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Quebec law and freedom of conscience for health care professionals

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Unlike other Canadian provinces, Quebec codes of ethics for health care professionals are enacted by provincial statute. Quebec is also unique in having a provincial euthanasia law, which includes a protection of conscience provision for health care professionals specific to that service.

Freedom of conscience for services other than euthanasia

Physicians

The *Code of Ethics for Physicians*[1] and the gloss on the Code by *ALDO Quebec*,[2] an authoritative document, require objecting physicians to advise patients of the consequences of not receiving the contested service, and "offer to help the patient find another physician." They are not obliged to help the patient find someone willing to provide the contested service. Objecting physicians are normally quite willing to explain how patients can find other physicians or health care professionals.

Previously, the Collège des Médecins du Québec required objecting physicians to connect a patient with a service provider, but that is no longer the case, probably because of the legalization of euthanasia. Speaking to Quebec legislators about the pending euthanasia law in 2013, the President and Director of the Collège said:

[I]f you have a conscientious objection and it is you who must undertake to find someone who will do it, at this time, your conscientious objection is [nullified]. It is as if you did it anyway.	Parce que, si on a une objection de conscience puis c'est nous qui doive faire la démarche pour trouver la personne qui va le faire, à ce moment-là, notre objection de conscience ne s'applique plus. C'est comme si on le faisait quand même.[3]

Pharmacists

The *Code of Ethics for Pharmacists* provision is identical to that of physicians, so the statutory text does not impose an obligation for the objector to direct the patient specifically to someone who will provide the contested service.[4] However, the Order of Pharmacists, the pharmacy regulator, states that the assistance must be "avec obligation de résultat" (with a commitment to getting results).[5] This requires the objecting pharmacist to connect the patient with a provider, which some find unacceptable for the reasons given above by the President of the Collège des

Médecins.

Nurses

The *Code of Ethics for Nurses* (registered nurses and nurse practitioners) and the *Code of Ethics for Nursing Assistants* (~ licensed practical nurses) do not address freedom of conscience. On this issue, some provisions can conflict with others, depending upon how they are interpreted. For example, nurses are told to act with integrity.[6,7] However, they are also told to subordinate their personal interest to that of a "client."[8,9] Is integrity a fundamental human good, or merely an aspect of "personal interest"?

Nurses must not terminate services to a patient unless they have "sound and reasonable grounds," the patient is informed in advance, and withdrawal "will not be prejudicial to the patient." Reasons of conscience are neither included nor excluded in the non-exhaustive list of recognized grounds,[10,11] but what counts as "sound and reasonable" or "prejudicial" can become polemical flashpoints. Similarly, it can be argued that declining to provide or facilitate a service or withdrawal based on conscientious objection is never considered patient abandonment,[12] but such accusations are often hurled at objecting practitioners.[13]

This ambiguity makes it difficult to predict the effect of other provisions in the nursing codes on freedom of conscience. For example, nurse and nurse practitioners "may not refuse to collaborate with health professionals engaged in providing care, treatment or services necessary for the client's welfare."[14] Collaboration is undefined, so it appears that collaboration may be required, notwithstanding conscientious objection. Similarly, nursing assistants are instructed to "fully cooperate" with patients who want to consult another health care professional or competent person,[15] which suggests that facilitation may be expected notwithstanding conscientious objection.

Euthanasia practice guidelines approved by the Order suggest that it considers section 44 of the *Code of Ethics* relevant to conscientious objection.[16] It insists that nurses must not be "negligent," must perform required assessments, "intervene promptly when the client's state of health so requires" and "take reasonable action to ensure continuity of care and treatment." Combined with the preceding provisions, the reference seems ominous.

Euthanasia in Quebec

The province's euthanasia law, the *Act Regarding End of Life Care* (ARELC), permits two kinds of euthanasia, distinguished here as reportable and non-reportable euthanasia.[17]

Reportable euthanasia is identified as "medical aid in dying" in ARELC.[18] Only physicians may administer a lethal substance, and only to a legally competent person who is at least 18 years old, meets other criteria and personally gives informed consent. Physicians must conform to procedural guidelines and reporting requirements.

Non-reportable euthanasia is not explicitly identified in the law, but is permitted for legally incompetent patients (including those under 14 years old) who are not dying. Substitute decision makers acting under the authority of Quebec's *Civil Code*[19] can order them to be starved and dehydrated to death. There are no procedural guidelines, no reporting requirements, and it appears that the order can be carried out by anyone responsible for patient care.[20]

Reportable euthanasia and individual freedom of conscience

Section 50 is the protection of conscience provision in ARELC for health care professionals. It pertains ONLY to reportable euthanasia.

Physicians

Section 50 distinguishes physicians (who alone can provide lethal injections) from other health professionals, ironically providing *less* protection for physicians than for others. Physicians may refuse only "to administer" the substance - a very specific action. The law does not prevent them from being forced to participate in other ways, and College guidelines now demand objecting physicians provide "clinical assessments of capacity to consent" and provide opinions about the prognosis of patients seeking euthanasia.

It is certainly understandable that some physicians would be reluctant to give an opinion that might confirm that one or other of the legal criteria authorizing MAID has been met, for fear that all the criteria would be met and that two colleagues would consider MAID acceptable. However, doing these assessments before deciding what the most appropriate care for the patient is (MAID and/or other types of care) means not participating in the recommendation or the administration of this care. Not doing so, just in case, would discriminate against people whose suffering is such that they request assistance in dying and who might then be deprived of the best possible care.	Il est certes compréhensible que certains médecins aient des réticences à donner un avis qui pourrait confirmer le respect de l'un ou l'autre des critères légaux autorisant une AMM, par crainte qu'éventuellement l'ensemble des critères soit présent et que deux confrères jugent que l'AMM serait acceptable. En revanche, effectuer de tels examens en amont de la décision de prodiguer les soins les plus appropriés au patient concerné (AMM et/ou autres) n'est participer ni à la recommandation ni à l'administration de tels soins. Ne pas le faire, au cas où, serait discriminatoire envers les personnes qui souffrent au point de demander de l'aide pour mourir et qui pourraient ainsi être privées des meilleurs soins.[21]

Under Section 31, physicians who refuse to administer a lethal substance for any reason other than non-eligibility must notify a designated administrator, who then becomes responsible for finding a physician willing to do so. The idea is to have the institution or health care system completely relieve the physician of responsibility for facilitating the procedure. However, some objecting physicians find this unacceptable because it requires them to put the euthanasia delivery system into motion with respect to a particular patient (as distinct from giving general notice to an administrator of their unwillingness to provide euthanasia for reasons of conscience).

Other health care professionals have broader protection than physicians. They may refuse to "take part" (*de participer*: participate) in the lethal administration of a substance for reasons of conscience.

Nurses

In 2015 the Ordre des infirmières et infirmiers du Québec advised objecting nurses to notify a supervisor as soon as possible, and the supervisor assumes responsibility for finding another nurse.[22]

This guidance has been incorporated into current official euthanasia guidelines.[23] It appears that the broader protection afforded to nurses by ARELC prevented the Order of Nurses from forcing them to participate at least by assisting with euthanasia assessments.

Pharmacists

The Order of Pharmacists seems to have been more thoughtful about freedom of conscience in relation to euthanasia than abortifacient drugs. It reminded Quebec legislators of a 2009 statement by the Collège des Médecins: "It is unthinkable that physicians become mere performers and that care is provided on demand."

> The Ordre des pharmaciens du Québec, like the Collège des médecins du Québec, considers that it cannot ethically compel one of its members to prepare and deliver medication in a context of medical aid to die without unduly restricting his freedom of conscience.
>
> The right of pharmacists (and other professionals) to conscientious objection in a context of medical aid in dying should not be restricted in the bill considering that its ethical and legal legitimacy is based in particular on the principle of human dignity.

The Order flatly denied that a code of ethics "could restrict the right of a professional to object to the provision of care for a reason of conscience," though it distinguished conscientious objection *per se* from its exercise. Noting that the *Code of Ethics for Pharmacists* requires objecting pharmacists to provide services if a patient's life is in danger or refusal would cause "serious harm to the patient's health," it expressed concern that this section could be used to force objecting pharmacists to personally dispense euthanasia drugs.[24]

Quebec guidelines for euthanasia approved by the Order state that objecting pharmacists "could immediately notify the competent authorities or support organizations," which, as in the case of physicians, would assume responsibility for finding another pharmacist.[25] While this is essentially the same mechanism the law provides for physicians, it can have a lesser impact on objecting pharmacists because of the difference between medical and pharmacy practice.

Pharmacists are not normally in direct contact with patients, so it is very unlikely they would receive a request for euthanasia. Moreover, ARELC does not permit assisted suicide, so patients do not come to them for lethal drugs. Thus, objecting pharmacists may well avoid conflicts by notifying supervisors and authorities in advance, so that physicians seeking euthanasia drugs are not directed to them in the first place.

Non-reportable euthanasia and individual freedom of conscience

ARELC does not protect conscientious objectors in relation to non-reportable euthanasia (starving and dehydrating patients). This does not appear to disadvantage pharmacists — who would not be asked to provide a lethal drug — or objecting physicians, who would seem to be free to withdraw. However, the codes of ethics of nurses and licensed practical nurses do not protect them from coerced collaboration or cooperation, and can be interpreted to support coercion.

Assessing the risk

Granted this legal framework, it is important to assess the risk faced by objecting nurses unwilling to comply, so we need to know if non-reportable euthanasia by starvation and dehydration is occurring in Quebec. Continuous palliative sedation (as defined by ARELC, not by palliative care protocols) is likely to be associated with non-reportable euthanasia,[26] so reports concerning it may help to answer the question.

1,704 cases of CPS were reported in Quebec between 10 December, 2015 and 31 March 2018, with a 25% increase in the number of cases reported between 2016 and 2017.[27] Just over half the patients receiving CPS died within 24 hours, just over 80% within three days and 99% in less than 10 days.[28] Further, 90% of the cases reported cancer, pulmonary, cardiovascular and neurodegenerative disorders as the underlying ailments, and most of the remaining 10% identified by the Commission sur le soins de fin de vie can have acute onsets near the end of life that may require CPS.[29]

These statistics seem consistent with the accepted use of CPS in palliative practice rather than in conjunction with non-reportable euthanasia by dehydration and starvation. They do not rule out the possibility that, for example, some patients with dementia have died by non-reportable euthanasia, since dementia is included among neurocognitive disorders (*des troubles neurocognitifs*) listed in the 10% "other" category of Quebec patients who received lethal injections.[30] However, the statistics seem to indicate that, if that is occurring, it is rare.

For this reason, it does not appear that ARELC's legalization of non-reportable euthanasia by dehydration and starvation currently poses a significant threat for Quebec health care professionals who object to euthanasia for reasons of conscience.

Euthanasia and institutional freedom of conscience

Section 13 of ARELC allows hospices to define what kind of care they provide, so they can refuse to provide both reportable and non-reportable euthanasia or permit the procedures on their premises. They must give advance notice of their policy to prospective patients. Section 72 of the *Act* provides the same protection for Maison Michel Sarrazin, a private, not-for profit palliative care hospital founded over 30 years ago that has a high reputation and considerable public support.[31]

Notes

1. Code of Ethics of Physicians, RSQ c M-9, r 17, s24, online: <http://legisquebec.gouv.qc.ca/en/ShowDoc/cr/M-9,%20r.%2017>.

2. Collège des Médecins du Québec, *Legal, Ethical and Organizational Aspects of Medical Practice in Québec (ALDO Quebec),* Quebec: CMQ, February, 2020, at 7.1.2, online: <http://www.cmq.org/publications-pdf/p-1-2019-04-18-fr-aldo-quebec.pdf?t=1580339976017#page=102>.

3. Quebec, Assemblée Nationale, la Commission permanente de la santé et des services sociaux, "Consultations particulières sur le projet de loi n° 52 - Loi concemant les soins de fin de vie (1), in *Journal des débats* , CSSS-34 (17 September 2013) at 13, online:

<http://www.assnat.qc.ca/Media/Process.aspx?MediaId=ANQ.Vigie.Bll.DocumentGenerique_81797&process=Original&token=ZyMoxNwUn8ikQ+TRKYwPCjWrKwg+vIv9rjij7p3xLGTZDmLVSmJLoqe/vG7/YWzz >.

4. Code of Ethics of Pharmacists, RSQ c P-10, r 7, s26, online: <http://legisquebec.gouv.qc.ca/en/pdf/cr/P-10,%20R.%207.pdf>.

5. Ordre des pharmaciens du Quebec, *L'interruption volontaire de grossesse pratiquée à l'aide de la pilule abortive: Guide à l'intention des pharmaciens,* Quebec: OPQ, 2017, at 8, online: <https://www.opq.org/doc/media/2819_38_fr-ca_0_guide_pilule_abortive_opq_vf.pdf#page=8>.

6. Code of Ethics of Nurses, RSQ c I-8, r 9, s10, online: <http://legisquebec.gouv.qc.ca/en/pdf/cr/I-8,%20R.%209.pdf> [*CEN*].

7. Code of Ethics of Nursing Assistants, RSQ c C-26, r 153.1, s8, online: <http://legisquebec.gouv.qc.ca/en/pdf/cr/C-26,%20R.%20153.1.pdf> [*CENA*].

8. *CEN*, *supra* note 6, s20.

9. *CENA*, *supra* note 7, s18.

10. *CEN*, *supra* note 6, s27.

11. *CENA*, *supra* note 7, s26–27.

12. Yves Robert, "L'objection de conscience" (10 November, 2015), Collège des Médecins du Québec (News), online <http://www.cmq.org/nouvelle/en/objection-de-conscience.aspx>.

13. Christian Fiala C, Joyce H. Arthur, "There is no defence for 'Conscientious objection' in reproductive health care" (2017) Eur J Obstet Gynecol Reprod Biol 216 254-258 at 254, online: <https://www.ejog.org/article/S0301-2115(17)30357-3/fulltext>.

14. *CEN*, *supra* note 6, s26.1, s46.

15. *CENA*, *supra* note 7, s4.

16. Collège des Médecins du Québec, Ordre des pharmaciens du Quebec, Ordre des infirmières et infirmiers du Québec, Ordre des travailleurs sociaux et des thérapeutes conjugaux et familiaux du Québec, Barreau du Quebec, Chambre des notaires, *L'Aide Médicale à Mourir, Mise à jour 11/2019: Guide d'exercice et lignes directrices pharmacogiques*, Quebec: CMQ, 2019, online: <https://numerique.banq.qc.ca/patrimoine/details/52327/4013472?docref=kkXd96jQyj_60SedqJb2zg> [*AMM 2019*] at 47.

17. Sean Murphy, "Quebec's *Act Respecting End of Life Care*:Reportable and non-reportable euthanasia" (24 August, 2020), Protection of Conscience Project (website), online: <https://www.consciencelaws.org/law/commentary/legal108.aspx>.

18. *Act Respecting End of Life Care*, RSQ c S-32.0001, s 3(6), online: <http://legisquebec.gouv.qc.ca/en/showdoc/cs/S-32.0001> [*ARELC*].

19. *Civil Code of Quebec*, RSQ c CCQ-1991, art 11– 25, online: <http://legisquebec.gouv.qc.ca/en/pdf/cs/CCQ-1991.pdf#page=32>.

20. *ARELC*, *supra* note 18, s 5.

21. *AMM 2019*, *supra* note 16 at 3.4.3.

22. Lucie Tremblay, "Le rôle déterminant des infirmières et infirmiers auprès des patients en fin de vie" (17 September, 2015), Ordre des infirmières et infirmiers du Québec (News), online: <https://www.oiiq.org/en/le-role-determinant-des-infirmieres-et-infirmiers-aupres-des-patients-en-fin-de-vie?inheritRedirect=true>.

23. *AMM 2019*, *supra* note 16 at 45.

24. Ordre des pharmaciens du Quebec, Mémoire relatif au projet de loin no. 52, Quebec: OPC, 17 September 2013, at 12– 14, online: <https://www.opq.org/doc/media/1729_38_fr-ca_0_memoire_opq_projet_loi_52.pdf#page=13>.

25. *AMM 2019*, *supra* note 16 at 5.5.3.

26. *Murphy*, *supra* note 17.

27. Commission sur le soins de fin de vie, Rapport sur la situation des soins de fin de vie au Québec (2019) Quebec: Government of Quebec, at 5.1, online: <https://aqdmd.org/download/commission-sur-les-soins-de-fin-de-vie-rapport-sur-la-situation-sur-les-soins-de-fin-de-vie-au-quebec/>.

28. *Ibid*, at 28, fig 5.9.

29. *Ibid*, at 25, fig 5.6.

30. *Ibid*.

31. Quebec, Assemblée Nationale, la Commission permanente de la santé et des services sociaux, "Consultations particulières sur le projet de loi n° 52 - Loi concemant les soins de fin de vie (5), in *Journal des débats* , CSSS-38 (25 September 2013) at 14, paragraph beginning, "L'article 65, une petite precision" (Mme Hivon), online: <http://www.assnat.qc.ca/Media/Process.aspx?MediaId=ANQ.Vigie.Bll.DocumentGenerique_81953&process=Original&token=ZyMoxNwUn8ikQ+TRKYwPCjWrKwg+vIv9rjij7p3xLGTZDmLVSmJLoqe/vG7/YWzz>.