Court File No.: DC-16-2217

ONTARIO
SUPERIOR COURT OF JUSTICE
(DIVISIONAL COURT)

B E T W E E N:

THE CHRISTIAN MEDICAL AND DENTAL SOCIETY OF CANADA, THE CANADIAN FEDERATION OF CATHOLIC PHYSICIANS' SOCIETIES, CANADIAN PHYSICIANS FOR LIFE, DR. MICHELLE KORVEMAKER, DR. BETTY-ANN STORY, DR. ISABEL NUNES, DR. AGNES TANGUAY and DR. DONATO GUGLIOTTA

Applicants

- and -

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Respondent

- and -

ATTORNEY GENERAL OF ONTARIO

Intervener

APPLICATION UNDER rules 14.05(1), 38 and 68 of the *Rules of Civil Procedure* and the *Judicial Review Procedure Act,* R.S.O. 1990, c.J.1, s. 2

AFFIDAVIT OF ANDRÉA FOTI

I, Andréa Foti, of the City of Toronto, in the Province of Ontario MAKE OATH AND SAY AS FOLLOWS:

1. I am a manager in the Policy Department of the College of Physicians and Surgeons of Ontario (the "College"). I have worked at the College for eleven (11) years. My experience has been exclusively in the Policy Department of the College. During my tenure, I have occupied the roles of Policy Analyst, Senior Policy Analyst, and Manager. I have been in the role of Manager since 2012. As Manager, I am head of the Department, charged with oversight of all

College policy development and review, along with a range of other functions the Policy department provides within the College. I also served as the College's Privacy Officer from 2005 to 2015.

2. In my capacity as Manager, I directly managed the College's development of the *Interim Guidance on Physician-Assisted Death*, the *Physician-Assisted Death* policy and the *Medical Assistance in Dying policy*, and I have recently reviewed the files pertaining to the development of these policies. I was also heavily involved in the development and management of the College's submissions to government on this issue. This includes the College's submission to the Provincial/Territorial Expert Advisory Group, the Federal Expert Panel on Options for a Legislative Response to *Carter v. Canada*, The House of Commons Standing Committee and the Senate Standing Committee. As such, I have knowledge or, where stated, information and belief, of the matters to which I hereinafter depose.

3. In terms of my educational background, I hold three university degrees. I hold a Bachelor of Arts degree in Honours English from the University of Guelph, from which I graduated with honours. I hold a Bachelor of Laws degree from Dalhousie University and earned a specialization in health law and policy from Dalhousie's Health Law Institute. I hold a Master of Arts degree in Medical Ethics and Law from the Centre for Medical Law and Ethics, at King's College, University of London (UK), from which I graduated with distinction. Attached as **Exhibit "A"** to this affidavit is a copy of my curriculum vitae.

I. Regulating the Medical Profession -- The College Of Physicians And Surgeons Of Ontario

4. The College is the self-regulating body for the medical profession in the Province of Ontario. Its mandate is to serve and protect the public interest by governing the medical profession.

5. All doctors in Ontario must be members of the College in order to practice medicine in the province. As of December 31, 2015, the College had a total membership of 40,243, including 31,803 physicians with certificates of registration permitting independent practice in Ontario, 6,171 physicians with educational certificates of registration permitting postgraduate medical training, 2,156 physicians practicing under restricted licenses, and 107 physicians with an academic practice. These physicians may be engaged in a tremendous range of practice areas, including medical and surgical specialities such as psychiatry, internal medicine, thoracic surgery, endocrinology and obstetrics and gynaecology. Physicians under the College's jurisdiction also engage in non-clinical roles, such as public health physicians, physician administrators or academics, research physicians and physician politicians. The College's 2015 Registration Report, *Registering Success 2015,* is attached to this affidavit as **Exhibit "B"**.

6. While the College does not gather information about the religious and cultural beliefs of its physician members, it does collect other information that provides some indication of the diversity of beliefs among practicing physicians in the province. I have reviewed information collected by the College about which medical schools Ontario physicians attended and what languages they speak. As of September 2016, the College had issued certificates of registration permitting independent practice to physicians with medical degrees from 131 different countries, and Ontario physicians spoke 125 different languages. And as the College's 2015 Annual Report (**Exhibit "C"**) indicates, in 2015, the College issued new certificates of registration to 4,831 individuals, 1,868 (39%) of whom obtained their medical degree outside of North America.

7. Physicians practice in locations across the province, in a wide variety of settings. These settings include practices in hospitals or clinics, in an office building with a single doctor's

office, or in an office in a physician's residence. They also practice in institutional settings such as jails, government offices, pharmaceutical companies or universities.

8. The College is responsible for issuing certificates of registration to physicians to allow them to practice medicine; monitoring and maintaining standards of practice of physicians; investigating complaints and other information it receives about physicians; and disciplining physicians who have committed acts of professional misconduct or who are incompetent. The College's jurisdiction extends to members and to former members who are alleged to have engaged in professional misconduct while members.

9. The role of the College, as well as its authority and powers, are set out in the *Regulated Health Professions Act, 1991* ("RHPA"), the Health Professions Procedural Code, being Schedule 2 to the RHPA (the "Code"), and the *Medicine Act, 1991.*

10. The objects of the College are outlined in the Code. They include:

- To regulate the practice of the profession and to govern the members in accordance with the *Medicine Act, 1991*, the Code and the RHPA, and the regulations and by-laws;
- To develop, establish and maintain programs and standards of practice to assure the quality of the practice of the profession;
- To develop, establish and maintain standards of knowledge and skill and programs to promote continuing evaluation, competence and improvement among the members;
- To develop, establish and maintain standards of professional ethics for the members;
- To develop, establish, and maintain standards and programs to promote the ability of members to respond to changes in practice environments, advances in technology and other emerging issues;
- Any other objects relating to human health care that the Council considers desirable.

11. In carrying out its objects, the College has an overriding duty to serve and protect the public interest.

12. The Legislature has given the College the mandate to regulate the practice of medicine in Ontario, including through enforcement of clinical and professional standards for physicians in Ontario. The College has the obligation, in keeping with its objects and its overriding duty, to ensure that standards of clinical and professional practice are in place to govern physicians in the service of the public interest.

13. The College has its own governing body, the Council. Council is composed of physicians elected by their peers and non-physicians or public members appointed by the provincial government, as well as physicians appointed from among representatives of the six faculties of medicine in Ontario. Physician members of Council have a broad range of experiences and expertise, and include physicians from diverse areas of specialty from across the province. Public members come from a cross-section of communities in Ontario, large and small, and have diverse vocational and professional backgrounds. The President of the College is elected from and by Council and serves a one-year term. The composition and functioning of Council are outlined in the College's General By-Law, which is attached as **Exhibit "D"** to this affidavit.

14. Council members sit on one or more committees of the College. Each committee has specific functions, most of which are governed by provincial legislation.

15. The Executive Committee of the College is the body that oversees the administration of the College. It has authority to exercise any power of the Council that requires immediate attention, other than making by-laws and regulations. It considers policy and operational issues, and can make decisions on behalf of Council between Council meetings. It is composed of

physician and non-physician Council members, and includes the President and Vice-President of Council.

16. The Registrar of the College is the most senior staff person at the College. He is appointed by Council and is responsible for all staff and reporting to Council. In addition to administrative duties similar to a Chief Executive Officer, the Registrar has specific statutory duties set out in the RHPA and the Code. The position is currently filled by Dr. Rocco Gerace, a specialist in emergency medicine who has served as Registrar since May 2002.

17. Council meetings are held four times a year, at which time the activities of the College are reviewed and matters of policy are debated and voted on, and direction is provided on on-going matters.

18. Executive Committee meetings take place from time to time at the direction of Council or the Executive Committee or at the call of the chair of the Executive Committee. They tend to take place about once a month.

19. The College is funded primarily by the membership fees generated from the physicians and surgeons who form its membership.

II. Development of College Policies

20. One of the College's duties as a medical regulator, in accordance with the objects outlined in the Code, is to provide guidance to physicians across Ontario (in both remote communities and large urban centres) on issues related to professionalism and ethics and on clinical and practice issues that are relevant to the practice of medicine. As the body with exclusive jurisdiction over the regulation of Ontario physicians, the College has a duty to ensure

that mechanisms are established to regulate both clinical issues and issues related to professionalism and ethics.

21. In keeping with this duty, the College publishes a number of documents outlining expectations for its members. The *Practice Guide* articulates the profession's values, which provide the foundation for the practice of medicine and the principles of medical practice. This document articulates for the profession its duties and the reasons for those duties, and organizes the policies of the College within a principled framework. The *Practice Guide* is attached to this affidavit as **Exhibit "E"**.

22. The College has also adopted over fifty (50) policies. College policies articulate the profession's expectations of the ethical and competent physician in a range of specific areas. College policies govern all members across the province, and set uniform expectations for physicians in Ontario regardless of practice location.

23. In developing policies, the College is guided at all times by its objects and by its overriding duty to serve and protect the public interest.

24. Policies of the College are developed with the input and direction of Council. They are adopted as official College documents following a vote at Council meetings, if approved by a majority of Council members present at the meeting. In exceptional circumstances, a College policy may be amended or approved by the Executive Committee.

25. The development of a new policy may be prompted by many factors, including emerging trends, changes to the medical or legal landscape, public or patient experience, and issues identified by College committees, Council and the medical profession. All existing College

policies are reviewed on a regular basis, every five to six years. Reviews may be expedited or delayed depending on a variety of factors. Reviews may be expedited to respond to important changes in the medical or legal landscape or public or patient experience. Reviews may be delayed to align with anticipated changes or developments in the legal or medical landscape, government initiatives, or because other more urgent policy reviews or College projects require more immediate attention.

26. Policy review and development is supported by staff in the Policy Department. A policy analyst is assigned to an issue and undertakes the initial components of the policy development or review, such as research and consultation. For many policies, a Working Group comprised of physician and public members of Council is formed to lead the development/review. The policy analyst conducts the review process, including the development of a draft policy under the direction of the Working Group.

27. Council and the Executive Committee guide the review and development of policies throughout the process. Once the Working Group has a draft policy that it is satisfied with, the draft is presented to the Executive Committee for consideration. The Executive Committee discusses the draft policy and may ask the Working Group to make revisions to the draft.

28. After considering the draft policy, the Executive Committee decides whether to forward the draft policy to Council for its consideration.

29. Should the draft policy be approved by the Executive Committee it is then presented to Council. Council examines the draft policy, debates its contents and may vote for revisions to the draft. Following this debate, Council votes on whether to engage in a public consultation

process regarding the policy or to return the policy to the Working Group for amendment. All policies undergo a public consultation prior to being finalized and approved as College policy.

30. When Council approves proceeding to public consultation in respect of a draft policy, an external consultation is conducted. A dedicated consultation webpage, accessible to all on the College's public website, is established for the draft policy. The draft policy is posted to the consultation webpage, along with background information. Consultation participants are asked for general feedback on the draft policy, including its clarity and comprehensiveness, the reasonableness of the positions, and how the document could be improved. Participants may also be asked specific questions tailored to the particular draft policy.

31. The College's consultation process is extensive, public and transparent. The College seeks to obtain feedback from a broad range of individuals and organizations, including physician members, healthcare organizations, public or patient organizations and other stakeholders, and the general public. The consultation and draft policy are promoted widely, including:

- By promoting the consultation through the College's social media channels, including Facebook and Twitter;
- By publishing a notice about the consultation on the College website, in *Dialogue*, the College's periodic publication for members, in *Patient Compass* (formerly *Noteworthy*), the College's free electronic newsletter for the public, and in other College publications; and
- By directly soliciting feedback from physician and patient organizations and other stakeholders, including organizations known to have a specific interest in the subject matter of the policy.

32. Stakeholders are provided with a variety of ways to participate and provide feedback, including via written comments (by mail or email), by responding to an online survey, or by posting comments to the consultation discussion page. All of the feedback received by the College is posted to the consultation webpage, and individuals can comment on the feedback provided by other participants in an online discussion forum. The consultation period typically lasts 60 days.

33. One of the things the College considers when evaluating feedback is that the nature of feedback received during an external consultation will often be influenced by selection bias, especially for contentious issues. Those who participate and provide feedback are typically individuals and organizations who already know of the College or who have a strong motivation to provide input on a subject. Consequently, in order to solicit feedback and gauge the views of a broader cross-section of society, the College may commission a public opinion poll regarding a specific policy, in addition to engaging in the standard external consultation described above.

34. The volume of responses that the College receives to policy consultations varies greatly, depending on the subject matter. Some consultations yield fewer than 100 responses and other consultations may yield 250-500 responses. The consultation held in 2015/2016 on the College's *Interim Guidance on Physician-Assisted Death* yielded a comparatively high volume of responses, with a total of 2194 submissions.

35. The feedback received during a consultation is reviewed by staff in the Policy Department, both as it is received and after the consultation period closes. A summary of the feedback, reflecting the key themes and survey results, is provided to the Working Group. The consultation feedback is considered carefully and thoroughly and may inform revisions to the

draft policy. The purpose of external consultation is to ensure the College has considered many diverse viewpoints and perspectives on the issues addressed in its policies before reaching a final position. The goal is not necessarily to achieve consensus or to reflect majority viewpoints within the policy. The overriding consideration in development of a policy remains the furtherance of the College's objects and protection of the public interest. Where a consultation reveals conflicting positions and viewpoints on an issue, the College attempts to reconcile positions by anchoring the policy to the College's mandate and the fundamental values of the profession, and by considering what will best serve and protect the public interest.

36. After the close of the consultation period, the Working Group presents a revised draft of the policy, along with a summary of the consultation feedback and the results of public polling, if any, to the Executive Committee. The Executive Committee discusses the feedback and the revisions the Working Group has made to the draft policy in response to feedback, and may pose questions and direct that further revisions be made to the draft policy. The Executive Committee determines whether to forward the revised draft policy to Council for consideration and possibly final approval, or to send it back to the Working Group for further consideration and revision.

37. Once the Executive Committee is satisfied with the revised draft policy, it is presented to Council, along with a report on the consultation, and a summary of other factors or information that have informed the revisions made. This may include data from public polling, if a poll has been commissioned. Council discusses the work that has been done, debates the policy and may vote to adopt further revisions to the revised draft policy or to require further work to be done. Council may then vote on whether to approve the revised draft policy as an official College policy.

38. If approved by a majority of the Council members present at the meeting, the revised draft policy is officially adopted as College policy.

39. The new policy is posted on the College website, announced via social media, and published in *Dialogue*. It is also included in the *Council Update*, which is sent to all physicians following a meeting of Council to communicate key Council decisions to the profession.

40. The process described above is followed both for the development of new policies and for the review of existing policies. One distinction between the development of a new policy and the review of an existing policy is that the College generally conducts a preliminary external consultation for existing policies, prior to developing an updated draft policy. The preliminary consultation with respect to the existing policy informs development of the new draft policy, which then goes out for consultation.

III. Decision of the Supreme Court in Carter v. Canada *and subsequent federal legislation*

41. On February 6, 2015, the Supreme Court of Canada released its decision in the case of *Carter v. Canada (Attorney General)* ("*Carter*"). The Court held that the criminal prohibition against physician-assisted death for consenting, competent adults suffering from a grievous and irremediable medical condition that causes enduring, intolerable suffering was unconstitutional. The Court issued a declaration of invalidity, striking down the offending Criminal Code provisions, but suspended the declaration for 12 months to allow Parliament and the provincial legislatures to enact legislation consistent with the decision.

42. On January 15, 2016, after the Attorney General of Canada sought a further six-month suspension of the declaration of invalidity, the Supreme Court granted a further four-month extension of the suspension of the declaration of invalidity beyond February 6, 2016.

43. In its decision granting the extension, the Supreme Court also determined that individuals who met the criteria for receiving physician-assisted death, outlined in *Carter*, could receive a judicial exemption from the suspension of the declaration of invalidity by applying to the superior court of their jurisdiction. These individuals could legally receive physician-assisted death between February 6, 2016 and June 6, 2016, and physicians could legally provide such assistance. On June 6 2016, the *Carter* decision would come into effect.

44. On June 17, 2016, the federal government passed Bill C-14: *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)* ("Bill C-14").

IV. Terminology

45. In this affidavit, I use the terms "physician-assisted death" ("PAD") and "medical assistance in dying" ("MAID"). PAD is the term used by the Supreme Court in the *Carter* decision. MAID is the term that was ultimately adopted by the federal government when it passed Bill C-14. Both terms refer to the same health care service, although MAID contemplates that the service could be provided by nurse practitioners as well as by physicians.

46. When developing guidelines and policies related to PAD/MAID, the College used the terminology of the relevant governing legal framework. Before federal legislation was passed, *Carter* set out the legal regime and the College used the term "PAD"; after legislation was passed dealing with this issue, the College adopted the term "MAID," as that is the terminology

used in federal legislation. In this affidavit, I will use the terminology employed by the College at the given time.

V. Development of the College's Interim Guidance on Physician-Assisted Death

a) Preliminary College consideration of *Carter*

47. In the months following the decision of the Supreme Court in *Carter*, the Registrar and College staff kept abreast of the evolving landscape of PAD, and provided ongoing updates to the Executive Committee and to Council on this issue. The College was aware that when PAD became legal in Canada, it would need to have policies in place to guide physicians' conduct in the provision of this service by Ontario physicians. In addition, the *Carter* decision might have implications for a number of existing College policies, including its *Decision-making for the End of Life* policy and its *Professional Obligations and Human Rights* policy.

48. On March 6, 2015, one month after the decision of the Supreme Court in *Carter* was released, Council met and was presented with a briefing note which provided an overview of the *Carter* decision. The briefing note presentation noted the following:

- The College's *Decision-making for the End of Life* policy was currently under review, and where relevant, the language in the draft policy would be modified to reflect the *Carter* decision before the draft was finalized and brought to Council.
- The College's *Physicians and the Ontario Human Rights Code* policy was also undergoing review, and the new draft policy, *Professional Obligations and Human Rights*, was currently undergoing consultation. The new draft policy specifically acknowledged physicians' right to conscience and religion, and did not compel physicians to perform medical services that conflict with their beliefs, except in emergency situations.

- At that time, no changes to the draft *Professional Obligations and Human Rights* policy were being proposed as a result of the *Carter* decision. The College would keep abreast of any legislative or regulatory developments that might necessitate modification to the language of this policy.

The Council Briefing Note presented on March 6, 2015, is attached to this affidavit as **Exhibit "F"**. The Proceedings of Council for March 6, 2015, are attached to this affidavit as **Exhibit "G"**.

49. On July 28, 2015, the Registrar provided the Executive Committee with an update on the PAD file. The Registrar informed the Committee that if the federal government did not pass legislation or request a stay of the Supreme Court's decision in *Carter*, PAD would become legal on February 6, 2016. It did not appear that any legislation would be in place by that time. Should no legislation be passed before *Carter* came into effect, Council might determine that the College should provide guidance to the profession on the subject of PAD, as it would be important to avoid a situation in which PAD was decriminalized without a framework being established to guide eligibility and implementation. To that end, the Registrar suggested that the College should develop a draft guideline document of general principles for physicians dealing with PAD. The Minutes of Proceeding of the Executive Committee for July 28, 2015, are attached to this affidavit as **Exhibit "H"**.

50. At its meeting on September 10 and 11, 2015, Council members participated in an educational session on PAD. Council members viewed excerpts of the documentary film "How to Die in Oregon", and heard from experts on the clinical, legal and ethical issues relating to PAD. Council heard from the following guests:

- Dr. David Lussier, Director, Geriatric Pain Clinic, McGill University Health Center;

- Dr. Charles Blanke, Chair, South West Oncology Group; Professor, OHSU Knight Cancer Institute;
- Ms. Sheila M. Tucker, Lawyer, DLA Piper, Co-counsel for Plaintiffs, *Carter v. Canada* (on behalf of the BC Civil Liberties Association);
- Dr. Jennifer Gibson, Director, Joint Centre for Bioethics, University of Toronto.

The PowerPoint Presentations used by Dr. Lussier and Dr. Blanke are attached to this affidavit as **Exhibit "I"**. Dr. Gibson and Ms. Tucker gave oral presentations without the use of supporting materials.

51. In the materials for the September 2015 meeting, Council was also provided with a Briefing Note which provided an informational update on the PAD file at the College. The Briefing Note provided Council with the following information:

- A brief overview of the *Carter* decision, and key policy considerations flowing from the decision;
- Key features of regulatory frameworks in place in other jurisdictions, where PAD has been legalized;
- The status of work underway, both provincially and nationally, to respond to the SCC decision; and
- The College's role in these activities, and planned next steps.

The Briefing Note and introductory materials related to the educational session, included in September Council materials, are attached as **Exhibit "J"**.

52. Council was advised that College staff would continue to monitor the external environment related to PAD and would keep Council informed of any changes. Council was also

provided with information regarding next steps and options moving forward. It was suggested that Ontario physicians would require different kinds of guidance, depending on whether or not the government established a legislative framework. If the government established and clarified a legislative framework, Council might wish to adopt a specific, complementary policy dealing with PAD, setting out the legal requirements, along with any professional expectations Council wished to articulate for physicians. On the other hand, if no legislative framework was established to guide Ontario physicians before February 2016, Council might wish to provide interim guidance to its membership, consistent with the *Carter* decision, on how to approach requests for PAD.

b) Submission to Provincial-Territorial Expert Advisory Group on Physician-Assisted Death

53. As well as work undertaken by regulators such as the College, work was also underway on the issue of PAD at the government level. In August 2015, eleven provinces and territories established the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying (the "Advisory Group"). The mandate of the Advisory Group was to provide non-binding advice to participating Provincial-Territorial Ministers of Health and Justice on issues related to PAD.

54. In September 2015, the Advisory Group requested that stakeholders, including the College, complete written submissions on a range of issues related to the implementation of PAD in Canada. At this point, the College was still considering the implications of the *Carter* decision for both patients and physicians, and did not yet have a formal position on all the issues canvassed by the Advisory Group. However, College President Dr. Joel Kirsh and Council members (and former College presidents) Dr. Carol Leet and Dr. Marc Gabel provided a response to the Advisory Group survey providing comment on those issues they felt they could

address. The College's response to the Advisory Group, dated September 24, 2015, is attached to this affidavit as **Exhibit "K"**.

55. One of the questions in the Advisory Group's survey dealt with whether physicians have the right to refuse PAD for reasons of conscience, and if so, what continuing obligations they had to patients, and whether they should provide an effective referral. The College responded to this question as follows:

> The CPSO has a position on conscientious objection in general which is set out in our Professional Obligations and Human Rights policy. That policy indicates that physicians do not have to provide a service to which they conscientiously object but they do have continuing positive obligations to their patients including: providing information about the intervention to which they object, providing an effective referral and treating patients with dignity and respect.
>
> That policy pre-dates the current analysis in relation to PAD. Generally speaking, it is the CPSO's view that physicians must not act in a manner to prevent or frustrate patient access to PAD or in a manner that is disrespectful of the patient's autonomous decision to seek PAD.
>
> The CPSO would welcome direction from the provincial government on this issue.

56. The College submission also expressed the view that barriers to access may arise both from geography and from access to physicians willing to provide PAD, and that the burden of seeking access should not be imposed on patients. Rather, the system, including physicians, should put processes and structures in place to ensure patient access to PAD.

57. The Advisory Group released its Final Report on November 30, 2015. The Report outlined duties that must be fulfilled by conscientiously objecting health care providers. The Report stated that while there is a communal responsibility to provide access to PAD, individual providers are not absolved of their personal/professional responsibilities, particularly in a

publicly-funded system. There were many competing values at stake in the context of PAD which had to be reconciled. The Report therefore recommended that conscientiously objecting health care providers be required to:

- Inform patients of all end-of-life options, including PAD, regardless of their personal beliefs;
- Inform their patients of the fact and implications of their conscientious objection to PAD, and provide any ongoing treatment of the patient in a non-discriminatory manner;
- Either provide a referral or a direct transfer of care to another health care provider, or contact a third party and transfer the patient's records through an effective publicly-funded care coordination system set up to ensure patient access to PAD.

The Final Report of the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying is attached to this affidavit as **Exhibit "L"**.

c) Submission to External Panel on Options for a Legislative Response to *Carter v. Canada*

58. In the fall of 2015, the federal government convened the External Panel on Options for a Legislative Response to *Carter v. Canada* (the "External Panel"), and invited Canadian provincial and territorial medical regulators to make submissions.

59. The College's written submission to the External Panel provided suggestions on a number of issues. One of these issues was conscientious objection. The submission outlined the College's general policy on conscientious objection as set out in the *Professional Obligations and Human Rights* policy. This policy stated that physicians have the right to assert a conscientious objection to providing a service, however, objecting physicians have ongoing positive obligations to patients including: providing information about the intervention to which

they object, providing an effective referral and treating patients with dignity and respect. The submission stated that although the College did not yet have a formal position on conscientious objection in the context of PAD, generally speaking, it was the College's view that physicians must not act in a manner to prevent or frustrate patient access to PAD or in a manner that is disrespectful of the patient's decision to seek PAD. The submission concluded by stating that the burden of seeking access to PAD should not be imposed on patients, but rather that the system, including physicians, should put processes and structures in place to ensure patient access. Dr. Gerace also appeared in person before the panel on November 6, 2015 and articulated the same position. The College's submission to the External Panel, dated October 19, 2015, is attached to this affidavit as **Exhibit "M"**.

60. The Report of the External Panel was provided to the government on December 15, 2015 and was released to the public on January 18, 2016. The Report discussed the issue of conscientious objections by physicians, noting that all stakeholders who had participated were unified in the view that physicians and other health care professionals' conscience rights must be respected and that those who choose not to participate must not face negative repercussions, but that views on whether a referral should be required were divided. The External Panel also reported on the results of its survey of 2000 Canadians, consisting of a representative sample of the population, on a number of issues related to PAD. According to this survey, as stated at p. 150 of Annex A to the Report, 79% of the population either "agreed" or "strongly agreed" that physicians who refuse to provide assisted dying should be required to provide referrals to other physicians who are willing to provide assistance. The relevant sections of the Report of the External Panel (the Introduction, Chapters 1 and 11, and Annexes A, B and C) are attached to this affidavit as **Exhibit "N"**.

d) Working Group Develops Draft Interim Guidance document on Physician-Assisted Death

61. As discussed above, the College began monitoring the issue of PAD after the *Carter* decision was released in February 2015. Beginning in the summer of 2015, staff in the Policy Department began work on developing a for-discussion draft of interim guidance on PAD for physicians ("Interim Guidance"), in anticipation of a Working Group being struck to direct work on this issue. Staff were aware that any Interim Guidance that would be developed would have to be finalized on an expedited basis, given the timeline set by the Supreme Court.

62. The for-discussion draft of the Interim Guidance document was largely based on the framework outlined in *Carter*. Staff also reviewed the law passed by the provincial government in Quebec dealing with this issue, as well as the principles and framework proposed by the Canadian Medical Association. In addition, staff conducted a jurisdictional review of key details surrounding the provision of PAD in the places where it was legal. This included a review of eligibility criteria; manner of assisted death; application process; patient safeguards; and reporting requirements. A chart containing the results of the jurisdictional review is attached to this affidavit at **Exhibit "O"**.

63. In September 2015, the Working Group to guide the College's work on PAD was struck. The Working Group was chaired by Dr. Carol Leet and also included other Council members: Dr. Gabel, Dr. Kirsh, and Ms. Lynne Cram. College staff and a College Medical Advisor[1] provided the Working Group with support.

[1] Medical Advisors are physicians employed by the College with expertise in different practice areas, who provide advice, information and support to College Committees and departments. The Medical Advisor assigned to the

64. Dr. Leet is a pediatrician based in Brampton, and has been in practice since 1989. Dr. Leet has been involved with the College since 2001, and has served as a member of numerous College Committees including the Inquiries, Complaints and Reports Committee, the Executive Committee and the Governance Committee. She was first elected to Council in 2008 and served as Council President from 2014-2015.

65. Dr. Gabel is a Toronto general practitioner practising in psychotherapy. He received a B.A. from Cornell University, an M.D. from Downstate Medical Centre, New York and a Master of Public Health from UCLA, with a special interest in tropical Medicine. Dr. Gabel has practiced in the United States, Asia and Canada. His practice has included pediatrics, public health, general practice and psychotherapy. He served as an assessor for the College for eight years, after which he was elected to the College's Council, where he served for more than eight years as well as serving as a Chair of the College's Discipline Committee for three years. Dr. Gabel served as President of the College from 2013-2014.

66. Dr. Kirsh specializes in pediatric cardiology at the Hospital for Sick Children in Toronto, and also has affiliations with Sensenbrenner Hospital (Kapuskasing), Hotel Dieu (Hearst), Mount Sinai Hospital (Toronto) and the University Health Network (Toronto). He has served as the Faculty of Medicine's representative on the University of Toronto's Governing Council for six years, as well as leading the Medical Staff Association of the Hospital for Sick Children (as Vice-President and then President), and served on the Hospital's Board of Trustees. Dr. Kirsh was first elected to Council in 2011. He currently serves on Council as the Academic Representative for the University of Toronto, prior to which he was an elected member of

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Working Group was a family physician whose practice included a focus on mental health, addictions, chronic pain, and chronic disease management.

Council for District 10. Dr. Kirsh is also the current President of the College, for the 2015-2016 term.

67. Ms. Cram was appointed as a Public Member of Council in 2012. She has served on a number of College Committees, including the Inquiries, Complaints and Reports Committee and the Outreach Committee. Ms. Cram is Vice Chair of Goodwill Industries of Ontario Great Lakes, and is a past Chair of King's University College, Western University. She has a background in business, as a former Executive Vice President in the hotel industry.

68. The Working Group met for the first time on October 2, 2015. At this meeting, the Working Group discussed the nature and purpose of the Interim Guidance document: it was to serve as interim guidance for the profession, in order to guide the provision of PAD in the absence of a comprehensive legislative framework. The Working Group considered that a formal College policy should be developed once the federal and provincial governments had clarified the legal regime for provision of PAD. In the meantime, the Interim Guidance would set out the *Carter* criteria and other legal obligations related to PAD, and would outline the implications in the PAD context of the professional obligations set out in College policies, including the *Professional Obligations and Human Rights* policy.

69. The Working Group reviewed the timelines for developing the Interim Guidance document, engaging in external consultation, and seeking Council approval of the Interim Guidance document. The Working Group contemplated that since *Carter* would take effect in early February 2016, the development, consultation and approval of any interim guidance would have to occur on an accelerated timeline. Whereas the policy development process typically takes 1.5-2 years, the draft Interim Guidance would have to be finalized, sent out for consultation

and approved by Council within 4 months, in order to ensure that the Interim Guidance would be in place before the February 6, 2016 deadline.

70. Despite the short timeline, the Working Group was committed to engaging in external consultation on the Interim Guidance document, given the importance of the issue. It opted to recommend engaging in the standard, broad-based external consultation, albeit with an abridged consultation period to ensure that a final draft of the Interim Guidance document would be in place before the February 6, 2016 deadline. The Working Group considered that it was important to solicit feedback widely, from physicians, organizational stakeholders and the general public.

71. The Working Group then reviewed and discussed a draft Interim Guidance document which had been prepared for discussion purposes ("Draft 1"). Draft 1 introduced the purpose of the Interim Guidance, to serve as guidance in the absence of comprehensive framework for the provision of PAD. It outlined the guiding principles of professionalism; described the *Carter* criteria for eligibility for PAD; and discussed conscientious objections, documentation requirements, and reporting and data collection.

72. In Draft 1 of the Interim Guidance document, the issue of conscientious objection was dealt with by indicating that *Carter* does not compel physicians to provide PAD, but that the Supreme Court noted that the *Charter* rights of patients and physicians would have to be reconciled. The draft indicated that the *Professional Obligations and Human Rights* policy sets out the College's expectations for physicians who limit health services for reasons of conscience or religion. The draft then included a list of professional expectations in the context of PAD consistent with that policy for the Working Group's consideration. Draft 1 of the Interim Guidance document is attached to this affidavit as **Exhibit "P"**

73. The Working Group discussed Draft 1 and their objectives for the Interim Guidance document. A primary goal was to provide clarity and assistance to the profession and the public on the issue of PAD. With respect to issues of conscience, the Working Group was of the view that the Interim Guidance should respect the conscience rights of physicians while upholding patient access to care. The Working Group considered that it was in the public interest to balance physicians' freedom of conscience and religion with patient access to care. It recognized that an integral aspect of regulating the practice of medicine in the public interest is ensuring that the College upholds Canadian and Ontario law, including the rights and freedoms guaranteed by the *Charter* and the obligations of physicians under the *Human Rights Code*. The Working Group recognized that the Supreme Court had indicated that physicians would not be compelled to provide PAD. The Working Group acknowledged that physicians' deeply held values are integral to their lives, and that the decision to provide PAD was a personal one which implicated physicians' values and their own perceptions of their professional role.

74. On the other hand, in relation to PAD in particular, the Working Group recognized that a patient's decision to seek PAD was an intensely personal and difficult decision, and that the individuals who sought such care would be people at the greatest stage of suffering, in exceptionally difficult circumstances. The type of patient who would come forward based on the *Carter* criteria would, by definition, be suffering from a grievous and irremediable medical condition, enduring suffering that was intolerable, and such patients needed assistance to find a willing provider with whom they could explore the option of PAD. From the outset, the Working Group sought to develop guidelines that would affirm the College's respect for physicians' freedom of conscience and religion while still ensuring that the public interest was protected and served.

75. In articulating the College's expectations in relation to conscientious objections, the Working Group considered whether the effective referral requirement from the *Professional Obligations and Human Rights* policy should be imported to the PAD context. The *Professional Obligations and Human Rights* policy had been approved by Council earlier that year, in March 2015, following the College's usual process for approving a policy, including an extensive consultation period. That policy set out the College's expectations in general when physicians object to providing care or treatment for reasons of conscience or religion. The policy upholds physicians' freedom of conscience and religion and recognizes that physicians may refrain from providing health care for reasons of conscience or religious belief, but requires objecting physicians to provide patients with an "effective referral," meaning a referral that is made in good faith, to a non-objecting, available and accessible healthcare provider. It also requires physicians to provide care in an emergency, where it is necessary to prevent imminent harm, even where that care conflicts with their conscience or religious beliefs. The *Professional Obligations and Human Rights* policy is attached to this affidavit as **Exhibit "Q"**.

76. During the development of the *Professional Obligations and Human Rights* policy, the inclusion of the "effective referral" requirement and the objections that had been raised to this requirement were carefully considered by Council, as well as by the Working Group responsible for developing that policy. During the consultation process on the *Professional Obligations and Human Rights* policy, many stakeholders had indicated their opposition to this requirement, stating that it infringed their freedom of conscience and religion. While acknowledging these concerns, Council chose to include the requirement of an effective referral as the best means of upholding patients' access to health care services and maintaining public confidence in the College as the protector and promoter of the public interest, while still respecting physicians'

desire not to provide care or treatment to which they object on the basis of conscience or religion.

77. In developing the *Professional Obligations and Human Rights* policy, the College was guided at all times by its overriding duty to serve and protect the public interest. In choosing to include the effective referral requirement in the *Professional Obligations and Human Rights* policy, the Working Group responsible for that policy and ultimately Council balanced a number of elements: physicians' *Charter*-protected freedom of conscience and religion; the duties physicians owe to patients as fiduciaries; the role of a physician as a provider of a public service and gatekeeper of access to health services; the values and duties of medical professionalism, including the commitments arising from the social contract; the wide range of religious views that could be held by physicians in our multicultural society, and the equally wide range of views that could be held by the patients seeking assistance from those physicians; the expectations of the public for how an ethical and professional physician should act; the need to protect patients' access to a wide range of health care services, in communities throughout Ontario, including remote or rural communities; the fact that the services or procedures to which physicians may have an objection are publicly funded and legally available; and the fact that a conscientious objection is based on physicians' personal conscience or religious beliefs and not on elements that would inform a clinical decision about the suitability of a patient's choice of treatment or procedure.

78. The members of the PAD Working Group were all members of Council who had been involved in the debate and ultimately the adoption of the *Professional Obligations and Human Rights* policy earlier that year. One member of the PAD Working Group had also served as a member of the Human Rights Working Group. PAD Working Group members were aware of the

reasons the effective referral requirement had been included in the *Professional Obligations and Human Rights* policy, and were also aware of the reasons many individuals were opposed to this requirement.

79. The Working Group decided that the Interim Guidance should clarify that the College did not yet have a formal position on conscientious objection in the PAD context, and that the Interim Guidance should refer to the *Professional Obligations and Human Rights* policy until a specific policy on PAD was developed. This approach was informed in part by the Working Group's uncertainty as to whether any forthcoming federal or provincial legislation on PAD would elect to deal with the issue of conscientious objection. The Working Group considered that the College should be clear that its ultimate position on conscientious objection in the PAD context would be subject to any legislative guidance provided by the government on this issue. The PowerPoint Presentation used at the October 2, 2015 meeting is attached to this affidavit as **Exhibit "R"**.

80. The Working Group had a specific rationale for arriving at this position. The Working Group upheld the view that when it became legal, PAD would be a necessary health care service to which certain patients were entitled. As a legal, publicly-funded health care service required by some highly vulnerable patients, the Working Group considered that conscientious objections to PAD should be managed in the same manner as conscientious objections to all other health care services. In its view, there was no principled reason to adopt a different position, or to exempt physicians who have conscientious objections to PAD from the College's guiding professional expectations regarding the management of conscientious objections as set out in the *Professional Obligations and Human Rights* policy. The Working Group recognized and affirmed that physicians have the right not to provide care or treatment to which they object on

the basis of conscience or religion, in the context of PAD as for other health care services. The Working Group considered, however, that these rights must be balanced against physicians' duties to their patient, and patients' rights to receive health care services.

81. Staff in the Policy Department made changes to Draft 1 of the Interim Guidance in accordance with the direction given by the Working Group, and prepared a revised draft ("Draft 2"). Included in the revisions to Draft 2 of the Interim Guidance document was a statement indicating that the College had not yet formed a position on how the *Charter* rights of patients and physicians should be reconciled in relation to PAD, but that in the interim, in the absence of a regulatory framework and until the College formulated a position, physicians were directed to comply with the expectations for conscientious objections in general, set out in the *Professional Obligations and Human Rights* policy. Draft 2 of the Interim Guidance Document is attached to this affidavit as **Exhibit "S"**.

82. Draft 2 of the Interim Guidance was presented to the Working Group on October 19, 2015. The Working Group reviewed key updates incorporated into Draft 2 in accordance with the direction provided at the first meeting. At this meeting, the Working Group engaged in further discussion of the conscientious objection/effective referral issue. In particular, the Working Group discussed how an effective referral may differ in the PAD context, given that it may be difficult for objecting physicians to find another health care provider to whom they could make an effective referral. The Working Group suggested that the draft be revised to acknowledge this fact. The Working Group directed that, once revisions had been made, the Interim Guidance be forwarded for consideration by the Senior Management Team and the Executive Committee. The PowerPoint Presentation used at the October 19, 2015 meeting is attached to this affidavit as **Exhibit "T"**.

83. Staff in the Policy Department incorporated the changes to Draft 2 of the Interim Guidance requested by the Working Group. The revised document, Draft 3, added a footnote to the section of the draft dealing with the requirement of providing an effective referral. The footnote indicated that the College acknowledged that the number of physicians and/or agencies to which an effective referral would be directed may be limited, particularly at the outset of the provision of PAD in Ontario, and that in consideration of these circumstances, the College expects physicians to make reasonable efforts to remain apprised of resources that become available in this new landscape. Draft 3 of the Interim Guidance Document is attached to this affidavit as **Exhibit "U"**.

e) Draft Interim Guidance approved for external consultation

84. The Senior Management Team considered Draft 3 of the Interim Guidance Document at its meeting on October 28, 2015, and suggested some minor changes to align the draft more closely with the Supreme Court's decision in *Carter*. The revised draft ("Draft 4") was circulated to the Working Group by email and is attached to this affidavit as **Exhibit "V".**

85. The Executive Committee considered Draft 4 of the Interim Guidance at a meeting on November 3, 2015. The Executive Committee discussed the draft document, including the section dealing with conscientious objection. It supported the positions articulated by the Working Group, and did not recommend any changes to the document. The Executive Committee directed that the document be forwarded to Council for consideration to release for external consultation. All documents associated with the November 3, 2015 meeting of the Executive Committee (Agenda, Briefing Note and Appendices, PowerPoint presentation with draft speaking notes, and Minutes of Proceeding) are included at **Tab 1 of the Record of Proceedings**.

86. The Draft Interim Guidance was considered by Council at its meeting on December 3, 2015. All documents associated with the December 3, 2015 meeting of Council (Agenda, Briefing Notes and Appendices, PowerPoint Presentation with draft speaking notes, and Minutes of Proceeding) are included at **Tab 2 of the Record of Proceedings**.

87. Dr. Leet presented the draft Interim Guidance document on behalf of the Working Group. The presentation noted that the draft document was grounded in the key values of professionalism as articulated in the College's *Practice Guide*, and that it emphasized, in particular, physicians' fiduciary duty to prioritize patient interests. The draft Interim Guidance document drew upon existing College policies applicable to the issue, including the policies on *Consent to Treatment*, *Planning for and Providing Quality End-of-Life Care*, *Medical Records,* and *Professional Obligations and Human Rights*.

88. The presentation to Council touched on the issue of conscientious objection, as dealt with in the draft Interim Guidance. Dr. Leet's draft speaking notes, which informed her presentation to Council, outlined that the *Carter* decision did not compel physicians to provide PAD, but that the Court had stated that the *Charter* rights of physicians and patients must be reconciled. The presentation noted that the College's general position on conscientious objection was set out in the *Professional Obligations and Human Rights* policy, and that the Working Group had determined that in the absence of a framework governing the provision of PAD, physicians should comply with that policy when asserting a conscientious objection. This included providing patients with an effective referral.

89. Dr. Leet's draft speaking notes indicated that in arriving at this position, the Working Group had considered:

- That physicians have a fiduciary duty to prioritize patient interests;
- That in *Carter*, the Supreme Court considered access to PAD in the context of the right to life, liberty and security of the person, which are protected under s. 7 of the *Charter*. The Court concluded depriving individuals of access to PAD in the circumstances set out in *Carter* was a violation of individuals' s. 7 rights;
- That it was uncertain at that time which physicians would be willing to provide PAD once it was legal, and that patients wishing to pursue this option would need assistance to find a physician who was prepared to be involved.

90. Dr. Leet's draft speaking notes indicated that the Working Group felt strongly that the effective referral requirement, as set out in the College's *Professional Obligations and Human Rights* policy, reconciled physician and patient rights in this context as required by the Supreme Court of Canada in *Carter*.

91. Following a discussion, Council approved engaging in an external consultation process in respect of the draft "Interim Guidance on Physician-Assisted Death".

f) External consultation and outreach

i. External consultation

92. On December 4, 2015, the external consultation was launched. The consultation continued until January 13, 2016. The draft document which formed the basis of the consultation ("Draft Interim Guidance") is attached as Appendix 1 to the Council Briefing Note of December 3, 2015 (**Tab 2B of the Record of Proceedings**).

93. Invitations to participate in the consultation were sent by email to a broad range of stakeholders, including the entire College membership and key stakeholder organizations. In addition, a general notice was posted on the College's website and Facebook page, and the consultation was announced on Twitter. It was also published in *Dialogue, Patient Compass,* and

in the *Council Update*. Stakeholders were given the option of submitting their feedback in writing, by email or regular mail; through a brief online survey, which included both closed and open-ended questions designed to elicit feedback on a number of specific issues; or by posting comments to a consultation-specific discussion page. The consultation invitation which was sent to stakeholders by email, as well as the notices published in *Dialogue, Patient Compass* and the *Council Update,* are attached to this affidavit as **Exhibit "W"**

94. In total, 2194 submissions were received in response to this consultation. This includes:

- 341 written comments either submitted by mail or email, or posted to the online discussion page;
- 546 completed online surveys; and
- 1307 petition signatories.

Of the written responses:

- approximately 25% were from members of the public;
- 53% were from physicians or health care practitioners;
- 16% were from anonymous individuals, and
- 7% were from organizations.

Of the survey responses:

- 50% from members of the public;
- 37% were from physicians;
- 2% from medical students;
- 8% from other health care professionals;
- 1% from anonymous individuals; and
- 1% from organizations.

An alphabetical list of organizational respondents, prepared by Policy staff in October 2016, is attached to this affidavit as **Exhibit "X"**.

95. All stakeholder feedback was posted publicly on the College's website as it was received, throughout the consultation. A copy of this written feedback (both letter mail/email and online comments) is attached to this affidavit as **Exhibit "Y"**. A comprehensive report of survey results is attached to this affidavit as **Exhibit "Z"**. A copy of the petition expressing opposition to the Interim Guidance document and in particular to the effective referral requirement is attached to this affidavit as **Exhibit "AA"**.

96. The nature and tone of the feedback was constructive and generally positive. It was clear from the feedback that physicians in particular were looking to the College for clinically-oriented guidance on this issue. Stakeholders also provided criticism and suggestions for revisions, focusing on a few core issues, including how to deal with physician conscientious objections.

97. Stakeholders generally agreed with the College's expectations for how physicians should assert and communicate a conscientious objection to the patient. However, the requirement that an effective referral be made garnered significant and divided feedback. Of the survey respondents, 52% indicated that they "strongly supported" requiring physicians who decline to provide PAD for reasons of conscience or religion to provide an effective referral, whereas 38% of respondents "strongly opposed" this requirement.

98. A number of notable stakeholders provided strong endorsements of the effective referral expectation contained in the Interim Guidance document. For example:

- Dying with Dignity commented that "the College has adopted the considered and compassionate approach necessary for the implementation of physician assisted dying." The submission concluded, "While Colleges of Physicians and Surgeons exist to reconcile the rights of both doctors and patients, in our experience, patients' rights are sometimes neglected. We believe you have struck a thoughtful balance between the two.

We strongly encourage you to stay the course. We believe your approach will not only serve Ontarians, but should be adopted as the gold standard across the country." (**Exhibit "BB"**)

- The British Columbia Civil Liberties Association stated, "It is clear that the College has been very thoughtful in its approach to the issue, and has taken leadership among the provincial colleges to facilitate patient access to physician-assisted dying as soon as possible ... We commend the College for its proactive work in creating this guidance, which we know are intended at ensuring that qualifying patients in Ontario can exercise their right to choose a dignified end to life." (**Exhibit "CC"**)

- Wayne Sumner, a Professor Emeritus in the University of Toronto's Department of Philosophy, expressed strong support for the draft Interim Guidance document, particularly the content on conscientious objection, stating, "I hope that the guidelines will serve as a model for all of the provinces and territories." Professor Sumner is one of the world's leading moral philosophers and has published widely on ethics and political philosophy, including his 2011 book *Assisted Death: A Study in Ethics and Law*. He is a leading Canadian ethicist who served as an expert witness for the plaintiffs in *Carter*. (**Exhibit "DD"**)

- Jocelyn Downie, a University Research Professor in the Faculties of Law and Medicine at Dalhousie University, expressed her support for the draft Interim Guidance document. Dr. Downie is a Fellow of both the Royal Society of Canada and the Canadian Academy of Health Sciences. She specializes in issues at the intersection of health care ethics, law and policy, and has published numerous articles and books on the subject of medical assistance in dying. Dr. Downie stated, "I would first like to commend the CPSO for its leadership in this area. I would also like to applaud you for taking a sometimes unpopular stand with respect to conscientious objection – your commitment to the rights and interests of patients is evident, appropriate, and appreciated." Dr. Downie stated her strong support for the position taken with respect to conscientious objection, which she believed reconciled physicians' freedom of conscience with patients' freedom of conscience and right to life, liberty and security of the person. She concluded, "I would

like to congratulate you on producing what is, in my opinion, the clearest, most useful, and most defensible position statement on the issue of physician-assisted dying of any College of Physicians and Surgeons in Canada. It is a model that I hope others follow (even those who have already drafted their own)." **(Exhibit "EE")**

99. Stakeholders in favour of the effective referral requirement noted that it represented the right balance between patients' right to access PAD and physicians' right to conscientious objection. Some noted that a self-referral approach, which gives patients the responsibility to find their own willing health care provider, is not acceptable in this context because it does not accord with physicians' professional and ethical obligations including the fiduciary duty owed to patients. Further, respondents noted that knowledge about referral pathways for PAD would not be reasonably accessible to patients, and that as patients seeking PAD would be sick and vulnerable, the burden in managing physician conscientious objections should not be shifted to patients. Some noted that the College's position on conscientious objection, including the effective referral requirement, "reconciles physician and patient rights", as the Supreme Court directed in *Carter*.

100. By contrast, many stakeholders, both individual and organizational, expressed concerns about and objections to the effective referral requirement. Stakeholders opposed to this requirement stated that requiring physicians to provide an effective referral in this context would make the physician complicit in PAD and therefore morally culpable for the patient's death. They argued that this was a severe infringement of physicians' *Charter*-protected right to freedom of conscience and religion.

101. Some stakeholders opposed to the effective referral requirement suggested that instead, objecting physicians should be obliged to facilitate a "transfer of care". Stakeholders did not

explicitly define what was meant by a "transfer of care," but implied this would entail physicians ending the treating relationship with the patient, and completely transferring responsibility for the patient's ongoing care (both the care which the physician objects to providing and the care to which the physician does not advance a conscientious objection) to another physician. It was argued that this may be a more morally acceptable requirement for objecting physicians than requiring an "effective referral".

102. Many stakeholders – both those opposed to and those in favour of the effective referral requirement – recommended that the College or the Ministry of Health and Long-Term Care develop a central database of physicians willing to provide PAD. Stakeholders opposed to the effective referral requirement supported the creation of a database in order to facilitate a patient self-referral model, not as a tool to assist objecting physicians in making an effective referral. They noted that a patient self-referral approach would be preferable, as it would avoid compelling physicians to provide an effective referral, which they argued was contrary to their conscience and religious beliefs.

103. Stakeholders supportive of the effective referral requirement advocated for the development of a database for different reasons. They felt that the development of the database would facilitate the making of effective referrals by physicians, which might otherwise prove difficult.

ii. Public polling

104. The College commissioned a poll to gauge public opinion on the issue of PAD. The poll was designed to be representative of the population of Ontario, accounting for age, gender and region. The results of the poll were considered accurate to +/- 3.5%, at the 95% level of

confidence, and the results can be generalized to the online population of Ontario, which represents approximately 84% of the adult population. The poll results indicated that 69% of Ontarians believed that physicians who object to providing PAD on the basis of moral or religious beliefs should nonetheless be required to provide a referral. The report on the polling results, prepared by the Strategic Counsel, is attached to this affidavit as **Exhibit "FF"**.

g) Revision and approval of Interim Guidance document

105. Staff in the Policy Department reviewed the consultation feedback as it was received, and presented a summary of the feedback to the Working Group on January 14, 2016. At this meeting, the Working Group also considered revisions proposed to the Interim Guidance in light of the feedback ("Revised Draft Interim Guidance"). The PowerPoint Presentation presented to the Working Group on January 14, 2016, is attached as **Exhibit "GG"** to this affidavit. The Revised Draft Interim Guidance, which incorporates revisions based on the consultation feedback received, is attached to this affidavit as **Exhibit "HH"**.

106. In discussing the consultation feedback, the Working Group discussed and acknowledged the range of opinions and beliefs expressed about the Interim Guidance and in particular about the requirement to provide an effective referral. The Working Group noted that many of the views expressed regarding effective referral in relation to the Interim Guidance were consistent with those expressed in relation to the effective referral requirement contained in the *Professional Obligations and Human Rights* policy. Having seen and considered the range of opinions regarding the effective referral requirement in the context of PAD, and respecting the views of those who voiced strong opposition to the effective referral requirement, the Working Group discussed potential alternatives to the effective referral requirement and considered

whether any alternatives to that requirement would achieve the Working Group's objectives. Some of these options were proposed by stakeholders and some were proposed by the Working Group members.

107. One alternative was that of a patient "self-referral" model. A self-referral model would require objecting physicians to provide patients with information or resources on how to find a non-objecting physician, but the responsibility for finding a non-objecting physician would ultimately fall to the patient. After considering the pros and cons, the Working Group rejected this option. The Working Group concluded that self-referral would place an undue burden on extremely vulnerable patients who may not have the capacity, knowledge or ability to seek out a non-objecting physician independently. This disadvantage was likely to be heightened in rural or remote communities, where there is a more limited range of health care providers or options for accessing care. Self-referral would also have a disproportionate impact on vulnerable and marginalized groups, including the homeless, mentally ill individuals and individuals dealing with addiction, and individuals with linguistic or cultural barriers. The Working Group noted that in *Carter*, the Court stated that in managing conscientious objections, physician and patient rights would need to be reconciled. The Working Group concluded that the act of reconciling these rights would essentially require a compromise from both patients and physicians: patients must be prepared to accept being referred for PAD if the patient's physician conscientiously objects, and physicians must be prepared to take positive steps to facilitate patient access for this service. The Working Group concluded self-referral did not represent a compromise for both physicians and patients. Rather, it made patients entirely responsible for managing the physician's conscientious objection and would impose a disproportionate burden on vulnerable patients.

108. Another alternative the Working Group considered was whether to permit physicians to effect a "transfer of care" as opposed to providing an effective referral. This option was proposed by some stakeholders, who indicated it may be more palatable to those who object to PAD for reasons of conscience or religion. The Working Group carefully considered this option. It concluded that the extent to which a "transfer of care" was an acceptable option would depend on how "transfer of care" was defined and implemented. If a transfer of care were construed broadly to mean that all care for the patient would be transferred to another provider, including care unrelated to PAD, the transfer would be tantamount to ending the physician-patient relationship. The Working Group felt this was unacceptable for a number of reasons. This option would effectively penalize the patient for voicing an interest in pursuing a legally available, publicly funded health care service. Patients would feel obliged to choose between pursuing a treatment option or maintaining their existing relationship with their physician. The Working Group also considered that ending a physician-patient relationship in these circumstances would not be consistent with the College's policy on *Ending the Physician-Patient Relationship*, or with the professionalism principle that patient autonomy must be respected. Further, the Working Group felt that a transfer of care that is defined broadly to represent a termination of the physician-patient relationship was a disproportionate response to managing physician conscience and religious objections: it would remove all care from the physician's responsibility when the physician only objected to specific elements of care.

109. The Working Group did, however, recognize that a "transfer of care", defined more narrowly, could be an acceptable option. If the "transfer of care" were limited to only those elements of care to which the physician asserted a conscientious objection, this would be acceptable. The patient would be transferred for the care or treatment to which the physician

objected but would continue to be treated by the physician for all other elements of care. The Working Group recognized that this appropriately reconciled physician and patient rights. Indeed, the Working Group subsequently specifically outlined this narrow conception of transfer of care as one example of how the requirement of an effective referral could be satisfied in the Fact Sheet: *Effective Referral: Ensuring Access to Care* (**Exhibit "II"**).

110. Ultimately the Working Group concluded that the self-referral model and the option of transferring total patient care were not acceptable alternatives to requiring an effective referral. These options did not meet the objectives of ensuring patient access to care, did not account for the realities of clinical practice, and did not conform with other College policies such as the policy on *Ending the Physician-Patient Relationship*. Further, the Working Group considered that these alternatives were contrary to the public's expectations of the College and of the profession, and were contrary to the values and duties of medical professionalism, including the principle of patient autonomy and the fiduciary duty of physicians to prioritize patient interests.

111. Having considered and rejected alternatives, as outlined above, the Working Group focused specifically on the effective referral requirement and the arguments against it made by consultation respondents. In particular, the Working Group examined the claim made by stakeholders that an effective referral is the equivalent to providing PAD. The Working Group determined it could not accept this argument. The Working Group concluded that this position did not accord with the purpose or implications of referrals in clinical practice. An effective referral does not foreshadow or guarantee an outcome, or determine that treatment will or will not be provided. Rather, it connects a patient with a physician who is willing to explore the treatment with the patient, and to provide that treatment *if* the physician who accepted the

referral deems the treatment clinically suited to the patient and *if* the patient provides informed consent and elects to proceed with the treatment.

112. The Working Group noted that providing patients with an effective referral required the physician to provide only a minimum amount of support to patients inquiring about PAD, by connecting patients with a non-objecting, available and accessible physician or agency, and by referring patients to this physician or agency in a timely manner. Objecting physicians were not required to assess patients' eligibility for PAD or to provide PAD. Providing an effective referral in no way determined the outcome for patients: both *Carter* and the draft Interim Guidance document set out a number of criteria which patients had to satisfy before they could receive PAD (i.e., be a competent adult, consent to termination of life, have a grievous and irremediable condition, and experience enduring suffering that is intolerable to the patient). The draft Interim Guidance further required that two physicians (attending and consulting) must be satisfied that the patient meets the criteria. An effective referral was therefore one, small step in supporting a patient inquiring about PAD: it by no means determined that the patient would be deemed eligible for PAD or would receive PAD. Thus, while acknowledging that some physicians considered that merely providing an effective referral would violate their freedom of conscience or religion, the Working Group concluded that providing an effective referral was not equivalent to the act of providing PAD, given the manner in which patients could access that service.

113. Further, the Working Group discussed the fact that for PAD, just as for any treatment or health care service, patient consent would need to be provided in order for PAD to be provided. That is, that even if deemed eligible for PAD, a patient would only ultimately receive PAD if he or she consented to proceed. The Working Group was aware that in jurisdictions where PAD is legal, not all patients who are eligible to obtain PAD ultimately proceed with this option. For

instance, the Working Group was aware that data from Oregon illustrates that even when individuals were determined to be eligible and were prescribed medications to facilitate PAD, less than two thirds of these patients died from ingesting legally prescribed medications. The Working Group felt that this data reinforced the conclusion that an effective referral is not equivalent to the act of providing PAD.

114. The Working Group further considered that there was value in maintaining the effective referral requirement in the context of PAD, from a principled perspective. It recognized that the analysis and considerations involved in managing and accommodating physicians' conscientious objections to PAD were comparable if not identical to those involved in managing and accommodating physicians' conscientious objections to other health care services or treatments. After extensive consultation, debate and consideration, Council had recently accepted that an effective referral requirement was justified and indeed required to manage physicians' conscientious objections in the context of the *Professional Obligations and Human Rights* policy. The Working Group believed that there was no qualitative difference between PAD and other health care services that would justify adopting a different position on conscientious objection in the context of PAD. Patients seeking PAD were no less entitled to physician support in being connected with a non-objecting physician provider, and physicians' professionalism obligations and duties to not abandon patients and to prioritize patient interests applied equally in the context of PAD.

115. After considering these options, the Working Group chose to maintain the requirement that physicians who are unwilling to provide PAD due to their moral or religious beliefs must provide an effective referral to a non-objecting, available, and accessible physician or agency.

The Working Group was of the opinion that the effective referral requirement appropriately reconciled physician and patient rights.

116. The Working Group did make revisions to the Sample Process Map for Physician-Assisted Death included in the draft Interim Guidance. The Sample Process Map set out the steps physicians were advised to follow after a patient requested PAD. The Working Group clarified this section in order to indicate that objecting physicians are not responsible for assessing whether a patient is eligible for PAD, and that the steps in the Sample Process Map were to be undertaken only by physicians willing to provide this service. The Working Group wished to clearly indicate that the only action required by an objecting physician was to provide the patient with an effective referral.

117. The Working Group recommended that the Revised Draft Interim Guidance be forwarded to the Executive Committee for consideration. On January 26, 2016, the Executive Committee considered the document and recommended that the Revised Draft Interim Guidance be forwarded to Council to be considered for final approval. The Executive Committee Minutes for January 26, 2016, are included at **Tab 3A of the Record of Proceedings.**

118. On January 26, 2016, a Special Meeting of Council was convened to consider whether to approve the Revised Draft Interim Guidance. Council was presented with a summary of the external consultation feedback, the results of the public polling, and the revisions made to the draft Interim Guidance document which had been made in light of the consultation feedback. Dr. Leet presented to Council on behalf of the Working Group. Her draft speaking notes outline the Working Group's rationale for maintaining the effective referral requirement.

119. Council was also provided with the revised timeline for legalization of PAD in Canada. Given the extension of the suspension of constitutional invalidity granted by the Supreme Court, as well as the Court's ruling that individuals may apply for a judicial exemption in the meantime, Council was advised that that physicians would likely be involved in some capacity in the court's assessment of individual exemptions, and the Interim Guidance document could serve as a resource for physicians assisting the court.

120. Following a discussion, Council approved the *Interim Guidance on Physician-Assisted Death* ("*Interim Guidance*"). The Council Briefing Note, PowerPoint Presentation and Minutes of Proceeding for the January 26, 2016, Special Meeting of Council are included at **Tab 4 of the Record of Proceedings.**

h) Publication of *Interim Guidance Document on Physician-Assisted Death*

121. Following Council's approval of the *Interim Guidance*, the document and a companion FAQ document were published on the College website and in *Dialogue*. The published versions of the *Interim Guidance* and the FAQ document are attached to this affidavit as **Exhibits "JJ" and "KK"**. An FAQ document for the public was also developed and published on the College's website; this is attached to this affidavit as **Exhibit "LL"**.

VI. Development of the College's Physician-Assisted Death *and* Medical Aid in Dying *Policies*

a) College continues to monitor PAD landscape and engage in outreach and support

122. Following Council's approval of the *Interim Guidance*, the College continued to monitor the evolving landscape surrounding PAD in Canada. During this time, the College focused on providing support to the public and the profession, and continued to liaise with key stakeholders regarding the implementation of *Carter*. It was anticipated that once PAD became legal in

Canada (rather than available only through court-ordered exemptions), Council would revisit the Interim Guidance and consider whether an official policy on PAD should be implemented in its stead to govern the provision of PAD by College members.

b) Stakeholder Outreach and Coordination

123. Beginning in January 2016, the College took a leading role in facilitating monthly meetings between representatives of key regulated health profession Colleges and the provincial government. The purpose of these meetings was to foster ongoing collaboration on issues of mutual interest and importance concerning the implementation of the *Carter* decision. One of the issues discussed at these meetings was the establishment of a database of clinicians willing to provide PAD/MAID, in order to facilitate referrals and patient access. The meetings were attended by representatives of the College, including the Registrar, the Director of Policy and Communications, and myself, and representatives of the Ministry of Health and Long-term Care, the Ministry of the Attorney General, the Colleges of Nurses, and the College of Pharmacists. The meetings took place on a regular basis until August 30, 2016, and may continue intermittently in the future.

c) College submissions respecting federal legislation

124. Throughout 2015 and 2016, the College took several opportunities to make submissions to appropriate bodies respecting the development of federal legislation. As discussed above, in October 2015, the College made submissions to both federal and provincial panels convened on the issue. Following Prime Minister Trudeau's assumption of office, a Special Joint Committee was struck to provide recommendations on this issue. On February 24, 2016, the Special Joint Committee released its report titled, "Medical Assistance in Dying: A Patient Centred Report." The Report was largely consistent with the College's *Interim Guidance*, and in specific

instances, drew content directly from the College document. For example, it adopted the College's language to describe the reflection period between the first and second requests for PAD, and mirrored the requirement in the *Interim Guidance* that PAD be available only to insured persons eligible for publicly funded health care services in Canada. In addition, the Report indicated that at a minimum, objecting physicians should provide an "effective referral". The Special Joint Committee Report is attached at **Exhibit "MM"**.

125. On April 14, 2016, the Parliament of Canada introduced proposed legislation dealing with PAD (Bill C-14). The proposed legislation adopted the term "Medical Assistance in Dying" ("MAID"), replacing the term "physician-assisted death" which had been used by the Supreme Court in *Carter*.

126. At its April 26, 2016, meeting, the Executive Committee approved developing submissions to the federal government in response to Bill C-14. On May 2, 2016, the College Registrar, Dr. Gerace, submitted a letter to the House of Commons Standing Committee on Justice and Human Rights. In the letter, Dr. Gerace stated that the College supported many elements of the Bill, but that it had some concerns with the proposed legislation in terms of potential barriers to access. Dr. Gerace indicated that the College would make more comprehensive submissions at a later date, including on the government's proposed non-legislative measures regarding access and the issue of conscientious objections. Materials related to the April 26, 2016 Executive Committee meeting are included at **Tab 5 of the Record of Proceedings.** The Registrar's letter to the Standing Committee on Justice and Human Rights, dated May 2, 2016, is attached to this affidavit as **Exhibit "NN"**.

127. On May 6, 2016, the College provided a submission to the Senate Committee on Legal and Constitutional Affairs in relation to Bill C-14. On May 10, 2013, College President Dr. Kirsh

and Registrar Dr. Gerace appeared before the Senate Committee on Legal and Constitutional Affairs to make submissions on Bill C-14. The submissions dealt with eligibility criteria for MAID, safeguards for MAID and conscientious objections to providing MAID. The submission dated May 6, 2016 is attached to this affidavit as **Exhibit "OO"**.

128. In respect of conscientious objections to MAID, Dr. Kirsh and Dr. Gerace submitted that the College supported recommendation #10 set out in the Report of the Joint Committee (**Exhibit "MM"**), which stated that in managing conscientious objections, the objecting practitioner must, at minimum, provide an effective referral for the patient. Drs. Kirsh and Gerace noted that managing or accommodating conscientious objections of practitioners would have direct implications for patient care, and recommended that the requirement of an effective referral be enshrined in legislation. If this requirement were not legislated, there may be a patchwork of regulatory approaches which arise, which could impede patient access. Drs. Kirsh and Gerace submitted that requiring an effective referral aligned with the Supreme Court's comments in *Carter* that practitioner and patient rights must be reconciled. The College submission addressed the "self-referral" model for MAID advocated by some, noting that this approach is contrary to the ethical and professional duties that physicians, nurses and other healthcare professionals owe to their patients. It also imposes the burden of managing the conscientious objections of practitioners on patients, which Drs. Kirsh and Gerace argued was unconscionable.

d) College adopts *Physician-Assisted Death* and *Medical Assistance in Dying* policies

129. With respect to its ongoing policy work related to PAD and MAID, one key challenge was whether Bill C-14 would pass prior to the June 6, 2016 deadline set by the Supreme Court. If the bill passed, the College would need to establish a policy dealing with MAID consistent with

the federal legislation. If the bill did not pass and the *Carter* decision came into effect, the College would have to establish a policy dealing with PAD consistent with the criteria outlined in *Carter*. In either case, once PAD/MAID became legal – either through legislation or through the effect of *Carter* – the College would be required to replace the *Interim Guidance* with a policy dealing with PAD/MAID consistent with the governing legal framework.

130. As the *Interim Guidance* was largely based on the *Carter* criteria, a Physician-Assisted Death policy would largely be consistent with the Interim Guidance. By contrast, a Medical Assistance in Dying policy, based on the federal legislation, would differ in key ways from the Interim Guidance document. At its meeting on April 26, 2016, the Executive Committee was provided with an update regarding Bill C-14, and the possible options in terms of policy development. The Committee was informed that the proposed legislation was silent on the matter of conscientious objections, but that the federal government had committed to working with the provinces and territories to support access to MAID while recognizing the personal convictions of health care providers. All materials related to the April 26, 2016, meeting of the Executive Committee (Agenda, Briefing Note and Minutes of Proceeding) are included at **Tab 5 of the Record of Proceedings**.

131. At its meeting on April 26, the Executive Committee decided that the College should begin policy work in the lead-up to the June 6, 2016 deadline imposed by *Carter* and the possible implementation of federal legislation. In order to develop materials consistent with the federal legislation, the *Interim Guidance* and related communication materials including FAQ documents would be revised in a few respects. Anticipated revisions included:

- Adopting the term "Medical Assistance in Dying" (MAID) to ensure consistency with legislative language;

- Clarifying that MAID may be provided by either a medical practitioner (i.e. physician) or nurse practitioner;
- Explicitly stating that advance directives for MAID are not permitted; and
- Revising the *Sample Process Map* to reflect legislated safeguards.

The goal was to have a PAD policy or a MAID policy in place as close as possible to the June 6, 2016 deadline, to ensure that the College continued to provide accurate and effective guidance to the profession and public on the issue.

132. Accordingly, the Working Group met again on May 13, 2016. At this meeting, the Working Group reviewed the key elements of Bill C-14, as well as regulatory changes to Bill C-14 that were expected to be forthcoming, based on the details it could glean of the federal legislative process. It also discussed ongoing work with provincial and territorial colleagues to support access to MAID while recognizing the personal convictions of health care providers, as well as other matters.

133. The Working Group also discussed the potential timelines and status of the draft federal legislation and its implications for the College. The Working Group acknowledged that should the draft federal legislation not be finalized and in force for June 6, 2016, when the *Carter* decision came into force, the College would need a policy that reflected the *Carter* decision, as that would be the governing legal regime in the absence of federal legislation. The Working Group discussed bringing two options forward to Council at its May 2016 meeting. One option was a Physician-Assisted Death policy that was largely consistent with the *Interim Guidance*, but removed mention of the interim judicial authorization process that was in place as a mechanism

to enable individual access to PAD from February to June 2016. The second option was a Medical Assistance in Dying policy which mirrored the draft federal legislation.

134. Draft versions of both policies were discussed by the Working Group at this meeting and the Working Group provided feedback. As the Physician-Assisted Death policy was largely consistent with the *Interim Guidance*, previously approved of by Council, very few revisions were required: essentially, the revision entailed removing the section in the *Interim Guidance* dealing with applications for judicial exemptions, and other minor changes. The Working Group discussions focused more extensively on the draft Medical Assistance in Dying policy. That new draft policy was based on the *Interim Guidance*, but included key additions and revisions from the *Interim Guidance* in order to align with the proposed federal legislation. With respect to the issue of conscientious objections, the draft stated that effective referrals may be directed to a physician, *health-care provider*, or agency. The addition of "health care provider" aligned with the text of the *Professional Obligations and Human Rights* policy, and reflected the role of nurse practitioners in providing MAID. Subsequent to the Working Group meeting, staff in the Policy Department made revisions to the draft policy in accordance with Working Group feedback.

135. The Working Group also discussed a Fact Sheet, *Ensuring Access to Care: Effective Referral* (the "Fact Sheet") which was developed to accompany the *Professional Obligations and Human Rights* and *Physician-Assisted Death/Medical Assistance in Dying* policies. The Fact Sheet defined "effective referral," set out the requisite steps for providing an "effective referral" and provided examples of acceptable ways to comply with the referral requirement. The Fact Sheet clarified that the physician could make the referral him/herself or assign the task to another, as long as the designate complied with the expectations for an effective referral. The

following examples were set out in the fact sheet as meeting the requirement for an effective referral:

- The physician or designate contacts a non-objecting physician or non-objecting health-care professional and arranges for the patient to see that physician/professional;
- The physician or designate transfers the patient to a non-objecting physician or non-objecting health-care provider. Transfer in this context must be specific to the care to which the physician objects, and is not equivalent to ending the physician-patient relationship;
- The physician or designate connects the patient with an agency charged with facilitating referrals for the health-care service, and arranges for the patient to be seen at that agency;
- A practice group in a hospital, clinic or family practice model identifies patient queries or needs through a triage system. The patient is directly matched with a non-objecting physician in the practice group with whom the patient can explore all options in which they have expressed an interest; and
- A practice group in a hospital, clinic or family practice model identifies a point person who will facilitate referrals or who will provide the health care to the patient. The objecting physician or their designate connects the patient with that point person.

The Fact Sheet would be posted on the College website alongside both the *Professional Obligations and Human Rights* policy and any policies/guidelines dealing with PAD/MAID. The PowerPoint Presentation presented to the Working Group on May 13, 2015, is attached to this affidavit as **Exhibit "PP"**. The draft MAID policy considered by the Working Group is attached to this affidavit as **Exhibit "QQ"**. The Fact Sheet is attached to this affidavit as **Exhibit "II"**.

136. At its meeting on May 30, 2016, Council was presented with an update on federal activity related to PAD/MAID, and was presented with two draft policies for consideration for approval. Council was advised that, given the uncertainty surrounding whether Bill C-14 would pass before the June 6, 2016, deadline, two draft policies had been developed. The draft *Medical Assistance in Dying* policy ("Draft MAID Policy") incorporated amendments to the *Interim Guidance* needed to ensure alignment with proposed federal legislation. The draft *Physician-Assisted Death* policy ("Draft PAD Policy") was also based on the *Interim Guidance*, but reflected the requirements of the *Carter* decision rather than the proposed legislation.

137. Council was informed that the federal government had committed to working with the provinces and territories to support access to MAID, while recognizing the personal convictions of health care providers. It was, however, unclear at this point what that work would entail and whether it would extend to conscientious objections by institutions.

138. Council then considered three motions in relation to the proposed policies:

- First, in the event that Bill C-14 was defeated or did not become law by June 6, 2016, Council approved the Draft PAD Policy. It would replace the *Interim Guidance* on the College website effective June 6, 2016;

- Second, in the event that Bill C-14 was passed and was in effect by June 6, 2016, Council approved the Draft MAID Policy in principle, subject to any revisions that might be necessary to ensure compliance with the law. It also directed staff to make any amendments necessary to bring the policy into compliance with the federal legislative scheme, with the changes to be approved by the Executive Committee.
- Finally, Council rescinded the *Interim Guidance* effective June 6, 2016.

139. Consequently, if no federal legislation regarding MAID was in effect as of June 6, 2016, the *Physician Assisted Death* policy would become effective as College policy. If federal

legislation was passed, the *Medical Assistance in Dying Policy* would take effect. If any amendments were required to bring the policy into compliance with federal legislation, Council directed staff to amend the policy as required, with any amendments to be approved by the Executive Committee. The amendments were to be reported back to Council at its next meeting.

140. All materials related to the May 30, 2016, meeting of Council, including the Briefing Note, PowerPoint Presentation (including draft speaking notes of Dr. Carol Leet) and the Minutes of Proceeding, are included at **Tab 6 of the Record of Proceedings**. The Draft MAID Policy and the Draft PAD Policy are included at Appendices A and B of the Council Briefing Note, respectively **(Tab 6B)**. The *Physician Assisted Death* policy and the *Medical Assistance in Dying Policy*, as passed by Council, are included at Appendices C and D of the draft Proceedings of the Meeting of Council, respectively (**Tab 6D**). The finalized Proceedings of Council for the meeting of May 30-31, 2016, are attached to this affidavit as **Exhibit "RR"**.

141. As no federal legislation was passed before June 6, 2016, the *Physician Assisted Death* policy took effect on that day. It was published on the College's website in keeping with the College's normal practice. On June 6, 2016, the Executive Committee also reviewed the Fact Sheet and accepted it as an accompaniment to the *Physician Assisted Death* policy. The Proceedings of the Executive Committee for June 6, 2016 are attached to this affidavit as **Exhibit "SS"**.

142. On June 17, 2016, Bill C-14 became law and the *Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)* came into force. On June 21, 2016, the Executive Committee met. The Executive Committee was provided with an oral

update regarding the passage of Bill C-14 and steps taken to revise the draft *Medical Assistance in Dying* policy in light of the federal legislation.

143. The Executive Committee considered the revisions made at the direction of the Working Group to the draft *Medical Assistance in Dying* policy. In keeping with the direction given by Council at its meeting on May 30, 2016, these revisions were made to conform with the newly passed federal legislation. As contemplated by Council, the Executive Committee reviewed and approved the updated draft *Medical Assistance in Dying* policy. The Executive Committee also directed that the *Physician Assisted Death* policy be rescinded. The revised *Medical Assistance in Dying* policy which was considered by the Executive Committee on June 21, 2016, is included at **Tab 7B of the Record of Proceedings**. The Proceedings of the Executive Committee for June 21, 2016, are included at **Tab 7C of the Record of Proceedings.**

144. Following the Executive Committee's approval, the *Medical Assistance in Dying* policy was published on the College website along with other reference documents prepared by the College, which had been updated to reflect the newly implemented legislation and College policy:

- Fact Sheet: Ensuring Access to Care — Effective Referral (**Exhibit "II"**);
- Frequently Asked Questions document (**Exhibit "TT"**);
- A document entitled "Medical Assistance in Dying Policy: 10 Things The Patient Should Know" (**Exhibit "UU"**)

145. Also on June 17, 2016, the Ministry of Health announced that it had established a referral service to support physicians in making an effective referral for consultation and assessment for

possible PAD/MAID cases. The Statement released by the Ministry on June 17, 2016 is attached to this affidavit as **Exhibit "VV"**.

V. Current Policies of Other Canadian and Ontario Regulators

146. In October 2016, staff in the Policy Department reviewed the websites of Canadian medical regulators and several Ontario Regulated Health Colleges to identify the policies that were currently in place governing the issue of conscientious objection and patient access to MAID. Staff advised me that the medical regulatory authorities of all Canadian provinces have policies in place governing this issue, as do the medical regulators in the Yukon and the Northwest Territories. The Ontario Colleges of Pharmacists and Nurses also have policies in place dealing with conscientious objections in the context of MAID. These policies, guidelines and standards are attached to this affidavit or are included as Exhibits to the Affidavit of Larry Worthen, as follows:

- British Columbia – *Professional Standards and Guidelines: Medical Assistance in Dying* **(Exhibit "WW" to this affidavit)**
    - Note: I am advised by policy staff that this reflects a more recent version of the standard than is included in the Affidavit of Larry Worthen
- Alberta – *Standard of Practice: Medical Practice: Medical Assistance in Dying* **(Exhibit "XX" to this affidavit)**
    - Note: I am advised by policy staff that this reflects a more recent version of the standard than is included in the Affidavit of Larry Worthen
- Saskatchewan – *Policy: Medical Assistance in Dying* **(Exhibit "YY" to this affidavit)**
    - Note: I am advised by policy staff that this reflects a more recent version of the policy than is included in the Affidavit of Larry Worthen
- Manitoba – *Schedule M to By-Law 11* **(Exhibit "F" to the Affidavit of Larry Worthen)**
- Quebec:
    - *Code of Ethics of Physicians* **(Exhibit "ZZ" to this affidavit)**

  - *Act Respecting End of Life Care* **(Exhibit "G" to the Affidavit of Larry Worthen)**
  - *Practice Guideline: Medical Assistance in Dying* **(Exhibit "AAA" to this affidavit)**

- New Brunswick – *Guideline: Assistance in Dying* **(Exhibit "K" to the Affidavit of Larry Worthen)**
- Nova Scotia – *Professional Standard Regarding Medical Assistance in Dying* **(Exhibit "I" to the Affidavit of Larry Worthen)**
- Prince Edward Island – *Policy: Medical Assistance in Dying* **(Exhibit "BBB" to this affidavit)**
  - Note: I am advised by policy staff that this reflects a more recent version of the policy than is included in the Affidavit of Larry Worthen
- Newfoundland and Labrador – *Standard of Practice: Medical Assistance in Dying* **(Exhibit "H" to the Affidavit of Larry Worthen)**
- Yukon:
  - *Standard of Practice: Medical Assistance in Dying* **(Exhibit "A" to the Affidavit of Larry Worthen)**
  - *Standard of Practice: Moral or Religious Beliefs Affecting Medical Care* **(Exhibit "CCC" to this affidavit)**
- Northwest Territories – *Medical Assistance in Dying: Interim Guidelines for the Northwest Territories* **(Exhibit "B" to the Affidavit of Larry Worthen)**
- Ontario College of Pharmacists:
  - *Medical Assistance in Dying — Guidance to Pharmacists & Pharmacy Technicians* **(Exhibit "DDD" to this affidavit)**
  - *Code of Ethics* **(Exhibit "EEE" to this affidavit)**
  - *Guideline: Professional Obligations when Declining to Provide a Pharmacy Product or Service due to Conscience or Religion* **(Exhibit "FFF" to this affidavit)**
- Ontario College of Nurses:
  - *Guidance on Nurses' Roles in Medical Assistance in Dying* **(Exhibit "GGG" to this affidavit)**

147. The policies currently in place in other Canadian provinces and territories demonstrate a range of approaches to physicians' conscientious objections to MAID. Although the wording of the policies in each province/territory differs, the policies share overarching themes. Generally, physicians who decline, for reasons of conscience or religion, to assess a patient's eligibility for MAID or to provide MAID have a duty to not abandon their patients, to ensure that continuity of care is maintained, and to not act as a barrier to patient access to MAID.

148. In addition, three jurisdictions – Quebec, Alberta and Nova Scotia – have policies in place which are similar to, or fulfil the requirements of, the College's "effective referral requirement". As discussed above, the College's Fact Sheet, *Ensuring Access to Care: Effective Referral* (**Exhibit "II"**), outlines several ways in which physicians can meet their obligation to provide an effective referral. These include:

- The physician (or the physician's designate) connecting the patient with an agency charged with facilitating referrals for the health-care service, and arranging for the patient to be seen at that agency; or
- The physician or designate transferring the patient to a non-objecting physician or non-objecting health-care provider. Transfer in this context must be specific to the care to which the physician objects, and is not equivalent to ending the physician-patient relationship.

149. Quebec requires objecting physicians to connect patients with a referral agency. Alberta requires objecting physicians to provide patients with reasonable access to the Alberta Health Services care coordination service without delay. Nova Scotia requires that the objecting physician complete an "effective transfer of care" for the patient who requests MAID, but clarifies that the physician must continue to provide care unrelated to MAID. Although these

jurisdictions do not use the term "effective referral", the obligations they impose on physicians are consistent with and would satisfy Ontario's definition of an effective referral.

150. In Quebec, the *Code of Ethics of Physicians* governs physicians' obligations upon asserting a conscientious objection in the context of MAID, as in the provision of other health care services. Section 24 of the *Code of Ethics* states:

> A physician must, where his personal convictions prevent him from prescribing or providing professional services that may be appropriate, acquaint his patient with such convictions; he must also advise him of the possible consequences of not receiving such professional services.
>
> The physician must then offer to help the patient find another physician.

151. Quebec's *Act Respecting End-of-Life Care* also discusses physicians' conscientious objection to providing MAID. Section 50 of the Act provides:

> A physician may refuse to administer medical aid in dying because of personal convictions, and a health professional may refuse to take part in administering it for the same reason.
>
> In such a case, the physician or health professional must nevertheless ensure that continuity of care is provided to the patient, in accordance with their code of ethics and the patient's wishes.

In addition, the physician must comply with the procedure established in section 31 of the Act. Section 31 requires physicians to take positive steps to notify a designated individual of the patient's request for MAID, and to forward the patient's request form for MAID to the designated individual. Essentially, through ss. 31 and 50 of the Act, Quebec requires the physician to connect the patient with an agency which will facilitate the patient's referral for MAID to another physician.

152. Section 3.4.3 of Quebec's *Practice Guideline: Medical Assistance in Dying* makes clear the relationship between the *Act Respecting End-of-Life Care* and the *Code of Ethics of Physicians*, and clarifies that s. 24 of the Code of Ethics, and the requirement that the physician help the patient to find another physician, does apply in the context of MAID:

> **The Code of ethics of physicians (s. 24) states that a physician may refuse to prescribe or provide professional services that may be appropriate for a patient because of his personal moral or religious convictions. He must then offer to help the patient find another physician.** In accordance with the Code of ethics, the Act reiterates that, for the same reasons, a physician may refuse to administer medical aid in dying but must ensure continuity of care for the patient (s. 50). The Act provides for certain mechanisms to help him do so. He must immediately notify the competent authorities who will then take the necessary steps to find another physician willing to accommodate the request in accordance with the procedures provided for in the Act (s. 31)
>
> ...
>
> For many physicians, providing medical aid in dying outside a meaningful therapeutic relationship may seem extremely difficult. It is also likely that for a dying person, receiving medical aid in dying from an unfamiliar physician, assigned to his bedside by an administrative body, will increase his suffering. Thus, in order to improve access to medical aid in dying for an end-of-life patient who is suffering from a serious and incurable disease and who is experiencing intolerable suffering, it is recommended that an attending physician who cannot provide medical aid in dying because of his personal convictions inform the patient sufficiently early on that he will not be able to do so. **At the same time, he must tell him about the range of available medical options and, by notifying the authorities, help him find a colleague who is willing to provide such aid provided the legal and medical requirements are met.** [Emphasis added.]

153. Alberta's *Standard of Practice: Medical Practice: Medical Assistance in Dying* states:

> A regulated member who receives an oral or written request from a patient for medical assistance in dying and who declines for reasons of conscience or religion to provide or to aid in providing medical assistance in dying must ensure that reasonable access to the Alberta Health Services medical assistance in dying care coordination service is provided to the patient without delay.

154. Nova Scotia's *Professional Standard Regarding Medical Assistance in Dying* takes a different approach, stating:

> 4.2. The physician unable or unwilling to participate must complete an effective transfer of care for any patient requesting medical assistance in dying.
>
> 4.3 In addition to completing an effective transfer of care, a physician unable or unwilling to provide medical assistance in dying must, at the earliest opportunity:
>
> ...
>
> 4.3.4 continue to provide medical services unrelated to medical assistance in dying unless the patient requests otherwise or until alternative care is in place.

Together, ss. 4.2 and 4.3 require that, although the physician has completed an effective transfer of care for MAID, the physician continue to provide care unrelated to MAID, unless the patient requests otherwise or alternative care is in place – thus satisfying the College of Physicians and Surgeons of Ontario's requirement of an effective referral as elaborated in the Fact Sheet.

155. In Ontario, the Colleges of Pharmacists and Nurses also have stringent guidelines in place obligating an objecting member to arrange for the patient/client who requests MAID to receive access to a non-objecting member.

156. The College of Pharmacists *Medical Assistance in Dying — Guidance to Pharmacists & Pharmacy Technicians* outlines that the same considerations governing conscientious objections in the provision of pharmacy services generally apply in the context of MAID. The *Guidance* explicitly requires the objecting pharmacist to provide "an effective referral" for MAID, stating at pp. 3-4:

> Where a pharmacist has a conscientious objection to providing MAiD he or she is required to comply with the College's expectations for conscientious objections in general, as set out in the Code of Ethics and Professional Obligations when Declining to Provide a Pharmacy Product or Service due to Conscience or Religion Guideline.
>
> In circumstances where a pharmacist declines to assist in MAiD on the basis of a conscientious objection, he or she must provide the patient with an effective referral to a non-objecting alternate provider where the patient can receive the desired services in a timely manner.

157. For the Ontario College of Nurses, the *Guidance on Nurses' Roles in Medical Assistance in Dying* states that an objecting nurse is responsible for transferring the care of the client to a non-objecting nurse, stating at p. 3:

> The law does not compel an individual to provide or assist in providing medical assistance in dying. However, conscientious objection must not be directly conveyed to the client and no personal moral judgments about the beliefs, lifestyle, identity or characteristics of the client should be expressed. Nurses who conscientiously object must transfer the care of a client who has made a request for medical assistance in dying to another nurse or health care provider who will address the client's needs. Nurses can work with their employers to identify an appropriate, alternative care provider. Until a replacement caregiver is found, a nurse must continue to provide nursing care, as per a client's care plan, that is not related to activities associated with medical assistance in dying.

SWORN before me at the City of Toronto, in the Province of Ontario, this 18th day of October, 2016.

A Commissioner for Taking Affidavits, etc.

ANDREA FOTI