Do Canadian doctors have a right to refuse to refer patients to physicians who will assist them to commit suicide?

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The unanimous decision in *Carter v. Canada (Attorney General)*,[1] released on February 6, 2015, drastically changed the landscape of Canadian law with respect to physician-assisted death ("PAD"). The first paragraph of *Carter* underscores why the Supreme Court of Canada's ("SCC") set aside those provisions in the *Criminal Code*[2] that criminalized PAD:

> It is a crime in Canada to assist another person in ending her own life. As a result, people who are grievously and irremediably ill cannot seek a physician's assistance in dying and may be condemned to a life of severe and intolerable suffering. A person facing this prospect has two options: she can take her own life prematurely, often by violent or dangerous means, or she can suffer until she dies from natural causes. The choice is cruel.[3]

Carter found that provisions in the *Code* which prohibiting PAD infringed on s. 7 of the *Canadian Charter of Rights and Freedoms*,[4] and were not justified under s. 1 of the *Charter*. The SCC called on Parliament to enact "legislation consistent with the constitutional parameters

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1 2015 SCC 5 (S.C.C.) ("*Carter*").

2 R.S.C. 1985, c. C-46 ("*Code*")

3 *Carter*, at para 1.

4 Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (U.K.), 1982, c. 11 ("*Charter*")

set out in these reasons."[5] The Court suspended its declaration of invalidity for 12 months, and then granted a further four-month extension.[6]

In part, in response to the issues raised by such interveners as the Catholic Civil Rights League, the Faith and Freedom Alliance, the Protection of Conscience Project, and the Catholic Health Alliance of Canada. The SCC[7] stated:

> In our view, nothing in the declaration of invalidity which we propose to issue would compel physicians to provide assistance in dying. The declaration simply renders the criminal prohibition invalid. What follows is in the hands of the physicians' colleges, Parliament, and the provincial legislatures. However, we note — as did Beetz J. in addressing the topic of physician participation in abortion in *R. v. Morgentaler* — that a physician's decision to participate in assisted dying is a matter of conscience and, in some cases, of religious belief (pp. 95-96). In making this observation, we do not wish to pre-empt the legislative and regulatory response to this judgment. Rather, we underline that the *Charter* rights of patients and physicians will need to be reconciled. (Emphasis added)

Nothing in this decision compels physicians to help patients commit suicide. But that's not the end of the story. The SCC made it clear it is not pre-empting the role of the legislative and regulatory bodies to reconcile the conflict between patients' right to PAD and certain physicians' conscience and religious beliefs. If The College of Physicians and Surgeons of Ontario ("College") have their way then those health care professionals have reason to be concerned.

The College is the body that regulates the practice of medicine in Ontario. On their website they published an article outlining their position

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[5] *Carter*, at para 126.

[6] Subsequently, due to the new government being voted into office in the 2015 election, the SCC extended the suspension of invalidity an additional 4 months. See *Carter v. Canada (Attorney General)*, 2016 SCC 4 (S.C.C.) at para 7.

[7] Carter, at para 132.

on Professional Obligations and Human Rights. We have excerpted certain portions of the article[8] relevant to our discussion:

> **Conscience or Religious Beliefs**
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> The Canadian Charter of Rights and Freedoms (the "Charter") protects the right to freedom of conscience and religion. Although physicians have this freedom under the Charter, the Supreme Court of Canada has determined that no rights are absolute. The right to freedom of conscience and religion can be limited, as necessary, to protect public safety, order, health, morals, or the fundamental rights and freedoms of others.
>
> Where physicians choose to limit the health services they provide for reasons of conscience or religion, this may impede access to care in a manner that violates patient rights under the Charter and Code. The courts have determined that there is no hierarchy of rights; all rights are of equal importance.
>
> Should a conflict arise, the aim of the courts is to respect the importance of both sets of rights to the extent possible.
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> The balancing of rights must be done in context. In relation to freedom of religion specifically, courts will consider the degree to which the act in question interferes with a sincerely held religious belief. Courts will seek to determine whether the act interferes with the religious belief in a manner that is more than trivial or insubstantial. The less direct the impact on a religious belief, the less likely courts are to find that freedom of religion is infringed. Conduct that would potentially cause harm to and interfere with the rights of others would not automatically be protected.
>
> While the Charter entitles physicians to limit the health services they provide for reasons of conscience or religion, this cannot impede, either directly or indirectly, access to these services for existing patients, or those seeking to become patients.
>
> Physicians have a fiduciary duty to their patients. The College requires physicians, who choose to limit the health services they provide for reasons of conscience or religion, to do so in a manner that . . . Ensures access to care.. Physicians must provide information about all clinical options that may be available or appropriate to meet

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[8] For those interested in the full article I refer the reader to the College's website at http://www.cpso.on.ca/policies-publications/policy/professional-obligations-and-human-rights

> patients' clinical needs or concerns. Physicians must not withhold information about the existence of any procedure or treatment because it conflicts with their conscience or religious beliefs.
>
> Where physicians are unwilling to provide certain elements of care for reasons of conscience or religion, an effective referral to another health-care provider must be provided to the patient. An effective referral means a referral made in good faith, to a non-objecting, available, and accessible physician, other health-care professional, or agency. The referral must be made in a timely manner to allow patients to access care. Patients must not be exposed to adverse clinical outcomes due to a delayed referral. Physicians must not impede access to care for existing patients, or those seeking to become patients.
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> The College expects physicians to proactively maintain an effective referral plan for the frequently requested services they are unwilling to provide.

In summary, the *Carter* decision specifically does not impose any obligation on doctors to participate in any way in PAD and leaves the balancing of patients' and doctors' rights to first be addressed by the legislature and regulating bodies. In its newly introduced legislation, Bill C-14, Prime Minister Trudeau's Liberal government chose not to address the issue. The College wants to impose an obligation on physicians to make referrals to patients seeking PAD. The rationale? *In their view, making a referral of PAD is sufficiently trivial or insubstantial that it has a less direct impact on a religious belief.*

In this article, the authors are specifically not addressing any metaphysical or religious analysis. But what is being attempted is to review the position taken by the College and assess whether imposing the obligation to refer patients out for PAD violates certain doctors' freedom of conscience and religion which are guaranteed in the Charter.

Background

i) — Criminal Code

The *Code* provisions challenged and declared invalid in *Carter* were ss. 14 and 241(b). Section 14 of the *Code* states:

> No person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given.

Section 241(b) of the *Code* states:

> Every one who
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> (a) [. . .], or
>
> (b) aids or abets a person to commit suicide,
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> whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.

ii) — Rodriguez v. British Columbia (Attorney General)[9]

In 1992, the validity of s. 241(b) of the *Code* was challenged by Sue Rodriguez, a woman with amyotrophic lateral sclerosis (ALS). Ms. Rodriguez was seeking to avoid the future stress and loss of dignity caused by the prospect of the death which usually results from ALS. In her application for an order declaring s. 241(b) of the *Code* invalid, Ms. Rodriguez relied on ss. 7, 12 and 15(1) of the *Charter*.[10] Ms. Rodriguez's application was dismissed,[11] as was her appeal.[12]

The SCC, in a five-to-four decision, also dismissed Ms. Rodriguez's appeal. The majority of the SCC held that although s. 241(b) of the *Code* deprived Ms. Rodriguez of her security of the person protected under s. 7 of the *Charter*, any resulting deprivation was not contrary to the principles of fundamental justice. Despite differing views on the issue of PAD, it was found that there is consensus in Canadian society that human life

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9 1993 CarswellBC 1267 (S.C.C.) ("*Rodriguez*").

10 Section 7 of the *Charter* states: "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice."

Section 12 of the *Charter* states: "Everyone has the right not to be subjected to any cruel and unusual treatment or punishment."

Section 15(1) of the *Charter* states: "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."

11 *Rodriguez v. British Columbia (Attorney General)*, 1992 CarswellBC 2292 (B.C. S.C.).

12 *Rodriguez v. British Columbia (Attorney General)*, 1993 CarswellBC 20 (B.C. C.A.).

must be respected and that the prohibition against PAD upholds this principle and protects vulnerable individuals.[13]

The majority of the SCC in *Rodriguez* also assumed that Ms. Rodriguez's equality rights under s. 15(1) of the *Charter* had been infringed, but found that this infringement was justified under s. 1 of the *Charter*. Justice Sopinka, writing for the majority, wrote that s. 241(b) of the *Code* protects all individuals against the control of others, and any exception to the blanket protection would create an inequality.[14]

iii) — Carter v. Canada (Attorney General)

In *Carter*, the SCC revisited the PAD issue, now brought to the court by Ms. Gloria Taylor. Like Ms. Rodriguez, Ms. Taylor was diagnosed with ALS, which causes progressive muscle weakness. Ms. Taylor had brought her claim before the British Columbia Supreme Court to challenge the constitutionality of the *Code* provisions prohibiting PAD.

In 2012, Justice Smith of the British Columbia Supreme Court ruled that the *Code* provisions prohibiting PAD contravened the constitutional rights that ought to be afforded to the seriously ill.[15] Justice Smith determined that a legal regime that is well-designed and administered properly and permissively could protect those vulnerable people, including those seeking a PAD, from any potential errors and abuses which the overly broad present legal regime seeks to protect against. If this new legal regime were put in place, there would be no need for the criminal sanctions that at present attach to PAD.

Justice Smith gave Parliament one year to rewrite the laws in the *Code*. The federal government thereafter appealed Justice Smith's decision.[16]

In its appeal, the federal government relied on the SCC decision in *Rodriguez* for the proposition that only the SCC has the right to consider whether the criminal sanctions related to PAD were constitutional. The Court of Appeal agreed and the trial decision was overturned. The SCC then granted the plaintiffs leave to appeal.

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[13] *Rodriguez*, at paras 58-59.

[14] *Ibid*, at para 74.

[15] *Carter v. Canada (Attorney General)*, 2012 BCSC 886 (B.C. S.C.).

[16] *Carter v. Canada (Attorney General)*, 2013 BCCA 435 (B.C. C.A.).

The question before the SCC this time was: "Whether the criminal prohibition that puts a person to this choice [of taking their own life prematurely, or suffering until death from natural causes] violates her *Charter* rights to life, liberty and security of the person [s. 7] and to equal treatment by and under the law [s. 15]."[17]

The SCC determined that the current criminal legislation forces individuals to make a choice between either intolerable suffering or a premature natural death. By decriminalizing PAD, the SCC rejected the notion that the right to life requires an absolute prohibition on PAD. The SCC stated that it does not agree that "individuals cannot "waive" their right to life", and continued that, "This would create a "duty to live", rather than a "right to life", and would call into question the legality of any consent to the withdrawal or refusal of lifesaving or life-sustaining treatment."[18]

The SCC found that the prohibition of PAD violated the rights enshrined in s. 7 in two ways:

> a. The current laws force some people to prematurely take their own lives, in anticipation of the suffering that they will later face; and
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> b. The prohibitions in the *Code* interfere with one's ability to make their own decisions regarding their body and medical care, which is not in accordance with principles of fundamental justice.

The Court's reasoning therefore necessitated a finding that the violations contained in the *Code* were overbroad, in that it catches those vulnerable people the law is seeking to protect, as well as those who have a fully-informed and competent desire to terminate their lives. In determining that PAD ought to be decriminalized, the SCC set out a declaration that ss. 14 and 241(b) of the *Code* are void insofar as they prohibit PAD for:

> 1. A competent adult;
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> 2. who clearly consents to the termination of his/her life; and
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> 3. has a grievous and irremediable medical condition that causes enduring suffering that is intolerable to that person in his/her condition.[19]

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[17] *Carter*, at para 2.

[18] *Carter*, at para 63.

[19] *Carter*, at para 127.

Conscientious Objector Health Practitioners

i) — The Joint Committee's Recommendation

When the SCC declared ss. 14 and 241(b) of the *Code* void for infringing the claimants' rights under s. 7 of the *Charter*, the Court stated that it was for Parliament and the provincial legislatures to respond, should they so choose, by enacting legislation consistent with the constitutional parameters set out in these reasons."[20] Parliament struck a committee to make recommendations that would "reconcile the rights of patients and physicians in accordance with *Carter*".

On December 11, 2015, Parliament passed motions to establish a joint committee ("Joint Committee"), for the purpose of making recommendations on the framework of federal legislation regarding PAD.[21] The Report of the Joint Committee, entitled "Medical Assistance in Dying: A Patient-Centred Approach" was released in February 2016 ("Joint Committee Report"). The Report makes 21 recommendations for a legislative response from Parliament to *Carter*. Part of the Joint Committee's mandate was to make recommendations that would "reconcile the rights of patients and physicians in accordance with *Carter*".

One of those recommendations were as follows:

> That the Government of Canada work with the provinces and territories and their medical regulatory bodies to establish a process that respects a health care practitioner's freedom of conscience while at the same time respecting the needs of a patient who seeks medical assistance in dying. At a minimum, the objecting practitioner must provide an effective referral for the patient (Emphasis added).[22]

The Joint Committee heard evidence from numerous individuals who objected to this conclusion. For example, Imam Sikander Hashmi, a spokesperson for the Canadian Council of Imams, stated the following:

> We would say that there should definitely be protection for individual physicians who want to avoid any type of participation in this

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[20] *Carter*, 2015, para. 126.

[21] Medical Assistance in Dying: A Patient-Centred Approach, Report of the Special Joint Committee on Physician-Assisted Dying, Hon. Kelvin Kenneth Ogilvie and Robert Oliphant, February 2016, 42nd Parliament, 1st Session (the "Report"), at pg 2.

[22] *Report*, at pg 26.

> type of procedure. I would also extend that to health care facilities that are faith-based to ensure that . . .. Again, it's a balance of rights. Those who want to stay away to whatever degree they feel is important for them, their faith, and their conscience, should have the ability to do so.[23]

Speaking on behalf of the Coalition for HealthCARE and Conscience, His Eminence Thomas Cardinal Collins echoed the concerns for the rights and values of health care practitioners:

> [. . .] it is clear that reasonable people, with or without religious faith, can have a well-founded moral conviction in their conscience that prevents them from becoming engaged in any way in the provision of assisted suicide and euthanasia. They deserve to be respected. It is essential that the government ensure that effective conscience protection be given to health care providers, both institutions and individuals. They should not be forced to perform actions that go against their conscience or to refer the action to others, since that is the moral equivalent of participating in the act itself. It's simply not right or just to say, "You do not have to do what is against your conscience, but you have to be sure it happens"[24]

Despite the pleadings for respect and protection of health practitioners' rights, the Joint Committee recommended to Parliament a regime of mandatory referrals.

ii) — What does Bill C-14 say with Respect to Health Practitioners' Rights?

On April 14, 2016, Prime Minister Trudeau's government introduced Bill C-14,[25] a proposed legislative response to the *Carter* decision. Bill

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[23] Special Joint Committee on Physician-Assisted Dying, Evidence, February 3, 2016, 1905.

[24] Special Joint Committee on Physician-Assisted Dying, Evidence, February 3, 2016, 1705.

[25] Bill C-14: *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*. 1st Reading, April 14, 2016, 42nd Parliament, 1st Session, 2015-2016. Available: http://www.parl.gc.ca/HousePublications/Publication.aspx?Mode=1&DocId=8183660&Language=E

C-14 received Royal Assent on June 17, 2016.[26] Bill C-14 does not adopt many of the recommendations made in the Joint Committee's Report. For instance the draft legislation does not include:

- That individuals not be excluded from eligibility for medical assistance in dying based on the fact that they have a psychiatric condition;
- That the Government of Canada implement a second stage of the legislative process allowing competent mature minors to request PAD within three years;
- That the permission to use advance requests for medical assistance in dying be allowed any time after one is diagnosed with a condition that is reasonably likely to cause loss of competence or after a diagnosis of a grievous or irremediable condition but before the suffering becomes intolerable;
- That the Government of Canada work with the provinces and territories and their medical regulatory bodies to establish a process that respects a health care practitioner's freedom of conscience while at the same time respecting the needs of a patient who seeks medical assistance in dying. At a minimum, the objecting practitioner must provide an effective referral for the patient.

These conditions were each recommended in the Joint Committee Report.

There are no specific provisions stating what steps an objecting health practitioner should take if he or she receives a request for PAD from a patient. On the one hand, the legislation does not require health practitioners to make a referral, thereby forcing them to participate in a practice with which they object. On the other hand, it is concerning that there are no provisions providing health practitioners with express religious and conscientious protections.

The government provided some clarification on this issue on the Government of Canada, Department of Justice website. The government released a "Questions and Answers" section online concurrently with the draft Bill C-14. With respect to the question of whether health care prov-

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[26] *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying),* Statutes of Canada: 2016, c. 3.

iders would be able to decline PAD requested by a patient, the government answered as follows:

> There is nothing in the proposed legislation that would compel a health care provider to provide medical assistance in dying or refer a patient to another medical practitioner. Balancing the rights of medical providers and those of patients is generally a matter of provincial and territorial responsibility. However, the federal government has committed to work with provinces and territories to support access to medical assistance in dying, while respecting the personal convictions of health care providers.[27]

The website then features the question of how patients can access PAD if their health care practitioner objects to providing it. This answer appears to suggest that the government may be prepared to infringe on the freedom of conscience of health care practitioners:

> The Supreme Court of Canada was clear that nothing in its reasons would compel physicians to provide medical assistance in dying and there is nothing that compels physicians to provide medical assistance in dying in the proposed legislation. However, physicians and nurse practitioners exercising their conscience rights may constitute a barrier to access for those who are seeking medical assistance in dying. The government will work with provinces and territories to explore options to facilitate access and care coordination, while recognizing the personal convictions of health care providers.[28]

Following Royal Assent of Bill C-14, the Government of Canada published further commentary on its website addressing this issue. The website states as follows:

> Not all health care providers will be comfortable with giving or helping to provide medical assistance in dying. The practice may not be consistent with a provider's beliefs and values. The legislation does not force any person to provide or help to provide medical assistance in dying.
>
> However, this could create problems for patients who want to access medical assistance in dying.

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[27] Government of Canada, Department of Justice, Medical Assistance in Dying: Questions and Answers, Available: http://www.justice.gc.ca/eng/cj-jp/ad-am/faq.html.

[28] *Ibid.*

> The federal government will work with provinces and territories to develop a national coordination system for end-of-life care services. The system would guide people to information about where they can find help.[29]

The suggestion that health practitioners exercising their rights may constitute a barrier to access to medical services raises concern for those that may be affected. The current legislative limbo leaves many health practitioners in the dark on the regulations that may be developed by Canada or by the provinces and territories.

iii) — Freedom of Religion and Conscience in Canada

Pursuant to s. 2(a) of the *Charter*, everyone has the fundamental freedom of conscience and religion. The seminal case regarding s. 2(a) of the *Charter* is *R. v. Big M Drug Mart Ltd.*[30] At para. 95 of *Big M Drug Mart*, in discussing the meaning of a freedom in the *Charter*, the majority of the SCC stated, "freedom can primarily be characterized by the absence of coercion or constraint."[31] If a person is compelled by the state or the will of another to a course of action or inaction which he would not otherwise have chosen, he is not acting of his own volition and he cannot be said to be truly free."[32] If health practitioners are required to make a referral for a patient who is seeking PAD, the Parliament would be forcing those doctors to participate in a course of action that may be contrary to their beliefs or their conscience. This may constitute an infringement of s. 2(a) of the *Charter*.

In the SCC decision *R. v. Morgentaler*,[33] the seminal case on abortion in Canada, the SCC discusses Canadian freedom of conscience in relation to abortion. Writing for the majority, Justice Beetz stated, "Given that the decision to appoint a [abortion] committee is in part one of conscience, and in some cases one which affects religious beliefs, a law cannot force

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[29] Government of Canada, Medical assistance in dying commentary. Available: http://healthycanadians.gc.ca/health-system-systeme-sante/services/palliative-pallatifs/medical-assistance-dying-aide-medicale-mourir-eng.php

[30] [1985] 1 S.C.R. 295, 1985 CarswellAlta 316 (S.C.C.) ["*Big M Drug Mart*"].

[31] *Ibid*, at para 95.

[32] *Big M Drug Mart*, at para 95.

[33] [1988] 1 S.C.R. 30 (S.C.C.) ["*Morgentaler*"].

a [hospital] board to appoint a [abortion] committee, any more than it could force a physician to perform an abortion."[34] This is authority for the proposition that Parliament is precluded from forcing physicians to provide procedures to which they object based on their freedom of religion or freedom of conscience.

iv) — The Medical Community's Position

The Canadian Medical Association ("CMA")[35] has demonstrated that they stand for the protection of the freedom of conscience and religion for health practitioners in Canada. Prior to the release of the Joint Committee's Report, on January 21, 2016 the CMA released its own set of recommendations for a Canadian approach to PAD.[36] These recommendations included a section on a doctor's moral opposition to PAD. The recommendation put forth by the CMA regarding conscientious objection by a physician is:

> Physicians are not obligated to fulfill requests for assisted dying. This means that physicians who choose not to provide or participate in assisted dying are not required to provide it or to participate in it or to refer the patient to a physician or a medical administrator who will provide assisted dying to the patient. There should be no discrimination against a physician who chooses not to provide or participate in assisted dying.[37]

The CMA also carried out a dialogue with its members in order to get positions directly from doctors on the issue. The CMA released a summary report of this member dialogue, which shows that the views of physician-members differed greatly. The summary report specifically explored the issue of mandatory referrals since this had been recommended by the Joint Committee. One viewpoint expressed by a doctor which is

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[34] *Morgentaler* at p. 112.

[35] Information on the CMA can be found online at: https://www.cma.ca/En/Pages/about-cma.aspx

[36] Principles-based Recommendations for a Canadian Approach to Assisted Dying, Canadian Medical Association. Available: https://www.cma.ca/Assets/assets-library/document/en/advocacy/cma-framework_assisted-dying_final-jan2016.pdf

[37] *Ibid*, at s. 5.2.

included in the Summary Report emphasizes that a referral can often constitute participation in the view of a health practitioner:

> When a doctor makes a referral, she puts her name behind the request and, in effect, indicates that she believes a patient would benefit overall from the service being sought . . . making a referral is a deliberate action undertaken by a doctor that has intended consequences for the patient. Although the referring doctor does not directly provide the requested service to the patient, in making a referral her actions are closely linked to and play a causal role in what ultimately happens . . . the principle that one shares responsibility for an action performed by another person if one facilitates or arranges that action is engrained in our society's norms and legal code. Carrying out an activity oneself or arranging for someone else to do it are morally equivalent. Therefore, requiring doctors to refer for services to which they morally object coerces them to become active participants in acts that they believe to be wrong and, hence, to grossly violate their consciences.

The Coalition for HealthCARE and Conscience ("CHCC"), which represents over 5,000 physicians across Canada, has also expressed concern for doctor's rights. The CHCC released a statement following the introduction of Bill C-14 on April 14, 2016, calling for strong protection for conscientious objectors. Included in this statement is the observation that no other foreign jurisdiction in the world that has legalized euthanasia/assisted suicide forces health care workers to act against their conscience, mission, or values.[38] The statement also points out that a Nanos Research poll found that 75% of Canadians agree that doctors should be able to opt out of offering assisted dying.

Many health practitioner Christian and Catholic groups have also been outspoken about the rights of health practitioners. The Christian Medical and Dental Society of Canada, the Catholic Health Alliance of Canada and the Catholic Health Sponsors of Ontario have all called for legislative protections for conscientious objectors.

On the other hand, the College of Physicians and Surgeons of Ontario ("CPSO") has shown support for a mandatory referral system. The CPSO

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[38] "Conscience protection still at risk with assisted death legislation: Coalition for HealthCARE and Conscience", News Release, Ottawa, Ontario (April 14, 2016).

released its "Interim Guidance on Physician-Assisted Death"[39] in January 2016. With respect to conscientious objection, the Interim Guide provides that where a physician declines to provide PAD, an effective referral must be provided. Like the Joint Committee's recommendation, this shows a disregard for the *Charter* rights of health practitioners. As further discussed below, it is the position of the authors that the rights of patients can be adequately protected without infringing the rights of health practitioners.

v) — Is it Legal to Force Conscientious Objectors to Participate in PAD?

If Parliament is to reconcile the rights of health practitioners and patients, it is important to consider whether it is necessary to force conscientious objectors to participate in PAD. In the United States, the two states that have had PAD regimes in place for the longest period of time are Oregon and Washington. By extrapolating the amount of PAD cases in these states, it can be estimated how widespread PAD may be in Canada in the coming years. A look at the statistics demonstrates that there is no reason that it is necessary to force conscientious objector health practitioners to participate in a PAD regime.

The state of Oregon passed the *Death with Dignity Act*[40] in 1994. This statute legalized PAD with certain restrictions, making it the first state in the U.S. to permit certain terminally ill patients to choose the time of their death. The Oregon Public Health Division is required to release an annual report which includes statistics on PAD in the state from the year. According to Oregon's annual report for 2014, 155 individuals received prescriptions for lethal doses of medications in 2014 as a result of Oregon's *Death with Dignity Act*. These numbers have also grown incrementally almost every year. In 1998, 4 years after Oregon legalized PAD, 24 individuals received lethal prescriptions.

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[39] Interim Guidance on Physician-Assisted Death, The College of Physicians and Surgeons of Ontario Policy Number 1–16. (Approved by council January 2016).

[40] ORS 127.800-995.

The state of Washington's *Death with Dignity Act*[41] came into effect on March 5, 2009. Similar to Oregon, the Washington Department of Health collects information from healthcare providers and produces an annual statistical report. According to the Washington State Department of Health 2014 *Death with Dignity Act* Report Executive Summary,[42] 176 individuals are known to have received lethal medication in 2014.

According to the U.S. government census data, in 2014 Oregon had a population of 3,971,202 people, and Washington had a population 7,063,166.[43] According to Statistics Canada,[44] the population of Canada as of 2015 is 35,851,800 people. By extrapolating the Oregon PAD statistics compared with its population, Canada's population may be receiving approximately 1,399 requests for PAD after 20 years of legalization, at which time the Canadian population will have grown. By extrapolating Washington's 2014 numbers, which come five years after the legalization of PAD, Canada can expect approximately 893 requests for PAD per year in the nearer future.

According to CMA Canadian physician statistics, as of January 2016 there were 80,544 active physicians in Canada.[45] With the amount of physicians in the country and the projected amounts of PAD requests based on extrapolated U.S. data, there is no reason why doctors and other health practitioners who object to PAD should be forced against their will to participate, either by way of a referral or otherwise. There are no statistics at this time showing how many doctors and health practitioners in Canada will be willing to participate in PAD, but it is expected that a great deal of physicians will be willing to do so. Health practitioners' freedom of conscience and religion should not be violated when there is enough doctors to provide the service in question.

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41 RCW 70.245.

42 Washington State Department of Health 2014 *Death with Dignity Act* Report Executive Summary, Available: http://www.doh.wa.gov/portals/1/Documents/Pubs/422-109-DeathWithDignityAct2014.pdf

43 Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2015, U.S. Census Bureau, Population Division (December 2015).

44 Government of Canada, Statistics Canada, Table 051-0001. Available: http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/demo02a-eng.htm.

45 "Number of Physicians by Province/Territory and Specialty, Canada, 2016", CMA Masterfile, January 2016, Canadian Medical Association.

vi) — What is a Solution to Reconcile the Rights of Health Practitioners and Patients?

The SCC stated that the *Charter* rights of patients and physicians will need to be reconciled. The Joint Committee's recommendation does not reflect reconciliation of these rights. Bill C-14 leaves the door open for provinces and territories to force health practitioners to make referrals against their conscience. A system is needed which allows patients to access PAD and that allows conscientious objectors to refrain from participation.

The CMA has already proposed an alternative to a mandatory referral system. Dr. Jeffrey Blackmer, an executive director at CMA, has discussed the creation of a central mechanism to facilitate access to PAD.[46] Conscientious objecting health practitioners could then refer patients to this service but not directly to a doctor.

The CHCC has also suggested the creation of a third-party agency that would give patients direct access to an assessment advisor who can provide resources and support and connect patients with health care practitioners and facilities that provide PAD.[47]

The Quebec legislation has also set out a system which does not force health practitioners to make a referral. Pursuant to *An Act Respecting End-of-Life Care* (the "*ARELC*"),[48] which came into force in Quebec on December 10, 2015, a physician who receives a request for PAD and who does not perform PAD must notify the executive director of the institution where they practice, or the executive director of the local authority serving the territory if the physician practices privately. The executive director must then take the necessary steps to find, as soon as possible, another physician willing to deal with the request.[49] This takes the referral obligation out of the hands of individual health practitioners

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[46] Shelby Ubelacker, "Canadian Medical Association Disappointed With Latest Assisted Suicide Recommendation", The Canadian Press. February 26, 2016. Available: http://www.huffingtonpost.ca/2016/02/26/assisted-suicide-canada_n_9331552.html

[47] "Canadians Shouldn't Have to Compromise Their Conscience", Coalition for HealthCARE and Conscience. Available: http://www.canadiansforconscience.ca/the_issues

[48] RSQ c S-32.0001.

[49] *ARELC*, s. 31.

and therefore does not force them to act against their conscience or religious beliefs.

While the federal government should have protected the freedoms of health practitioners directly in its legislation, the systems discussed above provide provinces and territories with options aside from mandatory referral mandates.

Concluding Remarks

While the SCC declared that PAD will be legalized in Canada in the *Carter* decision, the SCC was also clear that its decision did not impose on physicians and other health practitioners an obligation to participate. Instead, it called upon the legislature and regulatory bodies to balance health practitioners' freedom of religion and patients' rights to PAD. Given the silence of the legislation on the issue of referrals, it now falls upon the regulatory bodies. It remains to be seen if the regulatory bodies will endeavour to force physicians to make referrals for PAD.

In our view, imposing an obligation to make such a referral contravenes doctors' religious freedoms in a manner that is not demonstrably justifiable in a free and democratic society. We base this view on the Supreme Court of Canada decision of *Syndicat Northcrest c. Amselem*.[50]

In the *Syndicat* case there were Orthodox Jews living in Montreal who wanted to build a small hut outside their homes ("Succah") to celebrate the holiday of Sukkot. The city by-laws forbade setting up these units on the balconies of the condominiums in question which, *inter alia*, prohibited decorations, alterations and constructions on the balconies. Those who opposed the Sukkahs asked for a permanent injunction prohibiting the Orthodox Jews from setting up succahs. At trial and at the court of appeal the application for the injunction was granted. The Supreme Court of Canada allowed the appeal of the Orthodox Jews and found that the principle that freedom of religion must be exercised within reasonable limits and with respect for the rights of others, subject to such limitations as are necessary to protect public safety, order and health and the fundamental rights and freedoms of others.

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[50] 2004 SCC 47, [2004] 2 S.C.R. 551 (S.C.C.) ("Syndicat").

We quote several paras. of Syndicat case which we hope will be instructive:

> 57 Once an individual has shown that his or her religious freedom is triggered . . ., a court must then ascertain whether there has been enough of an interference with the exercise of the implicated right so as to constitute an infringement of freedom of religion under the Quebec (or the Canadian) *Charter*.
>
> 58 More particularly, as Wilson J. stated in *Jones*, *supra*, writing in dissent, at pp. 313-14:
>
> Section 2(*a*) does not require the legislature to refrain from imposing any burdens on the practice of religion. Legislative or administrative action whose effect on religion is trivial or insubstantial is not, in my view, a breach of freedom of religion. [Emphasis added.]
>
> Section 2(*a*) of the Canadian *Charter* prohibits only burdens or impositions on religious practice that are non-trivial. This position was confirmed and adopted by Dickson C.J. for the majority in R. v. Videoflicks Ltd., *supra*, at p. 759:
>
> All coercive burdens on the exercise of religious beliefs are potentially within the ambit of s. 2(*a*).
>
> This does not mean, however, that every burden on religious practices is offensive to the constitutional guarantee of freedom of religion . . .. Section 2(*a*) does not require the legislatures to eliminate every minuscule state-imposed cost associated with the practice of religion. Otherwise the *Charter* would offer protection from innocuous secular legislation such as a taxation act that imposed a modest sales tax extending to all products, including those used in the course of religious worship. In my opinion, it is unnecessary to turn to s. 1 in order to justify legislation of that sort . . .. The Constitution shelters individuals and groups only to the extent that religious beliefs or conduct might reasonably or actually be threatened. For a state-imposed cost or burden to be proscribed by s. 2(*a*) it must be capable of interfering with religious belief or practice. In short, legislative or administrative action which increases the cost of practising or otherwise manifesting religious beliefs is not prohibited if the burden is trivial or insubstantial: see, on this point, *Jones, per*, Wilson J. at p. 314. [Emphasis added.]
>
> 59 It consequently suffices that a claimant show that the impugned contractual or legislative provision (or conduct) interferes with his or her ability to act in accordance with his or her religious beliefs *in a*

> *manner that is more than trivial or insubstantial*. The question then becomes: what does this mean?
>
> 60 At this stage, as a general matter, one can do no more than say that the context of each case must be examined to ascertain whether the interference is more than trivial or insubstantial. But it is important to observe what examining that context involves.

Arguably, compelling doctors to make PAD referrals places a coercive burden on the exercise of their religious beliefs bringing them within the ambit of s. 2(a) of the *Charter*. To anyone who believes in the sanctity of life, the state's compelling participation of a physician in the ending of that life triggers a unwarranted substantive interference in that doctor's freedom of conscience and religion. There are those health care professionals who find PAD to be the antithesis of their mandate and view any participation in the process, *whether direct or indirect*, to be repugnant. These doctors would argue that they entered the profession to save lives — not end them. They would argue that compelling them to make a PAD referral constitutes interference that is certainly not trivial and not insubstantial. Furthermore, with the relatively small number of instances where patients want PAD and having in mind the large number of physicians willing to participate in that process there seems to be no demonstrably justifiable reason why the legislature or regulatory bodies need to compel reluctant doctors to participate.