the individual. (emphasis added).[45]

II.8 The terms "irremediable" and "incurable" are often used interchangeably, but sometimes a

---

[40] *Model Standard*, *supra* note 1 at 9.5.2, 9.6.4.

[41] *Advice*, *supra* note 2 at 4, question 3(a) and 5, question 4.

[42] *SJMAID 009*, *supra* note 38 at 23 (Dr. Mona Gupta).

[43] *Carter BCSC*, *supra* note 10 at para 24, 1385.

[44] *Ibid* at para 1393(a).

[45] *Carter SCC, supra* note *5* at para 127.

distinction is possible. When the effects of a medical condition can be alleviated or relieved, it may be considered remediable to that extent, even if it cannot be fully cured. The Supreme Court accepted the criterion of irremediability (not incurability) in the first sentence of paragraph 127 and affirmed patient freedom in the second (underlined). "Irremediable" appears in both sentences, but there are two different issues here, not one.

II.9 The distinction is exemplified in a practice direction from the Ontario High Court of Justice applying the *Carter* decision. It describes the evidence required from a physician supporting an application for EAS:

> 10. The application record should include an affidavit from the applicant's attending physician addressing whether,
>
> a) the applicant has *a grievous irremediable* medical condition (illness, disease, or disability) that causes suffering; (emphasis added)
>
> b) as a result of his or her medical condition, the applicant is suffering enduring intolerable pain or distress *that cannot be alleviated by any treatment acceptable to the applicant*; . . . (emphasis added)[46]

II.10 The Supreme Court of Canada in *Carter* and the practice direction from the Ontario High Court of Justice maintain the distinction between irremediability and patient freedom that was elided in the trial court ruling. The distinction is significant for both practitioner and patient. On the one hand, it prevents a practitioner's clinical judgement that a condition is not irremediable from being reversed by a patient's refusal to accept potentially beneficial treatments. On the other, the physician's determination does not force a patient to accept unwanted interventions, and EAS might be accessed through a different practitioner.

II.11 The distinction is also necessary to safeguard the concept of fiduciarity. The duty to act in the patient's best interests imposes an obligation upon practitioners to assess that independently and in good faith, using their own judgement, without becoming a "puppet" directed by others, including the patient and state regulators.[47] This obligation by no means excludes discussion and negotiation, but it may preclude a negotiated agreement.

---

[46] Heather J. Smith CJ, "Application for Judicial Authorization of Physician Assisted Death", Practice Advisory on *Carter v. Canada (Attorney General)*, 2016 SCC 4 (29 January, 2016), Ontario Superior Court of Justice (website), online: <https://www.ontariocourts.ca/scj/practice/application-judicial-authorization-carter/> at para 10.

[47] Canadian Aero Service Ltd. v. O'Malley, [1974] SCR 592, 1973 CanLII 23 (SCC)at 606; McInerney v MacDonald, [1992] 2 SCR 138, 1992 CanLII 57 (SCC) at 139, 149, 152; United Kingdom, Law Commission, Report No. 350 Fiduciary Duties of Investment Intermediaries (Williams Lea Group for HM Stationery Office,2014), Law Commission [UKLCR350] at para 3.53, note 107, citing *Selby v Bowie* (1863) 8 LT 372, *Re Brockbank* [1948] Ch 206.

Conflation of irremediability and patient freedom

II.12 However, the criterion of irremediability and recognition of patient freedom have been conflated in implementing the *Carter* decision, to the point that the distinction has been erased in the *Criminal Code.* The *Code* defines "grievous and irremediable medical condition" as "a serious and incurable illness, disease or disability" that has caused "an advanced state of irreversible decline in capability" resulting in intolerable "enduring physical or psychological suffering. . . that cannot be relieved under conditions that they consider acceptable."[48]

II.13 It appears that the Supreme Court's criterion of irremediability has been displaced in the *Code* by incurability *as determined by the will of the patient*. This position was neatly summed up by psychiatrist Dr. Derryk Smith at a 2022 parliamentary committee hearing into euthanasia and assisted suicide as treatments for mental illness: "The patient must agree. If they don't agree and there are no other treatments available, then the person has an irremediable condition."[49] His argument reiterated the position taken by Task Group member Jocelyn Downie six years earlier (see II.2).

Irremediability as a scientific/medical issue

II.14 Dr. Smith was among witnesses who believed that some mental illnesses can be considered irremediable and EAS services should be available as a treatment option when it is. Among those disagreeing with Dr. Smith was psychiatrist Dr. Sonu Gaind, physician chair of the Humber River Hospital's MAID committee. Dr. Gaind, who does not object to euthanasia/assisted suicide in principle, described the criterion of irremediability as "the primary safeguard" in the law. He insisted that what counts as an irremediable condition must be determined scientifically, and that science cannot determine that mental illness is irremediable.[50]

II.15 Like Task Group Chair Dr. Gupta before the parliamentary committee, Advice to the Profession effectively asks "How many treatments do we have to try?"[51,52] Both the irremediability-determined-by-patient solution (Prof. Jocelyn Downie and Dr. Derryk Smith) and the irremediability-is-negotiable evasion (Dr. Alison Freeland, Dr. Mona Gupta & the Standard) deny the primacy of

---

[48] *Criminal Code*, *supra* note 7 at s 241.2(2).

[49] House of Commons, *Special Joint Committee on Medical Assistance in Dying*, *No. 008: Evidence– Public Part Only* (25 May, 2022) (Cochairs: Marc Garneau & Yonah Martin) online: <https://parl.ca/Content/Committee/441/AMAD/Evidence/EV11814179/AMADEV08-E.PDF#page=5> at 3 (Dr. Derryk Smith).

[50] House of Commons, Special Joint Committee on Medical Assistance in Dying, *No. 003: Evidence* (25 April, 2022) (Cochairs: Marc Garneau & Yonah Martin) online: <https://parl.ca/Content/Committee/441/AMAD/Evidence/EV11721028/AMADEV03-E.PDF#page=26> at 24, 29 (Dr. Sonu Gaind).

[51] *SJMAID 009*, *supra* note 38 at 23 (Dr. Mona Gupta)..

[52] *Advice*, *supra* note 2 at 4, question 3(b).

medical science in determining the irremediability, incurability or irreversibility of medical conditions and subvert the concept of fiduciarity. This cannot have been intended by the Supreme Court of Canada, nor does the Court's ruling in *Carter* support it.

Determining irremediability/incurability/irreversibility

II.16 The question, "How many treatments do we have to try?" may be discussed, but the answer is not negotiable. The law is clear that the patient does not have to accept any treatment, and need not have what a practitioner considers a "good reason" to refuse. Thus, even if a practitioner believes that a determination of irremediability, incurability or irreversibility can be arrived at by negotiation, it is unclear how a practitioner could negotiate except by using the desired diagnosis as a bargaining chip (i.e., "I will conclude the condition is irremediable/incurable/irreversible only if you accept treatments X, Y or Z and they don't work").

II.17 In contrast, practitioners like Dr. Gaind, believe that determinations of irremediability, incurability or irreversibility must be established by evidence-based medical criteria: that they are independent of and cannot be established by patient refusal to accept treatment. This is a reasonable and plausible position that informs current medical practice and consistent with principles of fiduciarity. It is consistent with Advice to the Profession statements to the effect that practitioners cannot form opinions about exemptions for EAS in the absence of evidence needed to form them.[53]

II.18 In sum, the *Carter* decision enables practitioners to form an evidence-based opinion that a patient's medical condition is not irremediable, an opinion that cannot be overridden by a patient's unwillingness to accept potentially efficacious treatments. It remains to address the question unasked and unanswered by the Standard: "What happens if a patient disagrees with a practitioner's conclusion that medical criteria for exemption have not been met?"

III. Criminal law and practitioner exemptions for EAS

Obligation to comply with law

III.1 The Standard states that practitioners "have an obligation to comply with any and all applicable laws."[54] This obviously includes *all* physicians — not just those assessing for or providing EAS services. Further, the obligation is binding on individual practitioners even if other practitioners, professional associations and regulators take a different view of facts or law in a particular case.

III.2 The law on murder, manslaughter, criminal negligence and assisted suicide applies to practitioners in relation to a patient described in s 241.2(1) and (2) of the *Criminal Code* in one respect only. Practitioners are exempt from prosecution for these offences *only* if they believe the

[53] *Ibid* at 4–5, question 3(b) and at 5, question 4.

[54] *Model Standard*, *supra* note 1 at 4, para 4.

patient meets the criteria that exempt a practitioner from prosecution.[55]

When patients are believed to meet exemption criteria

III.3 Practitioners who reasonably believe that a patient meets the exemption criteria and who *knowingly fail or refuse* to adhere to procedural safeguards *cannot* be charged for murder or manslaughter. At most, they can be charged for an offence punishable on indictment or summary conviction for which the maximum penalty is imprisonment for five years:[56] the same penalty provided for assault.[57]

When patients are believed not to meet exemption criteria

III.4 Even prior to a formal EAS assessment, a conviction that a patient does not meet the exemption criteria may be grounded in professional judgement arising from a clinical relationship, or from a thorough and sensitive exploration of the reasons underlying a patient's interest in EAS. Practitioners who reasonably believe that a patient does *not* meet the exemption criteria under the *Code's* MAID provisions could be charged for murder, manslaughter, or assisting suicide were they to lethally inject the patient or assist with suicide. However, their legal liability would extend beyond personally providing the services to include being parties to offences, counselling offences and conspiracy.

III.5 One can be guilty of counselling an offence and a party to a conspiracy even if the offence is not committed.[58] Further, one can be a party to an offence by aiding or abetting[59] even if the principal party (the practitioner who actually provides euthanasia or assisted suicide) is not criminally liable, not charged or is acquitted.[60] All of these offences are relevant when a practitioner believes that a patient does not meet the exemption criteria.

III.6 The fact that practitioners having a different view of the exemption criteria may later provide euthanasia or assisted suicide and may not be criminally responsible, charged or convicted is not relevant to decision-making by practitioners obliged to comply with the criminal law in relation to a patient they consider does not meet the exemption criteria.

III.7 Actual jeopardy is not the point here. The obligation to comply with the law is binding whether or not one is likely to be charged and convicted for an offence. Those who consider a patient

---

[55] *Criminal Code*, *supra* note 7 at s 227, s 241.3.

[56] *Ibid* at s 241.3.

[57] *Ibid* at s 266.

[58] *Ibid* at s 464–465.

[59] *Ibid* at s 21(b) or (c).

[60] *R v Johnson*, 2017 NSCA 64 at para 78 (CanLII). online: <https://canlii.ca/t/hrj8h>. However, it is not clear if a homicide or assisted suicide must be shown to have occurred in relation to potential criminal responsibility for aiding or abetting.

has failed to meet the exemption criteria are obliged to act accordingly. The alternative — that physicians must provide or facilitate EAS even if they believe that patients who do not meet the exemption criteria — would eviscerate what is supposed to be a safeguard for patients.

Nonexemption must lead to practitioner refusal

III.8 In any case, as the Standard and Advice to the Profession document indicate, practitioners who believe that a patient does not meet the *Criminal Code's* exemption criteria are obliged to refuse to provide the service.[61,62] Further, they are constrained by criminal law not only to refuse to provide the service, but to refuse to become parties to an offence by doing anything to further a request for it. They would otherwise betray the trust reposed in them by Joseph Arvay (see I.3).

III.9 Patients in these cases may continue to look for a practitioner who may find they meet the exemption criteria, but cannot expect assistance from practitioners who believe that they do not.

IV. Standard 5.0: Practitioners unwilling/unable to participate

Limits on regulator authority

IV.1 In view of the foregoing, the Project's position is that regulators have no basis to proceed against practitioners who, having the opinion that a patient does not meet the exemption criteria for euthanasia or assisted suicide, refuse to do anything to further a request for the services, including effective referral/transfer of care as defined in the Standard.

IV.2 Practitioners are clearly able to provide information about legal assisted suicide in response to a patient's request or enquiries.[63] However, counselling (recommending) suicide remains a criminal offence. Practitioners may be criminally liable if they suggest assisted suicide as a treatment option to a patient who has not expressed an interest in it or MAID, which includes both euthanasia and assisted suicide.[64]

IV.3 If practitioners are of the opinion that a patient does not meet the exemption criteria for euthanasia or assisted suicide, it would seem that a regulator would commit the offence of counselling if it were to advise them or attempt to persuade or coerce them to provide effective referrals/transfers of care to EAS practitioners.[65] This would also seem to apply to advising practitioners or attempting to persuade or coerce them to suggest assisted suicide to a patient who

---

[61] *Model Standard*, *supra* note 1 at 10.3.4.1(b), 10.3.4.2(b).

[62] *Advice*, *supra* note 2 at 9 para 1.

[63] *Criminal Code*, *supra* note 7 at s 241(5.1).

[64] *Ibid* at s 241(1)a.

[65] *Ibid* at s 464.

has not expressed interest in it or in MAID.

No compulsion *to provide*

IV.4 The Standard states that no physician or nurse practitioner "can be compelled to prescribe or administer substances for the purpose of MAID."[66] This necessarily includes lethal substances, but the statement should be understood to include other substances that may be used to facilitate the EAS process, like the local anaesthetics, coma-inducing agents and sedatives currently in use.[67]

IV.5 This is an important statement because it reflects, to a limited extent, what the state ought to prescribe in relation to lawfully killing people. It is a notable improvement on the *Criminal Code* clarification that "nothing in this section compels an individual to provide or assist in providing medical assistance in dying."[68] This clarification is worthless because nothing in the *Criminal Code* (including the clarification) *prevents* physicians and nurse practitioners from being compelled by other laws, regulations or policies to provide or assist in providing EAS.

IV.6 The *Code*'s clarification does, however, highlight two significant omissions in the Standard's prohibition of compulsion. First, nothing in the Standard prevents practitioners from being compelled *to assist* in administering or prescribing substances used in EAS, by, for example, setting an IV line. Second, the Standard's prohibition protects only physicians and nurse practitioners, not nurses and other healthcare workers. This is presumably because the current text prohibits only compulsion to administer or prescribe substances used in EAS (which only physicians and nurse practitioners may do). However, the explanation serves only to emphasize the point that the Standard allows physicians, nurse practitioners and other individuals to be compelled to assist in euthanasia and assisted suicide. Demands for compulsory assistance are most likely to arise in situations characterized as "emergencies."

Compulsion to *assist*

IV.7 Physicians' traditional obligation to provide medical treatment in emergencies may be advanced as an exception to the Standard's prohibition of compulsion and to justify compulsory assistance. The obligation was never understood to include providing euthanasia or assisted suicide because the procedures were illegal and not considered medical treatment. However, they are now legal in Canada and viewed as health care services by a substantial part of the population — including key players in the medico-legal establishment. The silence of the Standard on this point is troubling in because it appears that requests for active assistance in providing EAS are treated as emergencies by mainstream actors in Canada's public healthcare system (see Appendix "B").

---

[66] *Model Standard*, *supra* note 1 at 5.1.

[67] Canadian Association of MAID Assessors and Providers (CAMAP), "Intravenous MAiD Medication Protocols in Canada: Review and Recommendations (CAMAP White Paper on Intravenous MAID)" (April, 2020), *CAMAP* (website), online: <https://camapcanada.ca/wp-content/uploads/2022/02/IV-protocol-final.pdf> [IV MAID].

[68] *Criminal Code* RSC 1985, c C-46, s 241.2(9).

IV.8 It is also revealing. If one believes that the state must not compel unwilling individuals to assist in lawfully killing other people, nor allow such compulsion, one would expect the Standard to make clear that no one can compelled under any circumstances to assist in providing EAS, even if experts or persons in authority believe that killing someone else is something that must sometimes be done "emergently." The absence of such a statement indicates that Canada's national government supports coercion of unwilling health care workers to force them to assist in killing their patients. Provincial governments and professional regulators should clearly reject this position by prohibiting coerced assistance in EAS.

V. Standard 5.0: Effective referral/transfer of care to providers

V.1 Practitioners who believe that patients have not met the exemption criteria for EAS cannot be compelled by regulators to do anything to facilitate the procedures (see Part IV). Discussion in this part presumes that practitioners "unable or unwilling" to participate have *not* concluded that a patient has not met the criteria.

Obligations imposed on unwilling practitioners

V.2 The Standard imposes obligations on physicians or nurse practitioners "unable or unwilling to *participate* in MAID practice *as set out in this Standard*," the first of which is to "complete an effective [referral/transfer of care] for any person seeking to make a request, requesting, *or eligible to receive* MAID."[69] (i.e., have met the exemption criteria; emphasis added)

> **Effective referral:** taking positive action to ensure the person requesting MAID is connected in a timely manner to a non-objecting, available, and accessible physician or nurse practitioner, other health-care professional, or [name of agency, program, office responsible for patient navigation] that provides the health service (eligibility assessments for, and provision of, MAID) or connects the person directly with a health-care professional who does. 'Timely manner' means such that the person will not experience an adverse clinical outcome or prolonged suffering due to a delay in making the connection. [*Note to users: delete this definition if the regulatory authority uses wording of effective transfer of care instead of effective referral*] (underlining added)[70]
>
> **Effective transfer of care:** a transfer made by one physician or nurse practitioner in good faith to another physician or nurse practitioner who is available to accept the transfer, accessible to the person requesting MAID, and willing to provide MAID to that person if the eligibility criteria are met. [*Note to users: delete this definition if the*

[69] *Model Standard*, *supra* note 1 at 5.2, 5.2.1.

[70] *Ibid* at 21.

regulatory authority uses the wording of effective referral instead of effective transfer of care][71]

V.3 As indicated by the italicized notes the Standard includes with the definitions, the terms are intended to be interchangeable. However, their moral/ethical significance differs. "Effective referral" as defined includes an alternative: connecting an individual with a 'navigator' ("agency, program, office responsible for patient navigation"). Subject to important caveats, this alternative may prove to be a generally satisfactory method of accommodating objecting practitioners. On the other hand, an "effective transfer of care" as defined requires positive action clearly intended to facilitate EAS and would therefore be unacceptable to many practitioners.

V.4 Accordingly, this submission addresses "effective referral" under two headings. The first (effective referral to providers) reflects the original, usual and controversial meaning of "effective referral" indicated by the underlined passage in the Standard's definition.[72] The second (connection to navigators) presents the alternative proposed by the Standard in a form clearly distinguished by name and modified to enable accommodation likely to be generally satisfactory to objecting practitioners.

V.5 Note that the discussion of effective referral to providers also applies to "effective transfer of care."

Effective referral to providers opposed by CMA

V.6 The Standard commends the *Code of Ethics and Professionalism* of the Canadian Medical Association (CMA) as a reliable ethical resource,[73] but a proposal for mandatory referral by objecting physicians was rejected when the CMA *Code of Ethics* was revised in 2018[74] and is not required.[75] In fact, the CMA opposes demands for effective referral to providers by objecting physicians.

V.7 For over 50 years the CMA has consistently opposed attempts to compel physicians to refer for procedures to which they object for reasons of conscience.[76] Its first foundational statement addressing physician freedom of conscience was a 2016 submission to the College of Physicians and Surgeons of Ontario (CPSO) opposing the CPSO demand for effective referral to providers for

---

[71] *Ibid* at 22.

[72] "Providers" includes individuals and entities that deliver EAS services.

[73] *Model Standard, supra* note 1at 4, para 6, para 10.3.3.

[74] Sean Murphy, "Canadian Medical Association and Referral for Morally Contested Procedures" (20 October, 2022), *Protection of Conscience Project* (website), online: <https://www.consciencelaws.org/ethics/ethics098-001.aspx> [*CMA and Referral*] at 2018; CMA *Code of Ethics and Professionalism*, online: <https://www.consciencelaws.org/ethics/ethics098-001.aspx#2018>

[75] The Canadian Medical Association, *Code of Ethics and Professionalism*, Ottawa: CMA, 8 December, 2018, online: <https://policybase.cma.ca/link/policy13937?>.

[76] *CMA and Referral*, *supra* note 74.

euthanasia and assisted suicide.[77] Important elements of the CMA statement were later incorporated into the CMA *Medical Assistance in Dying* policy. The first and most important element is the recognition of physicians as moral agents.

> It is in fact in a patient's best interests and in the public interest for physicians to act as moral agents, and not as technicians or service providers devoid of moral judgement. At a time when some feel that we are seeing increasingly problematic behaviours, and what some view as a crisis in professionalism, medical regulators ought to be articulating obligations that encourage moral agency, instead of imposing a duty that is essentially punitive to those for whom it is intended and renders an impoverished understanding of conscience.[78]

V.8 The CMA argues that physician freedom of conscience can be protected without impeding or delaying patient access to EAS by asking physicians to fulfil "a duty that is widely morally acceptable" that respects their moral agency, while requiring the community to accept its responsibility to ensure access.[79] That this can be done is demonstrated in British Columbia's Vancouver Island health region, which, according to the Canadian Association of MAID Assessors and Providers (CAMAP), had achieved the highest euthanasia rate in the world by 2020,[80] even though objecting physicians are *not* required to make an effective referral or transfer of care as defined by the Standard.[81]

V.9 Certainly, the CMA recognizes that some physicians who refuse to provide assisted suicide or euthanasia do not refuse to refer a patient to a colleague willing to provide the service. But it acknowledges that others find referral "categorically morally unacceptable" because they believe that

---

[77] Canadian Medical Association, "Submission to the College of Physicians and Surgeons of Ontario: Consultation on CPSO Interim Guidance on Physician-Assisted Death" (13 January, 2016), *Protection of Conscience Project* (website), online: <https://www.consciencelaws.org/background/policy/associations-003-002.aspx> [*CMA 2016*].

[78] *Ibid*.

[79] *Ibid*.

[80] Canadian Association of MAID Assessors and Providers, "Written Brief to the Standing Committee on Justice and Human Rights House of Commons Canada" (5 November, 2020), *Parliament of Canada* (website), online: <https://www.ourcommons.ca/Content/Committee/432/JUST/Brief/BR10946104/br-external/CanadianAssociationOfMaidAssessorsAndProviders-e.pdf> [*CAMAP Brief*] at 3.

[81] College of Physicians and Surgeons of British Columbia, "Practice Standard: Medical Assistance in Dying" (Last Revised 10 May, 2022), CPSBC (website), online: <https://www.cpsbc.ca/files/pdf/PSG-Medical-Assistance-in-Dying.pdf> The "effective transfer of care" in the CPSBC Practice Standard is defined as "advising patients that other physicians may be available to see them, suggesting the patient visit an alternate physician or service, and if authorized by the patient, transferring the medical records as required." In other words, objecting physicians need not initiate a transfer, but must cooperate in a patient-initiated transfer if asked to forward the patient's medical record. This is the usual requirement in foreign jurisdictions where euthanasia and assisted suicide are permitted, and, in the Project's experience, is not problematic.

referral makes them complicit in grave wrongdoing. In its submission to the CPSO, the Association characterized a demand for "effective referral" as illicit discrimination, not a solution, because it "respects the conscience of some, but not others."

> It is the CMA's strongly held position that there is no legitimate justification to respect one notion of conscience . . . the CMA [seeks] to articulate a duty that achieves an ethical balance between conscientious objection and patient access in a way that respects differences of conscience. It is the CMA's position that the only way to authentically respect conscience is to respect differences of conscience.[82]

V.10 Then CMA President Dr. Cindy Forbes and Vice President Dr. Jeff Blackmer vigorously defended the Association's approach in a letter to a parliamentary committee studying implementation of the *Carter* ruling:

> The Special Joint Committee was incorrectly informed that the CMA "has essentially said there should be a requirement to refer." This statement is categorically untrue and misrepresents the CMA's recommendations. . .
>
> Based on the experiences in other jurisdictions, it is the CMA's position that access will not be impeded based on the proportion of physicians that may choose not to participate based on conscience. We must re-emphasize that the arguments being advanced to suggest otherwise are unnecessarily creating conflict and forcing legislators and regulators to take a decision based on a false dichotomy.[83]

V.11 In a later submission the CMA emphasized the need to "respect the personal convictions of health care providers" and accommodation of both patients seeking euthanasia/assisted suicide and physicians unwilling to participate in the procedures for reasons of conscience. In particular, the submission noted, "From the CMA's significant consultation with our membership, it is clear that physicians who are comfortable providing referrals strongly believe it is necessary to ensure the system protects the conscience rights of physicians who are not."[84]

V.12 Current CMA EAS policy states that objecting physicians "are not required to provide it, or to otherwise participate in it, or to refer the patient to a physician or a medical administrator who will

---

[82] *CMA 2016*, *supra* note 77.

[83] Letter from Cindy Forbes and Jeff Blackmer, Canadian Medical Association, to Robert Oliphant, MP and Hon. Kenneth Ogilvie, PC MP, Co-Chairs Special Joint Committee on Physician-Assisted Dying, Parliament of Canada (4 February, 2016) re: Correcting misinformation about the position of the Canadian Medical Association, online: <https://www.ourcommons.ca/Content/Committee/421/PDAM/Brief/BR8116310/br-external/2016-02-04_PDAM_follow-up_Cdn_Medical_Association_e-e.pdf>.

[84] Canadian Medical Association, "Supporting the enactment of Bill C-14, Medical Assistance in Dying: Submission to the House of Commons Standing Committee on Justice and Human Rights" (2 May, 2016), online: <https://www.ourcommons.ca/Content/Committee/421/JUST/Brief/BR8234926/br-external/CanadianMedicalAssociation-e.pdf#page=4> at 3.

provide assistance in dying to the patient."[85] It also appears to put the onus on the state "to implement an easily accessible mechanism to which patients can have direct access" to obtain the services so that physicians can adhere to their moral commitments.[86]

Effective referral to providers and the *Carter* decision

V.13 The reasoning that underpins the law on parties to offences, including aiding or abetting murder, is unaffected by the *Carter* decision. But for *Carter*, making an effective referral to providers for euthanasia or assisted suicide would expose practitioners to prosecution as parties to murder or assisted suicide, or conspiracy to commit murder or assisted suicide. Indeed, even now a practitioner would be liable to be charged with first degree murder were he to take "positive action to ensure that [a] person requesting MAID is connected in a timely manner" to a *non-practitioner* who provided a lethal injection.

Effective referral to providers and complicity

V.14 The logic that underlies the law on criminal complicity is applied to moral complicity by practitioners who refuse to make an effective referral to providers of EAS. They reasonably hold that such positive action facilitates euthanasia by colleagues and would make them complicit in killing their patients, which they hold to be gravely wrong and/or contrary to good medical practice. However, consistent with the preliminary observations in I.4, nothing in the Standard acknowledges even the existence of legitimate concern about moral/ethical complicity in killing other people. Instead, the Standard implies that effective referral to providers is merely a form of involvement without serious moral implications, refusing to acknowledge that it can be considered a form of participation.

VI. Standard 5.0: Connection to navigators

Assisting patients

VI.1 Patients who are so debilitated or circumstantially handicapped that they are unable to contact health care personnel or obtain medical treatment are clearly at risk and in need of assistance in all circumstances, not just in relation to accessing a morally contested service. Physicians encountering such patients should recognize this problem and respond to it in all situations out of concern for their welfare and safety. This can be done by finding a responsible and reliable person who can help patients to overcome circumstantial handicaps, enabling them to obtain necessary assistance and navigate the health care system. The helper could be a family member, friend, social worker,

[85] The Canadian Medical Association, *Policy: Medical Assistance in Dying*, Ottawa: CMA; May, 2017, online: <https://policybase.cma.ca/media/PolicyPDF/PD17-03.pdf> at Addressing Adherence to Moral Commitments, (a) .

[86] *Ibid* at Relevant Foundational Considerations: 3. Respect for freedom of conscience.

outreach worker, etc.

VI.2 In the Project's experience, practitioners unwilling to be parties to EAS would be willing (and naturally) inclined to do this, whether or not a patient is seeking EAS. Further, objecting practitioners are generally willing to provide patients with information that enables them to make informed decisions and that facilitates patient contact with other health care service providers or agencies. This allows these practitioners avoid any positive action causally connected to contested services, while patients remain free to pursue them, with or without the assistance of others.

VI.3 On the other hand, objecting practitioners are likely to refuse to do something that they believe implies their support for or establishes a causal connection to EAS. Thus, they would provide contact information for health care providers or services generally, but may refuse to direct patients specifically to someone who provides EAS, or to an agency that delivers it.

VI.4 This willingness to cooperate (but not to collaborate) — if understood and honoured — makes it possible to accommodate practitioners and patients using the Standard's alternative to effective referral to a provider: "taking positive action" to connect a patient to an "agency, program, office responsible for patient navigation" that can connect the patient to EAS providers. In order to avoid confusion and mistrust, this alternative should *not* be identified or described as "effective referral," which has accumulated too much baggage: hence "connection to navigators" is used in this submission.

Unacceptable alternatives

Provincial-Territorial Expert Advisory Group

VI.5 It is critical to avoid arrangements that would push objecting practitioners beyond cooperation to collaboration. An unacceptable arrangement was proposed by the Provincial-Territorial Expert Advisory Group on Physician Assisted Dying (PT Experts): a publicly-funded EAS delivery system analogous to existing organ transplant systems. The PT Experts believed tht systems designed for delivering hearts and livers to save patients' lives could be replicated to deliver lethal injections and toxic prescriptions to end them. The proposed arrangement would have required objecting physicians to actively and practically demonstrate the same level of professional and moral commitment to killing patients and helping them commit suicide that they demonstrate in arranging for organ transplants.[87]

MAiD Care Coordination Services

VI.6 MAiD Care Coordination Services (CCS) established in some provinces are presumably useful for practitioners willing to participate in providing EAS. However, a MAID CCS is dedicated

[87] *Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying: Final Report* (30 November, 2015) Cochairs Jennifer Gibson, Maureen Taylor, online: <http://www.consciencelaws.org/archive/documents/2015-12-14-prov-panel.pdf> at 24, 44–45.

to delivering euthanasia and assisted suicide and would not, for that reason, be a navigator acceptable to objecting practitioners.

Acceptable alternatives

Canadian Medical Association model

VI.7 Based on a decision supported by about 75% of the delegates at the CMA Annual General Council of 2015,[88] the CMA sought accommodation through a "separate central information, counseling, and referral service" that differed from the PT Experts' proposal in three fundamental ways.

- First: unlike the Experts' proposal, but like the *Carter* ruling, the CMA model explicitly affirms physician freedom to refuse to provide *or participate* in euthanasia or assisted suicide.
- Second: the CMA model does not require objecting physicians to contact the central service or initiate a transfer of patients and records, but to advise patients how to access it. The initiative would remain with the patient. Objecting physicians would respond as usual to a patient-initiated request for transfer of care.
- Third: the CMA model is not presented or understood to require active participation of objecting physicians analogous to what is expected in relation to organ transplantation.[89]

Provincial health system navigators

VI.8 Some provinces have programmes or agencies that help patients navigate the public health care system: Alberta Health Link[90] and Health Connect Ontario,[91] for example. These programmes

[88] André Picard, "Less than a third of doctors willing to aid in assisted dying: CMA poll" The Globe and Mail (25 August, 2015), online: <http://www.theglobeandmail.com/news/national/less-than-a-third-of-doctors-willing-to-participate-in-assisted-dying-poll/article26100505/>.

[89] The Canadian Medical Association, *Principles-based Recommendations for a Canadian Approach to Assisted Dying*, Ottawa: CMA, 2015, in Letter from Cindy Forbes, Jeff Blackmer to Harvey Max Chochinov and Catherine Frazee (19 October, 2015) Re: CMA Submission to the Federal External Panel on Options for a Legislative Response to *Carter vs. Canada* (Federal External Panel), online: <https://policybase.cma.ca/media/BriefPDF/BR2016-01.pdf#page=4> at Appendix 2.

[90] Alberta Health Services, "811 Health Link: Health Advice 24/7" (2023), Alberta Health Services (website), online: <https://www.albertahealthservices.ca/info/page12630.aspx>.

[91] Ontario Ministry of Health, News Release, "Ontario Launches New Tool to Connect People to Nurses and Other Health Services from Anywhere at Any Time" (22 April, 2022), online: <https://news.ontario.ca/en/release/1002095/ontario-launches-new-tool-to-connect-people-to-nurses-and-other-health-services-from-anywhere-at-any-time>.

facilitate access to all services patients may be seeking, including EAS, but — but unlike a MAID CCS — they are not dedicated to EAS.

VI.9 Objecting practitioners are typically willing to enable patients to connect with such programmes, even if they might help a patient obtain services the practitioners decline to provide. There is no practical difference in terms of service delivery when patients seeking EAS connect with Alberta Health Link rather than a MAID CCS, but there is a significant ethical difference for practitioners who wish to avoid complicity in euthanasia and assisted suicide.

VI.10 Some might protest that there is "really" no difference between requiring connection with a MAID CCS rather than a general health navigator, so practitioners should be compelled to make the connection with a MAID CCS. But if there "really" is no difference, enabling a patient to connect with one OR the other should be sufficient. Further, the special concern taken by objecting practitioners in assessing their own involvement is consonant with the cautious approach recommended by Advice to the Profession in assessing patient capacity ("Greater thoroughness. . . is required for decisions with greater complexity or risk"[92]). And the care they take on this point is consistent with Joseph Arvay's high expectations of physicians (see I.3).

VII. Standard 6.0: Duties to patients

VII.1 Part 6.0 of the Standard is challenging. It trades on principles of informed consent to force practitioners to suggest EAS to patients who have expressed no interest in it simply because the patient might be "eligible" for it. This is most evident in the requirement that practitioners determine patients' views about euthanasia and assisted suicide in order to decide whether or not to present them as potential treatment options.[93] The exploration necessary to make the determination would itself would effectively present the procedures as options, just as a practitioner's exploration of a patient's views about having a sexual relationship with him could hardly fail to be understood as the presentation of an option.

VII.2 This is treacherous terrain. It would be incongruous for practitioners to see every pregnant woman primarily as someone who might be "eligible" for abortion. It is equally incongruous to demand that they see every suffering patient primarily as someone who might be "eligible" for lethal injection. A pregnant woman may not welcome and may be offended by the gratuitous offer of the options of abortion and adoption. Similarly, patients who appear to meet the criteria for practitioner exemption from prosecution may not welcome and many be offended by an unsolicited offer of the

[92] *Advice*, *supra* note 2 at 3.

[93] *Model Standard*, *supra* note 1 at 6.3; *Advice*, *supra* note 2 at 13, question 14.

option of lethal injection.[94]

VII.3 Generally speaking, what information practitioners should provide and the point at which it ought to be provided must be guided by and responsive to the circumstances and expressed interests of each patient. This should be left to the good judgement individual practitioners based on their knowledge of and interaction with their patients.

VII.4 However, practitioners cannot be expected to characterize what they believe to be an unethical/immoral practice as a normal or acceptable treatment, especially since they often judge practices to be unethical/immoral because they consider them actually or potentially harmful. Prescription of antibiotics for viral infections and ivermectin for Covid-19 are familiar examples. Refusal to present these as treatment options is usually glossed as a "professional" or "clinical" decision and typically justified on that basis, but refusal in these circumstances is an ethical or moral decision informed by clinical or professional judgement about the effects of the drugs.[95] Further, that a suffering patient would be better off dead (so that EAS would be a beneficial treatment) is a metaethical or metaphysical issue, not a conclusion that can be supported by science or clinical experience.[96]

VII.5 On the other hand, practitioners are required and willing to provide information necessary to enable patients to make informed medical decisions, including information about procedures or services they refuse to provide or recommend. Indeed, practitioners may be most interested in providing information about such services to patients who indicate an interest in them: again, the familiar examples of antibiotics for the flu and ivermectin for Covid-19.

VII.6 Consistent with this, the Project's experience is that objecting practitioners are willing to provide information on all relevant treatment options — including procedures to which they object. The Project is aware of experienced palliative care physicians who, though opposed to practitioner involvement in euthanasia and assisted suicide, are adamant that caring for patients requires practitioners to be fully and sympathetically responsive to patients' requests or interest in the procedures. This does not, however, imply that EAS should be offered as a treatment option absent some indication of interest on the part of the patient.

VII.7 Appendix "C" presents an alternative to Part 6.0 of the Standard consistent with principles of

---

[94] Peter Cowan, "'Not acceptable': Minister blasts suggestion of assisted suicide for person with disability," CBC News (27 July, 2017) online: <https://www.cbc.ca/news/canada/newfoundland-labrador/medical-assisted-dying-disability-reaction-1.4222833>.

[95] Ewan C. Goligher, "Understanding Conscience in Health Care" (21 April, 2021) *Christian Medical and Dental Association of Canada* (YouTube), online: <https://www.youtube.com/watch?v=KyakqSesnGA> at 00h:03m:00s to 00h:07m:12s.

[96] John Tambakis,Lauris Kaldijian & Ewan C Goligher, "The religious character of secular arguments supporting euthanasia and what it implies for conscientious practice in medicine" (Feb 2023) 44:1 Theoretical Medicine and Bioethics 57–74, online: <https://link.springer.com/article/10.1007/s11017-022-09602-2>.

informed consent.

Appendix "A"

Carter criteria, *Criminal Code* and Standard, etc.

Note: The Standard replicates the *Criminal Code* provisions *verbatim* at 9.1.5 and 9.4.2 and elsewhere. Only explanatory comments are referenced below.

***Carter SCC*, para. 127**	***Criminal Code*, s. 241.1(2)**	**Gloss by Standard etc.**
grievous	a) serious	
irremediable	a) incurable	No available reasonable treatments as determined jointly by practitioner and patient.[97]
medical condition	a) illness, disease, disability	Mental *disorder* includes "neurocognitive or neurodevelopmental disorders" e.g., "dementias, autism, spectrum disorders, or intellectual disabilities."[98]
including illness, disease or disability (emphasis added)		
	b) advanced state	Severe.[99]
	b) of irreversible	No available reasonable interventions as determined jointly by practitioner and patient.[100]
	b) decline	Reduction.[101]
	b) of capability	Functioning, ability to undertake personally meaningful activities. [102]

[97] *Standard*, *supra* note 1 at 9.5.2; *Advice*, *supra* note 2 at at 4: question 3(a).

[98] *Model Standard, supra* note 1 at 23 (Mental disorder).

[99] *Standard*, *supra* note 1 at 9.6.3; *Advice*, *supra* note 2 at 5: question 4

[100] *Advice*, *supra* note 2 at 5: question 4

[101] *Standard*, *supra* note 1 at 9.6.3; *Advice*, *supra* note 2 at 5: question 4

[102] *Standard*, *supra* note 1 at 9.6.2; *Advice*, *supra* note 2 at 5: question 4

***Carter SCC*, para. 127**	***Criminal Code*, s. 241.1(2)**	**Gloss by Standard etc.**
[medical condition] that causes	c) the illness, disease or disability or state of decline causes	Illness, disease or disability or state of decline causes.[103]
enduring	c) enduring	Consistent over time[104]
suffering	c) physical or psychological suffering	All dimensions of physical, psychological, social, existential suffering.[105]
that is intolerable to the person	c) that is intolerable to the person	Must respect subjectivity of suffering.[106]
	c) that cannot be relieved under conditions they consider acceptable	No available reasonable interventions as determined jointly by practitioner and patient[107].

[103] *Standard*, *supra* note 1 at 9.7.2(c).

[104] *Ibid* at 9.7.2(b).

[105] *Ibid* at 9.7.2(a).

[106] *Ibid* at 9.7.2(e).

[107] *Ibid* at 9.6.4.

Appendix "B"

"Emergency" provision of euthanasia/assisted suicide

B.1 "*Ideally*," according to the Canadian Association of MAID Assessors and Providers (CAMAP), "MAID should never be done as an emergency" (emphasis added),[108] obviously implying that it might be. CAMAP's concern was that many patients were so late in requesting the procedure that euthanasia/assisted suicide had to be expedited because natural death or loss of capacity was imminent. In such circumstances, euthanasia/assisted suicide was apparently considered an emergency.

B.2 CAMAP advises Canadian EAS practitioners attempting euthanasia in patients' homes to call 911 for ambulance personnel to help if they are unable to obtain IV access when it is immediately required, or if they are unable to provide "intraosseous infusion emergently." They are advised, or to transport the patient to hospital if need be so that an intravenous line can be inserted by emergency room (ER) staff.[109] According to CAMAP, 3 of over 300 Canadian ER practitioners had encountered such cases,[110,111] and in 1 of 13 known cases of self-administration of EAS drugs, a patient was taken to hospital by emergency medical services "as a result of adverse effects or a delayed death."[112] The problems that arise in such circumstances have been documented elsewhere.[113]

---

[108] *CAMAP Brief*, *supra* note 80 at 3.

[109] F Bakewell, VN Naik, "Complications with Medical Assistance in Dying (MAID) in the Community in Canada: Review and Recommendations" (28 March, 2019), Canadian Association of MAiD Assessors and Providers (website) [*CAMAP: Complications*] online: <https://camapcanada.ca/wp-content/uploads/2022/02/Failed-MAID-in-Community-FINAL-CAMAP-Revised.pdf> at Executive Summary para 7-10; p 7; Summary Flowchart.

[110] *Ibid* at 5, "Canadian experience".

[111] *CAMAP: Complications*, *supra* note 109 refers to 3 of 335 surveyed physicians, but the published report (by one of the authors of the CAMAP paper) states that there were 303 responses to the survey. cf F Bakewell, "Medical assistance in dying – a survey of Canadian emergency physicians" (2019) 21:S1 CJEM, 21(S1) S66 at S66, online: <https://www.cambridge.org/core/services/aop-cambridge-core/content/view/D96B1D187CDFDED97DAA905ED08FA2B2/S1481803519002008a.pdf/p009-medical-assistance-in-dying-a-survey-of-canadian-emergency-physicians.pdf>.

[112] *CAMAP: Complications*, *supra* note 109 at 8, "Canadian experience".

[113] David H Wang, "No Easy Way Out: A Case of Physician-Assisted Dying in the Emergency Department" (2018) 72(2) Annals of Emergency Medicine:206-210 at 206, online: <https://www.annemergmed.com/article/S0196-0644(17)31540-8/fulltext>.

B.3 Paramedic regulators in British Columbia,[114] Saskatchewan,[115] Nova Scotia[116] and Alberta[117] acknowledge that paramedics may be called by EAS practitioners to insert an intravenous line. Alberta Health Services has a detailed Emergency Medical Services protocol that anticipates 911 calls by practitioners seeking paramedic assistance in providing EAS.[118] EAS practitioners on Vancouver Island have made arrangements with hospitals to admit patients "as an emergency for continuation of the procedure" should difficulties arise with EAS provision outside hospital settings.[119] The protocol is available on British Columbia's General Practice Services Committee website, a committee representing physicians, Ministry of Health, Doctors of BC, BC Family Doctors and regional health authorities.[120] And calling 911 for help with EAS and taking EAS candidates to hospital emergency departments was suggested in Ontario even before publication of the CAMAP paper recommending it.[121] In sum, it appears that requests for active assistance in providing EAS are treated as emergencies by mainstream actors in Canada's public healthcare system.

B.4 Beyond requests for "emergency continuation" of EAS, the Project's 2015 submission to the

---

[114] "BC Emergency Health Services Clinical Practice Guidelines 2021" (February, 2021), *BC Emergency Health Services* (website), online: <https://handbook.bcehs.ca/Content/cpgmedia/BCEHS_ClinicalPracticeGuidelines.pdf#page=492> at P08: Medical Assistance in Dying (MAID).

[115] Saskatchewan College of Paramedics, "Medical Assistance in Dying (MAID): Guidelines for Paramedic Practitioners" (2 May 2017), *Saskatchewan College of Paramedics* (website), online: <https://collegeofparamedics.sk.ca/wp-content/uploads/2019/11/2017-MAID-Guidelines.pdf>.

[116] College of Paramedics of Nova Scotia, "CPNS Guidance on Medical Assistance in Dying (MAiD)", *College of Paramedics of Nova Scotia* (website), online: <https://www.cpns.ca/public/download/files/196033>.

[117] Alberta College of Paramedics, "Position Statement: Medical Assistance in Dying" (October, 2017), *Alberta College of Paramedics* (website), online: <https://abparamedics.com/wp-content/uploads/2020/02/Position-Statement-MAID-October-2017.pdf>.

[118] Alberta Health Services, "EMS requests related to medical assistance in dying events" (12 June, 2019), *Alberta Health Services* (website), online: <https://extranet.ahsnet.ca/teams/policydocuments/1/clp-prov-ems-req-med-assist-dying-events-ps-ems-09.pdf>.

[119] Jonathan Reggler, Tanja Daws, "Medical Assistance in Dying (MAID) Protocols and Procedures Handbook 2017 2nd edition",*General Practice Services Committee* (website), online: <https://divisionsbc.ca/sites/default/files/51936/Medical%20Assistance%20in%20Dying%20(MAID)%20Protocols%20and%20Procedures%20Handbook%20Comox%20Valley%202017%20-%202nd%20edition_0.pdf#page=18> at 16.

[120] General Practice Services Committee, "Who We Are" (2020), *General Practice Services Committee* (website), online: <https://gpscbc.ca/who-we-are >.

[121] Julie Campbell, "Taking the Mystery Out of MAID" (Powerpoint presentation delivered at the meeting of the Elgin South West Primary Care Alliance, 7 June, 2018), *South West Primary Care Alliance* (website), online: < https://swpca.ca/Uploads/ContentDocuments/Elgin_PCA_Meeting_Jun_7_2018.pdf#page=25> at slide 25.

External Panel on Options for a Legislative Response to *Carter v. Canada* warned that the condition of a patient approved and scheduled for EAS may suddenly and unexpectedly deteriorate, triggering an "emergency" request for EAS before the appointed time.[122] The warning was based on 2013 testimony by representatives of the College of Pharmacists of Quebec about Quebec's euthanasia legislation.[123] The specific scenario envisaged by the Project was proposed in a 2018 article within the context of Canadian hospital emergency room practice.[124]

B.5 It is almost inconceivable that an ER physician in such circumstances would be in a position to fulfil the legal obligations associated with the provision of EAS for a pre-approved and capable patient.[125] When EAS remains a legal option, one of the authors of *CAMAP: Complications* suggested in 2016 that it would likely be more appropriate to ask the initial EAS practitioner to come and "administer a lethal medication in the ED."[126] In any case, CAMAP warns, "No clinician should administer life-ending medications who was not involved in the MAID assessment and consent process."[127]

[122] "Protection of Conscience Project Submission to the (Federal) External Panel on Options for a Legislative Response to *Carter v. Canada*: Direct Consultation (Project Administrator) (26 October, 2015), *Protection of Conscience Project* (website), online: <https://www.consciencelaws.org/publications/submissions/submissions-019-001-carter-fed.aspx.> at "Urgent situations."

[123] Quebec, Assemblée Nationale, Journal des débats de la Commission permanente de la santé et des services sociaux, 40th Législature , 1st Sess, Vol. 43 No. 34 (17 septembre, 2013) at 51–52 (Mme. Véronique Hivon & Dianne Lamarre),online: <.https://www.assnat.qc.ca/Media/Process.aspx?MediaId=ANQ.Vigie.Bll.DocumentGenerique_81797&process=Original&token=ZyMoxNwUn8ikQ+TRKYwPCjWrKwg+vIv9rjij7p3xLGTZDmLVSmJLoqe/vG7/YWzz>. The Project has provided what appears to be the only English translation available: see "Consultations & hearings on Quebec Bill 52, College of Pharmacists of Quebec: Dianne Lamarre, Manon Lambert. Tuesday 17 September 2013 - Vol. 43 no. 34"*, Protection of Conscience Project* (website), online: <https://www.consciencelaws.org/background/procedures/assist009-005.aspx> at T#85–98>.

[124] Thara Kumar, Richard Hoang, "Dying to Know More: Death and Dying in the ED in the Era of MAiD" (20 September, 2018) *EM Ottawa* (blog), online: <https://emottawablog.com/2018/09/dying-to-know-more-death-and-dying-in-the-ed-in-the-era-of-maid/> [*Kumar & Hoang*] at Case 3.

[125] *Criminal Code*, *supra* note 7 at s 241.2(3).

[126] F Bakewell, "Medical Assistance in Dying (MAID) in the ED: Implications for EM Practice" (22 June, 2016) *CanadiEM* (blog), online: <https://canadiem.org/medical-assistance-dying-maid-ed-part-ii/>.

[127] *CAMAP: Complications*, *supra* note 109 at 7.

Appendix "C"

Practitioner Obligations to Patients* in relation to MAID (Regulatory adaptation of Model Standard Part 5.0 and 6.0)

*Including persons who wish to become patients.

Introduction

C1. No person can be compelled under any circumstances to prescribe, administer or assist or facilitate the prescription or administration of substances for the purpose of causing the death of a patient. **[Adapting Standard 5.1]**

C2. Practitioners who believe that a patient does not meet the criteria for practitioner exemption from prosecution in s 241.1(2) of the *Criminal Code* must not do anything that would facilitate the administration or self-administration of a substance intended to cause the death of the patient.

C3. To minimize inconvenience to patients and avoid conflict, practitioners who, for other reasons, are unwilling to provide or facilitate the administration or self-administration of a substance for the purpose of causing the death of the patient should develop a plan to meet the requirements of this policy. **[Supplementing Standard 5.2]**

Providing information to patients

C4. Practitioners must provide patients with sufficient and timely information to make them aware of relevant treatment options consistent with their values and goals, including MAID, so that they can make informed decisions about accepting or refusing treatment and care. **[Adapting Standard 6.1 & Advice, Question 14]**

- The Canadian Healthcare Association, the Canadian Medical Association, the Canadian Nurses' Association, the Catholic Health Association of Canada, *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care,* (Ottawa: CHA, 1999) online: <https://www.consciencelaws.org/background/policy/associations-001.aspx> [CHA, CMA, CNA, CHAC Joint Statement] at I.4, I.7.
- The Canadian Medical Association, *Code of Ethics and Professionalism,* Ottawa: CMA, 8 December, 2018, online: <https://policybase.cma.ca/link/policy13937?> [CMA Code of Ethics and Professionalism] at para 4–6, 11– 12.
- The Canadian Medical Association, *Principles-based Recommendations for a Canadian Approach to Assisted Dying*, Ottawa: CMA, 2015, online: <https://policybase.cma.ca/media/BriefPDF/BR2016-01.pdf#page=4> [Canadian

Medical Association *Principles*] at s 1.2, s 5.2.

- The Canadian Medical Association, *Policy: Medical Assistance in Dying*, Ottawa: CMA; May, 2017, online: <https://policybase.cma.ca/media/PolicyPDF/PD17-03.pdf> [Canadian Medical Association *MAID Policy*] at Addressing Adherence to Moral Commitments, b(i).
- Canadian Medical Protective Association, *Consent: A guide for Canadian physicians*, 4th ed (Ottawa: CMPA, May, 2006–updated April, 2021) online: <https://www.cmpa-acpm.ca/en/advice-publications/handbooks/consent-a-guide-for-canadian-physicians#standard> [CMPA *Consent*] at "Standard of disclosure."

C5. The information provided must be responsive to the needs of the patient, and communicated respectfully and in a way likely to be understood by the patient. Practitioners must answer a patient's questions to the best of their ability. **[Adapting Standard 6.4]**

- CHA, CMA, CNA, CHAC *Joint Statement* at I.4
- CMA *Code of Ethics and Professionalism* at para 5, 11, 14.
- Canadian Medical Association *Principles* at Foundational Principle 6, 10.
- CMPA *Consent* at "Patient comprehension."

C6. Practitioners must not assume that patients are aware that MAID is legal and available in Canada, nor that patients are not aware of it. **[Adapting Standard 6.2 & Advice Question 14]**

C7. Practitioners should be aware that patients who appear to meet the criteria for practitioner exemption from prosecution for providing MAID may or may not be disposed to beneficially assimilate that information. A decision to provide this information and the point at which it ought to be provided must be guided by and responsive to the circumstances and expressed interests of each patient. If a patient does not express an interest, careful reflection, prudent judgement and a focus on the good of individual patients are required to determine if, when and how the option of MAID should be presented. Practitioners must document their rationale if they exercise so-called "therapeutic privilege." **[Adapting Standard 6.3, Advice, Question 14]**

- CMPA *Consent* at "Some practical considerations about informed consent."

C8. Practitioners who are unable or unwilling to comply with these requirements must promptly arrange for a patient to be seen by another practitioner or health care worker who can do so. [**Adapting Standard 6.4**]

Declining to participate

C9. Subject to C2, practitioners who decline to provide or facilitate MAID must advise patients seeking it of their position and reasons for it. They must also advise patients that may seek the

services elsewhere, and advise them how to contact other health care practitioners or providers. Practitioners must, upon request, transfer the care of the patient and/or all necessary and relevant patient records to the practitioner or health care provider chosen by the patient. **[Adapting Standard 5.2.2, 5.2.3]**

- CHA, CMA, CNA, CHAC *Joint Statement* at II.10–11.
- CMA *Code of Ethics and Professionalism* at para 2, 4, 19.
- Canadian Medical Association *Principles* at s 5.2.
- Canadian Medical Association *MAID Policy* at Addressing Adherence to Moral Commitments – a (i); b (ii),(iii); c; d.

C10. In response to a patient request or inability, practitioners must take positive action to connect a patient either to a practitioner who provides MAID, or to an individual, agency, programme, or office that can facilitate patient contact with health care services, including but not limited to MAID. **[Adapting Standard 5.2.1]**

- CHA, CMA, CNA, CHAC *Joint Statement* at II.10–11.
- Canadian Medical Association *Principles* at s 5.2.
- Canadian Medical Association *MAID Policy* at Addressing Adherence to Moral Commitments – b (ii), (iii).

C11. In acting pursuant to C9 or C10, practitioners must continue to provide other treatment or care until a transfer of care is effected, unless the practitioner and patient agree to other arrangements. **[Adapting Standard 5.2.4, 5.3]**

- CHA, CMA, CNA, CHAC *Joint Statement* at I.16, II.11.
- CMA *Code of Ethics and Professionalism* at para 2.
- Canadian Medical Association *MAID Policy* at Addressing Adherence to Moral Commitments – b(iii); d.

C12. Physicians unwilling or unable to comply with these requirements must promptly arrange for a patient to be seen by another physician or health care worker who can do so. **[Adapting Standard 5.2.1]**