Protection of Conscience Project
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Canadian Medical Association: *Medical Assistance in Dying* (2017)
Project commentary

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Protection of Conscience Project

Introduction

The first statement by the Canadian Medical Association (CMA) addressing the subject of physician freedom of conscience at a foundational level was a 2016 submission to the College of Physicians and Surgeons of Ontario[1] in response to its demand that objecting physicians facilitate euthanasia and assisted suicide by an "effective referral" (i.e., "a referral made in good faith, to a non-objecting, available, and accessible physician, other health-care professional, or agency."[2] The principles enunciated in the submission to the CPSO were developed and applied the following year in *Medical Assistance in Dying*,3[3] the Canadian term for practitioner administered euthanasia and assisted suicide.

The CMA supports physicians who provide or otherwise participate in euthanasia and assisted suicide and those who refuse to do so. With respect to those who refuse, *Medical Assistance in Dying* states that objecting physicians "are not required to provide it, or to otherwise participate in it, or to refer the patient to a physician or a medical administrator who will provide assistance in dying to the patient." It also appears to put the onus on the state "to implement an easily accessible mechanism to which patients can have direct access" to obtain the services so that physicians can adhere to their moral commitments. The document addresses the circumstances of both patients and physicians in a more or less integrated manner, appropriately reflecting the nature of the subject. For analytical purposes, they are dealt with here separately.

Physicians as moral agents

The moral agency of physicians is implicitly acknowledged and supported by the CMA goal of "creating an environment in which practitioners are able to adhere to their moral commitments." The policy is meant to ensure "protection of physicians' freedom of conscience (or moral integrity) in a way that respects differences of conscience."

Consistent with this goal, the CMA states that it supports "the right of all physicians to follow their conscience" whether that takes the form of "conscientious participation" or "conscientious objection," whether their decisions follow from "reasons of moral commitments to patients and for any other reasons of conscience."

The sensitive issue of complicity in perceived wrongdoing is not discussed, but the CMA addresses it indirectly by insisting that physicians must be free to exercise freedom of conscience in relation to "any or all aspects" of the procedures, which encompass eligibility assessment and patient decision-making. Reflecting various forms of complicity, physicians are not required "to provide . . . or to otherwise participate . . . or to refer the patient" to a practitioner who will provide the services.

As in its 2016 submission to the CPSO, here the CMA insists that physicians' moral integrity must be protected by ensuring that they are "able to follow their conscience without discrimination," including discrimination in "general employment or contract opportunities" or in "evaluations and training advancement" in learning environments.

Finally, consistent its CPSO submission, the CMA asserts that the community has an obligation "to enable physicians to adhere to [their] moral commitments" by implementing "an easily accessible mechanism" to facilitate patient access to services.

Granted the critical importance of fostering the moral agency and integrity of physicians, the CMA acknowledges that exercise of freedom of conscience is not unlimited. Physicians must "never abandon or discriminate against [patients]", nor "impede or block access," nor make acceptance or retention of patients conditional upon their agreement not to request certain services.

Patient dignity

The policy does not articulate a rationale for the limits it sets on the exercise of physician freedom of conscience, but it is readily discerned in the document's references to patients. These are premised upon recognition of the centrality of the nature of the human person and human dignity.

Speaking of patients, the CMA asserts that "persons have inherent dignity regardless of their circumstances," that "services ought to be delivered, and processes and treatments ought to be applied, in ways that strive to preserve and enhance dignity," and that it is critical to "maintain the integrity of personhood." For these reasons, patients must be "free to make informed choices and autonomous decisions about their bodily integrity, their personal aims and their care that are consistent with their personal values and beliefs."

Equality of patients and physicians

Much of *Medical Assistance in Dying* is necessarily concerned with the application of ethical considerations and practical matters specific to the delivery of the services. However, its strong defence of the moral agency of physicians and its determined assertion of the need to respect and support the inherent dignity of patients illuminates another foundational principle: the essential equality patients and physicians as human persons.

The document considers the moral agency and moral integrity of physicians — but not their dignity; it emphasizes the dignity and bodily integrity of patients — but not their moral agency or moral integrity. In fact, everything that the CMA says in *Medical Assistance in Dying* about the moral agency and integrity of physicians applies equally to patients, and everything it says about the dignity of patients applies equally to physicians.

This explains why, on the one hand, physicians are told that they may refuse to provide or participate in any way, but may not "impede or block access," while, on the other, patients have the right to request the service, but this "does not compel individual physicians to provide it."

Conscientious objection

With these foundational elements in place, the guidelines for the conduct of physicians who object to euthanasia can be better understood and more accurately interpreted. The first point to note is that "patient" includes a patient's agent or designated medical decision maker.

Second, the requirement that physicians "should inform their patients of the fact and implications of their conscientious objection" helps patients and physicians who have different views arrange their relationship in a way that accommodates the moral agency of each.

Physicians are not obliged to fulfill a patient's request for euthanasia or assisted suicide by providing or otherwise participating in it, or to facilitate it by referring the patient to someone who will do so. Provision, participation and referral are all possible, but not obligatory, thus preserving the moral integrity of all physicians, regardless of their position on the issue. This is fully consistent with the CMA submission to the CPSO and its warning against illicit discrimination.

Apart from this, objecting physicians are obliged to respond to a patient request. This reflects the need to respect the person and dignity of patients by acknowledging their requests, taking them seriously, and providing information that they need to exercise their moral agency and give effect to their decisions. It explains the requirement to provide complete information, including information about how to access an appropriate health care network.

The expectation that objecting physicians will facilitate a direct transfer of care upon the request of the patient cannot be understood to require objecting physicians to facilitate euthanasia or assisted suicide by initiating either a transfer of care by finding a willing provider. This would make no sense in light of the policy's statement that referral is not required, since physician-initiated direct transfer of care would entail the same kind of complicity entailed by referral.

It follows that the transfer of care envisioned in the case of an objecting physician who also finds referral unacceptable must be patient-initiated, not physician-initiated. The transfer would be made after the patient — not the physician — has identified an individual or institution. The transfer would be required even if the person or institution selected will or is likely to provide euthanasia or assisted suicide. On the one hand, this safeguards the integrity of objecting physicians because they do not provide the impetus in favour of the intervention, nor do they participate in identifying a willing provider. On the other, it enables patients to exercise and give effect to their moral agency; they are entitled to find a different physician willing to manage all or part of their care, and an objecting physician cannot prevent them from doing so.

Similarly, the expectation that objecting physicians will provide the clinical records reflects the fact that the information in the records belongs to the patients. They are entitled to direct its disclosure to serve their purpose, and a physician who has expressed disagreement with that purpose is not entitled to do more. The situation is analogous to that of a trustee who is obliged to transfer an inheritance to an heir who has reached the age of majority, even if the trustee believes the heir will not make good

use of it.

Related:

Sean Murphy, “Canadian Medical Association and euthanasia and assisted suicide in Canada: Critical review of CMA approach to changes in policy and law” (September, 2018), Protection of Conscience Project (website), online: <https://www.consciencelaws.org/background/procedures/assist029-01.aspx>.

Sean Murphy, “Canadian Medical Association and Referral for Morally Contested Procedures” (20 October, 2022), Protection of Conscience Project (website), online: <https://www.consciencelaws.org/ethics/ethics098-000.aspx>.

Notes

1. Canadian Medical Association, "Submission to the College of Physicians and Surgeons of Ontario: Consultation on CPSO Interim Guidance on Physician-Assisted Death" (13 January, 2016), Protection of Conscience Project (website), online: <http://www.consciencelaws.org/background/policy/associations-003-002.aspx>.

2. College of Physicians and Surgeons of Ontario, "Professional Obligations and Human Rights" (March, 2015), College of Physicians and Surgeons of Ontario (website), online: <https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Professional-Obligations-and-Human-Rights>.

3. Canadian Medical Association, "Policy: Medical Assistance in Dying" (May, 2017), Canadian Medical Association (website), online: <https://policybase.cma.ca/media/PolicyPDF/PD17-03.pdf>.