Court File No. 499/16 and 500/16

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, DYING WITH DIGNITY CANADA, CATHOLIC CIVIL RIGHTS LEAGUE, FAITH AND FREEDOM ALLIANCE AND PROTECTION OF CONSCIENCE PROJECT, CHRISTIAN LEGAL FELLOWSHIP, THE EVANGELICAL FELLOWSHIP OF CANADA, AND THE ASSEMBLY OF CATHOLIC BISHOPS OF ONTARIO, CANADIAN CIVIL LIBERTIES ASSOCIATION, B'NAI BRITH OF CANADA LEAGUE FOR HUMAN RIGHTS, JUSTICE CENTRE FOR CONSTITUTIONAL FREEDOMS, HIV & AIDS LEGAL CLINIC ONTARIO, CANADIAN HIV/AIDS LEGAL NETWORK AND CANADIAN PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH

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TABLE OF CONTENTS

PART I - OVERVIEW

1. This case raises the question of whether doctors can, as a matter of professional ethics, allow their personal or religious beliefs to stand in the way of their patients' access to care.

2. Dying with Dignity Canada ("DWDC") supports the effective referral requirement set out in the College of Physicians and Surgeons of Ontario's ("CPSO") policies on Medical Assistance in Dying ("MAID") and Professional Obligations and Human Rights. The policies appropriately accommodate and balance the rights of vulnerable, grievously ill individuals seeking to end their suffering through MAID with the rights of doctors who do not wish to participate in MAID.

PART II - FACTS

3. In Canada, MAID is fully integrated into the health care system and in Ontario it is an insured service covered by OHIP.[1] Only medical practitioners and nurse practitioners can legally perform MAID.[2] The practitioner must assess the patient to determine whether they meet the eligibility criteria. A second practitioner must also conclude in writing that the patient meets the criteria for MAID.[3] The criteria include the existence of a serious and incurable illness, disease or disability, an advanced state of irreversible decline in capability, suffering that is intolerable to the patient, and the reasonable foreseeability of death. The patient must be at least 18 years old, and capable of making decisions with respect to their health. He or she must make a voluntary written request for MAID, signed by two independent witnesses, and must be capable of giving informed consent at the moment that MAID is performed.[4]

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[1] CPSO Policy No. 4-16, *Medical Assistance in Dying,* Applicants' Record Court File 500/16 ["AR 500/16"], Vo1. 1, p. 47 at p. 50 ["MAID Policy"].
[2] *Criminal Code*, RSC 1985, c C-46, s. 241.1 ["*Criminal Code*"]. Contrast to Switzerland, which does not require that the person seeking an assisted death have a medical condition and does not require a physician to be involved: *Carter v. Canada (A-G*), 2012 BCSC 886 (CanLII), ¶¶ 368, 591-592.
[3] *Criminal Code*, ss. 241.2(3)(a),(e).
[4] *Criminal Code*, s. 241.2(2)-(5). Note that if the patient is unable to sign the request, a person who will not benefit from the patient's death can sign the request on the patient's behalf.

4. Some doctors object to assessing whether patients are eligible for MAID and/or providing it. The CPSO requires objecting doctors to provide patients with a timely "effective referral". Effective referral is defined in the MAID policy as, "a referral made in good faith, to a non-objecting, available, and accessible physician, nurse practitioner or agency."[5]

5. The CPSO has a fact sheet that provides examples of effective referrals, including:

- The physician or designate contacts a non-objecting physician or non-objecting healthcare 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 healthcare provider.
- The physician or designate connects the patient with an agency charged with facilitating referrals for the healthcare 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.
- A practice group in a hospital, clinic or family practice model identifies a point person who will facilitate referrals or who will provide the healthcare to the patient. The objecting physician or their designate connects the patient with that point person.[6]

6. As can be seen from these examples, an effective referral does not necessarily require the patient's doctor to write to another doctor to ask them to see the patient. Rather, the essence of the requirement is that the patient must be connected with a person or agency who will either provide care or connect the patient with a willing provider of the service requested. This can be achieved through a number of different practice models which allow doctors to delegate their responsibility for an effective referral to a designate, including a staff person or colleague.[7]

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[5] MAID Policy, *supra* note 1, p. 47.
[6] Fact Sheet, Ensuring Access to Care – Effective Referral, Foti Affidavit, Respondent's Record Court File 500/16 ["RR 500/16"], Ex. II, p. 1038 ["Fact Sheet"].
[7] Fact Sheet, *ibid.*; Imrie Cross, pp. 6-7, q. 9; pp. 7-8, q. 11; p. 12, q. 23; p. 18-20 q. 42; p. 21, q. 45; p. 38-40, q. 86. Martin Cross, pp. 24-25, q. 47; Turnbull Cross, p. 59, q. 201.

PART III – ARGUMENT

A. The policies fall within the CPSO's mandate over professional ethics

7. The effective referral requirement places an ethical responsibility on doctors to ensure that their religious or personal beliefs do not stand in the way of patients receiving care to which they may be entitled. The policies fall squarely within the CPSO's statutory duty to establish standards of professional ethics for its members and its obligation to serve and protect the public interest.[8] They are consistent with the principles underlying other medical codes of ethics that require doctors to put the needs of their patients first and to advocate for access to appropriate resources on behalf of their patients.[9] They also promote equitable access to medical care, which is a cornerstone of the Canadian health care system.[10]

8. It is not necessary to determine whether patients have a constitutional right to health care or whether doctors have *Charter* obligations. As a statutory body that regulates the medical profession in the public interest, the CPSO must consider whether the professional standards it puts in place will cause or ameliorate harm to the public (including patients), and must balance these interests against possible infringements of the rights of doctors. In doing so, the CPSO has an obligation to act in accordance with *Charter* rights and values.[11]

B. The effective referral policy engages the rights of patients

9. In *Carter*, the Court recognized that the criminal prohibition on MAID violated s. 7 of the *Charter* in a number of ways. It violated the right to security of the person because it resulted in

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[8] *Regulated Health Professions Act, 1991*, SO 1991, c 18, schedule 2, *Health Professions Procedural Code*, ss. 3(1)5, 3(2) ["HPPC"].
[9] Turnbull Affidavit, RR 500/16, Vol. 3, pp. 1414-1415, ¶ 23, Turnbull Cross, pp. 33-34, q. 124-125; Martin Affidavit, RR 500/16, Vol. 3, pp. 1515-1516, ¶ 24-25.
[10] Turnbull Affidavit, RR 500/16, Vol. 3, p. 1411, ¶ 14 and pp. 1415-1416, ¶ 25; Martin Affidavit, RR 500/16, Vol. 3, p. 1514, ¶ 20.
[11] *Doré v. Barreau du Québec*, [2012] 1 SCR 395, ¶ 24 ["*Doré*"]; *Slaight Communications Inc. v. Davidson*, [1989] 1 SCR 1038, p. 1048; *Trinity Western University v. The Law Society of Upper Canada*, 2016 ONCA 518, ¶ 79, 112 ["*TWU v. LSUC*"].

individuals being forced to endure intolerable suffering.[12] It also violated Ms. Carter's liberty interests by "interfering with fundamentally important and personal medical decision-making imposing pain and psychological stress and depriving her of control over her bodily integrity."[13]

10. Today, MAID is legal, but access to MAID is managed and controlled by actors in the health care system. Where actors, policies, or structures within that system prevent grievously and irremediably ill people from accessing MAID, the s. 7 rights of those patients are engaged. An objecting doctor's refusal to provide an effective referral can thwart vulnerable patients from accessing MAID or result in delayed access to a willing provider.

11. There is no publicly available list of doctors who perform MAID. The Ministry of Health and Long-Term Care has a "clinician referral service" that physicians can call to obtain information about doctors who are willing to assess or perform MAID, but this number is not available to the public due to concerns over privacy and security.[14]

12. The Applicants presented mixed evidence about what objecting doctors would be willing to do when a patient requests a service they object to providing. A number of the Applicants' witnesses indicated they would provide "information" to the patient, but on cross-examination, they made it clear that they would only be willing to provide very general information – such as the name or number of a hospital, practice group, or a general health information service in the area – not information about how to contact willing MAID providers.[15]

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[12] *Carter v. Canada (Attorney General)*, [2015] 1 SCR 331, ¶¶ 65-66 ["*Carter*"].
[13] *Carter*, *ibid*., ¶ 65, quotation marks and citations removed.
[14] Dicerni Affidavit, AG Ont. Record ["AGO R"], p. 115, ¶ 13. Dr. Scott testified that the Ottawa Hospital's MAID team accepts self-referred patients, but he also acknowledged that many people do not have access to the Ottawa hospital or a direct self-referral option: Scott Cross, p. 47, ln. 1-19.
[15] Coelho Cross, p. 43-44, q. 194-198; Showalter Cross, p. 32-33 q. 153-156; p. 34, q. 162-164 ; Sulmasy Cross, pp. 44-47, q. 142-147.

13. This "information" is of very limited use. The patient would be required to call or visit these services, which may or may not have willing providers and which may or may not offer assistance in finding one.[16] In fact, many doctors will not accept a patient without a referral.[17] This leaves patients to conduct independent research in order to locate a willing provider who will see them without a referral. People seeking MAID are often extremely ill, have limited energy or ability to make calls, do research, and visit clinics, and are dealing with enormous emotional burdens associated with their condition.[18] These vulnerable patients could be passed from one clinic/doctor/hospital to the next, putting them at risk of falling through the cracks.

14. While some patients may be able to navigate the system effectively, others may not.[19] Furthermore, there are delays inherent to researching, contacting and making an appointment to see a willing provider. If they find a provider, the doctor may be unavailable for a timely consultation. Delay can prolong the suffering of a grievously ill individual. It can also effectively deprive an individual of access to MAID, as they may lose capacity before being connected with a willing provider or before the assessment process is complete.[20] Loss of capacity does not necessarily correspond with a quick death. Patients may be forced to go on living in pain, with limited autonomy, or in a manner that they feel is an affront to their dignity - the very things that they sought to avoid with MAID.

15. The Applicants suggest that the creation of a central coordinating service to put patients in touch with willing providers would be a solution. However, the Applicants do not suggest that doctors should be required to connect their patients with such a service. While some witnesses

[16] Some providers have indicated that they are willing to receive a limited number of MAID referrals in a given period of time; others are only willing to provide a second opinion: Dicerni Affidavit AGO R, p. 116-117, ¶¶ 18-21.
[17] Martin Affidavit, RR 500/16, Vol. 3, p. 1511, ¶ 13.
[18] Imrie Affidavit, RR 500/16, Vol. 3, p. 1685, ¶ 7(i); p. 1687, ¶¶ 10-11. Imrie Cross, pp. 46-48, q. 102.
[19] Turnbull Affidavit, RR, 500/16, Vol. 3 p. 1413, ¶¶ 18-19; pp. 1416-1419, ¶¶ 27-28; Martin Cross, p. 5-6, q. 6-7; p. 18-22, q. 35-44; Imrie Affidavit, RR 500/16, Vol. 3, p. 1687-88, ¶ 11; Imrie Cross, pp. 47-48, q. 102.
[20] Turnbull Affidavit, RR 500/16, Vol. 3, pp. 1420-1421, ¶ 32.

testified that they would be willing to provide the number for this service,[21] others indicated that they would not.[22] So even if a coordinating service is created, this does not mean that patients will know about it or that it will provide timely access to MAID. The clinician referral service that is currently accessible only to doctors has not always been successful in matching patients to a willing doctor in a timely manner. [23]

16. Furthermore, there are patients who would have difficulty connecting with a provider or coordinating service on their own, even if they were given instructions on how to do so. Dr. Imrie testified that this would include vulnerable patients in an advanced state of illness, who are in and out of consciousness or sedation, or who are completely dependent on others for care.[24] The Applicants blatantly misconstrue Dr. Imrie's evidence on this point in their factum.[25]

17. It is not sufficient to suggest that friends, family, caregivers, or social workers can help a patient access MAID in the absence of an effective referral from a physician. Family and friends may also experience difficulties in successfully and efficiently navigating the health care system because of barriers relating to language, poverty, disability, their own poor health, living in a remote community, or a lack of sophistication or research skills. Moreover, some patients may not have anyone in their lives or their circle of care who are willing to assist. Some may even be surrounded by others who actively seek to deprive them of access to MAID.

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[21] Janz Affidavit, Applicants' Supplementary Record Court File 500/16, ["ASR 500/16"], p. 261, ¶ 23; Brooks Cross, pp. 74-75, q. 351-354; Kotalik Cross, p. 72-73, q. 269; Story Cross, p. 89, q. 338; Nunes Cross, p. 76, q. 264.
[22] Tanguay Cross, pp. 149-150, q. 608-611; Bouchard Cross, p. 54, q. 194; Guigliotta Cross, pp. 31-33, q. 121-127 and pp. 59-60, q. 235 (note that unlike Drs. Tanguay and Bouchard, Dr. Guigliotta would provide the number if a patient came back and said they could not find it on their own).
[23] Dicerni Affidavit, AGO R, p. 116, ¶¶ 19-20.
[24] Imrie Affidavit, RR 500/16, Vol. 3., p. 1685, ¶7(i); pp. 1687-1688, ¶¶10-11. Imrie Cross, p. 47-48, q. 102. Amyotrophic lateral sclerosis ("ALS") is one of the top three medical conditions afflicting patients who have requested MAID in Ontario to date: Dicerni Affidavit, AGO R, p. 114, ¶ 9. This condition often affects speech and mobility, and these individuals would be unable to use the phone or visit another clinician on their own: Imrie Cross, pp. 22-23, q. 49.
[25] Applicant's Factum, 500/16, ¶ 134. The cited reference is to Dr. Imrie's evidence that conditions may deteriorate over weeks, months or years and that some patients have put considerable thought into the decision to access MAID.

18. A system requiring patients to rely on friends, family, caregivers or social workers to connect them with a MAID provider would also force patients to waive their right to privacy. Some patients may not want to disclose that they are considering MAID – an intimately personal medical decision – with anyone but their treating physician or the professionals directly involved in the MAID process. There are many reasons for this, including that patients may not want to worry their loved ones, they may fear disapproval, or they may view the exploration of the MAID option as a personal matter that they want to keep private.

19. The Supreme Court of Canada has long recognized that privacy is "essential for the well-being of the individual" and that "freedom not to be compelled to share our confidences with others is the very hallmark of a free society."[26] Medical information "is highly private and personal to the individual. It is information that goes to the personal integrity and autonomy of the patient."[27] Privacy, and medical privacy in particular, has been recognized as an interest that is protected by the *Charter*.[28]

20. Without effective referral, certain patients would be required to sacrifice their right to privacy and confidentiality as a precondition to accessing MAID. Disclosure of medical information in these circumstances cannot reasonably be viewed as voluntary because the patient has no other choice if they want access to a non-objecting doctor. This forced disclosure of personal medical information may impose psychological stress and constitutes a serious violation of dignity and liberty.[29] In the end, disclosure may do very little to ameliorate the patient's suffering and difficulty accessing MAID, since there is no assurance that family and friends or

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[26] *R. v. Dyment*, [1988] 2 SCR 417, p. 427 ["*Dyment*"]; *R v. Duarte*, [1990] 1 SCR 30, p. 53.
[27] *McInerney v. McDonald*,[1992] 2 SCR 138, p. 148.
[28] *Dyment*, *supra* note 26, pp. 432-434; *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 SCR 519, p. 617; *R. v. O'Connor*, [1995] 4 SCR 411, ¶17 (per Lamer CJ and Sopinka J) and ¶¶110-118 (per L'Heureux-Dubé J.) ["*O'Connor*"]; *M(A) v. Ryan*, [1997] 1 SCR 157, p. 175; *R v. Mills*, [1999] 3 SCR 668, ¶¶ 80-82.
[29] *O'Connor*, *ibid*., ¶¶ 111, 119 (per L'Heureux-Dubé J.); *Dyment*, *supra* note 26, p. 429.

even a social worker will be willing or able to help. A patient's interest in protecting their privacy could also dissuade them from seeking MAID altogether, particularly when the patient fears that their family and friends may respond negatively to their request or refuse to assist.

21. Based on all of the above, the CPSO's policies clearly engage the rights of patients. This Court must therefore decide whether a conflict of rights exists, and if so, determine whether the CPSO appropriately considered and balanced the competing interests.[30]

C. The policies do not infringe doctors' rights and freedoms

22. When there is a potential conflict of rights, the Court must first define the scope of the rights at issue as this may serve to avoid the conflict.[31] Doctors' s. 15 *Charter* rights to equality are not infringed by the effective referral requirement. It does not perpetuate disadvantage to, or stereotyping of, religious doctors.[32] Furthermore, when one examines the requirements and effects of the policies, there is no infringement of doctors' freedom of religion or conscience.

23. The test for establishing an infringement of s. 2(a) of the *Charter* is both subjective and objective. The subjective aspect of the test is limited to "establishing that there is a sincere belief that has a nexus with religion."[33] The issue of whether the policies actually infringe those sincere beliefs must be evaluated on an objective standard.[34] The question is not whether the Applicants believe that their rights have been infringed. Rather, the Applicants bear the burden of proving the purported infringement based on objective facts.[35]

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[30] *Dagenais v. Canadian Broadcasting Corp*., [1994] 3 SCR 835, p. 877 ["*Dagenais*"]; *R. v. N.S.*, [2012] 3 SCR 726, ¶¶ 2, 7-8 ["*N.S.*"]; *TWU v. LSUC*, *supra* note 11, ¶¶ 79, 112.
[31] *Trinity Western University v. British Columbia College of Teachers*, [2001] 1 SCR 772, ¶ 29 ["*TWU v. BCCT*"]; *N.S.*, *ibid*, ¶ 32.
[32] *R. v. Kapp*, [2008] 2 SCR 483, ¶¶ 25, 37.
[33] *S.L. v. Commission scolaire des Chênes*, [2012] 1 SCR 235, ¶ 24 ["*S.L.*"].
[34] *S.L.*, *ibid.*, ¶ 24.
[35] *Ibid.*, ¶¶ 23-24.

24. The Applicants have not met this burden. They have framed their argument in absolutist and subjective terms: any action that a doctor feels violates his or her religious beliefs or conscience is an infringement of his or her rights. Their argument is based on a number of false premises and a misreading of the requirements of the policies. In fact, when confronted with the compliance examples on the effective referral fact sheet,[36] a number of the Applicants' witnesses admitted that some of the available options were acceptable to them. .[37]

25. A referral on the basis of a conscientious objection does not mean that the referring doctor agrees with the patient's desired or intended outcome. To the contrary – *the very reason for the referral is that the doctor does <u>not</u> agree with MAID and is refusing to assess the patient*.[38] Physicians who refer a patient to be assessed for MAID are not making a professional judgement about MAID, nor are they recommending it;[39] they are simply connecting the patient with a doctor who is willing to answer questions about MAID, assess the patient for MAID eligibility, and explore treatment options with them, with MAID being one of those options.

26. An effective referral for a medical service is not the same as providing that service. There are many contexts in which a doctor provides a referral because the doctor is not skilled, licenced or experienced to perform the assessment or service that the patient has requested. As pointed out by Dr. Turnbull, once the patient is referred to a second doctor, it is the second doctor who is responsible for assessing the patient and determining which treatment options exist. The second doctor is required to provide an independent opinion and is wholly responsible for any treatment

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[36] Fact Sheet, *supra* note 6.
[37] Kotalik Cross, p. 73, q. 270; p. 77, q. 281; Showalter Cross, pp. 55-56, q. 261-266; Korevemaker Cross, pp. 56-57, q. 191; Nunes Cross, pp. 68-69, q. 230; Guyatt Cross, pp. 59-60, q. 162-164.
[38] This can be contrasted to other situations where a doctor has determined that a service would be of no clinical benefit. However, Dr. Turnbull testified that he has provided a referral in cases where he thinks a procedure would be of no benefit to the patient to enable the patient to obtain a second opinion: Turnbull Cross, pp. 56-57, q. 193-196.
[39] Imrie Affidavit, Respondent's Supplementary Record Court File 500/16 ["RSR 500/16"], p. 21, ¶ 7.

that they provide.[40] When a doctor refers a patient to a second practitioner, the referring doctor does not and cannot know what service will ultimately be provided.[41]

27. Furthermore, the doctor who provides an effective referral is not ordering MAID to take place or causing it to take place. A referring doctor is merely providing the patient with access to information and treatment options.[42] In many cases, a referral does not result in MAID.[43] There are a number of intervening factors that will determine whether the patient will actually have an assisted death: the patient may not be eligible, may lose capacity, may die of the underlying disease, or may, after discussing the matter with the second doctor, choose a different option.

28. Finally, the policies do not objectively infringe doctors' religious or conscientious beliefs because they do not even require objecting doctors to participate personally in the referral process. Physicians can delegate responsibility for the referral to another doctor or staff member in their practice or institution. The doctor's obligation therefore is to organize their practice in a manner that ensures that someone will connect the patient with the care that the doctor objects to providing. The Applicants have not alleged that it would be contrary to their religious beliefs to practice in a team with non-objecting doctors or staff.

29. In light of the above, on an objective basis, s. 2(a) has not been violated. In the alternative, to the extent that the policies may place additional burdens on doctors that affect the practice of their religion, the effect is trivial or insubstantial and does not violate s 2(a).[44]

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[40] Turnbull Affidavit, RR 500/16, Vol. 3, pp. 1422-1423, ¶ 37. The Applicants' witness Dr. Kotalik agreed with this point, Kotalik Cross, p. 39, q. 145.
[41] Imrie Affidavit, RSR 500/16, p. 23, ¶ 13.
[42] Turnbull Cross, pp. 52-55, q. 185-191; See also Kotalik cross, pp. 37-38, q. 134-137 and p. 39, q. 145.
[43] According to the limited anecdotal evidence supplied by the Applicants, in Dr. Scott's experience, 7 out of the 9 patients who initially requested MAID actually received palliative care or services other than MAID. In 3 cases, delirium and rapid disease progression occurred before the MAID assessment had been completed and the patient died after receiving palliative care. In 4 cases, the patient decided not to proceed after other options were explained. Scott Affidavit, ASR 500/16, pp. 278-279, ¶ 15.
[44] *Syndicat Northcrest v. Amselem,* [2004] 2 SCR 551, ¶¶ 58-61 ["*Amselem*"].

D. The policies minimally impair the rights of doctors and appropriately balance the interests of doctors and patients

30. If this Court find that the Applicants' freedom of religion and/or conscience has been infringed by the policies, it must evaluate whether the policies are nonetheless justified, either by engaging in a traditional s. 1 *Charter* analysis following the *Oakes* test, or by considering and balancing *Charter* rights, values and/or competing non-*Charter* interests as a principle of administrative law. DWDC takes no position on the appropriate approach. Both require a consideration of balance and proportionality.[45]

31. The Court must consider whether the CPSO balanced the *Charter* rights not only of doctors, but also of patients, so that both rights are limited no more than is necessary, given the statutory objectives of the CPSO.[46] It must also determine whether one or both rights can be accommodated to preserve them both.[47]

32. The Supreme Court has recognized that "a particular legislative regime may have a number of goals, and impairing a right minimally in the furtherance of one particular goal may inhibit achieving another goal" and that "on complex social issues, the minimal impairment requirement is met if Parliament has chosen one of several reasonable alternatives."[48] In this balancing exercise, the decision-maker is granted a degree of deference.[49]

33. The CPSO policies appropriately balance the competing rights at issue in light of the overarching policy goal of ensuring that patients are able to access medical services to which they are legally entitled. Objecting doctors are not required to assess a patient for MAID, are not

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[45] *Doré , supra* note 11, ¶ 5.
[46] *Loyola High School v. Quebec (Attorney General)*, [2015] 1 SCR 613, ¶ 4 ["*Loyola*"]; *Dagenais, supra* note 30, pp. 877, 890.
[47] *N.S., supra* note 30, ¶ 32; *Dagenais, ibid.*, p. 877.
[48] *Canada (Attorney General) v. JTI-Macdonald Corp.*, [2007] 2 SCR 610, ¶ 43.
[49] *RJR-MacDonald Inc. v. Canada (Attorney General)*, [1995] 3 SCR 199, pp. 305-306 ; *Doré, supra* note 11, ¶¶ 57-58; *Alberta v. Hutterian Brethren of Wilson Colony*, [2009] 2 SCR 567, ¶¶ 53-55.

required to perform MAID, and are not even required to make the referral themselves. Likewise, patients are not entitled to insist that the doctor of their choice assess and perform MAID. If objecting doctors' rights or freedoms are infringed, the impairment is minimal because their only obligation is to manage their practice in a manner that ensures that someone connects the patient with a willing provider in a timely manner.

34. The Applicants' suggested "information-only" requirement and/or the creation of a coordinating service (with no corresponding obligation on doctors to connect their patients with this service) would not meet the CPSO's objective of ensuring that patients are connected with care. Therefore, these are not minimally impairing solutions because they do not meet the decision-makers' objectives. In addition, these models, individually or in tandem, fail to minimally impair the rights of vulnerable patients who are unable to connect to a MAID provider without meaningful assistance.

E. The salutary effects outweigh the deleterious effects

35. If no accommodation/reconciliation of competing rights is possible, the final step of the analysis is to look at whether the salutary effects to patients and the public outweigh the deleterious effects on objecting doctors (and *vice versa*).

36. The Supreme Court has repeatedly asserted that religious freedoms are not absolute and may be limited by the rights (including the non-*Charter* rights) of others or by harm caused to others.[50] Anything less than effective referral impedes some of the most vulnerable patients from accessing MAID, which is a constitutionally protected right of considerable importance. The

[50] *R. v. Big M Drug Mart Ltd.*, [1985] 1 SCR 295, ¶¶ 95, 123; *B. (R). v. Children's Aid Society of Metropolitan Toronto*, [1995] 1 SCR 315, p. 383 (best interest of the child); *Amselem, supra* note 44, ¶¶ 61-62 (interests of neighbours to peaceful enjoyment of property); *Multani v. Commission scolaire Marguerite-Bourgeoys*, [2006] 1 SCR 256, ¶¶ 26, 30 (safety rights of students in school); *S.L., supra* note 33, ¶¶ 25, 31, 32; *TWU v. BCCT, supra* note 31, ¶¶ 29-31; *Loyola, supra* note 46, ¶ 43.

Supreme Court has described the patient's s. 7 right to MAID as "critical to their dignity and autonomy",[51] "very important to their sense of dignity and personal integrity",[52] and a "deeply personal response to serious pain and suffering."[53]

37. In addition to engaging the rights of patients, the effective referral requirement also engages the public interest. The CPSO is required by statute to serve and protect the public interest when carrying out its objects.[54]

38. A fundamental component of the publicly-funded health care system is that patients have equitable access to care on universal terms and conditions.[55] When doctors refuse to connect their patients to services, they effectively limit access to health care. Access becomes dependent on factors such as geography and income, the sophistication, abilities or even health of the patient, and whether the patient has other supports.[56] These systemic harms to the public and the health care system outweigh the minimal obligations the policies place on doctors.

39. Furthermore, permitting doctors to impose their personal beliefs over their patient's wishes undermines the patient-centred model of care that is an essential principle of a quality health care system.[57] A number of the Applicants' witnesses testified that they have decided that certain services, such as MAID, abortion, and birth control, are never "good" for the patient and therefore they cannot be obliged to connect patients with these services.[58]

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[51] *Carter*, *supra* note 12, ¶ 66.
[52] *Carter*, *ibid.*, ¶ 68.
[53] *Ibid.*
[54] HPPC, *supra* note 8, ss. 2.1, 3(2).
[55] *Canada Health Act*, RSC 1985, c C-6, ss. 3, 10; Martin Affidavit, RR 500/16, Vol 3, p. 1510, ¶ 11-12; Turnbull Affidavit, RR, 500/16, Vol. 3, p. 1415, ¶ 25.
[56] Turnbull Affidavit, RR 500/16, Vol. 3, p. 1412-1413, ¶¶18-19; Martin Affidavit, RR 500/16, Vol. 3, p. 1513-1514, ¶¶19-20.
[57] Turnbull Affidavit, RR, 500/16, p. 1412, ¶ 16.
[58] Sulmasy Affidavit, ASR, p. 3, ¶ 6 and p. 5, ¶ 9; Sulmasy Cross, p. 40, q. 132; Kaldjian Cross, p. 47, q. 108; Coelho Cross, p. 40, q. 185; p. 57-58, q. 247; Showalter Cross, p. 48, q. 232; Tanguay Cross, p. 39-42, q. 162-184.

40. This view is contrary to well-established jurisprudence that recognizes the primacy of patient autonomy in medical decision-making.[59] As pointed out in *Rasouli*, "The patient's autonomy interest - the right to decide what happens to one's body and one's life - has historically been viewed as trumping all other interests, including what physicians may think is in the patient's best interests."[60] After being appropriately informed of their treatment options and risks, competent adults are entitled to make decisions with which their doctors disagree.[61]

41. MAID is a fundamentally personal choice, based on whether suffering is intolerable *to the individual*.[62] The doctor's role is to assess whether a patient is eligible for MAID and to provide information about options that are available to relieve suffering and treat symptoms. Ultimately, however, the choice to have an assisted death belongs to the patient. It is inappropriate for doctors to decide that these services are wrong, and refuse to fulfill their professional obligations to ensure that patients have access to the health care they require. In conducting its balancing exercise (or in defining the scope of doctors' s. 2(a) rights), this Court should not allow the religious or personal views of doctors to override the important principle of individual autonomy.

42. This Court must balance the harms to doctors against the aforementioned individual and social harms. It is pure speculation that these policies will have the effect of forcing doctors to leave the profession. They may lead some doctors to change specialities, require them to hire and/or train staff who will do the referral work, or cause them to change their practice structure so that they work in a practice or team with non-objecting doctors or staff who can assist with

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[59] *Carter*, *supra* note 12, ¶ 67 and cases cited therein. See also *A.C. v. Manitoba (Director of Child and Family Services)*, [2009] 2 SCR 181, ¶¶ 39-46.
[60] *Cuthbertson v. Rasouli*, [2013] 3 SCR 341, ¶ 19.
[61] *Malette v. Shulman et al.*, 1990 CanLII 6868 (ON CA), cited with approval in *A.C. v. Manitoba (Director of Child and Family Services)*, [2009] 2 SCR 181, ¶ 41; *Starson v. Swayze*, [2003] 1 SCR 722, ¶¶ 6-7.
[62] *Carter*, *supra* note 12, ¶¶ 4, 127.

referral. These changes may alleviate or mitigate any moral distress faced by doctors. The moral distress of objecting doctors who connect their vulnerable patients with non-objecting doctors needs to be balanced against the pain, loss of dignity, invasion of privacy and moral distress faced by patients who are unable to access a willing provider for MAID.

F. CONCLUSION

43. The Applicants are seeking the privilege to practice medicine in a manner that allows their personal or religious beliefs to create barriers for patients seeking access to insured health services. The CPSO, in exercising its statutory power to set the standards of medical ethics and protect the public, has determined that this would be inconsistent with the physicians' role and their duties to their patients.

44. In crafting its policies, the CPSO has taken into account that some doctors have sincere religious and conscientious objections to performing certain services, and it has limited their obligation to taking minimal steps to ensure that their patients are connected to a willing provider. The CPSO has appropriately balanced the rights of its members and the rights of patients to have timely access to MAID. These policies are essential to ensuring that conscientious objections do not result in vulnerable patients being denied access to care.

ALL OF WHICH IS RESPECTFULLY SUBMITTED this 8th day of May, 2017.

Kelly Doctor, LSUC No. 54885A
Cynthia Petersen, LSUC No. 36228A

Counsel for the Intervener, Dying with Dignity Canada

SCHEDULE A – AUTHORITIES

A.C. v. Manitoba (Director of Child and Family Services), [2009] 2 SCR 181

Alberta v. Hutterian Brethren of Wilson Colony, [2009] 2 SCR 567

B. (R). v. Children's Aid Society of Metropolitan Toronto, [1995] 1 SCR 315

Canada (Attorney General) v. JTI-Macdonald Corp., [2007] 2 SCR 610

Carter v. Canada (A-G), 2012 BCSC 886 (CanLII)

Carter v. Canada (Attorney General), [2015] 1 SCR 331

Cuthbertson v. Rasouli, [2013] 3 SCR 341

Dagenais v. Canadian Broadcasting Corp., [1994] 3 SCR 835

Doré v. Barreau du Québec, [2012] 1 SCR 395

Loyola High School v. Quebec (Attorney General), [2015] 1 SCR 613

M(A) v. Ryan, [1997] 1 SCR 157

Malette v. Shulman et al., 1990 CanLII 6868 (ON CA)

McInerney v. McDonald,[1992] 2 SCR 138

Multani v. Commission scolaire Marguerite-Bourgeoys, [2006] 1 SCR 256

R. v. Big M Drug Mart Ltd., [1985] 1 SCR 295

R. v. Dyment, [1988] 2 SCR 417

R. v. Kapp, [2008] 2 SCR 483

R v. Mills, [1999] 3 SCR 668

R. v. N.S., [2012] 3 SCR 726

R. v. O'Connor, [1995] 4 SCR 411

RJR-MacDonald Inc. v. Canada (Attorney General), [1995] 3 SCR 199

Rodriguez v. British Columbia (Attorney General), [1993] 3 SCR 519

S.L. v. Commission scolaire des Chênes, [2012] 1 SCR 235

Slaight Communications Inc. v. Davidson, [1989] 1 SCR 1038

Starson v. Swayze, [2003] 1 SCR 722

Syndicat Northcrest v. Amselem, [2004] 2 SCR 551

Trinity Western University v. British Columbia College of Teachers, [2001] 1 SCR 772

Trinity Western University v. The Law Society of Upper Canada, 2016 ONCA 518 (CanLII)

SCHEDULE B - LEGISLATION

Canada Health Act, RSC 1985, c C-6

Primary objective of Canadian health care policy

3 It is hereby declared that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.

[…]

Universality

10 In order to satisfy the criterion respecting universality, the health care insurance plan of a province must entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions.

Canadian Charter of Rights and Freedoms, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11.

Rights and freedoms in Canada

1. The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

Fundamental freedoms

2. Everyone has the following fundamental freedoms:

(*a*) freedom of conscience and religion…

[…]

Equality before and under law and equal protection and benefit of law

15. (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

Affirmative action programs

(2) Subsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

***Criminal Code*, RSC 1985, c C-46**

Definitions

241.1 The following definitions apply in this section and in sections 241.2 to 241.4.

medical assistance in dying means

(a) the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or

(b) the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death. (*aide médicale à mourir*)

medical practitioner means a person who is entitled to practise medicine under the laws of a province. (*médecin*)

nurse practitioner means a registered nurse who, under the laws of a province, is entitled to practise as a nurse practitioner — or under an equivalent designation — and to autonomously make diagnoses, order and interpret diagnostic tests, prescribe substances and treat patients. (*infirmier praticien*)

pharmacist means a person who is entitled to practise pharmacy under the laws of a province. (*pharmacien*)

[…]

Grievous and irremediable medical condition

242.2 (2) A person has a grievous and irremediable medical condition only if they meet all of the following criteria:

(a) they have a serious and incurable illness, disease or disability;

(b) they are in an advanced state of irreversible decline in capability;

(c) that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and

(d) their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.

Safeguards

(3) Before a medical practitioner or nurse practitioner provides a person with medical assistance in dying, the medical practitioner or nurse practitioner must

(a) be of the opinion that the person meets all of the criteria set out in subsection (1);

(b) ensure that the person's request for medical assistance in dying was

(i) made in writing and signed and dated by the person or by another person under subsection (4), and

(ii) signed and dated after the person was informed by a medical practitioner or nurse practitioner that the person has a grievous and irremediable medical condition;

(c) be satisfied that the request was signed and dated by the person — or by another person under subsection (4) — before two independent witnesses who then also signed and dated the request;

(d) ensure that the person has been informed that they may, at any time and in any manner, withdraw their request;

(e) ensure that another medical practitioner or nurse practitioner has provided a written opinion confirming that the person meets all of the criteria set out in subsection (1);

(f) be satisfied that they and the other medical practitioner or nurse practitioner referred to in paragraph (e) are independent;

(g) ensure that there are at least 10 clear days between the day on which the request was signed by or on behalf of the person and the day on which the medical assistance in dying is provided or — if they and the other medical practitioner or nurse practitioner referred to in paragraph (e) are both of the opinion that the person's death, or the loss of their capacity to provide informed consent, is imminent — any shorter period that the first medical practitioner or nurse practitioner considers appropriate in the circumstances;

(h) immediately before providing the medical assistance in dying, give the person an opportunity to withdraw their request and ensure that the person gives express consent to receive medical assistance in dying; and

(i) if the person has difficulty communicating, take all necessary measures to provide a reliable means by which the person may understand the information that is provided to them and communicate their decision.

Unable to sign

(4) If the person requesting medical assistance in dying is unable to sign and date the request, another person — who is at least 18 years of age, who understands the nature of the request for medical assistance in dying and who does not know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death — may do so in the person's presence, on the person's behalf and under the person's express direction.

Independent witness

(5) Any person who is at least 18 years of age and who understands the nature of the request for medical assistance in dying may act as an independent witness, except if they

(a) know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death;

(b) are an owner or operator of any health care facility at which the person making the request is being treated or any facility in which that person resides;

(c) are directly involved in providing health care services to the person making the request; or

(d) directly provide personal care to the person making the request.

***Regulated Health Professions Act, 1991*, SO 1991, c 18, Schedule 2, *Health Professions Procedural Code*, ss. 3(1)5, 3(2)**

Objects of College

3 (1) The College has the following objects:

[…]

5. To develop, establish and maintain standards of professional ethics for the members.

Duty

3 (2) In carrying out its objects, the College has a duty to serve and protect the public interest.

Court File No. 499/16 and 500/16

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, DYING WITH DIGNITY CANADA, CATHOLIC CIVIL RIGHTS LEAGUE, FAITH AND FREEDOM ALLIANCE AND PROTECTION OF CONSCIENCE PROJECT, CHRISTIAN LEGAL FELLOWSHIP, THE EVANGELICAL FELLOWSHIP OF CANADA, AND THE ASSEMBLY OF CATHOLIC BISHOPS OF ONTARIO, CANADIAN CIVIL LIBERTIES ASSOCIATION, B'NAI BRITH OF CANADA LEAGUE FOR HUMAN RIGHTS, JUSTICE CENTRE FOR CONSTITUTIONAL FREEDOMS, HIV & AIDS LEGAL CLINIC ONTARIO, CANADIAN HIV/AIDS LEGAL NETWORK AND CANADIAN PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH

Interveners

CERTIFICATE OF THE INTERVENER
DYING WITH DIGNITY CANADA

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1. An Order under subrule 61.09(2) is not required
2. The Intervener, Dying with Dignity Canada, estimates 20 minutes will be required for its oral argument

May 8, 2017

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THE CHRISTIAN MEDICAL AND DENTAL SOCIETY OF CANADA et al.	- and -	**COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO**
Applicants		Respondent

Court File Nos. 499/16 and 500/16

ONTARIO
SUPERIOR COURT OF JUSTICE
DIVISIONAL COURT
(Proceeding commenced at Toronto)

FACTUM OF THE INTERVENER, DYING WITH DIGNITY

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