II. *Carter v. Canada* and CMA General Councils (2012-2014)

II.1 *Carter v. Canada*: trial court ruling (June, 2012)[1]

II.1.1 Among their claims, the plaintiffs in *Carter* argued that the law against assisted suicide violated *Charter* guarantees of "life, liberty and the security of the person" (Section 7) with respect to the "grievously and irremediably ill," who seek physician-assisted suicide and persons wishing to assist them to obtain that service, including physicians.[2]

II.1.2 The plaintiffs offered a definition of "grievously and irremediably ill" that was not limited to the terminally ill. It was quoted by the trial court judge.

> They say that "grievously and irremediably ill" means the following:
>
> 1. A person is "grievously and irremediably ill" when he or she has a serious medical condition that has been diagnosed as such by a medical practitioner and which:
>
> > a. is without remedy, as determined by reference to treatment options acceptable to the person; and
> >
> > b. causes the person enduring physical, psychological or psychosocial suffering that:
> >
> > > i. is intolerable to that person; and
> > >
> > > ii. cannot be alleviated by any medical treatment acceptable to that person.
>
> 2. A "medical condition" means an illness, disease or disability, and includes a disability arising from traumatic injury.[3]

II.1.3 An obligation to at least facilitate euthanasia and assisted suicide was implicit in the rights claims made in the plaintiffs' notice of claim[4] and in the testimony of their witness, Professor Margaret Battin. She implied that a physician's refusal to provide assisted suicide or euthanasia would amount to unethical abandonment of patients.[5]

II.1.4 The plaintiffs introduced into evidence the report by the Royal Society panel of experts.[6] It stated that if religious or moral conscience prevents health professionals from killing patients or assisting in suicide, "they are duty bound to refer their patients to a health care professional who will."[7] One of the authors of the report was Professor Jocelyn Downie of Dalhousie University. Professor Downie helped prepare the plaintiffs' expert witnesses for the trial.[8]

II.1.5 The introduction of the Royal Society report was one of the contested issues. The trial judge admitted it as evidence over the objections of Canada. In discussing the feasibility of safeguards, she quoted its recommendations for "the core elements of a permissive

regime" which included reference to referral (under Justice Smith's sub-heading "Features of the provider"):

> Health care professionals should be permitted to provide assistance with suicide or voluntary euthanasia. They must not be obligated to provide such assistance but, if unwilling, should refer the individual making the request to another professional who is willing to consider it.[9]

II.1.6 However, Madame Justice Smith stated that she was *not* relying upon the report in relation to any "contentious matters, such as the efficacy of safeguards."[10] In fact, she used the report (and other evidence) to illustrate a *lack* of social consensus concerning euthanasia and assisted suicide.[11] Hence, that the trial judge quoted this extract from the Royal Society report cannot be understood to mean that she supported compulsory referral.

II.1.7 Further, Madame Justice Smith noted that a theoretical assisted suicide/euthanasia regulatory model proposed by the plaintiffs did not require physicians to "participate" in the procedures.[12]

II.1.8 Finally, since the plaintiffs did not assert that physicians should be compelled to "perform euthanasia" or "assist in suicide," the judge explicitly left the issue aside in her ruling.[13]

II.1.9 It should be noted that Madame Justice Smith quoted extensively from the Canadian Medical Association (CMA) *Policy on Euthanasia and Assisted Suicide* in the course of her review of professional association policies on the subject.[14] The central point in the policy was that physicians should not participate in assisted suicide or euthanasia, but the judge's purpose in quoting the document was to demonstrate that professional associations are not unanimous in this view.

II.1.10 Thus, in ruling specifically in favour of *physician* assisted suicide and euthanasia, the judge deliberately sided with physicians willing to provide therapeutic homicide and suicide against their professional association.

II.1.11 On the other hand, physicians who, for reasons of conscience, were unwilling to participate in killing patients or helping them to commit suicide had the support of their professional association against the judge's ruling.

II.2 Canadian Medical Association (CMA) General Council (August, 2013)

II.2.1 When the CMA Annual General Council convened in August, 2013, an appeal of the *Carter* decision was in progress, and a euthanasia bill had been introduced in the Quebec legislature. Delegates were presented with a motion from the Quebec Medical Association that the CMA should ask "all relevant levels of government to conduct a large-scale public consultation to consider the recognition of medical aid in dying as appropriate end-of-life care."[15]

II.2.2 A contentious debate followed, centred on the wording of the motion and the definition of terms, and the motion was defeated. Instead, delegates voted "to refer the issue to the CMA Board for future deliberation." The outgoing chair of the medical ethics committee said that the vote reflected "deep divisions within the medical community."[15]

II.2.3 Another motion called for the CMA to replace the term "physician-assisted suicide" with "physician-assisted death" in all its official documents. According to a *Globe and Mail* report, this motion also generated a "passionate debate."

> "Suicide is an unhappy word," said John O'Brien-Bell of Surrey, B.C., a past CMA president. "Assisting suicide is also illegal." Lawrence Erlick of Scarborough, Ont., tried to find a compromise, suggesting the unwieldy term "patient-requested medically assisted death." Robin Saunders, chair of the CMA ethics committee, would have none of it. "Let's call a spade a spade: It's euthanasia," he said.

Delegates voted to have the CMA Board review the issue and make a decision.[16]

II.2.4 However, delegates did pass the following motion:

> 36. The Canadian Medical Association supports the right of any physician to exercise conscientious objection when faced with a request for medical aid in dying. (DM 5-22).[17]

II.3 BC Court of Appeal reverses *Carter* ruling (10 October, 2013)

II.3.1 In a 2-1 judgement, the British Columbia Court of Appeal reversed the Supreme Court decision in *Carter*. The majority held that the trial judge erred in failing to follow the precedent set by the Supreme Court of Canada in *Rodriguez* and ruled that the absolute prohibition of physician assisted suicide and euthanasia was not unconstitutional.

II.3.2 However, the majority also suggested that, should the Supreme Court of Canada reconsider its ruling in *Rodriguez*, it should consider allowing a "'constitutional exemption' in favour of persons on whom an otherwise sound law has an extraordinary and even cruel effect." Should that occur, the majority recommended that "court approval of some kind should be sought in addition to the bare requirement of two medical opinions and a request from the patient."[18]

II.3.3 The Court of Appeal also quoted the CMA policy against physician participation in euthanasia and assisted suicide, setting it beside the policies of other associations, as the trial judge did, to make the point that the evidence at trial "did not demonstrate a clear consensus of public or learned opinion on the wisdom of permitting physician-assisted suicide."[19]

II.4 CMA euthanasia and assisted suicide policy (January-June, 2014)

II.4.1 In December, 2013, the CMA Board approved changes to Association policy on euthanasia and assisted suicide.[20] The update, published in 2014, introduced new terminology and reiterated the Association's opposition to the procedures.[21] Three statements in the policy are of particular interest:

> A change in the legal status of these practices in Canada would represent a major shift in social policy and behaviour. For the medical profession to *support* such a change and subsequently *participate* in these practices, *a fundamental reconsideration of traditional medical ethics would be required*. (p. 2, emphasis added)
>
> Physicians, other health professionals, academics, interest groups, the media, legislators and the judiciary are all deeply divided about the advisability of changing the current legal prohibition of euthanasia and assisted suicide. Because of the controversial nature of these practices, their undeniable importance to physicians and their unpredictable effects on the practice of medicine, these issues must be approached cautiously and deliberately by the profession and society. (p. 2)
>
> The CMA recognizes that it is the prerogative of society to decide whether the laws dealing with euthanasia and assisted suicide should be changed. The CMA wishes to contribute the perspective of the medical profession to the examination of the legal, social and ethical issues. (p. 3)

II.4.2 Of equal interest was the *absence* of any reference to the resolution passed by the Annual General Council in 2013 asserting "the right of any physician to exercise conscientious objection when faced with a request for medical aid in dying." (II.2.4) This might have been because the Association still held that *no* physician should participate in assisted suicide or euthanasia, and both were still illegal. However, since the CMA executive claimed that it wished "to contribute the perspective of the medical profession," it is noteworthy that support for conscientious objection by physicians was not included.

II.5 CMA studies euthanasia & assisted suicide (January-June, 2014)

II.5.1 During 2014, CMA officials quietly studied the provision of physician assisted suicide and euthanasia in Oregon, Washington, Montana, Vermont and New Mexico, Netherlands, Belgium and Switzerland.[22] It also held town hall meetings across Canada in the first half of the year, ending on 27 May in Mississauga. Among the points noted in the report concerning the meetings:[23]

> . . . members of the public often had diametrically opposed views on the controversial topic of euthanasia and physician-assisted dying. (p. 1)

> The Canadian public is divided on whether the current Canadian ban on euthanasia and physician-assisted dying should be maintained or not. (p. 1, 17)
>
> The potential impact on the Canadian Medical profession of legalizing physician-assisted dying should be carefully considered and studied further. (p. 17)

II.5.2 In February, the Project Administrator wrote to Dr. Jeff Blackmer, Executive Director of the CMA Office of Ethics, to provide him with a copy of a paper concerning three Ottawa area physicians who were being attacked for refusing to provide or refer for contraceptives and abortion. The paper included an appendix detailing the controversy in the CMA about abortion referral and the Association's rejection of a policy of mandatory referral (Part I).[24] The Administrator commented:

> It is of continuing interest because of the perennial issue of referral, which, it seems, is the mechanism favoured by those attempting to impose upon physicians a duty to do what they believe to be wrong. As noted in the article, this pertains particularly to Quebec Bill 52, but the ultimate outcome of *Carter v. Canada* may also be significant.[25]

II.5.3 Six meetings were also held with physicians across the country, and a website was maintained for physician-only comment from February to the end of May. According to a report published in July,[26] the meetings and on-line responses were characterized by "diametrically opposed views" on euthanasia and assisted suicide.

> Overall, a majority of the CMA members who participated in the dialogue either in person or online favoured maintaining the current CMA policy opposing physician involvement in euthanasia and physician-assisted dying. A significant minority felt this policy should at least be reviewed if not revised to support some form of physician-assisted dying in Canada. (p. 2)

II.5.4 Of 151 members responding to an on-line poll, 71.5% agreed with the existing policy against euthanasia, 25.8% disagreed and 2.6% did not know. (p. 11)

II.5.5 Although the majority opinion would seem to have favoured the *status quo*, the consultation report stated that "the CMA was not given a clear cut mandate on future activity dealing with the sensitive area of euthanasia and physician-assisted dying." (p. 2)

II.5.6 In responding to the letter from the Project Administrator (II.5.2), Dr. Blackmer confirmed that he had reviewed the paper and referred to the ongoing consultations:

> As you may know, the CMA is currently undertaking a series of town hall meetings across Canada on the issue of care at the end of life. We have heard physicians at these meetings speak on the issue of conscientious objection with respect to euthanasia and assisted suicide. The CMA passed a resolution at its 2013 General Council meeting stating:

> "The Canadian Medical Association supports the right of any physician to exercise conscientious objection when faced with a request for medical aid in dying."

I agree that this will continue to be a topical and important issue for Canadian physicians.[27]

II.6 CMA announces plan to intervene in *Carter v. Canada* (April, 2014)

II.6.1 The month before the town hall meetings ended, CMA President Dr. Louis Hugo Francescutti and Dr. Jeff Blackmer announced that the CMA would intervene in the Supreme Court of Canada in the *Carter* case.

> . . . the CMA will be seeking intervener status before the Court, not to offer a polarizing "pro" or "con" view on an already divisive issue - our policy is clear and speaks for itself - but to share a narrative of insights on the physician's perspective. The goal would be to provide the Court with a deeper understanding and appreciation of the findings from the CMA's dialogue on end-of-life care, the spectrum of options and the current CMA policy perspective. We would also highlight the challenges posed to physicians' understanding of their traditional roles if the Court were to change the law.[28]

II.6.2 Dr. Blackmer and Francescutti also offered their view of the reason for the outcome of the contentious debate at the 2013 Annual General Council (II.2):

> The reason that the motion calling for national public consultation "to regard medical aid in dying as appropriate care" was defeated was because "medical aid in dying" had never, until that point, been properly defined. . .[28]

II.6.3 This appears to have substantially understated the significant differences that were evident to those observing the proceedings (II.2.2- II.2.3). They did, however, make the following observations:

> . . .we must recognize that decisions taken at the end of life are not made in a vacuum. They affect family members, loved ones, caregivers, healthcare providers … and even physicians. *One person's right is another person's obligation, and sometimes great burden. And in this case, a patient's right to assisted dying becomes the physician's obligation to take that patient's life.*
>
> *We have heard from many of our members that this prospect makes them not only uncomfortable but downright terrified*. Currently, when physicians enter a patient's room, their purpose is clear: to cure when possible, to care always. The fact that they might actively hasten the patient's death does not enter into the equation. It is not part of the doctor-patient relationship. *Legalizing medical aid in dying would irrevocably change this relationship, and many argue, not for the*

better. . .

. . .only a tiny minority of patients at the end of their lives request access to medical aid in dying. *Until we can provide access to palliative care to all Canadians who need it, this is where the focus of our attention should remain . . .* [28] (Emphasis added)

II.6.4 The observation by Dr. Francesutti and Dr. Blackmer that a patient's right to physician assisted suicide and euthanasia imposes an obligation to kill upon physicians was extremely important and requires further attention here.

II.7 The professional obligation to kill

II.7.1 An obligation to kill must be distinguished from the authority to use potentially deadly force by the police or military, or the justification for the use of potentially deadly force in self-defence. In the latter cases, the law recognizes that death resulting from the use of deadly force may sometimes be so highly probable as to be predictable. Nonetheless, the authority to use deadly force does not include an obligation to kill. Someone who shoots a deadly aggressor in self-defence may not administer a coup-de-grâce if the first shot is merely disabling. There is no obligation to kill even in military combat; deliberately killing disabled enemies is a crime.[29]

II.7.2 In common law countries an obligation to kill has been imposed only on public executioners. The essence of that obligation was captured by Blackstone's explanation that "if, upon judgment to be hanged by the neck till he is dead, the criminal be not thoroughly killed, but revives, the sheriff must hang him again."[30]

II.7.3 That is what an obligation to kill would require of a physician. If a lethal injection failed to cause death, a physician would have to inject him again, or take additional steps to ensure the patient is "thoroughly killed." This is implied in the Quebec euthanasia law, which requires a physician who has administered a lethal substance to a patient to remain with the patient "until death ensues."[31] It is also implied in the reasoning of the American Medical Association, which forbids physicians to participate in executions even by pronouncing death.[32]

II.7.4 Given the results of the CMA consultation (II.5.4), it seems doubtful that, when the intervention was announced, most Canadian physicians would have been willing to embark upon a course that would see the medical profession replace public executioners as an occupation uniquely characterized by the obligation to kill.

II.8 The professional obligation to kill: assisted suicide and euthanasia

II.8.1 Statistics produced by the CMA later in 2014 (II.13.2.3) indicated that, of physicians favouring legalization of physician assisted suicide and euthanasia, more supported legalization of the former than the latter, and, apparently, more were willing to

participate in assisted suicide than euthanasia.

II.8.2 However, where assisted suicide is legal, a physician who agrees to help a patient commit suicide would seem to have accepted an obligation to do something that will result in the patient's death, and to do it according to accepted standards. This obligation seems implicit in the agreement.

II.8.3 Euthanasia procedures are not foolproof, and methods used where assisted suicide is legal are less reliable still.[33] In the case of a failed physician-assisted suicide that incapacitates a patient, it is likely that the attending physician will be expected to fulfil his commitment to help bring about the death of the patient (where euthanasia is legal) by providing a lethal injection or finding someone willing to do so. The expectation would be stronger if the patient had sought assisted suicide to avoid the kind of incapacitation caused by the failed suicide attempt.

II.8.4 This reasoning also suggests that a physician who agrees to help cause the death of a patient by suicide would implicitly incur an obligation to provide euthanasia (or arrange for it) if the patient becomes or proves to be physically incapable of performing the lethal action.

II.8.5 For these reasons, physicians who are willing to provide or at least arrange for assisted suicide would, if the procedure failed, likely be expected to provide or at least arrange for euthanasia where both procedures are legal.

II.9 CMA officials avoid reference to the professional obligation to kill

II.9.1 Given the admission by Dr. Blackmer and Dr. Francescutti in April, 2014 that legalizing assisted suicide or euthanasia would impose an obligation to kill upon physicians, and the ramifications of doing so, one would expect this to have been a constant concern of the CMA Board of Directors.

II.9.2 However, reference to an obligation to kill does not appear in the reports of the 2014 cross-country town hall meetings and physician consultations. It does not appear to have received attention during the August, 2014 General Council. The issue was not raised in Dr. Simpson's affidavit to intervene in *Carter*, nor in the CMA factum or oral submission to the Supreme Court, nor in the revised policy on euthanasia and assisted suicide issued in December, 2014.

II.9.3 The failure to attend to this issue at any point left most physicians unaware of its significance, and of the significance of the policy direction taken by the CMA Board of Directors after the spring of 2014.

II.10 CMA applies for intervener status in *Carter v. Canada* (June, 2014)

II.10.1 In June, 2014, the CMA applied for leave to intervene at the Supreme Court of Canada in *Carter v. Canada*. The application was supported by an affidavit by Dr. Chris Simpson,

president-elect.[20] Dr. Simpson noted his research interests included "access to care" and "referral pathway development." (para. 4)

II.10.2 To emphasize the divisive nature of the subject, Dr. Simpson quoted then CMA policy:

> . . . "physicians, other health professionals, academics, interest groups, the media, legislators and the judiciary are all deeply divided about the advisability of changing the current legal prohibition…".(para. 23)

II.10.3 With reference to physicians, Dr. Simpson observed that a 2011 survey indicated that only 16% of Canadian physicians would provide euthanasia or assisted suicide, while 44% would refuse (para. 33). Members of the public expressed "diametrically opposed views" during the town hall meetings in 2014 (para. 38), where it became clear that the public was divided (para. 39d).

II.10.4 While drawing attention to the strong opposition of Quebec palliative care physicians to the province's proposed euthanasia law, as well as doubts expressed by some family physicians, Dr. Simpson nonetheless noted that physicians had "worked through and continue to assess the appropriate ethical perspectives" of euthanasia, and that both the Quebec Medical Association and Collège des médecins du Québec supported the legislation (para. 44).

II.10.5 In describing then current CMA policy, Dr. Simpson drew the court's attention to the "various perspectives" expressed during town hall meetings. With respect to worries about a "slippery slope," he made special note that the report of the Royal Society panel of experts concluded that there was "no basis to these arguments." (para. 29)

II.10.6 Particularly in view of Dr. Simpson's research interests in access to care and referral pathway development, it is inconceivable that he was unaware that the Royal Society panel had recommended that health care workers unwilling to kill patients or help them kill themselves should be forced to help them find colleagues who would do so.

II.10.7 The affidavit acknowledged but downplayed then current CMA policy against physician participation in euthanasia and assisted suicide, stating that it was "not a certainty nor is it perpetually frozen in time" (para. 28):

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

II.10.8 Despite then current policy, but consistent with statements made two months earlier by Dr. Blackmer and Dr. Francescutti (II.6.1), Dr. Simpson stated that a CMA intervention would not offer "a black and white perspective" (para. 57).

> It would be a disservice to the issues and the Court to set forth a black and white

> perspective. Such a perspective does not exist. The CMA's current policy is not static and can change. (para. 58) (Emphasis added)

II.10.9 The affidavit also envisaged a key role for physicians should the law be changed:

> If the law changes, physicians will be key players in any assisted death regime. They will play two critical roles. First, they will have to determine whether an individual patient's wish to be assisted in dying meets the threshold. Second, they will have to prescribe the agents leading to death, and to provide the patient with bedside care through the process leading to death. Plainly, assisted death, if sanctioned by law, has no prospect of implementation unless physicians in sufficient numbers across the country are persuaded that the sanctioned regime is ethical, practical, and in accordance with existing medical standards. . . (para. 56)

II.10.10 In short, notwithstanding the policy position of the CMA against physician and assisted suicide and euthanasia, nothing in the affidavit suggested that the Canadian Medical Association would oppose legalization of the procedures, nor that it would oppose the participation of physicians in the procedures should the court strike down the law. On the contrary: the affidavit implied that, should the court so so, the Association would likely change its policy precisely because physicians would be "key players" whose cooperation would be needed to make assisted suicide and euthanasia available.

II.10.11 What is noteworthy is the absence of specific reference to physician freedom of conscience and the 2013 resolution of the General Council supporting conscientious objection. However, Dr. Smith made one comment of particular interest:

> The CMA's purpose, in developing and setting policy, is not to override individual judgment or to mandate a standard of care. (para. 17) (See also III.1.3.12)

II.11 Resolution developed by CMA Board of Directors (June-July, 2014)

II.11.1 During 2014 there was continual discussion of physician assisted suicide and euthanasia by the CMA Board of Directors. CMA Board member Dr. Ewan Affleck proposed that the Board sponsor a resolution at the August Annual General Council. What he later told the *Northern News Service* suggests that this proposal was probably made in June.

> "CMA applied for intervener status with the Supreme Court," said Affleck.
>
> "That was some of the urgency in developing our position, we knew the Supreme Court was moving forward and we wished to have a clear position."[34]

II.11.2 At that point, the CMA's position was clear; the Association opposed physician participation in euthanasia and assisted suicide. If Dr. Affleck and others on the Board included in his "we" wanted a "clear position," they must have wanted something different.

II.11.3 Dr. Affleck, who described himself as "passionate about the issue of end-of-life choices" because of personal experiences, explained what happened.

> "We had been discussing this issue at length at the level of the board for a good long while because it is an important issue," said Affleck.
>
> "We had a lot of debates and then I sat down and wrote a proposal for a motion and then took it back to the board as a board member and it was quite uniformly well accepted."[34]

II.11.4 The resolution proposed by Dr. Affleck stated:

> The Canadian Medical Association supports the right of all physicians, within the bounds of existing legislation, to follow their conscience when deciding whether to provide medical aid in dying as defined in CMA's policy on euthanasia and assisted suicide.[35]

II.11.5 The Board thus agreed that the CMA should support physicians who participate in assisted suicide and euthanasia as well as those who refuse to do so, but this could hardly be considered a "clear position" when read in conjunction with the existing policy *against* physician participation. It would seem that the Board's support for the resolution was in conflict with existing policy.

II.11.6 However, the resolution had to be accompanied by a supporting rationale. CMA rules state that the rationale is the means through which the General Council gives policy guidance and direction to the Association and the Board.[36] Thus, as the sponsor of the resolution, the Board wrote - or at least approved in advance - the kind of policy guidance it wanted to use to resolve the apparent conflict.

II.12 The Board's rationale for the resolution

II.12.1 The rationale for the motion noted the "polarizing nature" of the subject reflected in divisions among the public and CMA members. It argued that unanimity among Association members seemed unlikely, and that those supporting and those opposing assisted suicide and euthanasia could marshal "just moral and ethical arguments" to support their respective positions.[35]

II.12.2 While the wording of the motion seemed to suggest that the Association should limit itself to taking a laissez-faire position concerning participation by individual physicians, the rationale went much further, asserting that the current prohibition "may adversely impact patients with terminal conditions and unremitting suffering from obtaining compassionate care."

> Implicit in CMA's mission statement, helping physicians care for patients is the centrality of the patient in the mandate of Canadian physicians.

> CMA's current policy on euthanasia and assisted suicide suggests that Canadian physicians should not participate in assisted death. This poses a dilemma for CMA, as it could be suggested that a prohibition on physician-assisted death bars physicians from providing a service desired by some patients to alleviate pain and suffering.[35]

II.12.3 The CMA *Code of Ethics,* it was argued, "implies the paramount importance of honouring the will of the patient in determining the course of therapy they receive, including end-of-life therapy."

> Given that evidence supports that there are competent Canadians with terminal illness who seek the services of physicians to assist them with dying, how then can Canadian physicians justify withholding a service against the will of a patient?[35]

II.12.4 Rhetorical questions are meant to elicit expected answers. The answer obviously expected by the Board of Directors in this case was that the CMA could not justify refusing assisted suicide and euthanasia to competent patients who are terminally ill and want to kill themselves or have a physician kill them. It would seem to follow from this that the Board of Directors believed that CMA should formally approve physician participation in assisted suicide and euthanasia.

II.12.5 The Directors did not put this to the General Council. Instead, they sponsored a resolution ostensibly limited to the exercise of freedom of conscience, supported by an appeal to adopt a policy of neutrality:

> Rather than choosing to prohibit or approve physician-assisted death, CMA will best serve Canadians *seeking quality health care* by highlighting that physicians may follow their conscience when deciding whether to participate within the bounds of existing law.[35] (Emphasis added)

II.12.6 Consistent with the conclusion noted in II.12.4, the appeal to neutrality included the decidedly non-neutral view that physician assisted suicide and euthanasia could be considered "quality health care" in at least some circumstances.

II.12.7 The resolution was received by the Resolutions Commitee on 11 July, three days before the deadline.[35] The Resolutions Committee processed and arranged all resolutions and made them available to delegates on 16 August, the day before the Council opened.[36]

II.13 CMA General Council (August, 2014)

II.13.1 Briefing materials

II.13.1.1 Briefing materials were prepared for the CMA board of directors and delegates to the Annual General Council of the Canadian Medical Association in August, 2014. The materials included relevant resolutions passed at the 2013 Annual General Council, an

outline of the town hall meetings held in 2014 and Appendix 2, "Care at the End of Life," a backgrounder for the strategy session of the same name.[37]

II.13.1.2 The 2013 resolution that physicians had a right to conscientious objection was listed with eight other resolutions passed at the same time (p. A2-1). It was not included under the summary the summary of CMA policy that followed.

Current CMA policy

II.13.1.3 Key elements of the then current CMA policy on euthanasia and assisted suicide were partially reproduced (A2-2):

> Physicians, other health professionals, academics, interest groups, the media, legislators and the judiciary are all deeply divided about the advisability of changing the current legal prohibition of euthanasia and assisted suicide.
>
> Canadian physicians should not participate in euthanasia or assisted suicide.

II.13.1.4 An elipsis in the policy extracts is of interest.

> For the medical profession to [*support such a change and subsequently*] . . . participate in these practices, a fundamental reconsideration of traditional medical ethics would be required." [*Replaced by elipsis*]

II.13.1.5 If even *supporting* legalization of euthanasia and assisted suicide would require "a fundamental reconsideration of traditional medical ethics," one would expect that a briefing note to delegates would have directed their attention *to* that point rather than *away* from it - unless the intention of those who prepared the briefing materials was to persuade delegates to support the procedures.

Reference to application to intervene in *Carter*

II.13.1.6 The backgrounder disclosed that the CMA had applied for leave to intervene at the Supreme Court of Canada in the *Carter* case. Adopting language previously used by CMA officials, (II.6.1, II.10.8), it stated that the proposed intervention would "not . . .offer a polarizing view on an already divisive issue" and would not "draw a black and white portrait." (A2-3)

Strategic questions

II.13.1.7 The backgrounder posed five strategic questions to delegates to focus the discussion. Three referred to euthanasia and assisted suicide (A2-4):

> 3) Should the CMA revise its current policy on euthanasia and assisted suicide?
>
> 4) If the law is changed in Canada to make euthanasia or assisted suicide legal how should the medical profession respond?

> 5) If access to palliative care services was universal, would it eliminate the need for euthanasia and assisted suicide?

II.13.1.8 Note that Question 5 presumed a "*need* for euthanasia and assisted suicide."

Schedule "A"

II.13.1.9 Included in Appendix 2 was Schedule "A." Schedule A stated that objecting physicians in Washington, Vermont, Oregon, Belgium, and Luxembourg "have a duty to transfer patient care to another physician who can fulfil the request."[38] This was erroneous and misleading.

II.13.1.10 It was erroneous because the law in Vermont says nothing of the sort: in fact, says nothing at all about this.[39]

II.13.1.11 It was misleading because it could be taken to mean that the objecting physician has a duty to initiate the transfer to a willing colleague. This is not required in any of the jurisdictions listed. All that is required is that objecting physicians transfer the patient's medical records as requested by the patient.[40,41,42,43]

II.13.2 Adoption of resolution on freedom of conscience (19 August, 2014)

II.13.2.1 As noted above, it appears that the CMA Board of Directors believed that CMA should reverse its policy and formally approve physician participation in assisted suicide and euthanasia (II.11.4). It did not put this issue to the General Council.

II.13.2.2 Instead, it sponsored the resolution proposed by Dr. Affleck and seconded by outgoing CMA President Dr. Francescutti:

> The Canadian Medical Association supports the right of all physicians, within the bounds of existing legislation, to follow their conscience when deciding whether to provide medical aid in dying as defined in CMA's policy on euthanasia and assisted suicide. (DM 5-6)[35]

II.13.2.3 It was argued on the floor that "current policy on euthanasia and physician-assisted suicide does not sufficiently reflect the broad spectrum of opinions on the matter held by Canadian physicians," since it prohibited physician participation in euthanasia and assisted suicide. In contrast, the most recent survey of Canadian physicians found almost 45% of physicians supported legalizing assisted suicide, about 36% favoured legalization of euthanasia, and almost 27% were willing to be involved with providing assisted suicide if the acts were legalized.[44]

II.13.2.4 Of course, the survey results also revealed that 55% of physicians surveyed were *against* legalizing assisted suicide, 64% *against* legalizing euthanasia, and 73% were *unwilling* to be involved with assisted suicide, but it appears that those citing the statistics preferred to accentuate the positive. It also appears that the numbers of those willing or unwilling to provide euthanasia, if available, were not reported.

II.13.2.5 On the face of it, the 2014 resolution did no more than affirm the 2013 resolution supporting physicians who refuse to participate in euthanasia and add the promise of support for physicians wanting to do so. In the event that the procedures were legalized, the resolution appeared to commit the CMA to impartially defend *both* groups - nothing more. Dr. Jeff Blackmer later explained the resolution as "the other side" of conscientious objection: "almost conscientious permission."[45]

II.13.2.6 This approach offered some strategic advantage in view of the possibility that the Supreme Court might strike down the law against assisted suicide and euthanasia, particularly if the Association maintained its policy that physicians should not kill patients or help them to commit suicide. In that case, the resolution would have left willing physicians free to follow the law without putting them in conflict with CMA policy. It offered the Association as a whole and individual members a way to agree to disagree.

II.13.2.7 Even delegates opposed to euthanasia and assisted suicide would probably have been swayed by such considerations. On the other hand, voting against the resolution would have been a vote against physician freedom of conscience that would arguably have nullified the 2013 resolution in support of a right to conscientious objection.

II.13.2.8 In view of the foregoing, it is not surprising that the outcome of the vote was 91% in favour of the resolution.

II.13.2.9 Professor Margaret Somerville, initially satisfied with the resolution, later changed her mind:

> The CMA's motion, as worded and subsequently interpreted, placed its voting members in an untenable situation. Their only options were to vote either for protection of conscience and for euthanasia or against both. The possibility of voting for freedom of conscience and against euthanasia, as I believe most would, was eliminated.[46]

II.13.2.10 Unnoticed at the time was the fact that the CMA's promise to support physicians providing legal euthanasia and assisted suicide was not qualified or circumscribed by any reference to criteria for the procedures.

II.13.2.11 A CMA report of the meeting noted that a "straw vote" showed 70% of delegates believed that the CMA should revise its policy on euthanasia and assisted suicide, and "78% felt universal access to palliative care services would not eliminate the need for euthanasia and physician-assisted death."[44] These votes were obviously in response to "strategic questions" 3 and 5 posed to the delegates in their briefing material (II.13.1.7-II.13.1.8)

II.13.2.12 The outcome of the "straw votes" complicates an evaluation of the proceedings because it conflicted with views expressed during the earlier extensive physician consultations

(II.5.3, II.5.4) and the bias evident in the information supplied to delegates (II.13.1, II.13.2.4). Further, one cannot determine whether the desire for policy change expressed in response to Strategic Question 3 indicated approval of euthanasia and assisted suicide, or a preference for a policy of neutrality - as urged by those supporting the Board resolution.

II.14 CMA officials comment (August-September, 2014)

II.14.1 Two days after the vote, the CMA Board of Directors confirmed the resolution on freedom of conscience in relation to assisted suicide and euthanasia.[47] The confirmation of the resolution left the prohibition against physician participation untouched.

II.14.2 Some commentators - Professor Somerville among them - initially believed that the resolution was an affirmation of physician freedom of conscience rather than an expression of support for physician participation in assisted suicide and euthanasia.

II.14.3 In fact, that is exactly what Dr. Jeff Blackmer told *The Catholic Register.*

> ". . .It (the new policy) doesn't say we favour a change in the law," said Dr. Jeff Blackmer, the CMA's executive director of ethics.
>
> The CMA stance opposing euthanasia remains in place.
>
> "Our position is still that Canadian physicians should not participate in euthanasia or assisted suicide," Blackmer said.[48]

II.14.4 Asked to reconcile this statement with the position taken in the first three paragraphs of the CMA factum (III.1.3.3) he suggested that the policy revision anticipated in the factum would be limited to the new resolution:

> I would anticipate that the current CMA policy will be revised to include the new resolution passed at our General Council meeting. *As long as medical aid in dying remains illegal, I do not anticipate that it will move from its stance that physicians should not participate.*
>
> I think it is fair to say that, should medical aid in dying become legal, the CMA would support those members who decide to participate. It would continue as well to protect the right of physicians not to participate. This was a decision taken by the delegates to General Council (emphasis added).[49]

II.14.5 Dr. Blackmer maintained the distinction in another interview:

> "One of the options would have been to say our policy is unchanged. We could say ethics trumps the law."
>
> He noted that in Belgium, where euthanasia was legalized in 2002, the Belgian Medical Association continues to discourage physician participation in the

practice.[45]

II.14.6 CMA President Dr. Chris Simpson also took this approach during an interview in the first week of September.

> Simpson said he is in full agreement with Affleck - that the CMA not taking a stance one way or the other on doctor-assisted deaths by passing the motion, but only allowing Canadian physicians to follow their conscience.
>
> "What we are doing is protecting doctors and allowing them to follow their conscience on this issue," he said.
>
> Simpson said if a doctor does not believe in helping a patient end their life, they shouldn't have to and shouldn't be forced by law to do so.[50]

II.14.7 With respect to euthanasia and assisted suicide, he noted that some commentator had described the resolution as "a softening of the CMA's stance on doctor-assisted death."

> "I prefer to think of it as a tightening of definitions when it comes to doctors and their role around end of life care. This is a very complex, controversial issue for doctors and the public at large."
>
> "The CMA had to be careful in its use of terminology in finalizing Affleck's motion."[50]

II.14.8 This response is noteworthy for three reasons.

II.14.9 First: that Dr. Simpson *preferred* to describe what happened as "a tightening of definitions"did *not* amount to a denial that softening had occurred or was occurring.

II.14.10 Second: the term "medical aid in dying" - the only specialized term used in the text of Dr. Affleck's motion - had been defined in CMA policy six months before he brought the motion to the Board. His motion involved no "tightening of definitions."

II.14.11 Third: what Dr. Simpson described as being "careful in its use of terminology in finalizing Affleck's motion" must have been a reference to the care taken in drafting the supporting rationale, since the text of the motion introduced no new terminology and changed no definitions.

II.14.12 Comments by Dr. Simpson in an earlier interview provide more insight into his thinking. He expressed sympathy for physicians concerned by the prospect that euthanasia and assisted suicide might be legalized.

> Most doctors aren't opposed to the notion of patients being able to choose how and when they die, "but they're uncomfortable with the role they're being asked to play," Simpson said.
>
> "That discomfort comes a lot from this uncertainty: Am I going to be compelled to

do it if I don't want to do it? Am I going to be asked to make decisions that I'm really uncomfortable with?"[51]

II.14.13 However, referring to some kinds of cancer and diseases that cause "uncontrollable pain" and suffering that cannot be alleviated by even the best palliative care, he said, "[W]e would all agree that if we were in that situation we would be looking for potentially other solutions" - an obvious if euphemistic reference to death by lethal injection or assisted suicide.[51]

II.14.14 Dr. Simpson's claim that "we would all agree" to such solutions was a remarkable assertion given the CMA's repeated acknowledgement that there was no consensus on euthanasia and assisted suicide. It appears to reflect the quite contrary assumption that everyone agrees that euthanasia and assisted suicide are sometimes acceptable. This was consistent with the views he expressed in the application to intervene in *Carter*, and with the arguments in favour of euthanasia and assisted suicide approved by the CMA Board in the rationale supporting Dr. Affleck's motion.

II.14.15 More significant was his response to the suggestion that someone other than physicians should provide euthanasia and assisted suicide, he said, "I don't think we want to be reneging on our responsibilities to serve our patients."[51] This could be understood to support the view that, in some circumstances, physicians have a legal or professional obligation to kill a patient or to help a patient kill himself.

II.14.16 As outgoing CMA President, Board member and seconder of Dr. Affleck's motion, Dr. Louis Francescutti was well placed to anticipate what the CMA Board would do. Parts II.11 and II.12 appear to explain a comment he made just after Dr. Affleck's motion was accepted by the General Council. He noted that the CMA's official policy had not changed, but "it's only a matter of time."[52]

Notes

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3. *Carter-BCSC*, para. 24.

4. In the BCSC, *Amended Notice of Civil Claim*, (15 August, 2011) Part 1, para. 55, 64(c); Part 1, para. 60; Part 3, para. 9-11, 18. (http://www.consciencelaws.org/archive/documents/carter/2011-08-15-noticeofclaim02.pdf)

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8. *Carter-BCSC*, para. 124

9. *Carter-BCSC*, para. 866e

10. *Carter-BCSC*, para. 120-129

11. *Carter-BCSC*, para. 290-292, 343-348

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19. *Carter-BCCA* (para. 248)

20. In the Supreme Court of Canada (On Appeal from the Court of Appeal of British Columbia) Affidavit of Dr. Chris Simpson, Motion for Leave to Intervene by the Canadian Medical Association (5 June, 2014) p. 10 (https://www.cma.ca/Assets/assets-library/document/en/advocacy/EOL/Supreme-Court-Affidavit-Carter-Case.pdf) Accessed 2015-06-22

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42. Washington: If a health care provider is unable or unwilling to carry out a patient's request under this chapter, and the patient transfers his or her care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the patient's relevant medical records to the new health care provider. (http://www.consciencelaws.org/law/laws/usa-washington.aspx)

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III. CMA writes a blank cheque for the Supreme Court

III.1 Hearing in the Supreme Court of Canada (15 October, 2015)

III.1.1 Appellants' submissions

III.1.1.1 Lawyer Joseph Arvay opposed the Project's intervention in the *Carter* appeal because his clients had never argued that physicians should be forced to kill patients,[1] and, in his oral submission, said, "[N]o one is suggesting that a physician who has a religious objection to assisting a patient with his or her death must do so."[2]

III.1.1.2 At the hearing, Arvay also explained that his clients wanted physicians to be responsible for providing assisted suicide and euthanasia precisely because physicians would normally be strongly opposed to the procedures, and their reluctance to be involved would act as a safeguard against abuse:

> . . . it is also an irrefutable truth, borne out by the evidence in this case from all sides, that all doctors believe it is their professional and ethical duty to do no harm, which means, in almost every case, that they will want to help their patients live, not die. And it's for the very reason that we advocate only physician assisted dying and not any kind of assisted dying, because we know physicians will be reluctant gatekeepers, and only agree to it as a last resort.[3]

III.1.2 Quebec's oral submission

III.1.2.1 Quebec intervened in the *Carter* appeal to advocate for its euthanasia law. When asked about the law's protection for conscientious objectors, Quebec's lawyer said the law "allows a doctor to refuse to administer aid in dying" and that physicians would "never [be] compelled to act against their conscience."[4] The Quebec Association for the Right to Die with Dignity had previously assured Quebec legislators that it had no intention of forcing physicians to provide euthanasia.[5]

III.1.2.2 However, Quebec's euthanasia law provides objecting physicians with *less* protection than is available for other health care professionals. Section 50 of the *Act Respecting End of Life Care* (ARELC) states that other health care professionals may refuse to "take part" (participate) in killing a patient for reasons of conscience. Physicians, on the other hand, may refuse only "to administer" euthanasia - a very specific action - which seems to suggest that they are expected to participate in other ways.[6]

III.1.2.3 ARELC allows physicians to refuse to *personally* kill patients, but adds that they "must nevertheless ensure that continuity of care . . . *in accordance with their code of ethics*."[6] The Collège des médecins *Code of Ethics* requires that physicians unwilling to provide a service for reasons of conscience "offer to help the patient find another physician."[7]

III.1.2.4 Further: some Quebec organizations advocating for euthanasia, some citing the Collège

des médecins *Code of Ethics*, told legislators that objecting physicians should be compelled to help patients find a colleague willing to kill them or help them commit suicide.[8],[9]

III.1.2.5 Strictly speaking, the text of the Collège des médecins *Code of Ethics* could be interpreted narrowly to exclude mandatory referral, though that is what is described in the official explanation provided by the Collège.[10] However, if the regulator decided to re-write the *Code of Ethics* to specify a requirement for "effective referral," the requirement would be affirmed by the Quebec euthanasia law.

III.1 2.6 Quebec's lawyer left all of this out when he told the Supreme Court that physicians would "never [be] compelled to act against their conscience." The Project's lawyer drew the contradiction to the attention of the Court, using it as an example of "precisely the sort of thinking that, in our submission, ought to be protected against."[11]

III.1.3 CMA's submissions

CMA Factum

III.1.3.1 The CMA factum in *Carter* was submitted to the Supreme Court of Canada one week after the end of the Annual General Council in August.[12] CMA President, Dr. Chris Simpson confirmed that it was "reviewed and approved by several senior CMA elected officials and reflects both current CMA policy as well as the recent session at General Council and the results of our consultation processes undertaken during the past year."[13]

III.1.3.2 Strictly speaking, it was true that the factum reflected existing CMA policy, inasmuch as the first paragraph referred the Court to the *Policy on Assisted Suicide and Euthanasia* as found in the trial record, as well as the updated *Policy on Assisted Death and Euthanasia (2014)* with new terminology.

III.1.3.3 However, it cautioned the Court that the policy would be updated as a result of the resolution passed in August supporting the right of physicians, subject to law, "to follow their conscience when deciding whether or not to provide medical aid in dying." (para. 1)

> 2) . . .It is anticipated that the policy, once amended, will continue to reflect the ethical principles for physicians to consider in choosing whether or not to participate in medical aid in dying.
>
> 3) The statement of support for matters of conscience now exists alongside the statement in the CMA policy that "Canadian physicians should not participate in euthanasia or assisted suicide." As long as such practices remain illegal, the CMA believes that physicians should not participate in medical aid in dying. If the law were to change, the CMA would support its members who elect to follow their conscience.

III.1.3.4 This explanation strongly implied that conflict between the two co-existing statements

was temporary, and would be resolved by an amendment dropping CMA's opposition to physician participation in euthanasia.

III.1.3.5 Note that the CMA's promise was unconditional. The factum implied that if the Court decided to strike down or re-write existing law, the CMA would support physicians who decided to participate in euthanasia or assisted suicide, no matter how broadly the Court or legislature might cast the rules governing the procedures.

III.1.3.6 While the factum did reflect policy then current, in one important respect, the reflection was unflattering. Taking note of the existing policy's statement that "adequate palliative care is a prerequisite" to legalization of euthanasia and assisted suicide, the factum challenged the statement with unanswered assertions that the adequacy and accessibility of palliative care were beside the point, since, "even if palliative care were readily available and effective, there would likely be some patients who would still opt for medical aid in dying over palliative care."

> Moreover, it seems wrong to deny grievously ill patients the option of medical aid in dying simply because of systemic inadequacies in the delivery of palliative care. (para. 20)

III.1.3.7 This was consistent with the previous observation that the Board of Directors appeared to believe that CMA should formally approve physician participation in assisted suicide and euthanasia. (II.12.4)

III.1.3.8 The factum referred to the motion supporting "the right of all physicians. . . to follow their consciences when deciding whether or *not*" to provide assisted suicide or euthanasia (para. 3, emphasis added). The CMA insisted that the law should protect both physicians providing the procedures and those who do not (para. 28).

> [N]o physician should be compelled *to participate in or provide* medical aid in dying to a patient, either at all, because the physician conscientiously objects . . . or in individual cases, in which the physician makes a clinical assessment that the patient's decision is contrary to the patient's best interests.(para. 27) (Emphasis added)

III.1.3.9 The distinction made between participation and provision is important. In this context, "participation" is a broader term that would seem to include referral. The factum added that "no jurisdiction that has legalized medical aid in dying compels physician participation."(para. 27)

III.1.3.10 However, the footnote to this comment included a citation of the unsatisfactory Quebec euthanasia law (III.1.2.2 to III.1.2.5). The factum continued:

> If the attending physician declines to participate, every jurisdiction that has legalized medical aid in dying has adopted a process for eligible patients to be transferred to a participating physician.(para. 27)

III.1.3.11 Here the footnote cites the erroneous and misleading "Schedule A" from the appendix prepared for the August AGM (II.13.1.9 to II.13.1.11).

III.1.3.12 Two statements made in the factum are of particular importance:

> The CMA's policies are not meant to mandate a standard of care for members or to override an individual physician's conscience. (para. 9)
>
> It is acknowledged that just moral and ethical arguments form the basis of arguments that both support and deny assisted death. The CMA accepts that, in the face of such diverse opinion, based on individuals' consciences, it would not be appropriate for it to seek to impose or advocate for a single standard for the medical profession. (para. 16) (See also II.10.11)

III.1.3.13 Where the joint intervention of the Protection of Conscience Project, Catholic Civil Rights League and Faith and Freedom Alliances explicitly asked the Court to protect health care workers who refused to participate directly *or indirectly* in killing patients or helping them to commit suicide, the CMA factum avoided any reference to the particularly contentious issue of referral, limiting itself to suggesting that the Court could "indicate that a practicable legislative regime for medical aid in dying must legally protect those physicians who choose to provide this new intervention to their patients, as well as those who do not." (para. 28)

CMA oral submission[14]

III.1.3.14 Consistent with Dr. Simpson's June affidavit and the resolution of the Annual General Council in August, Harry Underwood, the lawyer representing the CMA, made clear that the Association was not arguing for or against the legalization of assisted suicide or euthanasia, but would, instead, "try to show you why physician participation . . . in the practice if legalized, should be considered a matter of conscience and some of the implications that would arise for its adoption for the real world practice of medicine in Canada."

III.1.3.15 He explained that physicians had been historically barred from providing euthanasia and assisted suicide because of ethical considerations, notably a physician's obligation "to secure patient well-being."

> But the concept of patient well-being is capable of an interpretation which encompasses the patient's right to choose death, where the alternative is certain suffering, a choice which is also supported by the concept of patient autonomy. Thus, going back to first principles, the two approaches are each possible.
>
> . . . With the profession now divided between the two positions, each defensible on the basis of established medical ethical considerations and compassion for the patient, the CMA has decided to accept that physician assisted death, if it should become legal, may properly be undertaken by physicians who can square their

> *participation* with their own consciences, without overriding the consciences of those who object to *performing* it. And this is reflected in a resolution taken only this last August by the membership which we described in the factum. And the CMA policy will be amended to reflect this more fully. (Emphasis added.)

III.1.3.16 If the two approaches are "each possible" and "equally defensible," one would expect that the CMA would insist upon equal protection for those on both sides of the issue. However, "perform" (as opposed to the earlier reference to "participate") would seem to restrict respect for choices only to refusal to directly kill patients.

III.1.3.17 With respect to protection of physicians::

> Consistent with the matter as being a matter of conscience, the law should offer protection to those physicians who choose to *participate* in physician assisted death if it is legalized, and those who do not. (Emphasis added.)

III.1.3.18 Mr. Underwood did *not* say that the law should offer *equal* protection. Further:

> A good faith *attempt to comply* with the legislative regime ought to be a complete bar to civil, criminal and disciplinary charges. (Emphasis added.)

III.1.3.19 The request for a "complete bar to civil, criminal and disciplinary charges" refers only to those who *participate* in killing patients, *not* those who *refuse* to participate.

> As well, the choice of those who do not wish to *perform* the practice must be respected. (Emphasis added.)

III.1.3.20 That is, Mr. Underwood urged only *respect* for the choice of those who refused to *perform* euthanasia and assisted suicide, not a "complete bar" to prosecution. Nor did he urge *equal* respect for those who refuse to participate indirectly in killing by referral or other means.

III.1.3.21 However, an oral submission is not held to the same standards of terminological consistency and exactitude as a written submission, and the CMA's oral submission in *Carter* should not be understood to contradict its factum.

III.1.3.22 In the last half of his presentation, Mr. Underwood addressed practical concerns raised by the legalization of physician assisted suicide and euthanasia. He cautioned the court that patient decisions must be free and fully informed, and that the critical risks are real, but did not dispute the trial judge's finding that the risks "can be offset by rigorous assessments undertaken by doctors to rule them out."

III.1.3.23 He noted five specific areas of concern arising from "real world problems that exist in Canada."

- Not everyone has a family doctor, and most people do not have a long term relationship with one.

- Discussions about end-of-life issues do not routinely happen in advance of need.
- Not all general practitioners have a good understanding of palliative care.
- Patients goals may change with time, treatment and adaptation, but few general practitioners follow patients admitted to hospital.
- Palliative care services in Canada are a patchwork, and often unavailable.

III.1.3.24 Consistent with his brief, Mr. Underwood did not suggest that any or all of these problems should preclude legalization of assisted suicide and euthanasia. He did warn the Court that, should it strike down the law, time would be needed to put the necessary institutional supports in place.

III.1.3.25 The CMA's oral submission reinforced the message in the factum: that the Association would support physicians who decided to participate in legal euthanasia or assisted suicide, no matter how broadly the Court might cast the rules governing the procedures.

CMA intervention and the professional obligation to kill

III.1.3.26 As long as the CMA did not take a position either for or against euthanasia and physician assisted suicide, it did not have to take a position for or against an obligation to kill. However, by failing to take a position that an obligation to kill should *not* be imposed upon physicians, it left the Court free to do so.

III.2 CMA Board approves change in policy (December, 2014)

III.2.1 In December, 2014, the CMA Board of Directors approved a change in Association policy on euthanasia and assisted suicide, renaming it "Euthanasia and Assisted Death."[15]

III.2.2 When the revised policy was published, the CMA issued a statement that it "and other changes to the CMA's approach to end-of-life care issues . . . codify resolutions adopted by delegates at the association's annual meeting in August."[16]

Policy change compared with the AGC resolution

III.2.3 This was misleading. The revised policy did codify the resolution that urged the Association to support for physicians who "follow their conscience" when deciding whether or not to provide euthanasia and assisted suicide.

> The CMA supports the right of all physicians, within the bounds of existing legislation, to follow their conscience when deciding whether to provide medical aid in dying as defined in this policy.
>
> A physician should not be compelled to participate in medical aid in dying should it be become legalized.[15]

III.2.4 Recall, however, that one of the key elements in the rationale accompanying the

resolution was that the Association adopt a neutral position concerning physician participation in assisted suicide and euthanasia (II.12.5), and that both the CMA Director of Ethics and the CMA President emphasized that point shortly after the General Council. (II.14.3 to II.14.7)

III.2.5 Instead, the revised policy formally approved physician assisted suicide and euthanasia, subject to legal constraints, classifying both practices as "end of life care."

> There are rare occasions where patients have such a degree of suffering, even with access to palliative and end of life care, that they request medical aid in dying. In such a case, and within legal constraints, medical aid in dying may be appropriate. The CMA supports patients' access to the full spectrum of end of life care that is legal in Canada.[15]

No restrictions on criteria for assisted suicide and euthanasia

III.2.6 Once more, on behalf of Canadian physicians, the CMA Board of Directors promised to ensure patient access to "the full spectrum" of legal euthanasia and assisted suicide, *no matter what the criteria might be.* The policy does not exclude minors, the incompetent or the mentally ill, and it does not limit its application to the terminally ill or those with uncontrollable pain. It refers directly only to "patients" and "the suffering of persons with incurable diseases."

III.2.7 The Directors thus committed the Association to support euthanasia and assisted suicide not only for competent adults, but for any patient group and for any reason approved by the courts or legislatures.

III.2.8 Formal and unqualified approval of physician assisted suicide and euthanasia as forms of "end-of-life care" explains the limit the Board placed on respect for physician freedom of conscience: that "there should be no undue delay in the provision of end of life care."

Deletion of cautionary statements and references to concerns

III.2.9 In revising the policy, the Directors deleted a number of cautionary statements and references to concerns found in the earlier policy. What is of interest is that the statements and concerns were still valid when the policy was revised (Appendix "A").

Constitutionality of the policy change

III.2.10 Delegates were neither presented with nor did they approve a resolution approving physician assisted suicide and euthanasia as medical treatment or "end of life care" at the Annual General Council. However, by approving the resolution supporting the right of physicians to act according to their conscience, the delegates implicitly approved the accompanying rationale. The rationale, having been carefully drafted by the Directors (II.11.6), could be understood to authorize the changes.

III.2.11 In bringing about the change of policy in this manner, the CMA Board of Directors may have been following long-established practices acceptable to the members of the Association. They might, in addition, cite the "straw votes" at the General Council (II.13.2.11-II.13.2.12) and the absence of general protest as evidence of support for their decisions. It thus seems doubtful that the change of policy can be considered unconstitutional, whatever its merits or criticism of the Board's handling of the file.

Professional obligation to kill

III.2.12 However, by formally approving physician assisted suicide and euthanasia rather than adopting a neutral position, and by committing the CMA to support patients's access to physician assisted suicide and euthanasia under conditions set by law, the Directors implicitly agreed that, in some circumstances, physicians have a professional obligation to kill patients or to help them kill themselves.

III.2.13 Further, the Directors set the weight and influence of the entire Association against physicians who believe that it is wrong to participate in killing patients or helping them to kill themselves, or, at least, that physicians should not do so, even if someone else may.

III.2.14 Thus, the Directors agreed that freedom of conscience for objecting physicians might be limited in order to ensure patient access, but they placed no limits on criteria for euthanasia and assisted suicide, and no limits on what the Association and non-objecting physicians might agree to do.

III.3 Writing a blank cheque

III.3.1 The affidavit of Dr. Simpson in support of the application to intervene indicated that the CMA Board of Directors had a reasonable expectation that its input and policy might influence the judges.[17]

III.3.2 Certainly, the CMA intervention confirmed the assurances given to the Court in its application that the Association's policy against euthanasia and assisted suicide was "not a certainty" nor "perpetually frozen in time," that it was "not static and can change," (II.10.7- II.10.8).

III.3.3 The Board of Directors deleted statements of concern adverse to euthanasia and assisted suicide in the new policy, even though the deleted statements were valid when the policy was revised, thus removing considerations that might have impeded legalization (Appendix "A").

III.3.4 The revised policy unconditionally approved physician participation in assisted suicide and euthanasia should the procedures be legalized, amply demonstrating the willingness of the Association to accept and cooperate with legalization on whatever terms the Court set.

III.3.5 By adopting a policy of "conscientious permission," taking the position it did in its

intervention, and by rewriting CMA policy assisted suicide and euthanasia, the Board of Directors effectively wrote a blank cheque for the judges of the Supreme Court of Canada to legalize the killing of patients on any terms acceptable to the judges. In this respect, at least, the CMA does not seem to have lived up to Mr. Arvay's description of physicians as "reluctant gatekeepers" at death's door.

Notes

1. In the SCC on appeal from the BCCA, *Appellants' Response to Motions to Intervene*, 20 June, 2014, para. 5(c) (http://www.consciencelaws.org/archive/documents/carter/2014-06-20-response-to-interventions.pdf)

2. Murphy S. "Re: Joint intervention in *Carter v. Canada* -Selections from oral submissions." Supreme Court of Canada, 15 October, 2014. Joseph Arvay, Q.C. (Counsel for the Appellants). *Protection of Conscience Project.* (http://consciencelaws.org/law/commentary/legal073-009.aspx#Joseph_Arvay)

3. Supreme Court of Canada, 35591, Lee Carter, et al. v. Attorney General of Canada, et al.(British Columbia) (Civil) (By Leave) Webcast of the Hearing on 2014-10-15: *Oral submission of Joseph Arvay*, (81:09/491:20 - 82:12/491:20) (http://www.scc-csc.gc.ca/case-dossier/info/webcastview-webdiffusionvue-eng.aspx?cas=35591&urlen=http://www4.insinc.com/ibc/mp/md/open_protected/c/486/1938/201410150500wv150en,001&urlfr=http://www4.insinc.com/ibc/mp/md/open_protected/c/486/1940/201410150500wv150en,001&date=2014-10-15) Accessed 2015-06-26

4. Murphy S. "Re: Joint intervention in *Carter v. Canada* -Selections from oral submissions." Supreme Court of Canada, 15 October, 2014. Jean-Yves Bernard (Counsel for the Attorney General of Quebec) *Protection of Conscience Project.* (http://www.consciencelaws.org/law/commentary/legal073-009.aspx#Jean-Yves_Bernard)

5. *Consultations*, Wednesday, 25 September 2013 - Vol. 43 no. 38: Quebec Association for the Right to Die with Dignity (Hélène Bolduc, Dr. Marcel Boisvert, Dr. Georges L'Espérance), T#107 (http://www.consciencelaws.org/background/procedures/assist009-018.aspx#107)

6. "Quebec Bill 52, *An Act Respecting End-of-Life Care*. Original text and text as passed by the Quebec National Assembly." Protection of Conscience Project. (http://www.consciencelaws.org/background/procedures/assist009-041.aspx#050)

7. Collège des médecins du Québec, *Code of Ethics of Physicians*, para. 24 (http://www.cmq.org/en/Public/Profil/Commun/AProposOrdre/\u126~/media/Files/ReglementsANG/cmqcodedeontoan.ashx?61323) (Accessed 2015-06-26)

8. *Consultations*, Wednesday, 25 September 2013 - Vol. 43 no. 38: Provincial Association of User Committees (Claude Ménard, Pierre Blain), T#012 (http://consciencelaws.org/background/procedures/assist009-020.aspx#012)

9. *Consultations*, Wednesday 18 September 2013 - Vol. 43 no. 35: Quebec Association of Health Facilities and Social Services (Michel Gervais, Diane Lavallée), T#017 (http://consciencelaws.org/background/procedures/assist009-008.aspx#017)

10. "For example, a physician who is opposed to abortion or contraception is free to limit these interventions in a manner that takes into account his or her religious or moral convictions. However, the physician must inform patients of such when they consult for these kinds of professional services and assist them in finding the services requested." Collège des médecins du Québec, *Legal, Ethical and Organizational Aspects of Medical Practice in Québec. ALDO-Québec: Personal Convictions- Conscientious Objection.* (http://aldo.cmq.org/en/GrandsThemes/ConvictionsPerso/ObjectConsc.aspx) Accessed 2015-06-25

11. Murphy S. "Re: Joint intervention in *Carter v. Canada* -Selections from oral submissions." Supreme Court of Canada, 15 October, 2014. Robert W. Staley (Counsel for the Catholic Civil Rights League, Faith and Freedom Alliance, and Protection of Conscience Project) *Protection of Conscience Project.* (http://consciencelaws.org/law/commentary/legal073-009.aspx#Robert_W._Staley)

12. In the SCC on appeal from the BCCA, *Factum of the Intervener, The Canadian Medical Association* (27 August, 2014) (http://www.consciencelaws.org/archive/documents/carter/2014-08-27-cma-factum.pdf)

13. Somerville S. "There's no "mushy middle" on euthanasia." *Mercatornet*, 2 October, 2014 (http://www.mercatornet.com/careful/view/14885) Accessed 2014-11-27

14. Murphy S. "Re: Joint intervention in *Carter v. Canada* -Selections from oral submissions." Supreme Court of Canada, 15 October, 2014. Harry Underwood (Counsel for the Canadian Medical Association) *Protection of Conscience Project.* (http://consciencelaws.org/law/commentary/legal073-009.aspx#Harry_Underwood)

15. Canadian Medical Association Policy: *Euthanasia and Assisted Death* (Update 2014) (https://www.cma.ca/Assets/assets-library/document/en/advocacy/EOL/CMA_Policy_Euthanasia_Assisted%20Death_PD15-02-e.pdf) Accessed 2015-06-26

16. Rich P. "CMA updates assisted dying policy." Canadian Medical Association, 9 January, 2015 (https://www.cma.ca/En/Pages/cma-updates-assisted-dying-policy.aspx) Accessed 2015-06-25

17. In the Supreme Court of Canada (On Appeal from the Court of Appeal of British Columbia) *Affidavit of Dr. Chris Simpson, Motion for Leave to Intervene by the Canadian Medical Association* (5 June, 2014) para. 19-20 (https://www.cma.ca/Assets/assets-library/document/en/advocacy/EOL/Supreme-Court-Affidavit-Carter-Case.pdf) Accessed 2015-06-22