S.C.C. File No.: 35591

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

B E T W E E N:

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

Appellants

- and -

ATTORNEY GENERAL OF CANADA

Respondent

- and -

ATTORNEY GENERAL OF BRITISH COLUMBIA

Respondent

- and -

ATTORNEY GENERAL OF ONTARIO, ATTORNEY GENERAL OF BRITISH COLUMBIA and ATTORNEY GENERAL OF QUEBEC

Interveners

AFFIDAVIT OF DR. CHRIS SIMPSON

[Motion for Leave to Intervene by the Canadian Medical Association]

I, **DR. CHRIS SIMPSON**, of the Municipality of Kingston in the Province of Ontario, Physician, **MAKE OATH AND SAY**:

1. I am the current President-Elect of the Canadian Medical Association ("CMA"). As such, I have knowledge of the facts to which I hereinafter depose, except where stated to be on information and belief, in which case I state the source of my information and belief.

2. I was first elected to the CMA Board of Directors in 2013 as the CMA President-Elect. Currently, I am a professor of medicine and chief of cardiology at Queen's University, as well as medical director of the Cardiac Program at Kingston General Hospital/Hotel Dieu Hospital.

3. In my medical career, I have held numerous appointments, including such current roles as chair of the Wait Time Alliance - a federation of 14 medical specialty societies and chair of the Canadian Cardiovascular Society's ("CCS") Standing Committee on Health Policy and Advocacy. I am the lead for the Southeast (Ontario) Local Health Integration Network Cardiovascular Roadmap Project, which developed a regional model of integrated cardiovascular care for southeastern Ontario. I also serve on the executive of the CCS (member-at-large) and on the Cardiac Care Network of Ontario board of directors, and am an American College of Cardiology governor.

4. I obtained my medical degree from Dalhousie University in 1992. My clinical and research interests include access to care, medical fitness to drive, referral pathway development, atrial fibrillation, sudden death in the young, catheter ablation and cardiac resynchronization therapy. My current curriculum vitae is attached as **Exhibit "A"** to my Affidavit.

5. I am providing this affidavit in support of the CMA's motion for leave to intervene in this appeal.

THE CMA AND ITS EXPERTISE

A. ***The CMA Is The National Voice Of Canada's Physicians***

6. The CMA, founded in 1867, is a voluntary professional organization which represents the majority of Canada's physicians. It has over 80,000 members.

7. Its membership spans the spectrum of organized medicine and represents family physicians and specialists directly involved in the provision of medically necessary services.

17. The CMA's purpose, in developing and setting policy, is not to override individual judgment or to mandate a standard of care. CMA policy is intended to inform the organization's advocacy efforts and to offer guidance to our members grappling with difficult practice issues in their communities.

B. ***Recognition of the CMA's Role in Ethics and the Health Care Policy Setting Debate***

18. The CMA's significant role in the health care policy arena is evidenced by the numerous and regular appearances the CMA makes before both Standing and Special Parliamentary Committees. Between 2012 and 2014, the CMA made submissions to these committees and government departments on topics such as excise tax on tobacco (2014) and abuse and misuse of prescription drugs (2013). A list of the CMA's appearances and submissions to government from 2012-2014 is attached as **Exhibit "D"** to my Affidavit.

19. Courts of law have also recognized the CMA's role, whether as an intervener, or as the author of policy documents and position statements, in matters of ethics and policy concerning the health care system. For example:

a) In *Maheu v. IMS Health Canada*, 2003 FCT 647, the Federal Court reviewed the Privacy Commissioner's finding that physician prescribing data was not personal information; the CMA was granted intervener status in the proceeding;

b) In *RJR-MacDonald Inc.* v. *Canada (Attorney General*), [1995] 3 S.C.R. 199, this Court considered the constitutionality of tobacco advertising restrictions; the CMA was a participant in a coalition of health care organizations granted intervener status;

c) The CMA co-intervened with the Canadian Orthopaedic Association in *Chaoulli v. Québec (Attorney General)*, [2005] 1 S.C.R. 791 to present arguments on the need for timely access to quality health care; and

d) The CMA intervened in *Canada (Attorney General) v. PHS Community Services Society*, [2011] 3 S.C.R. 134, to support harm reduction programs such as supervised drug injection sites as ethical and evidence-based initiatives to prevent the spread of disease, save lives, and support some of Canada's most disadvantaged patients.

20. Furthermore, CMA policies and publications such as *The Code of Ethics* (a copy of which is attached as **Exhibit "E"** to my Affidavit) and *Determining Medical Fitness to Drive: A Guide*

for Physicians (formerly called, *The Physicians' Guide to Driver Examination*) have regularly been cited by this Court as it considered issues in health care policy, physicians' ethical obligations and clinical practice guidelines. For example:

a) In *R v. Morgentaler*, [1988] 1 S.C.R. 30, Dickson C.J. wrote at paragraph 30:

> *It is clear from the evidence that s. 251 harms the psychological integrity of women seeking abortions. A 1985 report of the Canadian Medical Association, discussed in the Powell report, at p. 15, emphasized that the procedure involved in s. 251, with the concomitant delays, greatly increases the stress levels of patients and that this can lead to more physical complications associated with abortion;*

b) In *R.* v. *Dyment*, [1988] 2 S.C.R. 417, LaForest J. considered the privacy implications of police seizure of a blood sample drawn by an emergency room physician, and wrote at paragraph 29:

> *The Code of Ethics of the Canadian Medical Association sets forth, as item 6 of the ethical physician's responsibilities to his patient, that he "will keep in confidence information derived from his patient, or from a colleague, regarding a patient and divulge it only with the permission of the patient except when the law requires him to do so…";*

c) In *McInerny* v *MacDonald*, [1992] 2 S.C.R. 138, LaForest J., writing for the Court, quoted at paragraph 13 a 1985 policy statement from the CMA:

> *The current position of the medical profession with respect to the right of patients to information in their medical records is reflected in the policy statement of the Canadian Medical Association published in 1985:*
>
> *CONFIDENTIALITY, OWNERSHIP AND TRANSFER OF MEDICAL RECORDS*
>
> *The Canadian Medical Association (CMA) regards medical records as confidential documents, owned by the physician/institution/clinic that compiled them or had them compiled. Patients have a right to medical [page146] information contained in their records but not to the documents*

> *themselves. The first consideration of the physician is the well-being of the patient, and discretion must be used when conveying information contained in a medical record to a patient. This medical information often requires interpretation by a physician or other health care professional. Other disclosures of information contained in medical records to third parties (e.g. physician-to-physician transfer for administrative purposes, lawyer, insurance adjuster) require written patient consent or a court order. CMA is opposed to legislation at any level which threatens the confidentiality of medical records;*

d) In *R.* v. *Dersch*, [1993] 3 S.C.R. 768, L'Heureux-Dubé, J wrote at paragraph 41:

> *The importance of maintaining confidentiality in the doctor-patient relationship is a longstanding goal which is, as expanded upon in Dyment, supra at p. 433, integrated into the Canadian Medical Association's Code of Ethics;*

e) Sopinka J, writing for the majority, referred to the CMA's position on euthanasia and assisted suicide in *Rodriguez v. Attorney-General of British Columbia*, [1993] 3 S.C.R. 519 at paragraph 175:

> *I also place some significance in the fact that the official position of various medical associations is against decriminalizing assisted suicide (Canadian Medical Association, British Medical Association, Council of Ethical and Judicial Affairs of the American Medical Association, World Medical Association and the American Nurses Association). Given the concerns about abuse that have been expressed and the great difficulty in creating appropriate safeguards to prevent these, it cannot be said that the blanket prohibition on assisted suicide is arbitrary or unfair, or that it is not reflective of fundamental values at play in our society. I am thus unable to find that any principle of fundamental justice is violated by s. 241(b);*

f) In *Chaoulli v. Québec (Attorney General)*, [2005] 1 S.C.R. 791, this Court cited evidence put forth by the CMA in its final decision about the health consequences of excessive wait times for medical care at paragraph 115; and

g) The trial judge in this case referenced the current CMA policy on euthanasia and assisted suicide as well as the policies of other medical organizations internationally at paragraph 248 of her reasons.

C. ***CMA's Policy on Euthanasia and Physician-Assisted Death***

21. With regard to end-of-life issues, the CMA has a long-standing history of advocacy and policy analysis.

22. The current policy on euthanasia and assisted suicide is found at **Exhibit "F"** to my Affidavit.

23. The policy notes that "physicians, other health professionals, academics, interest groups, the media, legislators and the judiciary are all deeply divided about the advisability of changing the current legal prohibition…". The policy recognizes the need for a dialogue between the membership and Canadian society on this important issue. Where there is unanimity within the medical profession, however, is on the need to uphold the central tenet of the CMA Code of Ethics: "Consider first the well-being of the Patient". How that principle applies in the very difficult circumstances of the late Ms. Taylor and Ms. Carter is not straightforward. It is, however, settled that, in seeking clarity on what is in the "well-being" of patients in end-of-life circumstances, physicians must look first and foremost to what patients themselves consider their well-being. This principle of patient autonomy informs all facets of medical decision-making and ethical codes.

24. The CMA comes to this Court seeking intervener status as a "friend of the court" amidst its own very active and current internal discussions and deliberations concerning its policy, and the ethical and medical complexities at play, in order to foster a deeper appreciation of the spectrum of options, the tensions in the current CMA policy perspective, and to assist the Court in gaining insight from the feedback we are actively soliciting and receiving from our physician members and the public. We will also highlight the challenges posed to physicians' understanding of their traditional roles if the Court were to change the law.

25. Thus, while the policy states that the CMA is opposed to physician-assisted death ("Canadian physicians should not participate in euthanasia or assisted suicide"), it frames it as a societal issue and envisages the possibility of change, as informed by a dialogue between

physicians, patients and the legislatures. The CMA is having a national dialogue in 2014 on end-of-life issues and we wish to share our findings from that exercise with this Honourable Court**.**

26. The current CMA policy also sets out a series of conditions for change to the policy, including increased access to palliative care, the need for a Canadian study on end-of-life decision-making, and public input. The CMA needs to consider whether those conditions have been met and/or whether those conditions have changed.

27. We also recognize that policy is formed within a social and legal context.[1] The CMA seeks to be responsive to social and legal changes, yet we also see the merit in ethical bulwarks that have stood the test of time.

28. If the law were to change and make physician-assisted death available to certain categories of patients, the CMA policy does not set out the appropriate safe guards. One can understand this in light of the fact that the policy currently opposes legalization. However, the policy does recognize that the CMA's oppositional stance is not a certainty nor is it perpetually frozen in time. It also underlines ethical principles from the CMA Code of Ethics that inform its provisions.

29. If the law were to change, the CMA policy sets out "slippery slope" arguments and cautionary notes. As set out further below, in the national dialogue on end-of-life care undertaken in 2014, we heard various perspectives from the public and the membership on these concerns. We also take note of the conclusions of the November 2011 Royal Society report on end-of-life decision-making, which expressly addressed "slippery slopes" in the context of the Dutch experience. In particular, it addressed the claim that to contemplate physician-assisted death for competent, incurably ill, adult patients will lead to the acceptance of involuntary acts against the vulnerable and disabled. The Royal Society report concluded that there was no basis to these arguments.[2]

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[1] CMA policy statements, for instance, often reference the legal framework, such as our policy on the Medical Record and Life sustaining interventions.

[2] Royal Society of Canada Expert Panel, "End of Life Decision-Making" November 2011[http://rsc-src.ca/en/expert-panels/rsc-reports/end-life-decision-making]

30. Since the trial judge referenced the CMA's policy on euthanasia and physician-assisted death and made it part of the trial record and our most recent General Council meeting in August 2013, the CMA has supplemented the policy with more current definitions.[3] In August 2013, at the CMA's General Council meeting of physician delegates, some commentators faulted us for getting bogged down in terminology and shirking our responsibilities. This was certainly not the intent. This Honourable Court will appreciate that words have meaning, particularly in our bilingual, bi-juridical nation and a special effort was undertaken since then to try to ensure clarity. In December 2013, the CMA Board approved revisions to the current policy on euthanasia and physician-assisted death to embed more current definitions. While the CMA Board did not undertake the full-scale consultation that would be required to assess the particular tenets of the policy, the definitions were envisaged as essential presuppositions to that policy review.[4] These definitions have also framed the discussions taking place at the 2014 national dialogue on end-of-life care.

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[3] The revisions were made in December, 2013.

[4] The new definitions are:

> *Medical aid in dying refers to a situation whereby a physician intentionally participates in the death of a patient by directly administering the substance themselves, or by providing the means whereby a patient can self-administer a substance leading to their death.*
>
> *Euthanasia means knowingly and intentionally performing an act, with or without consent, that is explicitly intended to end another person's life and that includes the following elements: the subject has an incurable illness; the agent knows about the person's condition; commits the act with the primary intention of ending the life of that person; and the act is undertaken with empathy and compassion and without personal gain.*
>
> *Physician assisted death means that a physician knowingly and intentionally provides a person with the knowledge or means or both required to end their own lives, including counseling about lethal doses of drugs, prescribing such lethal doses or supplying the drugs. This is sometimes referred to as physician assisted suicide.*
>
> *Euthanasia and physician assisted death are often regarded as morally equivalent, although there is a clear practical distinction, as well as a legal distinction, between them.*
>
> *Palliative sedation refers to the use of sedative medications for patients who are terminally ill with the intent of alleviating suffering and the management of symptoms. The intent is not to hasten death although this may be a foreseeable but unintended consequence of the use of such medications. This is NOT euthanasia or physician assisted death.*
>
> *Withdrawing or withholding life sustaining interventions, such as artificial ventilation or nutrition, that are keeping the patient alive but are no longer wanted or indicated, is NOT euthanasia or physician assisted death.*

31. The adoption of these new definitions illustrates the dynamic nature of the CMA's policy development process. The CMA's definition of "dying with dignity" deserves particular attention. Dignity has various forms and is not synonymous with physician-assisted death.[5]

D. *CMA Polling Data on Physician Assisted Death and Euthanasia*

32. The CMA has conducted its own polling of its members on end-of-life issues. We recognize, however, that despite best efforts, survey instruments are vulnerable to frailties in terminology and clarity and should not be considered determinative in matters of such sensitivity and diversity of views**.** Terminology is a critical element that can lead us astray in this debate, as some surveys cited as evidencing significant support from within the physician population are arguably fraught with some confusion of terminology. The same holds true for public polls on this issue. Support for palliation, palliative sedation, and withdrawal of life support might have heightened support in polls for physician-assisted death, as these were defined in the polls.[6]

33. The most extensive recent CMA polling on this issue was completed in July 2011 and released in January 2013. Of 2,125 physician member respondents, a quarter of respondents (24%) think physician-assisted death should remain illegal (another 14% said probably illegal),

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> *"Dying with dignity" indicates a death that occurs within the broad parameters set forth by the patient with respect to how they wish to be cared for at the end of life. It is NOT synonymous with euthanasia or physician assisted death.*
>
> *Advance care planning is a process whereby individuals indicate their treatment goals and preferences with respect to care at the end of life. This can result in a written directive, or advance care plan, also known as a living will.*
>
> *Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification, assessment and treatment of pain and other symptoms, physical, psychosocial and spiritual.*

[5] Advances in palliative care have resulted in, for example, "dignity preservation therapy." J Palliat Med. May 2010; 13(5): 495–500.
doi: 10.1089/jpm.2009.0279, "Assessment of Factors Influencing Preservation of Dignity at Life's End: Creation and the Cross-Cultural Validation of the Preservation of Dignity Card-Sort Tool, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2938912/ .

[6] Sondage sur l'euthanasie, Fédération des médecins specialists du Québec, Septembre 2009, https://www.fmsq.org/documents/10275/0/Euthanasie_CdeP+FMSQ.pdf.

while 34% said it should probably or definitely be legal. Responses concerning attitudes towards euthanasia were almost identical to those for physician-assisted death, and are basically unchanged since the CMA conducted a survey of members' views in 1993. 16% of respondents would assist, while 44% would refuse. More than a quarter of respondents (26%) are not sure how they would respond to such a request, and 15% did not answer. The polling was not broken down by geographic location in order to preserve the anonymity of the respondents. Results from the survey are considered accurate to within ±2.1%, 19 times out of 20.

34. At the time the poll was released, Dr. Jeff Blackmer, the CMA's Director of Ethics, International Affairs and Medical Professionalism, said that the review was needed because of evolving societal values, new technology and changing laws. "I think you can draw a parallel to the CMA's Code of Ethics, which has been revised more than a dozen times since 1868," he said. "When it comes to issues as complex as these, nothing is written in stone. We need to ensure that we are up to date."

35. Our most recent (2014) member consultations indicate a similar breakdown of support and opposition to physician-assisted death. Our members will receive a "pulse survey" on the issue in the summer of 2014 and the results will be available in August 2014.

E. ***The CMA's National Dialogue in 2014 on End-of-Life Care***

36. In 2014, as noted above, the CMA is actively engaged in a dialogue on end-of-life care issues with the membership and the public**.** Attached as **Exhibit "G"** is a brief explanatory hand-out distributed to participants and available on our website**.** We have chosen the term "dialogue" deliberately as it connotes an open exchange of ideas with shared ownership of the results; a dialogue is unpredictable, not closed or directive. In our policy, we called for governments to foster that debate "to help physicians, the public and politicians participate in any re-examination of the current legal prohibition of euthanasia and assisted suicide and arrive at a solution in the best interests of Canadians". So far, apart from Bill 52 in the National Assembly in Québec, that has not taken place.

37. As part of the national dialogue, public town halls have taken place on February 20 in St. John's, Newfoundland, on March 24 in Vancouver, British Columbia, on April 16 in Whitehorse, Yukon, on May 7 in Regina, Saskatchewan and on May 27 in Mississauga, Ontario. CMA President Dr. Louis Hugo Francescutti attended all of the public dialogues and offered welcoming and closing remarks. The panel changed in each location and was composed of local representatives of the patient-palliative care and physician community. Dr. Jeff Blackmer, the CMA's Director of Ethics, International Affairs and Medical Professionalism, attended all of the meetings and offered insights into the terminology which were illustrated via clinical video vignettes. Participants were invited to share their thoughts, experiences, and stories.

38. Physician-assisted death is not the sole focus of the CMA's dialogue on end-of-life care. Advance care planning and palliative care are also at the forefront as topics. We have heard from the public that many perspectives need to be taken into account, including the aboriginal understanding of what gifts the dying can share with the living. While it was clear that members of the public often had diametrically opposed views on euthanasia and physician-assisted dying, common ground was evident on many other important issues ranging from the importance of advance care directives to the need for a comprehensive palliative care strategy in Canada. Our provincial and territorial colleagues have also been very engaged in these issues. PTMAs, such as Doctors of B.C. and the Ontario Medical Association, have released public discussion papers on advance care planning. The Québec Medical Association has been an active contributor to the public discussions on Bill 52 in that jurisdiction.

39. Although a planned written report from the public town halls will not be released until mid-June 2014, several key points have emerged and include:

a) All Canadians should have access to appropriate palliative care services and many don't;

b) Funding for palliative and hospice care services should be increased;

c) More education about palliative care approaches and services as well as how to initiate discussions about advance care planning is required for medical students, residents and practicing physicians;

d) The Canadian public is divided on whether the current Canadian ban on euthanasia and physician-assisted death should be maintained or not;

e) If the law in Canada is changed to allow euthanasia or physician-assisted death, strict protocols and safeguards are required to protect vulnerable individuals and populations; and

f) The potential impact on the Canadian medical profession of legalizing physician-assisted dying should be carefully considered and studied further

40. In addition to the CMA's public town halls, physician member meetings, as part of the national dialogue, took place on February 21 in St. John's, Newfoundland, on March 15 in Edmonton, Alberta, on March 28 in Fredericton, New Brunswick, on April 2 in Vancouver, British Columbia, on April 17 in Whitehorse, Yukon, and on May 10 in Regina, Saskatchewan. These in-person member meetings have been supplemented by an online consultation with the membership. Over 1,000 members have registered and provided abundant comments on the website.

41. We have heard from the membership that, too often, discussions concerning end-of-life treatment occur in the context of a medical crisis, in the sometimes harried and hurried intensive care unit, and that these circumstances do not always lend themselves to an enhanced understanding of the issues. This is an instance in which advance care planning discussions on an ongoing basis within families and between patients and their caregivers are essential.

42. The member discussions evidence a thoughtful discussion with a fair amount of reflection and commentary on how individual physicians and the health care system can do better to offer the "good death" envisioned by all.

43. Physician members have also been deeply reflective about their own varied experiences: as clinicians, loved ones of ill family members, and patients themselves. Some have voiced concerns, echoing commentary from the public about what might be considered "over-treatment". We note from the Johns Hopkins Precursors Study that there is a divide between

what most physicians would choose for themselves at end-of-life (less invasive procedures) and what their patients receive.[7]

44. We also note that Québec physicians have worked through and continue to assess the appropriate ethical perspectives of physician-assisted death with regard to Bill 52 in that jurisdiction**.** The Collège des médecins du Québec, the body entrusted with regulating the medical profession in Québec, has favoured that proposed piece of legislation[8] as has the Québec Medical Association.[9] However, many palliative care physicians in Québec, those most intimately connected with end-of-life issues, have voiced strong opposition.[10] They invoke the role of physician as healer and the need to accompany patients through all stages of illness. Some family physicians, particularly with a patient population in longer term care, have expressed concerns that legalizing physician-assisted death could blur the doctor's role and undermine the trust that has been carefully nurtured.

45. I participated online at several of the public town halls via the live streaming option available through CMA's collaboration with Maclean's magazine, as well as attending in person the members' meeting in my home province of New Brunswick. At each of the town halls, my colleague, CMA President, Dr. Francescutti, shared his personal experience as the family member of a loved one who had received palliative care. Dr. Francescutti expressed his first hand insight into the crucial contribution palliative care makes in easing the burdens on patients and their families. He described the excellent and compassionate care his late mother received at the West Island Palliative Care Residence. We heard at the town halls that too few Canadians are as fortunate to have access to such stellar services. In fact, Dr. Francescutti noted that it is his intention to take a sabbatical from clinical work to research further the elements of palliative care

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[7] Gallo, J. J., Straton, J. B., Klag, M. J., Meoni, L. A., Sulmasy, D. P., Wang, N.-y. and Ford, D. E. (2003), *Life-Sustaining Treatments: What Do Physicians Want and Do They Express Their Wishes to Others?*. Journal of the American Geriatrics Society, 51: 961–969. doi: 10.1046/j.1365-2389.2003.51309.x

[8] Projet de loi n◦52 Loi concernant les soins de fin de vie, Mémoire présenté à la Commission de la santé et des services sociaux, Collège des médecins du Québec, 17 septembre 2013, http://www.cmq.org/fr/public/profil/commun/Nouvelles/2013/~/media/Files/Memoires/PL52-soins-fin-vie-memoire.pdf?61402.

[9] Mémoire sur le projet de loi 52 Loi concernant les soins de fin de vie, Association médicale du Québec, 17 septembre 2013, https://www.amq.ca/fr/en-action/nouvelles-amq/download/103/552/17.

[10] Projet de loi 52 concernant les soins de fin de vie, Société québécoise des médecins de soins palliatifs, 1er octobre 2013,http://www.assnat.qc.ca/Media/Process.aspx?MediaId=ANQ.Vigie.Bll.DocumentGenerique_75309&process=Default&token=ZyMoxNwUn8ikQ+TRKYwPCjWrKwg+vIv9rjij7p3xLGTZDmLVSmJLoqe/vG7/YWzz.

CMA Executive Director of Ethics, International Affairs and Medical Professionalism, and the moderator of the public town halls, noted that his clinical work involves people with spinal cord injuries. Studies have shown that health care providers believe many people with quadriplegia have a quality of life that is only rated at a two or a three out of ten, whereas if you ask those patients that same question, they will rate it at an eight or a nine out of ten, especially once they have adjusted to their new life.[12] Dr Blackmer highlighted that he often sees patients who, when they have just been injured, ask to have their life terminated. But after adjusting to their new reality, they often value the independence that they still have.

H. ***The CMA's Interest in this Appeal –Physician as a Key Player***

56. The CMA has a special interest in the issues before the Court and a real stake in this discussion. For end-of-life care issues in general, physicians partner with families to administer and implement advance care directives and wishes. If the law changes, physicians will be key players in any assisted death regime. They will play two critical roles. First, they will have to determine whether an individual patient's wish to be assisted in dying meets the threshold. Second, they will have to prescribe the agents leading to death, and to provide the patient with bedside care through the process leading to death. Plainly, assisted death, if sanctioned by law, has no prospect of implementation unless physicians in sufficient numbers across the country are persuaded that the sanctioned regime is ethical, practical, and in accordance with existing medical standards. The CMA can assist this Honourable Court on these questions.

PROPOSED SUBMISSIONS OF THE CMA

57. If granted leave to intervene, the CMA would appear before this Honourable Court as a "friend of the court," not with a playbook or a black and white perspective, but with a narrative of insights that we would like to share on the physician's perspective on this issue. I anticipate that the CMA's submissions will address the following:

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[12] Gerhart KA, Koziol-McLain J, Lowenstein SR, Whiteneck GG. *Quality of life following spinal cord injury: knowledge and attitudes of emergency care providers*. Ann Emerg Med. 1994 Apr;23(4):807-12.

(a) The findings from the CMA's national dialogue with the public and its members on end-of-life care, including the critical role of palliative care and whether physician-assisted death should be sanctioned before fully accessible palliative care is available across Canada;

(b) The safeguards required if the law changes to allow physician-assisted death, in order to protect patients from involuntary decisions and from those that may not be in their interests;

(c) The impact upon the doctor-patient relationship of such a change in the law;

(d) The safeguards required to protect physicians from criminal and civil liability;

(e) The accommodations to the health care system, including training and support, required to permit physicians to discharge the considerable additional accountabilities and responsibilities that will be placed upon them, such as assessments of competency and voluntariness in the particular circumstances of the end-of-life care setting; and

(f) The CMA's view on the appropriate remedy should the law change.

58. As those accompanying their patients through all stages of the life cycle and the continuum of care, physicians do not purport to have all the answers. They are patients and family members themselves and want to walk with their patients in their time of illness and need. It would be a disservice to the issues and the Court to set forth a black and white perspective. Such a perspective does not exist. The CMA's current policy is not static and can change. Finally, the CMA comes to the Court in a spirit of humility recognizing that, as human beings, we are all vulnerable and limited before the power of death. As physicians, we want to provide what our patients want and deserve: the proverbial good death. In this journey with our patients, we look to what patients and members have told us in 2014 as part of the national end-of-life dialogue.

59. There will be no prejudice to any party if leave to intervene is granted to the CMA. The CMA does not seek to delay the hearing of this appeal or to raise any new issues.

60. The CMA seeks no costs in the proposed intervention and asks that none be awarded against it.