Published: 2022 Nov 28

Submission to the College of Physicians and Surgeons of Ontario
Re: *Human Rights in the Provision of Health Services* (2022)

Abstract

The College of Physicians and Surgeons of Ontario (CPSO) has invited comment on a draft policy and related document, *Human Rights in the Provision of Health Services* (*Human Rights 2022*) and *Advice to the Profession: Human rights in the Provision of Health Services* (*Human Rights-Advice 2022*).

The draft revision updates the current policy through which the CPSO imposed a requirement for "effective referral" for morally contested services. Ontario physicians unwilling to provide a procedure they consider unethical/immoral/harmful are required by the CPSO to make an "effective referral" — to connect a patient with a practitioner willing to do what they refuse to do. The policy survived a constitutional legal challenge. It appears that judicial approbation has become a license to make increasingly oppressive demands on objecting physicians.

In particular, *Human Rights 2022* now requires physicians who make effective referrals to follow up and ensure that patients have connected with the practitioner or agency to whom they were referred. If not, physicians are required to take additional steps to bring the connection about. Further, the policy now emphasizes an obligation to provide formal clinical referrals for morally contested services, but anticipates that "many patients" will need physician help to get services even when they can be directly accessed.

Human Rights 2022 forbids physicians to "express" moral judgement about patient beliefs. That is impossible. Both agreement and refusal to provide or collaborate in a service *express* moral judgement about a service being sought, and implicitly *express* a similar judgement about a patient's beliefs.

Ontario physicians are now forbidden to "express" moral judgement about *services* sought by patients. This contradicts the Canadian Medical Association (CMA) *Code of Ethics and Professionalism*. It also obstructs physician-patient matching, which is an effective strategy for accommodating patients and physicians and improving health outcomes. Finally, the prohibition amounts to a *de facto* suppression of physician freedom of conscience, which necessarily entails an expression of moral or ethical judgement about services sought by patients.

A new provision requires physicians to consider patient access to services when making decisions about their scope of practice and clinical competence. This may be intended to pressure physicians to extend their scope of

practice/clinical competence to include services to which they object for reasons of conscience. Previously, the CPSO had assured the courts that physicians opposed to making effective referrals could avoid conflicts by changing their scope of practice: from general practice to hair restoration, for example.

Another new passage states that physicians must not "provide false, misleading, confusing, coercive, or incomplete information" about treatment options. The obligation to adhere to principles of informed consent is affirmed by *Human Rights 2022* and precludes such conduct, so the pejorative warning is unnecessary. Its location within the document indicates that it is addressed to physicians whose religious or moral beliefs cause them to object to certain procedures. The message conveyed is that these physicians are likely to lie, deceive, mislead and coerce their patients, so an explicit warning is needed. Demeaning innuendos of this kind are condemned by the CPSO in other contexts and considered a form of workplace harassment by the Ontario government.

Three disparate elements of the revised policy are noteworthy.

First: *Human Rights 2022* states that physicians must not comply with apparently discriminatory patient requests to be treated by a physician with a specific "social identity," and it authorizes them to refuse required medical care if the request has made them feel unsafe. In effect, the new provision instructs physicians that they must not comply with patient requests that would facilitate perceived wrongdoing by someone else (i.e., discrimination by the patient). This is exactly the same reasoning applied by physicians who refuse to facilitate euthanasia and assisted suicide by effective referral. Through *Human Rights 2022* the CPSO confirms the validity of their reasoning

Second: the policy directs physicians to incorporate policies that appear to be constitutive elements of a particular socio-political doctrine into their practices. Doctrinally defined policies bring doctrinal baggage that may be rejected by physicians who hold a variety of comprehensive religious and non-religious world views. The CPSO has not demonstrated that the socio-political doctrine it intends to impose through *Human Rights 2022* is the only one acceptable in Ontario medical practice.

Finally, all physicians working in faith-based hospitals and hospices are required to provide "access to information and care, including effective referrals for services, treatments and procedures that are not provided" in the institution. The direction is clearly intended to subvert the exercise of freedom of religion by religious groups operating healthcare facilities.

Objecting practitioners are typically willing to work cooperatively with patients and others to accommodate patient access to services as long as cooperation does not involve collaboration: an act that establishes a causal connection to or de facto support for the services to which they object. They are usually willing to provide patients with information to enable informed decision-making and contact with other health care practitioners. The distinctions between cooperation and collaboration and providing information vs. providing a service enable an approach that accommodates both patients and practitioners.

The Project recommends that the College adopt a single protection of conscience policy applicable to all services and procedures. This submission includes an example of such a policy. However, should current policy structure be maintained, specific recommendations are made for revisions to *Human Rights 2022* to address problematic elements identified in the submission.

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Introduction

The College of Physicians and Surgeons of Ontario (CPSO) has invited comment on a draft policy, *Human Rights in the Provision of Health Services* (*Human Rights 2022*),[1] and an accompanying resource, *Advice to the Profession: Human rights in the Provision of Health Services* (*Human Rights-Advice 2022*).[2] The draft documents are intended to replace the current policy, *Professional Obligations and Human Rights* (*POHR*)[3] and the related resource document (*POHR-Advice*).[4]

The Project's interest is confined to issues related to the exercise of freedom of conscience by practitioners who refuse to do what they believe to be unethical or immoral. While this necessarily entails discussion of legal issues, the Project does not provide legal advice. Practitioners should consult legal counsel before acting upon arguments advanced in the submission.

I. Defining Terms

I.1 *Human Rights 2022* opens by defining two key terms: "discrimination" and "effective referral." It directs readers to the CPSO *Equity, Diversity and Inclusion Glossary*[5] (*EDIG*) for further definitions and to "Advice to the Profession" documents for additional information and advice.[6]

Discrimination

I.2 The revised definition of discrimination in *Human Rights 2022* is largely editorial. However, a sentence has been added: "Discrimination is best identified by those who experience it

[1] College of Physicians and Surgeons of Ontario "Human Rights in the Provision of Health Services Draft" (ca September, 2022), *College of Physicians and Surgeons of Ontario* (website), online: <http://policyconsult.cpso.on.ca/wp-content/uploads/2022/08/Human-Rights-in-the-Provision-of-Health-Services_Draft-Policy.pdf> [*Human Rights 2022*].

[2] College of Physicians and Surgeons of Ontario "Advice to the Profession: Human Rights in the Provision of Health Services Draft" (ca September, 2022), *College of Physicians and Surgeons of Ontario* (website), online: <https://policyconsult.cpso.on.ca/wp-content/uploads/2022/08/Human-Rights-in-the-Provision-of-Health-Services_Draft-Advice.pdf > [*Human Rights-Advice 2022*].

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

[4] College of Physicians and Surgeons of Ontario, "Advice to the Profession: Professional Obligations and Human Rights" (2021), College of Physicians and Surgeons of Ontario (website), online: <https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Professional-Obligations-and-Human-Rights/Advice-to-the-Profession-Professional-Obligations> [*POHR-Advice*].

[5] College of Physicians and Surgeons of Ontario, "Equity, Diversity and Inclusion Glossary" (c2022), College of Physicians and Surgeons of Ontario (website), online: online: <https://www.cpso.on.ca/en/Physicians/Your-Practice/Equity-Diversity-and-Inclusion/EDI-Glossary> [*EDIG*].

[6] *Human Rights 2022*, *supra* note 1 at lines 2– 24.

given that there is a difference between intent and impact."[7] This seems to imply that, by default, the subjective views or impressions of someone complaining of discrimination should be given more weight than those of someone accused of discrimination.

Effective referral

I.3 The CPSO's demand for effective referral is central to the controversy about freedom of conscience in health care. The definition in *Human Rights 2022* is unchanged: "taking positive action to ensure the patient is connected to a non-objecting, available, and accessible physician, other health-care professional, or agency."[8] The requirements for effective referral will be considered in Part VIII.

EDIG terminology[9]

I.4 CPSO's *EDIG* is a resource meant to help bring "equity, diversity and inclusion (*EDI*) to [CPSO] processes and policies."[10] *Human Rights-Advice 2022* suggests some sound practices that can contribute positively to the practice environment: being aware of one's biases, learning about patients' lives, effective communication and collaboration with them, recognizing and responding to the effects of trauma, and identifying and addressing barriers to health care.[11]

I.5 However, *EDIG* terminology ("allyship", "intersectionality," and "microaggressions", for example) seems to be based on a particular socio-political doctrine. Consistent with this, *EDIG* and related *EDI* materials are explicitly described as resources for "learning and unlearning" — an apt description of indoctrination. Some of the terminology is incorporated directly into *Human Rights 2022*: "cultural humility", "cultural safety", "anti-racism" and "anti-oppression."

Cultural humility

I.6 Cultural humility means "the acknowledgement of oneself as a learner when it comes to understanding a patient's experience." This is particularly valuable attitude that can contribute much to a physician-patient relationship, but "humility" is a simpler, more familiar and more comprehensive term; "epistemic humility" might more closely approximate the attitude described. Since these terms have not been used, "*cultural* humility" must have a particular socio-political significance that is not apparent here.

Cultural safety

I.7 According to *EDIG*, a culturally "safe" environment is one "free of discrimination and racism, and patients *feel* safe." Further, "Safety is *defined by patients*," and is said to be "what is *felt or experienced* by patients" when physicians communicate respectfully and in an "inclusive way",

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[7] *Human Rights 2022*, *supra* note 1 at lines 18–19.

[8] *Human Rights 2022*, *supra* note 1 at lines 20–21.

[9] *EDIG*, *supra* note 5.

[10] *Human Rights Advice 2022*, *supra* note 2 at lines 31–32.

[11] *Ibid* at lines 50–62.

empower their decision-making and work with them "to ensure maximum effectiveness of care." The Canadian Medical Protective Society (CMPA) describes a culturally "safe" environment as one in which "patients feel safe in expressing their differing views, priorities and preferences."[12]

I.8 While it is important that patients should feel this way in order to fully benefit from therapeutic relationships,[13] being "safe" in this sense — roughly synonymous with feeling comfortable, supported or affirmed — is quite different from the usual definition of safety: being protected from danger, hurt or injury. The difference between the two — each proper and useful in different contexts — can be elided for partisan purposes. Thus, an expression of disagreement or failure to affirm (or adequately affirm) can be characterized as "aggression" that makes one feel "unsafe," making expression of disagreement unacceptable and affirmation mandatory.

Racism and anti-racism

I.9 According to *EDIG*, racism is *not* a belief or opinion that another race is inferior to one's own, deficient in essential human characteristics, inclined to wrongdoing or anti-social behaviour, or otherwise socially suspect or contemptible. Instead, racism is defined either as "*ways by which* differential consequences are created for different racial groups, even if not overtly intentional," or as "prejudice plus power." It is said to take "individual, cultural, institutional and systemic" forms. This doctrinal definition enables individuals or groups to be convicted of "racism," even if they are not motivated by or actually oppose conscious and unconscious racial prejudices.

I.10 Anti-racism is defined as "a process of actively identifying and eliminating racism by changing the systems, structures, policies, behaviours and beliefs that perpetuate racist ideas and actions." Like "safety", the term can be used polemically. To illustrate: to the extent that the preceding paragraph challenges the doctrinal definition of racism, it could be denounced as racist thinking because it perpetuates "racist ideas" — ideas that challenge the doctrinal definition.

Anti-oppression

I.11 "Anti-oppression work" presumes that oppression exists in society and that it is attributable to power imbalances. It involves ongoing efforts to identify oppression so that its effects can be mitigated by equalizing power imbalances. *EDIG* presumes but does not define oppression, so it does not explain how oppression can be identified for the purpose of mitigation.

I.12 Threatening physicians with regulatory discipline if they refuse to become parties to what they believe to be wrong — even killing their patients — would seem to be a classic example of oppression enabled by the imbalance of power between individuals and state actors. However, this policy is reinforced and amplified by *Human Rights 2022*. It appears that what counts as oppression

[12] Canadian Medical Protective Association, "Cultural safety" (January, 2021), Canadian Medical Protective Association (website), online: <https://www.cmpa-acpm.ca/en/education-events/good-practices/professionalism-ethics-and-wellness/cultural-safety>.

[13] Erica Steele, "Feeling Safe in Medical Settings" (12 August, 2022) *Psychology Today* (website), online: <https://www.psychologytoday.com/ca/blog/putting-the-care-back-in-healthcare/202208/feeling-safe-in-medical-settings>.

can be subjectively determined or manipulated for partisan purposes by the CPSO or by some unidentifiable socio-political authority.

II. Providing Health Services (1)

The Practice Environment

II.1 *Human Rights 2022* requires physicians to "take reasonable steps to create and foster a safe, inclusive, and accessible environment in which the rights, autonomy, dignity and diversity of all patients are respected, and where patients' needs are met" by complying with Ontario disabilities and human rights laws.[14] This is an unexceptionable editorial revision of the corresponding passage in *POHR*.[15]

II.2 In addition, however, physicians are directed to incorporate "cultural humility, cultural safety, anti-racism, and anti-oppression" into their practices.[16] These terms appear to be constitutive elements of a particular socio-political doctrine (I.6); they bring doctrinal baggage. Requiring physicians to assimilate doctrinal definitions is quite different from suggesting resources or practical steps that may help mitigate discrimination, as *Human Rights-Advice 2022* does.[17]

II.3 Physicians hold a variety of comprehensive world views — religious and non-religious — through which they incorporate commitments to equality and opposition to racism and oppression into their practices. Some may adhere to the socio-political doctrine from which the terms used in *Human Rights 2022* are drawn. Others may not, but nonetheless strive to achieve practice environments that have characteristics ascribed to "culturally safe" practice. This diverse response by physicians to social diversity is not surprising, and it is not a problem.

Issues

II.4 The CPSO has not demonstrated that the socio-political doctrine it intends to impose through *Human Rights 2022* is the only one acceptable in Ontario medical practice. *Human Rights 2022* §1(b) demonstrates unacceptable regulatory overreach inconsistent with the CPSO's professed commitment to inclusion, diversity and equality.

II.5 Some physicians committed to equality and respectful of diversity may reject *EDIG's* doctrinal definitions because they find them deficient, tendentious, self-contradictory, manipulative, open to partisan abuse or otherwise unsatisfactory. Others may reject the doctrinal baggage that comes with them. Nonetheless, all would be compelled by *Human Rights 2022* to affirm in some positive way what they do not believe.

II.6 Requiring physicians to incorporate the constitutive elements of a socio-political doctrine into their practices is an abuse of regulatory authority that violates fundamental freedoms of thought,

[14] *Human Rights 2022*, *supra* note 1 at §1, §1(a), lines 27–31.

[15] *POHR*, *supra* note 2 at §1(a).

[16] *Human Rights 2022*, *supra* note 1 at §1(b), lines 32–33.

[17] *Human Rights-Advice 2022*, *supra* note 2 at lines 51–62.

opinion and belief, and expression.[18] A majority of Supreme Court of Canada has held that this kind of coercion is unacceptable, a "totalitarian" practice that is "alien to the tradition of free nations."[19]

II.7 Imposing a socio-political doctrine as normative for medical practice in Ontario invites more aggressive regulatory abuse. It enables the CPSO to demand proof of conformity and enforce it by practice audits and other measures.

II.8 The CPSO's intention to impose a particular socio-political doctrine on physicians through *Human Rights 2022* is evocative of the controversy that raged for three years in the Law Society of Ontario. In 2016 the Society's board of directors demanded that all Ontario lawyers explicitly profess support for an EDI Statement of Principles. Most lawyers opposed the demand and elected a slate of directors who revoked the requirement in 2019.[20]

Recommendations

II.9 If the purpose of *Human Rights 2022* is to ensure that physicians are respectful of human rights and aware of the requirements of the *Ontario Human Rights Code* and related statutes, *Human Rights 2022* §1(a) is sufficient. *Human Rights 2022* should be amended to the following effect:

> **Human Rights 2022**
> **§1.** Physicians **must** take reasonable steps to create and foster a safe, inclusive, and accessible environment in which the rights, autonomy, dignity, and diversity of all patients are respected, and where patients' needs are met, by:
>
> a. complying with the relevant legal requirements under the Accessibility for Ontarians with Disabilities Act, 2005 and the Human Rights Code (the Code)~~; and~~
>
> ~~b. incorporating cultural humility, cultural safety, anti-racism, and anti-oppression into their practices.~~
>
> **Project recommendation**
> **§1.** Physicians **must** take reasonable steps to create and foster a safe, inclusive, and accessible environment in which the rights, autonomy, dignity, and diversity of all patients are respected, and where patients' needs are met, by complying with the relevant legal requirements under the *Accessibility for Ontarians with Disabilities Act, 2005* and the *Human Rights Code* (the *Code*).

[18] *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11, online:<https://laws-lois.justice.gc.ca/eng/const/page-12.html> at s 2(b).

[19] *National Bank of Canada v Retail Clerks' International Union et al* [1984] 1 SCR 269, 1984 CanLII 2 (SCC) at 296, online: <https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/23/index.do>.

[20] Irmak Aydemer, "The LSO Repeals Its Statement of Principles Requirement" (24 September, 2019), Obiter Dicta (website), online: <https://obiter-dicta.ca/2019/09/24/the-lso-repeals-its-statement-of-principles-requirement/>.

III. Providing Health Services (2)

Physician Expression

III.1 *Human Rights 2022* forbids physicians to express "personal moral judgments about patients' beliefs, lifestyle, identity, or characteristics", or promote their "spiritual, secular or religious beliefs when interacting with patients."[21] These prohibitions incorporate current policy,[22] differing only in (correctly) recognizing that everyone is a believer: that belief is not a peculiarly religious phenomenon.[23]

III.2 *Human Rights 2022* replaces the current specific prohibition of attempting to "convert" patients[24] with the vague statement that they must not "impose [their] beliefs on patients."[25] It also adds a new prohibition: that physicians must not express moral convictions about "the health services that patients are considering."[26]

Issues

III.3 *Human Rights 2022* prohibition on "imposing beliefs" is ironic in view of its requirement that physicians incorporate elements of a socio-political doctrine into their practices.

III.4 The new prohibitions against "imposing beliefs" and expressing moral judgements about services may be intended only to achieve the goals of the existing prohibition against trying to "convert" patients. Nonetheless, the formulations are grossly overbroad and mischievous in effect.

Imposing beliefs

III.5 *POHR's* statement that physicians must not attempt to convert patients is easily understood and acceptable. *Human Rights 2022* statement that physicians must not impose their beliefs is easily manipulated for partisan purposes; it is unacceptable.

III.6 Physicians have frequently been accused of "imposing beliefs" simply for refusing to act according to the beliefs of others. The accusations seem to have begun in relation to abortion and contraception, expanding more recently to euthanasia and assisted suicide. However, it is not difficult to imagine physicians being accused of "imposing beliefs" for refusing to perform infant male circumcision, for recommending vaccinations or refusing to prescribe ivermectin to treat Covid 19.

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[21] *Human Rights 2022*, *supra* note 1 at §2(a) and (c), lines 34–36, 39–40.

[22] *POHR*, *supra* note 2 at §11.

[23] Iain T. Benson, "Seeing Through the Secular Illusion" (2013) 54:S4 Nederduitse Gereformeerde Teologiese Tydkrif (Dutch Reformed Theological Journal) 12–29, online: <https://ngtt.journals.ac.za/pub/article/view/286>.

[24] *POHR*, *supra* note 2 at §11(a).

[25] *Human Rights 2022*, *supra* note 1 at §2(c), line 40.

[26] *Ibid* at §2(a), line 36.

III.7 *Human Rights 2022* should avoid language that can be weaponized for partisan purposes and which could enable or encourage inquisitorial crusades by activists and regulators.[27]

Moral judgment about patient beliefs

III.8 The prohibition against expressing moral judgement contradicts the new CPSO expectation that physicians must make and act upon a moral judgement about patient beliefs when requests for treatment from physicians are motivated by a patient's preference for race, ethnicity, etc.

III.9 Both agreement and refusal to provide or collaborate in a service *express* moral judgement in the form of agreement or disagreement about a service being sought, and implicitly *express* a similar judgement about a patient's beliefs. For example, it is absurd to suggest that at least implicit moral or ethical judgements are *not* expressed in claims that best medical practice in some circumstances requires prescribing antibiotics, or refusing to prescribe them: killing patients, or not killing them.[28]

III.10 Practitioners who refuse to comply with a patient request for moral or ethical reasons and explain that to a patient cannot avoid *expressing* at least implicit moral judgement about a patient's beliefs. To prohibit physicians from *expressing* moral judgement in such circumstances is unreasonable because it cannot be done. On the other hand, it is reasonable to insist that physicians not promote their own beliefs or belittle, criticize or attempt to change patient beliefs.

Moral judgement about services

III.11 The new prohibition in *Human Rights 2022* forbidding the expression of physicians' moral judgement about services sought by patients contradicts the Canadian Medical Association (CMA) *Code of Ethics and Professionalism*:

> 4. Inform the patient when your moral commitments may influence your recommendation concerning provision of, or practice of any medical procedure or intervention as it pertains to the patient's needs or requests.[29]

III.12 The statement represents the position the CMA has maintained since 1970.[30] It presumes at least disclosure of a physician's moral views (and thus moral judgement) about services sought by patients. Transparency on this point was recommended by the Project in its 2014 submission to the

[27] Sean Murphy, "NO MORE CHRISTIAN DOCTORS" (24 February, 2014), Protection of Conscience Project (website), online: <https://www.consciencelaws.org/background/procedures/birth002-01.aspx>.

[28] CMDA Canada, "Understanding Conscience in Health Care" (21 April, 2021), online:YouTube <https://www.youtube.com/watch?v=KyakqSesnGA>.

[29] The Canadian Medical Association, *CMA Code of Ethics and Professionalism*, Ottawa, CMA, 2018, online: <https://policybase.cma.ca/link/policy13937?> [*CMA Code*].

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

CPSO.[31] Transparency contributes to maintaining trust in the physician-patient relationship.

III.13 Patients may ask physicians about their moral or ethical views about a service because they may be seeking a physician whose views are consistent with their own, especially in relation to morally contested services. The new prohibition in *Human Rights 2022* would prevent physicians from replying to these patients and obstruct physician-patient matching, an effective strategy for preventing needless conflict, accommodating patients and physicians[32] and improving health outcomes.[33]

III.14 The new prohibition appears to reflect impoverished thinking, if not a technocratic or even robotic view of the practice of medicine, which is an inescapably moral enterprise.[34,35,36]

> [T]he work of doctors and nurses involves them in daily interaction with patients and with other healthcare professionals in which moral judgment and agency is required. [Their] work . . . would simply be impossible were they not to feel that they possessed scope within which to exercise such judgment.[37]

III.15 In any case, physician exercise of freedom of conscience during clinical encounters must entail, at some point and in some form, an expression of moral or ethical judgement about services sought by patients. Prohibiting such expression amounts to *de facto* suppression of physician freedom of conscience.

Recommendations

III.16 Within the context of the current policy structure, *Human Rights 2022* should be amended to the following effect:

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[31] Protection of Conscience Project, "Submission to the College of Physicians and Surgeons of Ontario Re: Physicians and the Ontario Human Rights Code" (3 August, 2014), Protection of Conscience Project (website), online: <https://www.consciencelaws.org/publications/submissions/submissions-012-001.aspx#V.2.04> at V.2.04.

[32] Holly Fernandez-Lynch, *Conflicts of Conscience in Health Care: An Institutional Compromise* (Cambridge, Mass.: The MIT Press, 2008) at 87-88, 90-93.

[33] *Human Rights-Advice 2022*, supra note 2 at lines 181–183.

[34] James W Maddock, "Humanizing health care services: The practice of medicine as a moral enterprise" (November, 1973) 500 – 504 J Natl Med Assoc 65(6), online: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2609038/pdf/jnma00496-0077.pdf>

[35] Mary Neal, Sara Fovargue, "Conscience and agent-integrity: a defence of conscience based exemptions in the health care context" (8 December, 2016) 544– 570 Med Law Rev 24(4),online: <https://academic.oup.com/medlaw/article-pdf/24/4/544/10020524/fww023.pdf> at 560.

[36] Sean Murphy et al, "The Declaration of Geneva: Conscience, Dignity and Good Medical Practice" (December, 2020) 66:4 World Med J 43, [WMJ Conscience] at 41. online: <https://www.wma.net/wp-content/uploads/2020/12/wmj_4_2020_WEB.pdf#page=43>.

[37] Daniel Weinstock, "Conscientious Refusal and Health Professionals: Does Religion Make a Difference?" (2014) 11–12 Bioethics 28(8), online: <https://onlinelibrary.wiley.com/doi/10.1111/bioe.12059> at 11.

Human Rights 2022
§2. In discharging provision 1, physicians **must not**:

a. ~~express personal moral judgments about~~ patients' beliefs, lifestyle, identity, or characteristics ~~or the health services that patients are considering;~~

c. promote their own spiritual, secular, or religious beliefs when interacting with patients or ~~impose these beliefs on patients.~~

Project Recommendation
§2. In discharging provision 1, physicians **must not**:

a. criticize, demean or attempt to modify patients' beliefs, lifestyle, identity, or characteristics. This does not preclude respectful discussion of beliefs or habits that may adversely affect a patient's health.

c. promote their own spiritual, secular, or religious beliefs when interacting with patients or attempt to persuade patients to adopt their beliefs.

IV. Providing Health Services (3)

The Duty to Accommodate

IV.1 *Human Rights 2022* introduces a new provision instructing physicians to refuse patient requests they deem discriminatory, while reasonably accommodating requests that are not. Nothing in the new provision implies that the patient making the request is aggressive, insulting or otherwise abusive, which could justify terminating a physician-patient relationship[38,39] or refusing to accept a patient or provide non-urgent treatment.[40,41]

IV.2 Since patients are legally entitled to refuse treatment of any kind from anyone, for any reason, the provision concerns only patients who ask for treatment or care by "a physician with a particular social identity (e.g., race, ethnicity, culture, sexual orientation and/or gender identity, spiritual/secular/religious beliefs, etc.)."[42]

IV.3 The policy states that physicians encountering such a request must (with patient consent) provide urgent or emergency treatment required,[43] accommodate requests they believe to be "ethically or clinically appropriate"[44] and refuse requests the physician believes discriminatory.[45]

IV.4 Further, in the case of requests believed to be discriminatory, physicians are to "determine whether it is *safe* and in *both* parties' best interest to provide any non-emergent or non-urgent care required."[46] (emphasis added).

IV.5 The new provision applies whether or not a physician-patient relationship exists. About

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[38] College of Physicians and Surgeons of Ontario, "Ending the Physician-Patient Relationship" (May, 2017) CPSO (website), online: <https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Ending-the-Physician-Patient-Relationship> [*CPSO Ending PPR*].

[39] Canadian Medical Protective Association"When physicians feel bullied or threatened" (October, 2020) CMPA (website) online: <https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2014/when-physicians-feel-bullied-effective-coping-strategies> [*CMPA Bullying*].

[40] Canadian Medical Protective Association, "Accepting new patients: The key to effective practice management" (October, 2022), CMPA (website), online: <https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2018/accepting-new-patients-the-key-to-effective-practice-management> at "Urgency and Need".

[41] "Treating Patient Bias", *Dialogue* (22 September, 2021) online: <https://dialogue.cpso.on.ca/2021/09/treating-patient-bias/>.

[42] *Human Rights 2022* §4, lines 49–51.

[43] *Ibid* at §4(a), lines 52–53.

[44] *Ibid* at §4(b), lines 54–57.

[45] *Ibid* at §4(c), lines 58–59.

[46] *Ibid* at §4(c), lines 60–61.

85% of Ontarians are attached to a primary care provider [47] and presumably have established physician-patient relationships. Within this group, requests of the kind relevant to this provision would most likely involve referral to specialists. Of the remaining 15%, it seems unlikely that many would be in a position to pick and choose among physicians. If relevant requests come from within this group, they would probably be made in practice environments like walk-in clinics and emergency rooms, where patients do not have established physician-patient relationships.

IV.6 Attending to the specifics of the new provision affords a clear understanding of its potential effects.

> i) A patient has made what the physician believes is a discriminatory request for access to a physician with a specified "social identity."
>
> ii) The patient requires non-emergent or non-urgent medical treatment.
>
> iii) The patient is willing to accept the treatment (since there would otherwise be no need for the physician to determine whether or not to provide it).
>
> iv) The patient obviously feels that it is"safe" to accept the treatment.
>
> v) Denying the required medical treatment cannot be in the patient's best interest, but the provision authorizes denial of treatment if it is not in *both* parties best interest.

IV.7 Recall, once more, that the issue here is the nature of the request, not abusive patient conduct (IV.1). Applying the doctrinal definition of "safety" (I.8), physicians can refuse to provide required non-emergent/non-urgent medical treatment because what they consider to be a discriminatory request has made them feel uncomfortable or disrespected, or providing treatment is not in their *own* best interest.[48]

Issues

IV.8 As the policy indicates, patient requests may be explained by personal circumstances, experiences or beliefs and may warrant accommodation.[49] The practical difficulty lies in distinguishing "appropriate" from "inappropriate" requests.[50]

IV.9 The new provision explicitly recognizes that patient requests can be based on their spiritual/secular/religious beliefs. Patients' spiritual/secular/religious beliefs will directly affect their moral judgement about services and procedures, and this may lead them to prefer care from a

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[47] Liisa Jaakkimainen et al, "Development and validation of an algorithm using health administrative data to define patient attachment to primary care providers" 2021 35:6 J Health Oranization & Management 733-743 online:<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8956282/>.

[48] *Human Rights-Advice 2022*, *supra* note 2 at lines 197–198.

[49] *Human Rights-Advice 2022*, *supra* note 2 at lines 176–185.

[50] "Ethical Responses If Patients Ask for Provider of Different Race" (1 August, 2020), Medical Ethics Advisor (website), online: <https://www.reliasmedia.com/articles/146579-ethical-responses-if-patients-ask-for-provider-of-different-race>.

physician with concordant beliefs, especially in relation to life and death issues.[51]

IV.10 Physician and patient beliefs about services and procedures may differ significantly. Nonetheless, physicians are required by the new provision *to express and to act upon* their moral/ethical judgement about patient beliefs motivating requests. This contradicts the prohibition against doing so in *Human Rights 2022* (III.1).

IV.11 Further, a physician who believes the patient's beliefs are discriminatory is instructed to refuse accommodation and authorized to refuse to provide required non-emergent or non-urgent medical treatment, even within the context of an existing physician-patient relationship.

IV.12 In effect, the new provision instructs physicians who conscientiously object to becoming parties to perceived wrongdoing (alleged discrimination) to impede patient access to other physicians and authorizes them to refuse to provide required medical care. This notably contradicts the approach taken later in *Human Rights 2022* to physician freedom of conscience and religion in relation to services like euthanasia and assisted suicide.

IV.13 The contradictions demonstrate the point made by the Project in its 2008 submission to the CPSO about its first human rights policy proposal.

> [W]hen professional associations are convinced that an act is seriously wrong - even if it is legal - one finds them willing to refuse all forms of direct and indirect participation in order to avoid moral complicity in the act. This is precisely the position taken by conscientious objectors in health care.[52]

IV.14 And that is exactly the position taken by *Human Rights 2022* in relation to discriminatory requests. The CPSO applies in this provision exactly the same moral reasoning about complicity in perceived discrimination that is applied by objecting physicians in relation to services like euthanasia and assisted suicide.

IV.15 Further, *Human Rights 2022* does not require a physician to make an effective referral or an effective transfer of care to facilitate perceived discrimination, just as physicians who object to euthanasia/assisted suicide are unwilling to make effective referrals or transfers of care to facilitate the killing of their patients.

IV.16 Finally, by authorizing physicians who conscientiously object to apparently discriminatory requests to refuse to provide required medical care based on their *own* comfort or best interest, *Human Rights 2022* contradicts its later statement that, in any conflict between physician and patient interest, "the interest of the patient prevails."[53]

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[51] Jacob A Blythe, Farr A Curlin, "How Should Physicians Respond to Patient Requests for Religious Concordance?" (2019) 21(6) AMA J Ethics E485-492, online: <https://journalofethics.ama-assn.org/article/how-should-physicians-respond-patient-requests-religious-concordance/2019-06>.

[52] Protection of Conscience Project, "Submission to the College of Physicians and Surgeons of Ontario Re: Physicians and the Ontario Human Rights Code" (11 September, 2008), Protection of Conscience Project (website), online: <https://www.consciencelaws.org/publications/submissions/submissions-006.aspx#III.21> at III.21.

[53] *Human Rights 2022, supra* note 1 at footnote 12.

IV.17 Accommodation of patient requests and harassment or abuse by patients are different issues that require different responses, even if a request arises within the context of bigoted or abusive patient remarks. This distinction is blurred in the new provision and in *Human Rights-Advice 2022*.[54]

Recommendations

IV.18 Adopting the Project's recommended revision of *Human Rights 2022* §2 (see III.16) will eliminate the contradiction noted in IV.10 without compromising physicians' obligation to avoid encouraging or facilitating wrongful discrimination.

IV.19 The likelihood of adverse prejudicial effect of physician bias should be reduced. This can be accomplished by two revisions.

> i) Incorporate guidance from the Canadian Medical Protective Association to the effect that the duty to accommodate normally includes a duty to reasonably accommodate patient *requests* related to their protected characteristics.[55] This would be consistent with *Human Rights-Advice 2022*.[56] *Human Rights 2022* §3 refers only to *needs*, which readers may not understand to include the kind of request contemplated in the provision.
>
> ii) Direct that patient requests directly or indirectly motivated by their beliefs about services or procedures should be reasonably accommodated.

The revisions will not compromise physicians' ability to decline requests motivated by discriminatory patient beliefs about races, ethnic groups, etc.

IV.20 Physicians who refuse a patient's request for a physician of a particular "social identity" should advise patients that they are free to contact other health care practitioners or services for assistance, and, if need be, indicate how that can be done. This mitigates the effect of erroneous identification of discrimination and supports patient autonomy. It does not amount to the complicity in discrimination, which can be reasonably associated with an effective referral to an available and accessible physician willing to facilitate it.

IV.21 The provision should not authorize denial of required medical services. Other guidelines can assist physicians who have actually been insulted, demeaned or otherwise abused by a patient within the context of a physician-patient relationship.[57,58] When a physician-patient relationship

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[54] *Human Rights-Advice 2022*, *supra* note 2 at lines 164–168, 190–191.

[55] Canadian Medical Protective Association, "When patients make special requests, how should you respond?" (February, 2021), CMPA (website), online:<https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2019/when-patients-make-special-requests-how-should-you-respond> at point 1.

[56] *Human Rights-Advice 2022*, *supra* note 2 at lines 176–185.

[57] *CPSO Ending PPR*, *supra* note 38.

[58] *CMPA Bullying*, *supra* note 39.

does not exist, physicians have no obligation to provide non-emergent or non-urgent medical services, although they may choose to do so.[59]

IV.22 Patient harassment and abuse of physicians can be a serious problem,[60] but it is unnecessary to address it in a human rights policy, and it confusing to do so within the context of a duty to accommodate patient requests.

> ***Human Rights 2022***
> **§4.** Where a patient requests to receive care from a physician with a particular social identity (e.g., race, ethnicity, culture, sexual orientation and/or gender identity, spiritual/secular/religious beliefs, etc.), physicians **must**:
>
> a. with appropriate consent, provide any emergent or urgent medical care the patient requires; and
>
> b. where non-emergent or non-urgent care is required, take reasonable steps to accommodate the patient's request if the physician believes that the request is ethically or clinically appropriate (e.g., patient would like to receive care from a physician who speaks the same language to facilitate communication); or
>
> c. tell the patient that their request will not be accommodated if the physician believes that the request is discriminatory (e.g., racist, sexist, ageist, heterosexist, etc.) ~~and determine whether it is safe and in both parties' best interest to provide any non- emergent or non-urgent care required.~~

> **Project Recommendation**
> §4. A patient may request to receive care from a physician with a particular social identity (e.g., race, ethnicity, culture, sexual orientation and/or gender identity, spiritual/secular/religious beliefs, etc.). The duty to accommodate normally applies to requests related to a patient's protected characteristics. [P]hysicians **must**:
>
> a. with appropriate consent, provide any emergent or urgent medical care the patient requires; and
>
> b. where non-emergent or non-urgent care is required,
>
> i) take reasonable steps to accommodate requests directly or indirectly motivated by patient beliefs about services or procedures;
>
> ii) in other cases, if the physician believes that the request is ethically or clinically appropriate (e.g., patient would like to receive care from a physician who speaks the same language to facilitate communication), take reasonable steps to accommodate the request; or

[59] *Human Rights-Advice 2022*, *supra* note 2 at lines 205–208.

[60] *Ibid* at lines 189–194.

iii) if the physician believes that the request is discriminatory (e.g., racist, sexist, ageist, heterosexist, etc.) tell the patient that their request will not be accommodated.

c. when a request is refused under (b)iii, advise patients that they are free to contact other health care practitioners or services for assistance, and, if need be, indicate how that can be done.

V. Providing Health Services (4)

The Duty to Provide Services Free from Discrimination

V.1 *Human Rights 2022* states that physicians "must not discriminate, either directly or indirectly, based on a protected ground under the [*Human Rights*] *Code*" when "making decisions" about providing or limiting services, accepting or refusing patients, providing information to patients, providing "clinical referrals and effective referrals" and ending physician-patient relationships."[61]

V.2 "Disability" is among the protected grounds identified in the *Human Rights Code*. Euthanasia and assisted suicide (EAS) are available for treatment of most of the disabilities identified in the *Code*, and will be available for treating mental illness in March, 2023.

Issues

V.3 Professor Amir Attaran of the University of Ottawa has offered a striking analysis of the application of laws like Ontario's *Human Rights Code* to medical practice in relation to EAS service.[62]

V.4 In brief, Prof. Attaran agreed that physicians could refuse to personally provide euthanasia and assisted suicide if they lacked necessary "skills, facilities or ability." However, he added that referral must not be used "as a tool of segregation."[63]

V.5 "Depriving disabled persons of a routinely available medical service without justification is illegal," he wrote.[64]

> For example, if a doctor willingly prescribes pain-relieving drugs to alleviate suffering—for arthritis, back pain, cancer, stomach ulcer, *et cetera* — but selectively refuses to prescribe seco-barbital or pentobarbital to a patient who lawfully chooses to die, that differential denial of service (i.e.,prescribing vs. not prescribing) needs a satisfactory justification, or it is discriminatory and illegal.[65]

V.6 This was a poorly chosen example, since it compared patients doubtfully eligible for EAS with someone clearly eligible. Considering referral, however, he cited a British Columbia case to make the point that, contrary to CPSO policy, human rights law *prohibits* effective referral as a means of avoiding the personal provision of EAS service. The case involved a physician who, concerned about legal liability, had referred a lesbian couple for the service rather than providing it

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[61] *Human Rights 2022*, supra note 1 at §5, lines 63–70.

[62] Amir Attaran, "The Limits of Conscientious and Religious Objection to Physician-Assisted Dying after the Supreme Court's Decision in *Carter v. Canada*" (2016) 36:1 Health Law Can. 2016 Feb;36(3):86, online: <https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2741748>.

[63] *Ibid* at 91.

[64] *Ibid* at 87.

[65] *Ibid*.

himself.

> By denying his patients medical services and instead referring them to other, willing doctors, Dr. Korn had tacitly conceded two things: (i) that the sought-after treatment was within the ordinary medical standard of care, and (ii) that his personal, considered refusal to provide that standard of care to lesbians was taken conscientiously, and was therefore intentionally discriminatory. [66]

V.7 The BC case parallels that of practitioners who provide EAS service for some legally eligible patients (those with terminal cancer) but not for others (those permanently paralyzed — or, in March, 2023, those with mental illness). According to Prof. Attaran, this differential treatment discriminates on the basis of disability.

V.8 If that is so, it would seem that practitioners who provide EAS service to *someone* eligible cannot refuse to provide it to *anyone* legally eligible. Further, according to Prof. Attaran, they cannot escape the obligation by making an effective referral.

Recommendations

V.9 The Project does not accept Prof. Attaran's claim that an effective referral must be construed as evidence of discrimination, nor does it accept his argument in relation to objecting practitioners who refuse to provide a contested service to *anyone*. However, his argument may apply to practitioners willing to provide EAS for some eligible patients but not others. It thus seems appropriate to include guidance on this issue in *Human Rights 2022*.

[66] *Ibid* at 92.

VI. Limiting Services

Clinical Competence/Scope of Practice Reasons

VI.1 *Human Rights 2022* introduces a new provision requiring physicians who limit their practices for reasons of clinical competence or scope of practice to "consider the risks and benefits of limiting the provision of health services and the impact it would have on patients (e.g., if they would have difficulties accessing the services elsewhere in a timely manner due to a lack of resources)."[67]

VI.2 Physicians must be able to keep practice patient loads to a manageable size and preserve freedom to focus on the needs of specific patient groups. Subject to these considerations and within this context, the impact on patients of a decision to limit the scope of one's practice is a factor that physicians may be asked to consider. It does not follow that the CPSO should be permitted to second-guess their conclusions.

Issues

VI.3 The CPSO expects all physicians to practise within the scope of their clinical competence.[68] It is remarkable that, having stated that physicians must make practice decisions in accordance with College expectations,[69] *Human Rights 2022* goes on to suggest that it is mandatory for physicians to consider practising beyond their clinical competence if necessary to facilitate patient access to services:[70] mandatory, that is, to contemplate serious professional misconduct that violates the terms of physician registration.[71]

VI.4 Alternatively, this may be intended to pressure physicians to extend their scope of practice or clinical competence to include services or procedures to which they object for reasons of conscience. Previously, the CPSO assured the courts that physicians opposed to the effective referral policy could avoid problems by changing their scope of practice: from general practice to hair restoration, for example.[72]

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[67] *Human Rights 2022, supra* note 1 at §6(a), lines 75–78.

[68] College of Physicians and Surgeons of Ontario, "Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice" (December, 2015), CPSO (website) online: <https://www.cpso.on.ca/en/Physicians/Policies-Guidance/Policies/Ensuring-Competence> [*CPSO Competence*] at point 1.

[69] *Human Rights 2022*, *supra* note 1 at §6, lines 73–74.

[70] *Ibid* at §6, lines 75–78.

[71] *CPSO Competence*, *supra* note 66 at footnote 4.

[72] *Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario,* 2019 ONCA 393 (CanLII), online: <https://canlii.ca/t/j08wq> [*CMDS v CPSO 2019*] at para 184.

Recommendations

VI.5 The new provision should be deleted. The existing requirements to conform to the *Human Rights Code* and College expectations (including physician competence, accepting patients, ending physician-patient relationships and communicating with patients) are sufficient.

Human Rights 2022
§6. Physicians **must** make any decisions to limit the provision of health services for reasons of clinical competence and/or scope of practice in good faith, and in accordance with the *Code* and College expectations.

~~a. In making this decision, physicians **must** consider the risks and benefits of limiting the provision of health services and the impact it would have on patients (e.g., if they would have difficulties accessing the services elsewhere in a timely manner due to a lack of resources).~~

Project Recommendation
§6. Physicians **must** make any decisions to limit the provision of health services for reasons of clinical competence and/or scope of practice in good faith, and in accordance with the *Code* and College expectations.

VII. Conflict with Physician Conscience/Religion (1)

Providing information

Medical decision-making

VII.1 *Human Rights 2022* requires physicians to provide patients with enough information to enable informed medical decision-making,[73] including information about services or treatments to which they object.[74] These are editorially revisions of corresponding passages in *POHR.*[75,76] A new provision specifies that physicians communicate with patients in "a clear, straightforward, and neutral manner."[77]

VII.2 In the Project's experience, objecting physicians are willing to provide information necessary to enable informed decision making. The expectation that they will provide information on all treatment options — including procedures to which they object — is not normally problematic.

VII.3 Generally speaking, what information should be provided and the point at which it ought to be provided must be guided by and responsive to the circumstances and expressed interests of each patient. This should be left to the good judgement individual practitioners based on of knowledge of and interaction with their patients. For example, it would be insensitive to gratuitously suggest the options of abortion and adoption to every pregnant woman in the absence of some indication by the patient of at least ambivalence about her pregnancy.

Issues

VII.4 The policy fails to recognize that appropriate reflection and caution may be required in presenting some treatment options.

Recommendations

VII.5 The comment in *Advice to the Profession: Medical Assistance in Dying (Draft)* can be adapted to qualify the requirement to discuss treatment options: "Physicians must use their professional judgement to determine if, when and how to discuss particular treatment options with their patients."[78]

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[73] *Human Rights 2022*, *supra* note 1 at lines 89–91.

[74] *Ibid* at §11(a), lines 117–119.

[75] *POHR*, *supra* note 3 at §12.

[76] Ibid at §13.

[77] *Ibid* at §10(a), lines 109–111.

[78] College of Physicians and Surgeons of Ontario, "Advice to the Profession: Medical Assistance in Dying Draft" (ca September, 2021), *College of Physicians and Surgeons of Ontario* (website), online: <https://policyconsult.cpso.on.ca/wp-content/uploads/2022/08/Medical-Assistance-in-Dying_Draft-Advice.pdf> at lines 24–25.

Impeding information/access

VII.6 Like *POHR*,[79] *Human Rights 2022* warns objecting physicians that they must not "impede access to information and/or care."[80]

VII.7 To "impede access" is unacceptable if that means some positive act of interference, such as discouraging other health care providers from seeing the patient, or some wrongful act, like misleading a patient or refusing to release medical records belonging to a patient. On the other hand, practitioners who simply refuse to help patients find someone willing to do what they believe to be wrong or harmful are no more impeding patients than colleagues who refuse to help patients find someone willing to provide virginity certificates.[81]

Issues

VII.8 The term "impeding access" is overbroad and thus open to polemical abuse at the expense of objecting practitioners.

Recommendations

VII.9 The phrase "impede access" should be replaced with "interfere with access."

Dishonest communication

VII.10 *Human Rights 2022* states that physicians must not "provide false, misleading, confusing, coercive, or incomplete information about available or appropriate clinical options."[82]

VII.11 The text of the passage is an almost verbatim copy of a passage in a paper published in 2013.[83] The manager of the CPSO policy department represented the College at a meeting apparently convened by the authors to review the paper prior to publication.[84] The College of Physicians and Surgeons of Saskatchewan policy on conscientious objection includes an identical

[79] *POHR*, *supra* note 3 at §15.

[80] *Human Rights 2022*, *supra* note 1 at §11(c), lines 117, 122.

[81] Niklas Juth & Niels Lynöe, "Zero tolerance against patriarchal norms? A cross-sectional study of Swedish physicians' attitudes towards young females requesting virginity certificates or hymen restoration" (2015) 41:3 J Med Ethics 215-219, online:<https://jme.bmj.com/content/41/3/215?>.

[82] *Human Rights 2022*, *supra* note 1 at §11(c), lines 117, 120–121.

[83] Jocelyn Downie, Carolyn McLeod and Jacquelyn Shaw, "Moving Forward with a Clear Conscience: A Model Conscientious Objection Policy for Canadian Colleges of Physicians and Surgeons" (2013) 21:3 Health Law Rev 28–32, online: <https://core.ac.uk/download/pdf/215386599.pdf> at 31 (Section 5.2).

[84] Letter from Bryan Salte to the Registrars of Colleges of Physicians and Surgeons in Canada (undated). Redacted in Document 200/14, College of Physicians and Surgeons of Saskatchewan, Report to Council from the Registrar, 31 July, 2014
online:<https://www.consciencelaws.org/archive/documents/cpss/2014-07-31-Report.pdf#page=8> at 8.

passage[85] from the same source.[86]

Issues

VII.12 The duty to adhere to the principle of informed consent precludes misrepresentation or providing information that is false, misleading, etc. *Human Rights 2022* explicitly reminds physicians of this obligation in a preceding section.[87] Hence, this additional and pejorative warning is unnecessary.

VII.13 The statement seems more representative of cut-and-paste polemics than evidence-based policy making.

VII.14 This statement is made within the section "Health Services that Conflict with Physicians' Conscience or Religious Beliefs," and is thus addressed directly and specifically to practitioners — including religious believers — who find themselves in this situation. The message communicated by this passage is that members of this group, by virtue of their religious or non-religious beliefs, are untrustworthy practitioners likely to lie, deceive, mislead and coerce their patients, and thus in need of an explicit warning.

VII.15 Directed at a group of physicians who are particularly concerned to preserve their personal moral/ethical integrity, it exemplifies what the CPSO elsewhere describes as a "disrespectful, insulting, demeaning . . . innuendo" that inhibits collegiality, collaboration and teamwork, impedes communication and undermines morale.[88] The Ontario government lists offensive innuendos among forms of workplace harassment.[89]

Recommendations:

VII.16 The passage is superfluous, unsupported by evidence and apparently discriminatory. It should be deleted.

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[85] College of Physicians and Surgeons of Saskatchewan, "Conscientious Objection" (November, 2020), *College of Physicians and Surgeons of Saskatchewan* (website), online: <https://www.cps.sk.ca/iMIS/Documents/Legislation/Policies/POLICY%20-%20Conscientious%20Objection.pdf> at §5.2.

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

[87] *Human Rights 2022*, *supra* note 1 at §8, lines 89–91, footnote 13.

[88] College of Physicians and Surgeons of Ontario, "Physician Behaviour in the Professional Environment" (May, 2016), *College of Physicians and Surgeons of Ontario* (website), online: <https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Physician-Behaviour-in-the-Professional-Environmen> at §8(a).

[89] Ministry of Labour, Immigration, Training and Skills Development "Preventing workplace violence and workplace harassment" (18 July, 2022), *Government of Ontario* (website), online: <https://www.ontario.ca/page/preventing-workplace-violence-and-workplace-harassment> at Workplace Harassment.

Summary

VII.17 Within the context of the current policy structure, *Human Rights 2022* should be amended to the following effect:

Human Rights 2022
§8. Physicians **must** provide patients with enough information about all available or appropriate clinical options to meet their clinical needs or concerns so that patients are able to make an informed decision about exploring a particular option.

Project Recommendation
§8. Physicians **must** provide patients with enough information about all available or appropriate clinical options to meet their clinical needs or concerns so that patients are able to make an informed decision about exploring a particular option. Physicians must use their professional judgement to determine if, when and how to discuss particular treatment options with their patients.

Human Rights 2022
§11. Physicians must not

~~b. provide false, misleading, confusing, coercive, or incomplete information about available or appropriate clinical options;~~

c) ~~impede~~ access to information and/or care, or

Project Recommendation
§11. Physicians must not

b) interfere with access to information and/or care, or

VIII. Conflict with Physician Conscience/Religion (2)

Effective Referral

Introduction

VIII.1 *Human Rights 2022* requires unwilling physicians to facilitate conduct they reasonably perceive to be gravely wrong and/or contrary to medical practice by making effective referrals. This is the principal problem with the policy from the perspective of protecting freedom of conscience.

VIII.2 Physicians who object to providing effective referrals reasonably hold that doing something *effective* to facilitate wrongdoing is collaboration that makes them morally culpable for wrongdoing. The validity of this position was demonstrated in the Project's 2016 submission to the CPSO by analogy to pre-*Carter* criminal law.[90] Its validity is confirmed by *Human Rights 2022* in its treatment of conscientious objection to apparently discriminatory patient requests (see IV.12 to IV.15).

VIII.3 The CPSO seems to consider the ruling of the Ontario Court of Appeal a license to discriminate and impose increasingly oppressive measures on physicians who refuse to do what they believe to be wrong, and who have not followed College advice to move from general practice or palliative care into safer fields like obesity medicine or hair restoration.[91]

Identifying conflict

VIII.4 *Human Rights 2022* states that if "a particular service, treatment, or procedure *might* be a relevant clinical option for a patient (emphasis added) but physicians are unwilling to provide it for reasons of conscience, they must "make any decisions to limit the provision of health services in accordance with the [Human Rights] *Code*" and advise the patient they do not provide it.[92] The revision introduces the following changes:

a) Reference to the *Human Rights Code* (i.e., duty of non-discrimination).

b) Makes explicit the need to advise the patient, which was presumed in *POHR*.[93]

c) The words "service, treatment or procedure" replace "care."

VIII.5 Replacing "care" with "service, treatment or procedure" is an improvement because the term "care" (like *medical* treatment or *health* service) presumes a point that is often disputed in relation to morally contested services.

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[90] "Protection of Conscience Project Submission to the College of Physicians and Surgeons of Ontario Re: Interim Guidance on Physician Assisted Death" (10 January, 2016), *Protection of Conscience Project* (website), online: <https://www.consciencelaws.org/publications/submissions/submissions-022-001-cpso.aspx#V.2> at V.2.

[91] *CMDS v CPSO 2019*, *supra* note 72.

[92] *Human Rights 2022*, *supra* note 1 at lines 93–98.

[93] *POHR*, *supra* note 3 at §14.

VIII.6 The policy describes the first responses expected from a physician when conflicts arise. It demonstrates no interest in avoiding conflicts by notifying patients in advance (when possible) of a physician's position. On the other hand, it does not preclude the strategy. Advance notification enables physicians and patients to negotiate mutually satisfactory accommodation, and gives patients an opportunity to find different physician if they wish.

Effective referral

Unchanged requirements

VIII.7 Once physicians advise a patient they do not provide service for reasons of conscience, *Human Rights 2022* demands that they provide an effective referral.[94] The policy specifies that the referral must be "timely,"[95] so that patients will not "be exposed to adverse clinical outcomes."[96] Examples of adverse outcomes are being prevented from obtaining emergency contraception, abortion, euthanasia or assisted suicide or "untreated pain or suffering is prolonged."[97]

VIII.8 To make an effective referral is to "take positive action to ensure the patient is connected in a timely manner to a non-objecting, available and accessible physician. . . health care professional or agency that provides the service or connects the patient directly with a health care professional who does."[98] "Available and accessible" means "operating and/or accepting patients"reasonably accessible to the patient virtually or at a physical location.[99] Physicians may delegate a responsible person to make effective referrals on their behalf;[100] by this means they can share moral responsibility, but they are not relieved of it.

VIII.9 *POHR* required physicians to "proactively maintain *an effective referral plan* for frequently requested services they are unwilling to provide (emphasis added),"[101] while *Human Rights 2022* requires that they have "a plan" to "connect patients" with services they do not provide.[102] It is doubtful that the difference is of any significance, since the plans are subject to review by the College.

Additional requirements

VIII.10 The definition of effective referral includes a requirement to "ensure" that a patient is

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[94] *Human Rights 2022*, *supra* note 1 at §9(b), line 99; cf *POHR*, *supra* note 3 at §14.

[95] *Human Rights 2022*, *supra* note 1 at §9(b)i, lines 102–103; cf *POHR*, *supra* note 3 at §14(a).

[96] *Human Rights 2022*, *supra* note 1 at §11(d), lines 123–124; cf *POHR*, *supra* note 3 at §15(b).

[97] *Human Rights-Advice 2022*, *supra* note 2 at lines 250–256; cf *POHR-Advice*, *supra* note 4 at step 3.

[98] *Human Rights 2022*, *supra* note 1 at lines 20–21.

[99] *Human Rights-Advice 2022*, *supra* note 2 at footnote 1; cf *POHR-Advice*, *supra* note 4 at endnote 2.

[100] *Human Rights-Advice 2022*, *supra* note 2 at lines 239–242; cf *POHR-Advice*, *supra* note 4 at step 1.

[101] *POHR*, *supra* note 3 at §16.

[102] *Human Rights 2022*, at §9(b)iv.

connected directly with a non-objecting practitioner or agency. *Human Rights 2022* substantially expands this:

> §9(b) ii. Physicians **must** take reasonable steps to confirm that a patient was connected, unless the patient has indicated that they prefer otherwise.
>
> §9(b) iii. If physicians learn that the patient was not connected, they **must** take further action to provide an effective referral.[103]

VIII.11 The new policy stresses that, in *every* case, objecting physicians must actively ensure that a patient has connected with the practitioner or agency to whom they were referred,[104] and that a failure to follow up in every case by contacting the patient or other practitioner is a breach of fiduciary duty.[105] If the patient has not connected, objecting physicians must take additional steps to bring the connection about.[106]

VIII.12 Further, it is expected that "many patients" will need help from objecting physicians to access morally contested services even when direct access is available.[107] POHR stated that effective referral "does not necessarily, but may in certain circumstances, involve a 'referral' in the formal clinical sense."[108] *Human Rights-Advice 2022* now emphasizes an obligation to provide a formal clinical referral for morally contested services.[109]

Additional examples

VIII.13 *POHR-Advice* offers four examples of effective referral (paraphrased in a to d below); *Human Rights-Advice 2022* incorporates these and adds three more (paraphrased in e to g below).

> a) An objector/delegate contacts a provider and arranges for the patient to be seen or transferred.[110]
>
> b) An objector/delegate connects the patient with an agency that delivers the contested service, like a abortion clinic or the Ontario Care Coordination Service.[111]

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[103] *Human Rights 2022*, *supra* note 1 at §9(b)ii & iii, lines 102–105.

[104] *Human Rights-Advice*, *supra* note 2 at lines 308–309.

[105] *Ibid* at lines 312–324.

[106] *Ibid* at lines 326–332.

[107] *Ibid* at lines 269–274.

[108] *POHR*, *supra* note 3 at endnote 1.

[109] *Human Rights-Advice 2022*, *supra* note 2 at lines 258-259; 271-273; 281-284.

[110] *Ibid* at lines 278-280.

[111] *Ibid* at 290-295.

> c) A practice group in a hospital, clinic or family practice identifies patients seeking a contested service through a triage system and connects them with a non-objecting practitioner.[112]
>
> d) A practice group identifies a provider/facilitator with whom an objecting practitioner connects the patient.[113]
>
> e) An objector makes clinical referral for a morally contested procedure only available through a specialist.[114]
>
> f) An objector/delegate partially transfers care to non-objector willing to discuss options and refer patient for morally contested service.[115]
>
> g) When a patient does not need assistance, an objector/delegate provides contact information for provider of morally contested procedure.[116]

VIII.14 Only example (c) is accommodation acceptable to all objecting physicians, precisely because it is *not* an effective referral as defined by the College. Someone in the group *other than* the objecting physician takes "positive action" to connect the patient with a non-objecting practitioner, so the objecting physician never meets the patient.

VIII.15 Each of the other examples requires some action by the objecting physician that many would reasonably consider to causally connect them to the provision of a morally contested procedure. And that is precisely the point of the policy. A referral that is not *effective* in facilitating the provision of a contested service is not an "*effective* referral."

VIII.16 Thus, in every case — except (c), because the objector will not even see the patient — an objecting practitioner must actively follow up to ensure that the patient has connected. For example, a physician who has provided only provider contact information must follow up and personally arrange for the patient to be seen if a connection has not been made.[117]

Emergencies

VIII.17 *Human Rights 2022* suggests that the traditional obligation to provide emergency medical treatment overrides conscience and religious beliefs.

> **§12.** Physicians **must** provide any necessary care in an emergency, even where that care conflicts with their conscience or religious

[112] *Ibid* at 300-303.

[113] *Ibid* at lines 304-306.

[114] *Ibid* at lines 281–284.

[115] *Ibid* at lines 285–289.

[116] *Ibid* at lines 296–298.

[117] *Ibid* at lines 328–332.

beliefs.[16]

fn16. For clarity, MAID would never be a treatment option in an emergency and physicians are not required to assess patients for or provide MAID under any circumstances.[118]

VIII.18 The Project has not encountered physicians who would refuse to render assistance in an emergency. The duty of physicians to intervene to prevent imminent death or serious injury is universally accepted. National codes of ethics variously articulate the circumstances that trigger the obligation. Usually, like the Canadian Medical Association's *Code of Ethics and Professionalism*, they refer only generically to emergencies.[119] Sometimes they specify imminent threats to life, limbs or organs[120] or immediate action needed to prevent death, disability or severe suffering.[121]

VIII.19 Consistent with this, the Canadian Medical Protective Association (CMPA) indicates that the obligation to act in an emergency is limited to situations in which there is "demonstrable severe suffering or an imminent threat to the life or health of the patient" and "undoubted necessity" to proceed immediately to prevent "prolonged suffering. . . or imminent threats to life, limb or health."[122]

VIII.20 The obligation has come to us through religious traditions, so the kind of conflict envisioned in the provision is very unlikely, unless the concept of "emergency" is stretched for marketing purposes (as in "emergency" contraception) or for other reasons. For example, requests for active assistance in providing EAS are treated as emergencies by mainstream actors in Canada's public healthcare system.[123] Hence, the footnote to the contrary is a welcome clarification.

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[118] *Human Rights 2022*, *supra* note 1 at §12, lines 125–126, footnote 16.

[119] *CMA Code*, supra note 29 at para 8, online: <https://policybase.cma.ca/media/PolicyPDF/PD19-03S.pdf>.

[120] The Saudi Commission for Health Specialties Department of Medical Education & Postgraduate Studies, *Code of Ethics for Healthcare Practitioners*, Translated by Ghaiath Hussein, Riyadh, Saudi Arabia: Saudi Commission for Health Specialties, 2014, at p 47, online:<https://www.iau.edu.sa/sites/default/files/resources/5039864724.pdf#page=53>.

[121] Indonesian Medical Association *Kode Etik Kedoctoran Indonesia*, Jakarta, Indonesia: IMA, 2012, (". . . harus segera dilakukan untuk mencegah kematian, kecacatan, atau penderitaan yang berat pada seseorang."at p 50), online: <http://mkekidi.id/wp-content/uploads/2016/01/KODEKI-Tahun-2012.pdf#page=64> at p 50.

[122] Canadian Medical Protective Association, "Consent: A guide for Canadian physicians, 4th ed" (May, 2006, Updated April, 2021) [*CMPA: Consent*], online: <https://www.cmpa-acpm.ca/en/advice-publications/handbooks/consent-a-guide-for-canadian-physicians#Emergency%20treatment>.

[123] "Protection of Conscience Project Submission to the College of Physicians and Surgeons of Ontario Re: Medical Assistance in Dying (2022)" (22 November, 2022), Protection of Conscience Project (website), online: <https://www.consciencelaws.org/publications/submissions/submissions-033-002-cpso.aspx#continuation> at I.4–I.5.

Subversion of freedom of religion

VIII.21 In *Human Rights-Advice 2022* the CPSO directs all physicians working in faith-based hospitals and hospices to provide "access to information and care, including effective referrals, for the services, treatments and procedures that are not provided in the faith-based hospital or hospice."[124] It appears that the policy expects objecting physicians to provide effective referrals, while non-objecting physicians are either expected or encouraged to provide "care" — not excluding euthanasia and assisted suicide.

Issues

VIII.22 *Human Rights 2022* instructs physicians that they must not comply with patient requests that would facilitate perceived wrongdoing by someone else (i.e., discrimination by the patient). This is exactly the same reasoning applied by physicians who refuse to facilitate euthanasia and assisted suicide by effective referral. Through *Human Rights 2022* the CPSO confirms the validity of their reasoning. The CPSO's policy that physicians must refuse to collaborate in apparently discriminatory patient requests but must agree to collaborate in killing their patients reflects authoritarian moral partisanship, since the morality of euthanasia and assisted suicide can be reasonably disputed and cannot be settled by law.

VIII.23 Objecting practitioners are typically willing to work cooperatively with patients and others in relation to patient access to services as long as cooperation does not involve collaboration: an act that establishes a causal connection to or de facto support for the services to which they object. They are usually willing to provide patients with information to enable informed decision-making and contact with other health care practitioners. The distinctions between cooperation and collaboration and providing information vs. providing a service enable an approach that accommodates both patients and practitioners. The CPSO has persistently refused to take this approach.

VIII.24 It appears that the CPSO intends to use its regulatory power to subvert freedom of religion of religious denominations and institutions and is conscripting physicians for that purpose. It is unfair to require physicians who are religious believers to participate in an attack on the fundamental freedoms of their own faith communities.

Recommendations

VIII.25 The CPSO should have a single general policy that accommodates the exercise of freedom of conscience by physicians and patient access to services based on distinctions between collaboration and cooperation and providing information vs. providing a service. It should not require effective referral. Appendix "B" offers such a policy.

VIII.26 The CPSO should delete the direction to physicians working in faith-based institutions.

[124] *Human Rights-Advice 2022*, *supra* note 2 at lines 335–338.

Appendix "A"

Human Rights 2022 and Project Recommendations

Providing Health Services (1): The Practice Environment		
POHR	***Human Rights 2022***	**Project Recommendation**
§1. Physicians **must** act in their patients' best interests. a) In doing so, physicians **must** strive to create and foster an environment in which the rights, autonomy, dignity and diversity of all patients,or those seeking to become patients, are respected.	**§1.** Physicians **must** take reasonable steps to create and foster a safe, inclusive, and accessible environment in which the rights, autonomy, dignity, and diversity of all patients are respected, and where patients' needs are met, by: a. complying with the relevant legal requirements under the Accessibility for Ontarians with Disabilities Act, 2005 and the Human Rights Code (the Code)~~; and~~ ~~b. incorporating cultural humility, cultural safety, anti-racism, and anti-oppression into their practices.~~	**§1.** Physicians **must** take reasonable steps to create and foster a safe, inclusive, and accessible environment in which the rights, autonomy, dignity, and diversity of all patients are respected, and where patients' needs are met, by complying with the relevant legal requirements under the Accessibility for Ontarians with Disabilities Act, 2005 and the Human Rights Code (the Code).
§2. Physicians **must** comply with the Ontario Human Rights Code (the "Code") . . .		

Providing Health Services (2): Physician Expression		
POHR	***Human Rights 2022***	**Project Recommendation**
§11. In the course of communicating their objection, physicians **must not** express personal moral judgments about the beliefs, lifestyle, identity, or characteristics of existing patients, or those seeking to become patients.	**§2.** In discharging provision 1, physicians **must not**: a. ~~express personal moral judgments about~~ patients' beliefs, lifestyle, identity, or characteristics ~~or the health services that patients are considering;~~	**§2.** In discharging provision 1, physicians **must not**: a. criticize, demean or attempt to modify patients' beliefs, lifestyle, identity, or characteristics. This does not preclude respectful discussion of beliefs or habits that may adversely affect a patient's health.
a) Furthermore, physicians **must not** promote their own religious beliefs when interacting with patients, or those seeking to become patients, nor attempt to convert them.	c. promote their own spiritual, secular, or religious beliefs when interacting with patients or ~~impose these beliefs on patients.~~	c. promote their own spiritual, secular, or religious beliefs when interacting with patients or attempt to persuade patients to adopt their beliefs.

Providing Health Services (3): The Duty to Accommodate	
Human Rights 2022	**Project Recommendation**
§4. Where a patient requests to receive care from a physician with a particular social identity (e.g., race, ethnicity, culture, sexual orientation and/or gender identity, spiritual/secular/religious beliefs, etc.), physicians **must**:	**§4.** A patient may request to receive care from a physician with a particular social identity (e.g., race, ethnicity, culture, sexual orientation and/or gender identity, spiritual/secular/religious beliefs, etc.). The duty to accommodate normally applies to requests related to a patient's protected characteristics. [P]hysicians **must**:
a. with appropriate consent, provide any emergent or urgent medical care the patient requires; and	a. with appropriate consent, provide any emergent or urgent medical care the patient requires; and
b. where non-emergent or non-urgent care is required,	b. where non-emergent or non-urgent care is required,
take reasonable steps to accommodate the patient's request if the physician believes that the request is ethically or clinically appropriate (e.g., patient would like to receive care from a physician who speaks the same language to facilitate communication); or	i) take reasonable steps to accommodate requests directly or indirectly motivated by patient beliefs about services or procedures; ii) in other cases, if the physician believes that the request is ethically or clinically appropriate (e.g., patient would like to receive care from a physician who speaks the same language to facilitate communication), take reasonable steps to accommodate the request; or
c. tell the patient that their request will not be accommodated if the physician believes that the request is discriminatory (e.g., racist, sexist, ageist, heterosexist, etc.) ~~and determine whether it is safe and in both parties' best interest to provide any non- emergent or non-urgent care required.~~	iii) if the physician believes that the request is discriminatory (e.g., racist, sexist, ageist, heterosexist, etc.) tell the patient that their request will not be accommodated.
	c. when a request is refused under (b)iii, advise patients that they are free to contact other health care practitioners or services for assistance, and, if need be, indicate how that can be done.

Providing Health Services (4): Duty of Non-Discrimination	
An argument by law professor Amir Attaran suggests that if EAS practitioners provide euthanasia/assisted suicide to *someone* who is eligible, human rights law requires them to provide the service to *anyone* legally eligible. He also asserts that they cannot escape the obligation by making an effective referral.	The Project does not accept Prof. Attaran's claim that an effective referral must be construed as evidence of discrimination, nor does it accept his argument in relation to objecting practitioners who refuse to provide a contested service to *anyone.* However, his argument may apply to practitioners willing to provide EAS for some eligible patients but not others. It thus seems appropriate to include guidance on this issue in *Human Rights 2022.*

Limiting Services: Clinical Competence/Scope of Practice		
POHR	***Human Rights 2022***	**Project Recommendation**
§6. Physicians **must** provide patients with quality health care in a safe manner. If physicians feel they cannot appropriately meet the health-care needs of an existing patient, or those who wish to become patients, they are not required to provide that specific health service or to accept that person as a patient. However, physicians **must**: a) comply with the Code, and College expectations, in so doing; and b) make any decision to limit the provision of health services on the basis of clinical competence in good faith.	**§6.** Physicians **must** make any decisions to limit the provision of health services for reasons of clinical competence and/or scope of practice in good faith, and in accordance with the *Code* and College expectations. ~~a. In making this decision, physicians **must** consider the risks and benefits of limiting the provision of health services and the impact it would have on patients (e.g., if they would have difficulties accessing the services elsewhere in a timely manner due to a lack of resources).~~	**§6.** Physicians **must** make any decisions to limit the provision of health services for reasons of clinical competence and/or scope of practice in good faith, and in accordance with the *Code* and College expectations.

Conflict with Physicians Conscience/Religion (1): Providing Information		
POHR	***Human Rights 2022***	**Project Recommendation**
§12. Physicians **must** provide information about all clinical options that may be available or appropriate to meet patients' clinical needs or concerns.	**§8.** Physicians **must** provide patients with enough information about all available or appropriate clinical options to meet their clinical needs or concerns so that patients are able to make an informed decision about exploring a particular option.	**§8.** Physicians **must** provide patients with enough information about all available or appropriate clinical options to meet their clinical needs or concerns so that patients are able to make an informed decision about exploring a particular option. Physicians must use their professional judgement to determine if, when and how to discuss particular treatment options with their patients.
	§11. Physicians must not	**§11.** Physicians must not
	~~b. provide false, misleading, confusing, coercive, or incomplete information about available or appropriate clinical options;~~	
§15. Physicians **must not** impede access to care for existing patients, or those seeking to become patients.	c) ~~impede~~ access to information and/or care, or	b) interfere with access to information and/or care, or

Advice to the Profession: Human Rights 2022	
Human Rights-Advice 2022	**Project Recommendation**
[333] **Does the expectation to provide patients with an effective referral apply in faith-based** [334] **hospitals and hospices?** [335] Yes. Physicians are required to comply with the expectations set out in the College's [336] policy. This means that physicians would be required to provide patients with access to [337]information and care, including an effective referral, for the services, treatments, and [338] procedures that are not provided in the faith-based hospital or hospice.	The CPSO should delete the direction to physicians working in faith-based institutions.

Appendix "B"

Recommended General Policy

The Project recommends the following general policy applicable to all procedures or services. Relevant provisions of *Human Rights in the Provision of Health Services* and the related advice document are noted in the text to facilitate comparison.

Conscience, Religion, Clinical Judgement and Access to Services

Introduction

To minimize inconvenience to patients and avoid conflict, physicians should develop a plan to respond to requests for services they are unwilling to provide for reasons of conscience, religion or clinical judgement in accordance with this policy. [*Human Rights 2022* §9(b)iv]

Definitions

"health care personnel" and "health care provider" include a member of a profession included in Schedule 1 of the *Regulated Health Professions Act,* 1991, S.O. 1991, c. 18.

"patient" includes persons seeking to be accepted as patients and persons lawfully designated to make a decision on the care to be provided to patients unable to express a decision.

A1. General

A1.1 Physicians may encounter patients who are isolated or burdened by illness, physical or mental disability, language barriers, etc. and unable to connect with health care personnel or obtain medical treatment or other necessary services. Patients so debilitated or circumstantially handicapped are clearly at risk.

A1.2 In all such cases, physicians should connect the patient to a responsible and reliable person who can address problems of isolation and neglect, help patients overcome circumstantial handicaps and enable them to obtain necessary assistance and navigate the health care system. The helper could be a family member, friend, social worker, outreach worker, etc. [*Human Rights 2022* §1, §3, §7] [*Human Rights-Advice*, lines 53–58, 60–62, 70–74, 99–124]

A2. Notice

A2.1 Physicians must give reasonable and timely notice to patients of religious, ethical or other conscientious convictions that influence their recommendations or practice or prevent them from providing certain procedures or services so that patients may consult or seek services from other health care personnel. Physicians must also give reasonable notice to patients if

their views change.[125,126] [*Human Rights 2022* §7, §9(a)]

a) Notice is reasonable if it is given as soon as it would be apparent to a reasonable and prudent person that a conflict is likely to arise concerning treatments or services the physician declines to provide, erring on the side of sooner rather than later. In many cases - but not all - this may be prior to accepting someone as a patient, or when a patient is accepted. [*Human Rights 2022* §7, §9(a)]

b) Notice is timely if it is provided as soon as it will be of benefit to the patient. Timely notice will enable interventions based on informed decisions that are most likely to cure or mitigate the patient's medical condition, prevent it from developing further, or avoid interventions involving greater burdens or risks to the patient. [*Human Rights 2022* §7, §9(a)]

c) In complying with these requirements, physicians should limit discussion related to their religious, ethical or moral convictions to what is relevant to the patient's care and treatment, reasonably necessary for providing an explanation, and responsive to the patient's questions and concerns. Physicians must not criticize or denigrate the beliefs, lifestyle, identity, or characteristics of patients. This should not be understood to preclude respectful discussion of beliefs or habits that may adversely affect a patient's health. [*Human Rights 2022* §2] [*Human Rights-Advice*, lines 86–95]

A2.2 Physicians who provide medical services in a health care facility must give reasonable notice to the facility of religious, ethical or other conscientious convictions that prevent them from providing procedures or services that are or are likely to be provided in the facility. In many cases - but not all - this may be when the physician begins to provide medical services at the facility. [*Human Rights 2022* §9(a)]

A3. Informed decision making

A3.1 Physicians must provide patients with sufficient and timely information to make them aware of relevant treatment options so that they can make informed decisions about accepting or refusing treatment or services.[127,128,129,130] [*Human Rights 2022* §8]

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[125] 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), *Protection of Conscience Project* (website) [*Joint Statement*] at I.16, online:<https://www.consciencelaws.org/background/policy/associations-001.aspx>

[126] *CMA Code*, *supra* note 29 at para 4.

[127] *Joint Statement, supra* note 125 aI.4.

[128] *CMA Code, supra* note 29 at para. 6, 11.

[129] *CMPA: Consent*, *supra* note 122.

[130] Canadian Medical Association, "Principles-based Recommendations for a Canadian Approach to Assisted Dying (January, 2016), *CMA* (website) [*CMA Recommendations*], at 5.2, online: <https://www.consciencelaws.org/archive/documents/cma-cmaj/2016-01-cma-framework.pdf>

a) Sufficient information is that which a reasonable patient in the place of the patient would want to have, including diagnosis, prognosis and a balanced explanation of the benefits, burdens and risks associated with each option.[131,132,133,134] [*Human Rights 2022* §8]

b) Information is timely if it is provided as soon as it will be of benefit to the patient. Timely information will enable interventions based on informed decisions that are most likely to cure or mitigate the patient's medical condition, prevent it from developing further, or avoid interventions involving greater burdens or risks to the patient. [*Human Rights-Advice*, lines 252–256]

c) Relevant treatment options include all legal and clinically appropriate procedures, services or treatments that may have a therapeutic benefit for the patient, whether or not they are publicly funded, including the option of no treatment or treatments other than those recommended by the physician.[135,136] [*Human Rights 2022* §8, §11(a)]

d) Physicians whose medical opinion concerning treatment options is not consistent with the general view of the medical profession must disclose this to the patient.[137] [*Human Rights 2022* §8]

e) The information provided must be responsive to the needs of the patient, and communicated respectfully and in a way likely to be understood by the patient. Physicians must answer a patient's questions to the best of their ability.[138,139,140,141] [*Human Rights 2022* §8, §10(a)]

f) Physicians who are unable or unwilling to comply with these requirements must promptly arrange for a patient to be seen by another physician or health care worker who can do so. [*Human Rights 2022*, §7] [*Human Rights-Advice*, lines 285–288]

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[131] *Joint Statement*, *supra* note 125 at I.7.

[132] *CMA Code*, *supra* note 29 at 6, 11.

[133] *CMPA: Consent*, *supra* note 122 Standard of disclosure; Some practical considerations.

[134] *CMA Recommendations*, *supra* note 130 at 1.2, 5.2.

[135] *CMA Code*, *supra* note 29 at para. 11.

[136] *CMPA: Consent*, *supra* note 122, Standard of disclosure; Some practical considerations.

[137] *CMA Code*, *supra* note 29 at para. 41.

[138] *Joint Statement*, *supra* note 125 at I.4.

[139] *CMA Code*, *supra* note 29 at para. 5, 11, 14.

[140] *CMPA: Consent*, *supra* note 122, Patient comprehension.

[141] *CMA Recommendations*, *supra* note 130, Foundational Principle (10).

A4. Declining to provide services

A4.1 Physicians who decline to recommend or provide services or procedures for reasons of conscience, religion or clinical judgement must advise affected patients that they may seek the services elsewhere and provide information about how to contact other service providers. [*Human Rights 2022* §7, §9(a)]

A4.2 If the patient appears to be unable to contact other service providers without assistance, physicians must ensure that the patient is connected with a family member or other responsible person who can assist. [See A.1] [*Human Rights 2022* §1, §3, §7][*Human Rights-Advice 2022* lines 268–270]

A4.3 When appropriate, physicians must communicate to a person in authority a patient's request for a complete transfer of care so that the person in authority can facilitate the transfer. [*Human Rights 2022* §7]

A4.4 Physicians must, upon request by a patient or person in authority, transfer the care of the patient or patient records to a physician or health care provider chosen by the patient.[142,143] [*Human Rights 2022* §7]

A4.5 In addition, upon a patient's request or enquiry, physicians may, if consistent with their conscientious convictions and clinical judgement,

a) arrange for the patient to be seen by a someone able and willing to provide the service; [*Human Rights-Advice*, lines 278–280] or

b) arrange for a transfer of care to health care personnel willing to provide the service; [*Human Rights-Advice*, lines 281–284] or

c) provide contact information for a person, agency or organization that provides or facilitates the service; [*Human Rights-Advice*, lines 296–299] or

d) enable patient contact with health care personnel or services in the community or in institutional settings who will ensure that the patient has access to all available treatment options, including services the physician declines to provide. [*Human Rights 2022* §7]

A4.6 Physicians unwilling or unable to comply with these requirements must promptly arrange for a patient to be seen by a physician or other health care provider who can do so. [*Human Rights 2022* §7] [*Human Rights-Advice*, lines 285–288]

A5. Continuity of care

A5.1 Physicians must continue to provide services unrelated to the services they decline to

[142] *Joint Statement, supra* note 125 at II.10.

[143] *CMA Recommendations*, *supra* note 130 at 5.2.

provide unless a physician and patient agree to other arrangements.[144,145] [*Human Rights-Advice,* lines 344–357]

A6. Non-abandonment

A6.1 When a patient is imminently likely to suffer death or permanent, serious physical injury if an intervention is not immediately provided, physicians must

a) provide the intervention if it is within their competence and no competent and willing health care personnel are available; or

b) immediately arrange for available, competent and willing health care personnel to provide the intervention,

unless the intervention is facilitated by a service or procedure provided by health care personnel deliberately causing the death or serious permanent injury of another person.[146] [*Human Rights 2022,* §12]

[144] *Joint Statement, supra* note 125 at I.16, II.11.

[145] *CMA Code*, *supra* note 29 at para. 2.

[146] *CMA Code*, *supra* note 29 at para. 8.