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# Submission to the College of Physicians and Surgeons of Ontario

**Re: CPSO Policy Statement #5-08**

***Physicians and the Ontario Human Rights Code***

**3 August, 2014**

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## Abstract

The Ontario Human Rights Commission made a serious error in 2008 when it attempted to suppress freedom of conscience and religion in the medical profession on the grounds that physicians are “providers of *secular* public services.” In publicly perpetuating this error, the Commission has contributed significantly to anti-religious sentiments and a climate of religious intolerance in Ontario. Both were on display earlier this year when it became front page news and a public scandal that three physicians had told their patients that they would not recommend, facilitate or do what they believed to be immoral, unethical, or harmful.

The physicians had followed the guidelines of the Canadian Medical Association and the College of Physicians and Surgeons of Ontario. Physicians must advise patients about treatments or procedures they are unwilling to recommend or provide for moral or religious reasons, so that patients can seek the services elsewhere, but are not required to help patients obtain services or procedures they believe to be wrong.

The arrangement is a compromise that safeguards the legitimate autonomy of patients and preserves the integrity of physicians, but it has been continually attacked by activists who want to compel objecting physicians to provide or facilitate abortion and contraception, and, lately, euthanasia. Essentially, the activists assert that physicians have a duty to do what they believe to be wrong because they must not act upon their moral or religious beliefs.

However, it is incoherent to include a duty to do what one believes to be wrong in a code of ethics, the very purpose of which is to encourage physicians to act ethically and avoid wrongdoing. Moreover, one cannot practise medicine without reference to beliefs, whether they reflect a secular ethic or a religious one, and neither a secular ethic nor a religious ethic is morally neutral. Thus, demands that physicians must not act upon their beliefs or must practise medicine in a morally “neutral” fashion are unacceptable because they are impossible.

The demand that physicians must not act upon *religious* beliefs because medical practice is a secular profession is unacceptable because it is erroneous. The Supreme Court of Canada has acknowledged that a secular society is not faith-free; it includes both religious and non-religious believers, and rational democratic pluralism must make room for them all. The full

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bench of the Court has warned that to disadvantage or disqualify the exercise of religiously informed conscience in public affairs is an illiberal distortion of liberal principles.

If it is legitimate to compel religious believers to do what they believe to be wrong, then it is equally legitimate to compel non-religious believers to do what they think is wrong; everyone would have a duty to do what is believed to be wrong. Hence, the compromise worked out by the Canadian Medical Association not only safeguards the integrity of physicians and legitimate autonomy of patients, but protects the community against the temptation to give credence to a dangerous idea: that a learned or privileged class, a profession or state institutions can legitimately compel people to participate in what they believe to be wrong - even gravely wrong - even murder - and punish them if they refuse.

Freedom of conscience and freedom of religion are not unlimited, but the mantra, “the freedom to hold beliefs is broader than the freedom to act on them” is inadequate. More refined distinctions are required to address the difficulties that arise in a pluralist democracy. One of them reflects the two ways in which freedom of conscience is exercised: by pursuing good and avoiding evil. There is a significant difference between preventing people from seeking perfection by doing the good that they wish to do and destroying their integrity by forcing them to do the evil that they abhor.

As a general rule, it is fundamentally unjust and offensive to force people to support, facilitate or participate in what they perceive to be wrongful acts; the more serious the wrongdoing, the graver the injustice and offence. It is a policy fundamentally opposed to civic friendship, which grounds and sustains political community and provides the strongest motive for justice. It is inconsistent with the best traditions and aspirations of liberal democracy. And it is dangerous, since it instills attitudes more suited to totalitarian regimes than to the demands of responsible freedom.

This does not mean that freedom of conscience exercised to preserve personal integrity can never be limited. It does mean, however, that even the strict approach taken to limiting other fundamental rights and freedoms is not sufficiently refined to be safely applied here. Like the use of potentially deadly force, if the restriction of preservative freedom of conscience can be justified at all, it will only be as a last resort and only in the most exceptional circumstances.

When the College of Physicians and Surgeons of Ontario receives complaints from patients who have been unable to obtain services they want, the College should help connect the patients with willing service providers. That would be more helpful than attempting to suppress freedom of conscience and religion in the medical profession.

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## I. Background

I.1 A realistic appraisal of *Physicians and the Human Rights Code* depends upon an adequate understanding of developments contributing to its formulation, and of developments since.

### I.2 1970-2006: A difficult compromise

I.2.01 Since the early 1970's, the Canadian Medical Association (CMA) has struggled repeatedly to resolve conflicts within the medical profession created by legalization of abortion. A prime source of conflict has been a continuing demand that objecting physicians be forced to provide or facilitate the procedure by referral. An early experiment with mandatory referral by objecting physicians was abandoned after a year because there was no ethical consensus to support it; there is no evidence that the policy was ever enforced.<sup>1</sup>

I.2.02 A difficult compromise has emerged. Physicians are required to disclose personal moral convictions that might prevent them from recommending a procedure to patients, but are not required to refer the patient or otherwise facilitate abortion. The arrangement preserves the integrity of physicians who do not want to be involved with abortion, while making patients aware of the position of their physicians so that they can seek assistance elsewhere. The compromise has been used as a model for dealing with other morally contested procedures, like contraception.

### I.3 2006: The compromise under attack

I.3.01 Nonetheless, some activists, influential academics, powerful interests, state institutions and professional organizations have been working steadily to overthrow the compromise and compel objecting physicians and other health care workers to provide, participate in or facilitate abortion, contraception and related procedures. This was attempted, for example, in a guest 2006 editorial in the *Canadian Medical Association Journal* (CMAJ) by Professors Sanda Rodgers and Jocelyn Downie.<sup>2</sup> The editorial elicited a flood of protest. Dr. Jeff Blackmer, CMA Director of Ethics, reaffirmed Association policy that referral was not required,<sup>3</sup> and the CMAJ declared the subject closed. The negative response caused Professor Downie to redirect her efforts to convince provincial regulatory authorities to adopt coercive policies.<sup>4</sup>

### I.4 2008: OHRC, CPSO and *Physicians and the Human Rights Code*

I.4.01 In 2008, two years after Professor Downie's tendentious CMAJ editorial, the Ontario Human Rights Commission (OHRC) attempted to suppress freedom of conscience in the medical profession in Ontario through the College of Physicians and Surgeons of Ontario (CPSO).<sup>5</sup> The key issue was made clear by a succinct statement in the OHRC's August, 2008 submission:

It is the Commission's position that doctors, as providers of services that are not religious in nature, must essentially "check their personal views at the door" in providing medical care.<sup>6</sup>

I.4.02 The CPSO prepared a new policy, *Physicians and the Human Rights Code*, the draft text

of which clearly reflected the influence of the OHRC. It stated that “there may be times when it may be necessary for physicians to set aside their personal beliefs,” and implied that those who failed to do so faced prosecution for professional misconduct or human rights offences.<sup>7</sup>

- I.4.03 A controversy erupted when news of the draft policy became public.<sup>8</sup> The 25,000 member Ontario Medical Association asked that it be withdrawn, stating, “We believe that it should never be professional misconduct for an Ontarian physician to act in accordance with his or her religious or moral beliefs.”<sup>9</sup>
- I.4.04 The public outcry made it necessary for the President of the College to issue a statement that “the College does not expect physicians to provide medical services that are against their moral or religious beliefs.”<sup>10</sup> An e-mail to physicians repeated this assurance and drew specific attention to concerns raised among respondents to a purported obligation to assist patients in obtaining morally controversial services.<sup>11</sup> Thus, the CPSO President effectively confirmed that the focus of the proposed policy reflected the long-standing activist determination to force physicians to facilitate contraception, abortion and related procedures, even at the cost of violating their religious or moral convictions.
- I.4.05 As a result of the controversy, the College delayed consideration of *Physicians and the Ontario Human Rights Code* and made some revisions to it. However, it kept the revisions secret until the day the document was considered by the College Council, thus preventing comment on it by the public and medical professionals prior to its approval.<sup>12</sup> The revisions deleted the most objectionable language in the policy, which has been in effect since that time.<sup>13</sup>
- I.4.06 The OHRC does not appear to have retreated from its position of marked hostility to freedom of conscience in the medical profession, as its submissions remain on its website without comment or qualification and continue to influence public opinion, as we shall see presently (I.7.07).<sup>14</sup>

## **I.5 2011: Mandatory referral for euthanasia and assisted suicide**

- I.5.01 Since 2008 there have been further developments. Professor Downie was a member of the “expert panel” of the Royal Society of Canada that, in 2011, recommended legalization of euthanasia and assisted suicide. The panel conceded that health care workers might, for reasons of conscience or religion, object to killing patients or helping them kill themselves. Professor Downie and her expert colleagues recommended that such objectors should be compelled to refer patients to someone who would do so.<sup>15</sup> They claimed that this was consistent with “[t]oday’s procedural solution to this problem. . . in Canada as well as many other jurisdictions” with respect to conscientious objection to abortion and contraception (“certain reproductive health services”). Objecting physicians, they declared, are required “to refer assistance seekers to colleagues who are prepared to oblige them.”<sup>16</sup>
- I.5.02 It is not surprising that the authors did not cite a reference to back up this assertion. In Canada, outside of Quebec, there is, in fact, *no* policy that objecting health care

professionals should be compelled to refer for abortions or other morally contested procedures. Given the repudiation of her views by the CMA in 2006 and the very public 2008 brouhaha about *Physicians and the Ontario Human Rights Code*, Professor Downie must have been aware of that. Although compulsory referral policies can be found in some jurisdictions, they are sharply contested. In the state of Victoria in Australia, for example, a physician made public the fact that he refused to refer a woman for a sex selective abortion, challenging the state and professional regulator to charge him for breaking the abortion law or professional misconduct. He was not charged.<sup>17</sup>

## **I.6 2014: Mandatory referral for euthanasia in Quebec**

I.6.01 In June, 2014, the Quebec National Assembly passed *An Act Respecting End of Life Care* (ARELC), which purports to legalize euthanasia by physicians.<sup>18</sup> A physician who does what the *Act* requires in killing a patient will have provided excellent evidence that the killing was intentional, planned and deliberate: first degree murder. It remains to be seen how this constitutional conflict between provincial and federal law will be resolved. Meanwhile, the medical and legal establishment in Quebec is proceeding to implement the law.

I.6.02 As noted previously, Quebec is the only province in Canada in which a regulatory authority requires that physicians who are unwilling to provide a service for reasons of conscience "offer to help the patient find another physician."<sup>19</sup> The gloss provided by the Collège mentions abortion and contraception and emphasizes an expectation of active assistance by the objecting physician to locate, not just another physician, but the services themselves.<sup>20</sup>

I.6.03 During hearings into the bill it was obvious that this provision was understood to require physicians who will not kill a patient to find someone who will. The Quebec Association of Health Facilities and Social Services cited it to underscore its insistence that physicians who refuse to provide euthanasia for reasons of conscience must not be relieved of the responsibility to find a willing colleague.<sup>21</sup>

I.6.04 Professor Jocelyn Downie spoke in favour of the law at legislative hearings in the fall of 2013, but did not address the subject of conscientious objection to euthanasia.<sup>22</sup> However, she and colleagues have drafted a *Model Conscientious Objection Policy for Canadian Colleges of Physicians and Surgeons*. Should euthanasia be allowed, Professor Downie's model policy would codify a requirement that a physicians unwilling to kill patients themselves for reasons of conscience must "must make a referral to another health care provider who is willing and able to accept the patient and provide the service."<sup>23</sup>

## **I.7 2014: Crusade against Ontario NFP-only physicians<sup>24</sup>**

I.7.01 A 25 year old woman could not obtain a prescription for contraceptives at an Ottawa clinic because the physician did not prescribe them for reasons of "medical judgment as well as professional ethical concerns and religious values;" he offered Natural Family Planning (NFP) instead. In accordance with CMA and CPSO guidelines, the woman was advised that she could see another physician if she wanted contraception.

- I.7.02 The young woman drove around the block and obtained the prescription at another clinic.<sup>25</sup> This was not surprising, since birth control services are “widely available” in Ottawa from Ottawa Public Health’s Sexual Health Centre, family doctors and drop-in services at more than 20 satellite locations. Responding to a report of incident, the Medical Officer of Health and the President of the Academy of Medicine of Ottawa urged people to “emphasize and celebrate” the wide availability of birth control services, the morning after pill, referrals for abortion, and vasectomies.<sup>26</sup>
- I.7.03 The physician in question was not forced to do something contrary to his medical judgement and religious beliefs, and the young woman obtained birth control pills by driving around the block. In more tolerant times and places this might have been considered a successful compromise.
- I.7.04 However, in Ottawa in 2014, that three out of 3,924 area physicians<sup>27</sup> did not prescribe The Pill made headlines.<sup>28</sup> A Facebook crusade was launched against the physician and two other NFP-only physicians who decline to prescribe contraceptives. Outraged Facebookers called the physician a “jerk,”<sup>29</sup> a “complete anachronism,”<sup>30</sup> “disgusting,”<sup>31</sup> incompetent,<sup>32</sup> “unethical and unprofessional,”<sup>33</sup> a “worthless piece of \_\_\_\_\_,”<sup>34</sup> a “crummy doctor,”<sup>35</sup> “an idiot,”<sup>36</sup> and judged him to be - *judgemental*.<sup>37</sup>
- Goofballs like this are the best walking arguments for the birth control they don’t believe in.<sup>38</sup>
- He should move to the states, or maybe Dubai, where he will be among his own kind.<sup>39</sup>
- I.7.05 One of the Facebookers made a fairly obvious suggestion that women should go to the clinic and make gratuitous requests for birth control pills, knowing they will be refused, for the sole purpose of fabricating complaints against the physician to the College of Physicians and Surgeons and Ontario Human Rights Commission.<sup>40</sup>
- I.7.06 Other Facebookers urged that formal complaints be lodged. “The only sane solution is to revoke his licence unless he agrees to perform the duties for which he is being paid,”<sup>41</sup> because he had chosen “the wrong damned profession,”<sup>42</sup> he had “no business practicing [sic] family medicine”<sup>43</sup> and “does not deserve to practice in Canada. PERIOD.”<sup>44</sup> A number suggested that the physician was guilty of professional misconduct and even unlawful discrimination.<sup>45</sup> “If this guy is still employed, and complaints aren’t filed against him,” wrote one, “then mission failed.”<sup>46</sup>
- I.7.07 The ‘pro-choice’ group assured their correspondent that they had received “lots of word” that people were calling the physician’s clinic, the College of Physicians and Surgeons, and the Ontario Human Rights Commission.<sup>47</sup> The crusaders posted a link to the OHRC’s February, 2008 submission to the CPSO, the document that led the College to produce *Physicians and the Human Rights Code*.<sup>48</sup>
- I.7.08 In short, it was front page news and a public scandal that three Ottawa physicians had told their patients that they would not recommend, facilitate or do what they believed to be immoral, unethical, or harmful. Consulted by the *Ottawa Citizen* columnist, officials from



the CMA and the CPSO seemed unsure about whether or not there is room for that kind of integrity in the medical profession.<sup>49</sup> A few days later, a reporter with the *Medical Post* expressed doubt that it was even legal.<sup>50</sup>

- I.7.09 As the deadline for submissions on *Physicians and the Ontario Human Rights Code* approached, a *Toronto Star* columnist referred once more to the Ottawa case. “If a doctor is so antediluvian as to be anti-contraception,” he wrote, “he’d best transition from medical to pastoral work. Playing God isn’t in the job description of physicians.”

Doctors don’t deserve special dispensation to discriminate, any more than a pharmacist who refused to fill a prescription for birth control pills. That’s why the College of Physicians and Surgeons must safeguard the public interest this time, not acquiesce yet again to vested interests at the OMA as in 2008.<sup>51</sup>

- I.7.10 It appears that the overwhelming majority of OMA members prescribe contraceptives, so that they can hardly be said to have a “vested interest” in supporting opposition to the practice. It is true, however, that, like all Canadians, they have a vested interest in safeguarding freedom of conscience and religion. Moreover, they may be more acutely aware of the consequences of its suppression. After all, if euthanasia were to be legalized, physicians - not newspaper columnists - will be asked to do the killing.

## II. The Issue

- II.1 As the Toronto columnist demonstrates, the issue has not changed since it was articulated by the OHRC in 2008. Should *Physicians and the Ontario Human Rights Code* be revised to demand that physicians set aside their religious, moral or ethical convictions and impose on them a duty to do what they believe to be wrong?

## III. Context

- III.1 A response to the issue requires the application of principles, the significance of which is affected by the social context within which the policy is to operate.
- III.2 Two factors contribute significantly to the social context that must be considered if *Physicians and the Ontario Human Rights Code* is to be revised: anti-religious secularism and the connection between the “reproductive rights” agenda and euthanasia/assisted suicide.

### III.3 Anti-religious secularism

- III.3.01 What generated the most frequent and heated anathemas in the crusade against the Ottawa physicians was that they were motivated, in part, by “religious values.” The crusaders’ opinions and beliefs seem to have been shaped from infancy by secularism.<sup>52</sup> Thus, they were infuriated by a refusal based on *religious* beliefs. *That* was heresy against the faith in which they had been raised, the response to which was obvious to them; extirpate the heretics: “NO MORE CHRISTIAN DOCTORS”<sup>53</sup>
- III.3.02 That explains why their response was not unlike the witch-hunt whipped up in Montreal after two daycare workers were seen wearing niqabs in a public place on an outing with

the children in their care.<sup>54</sup> It was a wildly disproportionate reaction to news that 0.08% of Ottawa area physicians do not prescribe or refer for contraceptives or abortion (both widely available without referral), or that a young woman had to drive around the block to get birth control pills.

- III.3.03 It is important that the College should not inadvertently inflame anti-religious sentiments and bigotry or contribute to a climate of intolerance by ill-advised revisions to *Physicians and the Ontario Human Rights Code*. It should, instead, encourage a rational pluralism respectful of our fundamental freedoms that adequately accommodates the practical living out of divergent non-religious and religious beliefs. Thus, the plan for careful and extended consultation is welcome.

#### **III.4 From abortion and contraception to euthanasia**

- III.4.01 The arguments now said to justify compelling objecting physicians to provide or refer for abortion and contraception are the same arguments put forward to compel objecting physicians to provide or facilitate euthanasia and assisted suicide. As illustrated by developments in Quebec, compulsion in the former case will inevitably lead to compulsion in the latter.
- III.4.02 When laws governing abortion and contraception became less restrictive almost fifty years ago, the kind of attacks now being made on physicians and other health care workers who decline to provide or facilitate the services was beyond imagining. No one would then have anticipated that the more liberal society they thought they were building would generate the vituperative intolerance now evident in Ontario.
- III.4.03 However, if current atmosphere and trends persist, it is not now beyond imagining that a columnist will eventually proclaim that physicians who are “so antediluvian as to be anti-euthanasia” had better find another job. That is not the approach to rational pluralism or medical ethics one would hope to find in a liberal democracy, and *Physicians and the Ontario Human Rights Code* should avoid encouraging attitudes that may contribute to such an outcome.

#### **IV. Scope and sequence of this submission**

- IV.1 *Physicians and the Ontario Human Rights Code* (POHRC)<sup>55</sup> is divided into two sections. The first concerns the obligation of physicians to avoid unjust discrimination. The second concerns the obligation of physicians to accommodate people with disabilities who are or who wish to become patients. Only the first section is relevant here.
- IV.2 The first part of the document is further subdivided into discussion of clinical competence and discussion of moral or religious beliefs. This submission concerns the discussion of physician freedom of conscience and religion included in the latter subdivision, which concludes with four expectations of physicians who act on moral or religious beliefs in their practices.
- IV.3 The guidance concerning moral or religious beliefs is presumably the basis for the four College expectations and will be addressed in this submission. It is important, because the

document states that “the extent to which a physician has complied with this guidance” will be considered by the College “when evaluating whether the physician’s behaviour constitutes professional misconduct.”<sup>56</sup>

- IV.4 The Project submission concerning POHRC reflects seven principles that ought to inform a policy on freedom of conscience in health care. They are not exhaustive, but are relevant to POHRC because of its history and the current social context. The principles will be stated and briefly explained before being applied in an analysis of the document. The submission will conclude by summarizing recommendations based upon the principles and the critique of the policy.
- IV.5 The Project’s 2008 submission concerning POHRC addressed a number of other issues that will not be reviewed here, such as the needs of the patient or obligations allegedly implied by social contract theory or fiduciary duty. The submission can be consulted online.<sup>57</sup>

## V. Principles

### V.1 Medicine is a moral enterprise.

- V.1.01 The practice of medicine is an inescapably moral enterprise precisely because physicians are always seeking to do some kind of good and avoid some kind of evil for their patients.<sup>58</sup> However, the moral aspect of practice as it relates to the conduct and moral responsibility of a physician is usually implicit, not explicit. It is normally eclipsed by the needs of the patient and exigencies of practice. But it is never absent; every decision concerning treatment is a moral decision, whether or not the physician specifically adverts to that fact.
- V.1.02 This point is frequently overlooked when a physician, for reasons of conscience, declines to participate in or provide a service or procedure that is routinely provided by his colleagues. They may be disturbed because they assume that, in making a moral decision about treatment, he has done something unusual, even improper. Seeing nothing wrong with the procedure, they see no moral judgement involved in providing it. In their view, the objector has brought morality into a situation where it doesn’t belong, and, worse, it is *his* morality.
- V.1.03 In point of fact, the moral issue was there all along, but they didn’t notice it because they have been unreflectively doing what they were taught to do in medical school and residency, and what society expects them to do. Nonetheless, in deciding to provide the procedure they also *implicitly* concede its goodness; they would not provide it if they did not think it was a good thing to do. What unsettles them is really not that the objector has taken a moral position on the issue, but that he has made an *explicit* moral judgement that differs from their *implicit* one.
- V.1.04 Hence, the demand that physicians must not be allowed to act upon beliefs is unacceptable because it is impossible; one cannot act morally without reference to beliefs, and cannot practise medicine without reference to beliefs. Relevant here is a comment by Professor

Margaret Somerville. “In ethics,” she writes, “impossible goals are not neutral; they cause harm.”<sup>59</sup>

**V.2 Consider first the well being of the patient.**

- V.2.01 Consistent with the practice of medicine understood as a moral enterprise, a physician first considers the well-being of the patient.<sup>60</sup> What constitutes or contributes to the “well-being” of a patient is largely determined by a competent patient, not by a physician, though a physician may well contribute to the patient’s decision. However, it does not follow that a physician is always obliged to agree with the patient’s decision or to give effect to it. What happens in the case of such disagreements is largely dependent upon patient and physician concerned and their respective evaluations of what is at stake. More relevant here is the obligation of the physician to offer the patient his best medical judgement about a recommended course of treatment or action, and, in so doing, select treatments that avoid or minimize health risks or adverse side effects.
- V.2.02 Sound medical judgement begins with and remains focussed on the patient and is exercised respectfully. It must be informed by correct science, avoiding or minimizing foreseeable risks or harm. It must seek a reasonably effective response to the needs of the patient, the anticipated benefits of which outweigh potential risks or harms. Medical judgement requires the reasonable exercise of discretion, which is shaped and refined by clinical wisdom born of experience. More could be added, but these elements are essential.
- V.2.03 Physicians are expected to provide patients with accurate information about all legal options available to them, the effectiveness of the methods, adverse effects or risks associated with each, benefits associated with each, and other information that someone in the position of a patient would reasonably want to know. In some cases the physician might have to provide a great deal of information; in others, it may simply be a matter of filling in some gaps in what the patient knows.<sup>61</sup> In all cases, the physician must take care to present the information in a form comprehensible to the patient.<sup>62</sup>
- V.2.04 The physician must disclose whether or not he has religious, ethical or other conscientious convictions that generally preclude him from providing some services or treatments, *even if* medical judgement is central to his practice.<sup>63</sup> The reason for this is that the patient is entitled to be apprised of non-medical factors that may influence a physician’s medical judgement and recommendations. The patient is also entitled to know whether or not the physician’s medical evaluation of the treatment in question is consistent with the general view of the medical profession.<sup>64</sup>
- V.2.05 The physician should invite questions from the patient at different stages in the consultation to ensure that he has been correctly understood.<sup>65</sup> The goal is to ensure that the patient has sufficient information and understanding to make an informed decision about what kind of treatment she will accept. With respect to any reference to his conscientious convictions, unless the patient questions him, asks for further explanation, or otherwise indicates that she does not understand his position, the physician need not and probably should not expand upon the basis for his own position. To do so would likely

invite the accusation that he is “preaching.”<sup>66</sup>

### **V.3 Morality is a human enterprise.**

V.3.01 All public behaviour - how one treats other people, how one treats animals, how one treats the environment - is determined by what one believes. All beliefs influence public behaviour. Some of these beliefs are religious, some not, but all are beliefs. This applies no less to “secular” ethics than to religious ethics. A secular ethic may be independent of religion,<sup>67</sup> but it is not faith-free, nor is it beyond the influence of faith. On the contrary: a secular ethic, like any ethic, is faith-based. That human dignity exists - or that it does not - or that human life is worthy of unconditional reverence - or merely conditional respect - and notions of beneficence, justice and equality are not the product of scientific enquiry, but rest upon faith: upon beliefs about human nature, the meaning and purpose of life, the existence of good and evil.

V.3.02 That everyone is a believer reflects the fact that the practice of morality is a human enterprise,<sup>68</sup> but it is not a scientific enterprise. The classic ethical question, “How ought I to live?” is not a scientific question and cannot be answered by any of the disciplines of natural science, though natural science can provide raw material needed for adequate answers.

V.3.03 Answers to the question, “How ought I to live?” reflect two fundamental moral norms; do good, avoid evil. These basics have traditionally been undisputed; the disputes begin with identifying or defining good and evil and what constitutes “doing” and “avoiding.” Such explorations are the province of philosophy, ethics, theology and religion. Internationally, religion continues to be the principal means by which concepts of good and evil and right and wrong conduct are sustained and transmitted.

V.3.04 Nonetheless, since the practice of morality is a human enterprise, reflections about morality and the development and transmission of ideas about right and wrong also occurs within culture and society outside the framework of identifiable academic disciplines and religions. In consequence, the secular public square is populated by people with any number of moral viewpoints, some religious, some not: some tied to particular philosophical or ethical systems, some not: but all of them believers. There is no reason to deny the freedom to act upon religious belief because it is religious: no reason, that is, apart from anti-religious bigotry.

### **V.4 A secular public square includes religious belief**

V4.01 It is for this reason that the Supreme Court of Canada has recognized that, in Canadian law, “secular” must be understood to *include* religious belief. In his paper, *Seeing Through the Secular Illusion*,<sup>69</sup> Dr. Iain Benson emphasizes this by referring to an explanation supported by the full bench of the Court:

In my view, Saunders J. below erred in her assumption that ‘secular’ effectively meant ‘non-religious’. This is incorrect since nothing in the *Charter*, political or democratic theory, or a proper understanding of pluralism demands that atheistically based moral positions trump

religiously based moral positions on matters of public policy. I note that the preamble to the *Charter* itself establishes that ‘... Canada is founded upon principles that recognize the supremacy of God and the rule of law’. According to the reasoning espoused by Saunders J., if one’s moral view manifests from a religiously grounded faith, it is not to be heard in the public square, but if it does not, then it is publicly acceptable. The problem with this approach is that everyone has ‘belief’ or ‘faith’ in something, be it atheistic, agnostic or religious. To construe the ‘secular’ as the realm of the ‘unbelief’ is therefore erroneous. Given this, why, then, should the religiously informed conscience be placed at a public disadvantage or disqualification? To do so would be to distort liberal principles in an illiberal fashion and would provide only a feeble notion of pluralism. The key is that people will disagree about important issues, and such disagreement, where it does not imperil community living, must be capable of being accommodated at the core of a modern pluralism.<sup>70</sup>

- V.4.02 Thus, the Supreme Court of Canada has acknowledged that secularists, atheists and agnostics are believers, no less than Christians, Muslims, Jews and persons of other faiths. Neither a secular state nor a secular health care system (tax-paid or not) must be purged of the expression of religious belief. Whether or not they are state employees in law or as a matter of public policy, physicians may act upon religious beliefs when practising medicine. The Supreme Court of Canada has acknowledged that rational democratic pluralism must make room for all of them.
- V.4.03 This undercuts the reasoning offered by the OHRC in 2008 for its attempt to suppress freedom of conscience and religion in the medical profession. The Commission, having identified physicians as “providers of *secular* public services”( emphasis added),<sup>71</sup> erroneously presumed that what is “secular” excludes religious belief. In its public perpetuation of this error, the OHRC has contributed significantly to anti-religious sentiments and a climate of religious intolerance in Ontario.
- V.4.04 Further, the approach taken by the Supreme Court of Canada on this issue contradicts the position taken by the OHRC with respect to the *Ontario Human Rights Code*. The OHRC advised the College that “‘moral beliefs,’ per se, are not protected. . .whereas religious beliefs and practices are protected under the ground of ‘creed.’”<sup>72</sup> The reasoning of the OHRC would have the effect of placing atheists and agnostics “at a public disadvantage or disqualification” vis-à-vis religious believers, surely not an outcome consistent with the thinking of the Supreme Court.
- V.5 Avoid authoritarian solutions.**
- V.5.01 Making room in the public square for people motivated by different and sometimes opposing beliefs can lead to conflict, as the present consultation demonstrates. The Supreme Court of Canada has warned that to single out and exclude religious belief in order to prevent or minimize such conflict would “distort liberal principles in an illiberal

fashion.”<sup>73</sup>

- V.5.02 It is also dangerous. It overlooks the possibility that some secularists - like some religious believers - can be uncritical and narrowly dogmatic in the development of their ethical thinking, and intolerant of anyone who disagrees with them. They might see them as heretics who must be driven from the professions, from the public square, perhaps from the country: sent to live across the sea with their “own kind.” University of Victoria law Professor Mary Anne Waldron provides a reminder and a warning:

Conflict in belief is an endemic part of human society and likely always will be. What has changed, I think, is the resurrection of the idea that we can and should compel belief through legal and administrative processes, or, if not compel the belief itself, at least force conformity. Unfortunately, that begins the cycle of repression that, if we are to maintain a democracy, we must break.<sup>74</sup>

- V.5.03 On this point, it is essential to note that a secular ethic is not morally neutral.<sup>75</sup> The claim that a secular ethic is morally neutral - or that one can practise medicine in a morally “neutral” fashion- is not merely fiction. It is, as Professor Jay Budziszewski says, “bad faith authoritarianism . . . a dishonest way of advancing a moral view by pretending to have no moral view.”<sup>76</sup>
- V.5.04 One of the most common examples of “bad faith authoritarianism” is the pretence that referral is an acceptable compromise that balances the respective “interests” of physicians and patients. While that may be the case for many physicians in many situations, it clearly is not the case when it is understood that referral or other forms of facilitation make a physician complicit in wrongdoing.<sup>77</sup>

## **V.6 There is no duty to do what is believed to be wrong.**

- V.6.01 If it is legitimate to compel religious believers to do what they believe to be wrong, then it is equally legitimate to compel non-religious believers to do what they think is wrong. It would, in principle, establish a duty to do what is believed to be wrong for everyone.
- V.6.02 For Andrei Marmor, “a duty to do what is wrong is surely an oxymoron,”<sup>78</sup> and most people would agree, as did Dr. John Williams, then Director of Ethics for the Canadian Medical Association. Speaking in 2002 of physicians who decline to provide or refer for contraceptives for religious reasons, he said, “[They’re] under no obligation to do something that they feel is wrong.”<sup>79</sup>
- V.6.03 When discussion about difficulties associated with the exercise of freedom of conscience in health care is repeatedly characterized as “the problem of conscientious objection,”<sup>80</sup> it becomes clear that the underlying premise is that people and institutions ought to do what they believe to be wrong, and that refusal to do what one believes to be wrong requires special justification. This is exactly the opposite of what one would expect. Most people believe that we should *not* do what we believe to be wrong, and that *refusing* to do what we believe to be wrong is the norm. It is *wrongdoing* that needs special justification or excuse, not *refusing* to do wrong.

- V.6.04 The inversion is troubling, since “a duty to do what is wrong” is being advanced by those who support the “war on terror.” They argue that there is, indeed, a duty to do what is wrong, and that this includes a duty to kill non-combatants and to torture terrorist suspects.<sup>81</sup> The claim is sharply contested,<sup>82</sup> but it does indicate how far a duty to do what is wrong might be pushed. In Quebec, it is now being pushed as far as requiring physicians to participate in killing patients, even if they believe it is wrong: even if they believe that it is first degree murder.<sup>83</sup>
- V.6.05 The difficult compromise described in I.2 safeguards the legitimate autonomy of the patient and preserves the integrity of the physician, but it also protects the community against the temptation to give credence to a dangerous idea: that a learned or privileged class, a profession or state institutions can legitimately compel people to do what they believe to be wrong - even gravely wrong - and punish them if they refuse.
- V.6.06 This, perhaps, was what was troubling a member of the Council of the College of Physicians of Ontario when, in September, 2008, the Council was considering the final draft of *Physicians and the Human Rights Code*. He drew his colleagues’ attention to a chilling *New England Journal of Medicine* article by Holocaust survivor, Elie Wiesel: *Without conscience*.<sup>84</sup> It was about the crucial role played by German physicians in supporting Nazi horrors. “How can we explain their betrayal?” Wiesel asked. “What gagged their conscience? What happened to their humanity?”<sup>85</sup>
- V.6.07 Finally, it would be incoherent to include a duty to do what one believes to be wrong in a code of ethics or ethical guidelines, the very purpose of which is to encourage physicians to act ethically and avoid wrongdoing.
- V.7 Forcing someone to do wrong is violation, not limitation.**
- V.7.01 The OHRC justified its intention to suppress freedom of conscience and religion in the medical profession by quoting a statement of the Supreme Court of Canada: “the freedom to hold beliefs is broader than the freedom to act on them.”<sup>86</sup>
- V.7.02 The statement is certainly correct, and has a pedigree consistent with the OHRC’s intentions; Oliver Cromwell applied the distinction to justify his suppression of the practice of Catholicism in Ireland.<sup>87</sup> However, it is doubtful that the Supreme Court of Canada intended its comment to be put to such use in a liberal democracy.
- V.7.03 The mantra, “the freedom to hold beliefs is broader than the freedom to act on them” is not wrong, but it is inadequate. It is simply not responsive to many of the questions about the exercise of freedom of conscience that arise in a society characterized by a plurality of moral and political viewpoints and conflicting demands. More refined distinctions are required. One of them is the distinction between perfective and preservative freedom of conscience, which reflects the two ways in which freedom of conscience is exercised: by pursuing apparent goods and avoiding apparent evils.<sup>88</sup>
- V.7.04 It is generally agreed that the state may limit the exercise of perfective freedom of conscience if it is objectively harmful, or if the limitation serves the common good. Although there may be disagreement about how to apply these principles, and restrictions



may go too far, no polity could long exist without restrictions of some sort on human acts, so some limitation of perfective freedom of conscience is not unexpected.

- V.7.05 If the state can legitimately limit perfective freedom of conscience by preventing people from doing what they believe to be good, it does not follow that it is equally free to suppress preservative freedom of conscience by forcing them to do what they believe to be wrong. There is a significant difference between preventing someone from doing the good that he wishes to do and forcing him to do the evil that he abhors.
- V.7.06 We have noted the danger inherent in the notion of a “duty to do what is wrong.” Here we add that, as a general rule, it is fundamentally unjust and offensive to suppress preservative freedom of conscience by forcing people to support, facilitate or participate in what they perceive to be wrongful acts; the more serious the wrongdoing, the graver the injustice and offence. It is a policy fundamentally opposed to civic friendship, which grounds and sustains political community and provides the strongest motive for justice. It is inconsistent with the best traditions and aspirations of liberal democracy, since it instills attitudes more suited to totalitarian regimes than to the demands of responsible freedom.
- V.7.07 This does not mean that no limit can ever be placed on preservative freedom of conscience. It does mean, however, that even the strict approach taken to limiting other fundamental rights and freedoms is not sufficiently refined to be safely applied to limit freedom of conscience in its preservative form. Like the use of potentially deadly force, if the restriction of preservative freedom of conscience can be justified at all, it will only be as a last resort and only in the most exceptional circumstances.

## **VI. Review of *Physicians and the Human Rights Code (POHRC)***

### **VI.1 Moral or religious beliefs**

- VI.1.01 In a statement obviously intended to encourage respect and deference, the policy acknowledges that “[p]ersonal beliefs and values and cultural and religious practices are central to the lives of physicians and patients.”<sup>89</sup>
- VI.1.02 The grouping might be understood as implying that beliefs, values, and cultural and religious practices are all more or less the same sort of thing. They are not, although they may be closely related and even intertwined. The focus of POHRC is *belief*: more specifically, moral or religious beliefs that motivate conduct. Nonetheless, the encouragement of an attitude of respect and deference encompassing a broader range of human goods is welcome.
- VI.1.03 Respect for religious belief or freedom of religion must include more than respect for “religious *practices*,” the term used in the text. While religious belief is expressed in specifically religious practices, like fasting during Ramadan or praying, it is also frequently expressed by adherence to a religiously informed moral code. Moreover, in a number of religious traditions, conduct motivated by religious belief is considered of equal or greater significance than religious practices.
- POHRC should avoid language that could be taken to mean that “freedom of religion”

means only “freedom of *worship*” or the freedom to indulge in specifically religious *practices*.

- POHRC should explicitly affirm that freedom of conscience and religion includes the freedom to act upon moral or religious convictions.

VI.1.04 The opening sentence under the heading “moral or religious beliefs” states:

“If physicians have moral or religious beliefs which affect or may affect the provision of medical services, the College advises physicians *to proceed cautiously . . .*” (emphasis added)<sup>90</sup>

VI.1.05 The reason for this advice is given later. Physicians who “restrict medical services offered” or “end physician-patient relationships” for reasons “based on physicians’ moral or religious beliefs” may be prosecuted by the Ontario Human Rights Commission (OHRC) for violations of the *Human Rights Code*.<sup>91</sup>

VI.1.06 The first sentence of this section implies that it is unusual for physicians to be influenced by moral or religious beliefs in providing medical services: that, as a rule, the practice of medicine is a morally neutral enterprise. This is not only untrue; it is impossible. Every decision with respect to the provision of medical services and every decision to end a physician-patient relationship engages moral or religious beliefs, if only implicitly (V.1, V.3, V.4). To provide or refer for abortion, contraception or euthanasia involves moral judgement, just as refusing to do so involves moral judgement. The assertion that one decision is morally neutral and the other is morally charged is an example of “bad faith authoritarianism.” (V.5)

VI.1.07 The warning that physicians should *proceed cautiously* if their decisions are influenced by moral or religious beliefs, while understandable in view of the aggressive tendencies of the OHRC, suggests that the exercise moral judgement by physicians is barely tolerable, when, in fact, it is an inescapable aspect of human life, including the practice of medicine (V.1, V.3, V.4).

VI.1.08 POHRC is specifically concerned with restricting or refusing to provide or facilitate services *primarily* for reasons of conscience or religion. Such decisions are always motivated by a desire to avoid complicity in wrongdoing. The implication of the warning to “proceed cautiously” and reference to the threat posed by the OHRC implies that refusal to do what one believes to be wrong needs to be defended, and may even be indefensible. This is a perversion of fundamental moral and ethical principles. (V.6)

- POHRC should avoid language that suggests that medical decision-making is morally neutral.
- POHRC should avoid language that implies that only religious believers bring their beliefs to bear in medical decision-making.
- POHRC should avoid language that suggests that people may be obliged to do what they believe to be wrong.

- POHRC should convey the message that the practice of medicine always entails the exercise of moral or ethical judgement, which may or may not be informed by religious belief.

## VI.2 **Ontario *Human Rights Code*: Current Law**

- VI.2.01 Physicians who decline to do something they believe to be wrong are concerned to avoid complicity in wrongdoing, not with the personal characteristics, status or inclinations of a patient.
- VI.2.02 For example, a physician who believes that sexual intercourse outside marriage is immoral may decline to prescribe oral contraception for an unmarried patient because he does not want to become complicit in extra-marital sexual activity. The marital status of the patient is relevant to his moral reasoning, but it is complicity in conduct that concerns him, not marital status.<sup>92</sup> The same physician might have no objection to prescribing an oral contraceptive for an unmarried patient in order to treat a disorder of some kind.
- VI.2.03 POHRC admits that “the College does not have the expertise or the authority to make complex, new determinations of human rights law,”<sup>93</sup> and prefaces its guidance with a warning:
- The law in this area is unclear, and. . . the College is unable to advise physicians how the Commission, Tribunal or Courts will decide cases where they must balance the rights of physicians with those of their patients.<sup>94</sup>
- VI.2.04 Nonetheless, POHRC states that “compliance with the [*Human Rights*] *Code* is one factor the College will consider” when adjudicating complaints of professional misconduct.<sup>95</sup>
- VI.2.05 Having admitted that the College lacks expertise in human rights law, that the law is unclear, and that the College cannot anticipate how commissions, tribunals and courts will rule in cases involving rights conflicts between physicians and patients, prudence suggests that compliance with the *Code* should not be a factor in the College’s assessment of a case except in the very clearest of cases.
- VI.2.06 Complaints involving physicians who have declined to do something for reasons of conscience or religion are not the clearest of cases. The profound and complex issues involved and the far-reaching consequences of decisions in such cases afford the College good reason to confine its review to issues clearly within its competence.
- In adjudicating allegations of professional misconduct, the College should confine itself to matters within its competence, leaving the investigation of alleged violations of the *Human Rights Code* to the OHRC.
  - POHRC should be revised to reflect this change. Nonetheless, it might warn physicians that an allegation of professional misconduct might lead to an investigation by the OHRC.
- VI.2.07 **“No hierarchy of rights”**: According to *Physicians and the Ontario Human Rights Code*,

“there is no hierarchy of rights in the *Charter*; freedom of religion and conscience, and equality rights are of equal importance.”<sup>96</sup>

VI.2.08 In the relevant passage in the judgement cited to support the statement, the Court addressed arguments that “religions whose beliefs preclude the recognition of same-sex marriage could find themselves required to participate in such marriages, or be discriminated against because of their beliefs.” The Court, however, did not think the concern was valid, because “there is no hierarchical list of rights in the *Charter*, and freedom of religion and conscience must live together with s. 15 equality rights.”

One cannot trump the other. . . the equality rights of same-sex couples do not displace the rights of religious groups to refuse to solemnize same-sex marriages which do not accord with their religious beliefs. Similarly, the rights of religious groups to freely practise their religion cannot oust the rights of same-sex couples seeking equality, by insisting on maintaining the barriers in the way of that equality.<sup>97</sup>

VI.2.09 The Court was considering an argument in the form of a hypothetical scenario: religious believers confronted by an equality rights claim made in order to force them to provide a service they believed to be wrong. That is, the equality rights claim was in conflict with *preservative* freedom of conscience or religion (V.7), although the distinction was not recognized. The scenario is analogous to that of a physician confronted by the OHRC asserting that equality rights trump freedom of conscience.

VI.2.10 The Court held that, in the scenario presented, the consequence was a draw. Note, in particular, that the court did not see the refusal of the religious believers as a “barrier.” The “barriers” in question were marriage laws, which the plaintiffs were challenging. By analogy, the refusal of a physician to do what he believes to be wrong should not be construed as a “barrier”; “barriers,” if they exist, are things of another kind: the unavailability of alternative methods of access, for example.

- POHRC should make clear that the College does not construe a refusal to provide or participate in a procedure or service for reasons of conscience as a “barrier” or “obstacle” to services;
- POHRC should make clear that, since there is no judicially recognized rational ordering of fundamental rights and freedoms, the College will not use rights claims to suppress them, but will try to resolve the conflict by accommodation.

VI.2.11 **No ‘interference’:** *Physicians and the Ontario Human Rights Code* asserts that the “[f]reedom to exercise genuine religious belief does not include the right to interfere with the rights of others.”<sup>98</sup>

VI.2.12 The single sentence in the case to which this statement refers appears a part of the judgement that discusses the failure of the BC College of Teachers to balance religious freedom against other freedoms.

Students attending [Trinity Western University] are free to adopt

personal rules of conduct based on their religious beliefs provided they do not interfere with the rights of others. Their freedom of religion is not accommodated if the consequence of its exercise is the denial of the right of full participation in society.<sup>99</sup>

- VI.2.13 To construe a refusal to participate in wrongdoing as “interference” would be inconsistent with the view expressed two years later by the Supreme Court of Canada in *Barbeau* (VI.2.09).
- VI.2.14 The word “genuine” does not appear in the judgement cited to support this statement,<sup>100</sup> and it is not clear what purpose the word serves in POHRC. Unfortunately, it could be understood to convey an attitude prejudiced against or suspicious of religious belief, and could inadvertently encourage anti-religious sentiment exemplified by the crusade against the Ottawa physicians.
- VI.2.15 Whatever significance one attaches to “genuine,” it is erroneous to apply this statement only to *religious* beliefs, and could leave the impression of an intention to privilege *non-religious* beliefs and discriminate against *religious* beliefs. Such an impression would be inconsistent with the view of the Supreme Court of Canada in *Chamberlain* (V.4) and would tend to foster prejudice against religious believers.
- VI.2.16 The substantive meaning of POHRC’s assertion turns in the first place, upon the validity of the rights claims asserted. In Quebec, for example, the *Act Respecting End of Life Care* (ARELC) claims that a patient has a right to euthanasia. Quite apart from constitutional issues, like many of the rights claims made with respect to demands made upon physicians, this claim is disputed on moral and ethical grounds.
- VI.2.17 The question in the present context is whether or not a physician’s refusal to participate in what he believes to be wrong constitutes “interference” with a patient’s “rights.” However, leaving aside the validity of the rights claim and *Barbeau* (VI.2.09), the demand by a patient that a physician do what he believes to be wrong can *also* be characterized as “interference” with the physician’s “rights.” It can even be said to have a “detrimental impact” (a consideration in the judgement) on the delivery of health care, since it can hardly be maintained that medical ethics will be vastly improved if the only physicians permitted to practice are those willing to do what they believe to be wrong.
- VI.2.18 More important, to characterize a refusal to do what one believes to be wrong as an “interference” with the rights of another would necessarily imply the incoherent conclusion that physicians have an ethical duty to do what they believe to be wrong (V.6).
- POHRC should make clear that the College does not consider a refusal to provide or participate in a procedure or service for reasons of conscience to constitute “interference” with the rights of others.
- VI.2.19 Limits to freedom:** According to *Physicians and the Ontario Human Rights Code*, “the right to freedom of religion is not unlimited; it is subject to such limitations as are necessary to protect public safety, order, health, morals or the fundamental rights or freedoms of others.”<sup>101</sup>

- VI.2.20 This statement, taken from a well-known ruling by the Supreme Court of Canada, is offered by POHRC as a principle supporting the limitation of religious freedom. In the cited case, the Court struck down the *Lord's Day Act* because its "acknowledged purpose" was "the compulsion of religious observance" and employed "a form of coercion inimical to the spirit of the *Charter*," thus offending its guarantee of freedom of religion and conscience.<sup>102</sup>
- VI.2.21 The part of the judgement from which the wording of POHRC is drawn deserves to be quoted at somewhat greater length:
- A free society is one which aims at equality with respect to the enjoyment of fundamental freedoms, and I say this without any reliance upon s. 15 of the *Charter*. Freedom must surely be founded in respect for the inherent dignity and the inviolable rights of the human person. . . .
- . . . One of the major purposes of the *Charter* is to protect, within reason, from compulsion or restraint. Coercion includes not only such blatant forms of compulsion as direct commands to act or refrain from acting on pain of sanction, coercion includes indirect forms of control which determine or limit alternative courses of conduct available to others. Freedom in a broad sense embraces both the absence of coercion and constraint, and the right to manifest beliefs and practices. Freedom means that, subject to such limitations as are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others, no one is to be forced to act in a way contrary to his beliefs or his conscience.<sup>103</sup>
- VI.2.22 In other words, the case quoted by POHRC to justify the *limitation* of religious freedom was actually about the *importance* of religious freedom and the need to protect religious minorities "from the threat of 'the tyranny of the majority'" - arguably represented, in this case, by the Facebook crusade against the three Ottawa physicians.
- VI.2.23 Moreover, in referring to circumstances that would justify the limitation of freedoms, the Court was speaking in general terms, making no distinction between the exercise of perfective and preservative freedom of conscience (V.7).
- VI.2.24 The preceding discussion indicates that the exercise of preservative freedom of conscience cannot be construed as a threat to the fundamental rights and freedoms of others. The case cited by POHRC indicates that, if the College intends to force a physician "to act in a way contrary to his beliefs or conscience" by compelling him to do what he believes to be wrong, the onus is on the College to demonstrate that the refusal of a physician to do what he believes to be wrong is unsafe, disorderly, unhealthy, or immoral.
- POHRC should make clear that the College will not force a physician to participate in procedures or services to which he objects for reasons of conscience unless it can demonstrate<sup>104</sup> that his refusal is unsafe, disorderly, unhealthy, or immoral.

- VI.2.25 Context:** *Physicians and the Ontario Human Rights Code* states that “balancing of rights must be done in context,” and that “courts will consider how directly the act in question interferes with a core religious belief.” Further:
- [c]ourts will seek to determine whether the act interferes with the religious belief in a ‘manner that is more than trivial or insubstantial.’ The more indirect the impact on a religious belief, the more likely courts are to find that the freedom of religion should be limited.<sup>105</sup>
- VI.2.26 Contrary to the impression created by POHRC, neither of the cases cited to support these statements refers to - let alone distinguishes between - direct and indirect impacts on religious belief. Neither of the cases cited uses the term “core” religious belief.
- VI.2.27 In *Ross v School District No. 15* the Supreme Court of Canada considered the case of a teacher who, when not working, was locally notorious for his virulently anti-semitic public statements and writings that were reasonably perceived to have poisoned the school environment against Jewish students.<sup>106</sup> The Court in *Ross* was not asked to consider the limitation of what is here called *preservative* freedom of conscience or religion, and the facts in *Ross* bear no resemblance to circumstances in which a physician refuses to do what he believes to be wrong.
- VI.2.28 Concerning the nature of religious belief, the principal value of *Syndicat Northcrest v. Amselem* is found in the Supreme Court’s affirmation that neither the state nor its courts are qualified to “to interpret and determine the content of a subjective understanding of a religious requirement.” It is open to the court only “to inquire into the sincerity of a claimant’s belief, where sincerity is in fact at issue.”<sup>107</sup>
- VI.2.29 “Trivial or insubstantial”:** *Syndicat Northcrest* resulted in a split 5-4 decision. Five judges found that infringement of rights had occurred and that it was *not* trivial or insubstantial; three ruled there was *no* infringement, except with respect to one of the appellants, which they found to be legitimate; one held that an infringement had occurred but was justifiable in view of the rights of others. The differing views of the judges and a ruling by the bare majority demonstrates the unpredictable nature of “rights-balancing” exercises that depend, ultimately, on an adjudicator’s subjective views about the relative importance of religious belief and other social concerns.
- VI.2.30 As *Syndicat Northcrest* demonstrates, the introduction of the terms “trivial” and “insubstantial” is meaningless in the absence of any ordering principle or standard by which something can be judged to be trivial or insubstantial, so the terminology does not shed any additional light on the problem of balancing conflicting rights and freedoms.
- VI.2.31 However, the reasoning leading to the distinction between preservative and perfective freedom of conscience is helpful because it provides a rational basis for the assertion that a violation of preservative freedom of conscience or religion - such as forcing a physician to do what he believes to be wrong - is never trivial or insubstantial (V.7)
- POHRC should avoid language that suggests that the College or other state institutions can decide what constitutes a “core” religious belief.

- POHRC should acknowledge that forcing physicians to do what they believe to be wrong is never a trivial or insubstantial matter.

### VI.3 College Expectations

- VI.3.01 Disclosure:** The requirement that physicians communicate clearly and promptly to patients what treatments or procedures they will not provide because of moral or religious beliefs is sensible. Concerning notice to patients, 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.<sup>108</sup>
- VI.3.02 Questions sometime arise about when such notice should be given. Holly Fernandez-Lynch insists that physicians fully disclose their objections to patients when they first accept them, reiterate them if they become relevant to treatment options, and notify patients if their views change.<sup>109</sup>
- VI.3.03 However, inflexible notification protocols do not serve the interests of either patients or physicians. 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 includes 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.
- VI.3.04 Interests of patients and physicians are better served by open and continuing communication. On the part of the physician, this involves a special responsibility to be attentive to the spoken and unspoken language of the patient, and to respond in a caring and truthful manner.
- If the College believes POHRC should provide more detail about the expectation of disclosure, it might add that a physician should disclose his position when it would be apparent to a reasonable and prudent physician that a conflict is likely to arise concerning treatments or services he declines to provide. In many cases - but not all - this may, indeed, be when a patient is accepted. The same holds true for notification of patients when a physician's views change significantly.
- VI.3.05 Providing information:** *Physicians and the Ontario Human Rights Code* states that physicians must provide information and advice to patients about all available procedures, even if they conflict with their moral or religious beliefs. The expectation presumes either that the mere giving of information or advice has no moral significance, or, if it does, that it is inconsequential. This is not necessarily the case.
- VI.3.06 This is demonstrated by the policies of the AMA on physician participation in execution and torture. The AMA prohibits physicians from rendering technical advice or consulting with executioners<sup>110</sup> or “providing . . .knowledge to facilitate the practice of torture.”<sup>111</sup> It is also demonstrated by the policy of the College of Physicians and Surgeons of British Columbia, which forbids disclosure to the parents of the sex of a child *in utero*.<sup>112</sup> Finally,



in 2002, the General Medical Council in the United Kingdom suspended the license of a physician for six months because he had provided information about live donor organ transplantation to undercover reporters and had thus encouraged the trade in human organs, even though he had not actually participated in the trade.<sup>113</sup>

- VI.3.07 The difficulty here is to balance the desire of a physician to avoid complicity in a wrongful act with the importance of informed decision-making by the patient, which requires that the patient have all of the information relevant for the purpose of choosing a course of treatment. It is necessary to respect both the freedom of conscience of the physician and the freedom and right of the patient to make a fully informed choice.
- VI.3.08 One satisfactory compromise would see the physician explain all legal options, including those he finds morally objectionable, and disclose the fact and reasons for his objections. In this way, the patient obtains the information he requires to make a fully informed choice, but the physician has not compromised his own integrity by appearing to recommend a procedure that he considers morally objectionable. In such circumstances it is important for the physician to convey his position in a manner that does not provoke justifiable concern about “preaching” or attempting to “convert” the patient to his opinion.
- VI.3.09 Note that the legalization of euthanasia and assisted suicide may make it difficult to maintain this compromise. Many physicians who object to euthanasia and assisted suicide for reasons of conscience believe that even to suggest the possibility of euthanasia or suicide to a vulnerable patient is abusive and harmful, particularly if the suggestion comes from a physician or other people in positions of authority or intimacy.
- VI.3.10 Treating with respect:** The expectation that a physician treat patients with respect includes the caution that physicians must “not express personal judgements about the beliefs, lifestyle, identity or characteristics of a patient.”<sup>114</sup>
- VI.3.11 This could be understood to preclude even discussion about smoking, the need for a change of diet or an increase in exercise. Health and lifestyle are usually related.
- VI.3.12 As amply illustrated by the crusade against the Ottawa physicians, physicians who comply with the requirement to disclose treatments or procedures they will not provide because of moral or religious beliefs may be accused of being “judgemental.”
- The expectation should be clarified to ensure that it does not inadvertently restrict physician-patient communication about health issues.
  - The expectation should be clarified to ensure that a physician will not be considered to have passed a personal judgement on a patient simply because he has complied with ethical guidelines that require him to disclose views that may influence his recommendations for treatment.
- VI.3.13 Physicians who comply with the ethical requirement to disclose moral or religious views that may influence medical decision making may sometimes have to provide further information about their reasoning to make themselves understood and to avoid giving offence to a patient. Unfortunately, this can be misconstrued as a form of preaching or

evangelization.

- POHCR should make clear that physicians will not be considered to be promoting their own religious beliefs or seeking to convert patients simply because they have complied with ethical guidelines that require him to disclose views that may influence his recommendations for treatment.

**VI.3.14 Help to find a physician:** Physicians who refuse to provide some treatments or services for reasons of conscience or religion will not normally have any difficulty in meeting the first three expectations of the College, but the fourth expectation ends on a potentially problematic note. *Physicians and the Ontario Human Rights Code* states:

Advise patients or individuals who wish to become patients that they can see another physician with whom they can discuss their situation and in some circumstances, help the patient or individual to make arrangements to do so.<sup>115</sup>

VI.3.15 The expectation that objecting physicians will advise the patients that they can see another physician is unremarkable. That has been at least an implied expectation for decades (I.2.02). The additional requirement to help the patient find another physician could be problematic, depending upon how it is interpreted.

VI.3.16 If ‘helping’ means simply directing the patient to the yellow pages or College of Physicians or local lists of clinics, it is unlikely to be contentious. The Project’s experience has been that objecting physicians are willing to do that.

VI.3.17 If, however, the requirement is understood to mean that the physician must help the patient find someone to provide the morally contested service by referral or some other means, that would be highly objectionable to physicians who believe that, by doing so, they would be morally culpable for what followed. Ironically, the issue was concisely and accurately stated by Dr. Charles Bernardin, the President of the Collège des Médecins du Québec. Speaking at a legislative committee hearing into what later became Quebec’s euthanasia law, Dr. Bernardin explained:

[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. / [Original French] Parce que, si on a une objection de conscience puis c'est nous qui doit 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.<sup>116</sup>

VI.3.18 The admission was ironic because, as previously noted, (I.5.02, I.6.02) Quebec is the only province in which the physician regulator demands that objecting physicians assist patients to obtain morally contested procedures. Here, Quebec’s chief physician regulator admitted that this policy nullifies freedom of conscience.

VI.3.19 More interesting yet, it is obvious from his testimony that this made him uneasy. Thus, Dr. Bernardin was pleased with the provision in the euthanasia law that allows a physician who refuses to kill a patient for reasons of conscience to notify a designated health systems

administrator, who assumes responsibility for finding a physician who will. Dr. Bernard felt that solved the problem of complicity, at least for the objecting physician. Concerning this arrangement, he said, "We like it a lot."<sup>117</sup>

- VI.3.20 Dr. Bernardin liked it because it sidestepped the problem he anticipated if the Collège des Médecins du Québec tried to apply the mandatory referral policy by forcing unwilling physicians to find someone willing to kill their patients. His discomfort about the anticipated problem and his relief that the euthanasia law might allow the Collège to sidestep it reflected his intuitive awareness that the policy is mistaken.
- VI.3.21 As a general rule, it is fundamentally unjust and offensive to human dignity to require people to support, facilitate or participate in what they perceive to be wrongful acts; the more serious the wrongdoing, the graver the injustice and offence (V.6, V.7). It is thus a serious error to include such a requirement in a code of ethics. College representatives were aware of this because, in the words of Project advisor Jay Budziszewski, this is one of those things we can't not know, though we may not know them "with unfailing perfect clarity" or have worked out "their remotest applications."<sup>118</sup>
- VI.3.22 An absence of clarity or sufficient reflection may explain why this error was not apparent to Collège des Médecins du Québec representatives with respect to contraception and abortion, but it became intuitively obvious to them when the subject shifted from facilitating access to birth control to facilitating the killing of patients.<sup>119</sup>
- VI.3.23 The fundamental moral and ethical principle that there can be no duty to do what one believes to be wrong is recognized in practice in the CMA policy on referral for abortion, and it was clearly the basis for the statement of the Ontario Medical Association in its response to the first draft of Physicians and the *Ontario Human Rights Code*: "We believe that it should never be professional misconduct for an Ontarian physician to act in accordance with his or her religious or moral beliefs."<sup>120</sup>
- VI.3.24 And the moral or religious beliefs of many objecting physicians includes the conviction that if they help a patient to obtain a morally contested procedure, they are morally complicit in wrongdoing. Speaking to this issue, Dr. John R. Williams, a former CMA Director of Ethics and now Director of Ethics for the World Medical Association,<sup>121</sup> said "[Physicians are] under no obligation to do something that they feel is wrong."<sup>122</sup>
- VI.3.25 The expectation of the College is that an objecting physician will help a patient "in some circumstances" to arrange to see another physician. Under what circumstances would this not, in Dr. Bernardin's words, nullify freedom of conscience? Briefly, when the physician is satisfied that the assistance he renders does not make him complicit in wrongdoing.
- The expectation that objecting physicians will, in some circumstances, help patients to find another physician should be clarified by adding that the expectation must not be understood to imply that the physicians have a duty to facilitate what they believe to be wrong.

- VI.3.26 For some reason, *Physicians and the Ontario Human Rights Code* does not follow relevant Canadian ethical guidance like the CMA policy on *Induced Abortion*<sup>123</sup> or the CMA approved *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care*.<sup>124</sup> Instead, its expectations follow those in *Personal Beliefs and Medical Practice*, a policy document produced by Britain's General Medical Council (GMC) in 2008.<sup>125</sup> The GMC document was updated in 2013.<sup>126</sup>
- VI.3.27 The sections of both the 2008 and 2013 versions of the British document relevant to referral or facilitation have ignored evidence concerning a euthanasia bill taken in 2004 and 2005 by a House of Lords Select Committee, and the conclusions of the Committee. These were brought to the attention of the GMC in a Project submission in 2013.<sup>127</sup> The bill, in its original form, included a requirement that objecting physicians refer patients to another colleague for euthanasia. Numerous submissions protested this provision because it made objecting physicians a moral party to the procedure.<sup>128</sup> The Joint Committee on Human Rights concluded that the demand was probably a violation of the European Convention on Human Rights.<sup>129</sup> The bill's sponsor, Lord Joffe, accepted the finding, and removed the requirement for referral. Indeed: he recognized the need to respect freedom of conscience for "the whole medical team, including the nurses and social workers and everybody involved."<sup>130</sup>
- VI.3.28 Since the College elected to follow the GMC's *Personal Beliefs and Medical Practice* in 2008, it may be the College's intention to follow the 2013 version of the document. In the Project's view, this would be ill-advised. Appendix "A" compares the sections of the 2008 and 2013 document relevant to referral. It is clear that the GMC is attempting to tighten the noose and force unwilling physicians to facilitate services or procedures to which they object for reasons of conscience. This creeping authoritarianism (V.5) imposes a duty to do what is believed to be wrong (V.6) and is an attack on preservative freedom of conscience (V.7).
- VI.3.29 It appears that the error is still not apparent to the GMC because euthanasia is illegal in the United Kingdom, and prosecutorial guidance precludes physician assisted suicide.<sup>131</sup> Hence, unlike the Collège des Médecins du Québec, the GMC has not yet had to consider how unwilling physicians might respond if ordered to find someone to kill their patients.
- If POHRC is revised, it should not follow GMC guidance with respect to referral or facilitation.
  - The CMA approved *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* appears to reflect a consensus and would be a better model to follow than *Personal Beliefs and Medical Practice*.

## **VII. Summary of Recommendations**

### **VII.1 Do not restrict the meaning of freedom of religion.**

VII.1.01 The College should avoid language or statements that could be taken to mean that “freedom of religion” means only “freedom of *worship*” or the freedom to indulge in specifically religious *practices*. It should explicitly affirm that freedom of conscience and religion includes the freedom to act upon beliefs, whether they are religious or non-religious.

### **VII.2 Acknowledge the practice of medicine entails reference to moral beliefs, whether or not they are religious.**

VII.2.01 The College should avoid language or statements that suggest that medical decision-making is morally neutral, or that imply that only religious believers bring their beliefs to bear in medical decision-making. It should convey the message that the practice of medicine always entails the exercise of moral or ethical judgement, which may or may not be informed by religious belief. It should affirm that physicians cannot be asked “check their beliefs at the door” when practising medicine because that is not merely unjust, but impossible.

### **VII.3 Accommodate rather than restrict or suppress freedom of conscience and religion.**

VII.3.01 The College should acknowledge that forcing physicians to do what they believe to be wrong is never a trivial or insubstantial matter. It should not consider forcing physicians to participate in procedures or services to which they object for reasons of conscience unless it can demonstrate that their refusal is unsafe, disorderly, unhealthy, or immoral, and that other remedies are unavailable.

### **VII.4 Leave enforcement of the *Human Rights Code* to the OHRC.**

VII.4.01 In adjudicating allegations of professional misconduct, the College should confine itself to matters within its competence. It should not attempt to rule upon what constitutes a valid religious belief or a “core” religious belief, and it should leave the investigation of alleged violations of the *Human Rights Code* to the OHRC.

VII.4.02 Since there is no judicially recognized rational ordering of fundamental rights and freedoms, the College should not use patient rights claims to suppress the rights and freedoms of physicians, but should resolve conflicts between patients and physicians by accommodating both.

VII.4.03 The College should not construe a refusal to provide or participate in a procedure or service for reasons of conscience as a “barrier” or “obstacle” to services, nor a refusal to provide or participate in a procedure or service for reasons of conscience to constitute “interference” with the rights of others.

**VII.5 Clarify the expectations concerning communication with and respect for patients.**

VII.5.01 The expectation that a physician will not express personal judgements about patient lifestyles or characteristics should be clarified to ensure

- that it does not inadvertently restrict physician-patient communication about health issues; and
- that a physician will not be considered to have passed a personal judgement on a patient simply because he has complied with ethical guidelines that require him to disclose views that may influence his recommendations for treatment;
- that physicians will not be considered to be promoting their own religious beliefs or seeking to convert patients simply because they have complied with ethical guidelines that require him to disclose views that may influence his recommendations for treatment.

**VII.6 Avoid rigid communication and notification protocols.**

VII.6.01 Interests of patients and physicians are better served by open and continuing communication than rigid rules concerning notification and disclosure. Physicians should notify patients of procedures or services they decline to offer or recommend for reasons of conscience or religion when it is reasonably apparent that a conflict is likely to arise in relation to them. In many cases - but not all - this may, indeed, be when a patient is accepted. The same holds true for notification of patients when a physician's views change significantly.

**VII.7 An obligation to assist a patient does not entail an obligation to do what one believes to be wrong.**

VII.7.01 Objecting physicians may assist patients seeking the services they will not provide in various ways, but they have no duty to facilitate what they believe to be wrong.

**VII.8 Do not follow the example of creeping authoritarianism found in the GMC's *Personal Beliefs and Medical Practice*.**

VII.8.01 Guidelines from the College should avoid the direction taken in the General Medical Council's 2013 edition of *Personal Beliefs and Medical Practice*. The CMA approved *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* appears to reflect a consensus and is a better model to follow.

**VIII. Conclusion**

VIII.1 The College of Physicians and Surgeons periodically receives complaints about physicians who have refused to provide a service for reasons of conscience or religion, and has an obligation to respond to such complaints. It is reasonable to ask what kind of response is best suited to the problem. If the goal is to ensure access to services, that goal is best served by connecting patients with physicians willing to help them. That would be a more

helpful and practical response than attempting to restrict or suppress freedom of conscience and religion in the medical profession.





## Appendix “A”

### Creeping Authoritarianism

#### General Medical Council (United Kingdom)

##### *Personal Beliefs and Medical Practice*

#### **2008 Edition**<sup>132</sup>

21. . . . you must tell patients of their right to see another doctor with whom they can discuss their situation and ensure that they have sufficient information to exercise that right. . .

22. . . . if the patient cannot readily make their own arrangements to see another doctor you must ensure that arrangements are made, without delay, for another doctor to take over their care. You must not obstruct patients from accessing services or leave them with nowhere to turn. . .

#### **2013 Edition**<sup>133</sup>

12b. Tell the patient they have a right to discuss their condition and the options for treatment (including the option that you object to) with another practitioner who does not hold the same objection as you and can advise them about the treatment or procedure you object to.

12c. Make sure that the patient has enough information to arrange to see another doctor who does not hold the same objection as you.

13. If it’s not practical for a patient to arrange to see another doctor, you must make sure that arrangements are made- without delay - for another suitably qualified colleague to advise, treat or refer the patient. You must bear in mind the patient’s vulnerability and act promptly to make sure they are not denied appropriate treatment or services. . .



## Notes:

1. A requirement that an objection physician “advise the patient of other sources of assistance,” was introduced by the CMA General Council in June, 1977, and revoked the following year. Geekie D.A. “Abortion referral and MD emigration: areas of concern and study for CMA.” *CMAJ*, January 21, 1978, Vol. 118, 175, 206 (<http://www.consciencelaws.org/archive/documents/cma-cmaj/1978-01-21-CMAJ-118-175-referral-geekie.pdf>) Accessed 2014-02-22; “Ethics problem reappears.” *CMAJ*, July 8, 1978, Vol. 119, 61-62 (<http://www.consciencelaws.org/archive/documents/cma-cmaj/1978-07-08-CMAJ-119-61-62-referral-out.pdf>) Accessed 2014-02-22. In 2000, during a telephone conversation with the Project Administrator, Dr. John R. Williams, then CMA Director of Ethics, confirmed that the Association did not require objecting physicians to refer for abortion. He explained that the CMA had once had a policy that required referral, but had dropped it because there was “no ethical consensus to support it.” This was clearly a brief reference to the short-lived 1977 revision of the *Code of Ethics* and ensuing controversy.
  2. For example, in a guest 2006 editorial in the *Canadian Medical Association Journal*, Professors Sanda Rodgers of the University of Ottawa and Jocelyn Downie of Dalhousie University complained that “[s]ome physicians refuse to provide abortion services and refuse to provide women with information or referrals needed to find help elsewhere.” Rodgers S. Downie J. “Abortion: Ensuring Access.” *CMAJ* July 4, 2006 vol. 175 no. 1 doi: 10.1503/cmaj.060548 (<http://www.cmaj.ca/content/175/1/9.full>) Accessed 2014-02-23
  3. Blackmer J. “Clarification of the CMA’s position on induced abortion.” *CMAJ* April 24, 2007 vol. 176 no. 9 doi: 10.1503/cmaj.1070035 (<http://www.cmaj.ca/content/176/9/1310.1.full>) Accessed 2014-02-22
  4. “(We decided to proceed by way of these provincial regulatory bodies rather than the CMA, in part, because of the negative reaction of the CMA to the Rodgers/Downie editorial, which made policy reform by the CMA seem unlikely.)” McLeod C, Downie J. “Let Conscience Be Their Guide? Conscientious Refusals in Health Care.” *Bioethics* ISSN 0269-9702 (print); 1467-8519 (online) doi:10.1111/bioe.12075 Volume 28 Number 1 2014 pp ii–iv
  5. *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*. 14 February, 2008. (<http://www.ohrc.on.ca/en/submission-ontario-human-rights-commission-college-physicians-and-surgeons-ontario-regarding-draft>) Accessed 2014-07-28.
- Submission of the Ontario Human Rights Commission to the College of Physicians and Surgeons of Ontario Regarding the draft policy, "Physicians and the Ontario Human Rights Code."* 15 August, 2008. (<http://www.ohrc.on.ca/en/resources/submissions/physur>) Accessed 2014-03-08

6. *Submission of the Ontario Human Rights Commission to the College of Physicians and Surgeons of Ontario Regarding the draft policy, "Physicians and the Ontario Human Rights Code."* 15 August, 2008. (<http://www.ohrc.on.ca/en/resources/submissions/physur>) Accessed 2014-03-08
7. *Physicians and the Ontario Human Rights Code*, p. 4. (<http://www.consciencelaws.org/archive/documents/2008-cpso-ohrc-app-a-consultation-draft.pdf>)
8. Murphy S. "Physicians and the Ontario Human Rights Code: Ontario Human Rights Commission attempts to suppress freedom of conscience." (August-September, 2008) *Protection of Conscience Project* (<http://www.consciencelaws.org/ethics/ethics078-000.aspx>)
9. "OMA Urges CPSO to Abandon Draft Policy on Physicians and the Ontario Human Rights Code." *OMA President's Update*, Volume 13, No. 23 September 12, 2008. "OMA Response to CPSO Draft Policy 'Physicians and the Ontario Human Rights Code.'" *Statement of the Ontario Medical Association*, 11 September, 2008.
10. Zuliani, P. "Doctors do not have to violate beliefs." *Ottawa Citizen*, 23 August, 2008 Responding to Warren, David, "Refusing to do harm." *Ottawa Citizen*, 20 August 2008. (<http://www.canada.com/ottawacitizen/news/letters/story.html?id=16631e26-c448-4694-8168-ec45d3bbdd63>) Accessed 2014-08-03
11. "We do not expect physicians to provide services that are contrary to their moral or religious beliefs." The e-mail acknowledged that a requirement that physicians may be required to help patients arrange for morally objectionable procedures had "raised concerns from respondents." E-mail from the College of Physicians and Surgeons of Ontario, 20 August 2008.
12. "Rights Commission threat "blasphemy against the human spirit": College of Physicians secrecy said unacceptable." *Protection of Conscience Project*, News Release, 13 September, 2008 (<http://consciencelaws.org/blog/?p=4979>)
13. College of Physicians and Surgeons of Ontario, Policy Statement #5-08: *Physicians and the Ontario Human Rights Code* (Approved September, 2008) (Hereinafter "POHRC (2008)") ([http://www.cpso.on.ca/CPSO/media/uploadedfiles/downloads/CPSOdocuments/policies/policies/human\\_rights.pdf?ext=.pdf](http://www.cpso.on.ca/CPSO/media/uploadedfiles/downloads/CPSOdocuments/policies/policies/human_rights.pdf?ext=.pdf)) Accessed 2014-03-06
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([http://rsc-src.ca/sites/default/files/pdf/RSCEndofLifeReport2011\\_EN\\_Formatted\\_FINAL.pdf](http://rsc-src.ca/sites/default/files/pdf/RSCEndofLifeReport2011_EN_Formatted_FINAL.pdf))  
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(<http://www.consciencelaws.org/repression/repression051.aspx>); Australian Medical Association Tasmania Ltd., *Submission to the Tasmanian Government on the law governing termination of pregnancy*. 5 April, 2013 (<http://www.consciencelaws.org/law/commentary/legal053.aspx>);  
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18. *An Act respecting end-of-life care* (Hereinafter "ARELC").  
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19. Collège des Médecins du Québec *Code of Ethics of Physicians*, para. 24  
(<http://www.cmq.org/en/Public/Profil/Commun/AProposOrdre/~~/media/Files/ReglementsANG/cmqcodeoan.ashx?61323>) Accessed 2013-06-23.
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26. Levy I. (Medical Officer of Health, Ottawa) and Abdullah A. (President, Academy of Medicine, Ottawa), *Letter to the Ottawa Citizen*, 1 February, 2014.
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31. Radical Handmaids FB, A \_\_\_ R \_\_\_, 29 January, 2014, 6:29 pm (<http://www.consciencelaws.org/background/procedures/birth002-C-01.aspx>) Accessed 2014-02-10
32. Radical Handmaids FB, M \_\_\_ A \_\_\_, 29 January, 2014, 7:19 pm (<http://www.consciencelaws.org/background/procedures/birth002-C-01.aspx>) Accessed 2014-02-10
33. Radical Handmaids FB, M \_\_\_ A \_\_\_, 29 January, 2014, 8:54 pm (<http://www.consciencelaws.org/background/procedures/birth002-C-01.aspx>) Accessed 2014-02-10
34. Radical Handmaids FB, M \_\_\_ C \_\_\_, 29 January, 2014, 8:57 pm. (Expletive deleted) (<http://www.consciencelaws.org/background/procedures/birth002-C-01.aspx>) Accessed 2014-02-10

35. Radical Handmaids FB, S \_\_\_ W \_\_\_, 29 January, 2014, 9:36 pm  
(<http://www.consciencelaws.org/background/procedures/birth002-C-01.aspx>) Accessed 2014-02-10
36. Radical Handmaids FB, L \_\_\_ J \_\_\_ M \_\_\_, 30 January, 2014, 9:24 am  
(<http://www.consciencelaws.org/background/procedures/birth002-C-03.aspx>) Accessed 2014-02-10
37. Radical Handmaids FB, T \_\_\_ D \_\_\_, 30 January, 2014, 4:25 am; C \_\_\_ B \_\_\_, 30 January, 2014, 5:07 am (<http://www.consciencelaws.org/background/procedures/birth002-C-02.aspx>) Accessed 2014-02-10
38. Radical Handmaids FB, J \_\_\_ L \_\_\_, 29 January, 2014, 10:10 pm  
(<http://www.consciencelaws.org/background/procedures/birth002-C-01.aspx>) Accessed 2014-02-10
39. Radical Handmaids FB, T \_\_\_ M \_\_\_, 29 January, 2014, 6:56 pm  
(<http://www.consciencelaws.org/background/procedures/birth002-C-01.aspx>) Accessed 2014-02-10
40. Radical Handmaids FB, C \_\_\_ F \_\_\_, 30 January, 2014, 6:53 am  
(<http://www.consciencelaws.org/background/procedures/birth002-C-02.aspx>) Accessed 2014-02-10
41. Radical Handmaids FB, J \_\_\_ O \_\_\_, 30 January, 2014, 1:38 pm  
(<http://www.consciencelaws.org/background/procedures/birth002-C-03.aspx>); Radical Handmaids FB, R \_\_\_ L \_\_\_ 29 January, 2014, 7:32 pm  
(<http://www.consciencelaws.org/background/procedures/birth002-C-01.aspx>); Radical Handmaids FB, K \_\_\_ N \_\_\_ H \_\_\_, 30 January, 2014, 11:48 am  
(<http://www.consciencelaws.org/background/procedures/birth002-C-03.aspx>); Radical Handmaids FB, L \_\_\_ C \_\_\_ 31 January, 2014, 7:52 am.  
(<http://www.consciencelaws.org/background/procedures/birth002-C-04.aspx>) Accessed 2014-02-10
42. Radical Handmaids FB, K \_\_\_ B \_\_\_, 29 January, 2014, 7:56 pm  
(<http://www.consciencelaws.org/background/procedures/birth002-C-01.aspx>) Accessed 2014-02-10
43. Radical Handmaids FB, A \_\_\_ M \_\_\_ 29 January, 2014, 7:41 pm  
(<http://www.consciencelaws.org/background/procedures/birth002-C-01.aspx>) Accessed 2014-02-10
44. Radical Handmaids FB, R \_\_\_ V \_\_\_, 29 January, 2014, 7:52 pm  
(<http://www.consciencelaws.org/background/procedures/birth002-C-01.aspx>) Accessed 2014-02-10

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(<http://www.consciencelaws.org/background/procedures/birth002-C-02.aspx>); Radical Handmaids FB, N \_\_\_ P \_\_\_, 30 January, 2014, 8:12 am  
(<http://www.consciencelaws.org/background/procedures/birth002-C-02.aspx>); Radical Handmaids FB, M \_\_\_ C \_\_\_, 30 January, 2014, 3:04 pm  
(<http://www.consciencelaws.org/background/procedures/birth002-C-03.aspx>); Radical Handmaids FB, A \_\_\_ O \_\_\_, 31 January, 2014, 5:26.  
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