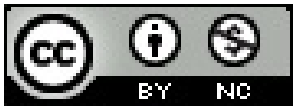

College of Physicians and Surgeons of Ontario
Consultation on Physicians and the Human Rights Code
4 June to August, 2014

Sean Murphy, Administrator
Protection of Conscience Project

Abstract

From 4 June to 5 August, 2014, the College of Physicians and Surgeons of Ontario conducted a public consultation on its policy, Physicians and the Human Rights Code (POHR). Respondents commented on the policy through give feedback portals (On-line Poll, On-line Survey, Discussion Forum, email, regular mail). An unknown number of respondents contributed through more than one of the portals . Hence, it is impossible to derive from the totality of consultation feedback a single, accurate global number of responses with respect to questions of particular interest.

This analysis demonstrates that the overwhelming majority of respondents who made comments through email, regular mail and in the Discussion Forum supported freedom of conscience for physicians with respect to refusing to provide non-emergency services. Consistent with this, On-line Survey responses did not support a policy of mandatory referral. They indicated only that mandatory referral was highly controversial.

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Introduction

The College of Physicians and Surgeons of Ontario is the regulatory and licensing authority for physicians and surgeons practising in Ontario. In February, 2008, the Ontario Human Rights Commission responded to a draft policy of the College with a submission recommending that physicians "must essentially 'check their personal views at the door' in providing medical care."[1]

The College, in response, released a draft policy, *Physicians and the Ontario Human Rights Code*, stating, "there will be times when it may be necessary for physicians to set aside their personal beliefs in order to ensure that patients or potential patients are provided with the medical treatment and services they require."[2]

As a result of the subsequent controversy and public pressure, the demand that physicians abandon their moral or religious beliefs was dropped before *Physicians and the Ontario Human Rights Code* was adopted.[3] The policy was slated for review by September, 2013, but a public announcement of the review was not made until June, 2014. The first stage of a public consultation about the policy closed on 5 August, 2014.[4]

The data used in this analysis is available in an Excel file.[5] Readers are asked to advise the Project Administrator if they find an error in the spreadsheets so that it can be corrected and the analysis revised accordingly.

Consultation process

The College invited the public and the profession to provide feedback on the policy by regular mail, email, and an On-line Survey. In addition, it provided an On-line Poll[6] and Discussion Forum.[7] The prompt for the On-line Poll, Discussion Forum and submissions was:

> **Do you think a physician should be allowed to refuse to provide a patient with a treatment or procedure because it conflicts with the physician's religious or moral beliefs?** (Yes) (No) (Don't Know)

Note that the prompt asked only about refusing to provide treatment. It did not address the contentious subject of referral by objecting physicians for services they deem morally unacceptable.

On-Line Poll

Table A: On-line Poll		
Total Responses:	32,912	
Yes:	25,230	(77%)
No:	7,616	(23%)
Don't Know:	66	(<1%)
Source: College Consultations: Physicians and the Ontario Human Rights Code		

There seems to have been no geographical limitation on responses. Further, some respondents in the Discussion Forum noted marked changes in voting patterns suggestive of technological manipulation of the on-line poll by both "yes" and "no" respondents (Response 183 and response to it; Responses 660, 937), and some had difficulty registering their votes (Responses 179, 680).

Thus, while the results seem to indicate overwhelming support for freedom of conscience among physicians, the accuracy of the On-line Poll as a reflection of opinion in Ontario is doubtful, and its validity is further undermined by the possibility of technological manipulation.

In fairness to the College, this kind of poll seems to be used on other websites primarily to increase traffic and readership rather than as a reliable source of data, and it may have been principally intended to serve that purpose in the consultation. The On-line Poll is given little weight in this analysis.

Discussion Forum (email, regular mail, forum participants)

The Discussion Forum was used to collect input on the policy from three sources: comments by forum participants, comments and submissions emailed to the College, and comments and submissions sent by regular mail. Submissions received by mail and email became numbered entries in the Forum, as did initial comments by forum participants. Forum participants posted replies and exchanged views in discussions under individual numbered entries. These exchanges were not numbered, and they are not included in this analysis.

The College states that it received 1,797 responses, but there are only 1,270 numbered entries on the discussion page. This analysis concerns the 1,270 numbered entries directed to the College concerning the policy, which actually reflect 1,737 individual responses. This requires an explanation.

- Two of the numbered entries appear to be duplicates from the same respondents (42-43, 70-71) and three are from the same organization (1094,1263,1265).
    - In this analysis, the duplicate and triplicate entries are not counted.
- In some cases (eg., 526) the College noted that it had received X number of identical responses, but posted only one to represent the group.
    - In this analysis, the actual number of responses under a single entry is counted.
- In other cases, the single entry included either a joint submission by more than one organization (1252) or represented the views of more than one person (1035).
    - In this analysis, the actual number of persons/groups represented by an entry is counted.
        - This is consistent with the approach taken with respect to multiple identical submissions under a single entry.

Table B: Discussion Forum Respondent Type (Including input through forum, email & regular mail)		
Total:	1,737	(100%)
Health Care Practitioners:[8]	124	(7%)
Public & Anonymous:	1,575	(90%)
Medical Organizations:[9]	7	(1%)
Other Organizations:[9]	30	(2%)

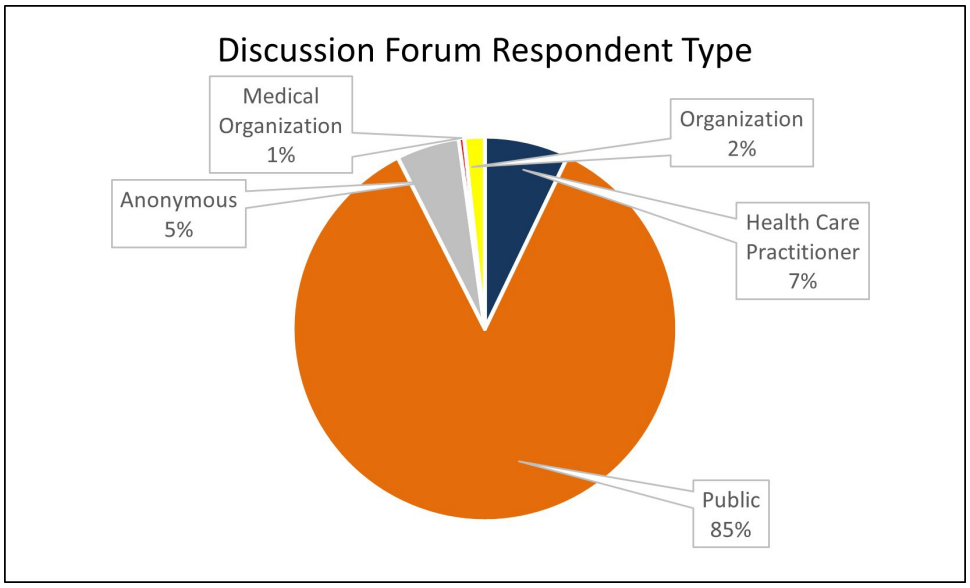


Figure 1

The responses are broken down here into six categories, defined as follows:

Status Quo: Explicit statement to the effect that the existing policy is satisfactory, without significant additional comments supportive of freedom of conscience. (eg., 1159)

For freedom of conscience: Supports physicians who refuse to provide services for reasons of conscience. Frequently qualified by the rider that support is limited to "non-emergency" situations or circumstances in which the patient's life is not in danger. May include support for status quo. (eg., 181)

Against freedom of conscience: Opposes refusal to provide service based on conscientious convictions or religious belief. Strength of opposition varies. (eg., 1180)

Null: Statements are not responsive to the issue (For example: criticism of consultation, criticism of abortion, or no position identifiable. (eg., 977)

Must Refer:[10] Response in the form, "if will not provide, must refer." (eg., 1021)

Balance: Makes suggestions attempting to balance what is thought to be the physician/patient interest. (eg., 984)

Assigning a response to a category sometimes requires subjective interpretation; a different analyst might assign a response to a different category. However, it is doubtful that this variation would significantly change the numbers reported below.

Table C: Discussion Forum Responses (Global)					
Status Quo	**For**	**Against**	**Null**	**Must Refer**	**Balance**
26	1355	187	104	40	7
(2%)	(79%)	(11%)	(6%)	(2%)	(<1%)

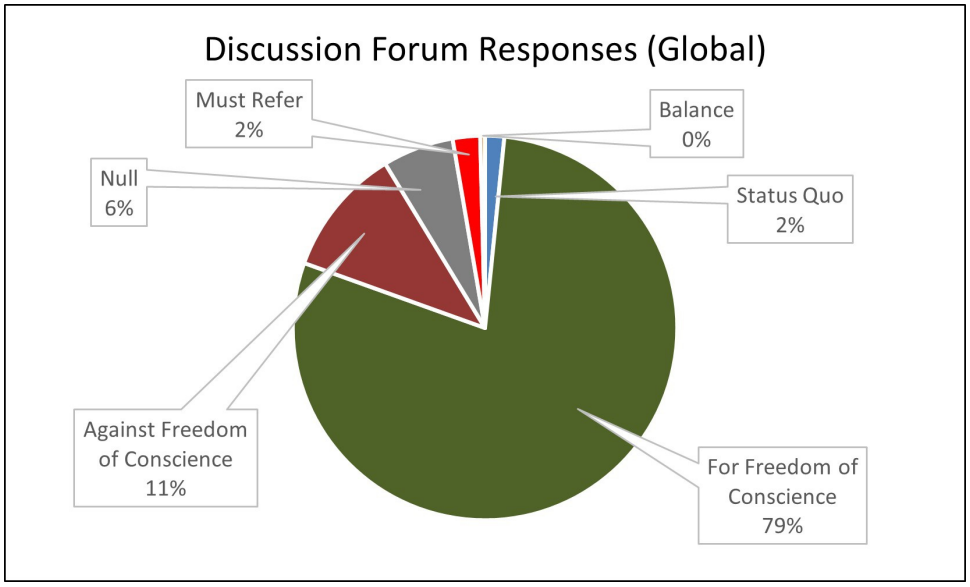


Figure 2

Table D: Discussion Forum Responses (Selected)						
Respondent	**Status Quo**	**For**	**Against**	**Null**	**Must Refer**	**Balance**
Public & Anonymous	20 (1%)	1260 (80%)	167 (11%)	88 (6%)	33 (2%)	7 (<1%)
Health Care Practitioners:[8]	5 (4%)	84 (68%)	17 (14%)	13 (10%)	5 (4%)	0
Medical Organizations:[9]	3 (43%)	3 (43%)	0	1 (14%)	0	0

Table D: Discussion Forum Responses (Selected)						
Other Organizations:[9]	0	23 (77%)	4 (13%)	3 (10%)	0	0

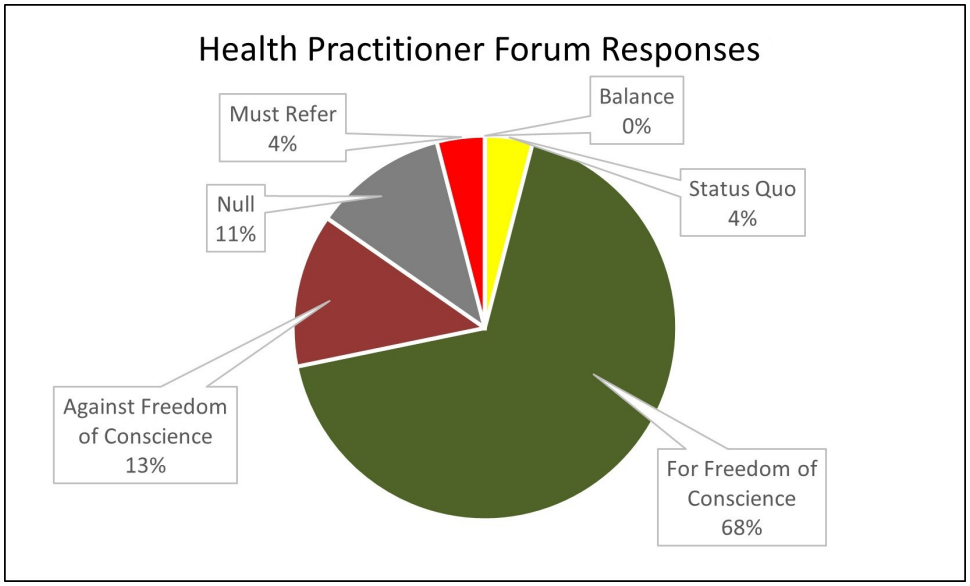


Figure 3

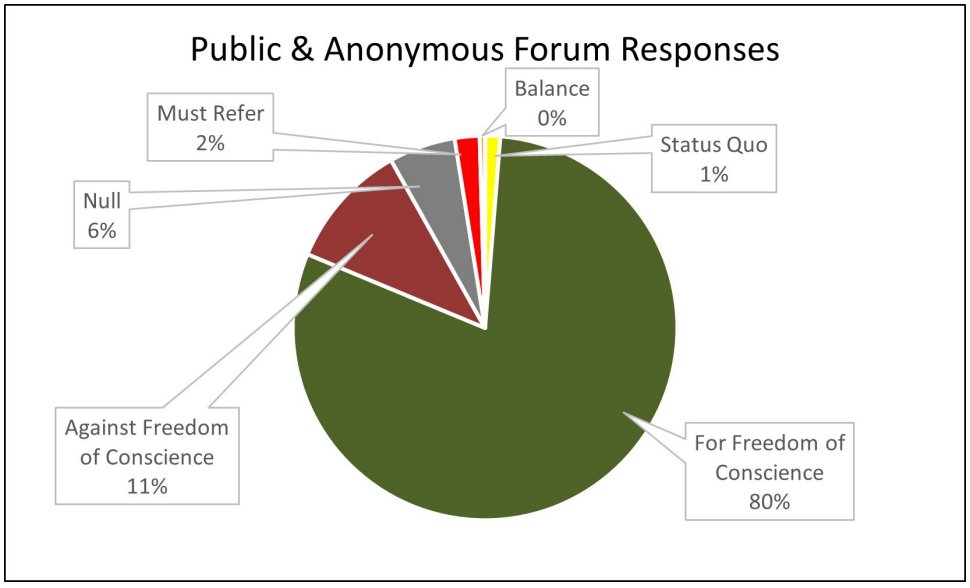


Figure 4

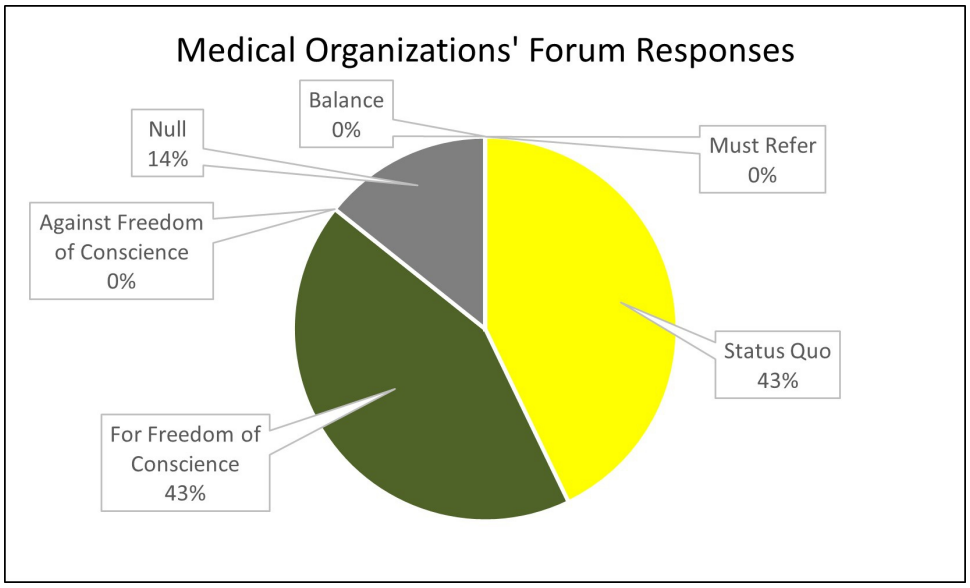


Figure 5

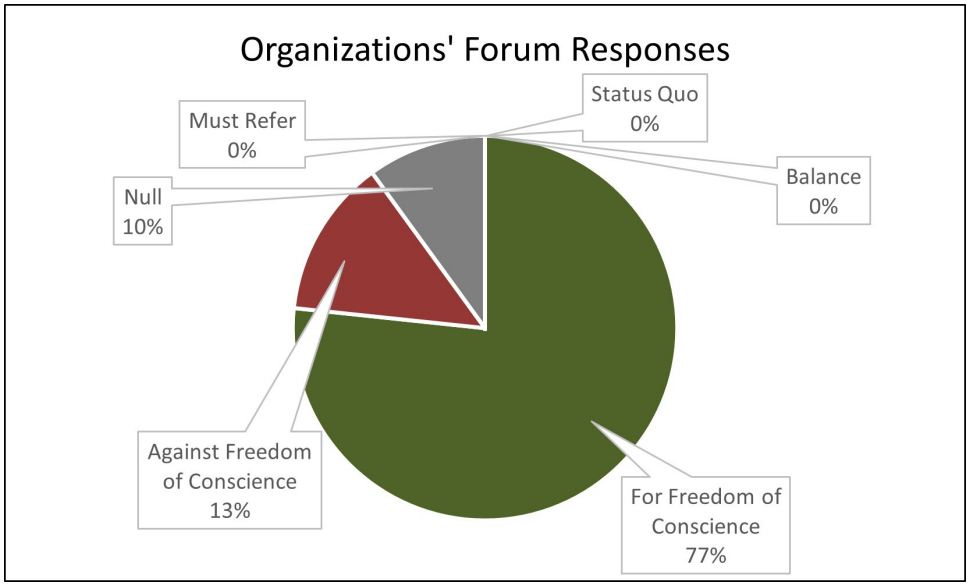


Figure 6

On-line Survey

A Report provided by the College provided the results of the On-line Survey.[4] Of the 6,400 surveys started, 3,103 were completed and 1,311 completed at least one substantive question. The Report concerned the 4,414 completed or partially completed surveys, 26 of which came from organizations. Note that at least some of those who completed or partially completed a survey also responded through the Discussion Forum, but these respondents have not been identified by the College.

Table E: On-line Survey Respondent Type		
Total:	4,414	
Physicians:	534	12.1%
Organization Staff (policy staff, registrar, senior staff)	39	0.89%
Member of the Public:	3306	74.9%
Other Health Care Professional:	339	7.7%
Other (specify):	196	4.4%
Clergy	15	
Medical Students	72	
Social Workers	6	
Teachers/Professors	8	
Other professionals or concerned citizens		
Source: Report, Tables 2, 3 Note 5.		

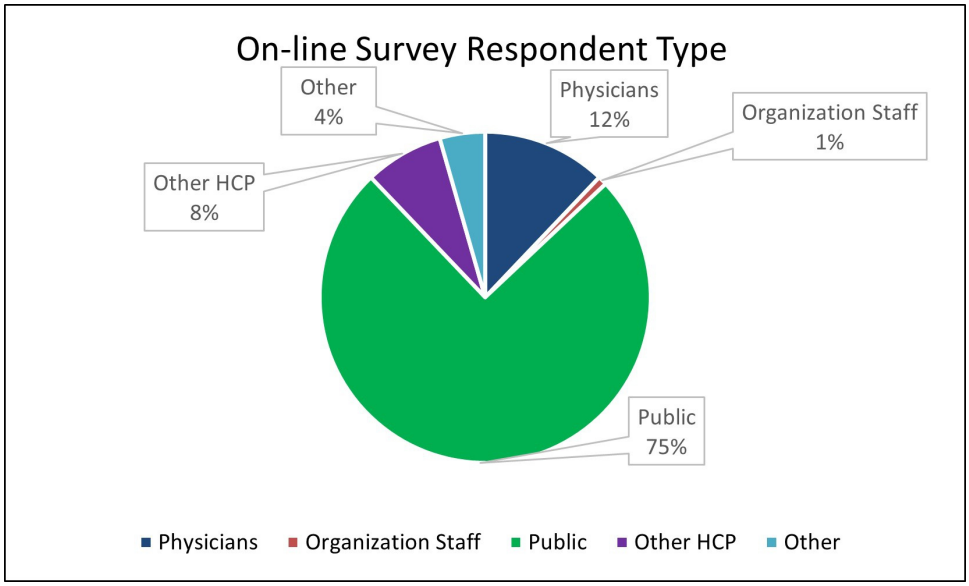


Figure 7

Policy Issues

The On-line Survey proposed a series of possible obligations for physicians who decline to provide a service for reasons of conscience or religion and asked respondents to indicate their level of agreement with each. 3,117 respondents replied. Since most of the respondents were members of the general public, the results do not represent the opinions of physicians.

Table F: On-line Survey re: Obligations on Refusal	
The physician must communicate clearly and promptly . . . about any treatments or procedures not provided because of moral or religious beliefs.	
Strongly Agree	67%
Somewhat Agree	15%
Somewhat Disagree	6%
Strongly Disagree	3%
Neither Agree/Disagree	8%
Don't Know	1%
(82% agree | 9% disagree | 9% uncertain)	
The physician must advise patients, or potential patients, that they can see another physician if the treatment conflicts with the physician's moral or religious beliefs.	
Strongly Agree	57%
Somewhat Agree	19%
Somewhat Disagree	7%
Strongly Disagree	4%
Neither Agree/Disagree	12%
Don't Know	1%
(76% agree |16% disagree | 13% uncertain)	
Physicians should not express personal judgments about the beliefs, lifestyle, identity or characteristics of a patient or an individual who wishes to become a patient.	
Strongly Agree	55%
Somewhat Agree	16%
Somewhat Disagree	8%

Table F: On-line Survey re: Obligations on Refusal	
Strongly Disagree	9%
Neither Agree/Disagree	11%
Don't Know	1%
(71% agree | 17% disagree | 12% uncertain)	
Physicians must not promote their own moral or religious beliefs when interacting with patients.	
Strongly Agree	48%
Somewhat Agree	13%
Somewhat Disagree	11%
Strongly Disagree	12%
Neither Agree/Disagree	15%
Don't Know	1%
(61% agree | 23% disagree | 16% uncertain)	
The physician must provide information about all clinical options , even if the treatment options conflict with the physician's moral or religious beliefs.	
Strongly Agree	47%
Somewhat Agree	14%
Somewhat Disagree	6%
Strongly Disagree	9%
Neither Agree/Disagree	23%
Don't Know	1%
(61% agree | 15% disagree | 24% uncertain)	
In some circumstances, the physician must help make arrangements to see another physician if the treatment conflicts with the physician's moral or religious beliefs.	
Strongly Agree	39%
Somewhat Agree	16%
Somewhat Disagree	8%

Table F: On-line Survey re: Obligations on Refusal	
Strongly Disagree	10%
Neither Agree/Disagree	26%
Don't Know	1%
(55% agree | 18% disagree | 27% uncertain)	

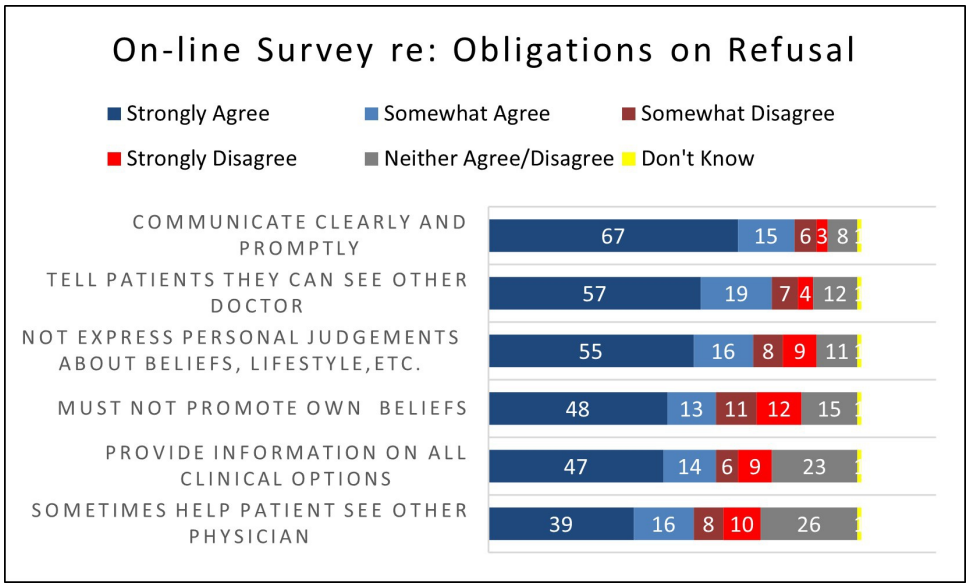


Figure 8

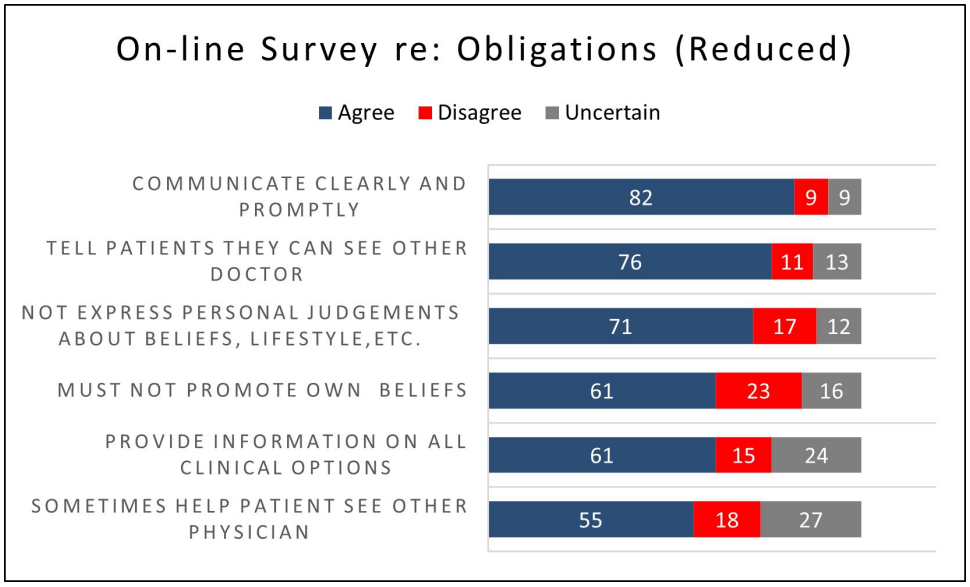


Figure 9

Note that the proposed obligation, *"In some circumstances. . .help make arrangements to see another physician"* left open the question of what those circumstances might be. Equally important, it did not specify that the objecting physician was obliged to help find someone willing to provide the contested service. Both are issues that could have significantly influenced respondents in different ways.

This became clear when the subject of referral was put specifically to respondents:

> **When physicians refuse to provide treatments or procedures on the basis of moral or religious belief, do you think those physicians must be required, in all instances, to refer patients to another physician or health care provider who will provide the treatment or procedure?**
>
> (Yes) (No) (Don't know)

The 3,104 responses to this question were sharply divided, a greater number opposing the requirement, while the number answering "don't know," had they answered "yes" or "no" would have resulted either in a slight majority opposed to mandatory referral, or to a tie.[11]

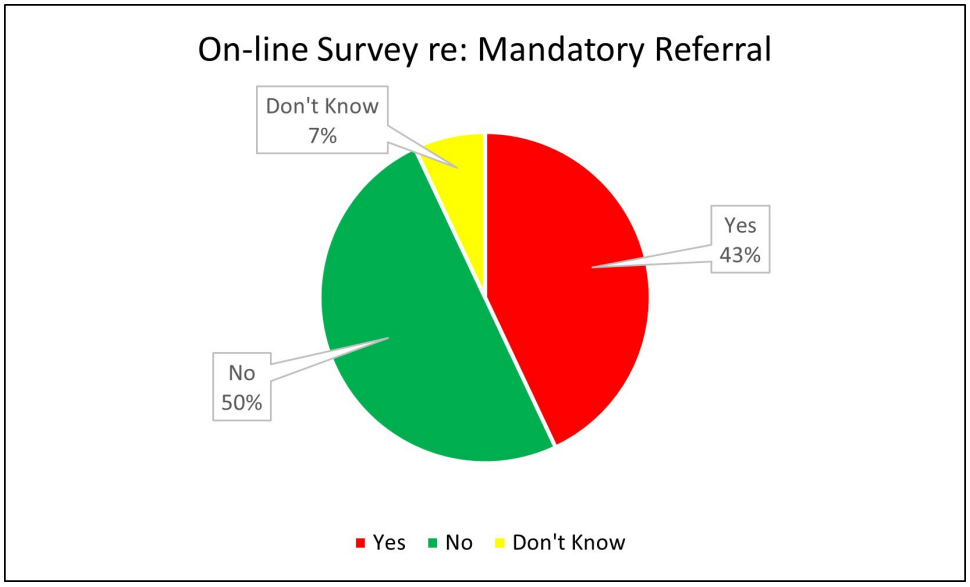


Figure 10

1,762 respondents provided further feedback on this question. Presumably, the five examples of these comments provided in the Report are representative of the range and nature of the views expressed.

> 1. It seems criminal that a physician should be allowed to bill the health care system for a visit from an existing or potential patient and not at least provide them with a referral elsewhere;
>
> 2. Referring a patient to another doctor is in some way collaborating with or enabling a procedure the physician may consider immoral, and is in some circumstances equivalent

to murder;

3. The physician can direct the patient to a directory of physicians to find a new doctor. The physician who is morally/religiously conflicted does not have to make a direct referral (doctor to doctor);

4. They have no right to deny treatment. If they feel strongly about their religious rights they need to find a different profession that would make them more comfortable.; and

5. If it is not an emergency situation, a physician should not be required to provide information on where to obtain a procedure they are morally opposed to. Patients are able to find that information themselves if they so desire.

Clarity and Comprehensiveness

The Report stated that 54% of the respondents agreed that Physicians and the Human Rights Code clearly articulated a physician's professional obligations, 55% thought it easy to understand, 57% thought it well written, and most (58%) considered it well organized. However, it also notes that almost 27% *had not read* the policy, while the percentages above refer to *the total number of responses* — not to the 73% who had actually read it. More confusing, the Report indicates that its analysis of comments on the comprehensiveness of the policy is based on 3,300 responses — without reference to whether or not the respondents had actually read the policy. Hence, this analysis does not respond to this section of the Report.

Discussion

General Remarks

An unknown number of respondents contributed through more than one of the consultation feedback portals (On-line Poll, On-line Survey, Discussion Forum, email, regular mail) and the College did not (and perhaps could not) identify them. For this reason, it is not possible to derive from the totality of consultation feedback a single, accurate global number of responses in any of the six categories used in this analysis.

For reasons given above, the On-line Poll and the Report's conclusions about the clarity and comprehensiveness of the existing policy are discounted in this analysis. This discussion is limited to the 1,719 responses/submissions in the Discussion Forum and to the Report's analysis of between 1,762 and 3,117 On-line Survey responses about policy issues.

Further, the College stated that the volume of responses was unprecedented - more than 6,700.[12] According to the briefing note for College Council, there were 6,710 responses, including "2296 comments posted to the online discussion page and 4414 completed online surveys."[13]

In fact, there were only 3,103 completed on-line surveys; 1,311 were only partially completed surveys.[4] Moreover, since an unknown number respondents contributed both to the On-line Survey and Discussion Forum, the number of unduplicated consultation responses available for analysis may have been far less than 6,700. On the extremely contentious issue of referral, for example, the College's analysis relies on less than half that number (Figure 10).

Discussion Forum Responses (Email, regular mail, forum participants)

The comments posted in the Discussion Forum were unstructured responses to the prompt:

> **Do you think a physician should be allowed to refuse to provide a patient with a treatment or procedure because it conflicts with the physician's religious or moral beliefs?**

The overwhelming majority of responses came from individual members of the public rather than health care practitioners or organizations (Table B, Figure 1). Almost 80% of respondents in the Discussion Forum (including 68% of health care practitioners, half of the medical organizations and 77% of other organizations) indicated their support for physician freedom of conscience by affirming that they should be able to decline to provide services for reasons of conscience or religion (Table C, Figure 2). However, in many cases, this was explicitly qualified by statements to the effect that this referred to non-emergency situations, sometimes more specifically identified as situations in which failing to provide the service would not endanger the life of the patient.

About 11% of respondents indicated that they were against physician freedom of conscience by affirming that they should *not* be able to refuse services for reasons of conscience or religion (Table C, Figure 2). This included 14% of health care practitioners and 13% of other organizations (Table D, Figure 3, Figure 5, Figure 6).

Only about 2% of respondents volunteered that objecting physicians should be required to refer a patient to a colleague who would provide the service (Table C, Figure 2). In a number of cases it appears that the respondents did not appreciate that referral involved a moral or ethical issue, and might not have made the recommendation if they had. In others, it appears that the respondents would not have altered their view even if they understood that a moral or ethical issue was involved. Only 4% of responding health care practitioners insisted upon referral (Table D, Figure 3).

> **Summary:** The overwhelming majority of respondents who made submissions through email or regular mail or as discussion forum participants support freedom of conscience for physicians with respect to refusing to provide non-emergency services. In contrast, they offer virtually no support for a policy of mandatory referral by objecting physicians.

On-line Survey: Policy Issues (re: policy statements)

It is instructive to arrange the policy statements in the On-line Survey in order of the level of overall agreement expressed with each (Table F, Figures 8 and 9).

With two exceptions, the reduction in the level of overall agreement corresponded to a reduction in the number of those who "strongly agree," but there was no corresponding increase in the overall level of disagreement. Instead, the overall level of agreement fell because more respondents seemed to be in doubt about how to interpret or apply the statements. They increasingly reported that they "neither agree[d] nor disagree[d]" rather than that they disagreed or didn't know. (Table F, Figures 8 and 9).

This is not surprising, since the proposed policy statements were vague on some critical points, notably what circumstances would trigger an obligation to help find another physician, and whether

or not the other physician must be a provider of the contested service. Similarly, respondents reflecting on an obligation to provide information about "all clinical options" may have wanted to know more about what was meant by the term.

Explanations follow the abbreviated references to the policy statements below.

The physician must communicate clearly and promptly. . . about any treatments or procedures they choose not to provide because of the physician's moral or religious beliefs.

It is common ground that conflicts should be avoided - especially in circumstances of elevated tension - and that they often can be avoided by timely notification of patients, erring on the side of sooner rather than later. Thus, the high level of support for this statement is not surprising. Nonetheless, some doubt or disagreement about it might be attributed to concern about excessive rigidity. Respondents who did not express support for this statement could have had two scenarios in mind.

First: it is unreasonable to expect physicians to anticipate, in advance, every conceivable request that might be made by patients. For example: it would probably be unnecessary for a physician who accepts a 55 year old single woman as a patient to begin their professional relationship by disclosing objections to abortion, and it could well be unsettling for the patient if her medical history included abortion. And, while it is possible that the woman might, six months after being accepted as a patient, ask for an embryo transplant, it does not follow that the mere possibility of such a request imposes a duty on the physician to disclose moral objections to artificial reproduction at their first consultation.

Second: a physician may decline to provide a procedure for medical reasons that are acceptable to his colleagues, but may also have religious or moral reasons for refusal. In such situations, the physician might believe that it is sufficient to advise the patient only of his medical reasons because his decision does not engage his moral or religious beliefs.

The physician must advise patients, or individuals who wish to become patients, that they can see another physician with whom they can discuss their situation if the treatment conflicts with the physician's moral or religious beliefs.

76% of survey respondents agreed with this statement, while disagreement and doubt ("neither agree nor disagree") were almost equal: 11% and 12% respectively (Figures 8 and 9).

The somewhat lower level of support for this statement might be attributed to belief by some respondents that one becomes complicit in a morally contested procedure merely advising a patient of his right to see another physician. Anonymous respondents and members of the general public comprised 90% of the survey participants (Table B, Figure 1), and this view may be more common outside the medical profession. In fact, the Project has not encountered an objecting physician who would refuse to advise patients that they can see a colleague.

Physicians should not express personal judgments about the beliefs, lifestyle, identity or characteristics of a patient or an individual who wishes to become a patient.

A clear majority of respondents support the idea that physicians must not "express personal judgments" about the beliefs, lifestyle identity or personal characteristics of patients. The level of agreement drops to 71%, and the level of doubt is about the same, but here we encounter the first exception to the general trend. In this case, the level of disagreement rises from 11% to 17% (Figure 7). Disagreement and doubt on this point are probably attributable to concern about excessive rigidity, for two reasons.

A clear majority of respondents supported the idea that physicians must not "express personal judgments" about the beliefs, lifestyle identity or personal characteristics of patients. The level of agreement dropped to 71%, and the level of doubt was about the same, but here we encounter the first exception to the general trend. In this case, the level of disagreement rises from 11% to 17%. Disagreement and doubt on this point are probably attributable to concern about excessive rigidity, for two reasons.

First: many conditions treated by physicians are the result of patient choices about diet and exercise, the use of alcohol, tobacco and illicit drugs and other risk-taking behaviours: sometimes, even, of criminal misconduct. Most people would agree that physicians are entitled to express judgements about patient choices that are relevant to health. However, such judgements involve a degree of subjective evaluation, and patients may not appreciate the distinction between a "personal" and a "professional" judgement. This may be further complicated for physicians whose religious beliefs conflict with patient choices, as when a religion proscribes the use of alcohol and/or tobacco. Will they be accused of violating this guideline, even if their advice is based on the same clinical reasoning and couched in the same clinical terms as that of a colleague who does not share their beliefs?

Second: there may be concern that ideologues will treat *bona fide* compliance with the first policy statement (communicate clearly and promptly) as a violation of this guideline. After all, a physician cannot express a conscientious objection without first forming the judgement that the treatment is immoral. It is reasonable to believe that the communication of the objection, which the College requires, will cause patients to infer (correctly) the beliefs of the physician about a contested treatment. Patients may thus "feel judged" by the physician, even if the physician's judgement pertains to the morality of the procedure rather than the personal culpability of the patient. It would be unjust to require physicians to disclose conscientious objections to patients and discipline them if a patient resents their beliefs, but fear of this outcome may explain why more respondents disagreed with this policy statement.

Physicians must not promote their own moral or religious beliefs when interacting with patients.

We encounter the second exception to the general trend in the case of the proposed policy statement against promoting one's own beliefs. The level of agreement drops to 61%, the level of disagreement rises to 23% and doubt increases to 15% (Figure 8). Once more, the most likely explanation for this is that if a physician communicates an objection to a procedure or service (as required by the first

guideline), a patient may well challenge his objection. A physician may, quite reasonably, provide further explanation, but then face an accusation that he was "promoting his own beliefs." On the other hand, if he fails to respond to the patient's challenge, the patient may conclude that he is acting arbitrarily, unlawfully discriminating, has something to hide, or is unable to defend his position. It is not surprising to find less support for a policy that may be perceived to contribute to this kind of no-win scenario.

The physician must provide information about all clinical options that may be available or appropriate based on the patient's medical needs or concerns, even if the treatment options conflict with the physician's moral or religious beliefs.

The requirement that physicians provide information about all clinical options enjoys the same level of overall agreement as the preceding statement (61%), but the level of disagreement falls to 9% and number of responses indicative of doubt increases to 23% (Figure 8). Here, the lower level of overall support and much higher level of doubt are most likely explained by concern about complicity and the possibility that euthanasia or assisted suicide may be legalized.

Those who object to X for reasons of conscience may hold that "merely" providing information is not necessarily a morally or ethically neutral act: that providing information can make one complicit in morally contested procedures. This position is neither unique nor unreasonable. In fact, it is held by the General Medical Council of the United Kingdom,[14,15] and the American Medical Association.[16] It was formerly the position of the College of Physicians and Surgeons of BC.[17,18,19] (See also the comment of the Catholic Archbishop of Toronto, below.)

The possibility that euthanasia and assisted suicide might be legalized by a case pending in the Supreme Court of Canada may also have influenced responses. Physicians who believe that they should never be involved in killing patients because patients are especially vulnerable to abuse may also believe that, in the absence of a patient request, even advising patients of the option of assisted suicide or euthanasia is an intrinsically abusive act.

In some circumstances, the physician must help the patient or individual make arrangements to see another physician with who they can discuss their situation if the treatment conflicts with the physician's moral or religious beliefs.

As noted above, the possibility of the legalization of assisted suicide and euthanasia may also have influenced responses under this head. An expectation that an objecting physician must sometimes help a patient find a colleague "with whom they can discuss their situation" does not necessarily amount to a requirement to help the patient obtain a morally contested service. The latter would be unacceptable to many objecting physicians because they believe it would make them complicit in the act. The policy proposal is uncomfortably close to that. The Catholic Archbishop of Toronto made this point in his submission:

> The second expectation "Provide information about all clinical options . . . " and the fourth "Advise patients or individuals . .. " could have the potential for an infringement upon the rights of conscience of a physician, depending on the extent to which he or she is required to become actively involved in

> facilitating actions which go against his or her conscience. A lot depends on what is involved in "help the patient or individual make arrangements to do so."[20]

Hence, it is not surprising that the level of agreement in this case drops to 55%, the level of "strong agreement" drops dramatically to 39%, the level of disagreement is double that of the preceding guideline, and the level of doubt rises to 26% (Figures 8 and 9).

> **Summary:** Levels of support for policy statements related to freedom of conscience for physicians decreased when they could be perceived as excessively rigid or vague. Levels of support fell and disagreement and doubt increased when they could be perceived to require complicity in morally contested procedures. On-line Survey responses under this head did not support a policy of mandatory referral. They indicated, instead, that such a policy would be controversial.

On-line Survey: Policy Issues (re: mandatory referral)

When physicians refuse to provide treatments or procedures on the basis of moral or religious belief, do you think those physicians must be required, in all instances, to refer patients to another physician or health care provider who will provide the treatment or procedure?

With respect to a policy of mandatory referral, the change from requests for levels of agreement with a policy statement to a "Yes-No-Don't Know" response prevents comparison with responses to the preceding policy statements, particularly the proposal that objectors should help to arrange for the physician to see a colleague.

However, the issue here was clearly the perennially contentious issue of coerced complicity in morally contested procedures. It is not surprising to find that support for such coercion dropped to 43% and disagreement rose dramatically to 50% (Figure 10).

Moreover, the sample of related comments provided in the Report indicate that the expressed levels of agreement and disagreement are somewhat unstable, depending on factors or nuances not captured by the survey question.

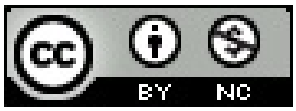
Of the five comments, two (Comment 2 and 5) appeared to have been taken from the "disagree" category, but the latter appears to have been willing to countenance coercion in emergencies.

Two seem to have come from the "agree" category, but only one (Comment 4) clearly favoured coerced participation. The respondent who offered Comment 1 seems to have been unaware that physicians who do not provide a service cannot bill for it, and that prudent objecting physicians may decide not to bill for a consultation that ends in refusal.

Comment 3 could have come from any of the three categories. It reflected some of the ambiguity associated with the term "referral", and a solution that, in the Project's experience, most objecting physicians seem willing to accept.

> **Summary**: Consistent with the responses in the Discussion Forum, On-line Survey

responses did not support a policy of mandatory referral. Rather, they indicated that mandatory referral was a highly controversial subject.



Notes

1. Submission of the Ontario Human Rights Commission to the College of Physicians and Surgeons of Ontario regarding the draft policies relating to establishing and ending physician-patient relationships [Internet]. Toronto, Ontario: Ontario Human Rights Commission; 2008 Feb 14;cited 2021 Jan 17. Available from: http://www.ohrc.on.ca/en/resources/submissions/surgeons.

2. College of Physicians and Surgeons of Ontario. Physicians and the Ontario Human Rights Code (Draft) [Internet]. Powell River, BC: Protection of Conscience Project; 2008 Sep 11; cited 2021 Jan 17. Available from: https://www.consciencelaws.org/archive/documents/cpso/2008-09-11-cpso-app-a-consultation draft.pdf.

3. College of Physicians and Surgeons of Ontario. Physicians and the Ontario Human Rights Code [Internet]. Powell River, BC: Protection of Conscience Project; 2008 Sep 11; cited 2021 Jan 17. Available from: https://www.consciencelaws.org/archive/documents/cpso/2008-09-18-cpso-physicians-hrcode.pdf.

4. Physicians and the Ontario Human Rights Code Consultation: Online Survey Report and Analysis [Internet]. Toronto, Ontario: College of Physicians and Surgeons of Ontario.; 2014 Aug; cited 2021 Jan 17. Available from: http://policyconsult.cpso.on.ca/wp-content/uploads/2014/08/Survey-Report-Human-Rights-FINAL.pdf.

5. Murphy, S. College of Physicians and Surgeons consultation on Physician Obligations and Human Rights (4 June-5 August, 2014): Analysis of results [Internet]. Powell River, BC: Protection of Conscience Project, 2021 Jan 17; cited 2021 Jan 17. Available from: https://www.consciencelaws.org/archive/statistics/2014-08-05-cpso-responses.xlsx.

6. College Consultations: Physicians and the Ontario Human Rights Code [Internet]. Toronto, Ontario: College of Physicians and Surgeons of Ontario; 2019; cited 2021 Jan 17. Available from: http://policyconsult.cpso.on.ca/?page_id=3403.

7. Physicians and the Ontario Human Rights Code - Discussion [Internet]. Toronto, Ontario: College of Physicians and Surgeons of Ontario; 2019; cited 2021 Jan 17. Available from: http://policyconsult.cpso.on.ca/?page_id=3405.

8. Among health care workers, the College identified only physicians (active and retired), categorizing nurses, pharmacists, etc. as members of the public. In this analysis, all active and retired medical students and health care workers are grouped as health care practitioners, based on self-identification by the respondents in the text of their submissions.

9. The College did not distinguish professional medical organizations from other organizations. This analysis makes that distinction.

10. Compulsory referral is considered by many objectors to be a denial of freedom of conscience. Some respondents who expect referral appear not to recognize that and consider their expectation to be consistent with freedom of conscience. Others appear either reject the idea that any moral or ethical issue is involved in referral, or insist that the physicians view must be suppressed in favour of the patient. Rather than attempt a subjective evaluation to distinguish these views as either for or against freedom of conscience, all responses in the form, "if will not provide, must refer" are grouped together.

11. Figure 4 in the CPSO analysis reported "Don't know" as 8%, which would add up to 101%. It is reduced to 7% here to facilitate charting.

12. Balancing MD and patient rights: Human rights draft policy open for consultation. Dialogue [Internet]. 2014 [cited 2021 Jan 17]; 10(4):49-50. Available from: http://www.joomag.com/magazine/dialogue-volume-10-issue-4-2014/0267666001419268812?short.

13. College of Physicians and Surgeons of Ontario. Annual Meeting of Council; 2014 Dec 4-5; 635 p.

14. The General Medical Council (GC) acted on this principle when it disciplined a physician who provided information about the sale of organs but did not actually engage in the practice. The Council found that the doctor had not participated in the organ trade, but that his conduct amounted to "encouragement of the trade in human organs from live donors". Organ trade GP suspended. BBC News [Internet]. 2002 Oct 15 [cited 2021 Jan 18]. Available from: http://news.bbc.co.uk/2/hi/health/2329447.stm.

15. The GC also applied this principle in guidance on assisted cecity Among the kinds of conduct that may constitute illicit facilitation or cooperation in assisted suicide, the GC includes: "encouraging a person to commit suicide, for example, by suggesting it (whether prompted or unprompted) as a 'treatment' option . . .providing practical assistance, for example, by helping a person who wishes to commit suicide to travel to the place where they will be assisted to do so . . . writing reports, knowing or having reason to suspect that the . . . reports would be used to enable the person to obtain encouragement or assistance in committing suicide. . . providing information or advice about other sources of information about assisted suicide, and what each method involves from a medical perspective . . .". Guidance for the Investigation Committee and case examiners when considering allegations about a doctor's involvement in encouraging or assisting suicide [Internet]. United Kingdom: General Medical Council; 2013 Mar [cited 2021

Jan 18]. Available from: https://www.gmc-uk.org/-/media/documents/DC4317_Guidance_for_FTP_decision_makers_on_assisting_suicide_51026940.pdf.

16. The American medical Association prohibits physicians from rendering technical advice or consulting with executioners or "providing . . .knowledge to facilitate the practice of torture." Capital Punishment: Code of Medical Ethics Opinion 9.7.3 [Internet]. American Medical Association; 2021 [cited 2021 Jan 18]. Available from: https://www.ama-assn.org/delivering-care/ethics/capital-punishment. Torture: Code of Medical Ethics Opinion 9.7.5 [Internet]. American Medical Association; 2021 [cited 2021 Jan 18]. Available from: https://www.ama-assn.org/delivering-care/ethics/torture.

17. Lee J. Official slams 'sex selection' blood test: Gender of fetus can be seen five weeks into pregnancy. The Vancouver Sun. 2005 Aug 13.

18. College of Physicians and Surgeons of British Columbia Resource Manual: Fetal Sex Selection Solely for Gender Determination (May, 2010) [Internet]. Powell River, BC: Protection of Conscience Project; 2021 [cited 2021 Jan 18]. Available from: https://www.consciencelaws.org/archive/documents/2010-05-cpsbc-fetal-sex.png.

19. College of Physicians and Surgeons of British Columbia Professional Standards and Guidelines: Disclosure of Fetal Sex [Internet]. Internet Archive Wayback Machine; 2016 May 07 [cited 2021 Jan 18]. Available from: https://web.archive.org/web/20160507193335/https://www.cpsbc.ca/files/pdf/PSG-Disclosure-of-Fetal-Sex.pdf.

20. Collins, Thomas (Archbishop of Toronto, President of the Assembly of Catholic Bishops of Ontario). Letter to: College of Physicians and Surgeons of Ontario. 2015 Aug 05. 3 leaves. [Internet]. Toronto, Ontario: College of Physicians and Surgeons of Ontario; 2012 [cited 2021 Jan 18]. Available from: http://policyconsult.cpso.on.ca/wp-content/uploads/2014/08/Archbishop-of-Toronto-Response.pdf.