Revision Date: 2020 Aug 26

Physician freedom of conscience in Saskatchewan

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Introduction

The College of Physicians and Surgeons of Saskatchewan (CPSS) policy *Conscientious Objection*[1] began as a virtual clone of *A Model Conscientious Objection Policy for Canadian Colleges of Physicians and Surgeons*,[2] a coercive policy proposed by an activist group of academics, including a leading euthanasia advocate. It was written for the purpose of compelling objecting physicians to facilitate morally contested services by "effective referral." The Associate Registrar of the Saskatchewan College, who had worked with the group, pushed for its adoption by Colleges across the country.[3]

As originally drafted, the policy was intended to apply to all procedures, including euthanasia and assisted suicide. It demanded that objecting physicians provide an "effective referral" for procedures or services they are unwilling to provide for reasons of conscience. For example, physicians unwilling to perform abortions, kill patients or help them to commit suicide would be required to arrange for a willing colleague to provide the services.

Speaking to Quebec legislators about the pending euthanasia law in 2013, President and Director of the Collège des Médecins du Québec explained why:

> [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.[4]

Nonetheless, the Associate Registrar stated publicly that physicians unwilling to facilitate euthanasia and assisted suicide by referral could be forced out of the profession.[5]

The proposal generated strong opposition in Saskatchewan and forced several revisions of the draft between January and September, 2015. It was not politically possible to pass a policy that would force unwilling physicians to collaborate in killing their patients, nor to agree on wording that would clearly require objecting physicians to collaborate in providing procedures they considered immoral.

As a result, CPSS policy on conscientious objection for euthanasia and assisted suicide is included in the policy *Physician Assisted Dying;*[6] it does not require effective referral. *Conscientious Objection* applies to everything else and is ambiguous with respect to referral.

CMA Code of Ethics (2018)

The College has formally adopted the code of ethics of the Canadian Medical Association (CMA),[7] but the CMA code has never required effective referral by objecting physicians and is opposed to mandating it.[8] The most recent version of the code (the CMA *Code of Ethics and Professionalism*) advises physicians to act according to their conscience does not require objecting physicians to refer or arrange for services to which they object for reasons of conscience.[9] Hence, the College quoted selectively from the *Code* when it incorporated the new version into *Conscientious Objection* in 2020.

Conscientious Objection (2015)

"Care" and "appropriate care"

In identifying relevant principles said to be associated with the physician-patient relationship the College exclusively uses the terms "care" and "appropriate care," notwithstanding the fact that objections are not to "care" but to interventions or procedures. This loads the rhetorical dice against objecting physicians, who are said to be refusing "care" rather than, for example, declining to collaborate in amputating a patient's penis and testicles in furtherance of a patient's desire to become or look like a woman. No one would support the refusal of "care" as such, but it is not unreasonable to refuse to become a party to a procedure, the morality and advisability of which reasonable people may disagree.

Thus, key principles identified by the College can be used to justify restriction or suppression of physician freedom of conscience only if they are interpreted ideologically. For example:

> Patients should not be disadvantaged or left without appropriate care due to the personal beliefs of their physicians;

It is possible to turn this statement against objecting physicians only if it is agreed that amputation of healthy body parts is "appropriate care" and that patients are "disadvantaged" by not having their genitals amputated, if that is what they want.

"Personal beliefs"

Further, the reference to "*personal* beliefs,"subtly disparaging in this context, is often associated with claims that physicians who act upon *personal* beliefs in medical practice are acting "unprofessionally." However, morality and ethics are intrinsic to medical practice. Physicians willing to provide or facilitate the amputation of healthy body parts also act upon personal beliefs, to the effect that the procedure is morally acceptable or that they do not act immorally in providing or collaborating in it.

Of course, some moral or ethical views may be erroneous, but that is a different matter that must be addressed by demonstrating that they are erroneous. It will not do to pretend that amputating healthy

body parts does not involve at least implicit moral or ethical judgements, or that such judgements are not based on beliefs. Moreover, such beliefs are always "personal," in the sense that one personally accepts them and is committed to them.

That does not mean that such "personal" beliefs are parochial, insignificant or erroneous. Christian, Jewish and Muslim beliefs, for example, are shared by hundreds of millions of people. They "personally" adhere to their beliefs, just as non-religious believers "personally" adhere to their non-religious beliefs. In neither case does the fact of this "personal" commitment provide grounds to set beliefs aside. Thus, it is important to recognize that pejorative or suspicious references to "personal" beliefs or "personal" values frequently reflect underlying and perhaps unexamined prejudice against them.[10]

Patients' "interests"

The College states that there is sometimes "a legitimate clinical reason or other good legal reason that the patient's interests should not be accommodated."

The assertion courts confusion by implying that the *best* interests of patients (central to the physician-patient relationship) are sometimes served by ignoring their interests. It appears that what the College meant to say is that physicians may refuse patient *requests* that are illegal or clinically judged to be not in their best interests.

Fiduciary duty

The duty to act in the patient's best interests reflects the fiduciary nature of the physician-patient relationship, the first principle identified by the College in this context. This is frequently cited as reason to compel objecting physicians to provide or facilitate services they consider to be immoral.

However, objecting physicians typically consider a contested procedure to be immoral *because* it is harmful, and, therefore, not in a patient's best interests. The law requires them to assess that independently and in good faith, using their own judgement, without becoming a "puppet" by taking direction from anyone else, including the patient and state medical regulators. If they thus conclude that doing X is not in a patient's best interest, the law *requires* them to refuse.[11]

Patient access to services

The statement that there may sometimes be good clinical or legal reasons to refuse patient requests (thereby implying that conscientious objection does not provide such a reason) seems to reflect the assumption that objecting physicians intend to impede or prevent patients from obtaining morally contested services, or that conscientious objection necessarily has this effect. The assumption is unwarranted.

Certainly, a physician who believes that X is immoral believes that *no one* should do X, just as someone who believes eating meat is immoral believes no one should eat hamburgers. It does not follow that physicians who refuse to perform or collaborate in X or vegetarians who refuse to eat or buy meat do so to prevent or impede access to X or Big Macs. Refusal is meant to preserve personal integrity by avoiding complicity in perceived wrongdoing.

Scope of the policy

The College explicitly excludes euthanasia and assisted suicide from the scope of *Conscientious Objection*. This reflects a pragmatic political compromise. As previously noted, the first draft of the policy was proposed with the possibility of the legalization of euthanasia and assisted suicide in mind, with the intention of forcing objecting physicians to facilitate the procedures by referral. There is no principled reason why the policy should not be understood to apply to the procedures if they thought to be medical services or health care.

The policy includes a number of passages drawn verbatim/almost verbatim (*) or substantially (✤) from the coercive activist proposal that inspired it.[12]

Access to "health services"

> *The Canadian medical profession as a whole has an obligation to ensure that people have access to the provision of legally permissible and publicly-funded health services.

There is less to this than meets the eye.

With respect to "legally permissible and publicly funded" services, legality is established by the mere absence of prohibition, there is no duty do something illegal, and illegal health services would not be publicly funded, so the reference to legality is superfluous. Many health services are not publicly funded, but the attributed obligation and coercive elements of the policy apply only to those that are. Rhetorical flourishes removed, the claim is simply that the medical profession as a whole is obliged to ensure access to publicly funded-health services.

However, the claim is contested by the Canadian Medical Association. The CMA's Dr. Jeff Blackmer, speaking of euthanasia and assisted suicide,said that, while individual physicians could be expected to "step forward" to provide services, "it shouldn't be up to the profession as a whole" to ensure access.[13] The CMA argues that obligation to ensure access to health services should fall on the federal government,[14] communities[15] and health systems,[16] not the medical profession, and it insists that this can be achieved without imposing a requirement for effective referral on objecting physicians.[17]

> *Physicians have an obligation not to interfere with or obstruct a patient's right to access legally permissible and publicly-funded health services.

In fact, a physician should ensure access to health care and not impede access to it whether or not it is publicly funded. Public funding is irrelevant on this point. The reference to public funding is an artifact of the original text, which reflected the ideological claim that public funding of a service is sufficient to justify compelling objecting physicians to provide or facilitate them.

Non-abandonment

> * Physicians have an obligation not to abandon their patients.

Accusations of patient abandonment are often hurled at objecting practitioners,[18] so it is not surprising to see reference to it in the policy. However, a physician does not abandon a patient by offering services the patient does not want (eg. obstetrical or palliative care) instead of providing or facilitating a service the patient wants (eg., abortion or euthanasia).

Further, two months after the CPSS approved *Conscientious objection*, the Secretary of the Collège des Médecins du Québec, addressing the subject, wrote, "[T]he exercise of conscientious objection is not and cannot be interpreted as the abandonment of the patient." He described this as a "unanimous" opinion, notwithstanding the concept "is understood and applied in various ways around the world."[19]

> ✤Physicians' exercise of freedom of conscience to limit the health services that they provide should not impede, either directly or indirectly, access to legally permissible and publicly-funded health services.

Once more the College employs the mantra "legally permissible and publicly-funded." The corollary of this statement is that physicians *may* impede access to health care as long as it is *not* publicly-funded.

Notwithstanding this absurdity, the passage has unmistakably strategic value. An impediment need not amount to or even remotely approximate complete obstruction. An impediment is a hindrance of any kind or degree, caused "directly *or indirectly*" by the exercise of freedom of conscience. The provision enables the College to prosecute a physician who does not prescribe oral contraceptives should a patient have to cross the street or drive around the block to obtain birth control pills. [20]

In light of all of this, and recalling that those who drafted the original policy were ready to force physicians out of medical practice if they refused to collaborate in killing their patients, objecting physicians may be disinclined to take comfort in the policy's statement, "Physicians freedom of conscience should be respected."

Physician obligations generally

The College's warning against providing false, misleading, intentionally confusing, coercive, or materially incomplete information is inflammatory and unwarranted. It indicates strong underlying prejudice against objecting physicians.

In other respects, the College and the Protection of Conscience Project are on common ground. By providing advance notice to patients of their views, physicians should be able to avoid or minimize conflicts with patients seeking a service they are unwilling to provide for reasons of conscience. Further, physicians:

- should respect patients' dignity and ensure their safety
- should communicate effectively
- should not demean patients' beliefs, lifestyle, choices, or values.
- should not promote their own moral or religious beliefs when interacting with patients

The policy recognizes the distinction between providing the patient with information (5.2) and providing or facilitating a morally contested service or procedure (5.3). This is the key to resolving conflicts between what a patient wants and physician freedom of conscience.

Providing information (5.2)

Physicians must provide information necessary to enable the patient to make informed decisions about medical treatment, such as prognosis, the treatments or procedures available, benefits and burdens of treatment, risks, etc., "including the option of no treatment or treatment other than that recommended by the physician." If unwilling to do so, they must arrange for the information to be provided by someone else.

The policy insists that such information must be provided "even if the provision of such information conflicts with the physician's deeply held and considered moral or religious beliefs." However, in the Project's experience, most objecting physicians are willing to discuss morally contested procedures with patients, and the Project has not encountered objecting physicians unwilling to at least refer patients to someone willing to provide the necessary information.

Facilitating access to services (5.3)

The whole point of the policy initiative was to force physicians unwilling to provide a procedure for reasons of conscience to arrange for it to be provided by someone else: to impose an obligation of "effective referral," even for assisted suicide and euthanasia. This was stoutly opposed by many objecting physicians for the reasons given by the President and Director of the Collège des Médecins du Québec.

Excluding euthanasia and assisted suicide from the policy was not sufficient to overcome principled opposition to the demand for effective referral. Ultimately, the controversy was settled by resort to ambiguity. College Council decided that objecting physicians must

> a) make an arrangement for the patient to obtain the full and balanced health information required to make a legally valid, informed choice about medical treatment as outlined in paragraph 5.2; and,
>
> b) make an arrangement that will allow the patient to obtain access to the health service if the patient chooses.
>
> Those obligations will generally be met by arranging for the patient to meet with another physician or other health care provider who is available and accessible and who can either provide the health service or refer that patient to another physician or health care provider who can provide the health service.
>
> If it is not possible to meet the obligations of paragraphs a) or b), the physician must demonstrate why that is not possible and what alternative methods to attempt to meet those obligations will be provided.

Section 5.3(a) ensures that objecting physicians will comply with section 5.2, which clearly states that objecting physicians may provide the information themselves or arrange for it to be provided in some other way. This should not present a problem for objecting physicians.

However, what constitutes "an arrangement" under (b) remains unclear, particularly in light of the two paragraphs following. The formulation reflects the intense controversy during the development of the policy that ended in a stalemate. Those opposed to effective referral understand *Conscientious objection* 5.3(b) to mean that they are not obliged to refer patients for morally contested services, and any attempt by the College to coerce or discipline them is likely to be met with a lawsuit.

"Necessary treatments to prevent harm or provide care"

Physicians are obliged to provide treatment that is within their competence in an emergency. Codes of ethics often acknowledge this without elaboration.[21] Circumstances triggering the obligation are variously described, but typically involve imminent death or serious injury.

The College of Physicians and Surgeons of Manitoba refers to a situation ("medical emergency") entailing "a sudden injury, illness or complication demanding immediate or early medical care to save life or to prevent serious disability, pain or distress."[22] Other examples:

> **Indonesia:** "Emergency aid is what [must immediately be done] to prevent death, disability, or severe suffering."("Pertolongan darurat yang dimaksud pada pasal di atas adalah pertolongan yang secara ilmu kedokteran harus segera dilakukan untuk mencegah kematian, kecacatan, atau penderitaan yang berat pada seseorang.")[23]
>
> **Israel:** "The physician has no ethical or legal obligation to carry out every demand of the patient, except in the case of urgent lifesaving treatments."[24]
>
> **Nepal:** "[A] emergency [means] that any delay in treatment would result in increased morbidity and mortality."[25]
>
> **New Zealand**: "Services to preserve life and prevent permanent disability must always be provided."[26]
>
> **Saudi Arabia:** "An emergency situation is a condition resulting from an injury or disease that could threaten a patient's life, one of his/her limbs, or internal/external organs."[27]

Conscientious Objection exploits this tradition in order to compel objecting physicians to personally provide morally contested interventions or make effective referrals. It states that physicians "must provide care in an emergency." According to the CPSS, this obligation overrides physician freedom of conscience.

However, by "care" the College means every imaginable service, procedure or treatment. More important here, what counts as an "emergency"?

As the examples above indicate, it has traditionally been understood to be a situation in which medical treatment must be provided immediately in order to prevent imminent death, permanent disability, severe suffering, loss or crippling of limbs or organs.

The authors of *Conscientious Objection* retooled the concept of emergency to include every situation in which there is there is a need to prevent imminent "harm" to a patient's "health or well-being." for the purpose of suppressing freedom of conscience, since harm, health and well-being can be as broadly construed as "care."

This was acknowledged two years earlier by the Ordre des pharmaciens du Quebec. Noting the traditional ethical obligation to provide services if a patient's life is in danger or refusal would cause "serious harm to the patient's health," the Order pointed out that the World Health Organization's definition of "health" could be used to force objecting pharmacists to personally dispense euthanasia drugs.[28]

The Project has not encountered objecting physicians who would refuse to fulfil their obligation to provide medical treatment in emergencies, as that obligation has been traditionally understood and expressed. However, that is not what is meant in *Conscientious Objection*.

Physician Assisted Dying (2015)

Physician Assisted Dying betrays strong underlying prejudice against objecting physicians by repeating the unwarranted and inflammatory warning that they must not provide false, misleading, intentionally confusing, coercive, or materially incomplete information. In other respects the policy is satisfactory.

The policy distinguishes between providing information and providing or facilitating a morally contested service or procedure. Objecting physicians are not expected to facilitate euthanasia or assisted suicide by referral if they believe that doing so makes them a party to wrongful acts. They are expected to provide information necessary to satisfy the requirements of informed medical decision making, such as prognosis, the treatments or procedures available, benefits and burdens of treatment, risks, etc. Only if they are unwilling to provide this information is an offer of "timely access" to another physician or resource. Offering timely access may be achieved in various ways.

The policy reflects the widespread intuitive and rational insight expressed by the Director of the Collège des Médecins du Québec that one cannot evade moral responsibility for an act by arranging for it to be done by someone else.

Summary

Physician Assisted Dying adequately accommodates both physician freedom of conscience and patients' access to services. It demonstrates that the College of Physicians and Surgeons of Saskatchewan could have taken the same approach to freedom of conscience in relation to other procedures and produced a satisfactory policy on conscientious objection.

Conscientious Objection is ambiguous with respect to effective referral and polemical in its treatment of a physician's traditional obligation to render assistance in an emergency. It demonstrates the authors' intention to suppress physician freedom of conscience by compelling them to provide or facilitate morally contested procedures, as well as the intricate wordplay necessary to achieve that end.

Notes

1. The College of Physicians and Surgeons of Saskatchewan, *Conscientious Objection*, Saskatoon: CPSS, 2015. Online:<https://www.cps.sk.ca/iMIS/Documents/Legislation/Policies/POLICY%20-%20Conscientious%20Objection.pdf>.

2. Jocelyn Downie, Carolyn McLeod, Jacquelyn Shaw, "Moving Forward with a Clear Conscience: A Model Conscientious Objection Policy for Canadian Colleges of Physicians and Surgeons" (2013) 21:3 Health Law Review 29, online: <https://ir.lib.uwo.ca/cgi/viewcontent.cgi?article=1479&context=philosophypub> [*Downie*].

3. Sean Murphy, "Submission to the College of Physicians and Surgeons of Saskatchewan Re: Conscientious Refusal" (5 March, 2015), Protection of Conscience Project (website) at I, Origin of the draft policy *Conscientious Refusal*, online: <http://www.consciencelaws.org/publications/submissions/submissions-014-001-cpss.aspx#I.> [*Submission to CPSS*].

4. 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 >.

5. *Submission to CPSS*, *supra* note 3 at Appendix "C".

6. The College of Physicians and Surgeons of Saskatchewan, *Physician Assisted Dying*, Saskatoon: CPSS, 2015, online: <https://www.cps.sk.ca/imis/Documents/Legislation/Policies/POLICY%20-%20Physician-Assisted%20Dying.pdf>

7. The College of Physicians and Surgeons of Saskatchewan, *Bylaw 7.1: The Code of Ethics*, Saskatoon: CPSS, 2020, online: <https://www.cps.sk.ca/imis/CPSS/Legislation__ByLaws__Policies_and_Guidelines/Legislation_and_Bylaws.aspx?Legislation_BylawsCCO=3#Legislation_BylawsCCO>.

8. The Canadian Medical Association, *Submission to the CPSO on CPSO Interim Guidance on Physician-Assisted Death,* Ottawa: CMA, 2016 at 3, online: <http://policyconsult.cpso.on.ca/wp-content/uploads/2016/01/CMA-Submission-to-CPSO.pdf#page=5> [*CMA 2016*].

9. The Canadian Medical Association, *CMA Code of Ethics and Professionalism*, Ottawa: CMA, 2018 at para 3–4, online: <https://policybase.cma.ca/documents/policypdf/PD19-03.pdf>.

10. Sean Murphy, "Medicine, morality and humanity" (30 July, 2020), Protection of Conscience Project (website), online: <http://www.consciencelaws.org/ethics/ethics092.aspx>.

11. Canadian Aero Service Ltd. v. O'Malley, [1974] SCR 592, 1973 CanLII 23 (SCC)at 606; McInerney v MacDonald, [1992] 2 SCR 138, 1992 CanLII 57 (SCC) at 139, 149, 152; United Kingdom, Law Commission, Report No. 350 Fiduciary Duties of Investment Intermediaries

(Williams Lea Group for HM Stationery Office,2014), Law Commission [UKLCR350] at para 3.53, note 107, citing Selby v Bowie (1863) 8 LT 372, Re Brockbank [1948] Ch 206.

12. *Downie*, *supra* note 2.

13. Kyle Duggan, "Assisted-dying exemptions hitting snag of doctor availability: lawyer", *iPolitics* (20 January 2016), online: <https://ipolitics.ca/2016/01/30/roadblocks-apparent-on-judge-approved-assisted-dying/>.

14. *Ibid*.

15. *CMA 2016*, *supra* note 8.

16. The Canadian Medical Association, *Medical Assistance in Dying*, Ottawa: CMA, 2017 at Relevant Foundational Considerations, para 3, Respect for freedom of conscience, online: <https://policybase.cma.ca/documents/policypdf/PD17-03.pdf>.

17. *CMA 2016*, *supra* note 8.

18. 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>.

19. 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>.

20. Sean Murphy, "'NO MORE CHRISTIAN DOCTORS' :Crusade against NFP-only physicians" (21 February, 2018), Protection of Conscience Project (website), online: <https://www.consciencelaws.org/background/procedures/birth002.aspx>.

21. General Medical Council, *Good Medical Practice*, Manchester: GMC, 2013 at para 26, online: <https://www.gmc-uk.org/-/media/documents/good-medical-practice---english-20200128_pdf-51527435.pdf?la=en&hash=DA1263358CCA88F298785FE2BD7610EB4EE9A530>.

22. The College of Physicians and Surgeons of Manitoba, *Standards of Practice in Medicine*, Winnipeg: 2019, online: <http://cpsm.mb.ca/assets/Standards%20of%20Practice/Standards%20of%20Practice%20of%20Medicine.pdf>.

23. Agus Purwadianto et al, *Indonesian Medical Ethics Code*, 2012 at 50 online: <http://www.idionline.org/wp-content/uploads/2015/01/Kode-Etik-Kedokteran-Indonesia-2012.pdf>

24. The Israeli Medical Association, *Ethics Board Rules and Position Papers*, Ramat Gan: IMA, 2018 at 85 <online: https://www.ima.org.il/userfiles/image/EthicalCode2018.pdf>.

25. The Nepal Medical Council, *Code of Ethics and Professional Conduct-2017*, Kathmandu: NMC, 2017 at 5, online: <https://nmc.org.np/files/4/Code%20of%20Ethics_Print_version.pdf>.

26. The New Zealand Medical Association, *Code of Ethics for the New Zealand Medical Profession*, Wellington: NZMA, 2014 at art 67, online: <https://global-uploads.webflow.com/5db268b46d028bbc0fc0b537/5e20cf2e84fda6324f82d2d6_NZMA-Code-of-Ethics-2014-A4.pdf>.

27. The Saudi Commission for Health Specialties, Department of Medical Education & Postgraduate Studies, *Code of Ethics for Healthcare Practitioners*, translated by Ghaiath Hussein, Riyadh: SCHS, 2014 at 47, online: <https://www.iau.edu.sa/sites/default/files/resources/5039864724.pdf>.

28. 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>.