Court File Nos.: 499-16; 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

Intervener

FACTUM OF THE INTERVENER,
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March 31, 2017

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"An arbitrary law is one that is not capable of fulfilling its objectives. It exacts a constitutional price in terms of rights, without furthering the public good that is said to be the object of the law."* – Chief Justice McLachlin in *Carter v. Canada (Attorney General)

"…where the government puts in place a scheme to provide health care, that scheme must comply with the Charter."* – Chief Justice McLachlin and Justice Major in *Chaoulli v. Quebec (Attorney General)

PART 1: OVERVIEW

1. Following the decision in *Carter v. Canada (Attorney General),*[1] the College of Physicians and Surgeons of Ontario (the "CPSO") passed Policy #4-16, "*Medical Assistance in Dying* (the "Policy"). The Policy requires the effective referral of patients for medical assistance in dying ("MAID"), as well as compliance with CPSO policy statement #2-15, which states that a physician must perform procedures in the event of an urgent care situation against her conscience. The Policy was passed despite the protests of many of the CPSO's member physicians and despite the majority of submissions the CPSO received, both from the public and from physicians, urging the CPSO to respect physicians' conscience rights.[2]
2. The Policy results in compelling physicians to refer a patient for killing via MAID, and requires a physician to perform procedures against her conscience, such as abortion or MAID, in some circumstances. The CPSO uses threats of professional sanction to compel conduct that overrides a practitioner's foundational right-and-wrong imperatives. The CPSO maintains that the compulsion of physicians against their wills is acceptable and necessary to carry out its objectives.
3. The Policy marks a stark and dramatic reversal in the policies of the CPSO. Prior to the decision in *Carter* and the enactment of Bill C-14, killing or assisting in the killing of a

[1] [2015] 1 SCR 331, 2015 SCC 5 ("*Carter*").
[2] Fresh and Amended Notice of Constitutional Question of the Applicants, paras. 28 and 34.

patient via passive euthanasia or active assisted suicide was a criminal offence, and prohibited by the CPSO.

4. In its dramatic reversal, the CPSO now claims to defend patients' "right to health care" by demanding that physicians ignore their own conscience when it comes to ethical concerns. The Supreme Court of Canada has repeatedly and consistently found, however, that there is no free-standing right to health care protected by the *Canadian Charter of Rights and Freedoms* (the "*Charter*"). In contrast, physicians do have rights protected by the *Charter*: section 2(a) freedom of conscience and religion as well as section 15 equality rights, which protect against state discrimination (differential treatment) on the basis of religious beliefs. The Policy infringes both the section 2(a) and section 15 *Charter* rights of physicians, and cannot be justified under section 1 in a free and democratic society.

5. The CPSO has overreached. There are no competing *Charter* rights to balance in the instant case. The CPSO has ignored the *Charter* rights of the physicians it governs in favour of patient "rights" which do not exist. The infringements of the Policy are neither trivial nor insubstantial. The Policy violates the very identity of physicians in a coercive and historically ominous fashion, by demanding they ignore their own conscience when interpreting their ethical obligations.

PART 2: FACTS

6. The facts in this matter are fully set out in the Notice of Application of the Applicants, as amended.

PART 3: ARGUMENT

No Freestanding Constitutional Right to Health Care

7. In *Chaoulli*, Chief Justice McLachlin held "[t]he *Charter* does not confer a freestanding constitutional right to health care."[3] It is immaterial whether the required procedure is hip surgery or suicide. In similar fashion, the Ontario Court of Appeal in *Flora v. Ontario Health Insurance Plan*[4] held that a patient has no constitutional right to a state-funded medical procedure, even if proven necessary to save or extend the life of a patient.
8. In *Chaoulli*, the Applicants successfully challenged Quebec's prohibition against the purchase of private health care for procedures that were provided exclusively by the government. Wait lists, not just in Quebec but across Canada, restrict services and jeopardize patient survival.[5] In striking down the prohibition against private health care in Quebec, Justice Deschamps noted that "[t]he public health care system, once a source of national pride, has become the subject of frequent and sometimes bitter criticism."[6]
9. The decision in *Chaoulli* turned on the restriction of personal choice. Wait lists in the public health system, at least in the context of serious illness, were found by the Court to infringe "personal inviolability" in the Quebec *Charter*, similar to the Canadian *Charter*'s protection of "life, liberty and security of the person".[7] As a result, the prohibition against private health care was struck down.
10. Similarly, in *Carter* the Supreme Court struck down the *Criminal Code* prohibitions in sections 241(b) and 14 against assisted suicide and euthanasia. As a result of this decision,

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[3] *Chaoulli v. Quebec (Attorney General),* [2005] 1 SCR 791 ("*Chaoulli*"), at para. 104.
[4] 2008 0NCA 538 at paras. 93, 108 ["Flora"].
[5] *Chaouilli*, paras. 112, 116, 117.
[6] *Chaouilli*, para. 2.
[7] *Chaoulli*, para. 4.

it became legal in limited circumstances for a willing doctor to help kill her willing patient without prosecutorial reprisal. Those circumstances were subsequently codified in *Bill C-14: An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*[8] ("Bill C-14").

11. In neither *Chaoulli* nor *Carter,* however*,* did the Court create a requirement for the provision of a service. The Court in both cases simply struck down the prohibitions which had improperly limited a patient's options. The law in Canada remains that there is no free-standing right to health care or any particular health care services. This is so even when the procedure is necessary to preserve or extend human life.

12. In *Flora,* the Ontario Court of Appeal upheld the validity of a regulation that denied Mr. Flora funding for a life-saving liver transplant. Mr. Flora had contracted Hepatitis C through a contaminated blood transfusion, resulting in life-threatening cirrhosis of the liver. Mr. Flora paid $450,000 to save his life through a successful liver transplant in the United Kingdom because the Ontario government had chosen not to provide the service he so desperately needed. Mr. Flora argued that section 7 of the *Charter* "imposes a positive obligation on the state to provide, and therefore to fund, life-saving medical treatments,"[9] and that Ontario should therefore be required to reimburse the $450,000.

13. The Court rejected Mr. Flora's argument, as have other Canadian courts,[10] noting that "[n]either the [*Ontario Health Insurance*] *Act* nor the Regulation promise that insured Ontarians will receive public funding for all medically beneficial treatments."[11] If

[8] S.C. 2016, c. 3
[9] *Flora*, para. 104.
[10] See, for example, *Auton (Guardian ad litem of) v. British Columbia (Attorney General)*, 2004 SCC 78, where the Province of British Columbia was not required to fund necessary autism treatments.
[11] *Flora*, at para. 80.

governments are permitted, under Canada's Constitution, to refuse to provide even life-saving treatments, it follows that patients have no *Charter* right to receive other treatments or services, whether life-saving or not.

14. No one discounts the suffering of those who are grievously and irremediably ill. Human existence itself is replete with suffering, and each of us has suffered, personally and vicariously through the pain of loved ones. Tens of thousands continue to suffer while on medical waiting lists for necessary procedures. Mr. Flora suffered from liver failure contracted from contaminated blood supplied to him by a state regulator, yet was found not to have a constitutional right to have the state pay for his life-saving treatment.

15. While the Constitution allows governments to legislate in the realm of health care, patients themselves do not enjoy a constitutional right to receive the medical services of their own choosing. Therefore, there is no free-standing constitutional right to compel a physician to assist with suicide.[12]

The CPSO's Pretense Re: MAID

16. The CPSO points out, correctly, that a patient can now receive assistance from physicians if she or he wishes to commit suicide. The CPSO errs when it argues that patients have a constitutional or other legal right to obtain this particular service by requiring all physicians to be willing and available to participate in the provision of this service. The CPSO argues that a patient has a right to suicide through the coerced participation of a fellow human being. This contention has no basis in law. It also manifests a profound disrespect for

[12] If in fact MAID can be properly considered a health care service at all, which is not conceded. It may be far more appropriate for provincial legislatures to establish an entirely separate profession comprised only of willing individuals to administer MAID, instead of conflating and confusing the practice of medicine, which is focused on life and healing, with the provision of death services.

professionals who should – and do – follow their conscience when interpreting and applying their own professional ethics in regard to the Practice Guide. A loss of physicians' *Charter*-protected freedom of conscience invariably has profound negative implications for patients. The Policy is dangerous for its potential as a precedent for further egregious state violations of conscience under the pretence of the "greater good."

17. The Court in both *Chaoulli* and *Carter* found that the restriction on a patient's ability to choose was foundational to the striking down of the respective legislative schemes in both cases. There is great irony, therefore, in the CPSO creating a Policy which removes a physician's ability to choose what he or she conscientiously believes to be ethical in a given situation. In doing so, the CPSO has recreated the same flaw that was struck down in both *Chaoulli* and *Carter*: the limitation of choice in a time of personal crisis and deliberation. The difference between the patient scenarios in *Chaoulli* and *Carter* and the within case is that in the former, the patient was precluded options and unable to act, and in the instant case, the physician is precluded options and *compelled* to act.
18. As the Court in *Chaoulli* noted, "where the government puts in place a scheme to provide health care, that scheme must comply with the *Charter*."[13] The CPSO's Policy does not comply with the *Charter*. The implementation of the Policy requires the overrunning and disregard of physicians' *Charter* rights.

No Fiduciary Obligation to Refer for Death

19. The Policy maintains that "the fiduciary nature of the physician-patient relationship

[13] *Chaoulli*, at para. 104.

requires that physicians act in their patients' best interests".[14] The CPSO's claim in this regard has two essential parts:

a) That physicians are fiduciaries; and
b) All physician duties are therefore fiduciary duties.

20. That CPSO contends that since physicians are fiduciaries, they have a universal fiduciary obligation to act in accordance with their patients' best interests (i.e., if a patient wants to die, the physician has no choice but to refer the patient to a physician who will willingly kill the patient). The CPSO claims, incorrectly, that the Supreme Court of Canada case of *McInerney v. MacDonald*[15] supports this proposition.[16]

21. *McInerney* dealt with the production of patient records that a physician had refused to release to the patient, on the ground that the records in question had been created by other doctors, and were therefore confidential and not releasable.

22. Justice La Forest, writing for a unanimous Court in *McInerney*, agreed with the proposition that there was a duty on physicians to account for patient records in most circumstances, but noted that a patient's right to records is not absolute. The Court noted:

> While patients should, as a general rule, have access to their medical records, this policy need not and, in my mind, should not be pursued blindly. The related duty of confidentiality is not absolute. In *Halls v. Mitchell, supra*, at p. 136, Duff J. stated that, *prima facie*, the patient has a right to require that professional secrets acquired by the practitioner shall not be divulged. This right is absolute unless there is some paramount reason that overrides it. For example, "there may be cases in which reasons connected with the safety of individuals or of the public, physical

[14] "The fiduciary nature of the physician-patient relationship requires that physicians act in their patients' best interests." "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: i. Respects patient dignity; ii. Ensures access to care; and iii. Protects patient safety." "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." *Excerpts from policy statement #2-15.*

[15] [1992] 2 SCR 138 ("*McInerney*")

[16] See CPSO Policy #2-15: "*CPSO's Professional Obligations and Human Rights*", footnote 1.

> or moral, would be sufficiently cogent to supersede or qualify the obligations *prima facie imposed* by the confidential relation". Similarly, the patient's general right of access to his or her records is not absolute. The patient's interest in his or her records is an equitable interest arising from the physician's fiduciary obligation to disclose the records upon request. As part of the relationship of trust and confidence, the physician must act in the best interests of the patient. If the physician reasonably believes it is not in the patient's best interests to inspect his or her medical records, the physician may consider it necessary to deny access to the information.[17] [Emphasis added]

23. Justice La Forest also noted that:

> …just as a relationship may be fiduciary for some purposes and not for others, this characterization of the doctor's obligation as "fiduciary" and the patient's interest in the records as an "equitable interest" does not imply a particular remedy. Equity works in the circumstances to enforce the duty. This foundation in equity gives the court considerable discretion to refuse access to the records where non-disclosure is appropriate.[18]

24. The following is notable from the above passages:

a. Not all obligations that arise from a physician-client relationship are fiduciary in nature – indeed, some are not;

b. A patient's right to *even his or her own records* is not absolute, and is subject to "paramount reason(s) that override it", such as the safety of the patient or the public, physical or moral;

c. That a fiduciary obligation is a creature of equity, and it is the Court that has the discretion (not the CPSO), on a case by case basis, to fashion an equitable remedy for an alleged infringement;[19]

d. The Court in *McInerney* refers to the patient's *best interest*, which is not necessarily the same thing as the patient's wish or desire.

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[17] *McInerney*, pages 153, 154
[18] *McInerney*, page 155
[19] *McInerney,* page 155

25. . Far from supporting the CPSO's premise, *McInerney* tends to refute it. There is no blanket fiduciary obligation on the part of a physician to refer a patient to a physician who will kill the patient.

26. Moreover, there is no law, written or unwritten, which says that a physician (or any other professional) must automatically do everything that a client or patient wishes, to the detriment of the professional's own judgment and conscience. Physicians routinely exercise their professional or ethical judgment independent of patient instructions, such as when determining not to perform an organ transplant[20] or deciding to discontinue patient inclusion in treatment programs.[21] Physicians are required to rely on their conscience and best judgment when interpreting ethical considerations.

27. Even if there were a fiduciary obligation to refer for MAID (which is denied), that obligation, according to the Court in *McInerney*, would not be absolute. Rather, the obligation would be subject to the "paramount reasons" of the individual physician. The Court in *McInerney* found that a physician may justifiably consider it necessary to withhold a patient's records even from the patient, under certain circumstances. We note that it is the physician who has the right and the obligation, on a case by case basis, to make such determinations, not the professional regulator. Fiduciary obligations stem from equity, and

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[20] See *Flora*, paras. 74-76: "A variety of considerations inform the medical decision whether to offer a liver transplant to a specific patient. These include issues regarding donor organ supplies, patient survival prospects and, in the case of LRLTs, ethical considerations concerning risk factors for prospective organ donors.
In particular, there was evidence before the Divisional Court from Dr. Peter Singer, an Ontario professor of medicine, a bio-ethicist and the Director of the University of Toronto Joint Centre for Bioethics, that the appropriateness of a proposed medical treatment for a particular patient is "not purely a medical concept". To the contrary, "[A] physician's determination about whether treatment is appropriate includes not only medical facts like the projected chance of success but also ethical considerations." Thus, with LRLTs, "[T]he potential risk to the donor, in relation to the benefit to the recipient, play[s] a significant role in the decision whether to offer a transplant." In their evidence before the Board, Mr. Flora's UK doctors and Dr. Wall also confirmed that ethical considerations form an essential part of medical decision- making concerning patient selection for a LRLT.
Thus, the thesis that the appropriateness of a LRLT turns solely on its medical efficacy brushes aside the centrality of ethical considerations in transplant decision- making." [emphasis added]

[21] See, for example *M.A. v J.H., 2014* CanLII 77216 (ON HPARB)

breaches of fiduciary obligations are equitable remedies. Equitable remedies, by their very nature, are not available as of right. Equitable remedies are granted only in the discretion of the Courts on a case by case basis.[22]

Fiduciary Obligations Not a Bar to Collective Bargaining

28. Strangely and contradictorily, the CPSO permits physicians to walk off the job as a negotiating tactic for higher wages, opening the door to causing profound harm on patients.[23] It is difficult to imagine a more disruptive event to patient care. The CPSO recognizes a right to strike despite acknowledging that when physicians do so that there can be "serious negative implications" to patient care.[24]

29. Even more perversely, the CPSO allows the same physicians who have chosen to strike, thereby "seriously" impacting patient care, to determine for themselves alone if an "urgent" situation exists that would compel the striking physician to act despite the walk out:

> What constitutes urgent and/or necessary medical care to prevent harm, suffering and/or deterioration is a matter to be determined by a physician's clinical judgment, and will be informed by the existing health status and specific needs of individuals, and physicians' individual and collective responsibilities to provide care.[25] [emphasis added]

30. A much greater right than wage increases is at stake in the instant case. Freedom of conscience, as a prerequisite to considering and applying ethical standards, is foundational

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[22] See *McInerney*, page 155; also see *Strother v. 3464920 Canada Inc*., 2007 SCC 24 (CanLII), 2007 S.C.J. 24 at para. 74: "This Court has repeatedly stated that "[e] equitable remedies are always subject to the discretion of the court." See also *Canson Enterprises Ltd. v. Boughton & Co. (1991),* [1991] 3 S.C.R. 534 (S.C.C.).

[23]According to the CPSO, "A physician must always act in the patient's best interests" and "Physicians should guard against compromising their duty to their patients by pursuing personal advantage, whether financial or otherwise, at the expense of the patient." (CPSO Practice Guide: Principles of Practice & Duty – Duties to the Patient) [*http://www.cpso.on.ca/Policies-Publications/The-Practice-Guide-Medical-Professionalism-and-Col/Principles-of-Practice-and-Duties-of-Physicians/Duties-To-the-Patient/Duties-To-the-Patient-Managing-Conflicts-of-Intere*]

[24] See CPSO Policy "Providing Physician Services During Job Actions" [http://www.cpso.on.ca/policies-publications/policy/withdrawal-of-physician-services-during-job-action]

[25] See CPSO Policy "Providing Physician Services During Job Actions" [*http://www.cpso.on.ca/policies-publications/policy/withdrawal-of-physician-services-during-job-action*]

not only the individual, but to the survival of the democratic state. The Court in *R. v. Big M Drug Mart*[26] ("*Big M Drug Mart*"), Justice Dickson for the Court stated the following:

> What unites enunciated freedoms in the American First Amendment, s. 2(a) of the *Charter* and in the provisions of other human rights documents in which they are associated is the notion of the centrality of individual conscience and the inappropriateness of governmental intervention to compel or to constrain its manifestation…
>
> It should also be noted, however, that an emphasis on individual conscience and individual judgment also lies at the heart of our democratic political tradition. The ability of each citizen to make free and informed decisions is the absolute prerequisite for the legitimacy, acceptability, and efficacy of our system of self-government. It is because of the centrality of the rights associated with freedom of individual conscience both to basic beliefs about human worth and dignity and to a free and democratic political system that American jurisprudence has emphasized the primacy or "firstness" of the First Amendment. It is this same centrality that in my view underlies their designation in the *Canadian Charter of Rights and Freedoms as* "fundamental". They are the *sine qua non*[27] of the political tradition underlying the Charter.[28] [emphasis added]

The CPSO Ignores Parliament's Intent

31. Parliament has recognized the right of medical practitioners to abstain from involvement in MAID, stating "nothing in this Act [Bill C-14] affects the guarantee of freedom of conscience and religion" enshrined in section 2(a) of the *Charter*.[29] The Federal Department of Justice added further prescient clarification in its legislative background to Bill C-14 in regard to the conscience and religious rights of physicians:

> The decriminalization of medical assistance in dying will lead to requests to healthcare providers to provide assistance that would be contrary to some healthcare providers' conscience or religious beliefs. Freedom of conscience and religion are protected from government interference by paragraph 2(a) of the

[26] [1985] 1 SCR 295.
[27] "A thing that is absolutely necessary."
[28] *Big M Drug Mart*, paras. 121 and 122.
[29] Preamble, Bill C-14.

> Charter. Nothing in the Bill compels healthcare providers to provide such assistance or could otherwise impact their paragraph 2(a) rights.[30] [Emphasis Added]

32. The Federal government has made no effort to compel physicians to participate in MAID. On the contrary, Parliament has taken steps to ensure that professional bodies such as the CPSO understand that the conscience rights of physicians remain protected. The CPSO has no legislative power. It must create policies in accordance with Bill C-14 but has failed to stay within the parameters established by Parliament.

Dignity of Patients Not Accomplished By Violating the Dignity of Physicians

33. Throughout the history of physician-patient relationships in Canada prior to *Carter*, MAID has been illegal, both criminally and regulatorily. The new legality of MAID cannot be said to have created a positive obligation on physicians to refer for it, simply because it is requested by a patient. This CPSO contention is absurd.

34. The Court in *Carter* stated the following in regard to the principles of fundamental justice:

> In *Re B.C. Motor Vehicle Act*, 1985 CanLII 81 (SCC), [1985] 2 S.C.R. 486 (the "*Motor Vehicle Reference*"), Lamer J. (as he then was) explained that the principles of fundamental justice are derived from the essential elements of our system of justice, which is itself founded on a belief in the dignity and worth of every human person. To deprive a person of constitutional rights arbitrarily or in a way that is overbroad or grossly disproportionate diminishes that worth and dignity. If a law operates in this way, it asks the right claimant to "serve as a scapegoat" (*Rodriguez*, at p. 621, per McLachlin J.). It imposes a deprivation via a process that is "fundamentally unfair" to the rights claimant".[31]

35. The above quote is just as applicable to the infringed rights of physicians in the instant case. In this case, the individuals deprived of dignity are the physicians, compelled by a government body to assist in causing the death of a patient by suicide.

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[30] "Health Care Providers Freedom of Conscience": Part 4, Statement of Potential Charter Impacts, Legislative Background: Medical Assistance in Dying (Bill C-14, as Assented to on June 17, 2016) http://www.justice.gc.ca/eng/rp-pr/other-autre/adra-amsr/p4.html#p4

[31] *Carter,* at para. 81.

36. It would be contradictory and irreconcilable to find that the state has no constitutional obligation to provide health services that maintain life, but that it must provide services that will end life upon request. It is still more incongruous to find that the state has an obligation to override the *Charter* section 2(a) conscience rights of physicians as a component of the process.

Unintended Consequences of Compelling Unethical Conduct in Physicians

37. The CPSO can reconcile the interests of patients with the *Charter* rights of physicians and other medical practitioners. The CPSO has already established a central hotline which connects the patient with a willing physician, without the forced participation of unwilling physicians through a referral process.[32] This demonstrates that there is no practical need to coerce every physician in Ontario to assist patients who wish to commit suicide, and suggests that the Policy is ideological in nature, lacking practical considerations. CPSO is already aware of the doctors who are willing to participate in consultations and implementations of MAID, or if unaware can obtain this information with little difficulty. The CPSO is neither obliged nor authorized to compel consciences. Obligations of conscience are not owed to employers or the state, and the CPSO has no jurisdiction to infringe them.

38. It is surprising that a government entity which is meant to safeguard and govern physicians would ignore the convictions of physicians which result, in part, from millennia-old prohibitions against killing patients. The fact that MAID is now legal does not erase the

[32] See footnote 11 to the Policy: "The Ministry of Health and Long-Term Care has established a toll-free referral support line to help Ontario physicians to arrange referrals for patients requesting medical assistance in dying. Clinicians seeking assistance in making a referral can call toll-free: 1-844-243-5880."

deeply and sincerely held convictions of physicians that they should not assist patients to commit suicide. The CPSO expects and requires physicians in all other areas of practice to listen to their conscience when evaluating their ethical obligations to patients. It must consider the consequences of mandating the overriding of a physician's conscience in one aspect of practice (i.e. MAID) and the necessary implications in other circumstances where the CPSO would rather have a physician's personal sense of ethics overrule inclination (such as the temptation to accept kickbacks in exchange for referrals to bypass waiting lists, or enter into sexual relationships with vulnerable patients).

39. It is to the detriment of society for the CPSO to communicate to physicians that they should ignore or disregard their conscience from time to time when pondering ethical matters. When the CPSO informs physicians that their personal ethics and conscience are "optional," this creates a risk for all patients, and undermines the general public's trust in physicians. Many physicians daily make difficult ethical decisions, and must constantly face themselves and their actions in the mirror of self-analysis. Determinations of self-worth and self-respect are largely dependent on past conduct and the knowledge that one has been true to one's own values and convictions.

40. The patient who commit suicide with the assistance of their physicians will be gone, but physicians must continue to perform their duties day by day. The CPSO has failed to properly consider the impact on physicians of the forced violation of their consciences and the compulsion to violate deeply-held ethical concerns. The CPSO's actions in this regard threaten the very integrity of the medical profession.

PART 3: CONCLUSION

41. The Policy uses threats and coercion to compel conduct that overrides a physician's foundational right-and-wrong imperatives. The CPSO's justifications as to why it is

necessary in the instant case to violate an individual's conscience are fallacious. There is no constitutional right to health care, and no fiduciary obligations exist to require a physician to assist with suicide. History is replete with examples of state entities that compelled their citizens to act contrary to conscience, with horrific and tragic results. In attempting to compel conduct against the wills and consciences of medical practitioners the CPSO adds itself to a list of infamy.

42. A physician is not an automaton to comply blindly with whatever the patient demands.

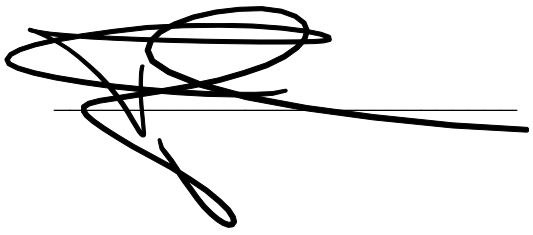
43. A referral is not a morally or ethically neutral action. The CPSO itself acknowledges this when it prohibits physicians not only from performing female genital mutilation, but also from *referring* for this procedure. A physician's obligations are mixed with a physician's own sense of consequences, and personal beliefs about right and wrong, life and death, civility and morality, conscience and religion. Conscience and religious rights are protected by section 2(a) of the *Charter* as fundamental and inviolate, except in narrow and precise circumstances as demonstrably justified in a free society. Their violation in the instant case is neither conscionable nor justifiable.

PART 4: ORDER SOUGHT

44. This intervener requests that the Application of the Applicants be granted, and states that no costs are sought on its own behalf, nor should be ordered against it.

ALL OF WHICH IS RESPECTFULLY SUBMITTED BY:

Jay Cameron
Counsel for the Intervener,
The Justice Centre For Constitutional Freedoms



Schedule A: Cases Cited:

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*Canson Enterprises Ltd. v. Boughton & Co. (1991), [*1991] 3 S.C.R. 534

Carter v. Canada (Attorney General), [2015] 1 SCR 331, 2015 SCC 5

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COURT FILE #:499-16; 500-16

Christian Medical and Dental Society of Canada et al **Applicants**	v.	College of Physicians and Surgeons of Ontario **Respondent**

ONTARIO
SUPERIOR COURT OF JUSTICE

Proceedings commenced at Ottawa
Transferred to Toronto
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