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Submission to the College of Physicians and Surgeons of Alberta

Re: Draft Standard of Practice: *Conscientious Objection*

Abstract

The Protection of Conscience Project is a non-profit, non-denominational initiative that advocates for freedom of conscience among health care workers. It does not take a position on the acceptability of morally contested procedures. Parts of the draft standard *Conscientious Objection* relevant to Project advocacy are the preamble, two sections that mention "effective referral" and an overbroad prohibition of practitioners' expression.

The title and preamble focus on conscientious *objection*, which seems to imply that conscience is extrinsic to medicine and intrudes upon it only in relation to service refusal. On the contrary: conscience and moral/ethical judgement are integral to medical practice. The title and preamble should acknowledge this to provide the proper context for CPSA expectations.

The preamble implies that the CPSA will adjudicate between physician and patient moral/ethical beliefs, a task arguably beyond its authority and competence. It should, instead, focus on respectful management of patient requests for services practitioners decline to provide.

Two sections mention "effective referral" for contested services, but the standard does not require it, nor define the term. A policy of "effective referral" would contradict the CPSA's longstanding position, notwithstanding contrary assertions by some CPSA officials since 2009. The CMA has opposed such a policy for over 50 years.

Even academics who advocate for "effective referral" admit that refusal to refer for immoral/unethical procedures is not only rationally defensible, but obligatory. Effective referral policies adopted in Ontario and Nova Scotia appear to originate in a model policy drafted for morally partisan purposes. However, incorporating moral partisanship into the regulation of medical practice is unacceptable. The references to "effective referral" thus invite confusion and controversy. They are also unnecessary.

The first section of concern should be revised to require practitioners to plan how to comply with the standard (which does *not* require "effective referral"). That done, the second section of concern becomes redundant and can be deleted.

The absolute prohibition of the expression of practitioner moral judgement is overbroad. It conflicts with requirements in the standard and *CMA Code of Ethics* and impedes physician-patient communication, concordance and transparency. It is also open to partisan misuse. A more specific provision is already in force in CPSA standards and is preferable.

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I. Introduction

I.1 The Protection of Conscience Project is a non-profit, non-denominational initiative that advocates for freedom of conscience among health care workers. It does not take a position on the acceptability of morally contested procedures. Comments and recommendations concerning the College of Physicians and Surgeons of Alberta (CPSA) draft standard of practice *Conscientious Objection*[1] are limited to issues directly or indirectly related to the protection of practitioner freedom of conscience.[2]

I.2 The draft standard includes "cultural beliefs" with religious beliefs and reasons of conscience. The term was introduced as a result of discussion with an Indigenous Advisory Circle, but it should not be narrowly construed; it can be taken to include beliefs like secularism and laicism that can become normative in state institutions. Readers from different cultural or faith perspectives can apply discussion of freedom of conscience in this submission to the extent that it is relevant to their religion, culture and religious or cultural beliefs.

II. Outline of this submission

II.1 Critical parts of the draft standard are the italicized parts of the following statements, numbered and named here for ease of reference in this submission:

> **1) Purpose:** The purpose of this standard is to outline expectations for regulated members in balancing the ethical dilemmas that occur *when one's beliefs and ethics conflict with the ethical beliefs of patients* [Source: Preamble, final paragraph]. See discussion in Part III.
>
> **2) Effective referral:** A regulated member must (f) proactively maintain *an effective referral plan* for the frequently requested services they are unwilling to provide [Source: Standard Section 1(f)]. See discussion in Part IV and Appendix "B".
>
> **3) Delayed effective referral:** A regulated member must not (c) expose patients to *adverse clinical outcomes due to a delayed effective referral* [Source: Standard Section 2(c)]. See discussion in Part V.
>
> **4) Expression of moral judgement:** A regulated member must not (e) *express personal moral judgements about the patient's request or choice* [Source: Standard Section 2(e)]. See discussion in Part VI.

II.2 The draft standard focuses exclusively on conscientious *objection*, which seems to imply that refusal to provide a service or procedure for moral/ethical reasons is exceptional. On the contrary: the exercise of conscience is integral to medical practice. See discussion in Part VII and Appendix

[1] College of Physicians and Surgeons of Alberta, *Standards of Practice: Conscientious Objection* (Draft Standard Under Review), Edmonton: CPSA, 2016, online: <https://cpsa.ca/wp-content/uploads/2023/12/Conscientious-Objection-clean.pdf>.

[2] In this submission, "practitioner(s)" means "regulated member(s)" .

"A."

II.3 The history of the CPSA practice standard *Conscientious Objection* (formerly *Moral or Religious Beliefs Affecting Medical Care*) in relation to "effective referral" is outlined in Appendix "B."

II.4 Recommended changes are provided in parallel with the draft standard text in Appendix "C."

III. Purpose of the standard

III.1 The final paragraph in the Preamble to the draft standard states:

> The purpose of this standard is to outline expectations for regulated members in balancing the ethical dilemmas that occur *when one's beliefs and ethics conflict with the ethical beliefs of patients* (emphasis added).

III.2 This passage implies that the CPSA is competent to adjudicate ethical conflicts between physicians and patients. This is surprising and probably unintended. It would require at least a critical examination of the ethical beliefs of each party, including their philosophical and metaphysical underpinnings, and the establishment of an acceptable standard by which to judge them. Canadian courts traditionally and assiduously avoid becoming "entangled in the affairs of religion" because they lack the legitimacy and institutional capacity to adjudicate conflicts about religious doctrine.[3] For the same reasons, it seems unlikely that the CPSA intends or would wish to become entangled in ethical conflicts between physicians and patients.

III.3 While the CPSA is responsible for addressing ethics in medical practice, the ethical obligations of a physician are not determined by comparative evaluation of physician and patient beliefs.

Recommendation

III.4 The final paragraph in the Preamble to the draft standard should be revised to the following effect:

> The purpose of this standard is to outline expectations for regulated members <u>*if they receive requests from patients for services or procedures that conflict with their moral/ethical/religious convictions or cultural beliefs.*</u>

III.5 This proposed revision acknowledges the possibility that patients' requests may conflict with physicians' ethical/moral convictions, but it does not imply that the CPSA intends or has the authority to adjudicate moral/ethical conflicts between physicians and patients arising from contested or differing beliefs.

[3] *Highwood Congregation of Jehovah's Witnesses (Judicial Committee) v. Wall*, 208 SCC 26, [2018] 1 SCR 750, online: <https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/17101/index.do?> at para 36–37.

IV. Effective referral

IV.1 Section 1(f) of the draft standard states:

> A regulated member must (f) proactively maintain *an effective referral plan* for the frequently requested services they are unwilling to provide (emphasis added).

IV.2 This section appears to assume that practitioners have an obligation to make an "effective referral" for services or procedures they decline to provide, but the draft standard does not introduce that expectation, nor does it define the term.

Definition

IV.3 "Effective referral" has been defined by the College of Physicians and Surgeons of Ontario (CPSO) as taking "positive action to ensure the patient is connected in a timely manner to a non-objecting, available and accessible physician, other health care professional or agency."[4] "Available and accessible" means "operating and/or accepting patients"reasonably accessible to the patient virtually or at a physical location.[5] A 2015 requirement that an effective referral must be to a provider of the contested service or to someone who would make that connection[6] has been deleted from the most recent iteration of the policy.[7] However, it appears that the policy is still intended to compel an objecting physician to actively help a patient to obtain a contested service, including euthanasia and assisted suicide.[8] The policy was the subject of a constitutional challenge.[9] It remains controversial, and is likely to become moreso if euthanasia and assisted suicide become available for mental disorders alone.

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[4] College of Physicians and Surgeons of Ontario, *Human Rights in the Provision of Health Services,* Toronto: CPSO 2023, at Definitions. online: <https://www.cpso.on.ca/en/Physicians/Policies-Guidance/Policies/Human-Rights-in-the-Provision-of-Health-Services>.

[5] *Ibid* at endnote 1.

[6] College of Physicians and Surgeons of Ontario, *Advice to the Profession: Professional Obligations and Human Rights,* Toronto: CPSO, 2015 at 1.

[7] College of Physicians and Surgeons of Ontario, *Advice to the Profession: Health Services that Conflict with Physicians' Conscience or Religious Beliefs,*Toronto: CPSO, 2023 at "What does an effective referral involve?" online: <https://www.cpso.on.ca/en/Physicians/Policies-Guidance/Policies/Human-Rights-in-the-Provision-of-Health-Services/Advice-to-the-Profession-Human-Rights>.

[8] *Ibid* at "What are some examples of effective referral?" (Helping patients to directly access the service, actively arranging for the patient to be seen, making a formal referral for the service, connecting a patient with an agency responsible for delivering the service, verifying the patient has connected and, if not, making the connection, etc.).

[9] *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*].

Mandatory effective referral contradicts longstanding CPSA policy

IV.4 Thus defined, a policy of "effective referral" for contested services in Alberta would radically contradict the position the CPSA has officially maintained since 1991, notwithstanding apparent efforts by some CPSA officials since 2009 to implement an effective referral policy through the back door, as it were (see Appendix "B").[10] Alerted by the Project to the situation in 2015, the President of the Alberta Medical Association agreed that requiring effective referral would dramatically change the CPSA position.[11]

IV.5 Practical considerations can be added to principled arguments on this point. The Project is aware of at least two physicians who left Ontario for Alberta because of the CPSO effective referral policy and its toxic effects on the practice environment, most recently in relation to demands for complicity by objecting physicians in euthanasia and assisted suicide. State medical regulators like Ontario don't want to become outliers.[12] They have a vested interest in preventing practitioner emigration by convincing provinces like Alberta to adopt a coercive effective referral policy. On the other hand, Albertans would not be well-served were CPSA to replace a policy that has attracted physicians with one likely to encourage their departure.

IV.6 Again, the CPSO has insisted that physicians who refuse to make effective referrals for euthanasia should transfer from family and palliative care (for example) to sleep medicine and hair restoration.[13] The CPSA may reasonably take a different view of the matter if Albertans have different health care priorities.

Mandatory effective referral contradicts CMA policy

IV.7 The Canadian Medical Association (CMA) has variously expressed support for physician freedom of conscience in codes of ethics, resolutions at successive General Councils and in policies concerning specific procedures. For over fifty years it has insisted that physicians should not be compelled to make referrals for procedures to which they object for reasons of conscience. It appears

[10] Sean Murphy, "Physician freedom of conscience in Alberta" (18 September, 2020), *Protection of Conscience Project* (website), online: <https://www.consciencelaws.org/archive/pdf/project002-cpsa.pdf> at 3–6 (The Project Administrator has been following this issue and has corresponded periodically with the CPSA and Alberta Medical Association since 2001).

[11] Letter from Richard G.R. Johnson, President, Alberta Medical Association to Sean Murphy, Administrator, Protection of Conscience Project (6 March 2015).

[12] Letter from Bryan Salte, Associate Registrar, College of Physicians and Surgeons of Saskatchewan to the Registrars of Colleges of Physicians and Surgeons in Canada (undated, redacted) in College of Physicians and Surgeons of Saskatchewan, *Report to Council from the Registrar, Document 200/14* (31 July, 2014), online: <https://www.consciencelaws.org/archive/documents/cpss/2014-07-31-Report.pdf#page=8> [Salte 2014] at 8, para 5.

[13] *CMDS v CPSO 2019*, supra note 9 at para 184.

that the great majority of CMA members support this position, but are unaware of its history.[14]

IV.8 The first CMA statement addressing the subject of physician freedom of conscience at a foundational level was a 2016 submission to the CPSO. "It is in fact in a patient's best interests and in the public interest," said the CMA, "for physicians to act as moral agents, and not as technicians or service providers devoid of moral judgement." In opposing the CPSO requirement for effective referral, the CMA submission recognized that the exercise of freedom of conscience is a fundamental freedom for everyone, not just for those whose moral judgement conforms to a dominant viewpoint. The statement characterized a demand for effective referral as illicit discrimination, not a solution, because it "respects the conscience of some, but not others."[15] Important elements of this statement were incorporated into the new CMA *Medical Assistance in Dying* policy and are evident in the 2018 revised draft of the CMA *Code of Ethics*.

Effective referral, complicity and moral partisanship

IV.9 Long-standing legal, religious and moral principles support the view that one can be held responsible for the actions of someone else. For example, the practice of "ethical investment" reflects a widespread belief that one is responsible for the good or the harm that flows indirectly from one's financial participation in a company.[16]

IV.10 It is thus not surprising that referral for morally contested services imposes "the serious moral burdens of complicity."[17] Practitioners' response to the problem of complicity varies. Some physicians who object to sex selective abortion may be willing to refer patients or initiate a transfer of care because they believe that doing so absolves them of moral responsibility for the procedure. Others, however, would refuse, because they believe that actively helping a patient to obtain a sex selective abortion would make them complicit in wrongdoing. This is not an idiosyncratic response. Even academics who demand that objecting physicians be forced to refer for abortion admit that refusal to refer for immoral/unethical procedures is not only rationally defensible, but obligatory.

IV.11 For example, in 2006, Carolyn McLeod admitted that referral is not a compromise. Being forced to refer, she said, would put objecting physicians "at serious risk of losing moral integrity

[14] 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>.

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

[16] CFI Team, "Ethical Investing" (2015–2024) *Corporate Finance Institute* (website), online: <https://corporatefinanceinstitute.com/resources/esg/ethical-investing/>.

[17] Holly Fernandez Lynch, *Conflicts of Conscience in Health Care: An Institutional Compromise* (Cambridge, London: The MIT Press, 2008) [*Lynch 2008*] at 229.

through self-betrayal," with profound consequences for their "psychological health and agency."[18] However, by 2008, concerned that "the pro-life side" was winning the intellectual argument on mandatory referral,[19] she proposed a new argument "to ensure that [physicians] do not get protections for refusal to refer."[20] She again admitted that requiring effective referral was not a compromise.[21] She nonetheless insisted that objecting physicians should be forced to refer for abortion because, she argued, "abortions *are* morally permissible."[22] Objecting physicians "ought not to be able to follow their consciences when the voice of their conscience misleads them."[23]

IV.12 Five years later, she and Lori Kantymir insisted that "referrals are *not* appropriate when the objection itself is morally justified": that "conscientious objections by healthcare professionals that *are* morally justified should *not* be followed up by referrals."[24] However, they insisted upon compulsory referral for most abortions because — in their view — most abortions *are* morally acceptable[25] — though not sex-selective abortions.[26] At this stage McLeod had co-authored a model conscientious objection policy that would force unwilling practitioners to refer for "health services" they believed to be immoral/unethical if the services were "publicly funded," public funding (not moral justification) trumping freedom of conscience.[27]

IV.13 McLeod and colleagues (the "Conscience Research Group" – CRG) organized a workshop on

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[18] Carolyn McLeod, "Demanding Referral in the Wake of Conscientious Objection to Abortion" (2006) Comparative Program on Health Law and Society, University of Toronto, Munk Centre for International Studies, Lupina Foundation Working Papers Series 2004–2005, online: <https://web.archive.org/web/20160329002356/https://munkschool.utoronto.ca/wp-content/uploads/2013/05/January_2006_CPHS_working_paper1.pdf#page=144> at 132.

[19] Carolyn McLeod, "Referral in the Wake of Conscientious Objection to Abortion" (2008) 23:4 Hypatia 30-47, online: <https://ir.lib.uwo.ca/cgi/viewcontent.cgi?article=1335&context=philosophypub> at 30.

[20] *Ibid*, 31.

[21] *Ibid*, 42.

[22] *Ibid,* 42 (emphasis added).

[23] *Ibid,* 40.

[24] Lori Kantymir & Carolyn McLeod, "Justification for Conscience Exemptions in Health Care" (2014) 28:1 Bioethics 16-23, online: <https://onlinelibrary.wiley.com/doi/10.1111/bioe.12055> at 18 (emphasis added).

[25] *Ibid* at 22 (noting that a pro-life panel might excuse someone from providing abortion "on the grounds that abortions are immoral, which is (arguably) false, at least about most abortions").

[26] *Ibid* at 21 (arguing it would be unfair to refuse to exempt practitioners from a duty to provide sex selective abortions).

[27] Jocelyn Downie, Carolyn McLeod & Jacquelyn Shaw, "Moving Forward with a Clear Conscience: A Model Conscientious Objection Policy for Canadian Colleges of Physicians and Surgeons" (2013) 21:3 Health L Rev 28-32, online: <https://heinonline.org/HOL/LandingPage?handle=hein.journals/hthlr21&div=17&id=&page=> at §5.3 ("Legally permissible and publicly funded health services" is the term used, but "legally permissible" is superfluous because there can be no duty to do something illegal, and illegal health services would not be publicly funded. The policy cites physicians' fiduciary obligations, but those pertain to *all* health services, many of which are *not* publicly funded. Since the model policy demanded compulsory referral *only* for publicly funded services, it was public funding alone that trumped freedom of conscience).

the model policy in 2013. Andréa Foti, Manager of the CPSO Policy Department, Dr. Gus Grant, Registrar of the College of Physicians and Surgeons of Nova Scotia (CPSNS) and Bryan Salte, Associate Registrar of the College of Physicians and Surgeons of Saskatchewan (CPSS) were among regulatory officials who attended.[28] Bryan Salte later urged all medical regulators to adopt such a policy[29] and attempted (unsuccessfully) to have CPSS adopt an almost exact duplicate of the CRG model policy.[30] The CPSO and CPSNS subsequently adopted mandatory effective referral policies.

IV.14 McLeod's obvious moral partisanship in advocating compulsory referral (except, perhaps, for sex selective abortion) is to be expected in politics and is not out of place in academic discourse, but incorporating moral partisanship into the regulation of medical practice is unacceptable. The CMA denounced this kind of discrimination in its submission to the CPSO.

Reference to effective referral not needed

IV.15 It appears that Section 1(f) is intended to prevent harm to patients by ensuring that regulated members will consider how to meet the expectations set by the draft standard and plan accordingly. That is a common-sense expectation that does not require reference to "effective referral."

Recommendation

IV.15 Section 1(f) of the draft standard should be revised to the following effect:

> A regulated member must (f) proactively maintain *a plan to meet the expectations set by this standard in relation to* the frequently requested services they are unwilling to provide.

V. Delayed effective referral

V.1 Section 2(c) of the draft standard states:

> A regulated member must not (c) *expose* patients to *adverse clinical outcomes due to a delayed effective referral* (emphasis added).

V.2 Comments in Part IV of this submission apply to Section 2(c).

Subjective and redundant

V.3 Like Section 1(f), this section appears to be intended to prevent harm to patients. However, the term "expose" refers to purely speculative possibilities; the adjectives "adverse" and "delayed" are subjective terms. The section thus formulated is open to manipulation for morally partisan

[28] *Salte* 2014, *supra* note 12 at 8, para 1.

[29] *Ibid* at 8, para 5.

[30] Protection of Conscience Project, "Submission to the College of Physicians and Surgeons of Saskatchewan Re: *Conscientious Refusal* (5 March, 2015): Appendix 'A'– Origin of the CPSS Draft Policy *Conscientious Refusal*" *Protection of Conscience Project* (website), online: <https://www.consciencelaws.org/publications/submissions/submissions-014-002-cpss.aspx>.

purposes of the kind described in IV.9 to IV.12.

V.4 Section 1(f), revised in accordance with this submission, would require practitioners to plan how meet the expectations of the draft standard in relation to requests for services they are unwilling to provide. This addresses the goal of preventing harm to patients.

V.5 Failure to comply with Section 1(f) would constitute professional misconduct. This would be aggravated were it to cause harm to a patient. Alternatively, an additional charge of professional misconduct might be laid if harm actually resulted from failure to comply with the standard.

V.6 The prospect of being charged for professional misconduct for failing to meet the draft standards would operate to prevent harm to patients, while a charge of aggravated professional misconduct would address actual harm shown to have been caused by failing to meet the draft standard's expectations. Thus, in addition to being open to partisan manipulation, Section 2(c) is redundant.

V.7 Section 2(c) could be revised to state simply that practitioners must not cause harm to patients by failing to comply with the standard, but that would be a superfluous re-statement of a basic tenet of medical ethics and redundant in view of V.5.

Recommendation

V.8 Section 2(c) should be deleted.

VI. Expression of moral judgement

VI.1 Section 2(e) of the draft standard states:

> A regulated member must not (e) *express personal moral judgements about the patient's request or choice* (emphasis added).

VI.2 This section is apparently intended to prevent practitioners from forcing their moral views upon patients overawed by their professional status. The is a reasonable goal, but the provision is overbroad.

Expectations are in conflict

VI.3 Practitioners who decline to provide a requested service for moral or ethical reasons must comply with Section 1(a) of the draft standard. They would be hard-pressed to do so without *expressing* moral judgement about a patient's choice or request, particularly in response to patient questions. To prohibit practitioners from *expressing* moral judgement when complying with Section 1(a) and responding to patient questions would be unreasonable.

Expectation contradicts CMA *Code of Ethics*

VI.4 On the face of it, Section 2(e) 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.[31]

VI.5 This statement represents the position the CMA has maintained since 1970.[32] It presumes at least disclosure of a physician's moral views (and thus moral judgement) about services sought by patients. Transparency on this point contributes to maintaining trust in the physician-patient relationship.

Expectation impedes patient enquiries

VI.6 Further, patients may ask practitioners about their moral or ethical views about a service because they are seeking a practitioner whose views are consistent with their own, especially in relation to morally contested services. To prevent physicians from replying to these patients would be unfair to these patients and obstruct physician-patient matching, which is an effective strategy for preventing needless conflict, accommodating patients and physicians[33] and may positively affect health outcomes.[34]

Expectation seems redundant

VI.7 Granted that it is important to ensure that practitioners do not force their moral views upon patients overawed by their professional status, this goal is already addressed in CPSA practice standards:

> A regulated member must not promote his/her personal or religious beliefs or causes to a patient in the context of the physician-patient relationship.[35]

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

[32] 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>.

[33] *Lynch 2008*, *supra* note 17 at 87-88, 90-93.

[34] Megan Johnson Shen et al, "The Effects of Race and Racial Concordance on Patient-Physician Communication: A Systematic Review of the Literature", (2018) 5:1 J Racial Ethnic Health Disparities 117–140, online: <https://link.springer.com/article/10.1007/s40615-017-0350-4>; Brad N Greenwood et al, "Physician-patient racial concordance and disparities in birthing mortality for newborns" (2020) 117:35 Proceedings Natl Acad Sci USA 21194-21200, online: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7474610/>; Jacob A Blythe & Farr A Curlin, "How Should Physicians Respond to Patient Requests for Religious Concordance?" (2019) 21:6 Am Med A J Ethics E485–492, online: <https://journalofethics.ama-assn.org/article/how-should-physicians-respond-patient-requests-religious-concordance/2019-06>.

[35] College of Physicians and Surgeons of Alberta, *Standards of Practice: Consolidated Version,* Edmonton: CPSA, 2023, online: <https://cpsa.ca/wp-content/uploads/2021/06/SoP-Consolidated-Version.pdf#page=13> at 12, para 5.

Expectation invites misuse

VI.8 Even respectful communication of a practitioner's position may lead a patient to infer (correctly) the beliefs of the practitioner about their requests or choices. Some patients may then resent and impugn the expression of the practitioner's belief simply because it contradicts their own. The draft text of Section 2(e) could be misused by patients who characterize practitioners' unwillingness to agree with them as an unacceptable form of aggression amounting to professional misconduct.

Recommendation

VI.9 If the CPSA believes that the existing standard prohibiting practitioners' promotion of their beliefs (see VI.9) should be reinforced in *Conscientious Objection*, Section 2(e) of the draft standard should be revised to the following effect:

> A regulated member must not (e) *in complying with Section 1(a) of this Standard or in other interactions with patients, promote his own moral/ethical beliefs or causes or attempt to convince a patient to adopt them*.

VI.10 The revision achieves the apparent purpose of Section 2(e) without interfering with respectful practitioner-patient communication necessary to explore and address patient health concerns and needs.

VII. Conscience and medical practice

VII.1 The draft standard Preamble states:

> CPSA recognizes that *regulated members have the right to limit the health services they provide for reasons of conscience, cultural belief or religion.* Regulated members are expected to act in their patients' best interest by providing enough information and assistance to allow them to make informed choices for themselves (emphasis added).
>
> Regulated members *limiting the services they provide to patients for reasons of conscience, cultural belief or religion* should do so in a manner that respects patient dignity, facilitates timely access to care and protects patient safety (emphasis added).

VII.2 The title of the draft standard and the Preamble imply that conscience comes into play in medical practice *only* when practitioners decline to provide or facilitate services to which they object for reasons of conscience or religion. That is not the case.

VII.3 Both refusal *and* agreement to provide or collaborate in a service express at least implicit moral/ethical judgement about a requested service. For example, that one ought to prescribe antibiotics in some circumstances but not in others should certainly be an evidence-based assertion,

but the decision to prescribe or to refuse to prescribe requires something more than evidence. It requires at least an implicit judgement that, based on the evidence, prescribing antibiotics will be beneficial in a given case (hence ethical) or harmful in another (hence unethical).[36] The moral/ethical aspect of practice may be unnoticed, but it is never absent:

> [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]

Medicine: a moral enterprise

VII.4 The practice of medicine is an inescapably moral enterprise (Appendix "A").[38,39,40] For that very reason it generates differences of opinion among practitioners and between practitioners and patients. It is thus understandable that the draft standard should attempt to avoid, minimize, accommodate and respectfully resolve such differences. However, these goals can only be achieved if the standard acknowledges and encourages practitioners and the public to recognize that judgements of conscience (including conscientious objection) are the norm in medical practice, not the exception.

VII.5 From the beginning, probably because of a conflict-based focus, this standard has addressed practitioner refusal to provide services for reasons of conscience. Nonetheless, its original title — *Moral or Religious Beliefs Affecting Medical Care* — was more consistent with the moral/ethical aspect of medical practice than the title *Conscientious Objection*. Thus, a return to some form of the original title is desirable.

Recommendations

VII.6 The title of the standard should be changed to *Conscience in Medical Practice.*

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

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

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

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

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

VII.7 The draft standard Preamble should be revised to the following effect:

> CPSA recognizes that *moral/ethical decision-making is intrinsic to the practice of medicine, and that practitioners may sometimes receive patient requests that they must decline* for reasons of conscience, cultural belief or religion. Regulated members are expected to act in their patients' best interest by providing enough information and assistance to allow them to make informed choices for themselves.
>
> Regulated members *must communicate and act upon their decisions* in a manner that respects patient dignity, facilitates timely access to care and protects patient safety.

Appendix "A"

Conscience in medical practice

Morality in the secular public square

A1. All public behaviour - how one treats other people, how one treats animals, how one treats the environment - is determined by what one believes. All beliefs influence public behaviour. Some beliefs are religious, some not, but all are beliefs.[41] This applies no less to "secular" ethics than to religious ethics. Secular ethics may be independent of religion,[42] but they are not faith-free, nor are they beyond the influence of faith. On the contrary: a secular ethic, like any ethic, is faith-based. That human dignity exists — or that it does not — or that human life is worthy of unconditional reverence — or merely conditional respect — and notions of beneficence, justice and equality are not the product of scientific enquiry, but rest upon faith: upon beliefs about human nature, the meaning and purpose of life, the existence of good and evil.

A2. That everyone is a believer reflects the fact that the practice of morality is a human enterprise,[43] but it is not a scientific enterprise. The classic ethical question, "How ought I to live?" is not a scientific question and cannot be answered by any of the disciplines of natural science, though natural science can provide raw material needed for adequate answers.[44]

A3. Answers to the question, "How ought I to live?" reflect two fundamental moral norms; do good, avoid evil. These basics have traditionally been undisputed; the disputes begin with identifying or defining good and evil and what constitutes "doing" and "avoiding." Such explorations are the province of philosophy, ethics, theology and religion.

A4. Nonetheless, since the practice of morality is a human enterprise, reflections about morality and the development and transmission of ideas about right and wrong also occurs within culture and society outside the framework of identifiable academic disciplines and religions. In consequence, the secular public square is populated by people with any number of moral viewpoints, some religious, some not: some tied to particular philosophical or ethical systems, some not: but all of them believers.

A5. Further, since morality is a human enterprise, moral judgement is an essential activity of

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[41] Iain T. Benson, "There are no secular 'unbelievers'" (2000) 4:1 Centrepoints 1-3, online: <https://www.consciencelaws.org/religion/religion010.aspx>.

[42] Peter Singer, *Practical Ethics* 2nd ed (Cambridge: Cambridge University Press, 1993) at 3.

[43] This presumption obviously underlies standard bioethics texts. See, for example, Tom L Beauchamp & James F Childress, *Principles of Biomedical Ethics* 7th ed (New York: Oxford University Press, 2013).

[44] Sean Murphy, "Science, religion, public funding and force feeding in modern medicine" (8 June, 2015), Protection of Conscience Project (website), online: <https://news.consciencelaws.org/?p=6181> (Responding to Tristan Bronca,"A conflict of conscience: What place do physicians' religious beliefs have in modern medicine?" *Canadian Health Care Network*, 26 May, 2015).

every human person, moral judgement necessarily involves some kind of individual or personal conviction, and maintaining one's personal moral integrity is the aspiration of anyone who wishes to live rightly. Thus, beliefs are "personal," in the sense that one personally accepts them and is committed to them.

A6. However, this does not mean that such "personal" beliefs are parochial, insignificant or erroneous. Christian, Jewish and Muslim beliefs, for example, are shared by hundreds of millions of people. They "personally" adhere to their beliefs, just as non-religious believers "personally" adhere to their non-religious beliefs. In neither case does the fact of this "personal" commitment provide grounds to set beliefs aside. Thus, it is important to recognize that pejorative or suspicious references to "personal" beliefs or "personal" values frequently reflect underlying and perhaps unexamined prejudice against them.

A7. The Supreme Court of Canada has acknowledged that secularists, atheists and agnostics are believers, no less than Christians, Muslims, Jews and persons of other faiths. Neither a secular state nor a secular health care system (tax-paid or not) must be purged of the expression of philosophical, moral, religious or cultural beliefs.

> The problem with this approach is that everyone has 'belief' or 'faith' in something, be it atheistic, agnostic or religious. To construe the 'secular' as the realm of the 'unbelief' is therefore erroneous. Given this, why, then, should the religiously informed conscience be placed at a public disadvantage or disqualification? To do so would be to distort liberal principles in an illiberal fashion and would provide only a feeble notion of pluralism. The key is that people will disagree about important issues, and such disagreement, where it does not imperil community living, must be capable of being accommodated at the core of a modern pluralism.[45]

Medicine: a moral enterprise

A8. The practice of medicine is an inescapably moral enterprise precisely because physicians are always seeking to do some kind of good and avoid some kind of evil for their patients.[46] However, the moral aspect of practice as it relates to the conduct and moral responsibility of a physician is usually implicit, not explicit. It is normally eclipsed by the needs of the patient and exigencies of practice. But it is never absent; every decision concerning treatment is a moral decision, whether or not the physician specifically adverts to that fact. Xavier Symons has recently highlighted this point:

> To claim that conscience is relevant to moral decision-making while denying its indispensable role in clinical judgements about controversial treatments is to draw an arbitrary distinction between situations in which conscience matters and situations in

[45] *Chamberlain v. Surrey School District No. 36* [2002] 4 S.C.R. 710 (SCC), online: <https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/2030/index.do?r=AAAAAQALIm1hbmRhdG9yeSIAAAAAAAAB> at para 137, (Gonthier J dissenting, but the full court concurring on this point).

[46] *Maddock 1973*, *supra* note 38.

which it does not.[47]

A9. It is a mistake, argues Symons, to propose "an arbitrary dichotomy between *technical* and *moral* judgements in medicine" because this presupposes a distinction "between matters in medicine that are of a technical nature and on which physicians should be able to exercise their discretionary judgement and matters of a moral nature where physicians should defer to patients."[48] Technical and moral matters are, he observes, "two dimensions of the same clinical reality."

> While some contemporary philosophers might contend that the domains of science and ethics are entirely separate, the lived experience of professionals is such that faccts and values are inextricably linked, and both come into play in clinical decision making. Indeed, even the most banal decisions in medicine are directed at some good, be it health or the relief of suffering or even just human solidarity. As such, these decisions have an ethical dimension.[49]

A10. This is frequently overlooked when a physician, for reasons of conscience, declines to participate in or provide a service or procedure that is routinely provided by his colleagues. They may be disturbed because they assume that, in making a moral decision about treatment, he has done something unusual, even improper. Seeing nothing wrong with the procedure, they see no moral judgement involved in providing it. In their view, the objector has brought morality into a situation where it doesn't belong, and, worse, it is *his* morality.

A11. In point of fact, the moral issue was there all along, but they didn't notice it because they have been unreflectively doing what they were taught to do in medical school and residency, and what society expects them to do. Nonetheless, in deciding to provide the procedure they also *implicitly* concede its goodness; they would not provide it if they did not think it was a good thing to do. What unsettles them is really not that the objector has taken a moral position on the issue, but that he has made an *explicit* moral judgement that differs from their *implicit* one.

A12. Once medicine is understood to be a moral enterprise, it becomes easier to understand why it is a mistake to think that moral or ethical views are unwelcome intruders upon the physician-patient relationship. The demand that physicians must not be allowed to act upon beliefs is unacceptable because it is impossible; one cannot act morally without reference to beliefs, and cannot practise medicine without reference to beliefs. Relevant here is a comment by Professor Margaret Somerville. "In ethics," she writes,"impossible goals are not neutral; they cause harm."[50]

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[47] Xavier Symons, *Why Conscience Matters: A Defence of Conscientious Objection in Healthcare* (London/New York: Routledge, 2023) at 37 [*Symonds 2023*].

[48] *Ibid*, citing Warren Kinghorn, "Conscience as clinical judgement: Medical education and the virtue of prudence" (2013) 15:3 Virtual Mentor 202–205.

[49] *Ibid*.

[50] Margaret Somerville, "Fundamentalism, religious or secular, gets us nowhere", *The Age* (1 June, 2007) online: <https://www.theage.com.au/national/fundamentalism-religious-or-secular-gets-us-nowhere-20070528-ge4zsc.html>.

A13. Further, moral judgement being an essential activity of every physician, it necessarily involves individual or personal adherence to moral convictions relevant to medical practice. Hence, the maintenance of personal and professional moral integrity is the aspiration of all physicians who wish to practise medicine in good conscience. Medicine is a moral enterprise, morality is a human enterprise, and physicians, no less than patients, are moral agents.

A14. Consistent with this account of the practice of medicine understood as a moral enterprise, the *CMA Code of Ethics* states that a physician first considers the well-being of the patient and always acts to benefit and promote the good of the patient.[51]

A15. What benefits the patient? What constitutes the good of the patient? How is that good best promoted? Answers to these questions depend not only upon one's conception of morality, but upon one's conception of reality. It is thus important for the CPSA to cultivate a form of rational moral pluralism that enables physicians to discharge their obligations to patients with integrity, notwithstanding deep and persisting differences in comprehensive world views that operationalize concepts of the human person foundational to the practice of medicine.

[51] *CMA Code*, *supra* note 31 at 2, B.

Appendix "B"

CPSA and referral for morally contested services (1991–2020)

B1. From 1991 to 2008 the College of Physicians and Surgeons of Alberta (CPSA) policy on abortion provided the framework for accommodating patients seeking morally contested services and physicians unwilling to provide them for reasons of conscience. The policy required physicians to provide patients with information necessary to enable informed medical decision-making, but did not require them to provide contested services or to facilitate them by referral or other means. The CPSA Registrar promised that this would not change when Standards of Practice were adopted in 2009.

B2. The standard *Moral or Religious Beliefs Affecting Medical Care* was adopted in 2010 and re-issued in 2011 and 2014. Among other things, it required objecting physicians unwilling to provide or offer access to information about a contested procedure to offer patients "timely access" to a physician or resource able to provide accurate information about "all available medical options." This was not problematic because objecting physicians were generally willing to provide information about contested procedures, and those who were not had to offer patients access to someone willing to provide information, but not to someone providing the contested procedure.

B3. While the Registrar had promised in 2009 that the new standards of practice would not change CPSA policy about referral for contested procedures, from the outset he offered mixed messages on the subject. The Alberta Medical Association elected to accept his assurance that physicians would not be obliged to facilitate procedures to which they objected for reasons of conscience. However, by 2014 media were reporting that CPSA policy required objecting physicians to make such referrals and the CPSA published an ethics commentary to the same effect.

B4. Further, in 2015, without the approval of College Council, a CPSA official expressed strong support for a policy of mandatory effective referral in a formal submission to the College of Physicians and Surgeons of Ontario. Meanwhile, at least one CPSA staffer was reportedly telling Alberta physicians that CPSA policy required effective referral. Finally, directly contradicting the assurance he had given the medical profession six years earlier, the College Registrar openly advocated effective referral for euthanasia and assisted suicide.

B5. *Moral or Religious Beliefs Affecting Medical Care* was reviewed in 2015/2016, when "effective referral" was rejected by four of six stakeholders and all but 31 of 645 consultation respondents. It was re-issued as *Conscientious Objection*, which was virtually identical to the original standard. It differed principally in requiring *either* "timely access" to a practitioner willing to provide the contested service *or* to a resource able to provide information about all available medical options. Once more, the policy was not problematic because 'offering access' to someone who would provide the contested service was optional. However, accommodation of objecting physicians is complicated by differences between two practice standards, *Conscientious Objection* and *Medical Assistance in Dying*.

B6. If accommodation of physician freedom of conscience in Alberta has been satisfactory, it has probably been so in spite of the efforts of influential College officials, because tolerance has encouraged by broad-minded individuals in key positions in government and the health professions, and because the relatively few physicians who refuse to refer patients for morally contested services treat patients respectfully, discuss their concerns and options and provide them with contact information for Alberta Health Link.

For full details and documentation, see -

- Sean Murphy, "Physician freedom of conscience in Alberta"(18 September, 2020), *Protection of Conscience Project* (website), online: <https://www.consciencelaws.org/background/policy/project002.aspx>.

Related:

- Protection of Conscience Project, "Submission to the College of Physicians and Surgeons of Alberta Re: *CPSA Draft Standards of Practice"* (8 October, 2008*), Protection of Conscience Project* (website), online: <https://www.consciencelaws.org/publications/submissions/submissions-007-001.aspx>
- Protection of Conscience Project, "Submission to the College of Physicians and Surgeons of Alberta Re: Informed Consent (Draft) (28 October, 2015), *Protection of Conscience Project* (website), online: <https://www.consciencelaws.org/publications/submissions/submissions-020-001-carter-cpsa.aspx

Appendix "C"

Recommended Changes to draft standard *Conscientious Objection*

DRAFT STANDARD	RECOMMENDED CHANGES
Title	
Conscientious Objection	*Conscience in Medical Practice*
Preamble	
CPSA recognizes that ~~regulated members have the right to limit the health services they provide~~ for reasons of conscience, cultural belief or religion. Regulated members are expected to act in their patients' best interest by providing enough information and assistance to allow them to make informed choices for themselves.	CPSA recognizes that *moral/ethical decision-making is intrinsic to the practice of medicine, and that practitioners may sometimes receive patient requests that they must decline* for reasons of conscience, cultural belief or religion. Regulated members are expected to act in their patients' best interest by providing enough information and assistance to allow them to make informed choices for themselves.
Regulated members ~~limiting the services they provide to patients for reasons of conscience, cultural belief or religion~~ should do so in a manner that respects patient dignity, facilitates timely access to care and protects patient safety.	Regulated members *must communicate and act upon their moral/ethical decisions* in a manner that respects patient dignity, facilitates timely access to care and protects patient safety.
The purpose of this standard is to outline expectations for regulated members ~~in balancing the ethical dilemmas that occur when one's beliefs and ethics conflict with the ethical beliefs of patients~~	The purpose of this standard is to outline expectations for regulated members *if they receive requests from patients for services or procedures that conflict with their moral/ethical/religious convictions or cultural beliefs.*
§1. A regulated member must:	
(f) proactively maintain ~~an effective referral plan~~ for the frequently requested services they are unwilling to provide.	(f) proactively maintain *a plan to meet the expectations set by this standard in relation to* the frequently requested services they are unwilling to provide.

DRAFT STANDARD	RECOMMENDED CHANGES
§2. A regulated member must not:	
(c) ~~expose patients to adverse clinical outcomes due to a delayed effective referral~~	[Delete]
(e) ~~express personal moral judgements about the patient's request or choice~~	(d) *in complying with Section 1(a) of this Standard or in other interactions with patients*, *promote his own moral/ethical beliefs or causes or attempt to convince a patient to adopt them*.