



Protection of Conscience Project

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Submission to the College of Physicians and Surgeons of Ontario

Re: *Professional Obligations and Human Rights*

20 February, 2015

Abstract

The focus of this submission about *Professional Obligations and Human Rights* (POHR) is its demand for “effective referral” - the demand that physicians do what they believe to be wrong - even gravely wrong - even arranging homicide or suicide - and the implied threat that they will be punished if they refuse.

This is a dangerous and extraordinarily authoritarian policy, completely at odds with liberal democratic aspirations and our national traditions. The burden of proof is on the working group to prove beyond doubt that it is justified and that no reasonable alternatives are available. The working group has not done so.

The working group provided no evidence that such a policy is necessary, and there is evidence that it is *not*. The briefing materials supplied to Council in support of POHR were not only seriously deficient, but erroneous and seriously misleading. “Public sentiment” captured by a random poll does not justify the suppression of fundamental freedoms, and the results of consultation, when carefully considered, suggest that a policy of “effective referral” is highly controversial.

An example of a reasonable alternative is available from the Australian Medical Association - an example not offered to Council members by the working group, which, instead, completely misrepresented AMA policy.

This submission, supported by detailed analysis in the appendices, provides good reason for Council members to doubt that the requirement for effective referral in POHR is necessary or justifiable, or prudent policy. It also provides reason for them to believe that reasonable alternatives can be developed.

Council members unpersuaded by the working group or left in doubt about POHR should give the benefit of doubt to freedom of conscience and refuse to approve the draft policy in its present form. They should direct the working group to collaborate with those opposed to the present draft to produce a broadly acceptable text. If the *real* goal is to ensure access - not ideologically driven ethical cleansing - there is no reason to demand that physicians do what they believe to be wrong. If the College’s *real* goal is to ensure access to services - not to punish objecting physicians, or drive them out of family practice, or out of the profession - that goal is best served by connecting patients with physicians willing to help them.

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I. Introduction

Focus of the submission

- I.1 The Project's concern with *Professional Obligations and Human Rights* (POHR) is its demand that physicians must do what they believe to be wrong: that physicians who object to a procedure for reasons of conscience are obliged to provide "an effective referral" even if they find that equally objectionable. That is the focus of this submission.

What the working group seeks

- I.2 Each member of Council is being asked
- to approve a policy intended to force physicians who are unwilling to kill patients or help them commit suicide to find a colleague who will;
 - to approve a policy intended to force physicians who are unwilling to kill developing infants *in utero* to find a colleague who will;
 - to approve a policy that the chair of the working group has admitted will expose physicians unwilling to participate in killing developing infants *in utero* to discipline by the College¹ and effectively force them out of family medicine;²
 - to approve a policy that, since the decision of *Carter v. Canada*, will expose physicians unwilling to participate in killing patients or helping them to kill themselves to discipline by the College,¹ and effectively force them out of family medicine and palliative care.³
- I.3 A Council member who approves *Professional Obligations and Human Rights* will thereby approve the principle that a learned or privileged class, a profession or state institution can legitimately compel people to do what they believe to be wrong - even gravely wrong - even murder - and punish them if they refuse.

Burden of proof

- I.4 This is a dangerous and extraordinarily authoritarian policy that is completely at odds with liberal democratic aspirations and our national traditions. The burden of proof is on the working group to prove beyond doubt that it is justified and that no reasonable alternatives are available. It is the responsibility of Council members to insist that the working group fully discharges the burden of proof.

Responsibility of Council members

- I.5 If a member of Council is to approve such an extraordinarily authoritarian policy, so completely at odds with liberal democratic aspirations and our national traditions, he or she must have absolutely no doubt that POHR must be adopted, and that no better alternative can be developed.
- I.6 On the other hand, if there is *any* doubt that *Professional Obligations and Human Rights* is necessary and completely justifiable, or if there is *any* reasonable possibility that a less

authoritarian policy might be drafted, POHR should be rejected.

Project submission

- I.7 It is the submission of the Protection of Conscience Project that Council members have good reason to doubt that the requirement for “effective referral” in *Professional Obligations and Human Rights* is a necessary or satisfactory policy. Further: a Council member has good reason to believe that a less authoritarian policy can be developed.
- I.8 Doubts about POHR should be resolved in favour of freedom of conscience. *Professional Obligations and Human Rights* should be rejected. The working group that produced it should be required to collaborate with those opposed to the present draft to produce a broadly acceptable text. This is consistent with the approach to conflict resolution recommended by the Royal College of Physicians and Surgeons of Canada.⁴
- I.9 The Protection of Conscience Project’s 2014 submission concerning *Physicians and the Human Rights Code* remains relevant to *Professional Obligations and Human Rights* (POHR). Among the points made in the previous submission, the following bear repetition here:

. . .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. . .

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.

II. Reasons for doubt

- II.1 There is reason to doubt that the requirement for effective referral in POHR is necessary or justifiable because
- the working group provided no evidence that the policy is necessary,
 - there is evidence that the policy is not necessary,
 - the justification offered for the policy by the working group is doubtful, and
 - the briefing materials supplied to Council in December in support of POHR were not only seriously deficient, but erroneous and misleading.

- II.2 There is reason to believe that a less authoritarian policy can be developed because
- examples of more reasonable policies can be found elsewhere or may be forthcoming in 2015, and
 - the working group failed to reference significant and relevant documents from Canadian authorities.

No evidence of necessity

- II.3 The chair of the working group justifies POHR on the grounds that it is necessary to “facilitate access” to services (I.3). The working group provided no evidence to support this assertion.
- II.4 On the other hand, there is evidence that the effective referral provision in POHR is not necessary to facilitate access to services. The evidence is found in the case of three Ottawa physicians who provide Natural Family Planning assistance in birth control and who refuse to provide, recommend or refer patients for abortion or contraception. (Appendix “D”)
- II.5 Finally, while there is anecdotal evidence of a disturbing pattern of disrespectful communication by physicians, there are already policies that can deal with this problem, though they may need to be reinforced and enforced. However, the POHR requirement for “effective referral” in order to “facilitate access” to widely available services like contraception and abortion is not necessary. It is a solution in search of a problem, or, to put it in terms of *Charter of Rights* jurisprudence, a policy that is unconstitutional because it is “overbroad.” (Appendix “D”, DIV.)

Questionable justification

- II.6 **Public Polling:** As part of the review process (Appendix “A”), the College surveyed 800 Ontario residents in May, 2014 “to capture public sentiment on conscientious objection in the health services context.”
- II.7 When POHR was released in December, 2014, Dr. Marc Gabel, then President of the College, stated that this polling demonstrated that “the vast majority of Ontarians believe that [objecting physicians] should be required to identify another physician who will provide the treatment, and make and/or coordinate a referral.”⁵
- II.8 There is little doubt that a poll conducted in Alabama in 1950 about racial segregation would have indicated overwhelming popular support for the practice. It is at least doubtful that “public sentiment” is a trustworthy guide for policy makers, particularly with respect to the exercise of fundamental freedoms by minorities.
- II.9 **On-line Survey:** The working group advised members of College Council that “the vast majority of respondents expressed their support for freedom of conscience, and the idea that physicians should not have to provide services that conflict with their moral and/or religious beliefs,” but added that the feedback was polarized.⁶ On the question of referral, the Council was told “many respondents were in support of a referral requirement” but that “the opposing viewpoint was also strongly represented.”⁷

- II.10 Appendix "C" demonstrates that this summary of the consultation process provided by the working group was inadequate and misleading.
- II.11 According to the briefing note for College Council, there were 6,710 responses, including "2296 comments posted to the online discussion page and 4414 completed online surveys."⁸
- II.12 In fact, there were 3,103 complete and 1,311 partially completed surveys, not 4,414 completed surveys.⁹ Moreover, since an unknown number of respondents contributed both to the On-line Survey and Discussion Forum, the number of unduplicated consultation responses actually available for analysis may have been far less than 6,700. On the extremely contentious issue of referral, for example, the College's analysis relies on less than half that number (Appendix "C", Figure 13).
- II.13 The overwhelming majority of respondents who made submissions through email or regular mail or as discussion forum participants support freedom of conscience for physicians with respect to refusing to provide non-emergency services. In contrast, they offer virtually no support for a policy of mandatory referral by objecting physicians (Appendix "C", CIV.2).
- II.14 Levels of support for policy statements related to freedom of conscience for physicians decrease when they are perceived as excessively rigid or insufficiently attuned to the realities of practice. Levels of support fall and disagreement and doubt increase when they are perceived to require complicity in morally contested procedures. On-line Survey responses under this head do not support a policy of mandatory referral, suggesting, instead, that such a policy is highly controversial because it is associated with coerced complicity in perceived wrongdoing (Appendix "C", CIV.3).
- II.15 This is illustrated by responses to a "Yes-No-Don't Know" question about agreement with a policy of mandatory referral. Here the level of agreement drops to 50% and the level of disagreement rises dramatically to 43% (Appendix "C", Figure 13). Moreover, the sample of comments provided in the Report indicate that the expressed levels of agreement and disagreement are somewhat unstable, depending on factors or nuances not captured by the survey question.
- II.16 **Research:** The working group told Council members that POHR reflects the results of their research,¹⁰ but has either failed to provide information about the results of its review of professional literature or case law, or has not made that information public.¹¹
- II.17 In the absence of such information, the public and members of the profession must rely entirely on the working group's assurance that POHR faithfully reflects what is found in legal and professional literature. Council members were similarly dependent upon the information provided by the working group during the December meeting.
- II.18 The claim that the kind of policy proposed in POHR is consistent with human rights legislation and jurisprudence was challenged by lawyers who made submissions during the preliminary consultation (Appendix "E"). It is the Project's understanding that further legal submissions specific to POHR will be made to the same effect, so this issue is not pursued here.

II.19 A second reason to question the reliability of the working group’s research into professional literature and law is that, with respect to much simpler research concerning policies in different jurisdictions, the briefing material provided to Council members in December was deficient, erroneous and misleading.

Deficient, erroneous and misleading briefing materials

- II.20 With respect to the issue of physician freedom of conscience and referral in particular,
- A. the accounts provided of the policies of the Canadian Medical Association were **deficient**;
 - B. the accounts provided of the policies of the Colleges of Physicians of British Columbia, Alberta, Nova Scotia, Prince Edward Island, Newfoundland, New Brunswick and Quebec were **deficient**;
 - C. the information provided concerning the Australian Medical Association was **erroneous and seriously misleading**;
 - D. the information provided concerning New Zealand was **deficient and seriously misleading**;
 - E. the account provided concerning policies in the United States was **deficient and superficial**;
 - F. the account provided concerning nursing policies in Ontario was **deficient and misleading**;
 - G. the account provided in Appendix 3 concerning midwifery policies in Ontario was **deficient**;
 - H. briefing materials failed to reference significant documents from Canadian authorities relevant to the issues.
- II.21 Particulars of the deficiencies are provided in Appendix “B”. In some cases, the deficiencies are fully accounted for by the fact that the working group did not know about the existence of correspondence between the Protection of Conscience Project and Colleges of Physicians concerning the meaning of their policies.
- II.22 However, in many cases, the errors and deficiencies are not easily explained: for example, the grossly inaccurate presentation of the position of the Australian Medical Association concerning the exercise of physician freedom of conscience in general, and referral in particular.
- II.23 Especially troubling is the fact that almost every one of the errors, omissions, and deficiencies (apart from those noted in II.21) tend to favour the demand for “effective referral” in POHR. This gives rise to legitimate concern about researcher bias, which brings into question the soundness of the research undertaken. This is of particular concern to the public and members of the profession, who do not have access to the information presented to Council members during the meeting in December.

- II.24 The deficiencies and errors in the briefing materials supplied to Council members by the working group challenge Dr. Gabel's assertion that POHR "is nothing new" because similar policies already exist in Alberta, Manitoba, Quebec and New Brunswick.¹²
- II.25 Notwithstanding the impression that might be created by Dr. Gabel's claim, the Collège des Médecins du Québec is the only medical regulator in Canada that requires what POHR calls "an effective referral" by objecting physicians (Appendix "B", BII.2). Moreover, it appears that Quebec's legalization of euthanasia prompted the intuitive recognition that the requirement nullifies freedom of conscience (Appendix "B", BII.2.29).

Example of more reasonable policies

- II.26 Contrary to the briefing material provided to Council members in December, the Australian Medical Association (AMA) supports both patient access to services and physician freedom of conscience, including the freedom to decline to provide "an effective referral" (Appendix "B", BII.3).
- II.27 In 2013 the AMA produced a lengthy and thoughtful statement about physician exercise of freedom of conscience called *Conscientious Objection* (BII.3.9). Although this document is readily available on the AMA website, the working group did not provide Council members with extracts from it, or, indeed, even refer to it in the jurisdictional review. The AMA's *Conscientious Objection* differs markedly from POHR in tone and, unlike POHR, leaves the impression that it was produced through the kind of collaborative process recommended for conflict resolution by the Royal College of Physicians and Surgeons of Canada.¹³

Policies forthcoming in 2015

- II.28 The working group selected the American Medical Association as one of the international authorities suitable for policy comparison. However, rather than citing Association policy documents, it provided Council members with only a single sentence making general reference to Association policy taken from an article about conscientious objection among pharmacists (BII.5.1).
- II.29 In November, 2014, the American Medical Association House of Delegates adopted a new policy concerning physician exercise of freedom of conscience, which will be formally issued in June, 2015 (BII.5.2). The College Council meeting at which POHRC will be discussed is scheduled for the end of May. It is open to Council members who are doubtful about POHR to postpone consideration of the draft until the fall. By that time they will have had the opportunity to consider the new policy issued by the American Medical Association, which is likely to be more informative than the single sentence they were given by the working group.
- II.30 Postponing consideration of POHR until the fall is unlikely to be problematic, since the working group has produced no evidence that anyone in Ontario has been denied access to services or procedures because physicians have exercised freedom of conscience (II.3).

Neglect of relevant and significant Canadian policy statements

- II.31 The Canadian Medical Association, Canadian Healthcare Association, Canadian Nurses' Association and Catholic Health Association of Canada have produced a *Joint Statement on Preventing and Resolving Ethical Conflicts involving Health Care Providers and Persons Receiving Care* that has been cited by the Supreme Court of Canada and the Royal College of Physicians and Surgeons of Canada (Appendix "B", BII.8)
- II.32 The working group did not refer to this document, and POHR is inconsistent with its approach.
- II.33 The Royal College of Physicians and Surgeons of Canada discusses conflict resolution at length, and stresses that a collaborative approach is the preferred method that leads to "creative, durable outcomes."¹⁴ It is not evident that the working group has hitherto been inclined to adopt a collaborative approach in developing POHR.

III. POHR in practice

- III.1 Council members may also conclude that for practical reasons connected with the realities of medical practice, the effective referral requirement in POHR is ill-advised. A practical example is available from Australia.
- III.2 Despite the opposition of the Australian Medical Association and others, in 2008 the government of the Australian state of Victoria passed an abortion law that includes a requirement for the kind of effective referral contemplated in POHR (Appendix "B", BIII.)
- III.3 In April, 2013, a physician in the state of Victoria who is opposed to abortion for reasons of conscience¹⁵ publicly announced that he had refused to provide a referral for a woman who had come to him seeking an abortion. His statement presented a challenge to the state government and medical regulator to prosecute or discipline him for his refusal.¹⁶
- III.4 Responding to the media, a spokeswoman for the Medical Practitioners Board warned that all doctors were bound by the law and by their code of conduct, and that they were expected "to practise lawfully" and meet professional standards.¹⁶
- III.5 The physician was adamant and unrepentant in his refusal, and the case repeatedly made the news, even outside Australia. For at least five months he was the subject of an investigation by the state Medical Board. The investigation was based on a newspaper article and initiated by a member of the Board because the woman refused the abortion did not complain.¹⁷
- III.6 Ultimately, the physician was cautioned for allegedly having made a statement in the media that he would not obey the law, but he was *not* cautioned for refusing to refer for abortion, as required by the law.¹⁸ It appears that, the law notwithstanding, no one in a position of authority was prepared to prosecute, discipline or even caution a physician who refused to refer a woman 19 weeks pregnant for a sex-selective abortion; she and her husband did not want a girl. They obtained an abortion elsewhere a few days later without the assistance of the objecting physician.¹⁷

- III.7 This case was cited by the Victorian branch of the Australian Medical Association to illustrate one of the reasons the Association was opposed to the mandatory referral provision in the law. A spokeswoman said:
- “We disagreed with the conscientious objection clause for a number of reasons, including people’s rights not to be involved in activities which offend their conscience, but also because of the impracticality of the clauses which have been included.”
- She said Dr Hobart’s case highlighted these impracticalities, “ie that it is hard for a doctor to judge whether or not another doctor would or wouldn’t hold an objection in a particular circumstance.”¹⁹
- III.8 This statement by AMA Victoria was made five months *after* the association published the fact sheet provided by the working group that implied the AMA’s support for a policy of mandatory referral (Appendix "B", BII.3).
- III.9 Two further points should be noted. First: sex-selective abortion is legal in Canada, as it is in the state of Victoria, so a case of this kind can arise here. Second: the woman was obviously able to access sex-selective abortion without the assistance of the objecting physician, as a woman would be able to access sex-selective abortion here. This further demonstrates the point made in II.5: that the POHR requirement for "effective referral" in order to "facilitate access" to widely available services like contraception and abortion is a solution in search of a problem.

IV. Giving freedom of conscience the benefit of the doubt

- IV.1 The preceding arguments, supported by detailed analysis in the appendices, provide good reason for a Council member to doubt that the working group has demonstrated that the requirement for effective referral in POHR is necessary or justifiable, or prudent policy.
- IV.2 The working group provided no evidence that the policy is necessary. In contrast, there is evidence that it is not necessary.
- IV.3 Neither the poll conducted by the working group nor its consultation can be cited to support a policy of "effective referral." Public sentiment captured by a random poll of people who may have no understanding of the issues is an unreliable guide to the formulation of policy about the exercise of fundamental freedoms. The results of the consultation not only fail to support a policy of mandatory referral, but suggest that such a policy is highly controversial because it is associated with coerced complicity in perceived wrongdoing. In light of this, a Council member is justified in taking a sceptical view of POHR.
- IV.4 A Council member is also entitled to entertain grave doubts about the acceptability of POHR because of the seriously deficient, erroneous and misleading material provided by the working group in its jurisdictional review.
- IV.5 The statement of the Australian Medical Association gives a Council member good reason to believe that a more reasonable policy can be developed if the working group attends to advice from neglected Canadian authorities and adopts the collaborative approach recommended by the Royal College of Physicians and Surgeons of Canada.
- IV.6 Finally, the case of the physician in the state of Victoria, Australia, illustrates the kind of conflicts that can be generated by a policy of "effective referral" - unnecessary conflicts generated by a policy that, moreover, is not necessary to ensure "access" to services.
- IV.7 It is not necessary for a Council member to disprove the claims made by the working group in support of *Professional Obligations and Human Rights*. Rather, the burden is on the working group to prove to Council members that the suppression of fundamental freedoms entailed by POHR is justified, and that no practical problems will arise if POHR is adopted.
- IV.8 A Council member unpersuaded by the working group or left in doubt about POHR should give the benefit of doubt to freedom of conscience and refuse to approve the draft policy in its present form.

V. Conclusion

- V.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.
- V.2 Council should direct the working group to collaborate with those opposed to the present draft to produce a broadly acceptable text. If the *real* goal is to ensure access - not ideologically driven ethical cleansing - there is no reason to demand that physicians do

what they believe to be wrong. If the College's *real* goal is to ensure access to services - not to punish objecting physicians, or drive them out of family practice, or out of the profession - 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.

Notes

1. The following report was based upon interviews with Dr. Gabel and Dr. Carol Leet, President of the College. Neither has ever denied the accuracy of the report.

Dr. Marc Gabel, a Toronto psychotherapist and past president of the college, told LifeSiteNews on Thursday that if his committee's proposed revision of the college's "Professional Obligations and Human Rights" is adopted, then if doctors refuse to refer patients to abortionists, or to doctors willing to prescribe contraceptives, they could face disciplinary action.

"If there were a complaint, every complaint is investigated by the complaint committee," Dr. Gabel said. The complaint committee could deliver a mild private rebuke or turn over the matter to the disciplinary committee, which Gabel chaired for several years.

According to Dr. Carol Leet, the new president of the college, a doctor found guilty of professional misconduct by the disciplinary committee could face anything from remedial instruction to loss of his or her medical licence.

Weatherbe S. "Doctors who oppose abortion should leave family medicine: Ontario College of Physicians." *LifeSite News*, 19 December, 2014.
(<https://www.lifesitenews.com/news/doctors-who-oppose-abortion-should-leave-family-medicine-ontario-college-of-physicians>) Accessed 2014-12-21

2. The following report was based upon a tape-recorded interview with Dr. Gabel. He has never denied its accuracy.

Catholic doctors who won't perform abortions or provide abortion referrals should leave family medicine, says an official of the College of Physicians and Surgeons of Ontario.

"It may well be that you would have to think about whether you can practice family medicine as it is defined in Canada and in most of the Western countries," said Dr. Marc Gabel, chair of the college's policy working group reviewing "Professional Obligations and Human Rights."

Gabel said there's plenty of room for conscientious Catholics in various medical

specialties, but a moral objection to abortion and contraception will put family doctors on the wrong side of human rights legislation and current professional practice.

Swan, M. "Catholics doctors who reject abortion told to get out of family medicine." *The Catholic Register*, 17 December, 2014
(<http://www.catholicregister.org/item/19394-catholics-doctors-who-reject-abortion-told-to-get-out-of-family-medicine>) Accessed 2014-12-19

3. Interviewed in anticipation of the Supreme Court ruling in *Carter v. Canada*, Dr. Gabel did not deny this.

Whatever its policy ultimately looks like, the college is clear: a patient's right to access services outweighs a doctor's right to refuse them. "We prioritize the interests of our patients in facilitating access," says Dr. Marc Gabel, past president of the college and chair of the policy's working group.

Nasser S. "If Supreme Court decriminalizes physician-assisted suicide, doctors may be obligated to help with euthanasia." *National Post*, 4 February, 2015
(<http://news.nationalpost.com/2015/02/04/if-supreme-court-decriminalizes-physician-assisted-suicide-doctors-may-be-obligated-to-help-with-euthanasia/>) Accessed 2015-02-17.

4. Marshall P, Robson R. "Conflict Resolution." Royal College of Physicians and Surgeons of Canada
(http://www.royalcollege.ca/portal/page/portal/rc/resources/bioethics/primers/conflict_resolution#processes) Accessed 2015-02-17

5. Gabel, M. "Dear Colleagues." College of Physicians and Surgeons of Ontario, *Dialogue*, Vol. 10, Issue 4, 2014, p. 6.
(<http://www.joomag.com/magazine/dialogue-volume-10-issue-4-2014/0267666001419268812?s hort>) Accessed 2015-02-02.

6. College of Physicians and Surgeons of Ontario, *Council Briefing Note: Professional Obligations and Human Rights - Draft for Consultation (For Decision)* (December, 2014)
(<http://www.consciencelaws.org/archive/documents/cpso/2014-12-cpso-briefing.pdf>). In Annual Meeting of Council, December 4-5, 2014, p. 329. Accessed 2015-02-03.

7. College of Physicians and Surgeons of Ontario, *Council Briefing Note: Professional Obligations and Human Rights - Draft for Consultation (For Decision)* (December, 2014)
(<http://www.consciencelaws.org/archive/documents/cpso/2014-12-cpso-briefing.pdf>). In Annual Meeting of Council, December 4-5, 2014, p. 329-330. Accessed 2015-02-03.

8. College of Physicians and Surgeons of Ontario, *Council Briefing Note: Professional Obligations and Human Rights - Draft for Consultation (For Decision)* (December, 2014). In,

Annual Meeting of Council, December 4-5, 2014, p. 328

(<http://www.consciencelaws.org/archive/documents/cpso/2014-12-cpso-briefing.pdf>)

9. College of Physicians and Surgeons of Ontario, *Physicians and the Ontario Human Rights Code Consultation, Online Survey Report and Analysis*, Table 1.

(<http://www.consciencelaws.org/archive/documents/cpso/2014-12-cpso-survey-report.pdf>)

10. College of Physicians and Surgeons of Ontario, *Council Briefing Note: Professional Obligations and Human Rights - Draft for Consultation (For Decision)* (December, 2014)

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Appendix "A"

The Review Process

AI. Introduction

Physicians and the Ontario Human Rights Code was adopted in 2008.¹ The policy was slated for review by September, 2013, but a public announcement of the review was not made until June, 2014.

AII. Public polling

AII.1 As part of the review process, the College surveyed 800 Ontario residents in May, 2014 "to capture public sentiment on conscientious objection in the health services context."

The online panel was recruited randomly using an Interactive Voice Response system. Results can therefore be generalized to the online population of Ontario, which represents approximately 80% of the adult population. Findings are accurate to +3.5% at the 95% level of confidence.²

AIII. Preliminary consultation

AIII.1 The College invited the public and the profession to provide feedback on Physicians and the Ontario Human Rights Code by regular mail, email, and an on-line survey. In addition, it provided an On-line Poll³ and Discussion Forum.⁴ The prompt for the On-line Poll, Discussion Forum and submissions was:

Do you think a physician should be allowed to refuse to provide a patient with a treatment or procedure because it conflicts with the physician's religious or moral beliefs?
(Yes) (No) (Don't Know)⁵

AIII.2 The first stage of a public consultation about the policy closed on 5 August, 2014.

AIV. Research

AIV.1 **Literature Review:** The working group conducted what was described as "a comprehensive literature review of Canadian and international scholarly articles, research papers, newspaper publications, conference proceedings and organizational publications."⁶

AIV.2 **Jurisdictional Research:** The working group compared and contrasted "the policy positions of Canadian medical regulators, Ontario regulated health professions, and selected international bodies with respect to conscientious objection and fulfilling obligations under Human Rights legislation."⁷

AIV.3 **Legal Research:** The working group reviewed the Ontario Human Rights Code and current case law concerning equality rights and freedom of conscience and religion.⁸

AV. Report to College Council

AV.1 On December 4-5, 2014 the full College Council met to consider College business. It was provided a 630 page briefing book dealing with agenda items.⁹ This included a seven page briefing note,¹⁰ a copy of the existing *Physicians and the Ontario Human Rights Code* and a copy of its draft replacement, *Professional Obligations and Human Rights (POHR)*.¹¹

Public Polling

AV.2 The briefing note from the working group provided the following information to the College Council concerning the poll conducted in May:

71% believed that physicians should not be allowed to refuse to provide a treatment or procedure because it conflicts with the physicians' religious or moral beliefs.

- Objectors should be required Provide patients with information about treatment or procedure options (94%)
- Identify another physician who will provide the treatment, and advise the patient to contact them (92%)
- Make/coordinate the referral (87%)¹²

Consultation

AV.3 Concerning the consultation, the working group told that Council that "the vast majority of respondents expressed their support for freedom of conscience, and the idea that physicians should not have to provide services that conflict with their moral and/or religious beliefs," but added that the feedback was polarized.¹³ On the question of referral, the Council was told "many respondents were in support of a referral requirement" but that "the opposing viewpoint was also strongly represented."¹⁴

AV.4 Appendix "C" demonstrates that this summary was inadequate and misleading.

Research

AV.5 An appendix to the working group's briefing note (Appendix 3) summarized the jurisdictional research.¹⁵ Council was advised that the proposed draft policy, *Professional Obligations and Human Rights (POHR)*, "reflects research undertaken, feedback received during the preliminary consultation and public polling results."¹⁶

Action

AV.6 The working group asked the Council for feedback on the document and asked that it recommend that *Professional Obligations and Human Rights (POHR)* be released "for external consultation." Council agreed.

AVI. Working group comments

AVI.1 When POHR was released in December, 2014, Dr. Marc Gabel, then President of the College, stated that public polling by the College (AV.2) demonstrated that "the vast majority of Ontarians believe that [objecting physicians] should be required to identify another physician who will provide the treatment, and make and/or coordinate a referral."¹⁷

AVI.2 The Supreme Court of Canada announced that it would release its decision in *Carter v. Canada* on 6 February, 2015. It was widely expected that the Court would legalize physician assisted suicide and euthanasia. Media reports took note that *Professional Obligations and Human Rights* (POHR) would compel objecting physicians to refer for euthanasia. Interviewed in anticipation of the ruling, Dr. Gabel did not deny this.

Whatever its policy ultimately looks like, the college is clear: a patient's right to access services outweighs a doctor's right to refuse them. "We prioritize the interests of our patients in facilitating access," says Dr. Marc Gabel, past president of the college and chair of the policy's working group.¹⁸

AVI.3 In addition, he claimed that POHR introduced nothing new:

Similar policies are already in place in Alberta, Manitoba, Quebec and New Brunswick, Dr. Gabel says: "This is nothing new."¹⁹

AVI.4 Appendix "B" demonstrates that, apart from Quebec, this claim is seriously misleading.

Notes

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3. College of Physicians and Surgeons of Ontario, College Consultations: *Physicians and the Ontario Human Rights Code*. (http://policyconsult.cpso.on.ca/?page_id=3403) Accessed 2015-02-16
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10. College of Physicians and Surgeons of Ontario, *Council Briefing Note: Professional Obligations and Human Rights - Draft for Consultation (For Decision)* (December, 2014) (<http://www.consciencelaws.org/archive/documents/cpso/2014-12-cpso-briefing.pdf>). In *Annual Meeting of Council, December 4-5, 2014*, p. 326-332 (Accessed 2015-02-03)
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12. College of Physicians and Surgeons of Ontario, *Council Briefing Note: Professional Obligations and Human Rights - Draft for Consultation (For Decision)* (December, 2014) (<http://www.consciencelaws.org/archive/documents/cpso/2014-12-cpso-briefing.pdf>). In *Annual Meeting of Council, December 4-5, 2014*, p. 330. Accessed 2015-02-03.
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15. College of Physicians and Surgeons of Ontario, *Appendix 3- Jurisdictional Review*. ([../archive/documents/cpso/2014-12-cpso-briefing-appendix.pdf](http://www.consciencelaws.org/archive/documents/cpso/2014-12-cpso-briefing-appendix.pdf)) In *Annual Meeting of Council, December 4-5, 2014*, p. 342-352. Accessed 2015-02-03.

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Appendix “B”

Unreliability of Jurisdictional Review by College Working Group

BI. Overview of deficiencies in briefing supplied to Council

BI.1 In Appendix 3 to the briefing note on *Professional Obligations and Human Rights*,¹ the Council was provided with an overview of policies on discrimination and conscientious objection in Canada, the United Kingdom, the United States, Australia and New Zealand, as follows:

CANADA

Canadian Medical Association
Society of Obstetricians and Gynecologists of Canada

British Columbia

- College of Physicians and Surgeons

Alberta

- College of Physicians and Surgeons

Saskatchewan

- College of Physicians and Surgeons

Manitoba

- College of Physicians and Surgeons

Ontario

- Pharmacists
- Nurses
- Midwives

Quebec

- Collège des Médecins du Québec

New Brunswick

- College of Physicians and Surgeons

AUSTRALIA

- General Medical Council
- Australian Medical Association
- Australian Medical Students’ Association

NEW ZEALAND

- General Medical Council

UNITED KINGDOM

- General Medical Council

UNITED STATES

- American Medical Association
- American College of Obstetricians and Gynecologists
- American Academy of Pediatrics
- American College of Emergency Physicians

BI.2 With respect to the issue of physician freedom of conscience and referral in particular,

- A. the accounts provided in Appendix 3 of the policies of the Canadian Medical Association were **deficient**;
- B. the accounts provided in Appendix 3 of the policies of the Colleges of Physicians of British Columbia, Alberta, Nova Scotia, Prince Edward Island, Newfoundland, New Brunswick and Quebec were **deficient**;
- C. the information provided in Appendix 3 concerning the Australian Medical Association was **erroneous and seriously misleading**;
- D. the information provided in Appendix 3 concerning New Zealand was **deficient and seriously misleading**;
- E. the account provided in Appendix 3 concerning policies in the United States was **deficient and superficial**;
- F. the account provided in Appendix 3 concerning nursing policies in Ontario was **deficient and misleading**;
- G. Appendix 3 failed to reference significant documents from Canadian authorities relevant to the issues.

BII. Particulars of deficiencies in briefing supplied to the Council

BII.1 Deficient accounts of CMA policies

BII.1.1 Extracts from the CMA *Code of Ethics* and policy documents were provided in Appendix 3 at P. 7 (p. 348). However, the following sections were left out of the extract from the CMA *Code of Ethics*:

- 7. Resist any influence or interference that could undermine your professional integrity.
- 9. Refuse to participate in or support practices that violate basic human rights.²

BII.1.2 In addition, the following sections were left out of the extract from the CMA *Policy on Induced Abortion*:³

- No discrimination should be directed against doctors who do not perform or assist at

induced abortions. Respect for the right of personal decision in this area must be stressed, particularly for doctors training in obstetrics and gynecology, and anesthesia.

- No discrimination should be directed against doctors who provide abortion services.

BII.1.3 The working group failed to include the following clarification of CMA policy provided in response to a claim that CMA policy required physicians to refer for abortions:

- **CMAJ April 24, 2007 vol. 176 no. 9 1310** CMA policy states that “a physician should not be compelled to participate in the termination of a pregnancy.” In addition, “a physician whose moral or religious beliefs prevent him or her from recommending or performing an abortion should inform the patient of this so that she may consult another physician.” You should therefore advise the patient that you do not provide abortion services. You should also indicate that because of your moral beliefs, you will not initiate a referral to another physician who is willing to provide this service (unless there is an emergency). However, you should not interfere in any way with this patient’s right to obtain the abortion. At the patient’s request, you should also indicate alternative sources where she might obtain a referral. This is in keeping with the obligation spelled out in the CMA policy: “There should be no delay in the provision of abortion services.”⁴

BII.1.4 The working group failed to include the following CMA policy document:

- **Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care (1999)** Para. 16. Health care providers should not be expected or required to participate in procedures that are contrary to their professional judgement or personal moral values or that are contrary to the values or mission of their facility or agency. Health care providers should declare in advance their inability to participate in procedures that are contrary to their professional or moral values. Health care providers should not be subject to discrimination or reprisal for acting on their beliefs. The exercise of this provision should never put the person receiving care at risk of harm or abandonment.⁵

BII.1.5 The working group failed to include the following from the CMA intervention in *Carter v. Canada* at the Supreme Court:

- **CMA Factum: 3)** As long as such practices remain illegal, the CMA believes that physicians should not participate in medical aid in dying. If the law were to change, the CMA would support its members who elect to follow their conscience.⁶
- **CMA Factum: 9)** . . . The CMA's policies are not meant to mandate a standard of care for members or to override an individual physician's conscience.⁵
- **CMA Factum: 16)** It is acknowledged that just moral and ethical arguments form the basis of arguments that both support and deny assisted death. The CMA accepts that, in the face of such diverse opinion, based on individuals' consciences, it would not be appropriate for it to seek to impose or advocate for a single standard for the medical profession.⁵

- **CMA Factum:** 27) In addition, if the law were to change, no physician should be compelled to participate in or provide medical aid in dying to a patient, either at all, because the physician conscientiously objects to medical aid in dying, or in individual cases, in which the physician makes a clinical assessment that the patient's decision is contrary to the patient's best interests. Notably, no jurisdiction that has legalized medical aid in dying compels physician participation. If the attending physician declines to participate, every jurisdiction that has legalized medical aid in dying has adopted a process for eligible patients to be transferred to a participating physician.⁵
- **CMA Counsel Harry Underwood, oral submission** [Webcast 228:32/491:20]: With the profession now divided between the two positions, each defensible on the basis of established medical ethical considerations and compassion for the patient, the CMA has decided to accept that physician assisted death, if it should become legal, may properly be undertaken by physicians who can square their participation with their own consciences, without overriding the consciences of those who object to performing it.⁷

BII.2 Deficient accounts of Colleges of Physicians policies

- BII.2.1 The Colleges of Physicians and Surgeons of British Columbia, Alberta, Saskatchewan, Nova Scotia, Newfoundland and Prince Edward Island have all adopted the *CMA Code of Ethics*.⁸ The working group failed to include this information in the briefing materials. The policies of these Colleges thus include the following:
- 12. Inform your patient when your personal values would influence the recommendation or practice of any medical procedure that the patient needs or wants.
 - 18. Provide whatever appropriate assistance you can to any person with an urgent need for medical care.
 - 21. Provide your patients with the information they need to make informed decisions about their medical care, and answer their questions to the best of your ability.
- BII.2.2 Since these six Colleges have adopted the *CMA Code of Ethics*, one would expect them to subscribe to related CMA policies, subject to changes explicitly adopted by each College. These include:
- No discrimination should be directed against doctors who do not perform or assist at induced abortions. Respect for the right of personal decision in this area must be stressed, particularly for doctors training in obstetrics and gynecology, and anesthesia.
 - No discrimination should be directed against doctors who provide abortion services.
- BII.2.3 **British Columbia:** Extracts of the CPSBC policy document *Access to Medical Care*⁹ were provided in Appendix 3, P. 4 (p. 345). However, the working group failed to provide a relevant passage in the policy. The working group also included one sentence from the text (italicized below) under the sub-heading “Referrals.” The sub-heading does not exist in the original text. The complete text follows. The parts **not included** by the working group are

in bold face.

- **Physicians are not obliged to provide treatments or procedures to patients which are medically unnecessary or deemed inappropriate based on scientific evidence and their own clinical expertise.**
- **While physicians may make a personal choice not to provide a treatment or procedure based on their values and beliefs,** the College expects them to provide patients with enough information and assistance to allow them to make informed choices for themselves. This includes advising patients that other physicians may be available to see them, or suggesting that the patient visit an alternate health-care provider. *Where needed, physicians must offer assistance and must not abandon the patient.*
- **Physicians in these situations should not discuss in detail their personal beliefs if not directly relevant and should not pressure patients to disclose or justify their own beliefs.**
- **In all cases, physicians must practise within the confines of the legal system, and provide compassionate, non-judgmental care according to the CMA Code of Ethics.**

BII.2.4 In response to queries from the Protection of Conscience Project, the Deputy Registrar of the CPSBC provided the following explanation of this document:

- . . . Your concern focused on the paragraph dealing with conscientious objection and specifically our advice that "where needed physicians must offer assistance and must not abandon the patient." I would like to reassure you that we did not intend this sentence or the paragraph that preceded it to require physicians to provide any treatment that they believe to be either clinically inappropriate or unethical. We were trying to direct physicians to offer whatever assistance they feel professionally and ethically able to offer, and not to withdraw from the care of a patient when unable to provide what the patient is specifically requesting. . .
. . .It was our intention to support the position that all patients have a right to access appropriate medical care but cannot oblige physicians to provide treatments which they believe to be medically inappropriate or unethical.¹⁰
- **Administrator:** Is *Access to Medical Care* to be understood to require physicians to *do* what they believe to be immoral or unethical?
Deputy Registrar: No
- **Administrator:** Does the College propose to take disciplinary action against physicians who refuse to *do* what they believe to be immoral or unethical?
Deputy Registrar: No, unless the College considers that in those specific circumstances the physician abandoned the patient without providing an appropriate level of medical care.¹¹

- BII.2.5 In brief, the CPSBC document *Access to Medical Care* does not require that objecting physicians provide what the CPSO draft policy calls “an effective referral.”
- BII.2.6 **Alberta:** A copy of the CPSA policy document *Moral or Religious Beliefs Affecting Medical Care*¹² was provided in Appendix 3, P. 4 (p. 345). The working group also included one sentence from the text under the sub-heading “Referrals.” The sub-heading does not exist in the original text:
- When moral or religious beliefs prevent a physician from providing or offering access to information about a legally available medical or surgical treatment or service, that physician must ensure that the patient who seeks such advice or medical care is offered timely access to another physician or resource that will provide accurate information about all available medical options.
- BII.2.7 The working group was obviously unfamiliar with the development and meaning of *Moral or Religious Beliefs Affecting Medical Care*.
- BII.2.8 This provision is part of the *Standards of Practice* adopted by the CPSA following public consultation in 2008. The original draft *Standards* included a section concerning the termination of pregnancy which included the statement, “ensure that the patient. . . is offered access to available medical options.” In its submission to the College, the Project warned that the wording was likely to be interpreted to impose a duty to refer for or otherwise facilitate procedures or services the physician believes to be wrong, and that many objecting physicians would find that unacceptable.¹³
- BII.2.9 Consistent with this warning, the Registrar of the College later stated:
- Most respondents take exception with the draft, believing that the College will require physicians to refer patients for termination of pregnancy, or at the very least to be compliant in arranging a patient’s abortion, contrary to the physician’s personal beliefs. This is not true. . . .
- . . . The College’s current policy (in place for the past decade) states:
- While recognizing the varied personal convictions of physicians it must still be the responsibility of physicians to ensure that pregnant women who come to them for medical care are provided with or are offered access to information or assistance to enable them to make informed decisions on all available options for their pregnancies including termination.
- The points I wish to make are these: A Standard of Practice on this subject will not change the obligations of physicians that have been accepted by this College since 1991. The words are a little different, but the intent is not, as the principles underlying the standard have not changed over the past 20 years. (Emphasis in the original)¹⁴
- BII.2.10 The section concerning terminations of pregnancy was deleted from the final version of the Standards and the policy *Moral or Religious Beliefs Affecting Medical Care* adopted.

BII.2.11 As a result of questions from physicians, the Project Administrator wrote to the Registrar of the College and was provided with the new policy, *Moral or Religious Beliefs*. The Administrator asked the Registrar to confirm that he correctly understood the policy:

- I understand the expectation of referral . . . to hold in those cases in which a physician, for reasons of conscience, is unwilling to advise a patient that a procedure is legally available, or unwilling to explain precisely what is involved with the procedure, its purported risks and benefits, or provide other information a reasonable patient would need to have in order to decide whether or not to undergo an abortion (or assisted suicide, euthanasia, etc.).

In such cases, the physician is expected to direct the patient to another physician or resource who is willing to provide this information. It seems clear from the wording of all of these passages that they are meant to ensure that a patient has all of the information necessary to make an informed decision about treatment options. None of these passages imply that there is a duty to refer patients in order to facilitate abortion (or assisted suicide, euthanasia, etc.).¹⁵

BII.2.12 The Registrar responded:

- You are correct in your understanding that it is a physician’s obligation to ensure his or her patient has the necessary information to make an informed decision. It would be unacceptable behaviour for a physician to deny a patient access to such information.¹⁶

BII.2.13 The working group was not aware of this correspondence. However, it did not include the CPSA explanation of the policy that is available on its website to the same effect.¹⁷

BII.2.14 The correspondence and explanation make clear that the focus of the policy is the communication of information. If, for reasons of conscience, the physician cannot provide information about a treatment or service, the patient must be directed to a physician who can supply that information. *Moral or Religious Beliefs Affecting Medical Care* does not require an objecting physician to provide what the CPSO draft policy calls “an effective referral.”

BII.2.15 **Newfoundland:** The working group made no reference to Newfoundland. In addition to subscribing to the CMA policies noted in II.2.1 and II.2.2, the College in Newfoundland has adopted the *Physician’s Charter* “as forming part of the ethical foundation of medical practice in Newfoundland and Labrador.” This includes the following statement:

- Physicians must be honest with their patients and empower them to make informed decisions about their treatment. Patients' decisions about their care must be paramount, as long as those decisions are in keeping with ethical practice and do not lead to demands for inappropriate care.¹⁸

BII.2.16 The policies of the College of Physicians and Surgeons of Newfoundland and Labrador do not reflect the view that objecting physicians must provide what the CPSO draft policy calls “an effective referral.”

- BII.2.17 **Saskatchewan:** In addition to failing to note the CPSS adherence to the CMA *Code of Ethics* and related policies, the working group failed to note the College’s guideline, *Unplanned Pregnancy*.¹⁹
- BII.2.18 While it was still in preparation, media reports stated that the policy would require referral by objecting physicians.²⁰ However, the Deputy Registrar stated that the College was merely clarifying the 1991 policy, not changing it,²¹ and the 1991 policy did not require objecting physicians to refer a patient to someone who would provide an abortion.²² As adopted, *Unplanned Pregnancy* is ambiguous with respect to referral.²³
- BII.2.19 The policies of the College of Physicians and Surgeons of Saskatchewan do not reflect the view that objecting physicians must provide what the CPSO draft policy calls “an effective referral.”
- BII.2.20 **New Brunswick:** An extract of the CPSNB policy document *Moral Factors and Medical Care*²⁴ was provided in Appendix 3, P. 5 (p. 346). However, the working group failed to note that it was based on the Alberta policy (BII.2.6) and failed to include the following relevant introductory paragraphs:
- From time to time, physicians may be confronted with situations where they may be requested to provide a treatment or procedure to which they have an objection on moral or religious grounds. In that regard, physicians should be guided by the *Code of Ethics*, which advises as follows:
 - 12. Inform your patient when your personal values would influence the recommendation or practice of any medical procedure that the patient needs or wants.
 - 21. Provide your patients with the information they need to make informed decisions about their medical care, and answer their questions to the best of your ability.
- BII.2.21 The preceding paragraphs provide the context for the direction extracted by the working group. The extract included one paragraph (reproduced below) under the sub-heading “Referrals.” The sub-heading does not exist in the original text.
- When moral or religious beliefs prevent a physician from providing or offering access to information about a legally available medical or surgical treatment or service, that physician must ensure that the patient who seeks such advice or medical care is offered timely access to another physician or resource that will provide accurate information about all available medical options.
- BII.2.22 *Moral Factors and Medical Care*, like that of the College in Alberta upon which it is based, does not reflect the view that objecting physicians must provide what the CPSO draft policy calls “an effective referral.”
- BII.2.23 **Manitoba:** An extract of the CPSM policy document *Discrimination in Access to Physicians*²⁵ was provided in Appendix 3, P. 1 (p. 342). However, the working group failed to include the paragraph following the extract provided:

- The College has been advised that some physicians:
 1. are refusing to provide care to existing patients in their practice in relation to medical issues that involve MPI, WCB or an insurance claim.
 2. are refusing to accept new patients into their practice on the grounds that the patient needs assistance with respect to MPI, WCB, or an insurance claim or that the patient’s care needs are too complex.
- BII.2.24 *Discrimination in Access to Physicians* was issued as a result of a problem completely unrelated to the exercise of freedom of conscience by physicians. It does not reflect the view that objecting physicians must provide what the CPSO draft policy calls “an effective referral.”
- BII.2.25 The working group provide an extract of a CPSM document in Appendix 3, P. 4 (p. 345), incorrectly identified as *Discrimination in Access to Physicians*. The document in question is actually *Members Moral or Religious Beliefs Not to Affect Medical Care*.²⁶ The extract included one paragraph (reproduced below) under the sub-heading “Referrals.” The sub-heading does not exist in the original text.
- If the moral or religious beliefs of a member prevent him or her from providing or offering access to information about a legally available medical or surgical treatment or service, the member must ensure that the patient who seeks such advice or medical care is offered timely access to another physician or resource that will provide accurate information about all available medical options.
- BII.2.26 The wording is virtually identical to the wording of previously noted policies of the Colleges of Alberta (II.2.6) and New Brunswick (II.2.21). These policies are directed to ensuring that patients have information about all available medical options. They do not reflect the view that objecting physicians must provide what the CPSO draft policy calls “an effective referral.”
- BII.2.27 **Quebec:** An extract of *Legal, Ethical and Organizational Aspects of Medical Practice in Québec (ALDO-Québec)*²⁷ concerning the Collège des Médecins du Québec *Code of Ethics* was provided in Appendix 3, P. 5 (p. 346). The extract included one sentence from the *Code of Ethics* under the sub-heading “Referrals.” The sub-heading does not exist in the original text or *Code of Ethics*. *ALDO-Quebec* provides guidance on the interpretation and application of the *Code of Ethics*. The key passage included in the extract provided is:
- For example, a physician who is opposed to abortion or contraception is free to limit these interventions in a manner that takes into account his or her religious or moral convictions. However, the physician must inform patients of such when they consult for these kinds of professional services and assist them in finding the services requested.
- BII.2.28 This is the requirement for “effective referral” found in the CPSO draft policy.
- BII.2.29 The working group did not explain that the President and Director General of the Collège des Médecins du Québec has publicly acknowledged that this nullifies freedom of

conscience. This information was provided to the working group in the first Protection of Conscience Project submission. The working group did refer to it. Dr. Charles Bernard told Quebec legislators:

- [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.²⁸

BII.3 Erroneous and seriously misleading accounts of Australian policies

- BII.3.1 Extracts from a document identified as *Information for GPs: Conscientious Objection to the Termination of Pregnancy* were provided in Appendix 3 at P. 9 (p. 350). The extracts chosen by the working group purport to represent the position of the Australian Medical Association with respect to referral for abortion by objecting physicians. They do not.
- BII.3.2 *Conscientious Objection to the Termination of Pregnancy: Information for GPs* is actually a document released in June, 2013 by the Australian Medical Association's branch in the state of Victoria (AMA Victoria).²⁹ It does not represent the policy of the Australian Medical Association concerning referral for morally contested services. This is not evident from the extract provided because, in copying the extracts, the working group deleted information identifying the source.
- BII.3.3 *Conscientious Objection to the Termination of Pregnancy: Information for GPs* pertains to the *Abortion Law Reform Act of 2008* in the state of Victoria, not to national legislation. This is not evident from the extract provided because, in copying the extracts, the working group deleted the first paragraph, which identifies this *Act* as the focus of the document.
- BII.3.4 The *Abortion Law Reform Act of 2008* includes a provision that requires physicians who object to abortion for reasons of conscience or religion to refer patients to physicians who do not have such an objection.³⁰ Contrary to the impression created by the extracts, AMA Victoria opposed the provision when the legislation was under consideration.
- Victoria's doctor union has told the state government it cannot support forcing doctors who conscientiously object to abortions to refer patients on.
Their objection is the same one over which the Catholic Church has threatened to close its hospitals.
The Australian Medical Association (AMA) Victoria wrote to Premier John Brumby on September 1, telling him it could not support the conscientious objection clause of the Abortion Law Reform Bill.
The bill would legalise abortion at up to 24 weeks gestation and make it compulsory for doctors who conscientiously object to abortions to refer the woman to another health professional who has no objections.

The AMA said while it welcomed parliament legalising abortion, it could not support the conscientious objection clause and asked it to be removed or amended to reflect existing law.

“Doctors are currently not forced to provide a service they believe to be unethical or immoral,” AMA Victoria president Douglas Travis said in the letter.

“AMA Victoria supports the existing law and ethical obligation to properly inform patients and ensure that services are elsewhere available.

“Respect for a conscientious objection is a fundamental principle in our democratic country, and doctors expect that their rights in this regard will be respected, as for any other citizen.” . . .³¹

BII.3.5 Despite the opposition of AMA Victoria and others, the mandatory referral provision was retained. *Conscientious Objection to the Termination of Pregnancy: Information for GPs* was issued to help physicians in the state of Victoria avoid conflict with the law. In fact, five months *after* AMA Victoria published it, the Association continued to lobby for the removal of the mandatory referral provision.³²

BII.3.6 The actual position of the Australian Medical Association is set out in its *Code of Ethics* and in a supplementary policy on conscientious objection issued in 2013. Neither of these documents was included in Appendix 3 by the working group. The AMA *Code of Ethics* states:

- 1.1.p. When a personal moral judgement or religious belief alone prevents you from recommending some form of therapy, inform your patient so that they may seek care elsewhere.³³

BII.3.7 Similar statements are included in two other AMA documents, neither of which were included in Appendix 3 by the working group.

- **Reproductive Health And Reproductive Technology (1998: Revised 2005)**

6. When a personal moral judgement or religious belief prevents doctors from recommending some form of therapy, they should so inform their patients. They should also inform patients that such therapy may be available elsewhere.³⁴

- **Ethical Issues in Reproductive Medicine (2013)**

1.6. A doctor who chooses not to provide clinical services, or conduct research, in reproductive medicine should not be subject to discrimination or stigmatisation.

1.7. A doctor should not be expected to participate in clinical or research activities that conflict with his or her personal convictions. When a doctor faces these conflicts, they should inform their patients so that they may seek care elsewhere and should not impede access to care. In an emergency situation, doctors are required to continue care for the patient until their services are no longer required.³⁵

BII.3.8 An explanation of this section of the *Code* within the context of the state of Victoria’s

abortion law was provided in 2009 by AMA Secretary General Francis Sullivan. He stated that the *Code* “does not mean that doctors have a duty to directly refer the patient for the specific treatment in question.” Further:

- Proponents for the bill argued that the existing Victorian law was not changing, and the inclusion of the referral clause for doctors exercising their conscience was no different to what doctors understood their *Code* to instruct. Their *Code* being the AMA *Code*. Now it’s important to know that in actual fact the AMA *Code* does not say that doctors are obliged to refer.³⁶

BII.3.9 The Australian Medical Association’s lengthy position statement, *Conscientious Objection* was issued in 2013.³⁷ Of particular relevance to the draft CPSO policy is the following:

- 1. Doctors (medical practitioners) are entitled to have their own personal beliefs and values, as are all members of society. There may be times, however, where a doctor’s personal beliefs conflict with their peer-based professional practice. In exceptional circumstances, and as a last resort, a doctor may refuse to provide, or participate in, certain medical treatments or procedures that conflict with his or her own personal beliefs. [For the purposes of this position statement, ‘participation’ may include indirect actions such as referring the patient to another doctor who will provide the service.]

BII.3.10 Thus, the actual position of the Australian Medical Association on this point is exactly the opposite of what is implied in the materials supplied by the working group.

BII.3.11 The materials supplied by the working group in Appendix 3 do not advert to the position taken by AMA Tasmania when the state legislature was considering the *Reproductive Health (Access to Terminations) Act* (No. 72 of 2013). An early version of the bill included a provision like that in the Victoria law that would have required a physician who objected to abortion to refer a patient to a non-objecting physician. AMA Tasmania opposed this clause.

- Mandating a conscientious objector to make a referral to another doctor could be viewed as denying that doctor the ability to live according to their beliefs (if the person considers providing a referral to be participating in an activity to which they object).³⁸

BII.3.12 It is instructive to note that a representative of the Australian Health Practitioner Regulation Association reportedly told a Tasmanian legislative committee that physicians who object to a procedure for reasons of conscience are obliged by professional codes of ethics to refer patients to another physician.³⁹ This was precisely the kind of misrepresentation described by Francis Sullivan with respect to the Victoria abortion law (BII.3.8). The AMA Tasmania submission disproved that claim, quoting the AMA *Code of Ethics*, the AMA position statement on *Reproductive Health and Technology*, and the Medical Board of Australia *Code of Conduct*.

BII.3.13 The Australian Medical Council is a national standards body for medical education and training.⁴⁰ The extracts in Appendix 3, p. 9 (P. 350) attributed to a General Medical

Council are from a draft code of conduct developed by the Council⁴¹ and subsequently adopted by the Medical Board of Australia.⁴²

BII.3.14 Contrary to the impression created by the extracts in Appendix 3 at p. 9 (P. 350), the policies of the Australian Medical Council, Medical Board of Australia and the Australian Medical Association do not reflect support of a policy of “effective referral” proposed in the CPSO draft policy. In fact, the actual position of the Australian Medical Association on this point is exactly the opposite of what is implied in the materials supplied by the working group.

BII.4 Deficient and seriously misleading accounts re: New Zealand

BII.4.1 Extracts of the Medical Council of New Zealand policy document *Good Medical Practice* concerning “Personal Beliefs and the Patient” were provided in Appendix 3, P. 8 (p. 349).⁴³ The extracts were accurate, but the working group failed to include reference to the *Contraception, Sterilisation, and Abortion Act (1977)*⁴⁴ which provides for conscientious objection by health care workers, including physicians, nurses and pharmacists:

- **46. Conscientious objection**

(1) Notwithstanding anything in any other enactment, or any rule of law, or the terms of any oath or of any contract (whether of employment or otherwise), no registered medical practitioner, registered nurse, or other person shall be under any obligation-

(a) To perform or assist in the performance of an abortion or any operation undertaken or to be undertaken for the purpose of rendering the patient sterile:

(b) To fit or assist in the fitting, or supply or administer or assist in the supply or administering, of any contraceptive, or to offer or give any advice relating to contraception,

if he objects to doing so on grounds of conscience.

BII.4.2 The working group also failed to include reference to the *Health Practitioners Competence Assurance Act 2003*:⁴⁵

- **174. Duty of health practitioners in respect of reproductive health services**

(1) This section applies whenever -

(a) a person requests a health practitioner to provide a service (including, without limitation, advice) with respect to contraception, sterilisation, or other reproductive health services; and

(b) the health practitioner objects on the ground of conscience to providing the service.

(2) When this section applies, the health practitioner must inform the person who requests the service that he or she can obtain the service from another health practitioner or from a family planning clinic.

- BII.4.3 The working group also failed to include reference to a 2010 decision of the High Court in Wellington, New Zealand, that considered both of these statutes. Mr. Justice Alan MacKenzie unambiguously ruled that the General Medical Council could not force objecting physicians to provide what the draft CPSO policy calls “an effective referral” for abortion.⁴⁶
- BII.4.4 The failure to include the statutory provisions and outcome of *Hallagan et al v. General Medical Council NZ* in Appendix 3 is likely to leave a reader with the false impression that New Zealand has no guidelines concerning referral for morally contested procedures.
- BII.4.5 Contrary to the impression that might be created by the extracts in Appendix 3, P. 8 (p. 349), GMC New Zealand policies do not reflect support of a policy of “effective referral” proposed in the CPSO draft policy. In fact, the law in New Zealand prohibits it.

BII.5 Deficient and superficial accounts re: United States

- BII.5.1 A single sentence from an article in *Virtual Mentor* titled “Legal Protection for Conscientious Objection by Health Professionals” was provided in Appendix 3, P. 10 (p. 351) as representative of the position of the American Medical Association. *Virtual Mentor* (now the *AMA Journal of Ethics*) is a source of short essays about medical ethics that present a wide range of opinions on a variety of topics, including freedom of conscience in health care. They do not necessarily represent the position of the American Medical Association. In fact, the article was about conscientious objection among pharmacists, not about the policies of the American Medical Association concerning freedom of conscience in health care.⁴⁷
- BII.5.2 In November, 2014, the AMA House of Delegates adopted a new policy concerning physician exercise of freedom of conscience, which will be formally issued in June. The AMA website states, “Reports not available online (such as those recently adopted by the AMA and pending publication) are made available upon request by contacting CEJA staff.”⁴⁸
- BII.5.3 A policy document of the American College of Obstetricians and Gynecologists was quoted at length in Appendix 3, P. 10 (p. 351). *The Limits of Conscientious Refusal in Reproductive Medicine*⁴⁹ is a controversial document. It was discussed in hearings into “Conscience in the Practice of the Health Professions” held by the President’s Council on Bioethics under the chairmanship of Dr. Edmund D. Pellegrino. Professor Robert P. George critiqued the document.
- . . .The report . . . in its driving assumptions, reasoning, and conclusions is not morally neutral. . . It represents a partisan position among the family of possible positions debated or adopted by people of reason and goodwill in the medical profession and beyond. Indeed, for me, the partisanship of the report is its most striking feature. . .
- . . .The report's "my way or the highway" view of the thing is anything but an acknowledgement of the widespread and thoughtful disagreement among physicians

and society at large and the moral sincerity of those with whom one disagrees. Indeed, it is a repudiation of it.⁵⁰

- BII.5.4 *The Limits of Conscientious Refusal in Reproductive Medicine* and the response to it by critics is a practical introduction to the kind of serious conflicts underway in the United States concerning the exercise of freedom of conscience by health care workers. It is by no means an uncontested model policy.
- BII.5.5 The recommendations of the American Academy of Pediatrics are quite different in tone and substance and largely unexceptionable. A duty of referral is generally recognized by objecting health care workers when failure to do so would result in death or serious injury to a patient, so the acceptability of the AAP assertion of a duty to refer to avoid “harm” to a patient depends entirely upon what the AAP means by “harm.”⁵¹
- BII.5.6 As in the case of New Zealand, Appendix 3 failed to refer to the existence of American laws that are relevant to the exercise of freedom of conscience by physicians. There are numerous federal laws protection of conscience laws, and almost every state has protection of conscience provisions in its laws.⁵²
- BII.5.7 For example: the new *Patient Protection and Affordable Care Act*, a federal law intended to provide health care insurance coverage, includes the following provision:
- IN GENERAL -Nothing in this Act shall be construed to have any effect on Federal laws regarding-
 - (i) conscience protection;
 - (ii) willingness or refusal to provide abortion; and
 - (iii) discrimination on the basis of the willingness or refusal to provide, pay for, cover, **or refer for** abortion or to provide **or participate in** training to provide abortion. (Emphasis added)⁵³
 - In General- The Federal Government, and any State or local government or health care provider that receives Federal financial assistance under this Act (or under an amendment made by this Act) or any health plan created under this Act (or under an amendment made by this Act), may not subject an individual or institutional health care entity to discrimination on the basis that the entity does not provide any health care item or service furnished for the purpose of causing, or for the purpose of **assisting in causing**, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing. (Emphasis added)⁵⁴
- BII.5.8 Among state laws, Illinois’ *Health Care Right of Conscience Act* is the most comprehensive. In force since 1998, it prohibits discrimination against individuals or facilities that refuse to “receive, obtain, accept, perform, assist, counsel, suggest, recommend, **refer or participate in any way** in any particular form of health care services contrary to his or her conscience.” (Emphasis added)⁵⁵
- BII.5.9 As an outline of the situation in the United States relevant to the draft CPSO policy

requiring “an effective referral,” Appendix 3 is deficient and superficial.

BII.6 Deficient and misleading account of Ontario nursing policies

- BII.6.1 A paragraph of the College of Nurses of Ontario policy document *Ethics* was provided in Appendix 3, P. 6 (p. 347). The paragraph appears in three places in the document. The first was taken from a discussion of conflict between client choice and a nurse’s values. The context for the chosen paragraph was a discussion of a client’s choice of risky behaviours. This was summarized in the sentence immediately preceding the chosen paragraph:
- Nurses may believe that, as health care professionals, they know what is best for clients; however, clients have the right to choose a risky course of action.⁵⁶
- BII.6.2 The scenarios and behavioural directives provided in *Ethics* following the chosen paragraph confirmed the context: an competent 85 year old patient who likes to walk along a busy highway, and a patient with difficulty swallowing who insists on solid rather than puréed food.⁵⁷
- BII.6.3 The paragraph appears a second time under the heading, “Respect for life,” the context for which was established in the preceding paragraph:
- Health care professionals need to make every reasonable effort to preserve human life. Technology now allows life to be preserved longer. Many health care professionals and clients believe that some treatments that preserve life at all costs are unacceptable when the quality of life is questionable.⁵⁸
- BII.6.4 The scenario and behavioural directives provided in *Ethics* following the chosen paragraph concerned a case in which the health care team was considering the use of a feeding tube, contrary to direction given by a patient who has since become uncommunicative, subject to the consent of her spouse.⁵⁹
- BII.6.5 The paragraph appears a third time under the heading, “Maintaining commitments to oneself,” the context for which was established in the preceding paragraph:
- As people learn and grow, they develop their personal values and beliefs. Nurses need to recognize and function within their value system and be true to themselves. Nurses’ values sometimes differ from those of other health care professionals, employers and clients, causing ethical conflict. Nurses must provide ethical care while at the same time remaining committed to their values.⁶⁰
- BII.6.6 The scenario and behavioural directives provided in *Ethics* following the chosen paragraph concerned a case in which a family had directed the withdrawal of a feeding tube from a comatose patient.⁶¹
- BII.6.7 The working group selected the paragraph from *Ethics* provided in Appendix 3 without providing the context. The first case is not analogous to situations in which nurses decline to participate in treatment for reasons of conscience. The second and third scenarios do not involve situations in which a nurse is ordered to do something she believes to be wrong.

More important, the problems presented in the latter scenarios can be resolved by referring to documents and legislation neglected by the working group.

- BII.6.8 The working group did not provide relevant information from another College of Nurses policy document, *Refusing Assignments and Discontinuing Nursing Services*, more pertinent to situations in which nurses decline to provide treatment for reasons of conscience. According to this document, discontinuing nursing services constitutes patient abandonment when, having accepted an assignment, a nurse discontinues care without
- getting the client’s permission;
 - arranging a suitable alternative or replacement service; or
 - **allowing a reasonable opportunity for alternative or replacement services to be provided.**⁶² (Emphasis added)
- BII.6.9 This almost exactly parallels the legal definition of professional misconduct in such circumstances defined by Ontario Regulation 799/93, which, in defining professional misconduct, includes the following:
5. Discontinuing professional services that are needed unless,
- i. the client requests the discontinuation,
 - ii. alternative or replacement services **are arranged**, or
 - iii. **the client is given a reasonable opportunity to arrange alternative or replacement services.**⁶³ (Emphasis added)
- BII.6.10 *Refusing Assignments and Discontinuing Nursing Services* and the regulation both provide alternatives that would likely be acceptable to most objecting nurses (see boldface passages above), since they do not require an objecting nurses to actively find someone willing to do what they find objectionable. The alternatives they provide would resolve the problems presented in the scenarios presented in *Ethics*, without requiring the objecting nurse to arrange for the morally contentious treatment or procedure to be done by someone else, or forcing the objecting nurse to quit her job or leave the profession.
- BII.6.11 Finally, the working group failed to include reference to the *Code of Ethics of the Canadian Nurses Association*:
- 7. If nursing care is requested that is in conflict with the nurse’s moral beliefs and values but in keeping with professional practice, the nurse provides safe, compassionate and competent ethical care **until alternative care arrangements are in place** to meet the person’s needs or desires. If nurses can anticipate a conflict with their conscience, they have an obligation to notify their employers, or, if the nurse is self-employed, persons receiving care in advance, **so that alternative arrangements can be made.**⁶⁴ (Emphasis added)
- BII.6.12 This is considered in greater detail in Appendix “D” to the *Code*, which provides:

- 4. When a moral objection is made, the nurse provides for the safety of the person receiving care **until there is assurance** that other sources of nursing care are available.⁶⁵

BII.6.13 Note that the *Code* does not require the objecting nurse to find someone to provide morally contested treatment (see boldface passages above), and that this is consistent with one of the alternatives available in *Refusing Assignments and Discontinuing Nursing Services* and the Ontario regulation. This is consistent with the experience of an Advanced Practice Nurse commenting on the draft CPSO policy:

- I've always worked as a nurse on health care teams that respect diversity. If I were assigned the care of a patient who has a medication or procedure that I can't provide for reasons of conscience, I would continue to provide nursing care to her and alert my team that I couldn't provide the treatment as soon as the ethical dilemma arose. However, I wouldn't make "an effective referral" to a colleague the way the CPSO draft recommends.⁶⁶

BII.6.14 The deficient information provided by the working group in Appendix 3 is likely to mislead readers by causing them to believe that nurses in Ontario are obliged to provide treatments to which they object for reasons of conscience, to find someone who will provide such treatments in their stead, or to quit their jobs or leave the profession. That is incorrect.

BII.7 Deficient account of Ontario midwife policies

BII.7.1 Three sections of the College of Midwives of Ontario *Code of Ethics* were provided in Appendix 3, P. 6 (p. 347). The working group included one section from the text under the sub-heading "Referrals." The sub-heading does not exist in the *Code*. The section states:

- 11. Assist clients to find appropriate alternate care if for any reason she finds herself unable to provide care.⁶⁷

BII.7.2 Assuming that "unable" may include "*unwilling* for reasons of conscience," there is a conflict between the *Code* and the relevant regulation. Ontario Regulation 388/09 defines professional misconduct in such circumstances:

8. Discontinuing professional services respecting a client unless,
 - i. the client requests the discontinuation,
 - ii. alternative services acceptable to the client **are arranged**,
 - iii. there is no longer a relationship of trust and confidence between the midwife and the client **and the client is given a reasonable opportunity to arrange alternative services**, or
 - iv. the client requests services inconsistent with the standards of practice of the profession and the midwife has adhered to the standard of practice for discontinuing care in such circumstances.⁶⁸

BII.7.3 The regulation provides alternatives that would likely be acceptable to most objecting

midwives (see boldface passages above), since they do not require an objecting midwives to actively find someone willing to do what they find objectionable.

- BII.7.4 There are two significant differences between the practice of midwives and other health professionals like nurses or physicians which reduce the probability of unreconcilable conflicts of conscience.
- First: their scope of practice is restricted to “assessment and monitoring of women during pregnancy, labour and the post-partum period and of their newborn babies, the provision of care during normal pregnancy, labour and post-partum period and the conducting of spontaneous normal vaginal deliveries,”⁶⁹ and to a limited number of activities or procedures specified by statute.⁷⁰ On the surface, at least, none of these seem to involve morally contentious services.
 - Second: in order to ensure continuity, midwifery care is supposed to be delivered not by one but by a group of up to four midwives, one of whom is identified as the coordinating midwife,⁷¹ and two midwives must attend each birth.⁷² This would seem to allow accommodation of conscientious objections by individuals with minimal conflict, particularly in view of the options made available by regulation.
- BII.7.5 It is thus doubtful that the *Code of Ethics* for midwives is a suitable model for comparison with the draft CPSO policy, but this is not apparent because the information provided by the working group in Appendix 3 is deficient.

BII.8 Neglect of significant documents from Canadian authorities

- BII.8.1 A joint statement relevant to the subject of the draft CPSO policy has been produced by:
- the Canadian Medical Association
 - the Canadian Healthcare Association
 - the Canadian Nurses Association
 - Catholic Health Association of Canada
 - **Joint Statement on Preventing and Resolving Ethical Conflicts involving Health Care Providers and Persons Receiving Care (1999)**
- Part I, Para. 16. Health care providers should not be expected or required to participate in procedures that are contrary to their professional judgement or personal moral values or that are contrary to the values or mission of their facility or agency. Health care providers should declare in advance their inability to participate in procedures that are contrary to their professional or moral values. Health care providers should not be subject to discrimination or reprisal for acting on their beliefs. The exercise of this provision should never put the person receiving care at risk of harm or abandonment.
- Part II, Para. 10: If the person receiving care or his or her proxy is dissatisfied with the decision, and another care provider, facility or agency is prepared to accommodate

the person's needs and preferences, provide the opportunity for transfer.

Part II, Para. 11: If a health care provider cannot support the decision that prevails as a matter of professional judgement or personal morality, allow him or her to withdraw without reprisal from participation in carrying out the decision, after ensuring that the person receiving care is not at risk of harm or abandonment.⁵

- BII.8.2 The Supreme Court of Canada cited this document in *Cuthbertson v. Rasouli* as one of the statements of professional organizations that provide guidance to physicians.⁷³ It is also cited by the Royal College of Physicians and Surgeons of Canada in its primer on conflict resolution.⁷⁴
- BII.8.3 The Royal College of Physicians and Surgeons of Canada has published a primer on conflict resolution. It stresses that a collaborative approach is the preferred method that leads to "creative, durable outcomes."⁷⁴
- BII.8.4 The working group did not refer to any of these documents.

Notes

1. Council Briefing Note: *Professional Obligations and Human Rights- Draft for Consultation*. Appendix 3: Jurisdictional Review.
(<http://www.consciencelaws.org/archive/documents/cpso/2014-12-cpso-briefing-appendix.pdf>)
2. Canadian Medical Association *Code of Ethics* (Update 2004)
(<http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf>) Accessed 2015-02-16
3. CMA Policy: *Induced Abortion* (1988).
(https://www.cma.ca/Assets/assets-library/document/en/advocacy/CMA_induced_abortion_PD88-06-e.pdf#search=abortion) Accessed 2015-02-13
4. Blackmer J. "Clarification of the CMA's position concerning induced abortion." *CMAJ* April 24, 2007 vol. 176 no. 9 1310 (<http://www.cmaj.ca/content/176/9/1310.1.full.pdf+html>) Accessed 2015-02-13
5. Canadian Medical Association, Canadian Healthcare Association, Canadian Nurses' Association, Catholic Health Association of Canada, *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999)
(<http://www.consciencelaws.org/background/policy/associations-001.aspx>)
6. In the SCC on appeal from the BCCA, *Factum of the Intervener, The Canadian Medical Association*.
(<http://www.consciencelaws.org/archive/documents/carter/2014-08-27-cma-factum.pdf>)
7. Supreme Court of Canada Webcast, 15 October, 2014 [228:32/491:20] *Harry Underwood (Counsel for the Canadian Medical Association) oral submission*,
(<http://www.scc-csc.gc.ca/case-dossier/info/webcastview-webdiffusionvue-eng.aspx?cas=35591>)

&urlen=http://www4.insinc.com/ibc/mp/md/open_protected/c/486/1938/201410150500wv150en,001&urlfr=http://www4.insinc.com/ibc/mp/md/open_protected/c/486/1940/201410150500wv150en,001&date=2014-10-15) (Accessed 2015-02-12)

8. College of Physicians and Surgeons of British Columbia, *Code of Ethics*. (<https://www.cpsbc.ca/files/pdf/PSG-Code-of-Ethics.pdf>) Accessed 2015-02-11; College of Physicians and Surgeons of Alberta, *Code of Ethics*. (<http://www.cpsa.ab.ca/Resources/codeofethics.aspx>) Accessed 2015-02-11; College of Physicians and Surgeons of Saskatchewan, *Code of Ethics*. (http://www.cps.sk.ca/CPSS/Legislation_ByLaws_Policies_and_Guidelines/Legislation_and_Bylaws.aspx?Legislation_BylawsCCO=3) Accessed 2015-02-12; College of Physicians and Surgeons of Nova Scotia, *CMA Code of Ethics*. (<http://www.cpsns.ns.ca/Policies-Guidelines/Canadian-Medical-Association-Code-of-Ethics>) Accessed 2015-02-11; College of Physicians and Surgeons of Newfoundland and Labrador, *By-Law 5: Code of Ethics (Amended)* (<http://www.cpsnl.ca/default.asp?com=Bylaws&m=292&y=&id=11>) Accessed 2015-02-11; College of Physicians and Surgeons of PEI, *CMA Code of Ethics (Updated 2004)* (<http://cpspei.ca/wp-content/uploads/2013/11/CMA-CODE-OF-ETHICS-UPDATED-2004-P.pdf>) Accessed 2015-02-11
9. College of Physicians and Surgeons of British Columbia, *Access to Medical Care*. (<https://www.cpsbc.ca/files/pdf/PSG-Access-to-Medical-Care.pdf>) Accessed 2015-02-13
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Appendix "C"

Consultation on *Physicians and the Human Rights Code* (Ending 5 August, 2014)

CI. Consultation process

CI.1 The College invited the public and the profession to provide feedback on the policy by regular mail, email, and an on-line survey. In addition, it provided an On-line Poll and Discussion Forum. The prompt for the On-line Poll, Discussion Forum and submissions was:

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

CII. Results¹

CII.1 On-Line Poll

Total Responses:	32912	
Yes:	25230	(77%)
No:	7616	(23%)
Don't Know:	66	(<1%)

Table A

CII.1.1 Respondents on the discussion page noted marked changes in voting patterns suggestive of technological manipulation of the poll by both "yes" and "no" respondents, and that some had difficulty registering their votes (179, 183, 197). There seems to have been no geographical limitation on responses. Thus, while the results seem to indicate overwhelming support for freedom of conscience among physicians, the value of the poll is doubtful except as a general indicator of interest in the subject and general trend among respondents.

CII.1.2 In fairness to the College, this kind of poll seems to be used on other websites primarily to increase traffic and readership rather than as a reliable source of data, and it probably did serve that purpose in the consultation.

CII.2 Discussion Forum (Email, regular mail, forum participants)

CII.2.1 The Discussion Forum included numbered entries by forum participants directed to the College concerning the policy, as well as numbered entries with submissions received by the College through email and regular mail. In addition, forum participants posted replies and exchanged views in discussions under individual numbered responses. Entries in these exchanges were not numbered.

CII.2.2 The College states that it received 1,797 responses, but there are only 1,270 numbered entries on the discussion page. The difference (+527) is accounted for by the replies and exchanges under the numbered entries.²

CII.2.3 The present analysis concerns only the 1,270 numbered entries directed to the College concerning the policy, which include 1,719 responses.³

DISCUSSION FORUM RESPONDENTS

Total:	1719	
Health Care Practitioners:⁴	124	(7%)
Public & Anonymous:	1557	(91%)
Medical Organizations:⁵	8	(<1%)
Other Organizations:⁵	30	(2%)

Table B

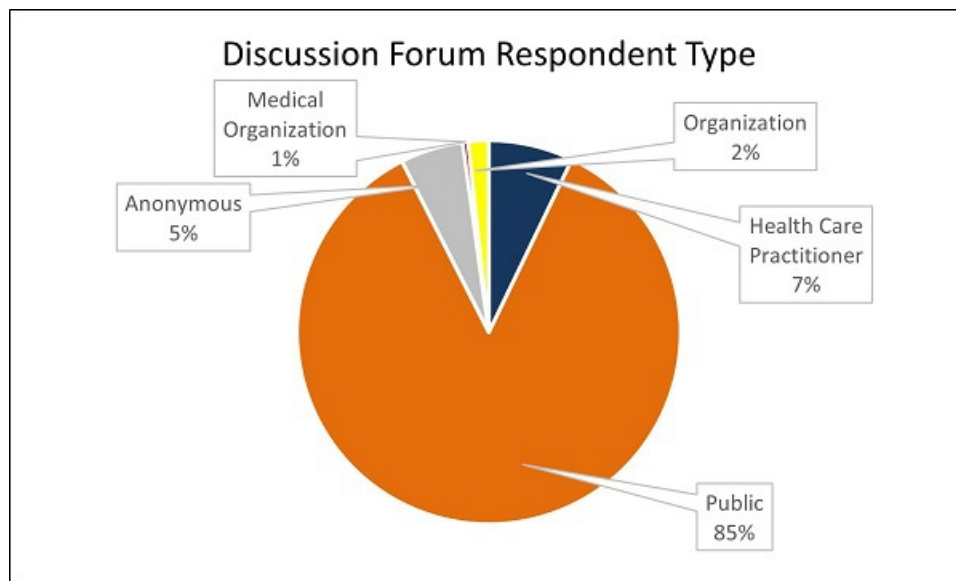


Figure 1

CATEGORIES⁶

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

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

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

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

Refer:⁷ Response in the form, "if will not provide, must refer." (eg., 1021)

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

DISCUSSION FORUM RESPONSES (Global)

Status Quo	For	Against	Null	Refer	Balance
26	1355	187	104	40	7
(2%)	(79%)	(11%)	(6%)	(2%)	(<1%)

Table C.

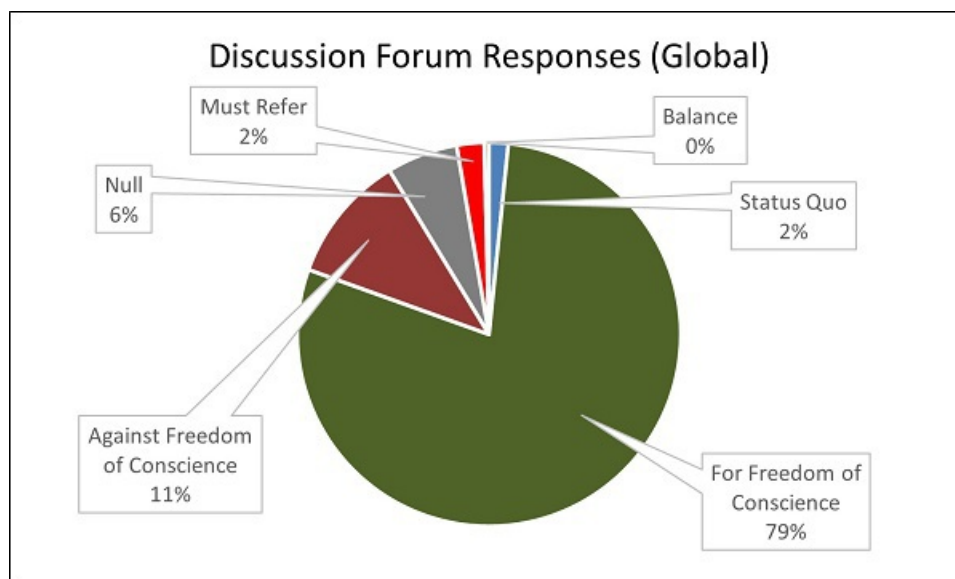


Figure 2

DISCUSSION FORUM RESPONSES (Selected)

Respondent	Status Quo	For	Against	Null	Refer	Balance
Health Care Practitioners:⁴	5 (4%)	84 (68%)	17 (14%)	13 (10%)	5 (4%)	0
Medical Organizations:⁵	2 (25%)	4 (50%)	0	2 (25%)	0	0
Other Organizations:⁵	0	23 (77%)	4 (13%)	3 (10%)	0	0

Table D.

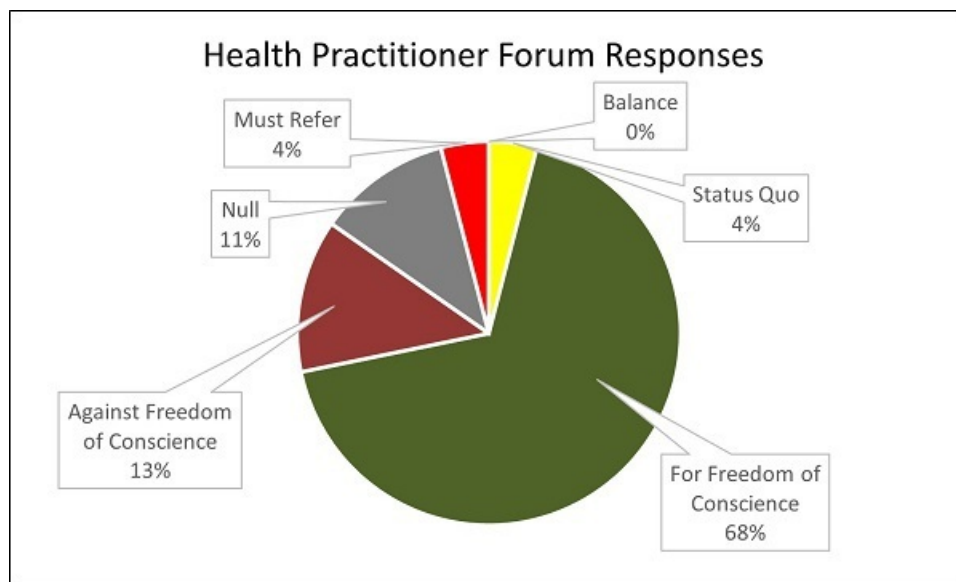


Figure 3

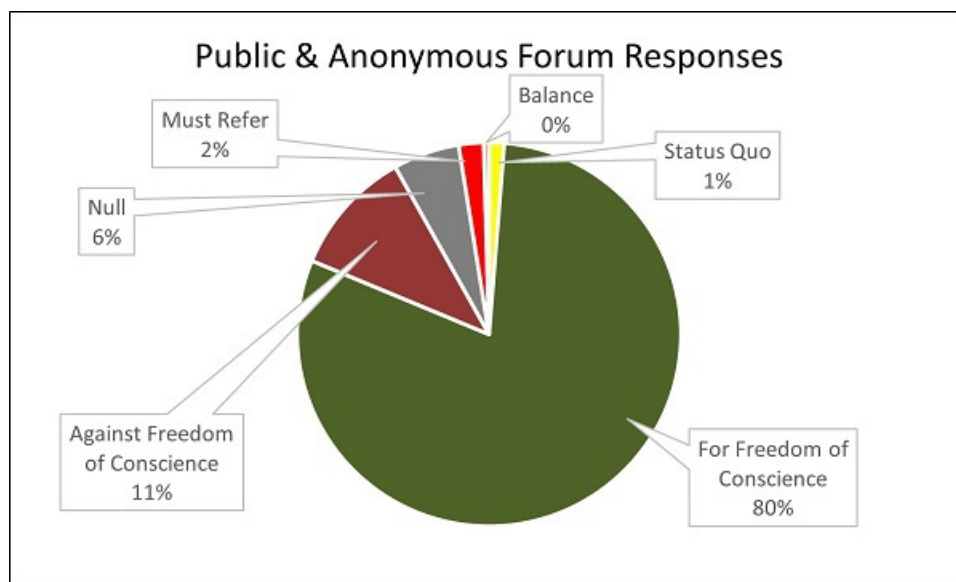


Figure 4

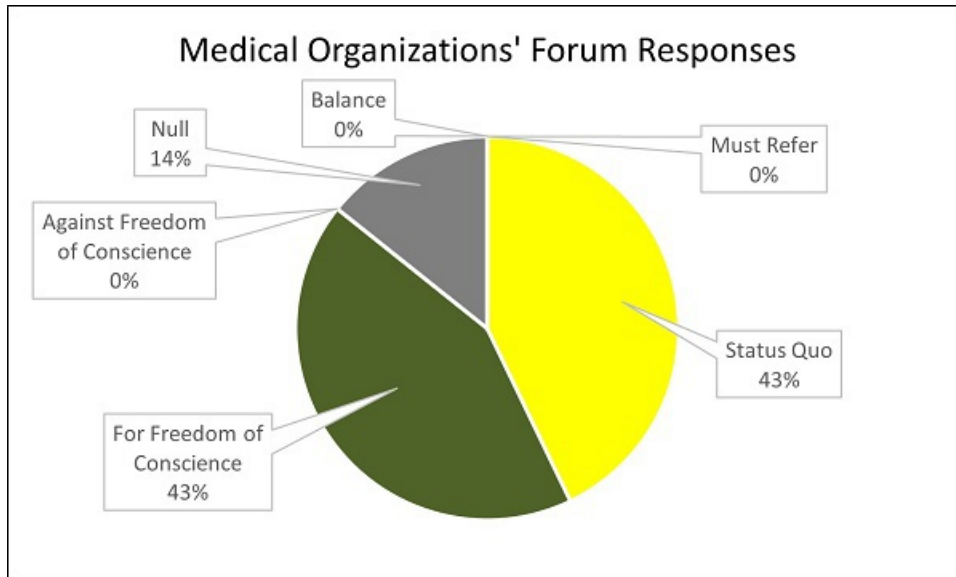


Figure 5

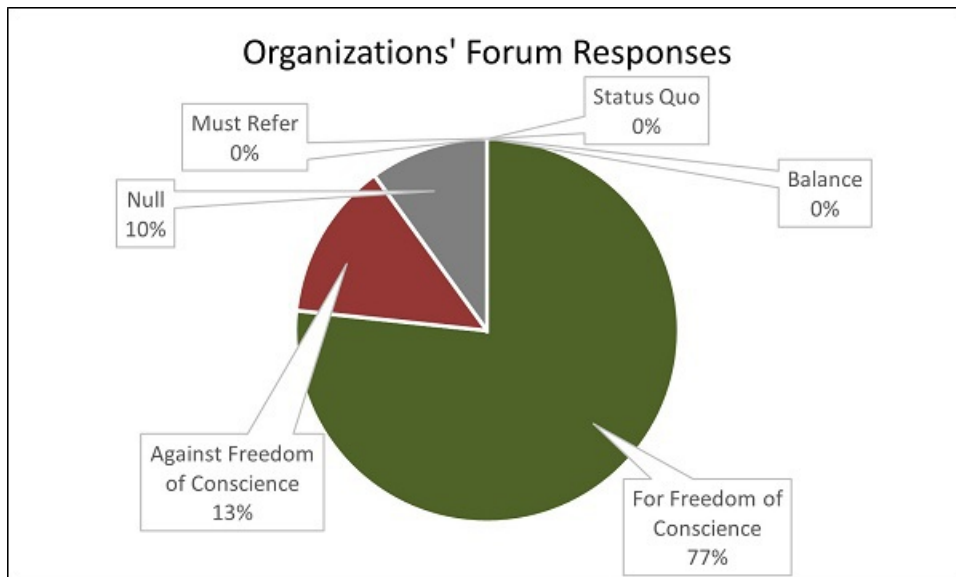


Figure 6

CII.3 On-line Survey

CII.3.1 The following information is taken from a Report provided by the College analyzing the results of the On-line Survey.

CII.3.2 Of the 6,400 surveys started, 3,103 were completed and 1,311 completed at least one substantive question. The report concerns these 4,414 completed or partially completed surveys, 26 of which came from organizations. Note that at least some of those who completed or partially completed a survey also responded through the discussion page above, but these respondents have not been identified by the College.

ON-LINE SURVEY RESPONDENTS

Total:	4414	
Physicians:	534	12.1%
Organization Staff (policy staff, registrar, senior staff)	39	0.89%
Member of the Public:	3306	74.9%
Other Health Care Professional:	339	7.7%
Other (specify):	196	4.4%
Clergy	15	
Medical Students	72	
Social Workers	6	
Teachers/Professors	8	
Other professionals or concerned citizens		

Table E.

Source: Report, Table 2 & Note 5.

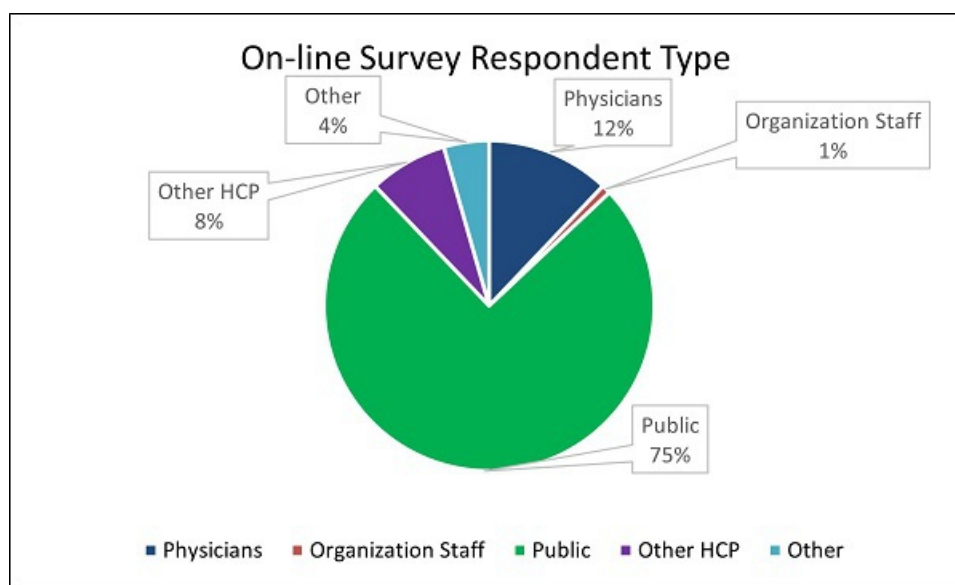


Figure 7

Clarity and Comprehensiveness

- CII.3.3 The Report states that 54% of the respondents stated that Physicians and the Human Rights Code clearly articulated a physician's professional obligations, 55% thought it easy to understand, 57% thought it well written, and most (58%) considered it well organized.
- CII.3.4 However, it also notes that almost 27% had not read the policy, while the percentages above refer to the total number of responses, not to the 73% who had actually read it.
- CII.3.5 More confusing, the Report indicates that its analysis of comments on the comprehensiveness of the policy is based on 3,300 responses, again, without reference to whether or not the respondents had actually read the policy.
- CII.3.6 It may be possible for the College to review the survey returns and limit the analysis of clarity and comprehensiveness of the policy to the respondents who actually read it. Unless that is done, its analysis under this head will remain unsatisfactory.

Policy Issues

- CII.3.7 The following charts are derived from Figure 3 of the Report. The percentages refer to a total of 3,117 responses. The charts are arranged in diminishing order of agreement (i.e., either strongly or somewhat agree), agreement indicated by dark blue shading. Bear in mind that most of the responses are from the general public, so the charts do not represent the opinions of physicians.

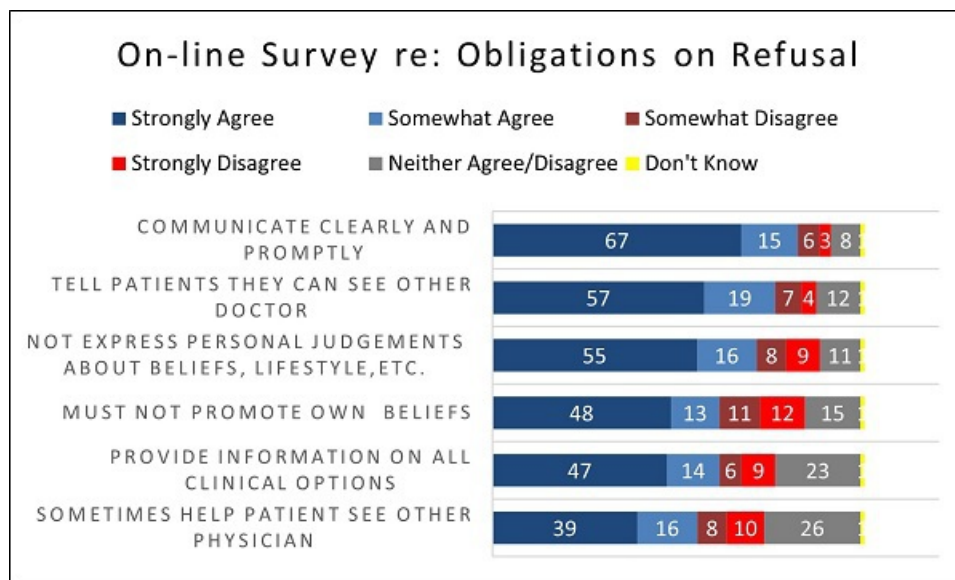


Figure 8

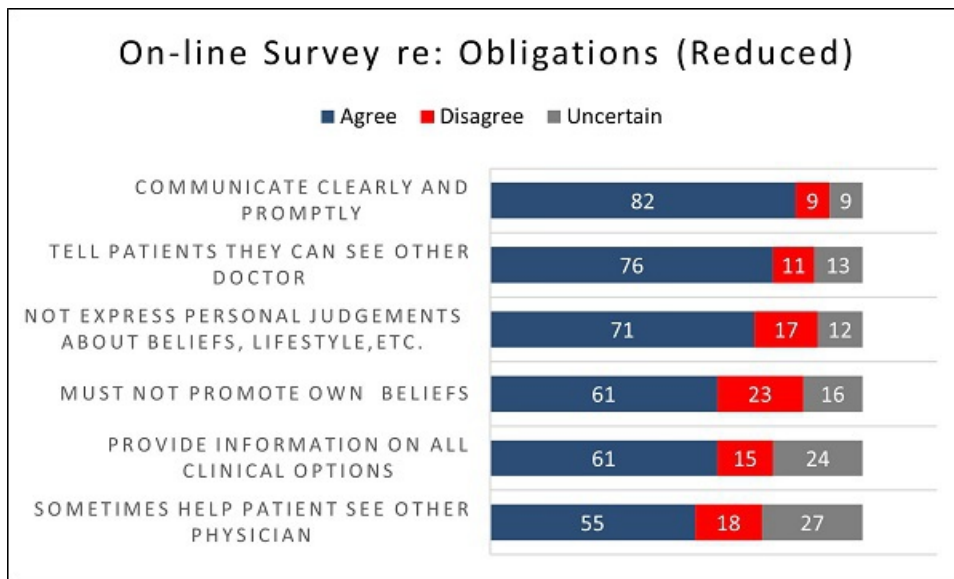


Figure 9

CII.3.8 The subject of referral was handled differently. Respondents were asked the following question:

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

CII.3.9 The following chart is derived from Figure 4 in the Report, which is based on 3,104 responses to this question.⁸

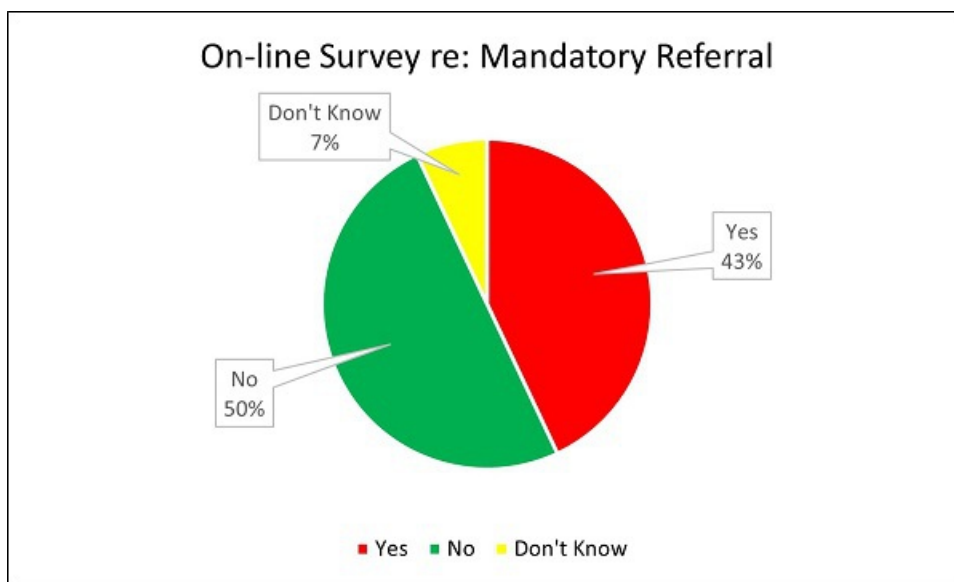


Figure 10

- CII.3.10 1,762 respondents provided further feedback on this question. Presumably, the five examples of the feedback provided in the Report are representative of all of the feedback.
- Comment 1) It seems criminal that a physician should be allowed to bill the health care system for a visit from an existing or potential patient and not at least provide them with a referral elsewhere;
 - Comment 2) Referring a patient to another doctor is in some way collaborating with or enabling a procedure the physician may consider immoral, and is in some circumstances equivalent to murder;
 - Comment 3) The physician can direct the patient to a directory of physicians to find a new doctor. The physician who is morally/religiously conflicted does not have to make a direct referral (doctor to doctor);
 - Comment 4) They have no right to deny treatment. If they feel strongly about their religious rights they need to find a different profession that would make them more comfortable.; and
 - Comment 5) If it is not an emergency situation, a physician should not be required to provide information on where to obtain a procedure they are morally opposed to. Patients are able to find that information themselves if they so desire.

CIV. Discussion

CIV.1 General Remarks

- CIV.1.1 An unknown number of respondents contributed through more than one of the consultation feedback portals (On-line Poll, On-line Survey, Discussion Forum, email, regular mail) and the College has not (and perhaps cannot) identify them. For this reason, it is not possible to derive from the totality of consultation feedback a single, accurate global number of responses in any of the six categories used in this analysis.
- CIV.1.2 For present purposes, the On-line Poll is discounted because it is of doubtful value (see above). Further, the Report's analysis of the clarity and comprehensiveness of the existing policy is also discounted because it is unsatisfactory (see above). Hence, this discussion is limited to the 1,719 responses/submissions in the discussion forum and to the Report's analysis of between 1,762 and 3,117 On-line Survey responses about policy issues.
- CIV.1.3 A further point to note is that the College stated that the volume of responses was unprecedented - more than 6,700.⁹ According to the briefing note for College Council, there were 6,710 responses, including "2296 comments posted to the online discussion page and 4414 completed online surveys."¹⁰
- CIV.1.4 In fact, there were 3,103 complete and 1,311 partially completed surveys, not 4,414 completed surveys.¹¹ Moreover, since an unknown number of respondents contributed both to the On-line Survey and Discussion Forum, the number of unduplicated consultation responses actually available for analysis may have been far less than 6,700. On the extremely contentious issue of referral, for example, the College's analysis relies on less

than half that number (Figure 13).

CIV.2 Discussion Forum Responses (Email, regular mail, forum participants)

CIV.2.1 The comments posted in the Discussion Forum were unstructured responses to the prompt:

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

CIV.2.2 Almost 80% of respondents in the Discussion Forum (including 68% of health care practitioners, half of the medical organizations and 77% of other organizations) indicated their support for physician freedom of conscience by affirming that they should be able to decline to provide services for reasons of conscience or religion (Table C, Figure 1). However, in many cases, this was explicitly qualified by statements to the effect that this referred to non-emergency situations, sometimes more specifically identified as situations in which failing to provide the service would not endanger the life of the patient.

CIV.2.3 About 11% of respondents indicated that they were against physician freedom of conscience by affirming that they should not be able to refuse services for reasons of conscience or religion (Table C, Figure 1). This included 14% of health care practitioners and 13% of other organizations (Table D, Figure 2, Figure 4)

CIV.2.4 Only about 2% of respondents volunteered that objecting physicians should be required to refer a patient to a colleague who would provide the service (Table C, Figure 1). In a number of cases it appears that the respondents did not appreciate that referral involved a moral or ethical issue, and might not have made the recommendation if they had. In others, it appears that the respondents would not have altered their view even if they understood that a moral or ethical issue was involved. Only 4% of responding health care practitioners insisted upon referral (Table D, Figure 2).

CIV.2.5 **Summary:** The overwhelming majority of respondents who made submissions through email or regular mail or as discussion forum participants support freedom of conscience for physicians with respect to refusing to provide non-emergency services. In contrast, they offer virtually no support for a policy of mandatory referral by objecting physicians.

CIV.3 On-line Survey: Policy Issues (re: policy statements)

CIV.3.1 It is instructive to arrange the policy statements in the On-line Survey in order of the level of overall agreement expressed with each (Figures 5 to 10).

CIV.3.2 With two exceptions, the reduction in the level of overall agreement corresponds to a reduction in the number of those who "strongly agree," but there is no corresponding increase in the overall level of disagreement. Instead, the overall level of agreement falls because more respondents seem to be in doubt about how to interpret or apply the statements, reporting that they "neither agree nor disagree" rather than that they "disagree" or "don't know." (Figure 11, Figure 12)

CIV.3.3 Two explanations can account for disagreement or doubt. First: the policy statement may

be perceived as excessively rigid, insufficiently attuned to the realities of practice. Second: complying with a statement may be perceived to involve complicity in a morally contested procedure.

CIV.3.4 These explanations are likely to be overlooked or dismissed as irrelevant by those bent on enforcing physician compliance with establishment expectations, but it is appropriate to consider them from the perspective of protecting the legitimate exercise of freedom of conscience. Explanations follow the abbreviated references to the policy statements below.

Communicate clearly and promptly:

CIV.3.5 It is common ground that conflicts should be avoided - especially in circumstances of elevated tension - and that they often can be avoided by timely notification of patients, erring on the side of sooner rather than later. Thus, the high level of support for this statement (Figure 5) is not surprising. Nonetheless, some doubt or disagreement about it might be attributed to concern about excessive rigidity. Respondents who did not express support for this statement could have had two scenarios in mind.

CIV.3.6 First: it is unreasonable to expect physicians to anticipate, in advance, every conceivable request that might be made by patients. For example: it would probably be unnecessary for a physician who accepts a 55 year old single woman as a patient to begin their professional relationship by disclosing objections to abortion, and it could well be unsettling for the patient if her medical history 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.

CIV.3.7 Second: a physician may decline to provide a procedure for medical reasons that are acceptable to his colleagues, but may also have religious or moral reasons for refusal. In such situations, the physician might believe that it is sufficient to advise the patient only of his medical reasons because his decision does not not engage his moral or religious beliefs.

Tell patients they can see another doctor:

CIV.3.8 76% of survey respondents agreed with this statement, while disagreement and doubt ("neither agree nor disagree") were almost equal: 11% and 12% respectively (Figure 6).

CIV.3.9 The somewhat lower level of support for this statement might be attributed to belief by some respondents that one becomes complicit in a morally contested procedure merely advising a patient of his right to see another physician. Members of the general public comprised almost 75% of the survey participants (Table E), so disagreement or doubt may reflect popular rather than professional views. In fact, the Project has not encountered an objecting physician who would refuse to advise patients that they can see a colleague.

Not express personal judgements:

CIV.3.10 A clear majority of respondents support the idea that physicians must not "express personal judgments" about the beliefs, lifestyle identity or personal characteristics of patients. The level of agreement drops to 71%, and the level of doubt is about the same, but here we

encounter the first exception to the general trend. In this case, the level of disagreement rises from 11% to 17% (Figure 7). Disagreement and doubt on this point are probably attributable to concern about excessive rigidity, for two reasons.

- CIV.3.11 First: many conditions treated by physicians are the result of patient choices about diet and exercise, the use of alcohol, tobacco and illicit drugs and other risk-taking behaviours: sometimes, even, of criminal misconduct. Most people would agree that physicians are entitled to express judgements about patient choices that are relevant to health. However, such judgements involve a degree of subjective evaluation, and patients may not appreciate the distinction between a "personal" and a "professional" judgement. This is further complicated for physicians whose religious beliefs conflict with patient choices, as when a religion proscribes the use of alcohol and/or tobacco. Will they be accused of violating this guideline, even if their advice is based on the same reasoning and couched in the same terms as that of a colleague who does not share their beliefs?
- CIV.3.12 Second: there may be concern that ideologues will treat bona fide compliance with the first policy statement (communicate clearly and promptly) as a violation of this guideline. After all, a physician cannot express a conscientious objection without first forming the judgement that the treatment is immoral. It is reasonable to believe that the communication of the objection, which the College requires, will cause patients to infer (correctly) the beliefs of the physician concerning the treatment. Patients may thus "feel judged" by the physician, even if the physician's judgement pertains to the morality of the procedure rather than the personal culpability of the patient. It would be unjust to require physicians to disclose conscientious objections to patients and then discipline them because a patient resents their beliefs, but this possibility might well explain why more respondents disagreed with this policy statement.

Not promote own beliefs:

- CIV.3.13 We encounter the second exception to the general trend in the case of the policy against promoting one's own beliefs. The level of agreement drops to 61%, the level of disagreement rises to 23% and doubt increases to 15% (Figure 8). Once more, the most likely explanation for this is that the policy is perceived to be excessively rigid and fails to take into account the realities of practice.
- CIV.3.14 That reality includes the fact that, if a physician communicates an objection to a procedure or service (as required by the first guideline), a patient may well challenge his objection. A physician may, quite reasonably, provide further explanation or justification in subsequent conversation - and later get a letter from the College advising him that the patient has complained that he was "promoting his own beliefs." On the other hand, if he fails to respond to the patient's challenge, the patient may conclude that he is acting arbitrarily, has something to hide, or is unable to defend his position.
- CIV.3.15 It is not surprising to find less support for a policy that may be perceived to contribute to this kind of no-win scenario.

Provide information on all clinical options:

- CIV.3.16 The requirement that physicians provide information about all clinical options enjoys the same level of overall agreement as the preceding statement (61%), but the level of disagreement falls to 9% and number of responses indicative of doubt increases to 23% (Figure 9).
- CIV.3.17 Here, the lower level of overall support and much higher level of doubt are most likely explained by concern about complicity.
- CIV.3.18 Those who object to X for reasons of conscience may hold that "merely" providing information is not necessarily a morally or ethically neutral act: that providing information can make one complicit in morally contested procedures. This position is neither unique nor unreasonable. In fact, it is held by the General Medical Council of the United Kingdom,¹² and the American Medical Association.¹³ It was formerly the position of the College of Physicians and Surgeons of BC.¹⁴ (See also the comment of the Catholic Archbishop of Toronto, below.)
- CIV.3.19 The possibility that euthanasia and assisted suicide may be legalized by the Supreme Court may also have influenced responses. Physicians who believe that physicians should never be involved in killing patients because patients are especially vulnerable to abuse may also believe that, in the absence of a patient request, even advising patients of the option of assisted suicide or euthanasia is an intrinsically abusive act.

Sometimes help to find another doctor:

- CIV.3.20 As noted above, the possibility of the legalization of assisted suicide and euthanasia may also have influenced responses under this head. An expectation that an objecting physician must sometimes help a patient find a colleague "with whom they can discuss their situation" does not necessarily amount to a requirement to help the patient obtain a morally contested service, which many objecting physicians would find unacceptable because they believe it would make them complicit in the act. However, it is uncomfortably close to that. The Catholic Archbishop of Toronto made this point in his submission:

The second expectation "Provide information about all clinical options . . ." and the fourth "Advise patients or individuals . . ." could have the potential for an infringement upon the rights of conscience of a physician, depending on the extent to which he or she is required to become actively involved in facilitating actions which go against his or her conscience. A lot depends on what is involved in "help the patient or individual make arrangements to do so."¹⁵

- CIV.3.21 Hence, it is not surprising that the level of agreement in this case drops to 55%, the level of "strong agreement" drops dramatically to 39%, the level of disagreement is double that of the preceding guideline, and the level of doubt rises to 26% (Figure 10).
- CIV.3.22 **Summary:** Levels of support for policy statements related to freedom of conscience for physicians decrease when they are perceived as excessively rigid or insufficiently attuned to the realities of practice. Levels of support fall and disagreement and doubt increase when

they are perceived to require complicity in morally contested procedures. On-line Survey responses under this head do not support a policy of mandatory referral, suggesting, instead, that such a policy is controversial.

CIV.4 On-line Survey: Policy Issues (re: mandatory referral)

- CIV.4.1 With respect to a policy of mandatory referral, the change from requests for levels of agreement with a policy statement to a "Yes-No-Don't Know" response prevents comparison with responses to the preceding policy statements. However, the concern here more clearly being the perennially contentious issue of coerced complicity in morally contested procedures, it is not surprising to find that the level of agreement drops further to 50% and disagreement rises dramatically to 43% (Figure 13).
- CIV.4.2 Moreover, the sample of comments provided in the Report indicate that the expressed levels of agreement and disagreement are somewhat unstable, depending on factors or nuances not captured by the survey question.

Sample Comments

1. It seems criminal that a physician should be allowed to bill the health care system for a visit from an existing or potential patient and not at least provide them with a referral elsewhere
2. Referring a patient to another doctor is in some way collaborating with or enabling a procedure the physician may consider immoral, and is in some circumstances equivalent to murder.
3. The physician can direct the patient to a directory of physicians to find a new doctor. The physician who is morally/religiously conflicted does not have to make a direct referral (doctor to doctor)
4. They have no right to deny treatment. If they feel strongly about their religious rights they need to find a different profession that would make them more comfortable.
5. If it is not an emergency situation, a physician should not be required to provide information on where to obtain a procedure they are morally opposed to. Patients are able to find that information themselves if they so desire.

CIV.4.3 Of the five comments, two (**Comment 2** and **Comment 5**) appear to be taken from the "disagree with mandatory referral" category, but Comment 5 disagrees only in non-emergency situations.

CIV.4.4 Two seem to come from the "agree" category, but only one (**Comment 4**) clearly favours coerced participation. The respondent who offered **Comment 1** seems unaware that physicians who do not provide a service cannot bill for it, and that prudent objecting physicians may not bill for a consultation that ends in refusal.

CIV.4.5 **Comment 3** could have come from any of the three categories. It reflects some of the ambiguity associated with the term "referral", and reflects a solution that, in the Project's experience, most objecting physicians seem willing to accept.

CIV.4.6 **Summary:** On-line Survey responses do not support a policy of mandatory referral. Rather, they indicate that mandatory referral is a highly controversial subject.

Notes:

1. This analysis uses spreadsheets in an Excel file, a copy of which is available at <http://www.consciencelaws.org/archive/documents/cpso/2014-08-05-cpso-responses.xlsx>.
2. Email from College of Physicians and Surgeons of Ontario (humanrights@cpso.on.ca) to the Project Administrator, 9 February, 2015, 3:55 PM
3. Two of the numbered entries appear to be duplicates from the same respondents (42-43, 70-71) and three are from the same organization (1094,1263,1265). In this analysis, the duplicate and triplicate entries are not counted. In some cases (eg., 526) the College noted that it had received X number of identical responses, but posted only one to represent the group. In this analysis, the actual number of responses under a single entry is counted. In other cases, the single entry included either a joint submission by more than one organization (1252) or represented the views of more than one person (1035). In this analysis, the actual number of persons/groups represented by an entry is counted, which is consistent with the approach taken with respect to multiple identical submissions under a single entry.
4. Among health care workers, the College identified only physicians (active and retired), categorizing nurses, pharmacists, etc. as members of the public. In this analysis, all active and retired physicians and medical students and health care workers are grouped as health care practitioners, based on self-identification by the respondents in the text of their submissions.
5. The College did not distinguish professional medical organizations from other organizations. This analysis makes that distinction.
6. Categorizing responses may sometimes involve subjective interpretation. In some cases, a different analyst might assign a response to a different category. It is doubtful that this variation would significantly change the numbers reported in each category.
7. Compulsory referral is considered by many objectors to be a denial of freedom of conscience. Some respondents who expect referral appear not to recognize that and consider their expectation to be consistent with freedom of conscience. Others appear either reject the idea that any moral or ethical issue is involved in referral, or insist that the physicians view must be suppressed in favour of the patient. Rather than attempt a subjective evaluation to distinguish these views as either for or against freedom of conscience, all responses in the form, "if will not provide, must refer" are grouped together.

8. Figure 4 reported "Don't know" as 8%, which would add up to 101%. It is reduced to 7% here to facilitate charting. College of Physicians and Surgeons of Ontario, *Physicians and the Ontario Human Rights Code Consultation, Online Survey Report and Analysis*. (<http://www.consciencelaws.org/archive/documents/cpso/2014-12-cpso-survey-report.pdf>)

9. "Balancing MD and patient rights: Human rights draft policy open for consultation." *Dialogue*, Vol. 10, Issue 4, 2014, p. 49. (<http://www.joomag.com/magazine/dialogue-volume-10-issue-4-2014/0267666001419268812?s hort>) Accessed 2015-01-30)

10. College of Physicians and Surgeons of Ontario, *Council Briefing Note: Professional Obligations and Human Rights - Draft for Consultation (For Decision)* (December, 2014). In, Annual Meeting of Council, December 4-5, 2014, p. 328 (<http://www.consciencelaws.org/archive/documents/cpso/2014-12-cpso-briefing.pdf>)

11. College of Physicians and Surgeons of Ontario, *Physicians and the Ontario Human Rights Code Consultation, Online Survey Report and Analysis*, Table 1. (<http://www.consciencelaws.org/archive/documents/cpso/2014-12-cpso-survey-report.pdf>)

12. The GMC acted on this principle when it disciplined a physician who provided information about the sale of organs but did not actually engage in the practice. The Council found that the doctor had not participated in the organ trade, but that his conduct amounted to "encouragement of the trade in human organs from live donors". BBC News, "Organ trade GP suspended." 15 October, 2002 (<http://news.bbc.co.uk/2/hi/health/2329447.stm>) Accessed 2015-02-01.

It has also applied this principle in guidance on assisted suicide. Among the kinds of conduct that may constitute illicit facilitation or cooperation in assisted suicide, the GMC includes: "encouraging a person to commit suicide, for example, by suggesting it (whether prompted or unprompted) as a 'treatment' option . . . providing practical assistance, for example, by helping a person who wishes to commit suicide to travel to the place where they will be assisted to do so . . . writing reports, knowing or having reason to suspect that the . . . reports would be used to enable the person to obtain encouragement or assistance in committing suicide. . . providing information or advice about other sources of information about assisted suicide, and what each method involves from a medical perspective . . ." General Medical Council, *Guidance for the Investigation Committee and case examiners when considering allegations about a doctor's involvement in encouraging or assisting suicide: a draft for consultation*. (http://www.gmc-uk.org/DC4317_Guidance_for_FTP_decision_makers_on_assisting_suicide_51026940.pdf) Accessed 2015-02-01)

13. The AMA prohibits physicians from rendering technical advice or consulting with executioners or "providing . . . knowledge to facilitate the practice of torture." American Medical Association Policy E-2.06: Capital Punishment (June, 1998) (<http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion206.page?>) Accessed 2015-02-01); American Medical Association Policy E.2.067: Torture.

(<http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2067.page>) Accessed 2015-02-01)

14. The Deputy Registrar of the College of Physicians and Surgeons of British Columbia (CPSBC) was horrified in August, 2005, when he learned that a pre-natal gender testing kit was being marketed on the internet. He described gender selection as "immoral." He explained that College policy was not to disclose the sex of a baby until after 24 weeks gestation in order to reduce the risk of gender selection, and that physicians violating the policy were liable to be disciplined by the College. Clearly, in this case, "providing information" (about the sex of the baby) was not considered an ethically or morally "neutral" act. Lee, Jenny, "Official slams 'sex selection' blood test: Gender of fetus can be seen five weeks into pregnancy." Vancouver Sun, 13 August, 2005.

(<http://www.canada.com/vancouver/vancouvernews/story.html?id=1735ec8d-56cc-4510-89e8-c62c480e97b6>) Accessed 2005-10-10). See also College of Physicians and Surgeons of British Columbia, Resource Manual, *Fetal Sex Selection Solely for Gender Determination* (May, 2010). (<http://www.consciencelaws.org/archive/documents/2010-05-cpsbc-fetal-sex.png>). The CPSBC revised the policy in January, 2012, apparently because of a legal requirement to disclose information to patients. (College of Physicians and Surgeons of British Columbia, Professional Standards and Guidelines, *Disclosure of Fetal Sex*. (January, 2012) (<https://www.cpsbc.ca/files/pdf/PSG-Disclosure-of-Fetal-Sex.pdf>) Accessed 2015-02-02.

15. Collins, T. *Letter to the College of Physicians and Surgeons of Ontario*, 5 August, 2014. (<http://policyconsult.cpsoc.on.ca/wp-content/uploads/2014/08/Archbishop-of-Toronto-Response.pdf>) Discussion Forum entry 1171 (http://policyconsult.cpsoc.on.ca/?page_id=3405) Both accessed 2015-01-23.

Appendix "D"

A case for evidence-based policy making

DI. Background

- DI.1 This case centres on Dr. K., a physician in general practice in a walk-in clinic in Ottawa, Ontario, who declined to prescribe or refer for manufactured contraceptives or post-coital interceptives for medical, professional and religious or moral reasons. Similarly, he would not provide or refer for abortion or surgical sterilization. He offered support for Natural Family Planning (NFP), a generic term covering various kinds of birth control based on recognition of natural fertility cycles. Two other Ottawa physicians had similar practices.¹
- DI.2 Factors relevant to the formation of medical judgement may also inform professional ethical and religious/moral judgement. Among these is that the Society of Obstetricians and Gynaecologists of Canada (SOGC) recognizes NFP methods “can be quite reliable when used correctly,” include “non-contraceptive benefits,” and have no health risks or adverse side effects.² When the effectiveness of alternative treatments or procedures falls within the same range, it is reasonable to provide, recommend or refer patients for treatments or procedures that minimize health risks and adverse side effects.
- DI.3 Knowing that this approach to birth control and related issues would be unexpected, Dr. K. ensured that his patients were aware of his position in advance and that potential patients seeking contraceptives and related services were notified when they presented to the clinic receptionist. A written notice was provided in the reception area that briefly summarized his practice policy.
- DI.4 Advance notification of patients of limitations of practice is recognized and recommended by professional and regulatory authorities, including the College of Physicians and Surgeons of Ontario.³

DII. The incident

- DII.1 On the morning of 29 January, 2014, a 25 year old married woman went to the walk-in clinic where Dr. K. was practising. When she told the receptionist that she wanted a prescription for birth control pills, she was advised of the physician’s position and given a copy of the explanatory notice.
- DII.2 The young woman drove around the block to a clinic about two minutes away and obtained the prescription and pills.

DIII. Evidence re: access

- DIII.1 The evidence is that, in Ottawa in 2014, three out of 3,924 area physicians did not prescribe oral contraceptives: 0.08% of the medical profession in the area.⁴
- DIII.2 Birth control services were widely available in Ottawa at the time. 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.⁵

- DIII.3 The wait list for abortion in Ottawa in 2014 was estimated to be 42 days.⁶ The average emergency room wait time in five major Ottawa hospitals was over 6 hours for complex conditions and almost three hours for minor or uncomplicated conditions.⁷ Wait times for MRI and CT scans in the city were up to 52 and 68 days respectively. Ottawa patients waited up to almost three months for surgery for some life threatening conditions: from 23 days for breast cancer surgery to 87 days for a cardiac bypass.⁶
- DIII.4 In contrast, the young woman in this case obtained her birth control pills by driving around the block to another clinic, about a two minute drive. Another patient who was unable to get a birth control prescription at the walk-in clinic two years earlier went to the same alternative clinic, which she described as being “across the street.”⁸

“Health risks”

- DIII.5 The accusation that physicians who refuse to prescribe contraceptives thereby expose women to “serious risk” to their “health and safety” makes at least two assumptions. First: it assumes that pregnancy itself presents a “serious” risk to health and safety. Second: it assumes that pregnancy cannot be avoided without the use of contraceptives. Neither assumption withstands scrutiny.
- DIII.6 While any pregnant woman faces health risks that are not faced by a woman who is not pregnant, serious risks are the exception, not the rule, and ordinary risks associated with pregnancy are readily managed by appropriate care. The vast majority of women who use contraception want to avoid pregnancy *per se*, not health risks that might be associated with it.⁹
- DIII.7 Whatever reason a woman might have for wanting to avoid pregnancy, she need not use contraceptives. In the first place, as the SOGC recognizes, Natural Family Planning can be as effective as contraception in avoiding pregnancy, and the three physicians were willing to support patients who wished to use it. Thus, their refusal to prescribe contraceptives did not expose women to avoidable health risks, let alone ‘serious risks to health and safety.’
- DIII.8 Second, a woman who rejects an offer of NFP and who is refused a prescription for contraceptives can avoid pregnancy by avoiding acts likely to lead to pregnancy until she has obtained the prescription she wants. The comments of Ottawa’s Medical Officer of Health (III.3.1) is evidence that the duration of abstinence required of patients refused contraception by one of the three physicians would be substantially less than wait times at emergency rooms in Ottawa hospitals. The duration of the abstinence required in this case - a two minute drive to the alternative clinic - was not unduly burdensome.
- DIII.9 Finally, 68 day waits for CT scans and 87 day wait lists for cardiac bypass surgery involve unquestionably serious risks to health and safety, including the possibility of death or disabling injury. Moreover, the patients in these cases are largely unable to control factors tending to such outcomes. Particularly within this broader context, the claim that the failure to prescribe contraceptives exposes women to serious risks to their health and safety

is untenable.

DIV. A solution in search of a problem

DIV.1 It is instructive to consider a case of alleged professional misconduct based on conscientious objection provided by a commentator on a ‘pro-choice’ Facebook page:

- My doctor has told me to my face that it is my womanly duty to have children and she will never condone me to prevent the birth of a child in any way. She also said she would not sign the vasectomy papers for my husband to get one. . .She lectures me often when I go in. She has 3 or 4 kids and says she is not done.¹⁰

DIV.2 Assume, for present purposes, that this brief narrative is an essentially accurate summary of the physician’s conduct. Assume, as well, that the physician has religious or moral objections to contraception, abortion, and contraceptive sterilization, all of which are morally contested procedures that she may decline to provide or facilitate. Finally, assume that the physician believes, for moral or religious reasons, that women should have many children.

DIV.3 What is described here remains conduct unacceptable in ethical medical practice.

DIV.4 While a physician is obliged to disclose the existence of moral or religious convictions that would influence her recommendations or preclude the provision of certain procedures, the disclosure must be respectful of the patient and must not take the form of “preaching” or “lecturing.” Such a disclosure is meant to be about what a physician will not do and why, not about what the patient should do.

DIV.5 Further: while it is not inconceivable that, in some circumstances, a physician might disclose some personal information or experience in a manner supportive of a patient, to set oneself up as a kind of role model (‘you should have as many children as I do’) is highly objectionable.

DIV.6 Similar stories were told by women calling a CBC radio programme broadcast throughout Ontario in 2014.¹¹ Many had experienced equally condescending or obnoxious treatment by physicians.

DIV.7 The problem in such cases is disrespectful communication by physicians. The College has policies that can deal with this problem, though they may need to be reinforced and enforced. But the POHR requirement for “effective referral” in order to “facilitate access” to widely available services like contraception and abortion is a solution in search of a problem, or, to put it in terms of *Charter of Rights* jurisprudence, an example of a policy that is “overbroad.”

Notes

1. For a complete account, see Murphy S. “NO MORE CHRISTIAN DOCTORS” *Protection of Conscience Project*, 25 February, 2014 (Revised 2 March, 2014) (<http://www.consciencelaws.org/background/procedures/birth002.aspx>)

2. Black A, Francoeur D, Rowe T. *Canadian Contraception Consensus*. SOGC Practice Guideline No. 143- Part 3 of 3 (April, 2004) Chapter 9, p. 365
(<http://sogc.org/guidelines/canadian-contraception-consensus-part-3-of-3-replaces-131aug-2003-and-49-sept-1996/>) Accessed 2014-02-11
3. In 2002 the College formally approved a written notice to patients and directed that it be made available in the physician’s waiting room. Citing the Canadian Medical Association’s *Code of Ethics*, the notice conveyed in explicit terms the physician’s religiously based objection to providing or arranging for abortions, or for prescriptions for birth control for unmarried patients, or Viagra for unmarried men. Murphy S. “Ontario College of Physicians and Surgeons accommodates Christian physician.” *Protection of Conscience Project*, August, 2002
(<http://www.consciencelaws.org/repression/repression017-003.aspx>)
4. College of Physicians and Surgeons of Ontario, *All Doctor Search*
(<http://www.cpso.on.ca/Public-Register/All-Doctors-Search>) Accessed 2014-07-29
5. Levy I. (Medical Officer of Health, Ottawa) and Abdullah A. (President, Academy of Medicine, Ottawa), *Letter to the Ottawa Citizen*, 1 February, 2014.

6.

Nov/Dec/Jan 2014	Surgery/Imaging Wait Times for 9 out of 10 Patients (Up to- days)						Up to-Days
Hospital Site	Breast Cancer*	Prostate Cancer*	Cardiac (Angioplasty)*	Cardiac (Bypass)*	CT Scan*	MRI Scan*	Abortion*
Provincial	36	87	18	48	42	69	
Ottawa Average	29	76	23	87	68	52	42
Children’s Hospital of Eastern Ontario					91	44	
University of Ottawa Heart Institute			23	87	23		
Hopital Montfort	28				42	48	
Ottawa Hospital	30	90			78	60	
Queensway Carelton Hospital	29	62			105	56	

Sources:

**Ontario Wait Times: Wait Times for Surgery, MRIs and CTs*

Ontario Ministry of Health and Long Term Care.

(<http://www.waittimes.net/Surgerydi/en/PublicMain.aspx?View=0&Type=0>) Accessed 2014-03-10

** Society, the Individual and Medicine: Facts and Figures on Abortion.

University of Ottawa (http://www.med.uottawa.ca/sim/data/Abortion_e.htm) Accessed 2014-03-10

7.

January, 2014	Average Time Spent in Emergency Room	
	Complex Conditions (Hours)	Minor/Uncomplicated Conditions (Hours)
Provincial	5.8	2.2
Ottawa Average	6.38	2.92
Children's Hospital of Eastern Ontario	3.6	2.5
Hopital Montfort	7.8	2.8
Ottawa Hospital- Civic Campus	7.8	3
Ottawa Hospital- General Campus	7	2.8
Queensway Carelton Hospital	5.7	3.5

Source: *Ontario Wait Times: Emergency Room Section.*

Ontario Ministry of Health and Long Term Care.

(<http://edrs.waittimes.net/en/PublicMain.aspx>) Accessed 2014-03-10

8. S ____ C ____ . 30 January, 2014: 7:03 am | 7:05 am. Radical Handmaids
(<http://www.consciencelaws.org/background/procedures/birth002-C-02.aspx>) Accessed 2014-02-08

9. Frost JJ, Duberstein-Lindberg L. "Reasons for using contraception: Perspectives of US women seeking care at specialized family planning clinics." *Contraception*, Vol. 87(4) April 2013, p. 465-472 (<http://www.guttmacher.org/pubs/journals/j.contraception.2012.08.012.pdf>) Accessed 2014-03-10

10. L___ S___, 30 January, 5:39 pm & 5:46 pm
(<http://www.consciencelaws.org/background/procedures/birth002-C-03.aspx>)

11. CBC Radio, Ontario Today, 25 February, 2014: *Should doctors have the right to say no to prescribing birth control?*
(<http://www.cbc.ca/ontariotoday/2014/02/25/tuesday-should-doctors-have-the-right-to-say-no-to-prescribing-birth-control/>) Accessed 2015-02-18

Appendix "E" Legal criticism

EI. Submission 853: Ontario Barrister and Solicitor

- EI.1 Two crucial considerations have been overlooked in the Policy:
1. The legal rights of physicians to have their religious/conscientious beliefs and practices accommodated by their employers, unions, and vocational associations to the point of undue hardship; and,
 2. The CPSO's obligation as a quasi-governmental body to consider its members' constitutional rights of freedom of conscience and religion in its policymaking process.
- EI.2 I address these issues and make corresponding recommendations in Parts I and II of this submission.
- EI.3 In Part 111, I respond to submissions that appear to be before the CPSO which suggest that physicians may be compelled, as a matter of blanket policy, to perform medical services which violate their deeply held religious and conscientious beliefs. My submission affirms that not only is the CPSO under no legal obligation to adopt and enforce such a policy, but it would also risk violation of both the *Ontario Human Rights Code* and the *Canadian Charter of Rights and Freedoms* were it to do so.
- EI.4 Finally, in Part IV, I summarize and submit my recommendations.

[Source: <http://policyconsult.cpso.on.ca/wp-content/uploads/2014/09/D-BM-R-letter-V2-redacted.pdf>]

EII. Submission 1173: Christian Legal Fellowship

- EII.1 . . . The CLF's membership consists of approximately 550 lawyers, law students, professors, and others who support its work; with approximately one third of its members in the Province of Ontario. It has 14 chapters in cities across Canada and student chapters in most Canadian law schools. While having no direct denominational affiliation, CLF's members represent more than 30 Christian denominations working in association together. . .
- EII.2 The CLF has intervened in numerous legal cases relating to matters of conscience and religious freedom at the appellate and Supreme Court level. The organization also engages in policy consultations raising issues that impact, among other things, religious freedom and human rights. CLF is therefore knowledgeable and well-positioned to comment on this CPSO Policy.
- EII.3 In reviewing the Policy, there are three broad areas of concern for CLF. First, we submit that the Policy fails to recognize that physicians have the right to freedom of religion and conscience. Second, the Policy fails to recognize that the law protects physicians with religious beliefs from engaging in activities that violate their religious beliefs. their moral

beliefs and their conscience. Third, the Policy obligates physicians, in "some circumstances" to actively refer a patient for services which violate the beliefs or conscience of the physician. . .

- EII.4 Under the law, physicians must be afforded the ability to align their practices with their conscience in these controversial areas and others, and that right must be made clear in the CPSO Policy. CLF therefore urges the CPSO to modify its Policy to reflect the principles outlined above, ensuring it accurately reflects physicians' rights pursuant to the *Charter* and the *Human Rights Code*.

[Source: <http://policyconsult.cpso.on.ca/wp-content/uploads/2014/08/Christian-Legal-Fellowship-Response-redacted.pdf>]

EIII. Submission 1181: Justice Centre for Constitutional Freedoms

- EIII.1 . . .In its current form, the CPSO Policy misinterprets *Ontario's Human Rights Code* ("Code") as providing patients with a legal right or entitlement to receive medical services they may desire, and to receive these from any physician they may choose. Contrary to this misinterpretation, the *Code* protects the patient from being discriminated against on the basis of *the patient's personal characteristics* (e.g. race, religion, sexual orientation). This protection is fundamentally different from creating an entitlement to any particular drug, therapy, treatment, or medical procedure, or an entitlement of receiving this from every doctor.
- EIII.2 Further, the current CPSO Policy fails to recognize the *Charter's* Section 2(a) freedom of conscience and religion, and the manner in which the *Charter* applies to protect physicians from state coercion. The *Charter* is part of Canada's Constitution - Canada's supreme law - and the CPSO cannot exclude it from consideration. This means that the CPSO Policy must interpret the *Code* in a manner consistent with the *Charter*. The current CPSO Policy fails to do so. . .

[Source: <http://policyconsult.cpso.on.ca/wp-content/uploads/2014/08/JCCF-Response-redacted.pdf>]