Court File No.: 15-63717

ONTARIO
SUPERIOR COURT OF JUSTICE

B E T W E E N:

THE CHRISTIAN MEDICAL AND DENTAL SOCIETY OF CANADA, THE CANADIAN FEDERATION OF CATHOLIC PHYSICIANS' SOCIETIES, CANADIAN PHYSICIANS FOR LIFE, DR. MICHELLE KORVEMAKER, DR. BETTY-ANNE STORY, DR. ISABEL NUNES, DR. AGNES TANGUAY and DR. DONATO GUGLIOTTA

Applicants

- and -

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Respondent

- and -

ATTORNEY GENERAL OF ONTARIO

Intervener

AFFIDAVIT OF ANDRÉA FOTI

I, Andréa Foti, of the City of Toronto, in the Province of Ontario MAKE OATH AND SAY AS FOLLOWS:

1. I am a manager in the Policy Department of the College of Physicians and Surgeons of Ontario (the "College"). I have worked at the College for eleven (11) years. My experience has been exclusively in the Policy Department of the College. During my tenure, I have occupied the roles of Policy Analyst, Senior Policy Analyst, and Manager. I have been in the role of Manager since 2012. As Manager, I am head of the Department, charged with oversight of all College policy development and review, along with a range of other functions the Policy department provides within the College. I also served as the College's Privacy Officer from 2005 to 2015.

2. In my capacity as Policy Analyst, I was the staff lead on the College's *Physicians and the Ontario Human Rights Code* policy, developed in 2008. I was charged with developing the policy, managing the consultation, and finalizing the policy. In 2014/2015, in my capacity as Manager, I oversaw the review and finalization of the College's current policy on this topic, *Professional Obligations and Human Rights.* I also have recently reviewed the files pertaining to the development of both policies. As such, I have knowledge or, where stated, information and belief, of the matters to which I hereinafter depose.

3. In terms of my educational background, I hold three university degrees. I hold a Bachelor of Arts degree in Honours English from the University of Guelph, from which I graduated with honours. I hold a Bachelor of Laws degree from Dalhousie University and earned a specialization in health law and policy from Dalhousie's Health Law Institute. I hold a Master of Arts degree in Medical Ethics and Law from the Centre for Medical Law and Ethics, at King's College, University of London (UK), from which I graduated with distinction. Attached as **Exhibit "A"** to this affidavit is a copy of my curriculum vitae.

I. Regulating the Medical Profession -- The College Of Physicians And Surgeons Of Ontario

4. The College is the self-regulating body for the medical profession in the Province of Ontario. Its mandate is to serve and protect the public interest by governing the medical profession.

5. All doctors in Ontario must be members of the College in order to practice medicine in the province. As of December 31, 2015, the College had a total membership of 40,243, including 31,803 physicians with certificates of registration permitting independent practice in Ontario,

6,171 physicians with educational certificates of registration permitting postgraduate medical training, 2,156 physicians practicing under restricted licenses, and 107 physicians with an academic practice. These physicians are engaged in a tremendous range of practice areas, including medical and surgical specialities such as psychiatry, internal medicine, thoracic surgery, endocrinology and obstetrics and gynaecology. Physicians under the College's jurisdiction also engage in non-clinical roles, such as public health physicians, physician administrators or academics, research physicians and physician politicians. The College's 2015 Registration Report, *Registering Success 2015,* is attached to this affidavit as **Exhibit "B"**.

6. While the College does not gather information about the religious and cultural beliefs of its physician members, it does collect other information that provides some indication of the diversity of beliefs among practicing physicians in the province. I have reviewed information collected by the College about which medical schools Ontario physicians attended and what languages they speak. As of September 2016, the College had issued certificates of registration permitting independent practice to physicians with medical degrees from 131 different countries, and Ontario physicians spoke 125 different languages. And as the College's 2015 Annual Report (**Exhibit "C"**) indicates, in 2015, the College issued new certificates of registration to 4,831 individuals, 1,868 (39%) of whom obtained their medical degree outside of North America.

7. Physicians practice in locations across the province, in a wide variety of settings. These settings include practices in hospitals or clinics, in an office building with a single doctor's office, or in an office in a physician's residence. They also practice in institutional settings such as jails, government offices, pharmaceutical companies or universities.

8. The College is responsible for issuing certificates of registration to physicians to allow them to practice medicine; monitoring and maintaining standards of practice of physicians; investigating complaints and other information it receives about physicians; and disciplining physicians who have committed acts of professional misconduct or who are incompetent. The College's jurisdiction extends to members and to former members who are alleged to have engaged in professional misconduct while members.

9. The role of the College, as well as its authority and powers, are set out in the *Regulated Health Professions Act, 1991* ("RHPA"), the Health Professions Procedural Code, being Schedule 2 to the RHPA (the "Code"), and the *Medicine Act, 1991.*

10. The objects of the College are outlined in the Code. They include:

- To regulate the practice of the profession and to govern the members in accordance with the *Medicine Act, 1991* the Code and the RHPA, and the regulations and by-laws;
- To develop, establish and maintain programs and standards of practice to assure the quality of the practice of the profession;
- To develop, establish and maintain standards of knowledge and skill and programs to promote continuing evaluation, competence and improvement among the members;
- To develop, establish and maintain standards of professional ethics for the members;
- To develop, establish, and maintain standards and programs to promote the ability of members to respond to changes in practice environments, advances in technology and other emerging issues;
- Any other objects relating to human health care that the Council considers desirable.

11. In carrying out its objects, the College has an overriding duty to serve and protect the public interest.

12. The Legislature has given the College the mandate to regulate the practice of medicine in Ontario, including through enforcement of clinical and professional standards for physicians in Ontario. The College has the obligation, in keeping with its objects and its overriding duty, to ensure that standards of clinical and professional practice are in place to govern physicians in the service of the public interest.

13. The College has its own governing body, the Council. Council is composed of physicians elected by their peers and non-physicians or public members appointed by the provincial government, as well as physicians appointed from among representatives of the six faculties of medicine in Ontario. Physician members of Council have a broad range of experiences and expertise, and include physicians from diverse areas of specialty from across the province. Public members come from a cross-section of communities in Ontario, large and small, and have diverse vocational and professional backgrounds. The President of the College is elected from and by Council and serves a one-year term. The composition and functioning of Council are outlined in the College's General By-Law, which is attached as **Exhibit "D"** to this affidavit.

14. Council members sit on one or more committees of the College. Each committee has specific functions, most of which are governed by provincial legislation.

15. The Executive Committee of the College is the body that oversees the administration of the College. It has authority to exercise any power of the Council that requires immediate attention, other than making by-laws and regulations. It considers policy and operational issues, and can make decisions on behalf of Council between Council meetings. It is composed of physician and non-physician Council members, and includes the President and Vice-President of Council.

16. The Registrar of the College is the most senior staff person at the College. He is appointed by Council and is responsible for all staff and reporting to Council. In addition to administrative duties similar to a Chief Executive Officer, the Registrar has specific statutory duties set out in the RHPA and the Code. The position is currently filled by Dr. Rocco Gerace, a specialist in emergency medicine who has served as Registrar since May 2002.

17. Council meetings are held four times a year, at which time the activities of the College are reviewed and matters of general policy are debated and voted on, and direction is provided on on-going matters.

18. Executive Committee meetings take place from time to time at the direction of Council or the Executive Committee or at the call of the chair of the Executive Committee. They tend to take place about once a month.

19. The College is funded primarily by the membership fees generated from the physicians and surgeons who form its membership.

II. Development of College Policies

20. One of the College's duties as a medical regulator, in accordance with the objects outlined in the Code, is to provide guidance to physicians across Ontario (in both remote communities and large urban centres) on issues related to professionalism and ethics and on clinical and practice issues that are relevant to the practice of medicine. As the body with exclusive jurisdiction over the regulation of Ontario physicians, the College has a duty to ensure that mechanisms are established to regulate both clinical issues and issues related to professionalism and ethics.

21. In keeping with this duty, the College publishes a number of documents outlining expectations for its members. The *Practice Guide* articulates the profession's values, which provide the foundation for the practice of medicine and the principles of medical practice. This document articulates for the profession its duties and the reasons for those duties, and organizes the policies of the College within a principled framework. The *Practice Guide* is attached to this affidavit as **Exhibit "E"**.

22. The College has also adopted over fifty (50) policies. College policies articulate the profession's expectations of the ethical and competent physician in a range of specific areas. College policies govern all members across the province, and set uniform expectations for physicians in Ontario regardless of practice location.

23. In developing policies, the College is guided at all times by its objects and by its overriding duty to serve and protect the public interest.

24. Policies of the College are developed with the input and direction of Council. They are adopted as official College documents following a vote at Council meetings, if approved by a majority of Council members present at the meeting. In exceptional circumstances, a College policy may be amended or approved by the Executive Committee.

25. The development of a policy may be prompted by many factors, including emerging trends, changes to the medical or legal landscape, public or patient experience, and issues identified by College committees, Council and the medical profession. All existing College policies are reviewed on a regular basis, every five to six years. Reviews may be expedited or delayed depending on a variety of factors. Reviews may be expedited to respond to important changes in the medical or legal landscape or public or patient experience. Reviews may be

delayed to align with anticipated changes or developments in the legal or medical landscape, government initiatives, or because other more urgent policy reviews or College projects require more immediate attention.

26. Policy review and development is supported by staff in the Policy Department. A policy analyst is assigned to an issue and undertakes the initial components of the policy development or review, such as research and consultation. For many policies, a Working Group comprised of physician and public members of Council is formed to lead the development/review. The policy analyst conducts the review process, including the development of a draft policy under the direction of the Working Group.

27. Council and the Executive Committee guide the review and development of policies throughout the process. Once the Working Group has a draft policy that it is satisfied with, the draft is presented to the Executive Committee for consideration. The Executive Committee discusses the draft policy and may ask the Working Group to make revisions to the draft.

28. After considering the draft policy, the Executive Committee decides whether to forward the draft policy to Council for its consideration.

29. Should the draft policy be approved by the Executive Committee, it is then presented to Council. Council examines the draft policy, debates its contents and may vote for revisions to the draft. Following this debate, Council votes on whether to engage in a public consultation process regarding the policy or to return the policy to the Working Group for amendment. All policies undergo a public consultation prior to being finalized and approved as College policy.

30. When Council approves proceeding to public consultation in respect of a draft policy, an external consultation is conducted. A dedicated consultation webpage, accessible to all on the College's public website, is established for the draft policy. The draft policy is posted to the consultation webpage, along with background information. Consultation participants are asked for general feedback on the draft policy, including its clarity and comprehensiveness, the reasonableness of the positions, and how the document could be improved. Participants may also be asked specific questions tailored to the particular draft policy.

31. The College's consultation process is extensive, public and transparent. The College seeks to obtain feedback from a broad range of individuals and organizations, including physician members, healthcare organizations, public or patient organizations and other stakeholders, and the general public. The consultation and draft policy are promoted widely, including:

- By promoting the consultation through the College's social media channels, including Facebook and Twitter;
- By publishing a notice about the consultation on the College website, in *Dialogue*, the College's periodic publication for members, in *Patient Compass* (formerly *Noteworthy*), the College's free electronic newsletter for the public, and in other College publications; and
- By directly soliciting feedback from physician and patient organizations and other stakeholders, including organizations known to have a specific interest in the subject matter of the policy.

32. Stakeholders are provided with a variety of ways to participate and provide feedback, including via written comments (by mail or email), by responding to an online survey, or by posting comments to the consultation discussion page. All of the feedback received by the

College is posted to the consultation webpage, and individuals can comment on the feedback provided by other participants in an online discussion forum. The consultation period typically lasts 60 days.

33. One of the things the College considers when evaluating feedback is that the nature of feedback received during an external consultation will often be influenced by selection bias, especially for contentious issues. Those who participate and provide feedback are typically individuals and organizations who already know of the College or who have a strong motivation to provide input on a subject. Consequently, in order to solicit feedback and gauge the views of a broader cross-section of society, the College may commission a public opinion poll regarding a specific policy, in addition to engaging in the standard external consultation described above.

34. The volume of responses that the College receives to policy consultations varies greatly, depending on the subject matter. Some consultations yield fewer than 100 responses and other consultations may yield 250-500 responses. The consultations held in 2008 on the College's *Physicians and the Ontario Human Rights Code* policy and in 2014/2015 on the *Professional Obligations and Human Rights* policy have yielded the highest volume of responses to date, ranging from 1300 to 6500 responses per consultation.

35. The feedback received during a consultation is reviewed by staff in the Policy Department, both as it is received and after the consultation period closes. A summary of the feedback, reflecting the key themes and survey results, is provided to the Working Group. The consultation feedback is considered carefully and thoroughly and may inform revisions to the draft policy. The purpose of external consultation is to ensure the College has considered many diverse viewpoints and perspectives on the issues addressed in its policies before reaching a final

position. The goal is not necessarily to achieve consensus or to reflect majority viewpoints within the policy. The overriding consideration in development of a policy remains the furtherance of the College's objects and protection of the public interest. Where a consultation reveals conflicting positions and viewpoints on an issue, the College attempts to reconcile positions by anchoring the policy to the College's mandate and the fundamental values of the profession, and by considering what will best serve and protect the public interest.

36. After the close of the consultation period, the Working Group presents a revised draft of the policy, along with a summary of the consultation feedback and the results of public polling, if any, to the Executive Committee. The Executive Committee discusses the feedback and the revisions the Working Group has made to the draft policy in response to feedback, and may pose questions and direct that further revisions be made to the draft policy. The Executive Committee determines whether to forward the revised draft policy to Council for consideration and possibly final approval, or to send it back to the Working Group for further consideration and revision.

37. Once the Executive Committee is satisfied with the revised draft policy, it is presented to Council, along with a report on the consultation, and a summary of other factors or information that have informed the revisions made. This may include data from public polling, if a poll has been commissioned. Council discusses the work that has been done, debates the policy and may vote to adopt further revisions to the revised draft policy or to require further work to be done. Council may then vote on whether to approve the revised draft policy as an official College policy.

38. If approved by a majority of the Council members present at the meeting, the revised draft policy is officially adopted as College policy.

39. The new policy is posted on the College website, announced via social media, and published in *Dialogue*. It is also included in the *Council Update*, which is sent to all physicians following a meeting of Council to communicate key Council decisions to the profession.

40. The process described above is followed both for the development of new policies and for the review of existing policies. One distinction between the development of a new policy and the review of an existing policy is that the College generally conducts a preliminary external consultation for existing policies, prior to developing an updated draft policy. The preliminary consultation with respect to the existing policy informs development of the new draft policy, which then goes out for consultation.

III. Physicians and the Ontario Human Rights Code - 2008

41. In the spring of 2008, the College commenced preliminary research and consultation on a draft policy regarding physicians and their obligations under the Ontario *Human Rights Code*. Council directed that a draft policy ("2008 Draft Policy") be sent out for external consultation on June 26, 2008. The 2008 Draft Policy is attached to this affidavit as **Exhibit "F"**.

42. The external consultation occurred between July 2 and September 12, 2008. In addition, the Executive Committee approved commissioning a public opinion poll regarding the expectations included in the 2008 Draft Policy, in order to gauge the views of the broader Ontario public and contextualize the feedback received from consultation participants. The results of the public opinion poll were received on September 15, 2008.

43. The 2008 Draft Policy included several sections dealing with the balancing of a physician's responsibility to patients with his or her personal moral or religious beliefs. The 2008 Draft Policy stated:

> [A]s a physician's responsibility is to place the needs of the patient first, there will be times when it may be necessary for physicians to set aside their personal beliefs in order to ensure that patients or potential patients are provided with the medical treatment and services they require.

44. The above content was informed by a document published by the General Medical Council in the United Kingdom, the regulatory body for physicians in the United Kingdom in 2008. The General Medical Council document was entitled, *Personal Beliefs and Medical Practice,* and the passage in the 2008 Draft Policy was informed by paragraph eight (8) of that document. A copy of *Personal Beliefs and Medical Practice* is attached as **Exhibit "G"** to this affidavit.

45. The 2008 Draft Policy also outlined the College's expectation regarding referrals in the event that a physician limited his or her practice, refused to accept individuals as patients, or ended a physician-patient relationship on the basis of moral or religious belief. In this situation, the 2008 Draft Policy stated that the College expects physicians to:

> Tell patients about their right to see another physician with whom they can discuss their situation and ensure they have sufficient information to exercise that right. If patients or potential patients cannot readily make their own arrangements to see another doctor or health care provider physicians must ensure arrangements are made, without delay, for another doctor to take over their care.

46. During the consultation process, the College received extensive feedback on the 2008 Draft Policy with submissions from more than 1300 individuals or organizations.

47. As of September 11, 2008 feedback was received from:

- 537 members of the public, 208 of whom identified themselves as Ontario citizens;
- 304 physicians, 268 of whom were Ontario physicians;

- 45 organizations, 29 of which were from Ontario;
- 3 political figures (M.P.'s), 1 of whom was from Ontario;
- 14 religious figures, 10 of whom were from Ontario.

48. Between September 11 and September 18, the College received nearly 180 additional responses, which included 97 submissions from members of the public; 50 from physicians, 20 from organizations, and 5 from religious figures.

49. In addition, the College received a form email promoting freedom of conscience during the consultation process. Messages containing slight variations of this form email were received from over 500 members of the public, from across Canada.

50. The majority of consultation feedback focused on content in the 2008 Draft Policy under the heading 'Moral or Religious Beliefs'. Responses to this section of the draft were mixed, with the majority of respondents criticizing the draft policy. Respondents opposed to the draft argued that it violated freedom of conscience and religion by including the expectation that physicians discuss or provide information about medical services to which they object and that they assist patients or individuals who wish to become patients in making arrangements to see another physician. Respondents in favour of the draft argued that freedom of conscience and religion does not entitle physicians to refuse to provide medical services to patients or refuse to assist patients or individuals to access medical services.

51. In addition to this feedback, the College also commissioned a polling and market research firm, Environics Research Group, to poll the Ontario public on key elements included in the 2008 Draft Policy. A random sample of 500 Ontarians was polled to gauge public attitudes and expectations regarding the "Moral or Religious Beliefs" section of the draft policy. The margin

of sampling error for the poll was plus or minus 4.4% at the standard 95% confidence level. A substantial majority of those polled (85%) felt that physicians should not be able to refuse to provide a medical service because the service conflicts with their moral or religious beliefs. More than 90% felt that physicians should be required to provide patients with information about all clinical options and provide patients with a referral. The results of the Environics poll are attached to this affidavit as **Exhibit "H".**

52. The Ontario Human Rights Commission ("OHRC") provided feedback during the consultation, and made extensive comments about the section of the 2008 Draft Policy dealing with moral or religious beliefs. The OHRC praised the College for detailing the obligations of doctors to ensure that they do not make professional decisions based on their personal moral or religious beliefs in a way that has a discriminatory impact. The OHRC suggested amending the section dealing with contravention of the Ontario *Human Rights Code* and competing rights to clarify that a physician's refusal to provide a service or accept a patient on the basis of a prohibited ground, such as sex or sexual orientation, is *prima facie* discrimination, even if the refusal is based on the physician's moral or religious belief, and that a court's balance of competing rights claims is complex and case-specific. The submission of the OHRC, dated August 15, 2008, is attached to this affidavit as **Exhibit "I".**

53. Following the external consultation, revisions were made to the 2008 Draft Policy. Notably, the sections in the 2008 Draft Policy dealing with the balancing of a physician's responsibility to patients with his or her personal moral or religious beliefs, and the College's expectation that in certain circumstances, physicians must ensure arrangements are made for another doctor to take over a patient's care, were amended. The requirement that a physician must ensure arrangements are made for another doctor to take over the patient's care, if a patient

or potential patient cannot make their own arrangements, was altered to state the College's expectation that an objecting physician:

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

54. The Executive Committee considered a summary of the consultation feedback and the revised 2008 Draft Policy, together with the results of the public poll, at its meeting on September 4, 2008. The Executive Committee recommended that the revised 2008 Draft Policy be referred to Council for approval.

55. At its meeting on September 18, 2008, Council was presented with the summary of consultation feedback, the results of the public poll, and the revised 2008 Draft Policy. Council voted to adopt the revised 2008 Draft Policy as Policy Statement #5-08: *Physicians and the Ontario Human Rights Code*. The Briefing Note presented to Council, with appendices, is attached to this affidavit as **Exhibit "J"**. Included as Appendices to the Briefing Note are:

- Chart, Summary of Consultation Themes (Appendix C)
- Environics Public Survey Questionnaire (Appendix D)
- Memorandum of polling results from Environics (Appendix E)
- Revised Draft Policy, blacklined to show the revisions proposed following the consultation process (Appendix F)

In addition to the consultation summary, copies of all the feedback obtained through the consultation process were also provided to Council.

56. The policy was posted on the College website and disseminated according to the College's usual practice. The published version of Policy Statement #5-08: *Physicians and the Ontario Human Rights Code* is attached to this affidavit as **Exhibit "K"**.

IV. Professional Obligations and Human Rights Policy – 2015

a) Preliminary consultation and research

57. In the summer of 2014, the College undertook a review of the 2008 *Physicians and the Ontario Human Rights Code* policy, in keeping with its standard practice of periodically reviewing and updating College policies.

i. External consultation

58. The College conducted a preliminary external consultation from June 4 to August 5, 2014. The purpose of the preliminary consultation was to obtain stakeholders' feedback on the existing policy (*Physicians and the Ontario Human Rights Code*). Feedback received would inform the College's review and revision of that policy.

59. Invitations to participate in the consultation were sent by email to a broad range of stakeholders, including the College's entire membership, patient organizations, community organizations, and religious organizations. This included one of the Applicants, the Christian Medical and Dental Society. In addition, a general notice of the preliminary consultation was posted on the College's website and Facebook page, and the preliminary consultation was announced on Twitter. It was also published in *Dialogue* and *Noteworthy* (the College's public e-newsletter, now called *Patient Compass*). Stakeholders were given the option of submitting their feedback in writing, by email or regular mail, through a brief online survey, or by posting

comments to an online discussion page. The invitation circulated to all stakeholders is attached to this affidavit as **Exhibit "L"**.

60. I am advised by staff in the Policy department, and I believe, that during the preliminary consultation regarding the *Physicians and the Ontario Human Rights Code* policy, the College received a total of 6678 responses.[1] This included 2264 comments posted to the online discussion page or received by email or letter mail, and 4414 completed online surveys. Approximately 74% of respondents identified themselves as members of the public, 11% as physicians, and 1% as organizations. The remaining respondents were categorized as either anonymous or "other". The organizational respondents included medical regulators and professional associations, as well as advocacy, religious, and patient organizations. An alphabetical list of organizations which responded to the consultation, prepared by Policy staff in October 2016, is attached to this affidavit as **Exhibit "M"**.

61. In addition, the consultation webpage included a "quick response" poll question, which asked, "Do you think a physician should be allowed to refuse to provide a patient with a treatment or procedure because it conflicts with the physician's religious or moral beliefs?" 32,912 responses were received in this poll: 77% of the responses indicated "Yes" and 23% indicated "No". The quick response poll results are included in the Applicants' Application Record as **Exhibit "F" to the Affidavit of Larry Worthen** (vol. 5, p. 1187).

62. The "quick response" poll question was included as a means of capturing the attention of would-be participants and encouraging them to review the actual consultation materials and provide substantive feedback. The 'quick response' poll option was structured in a way that

[1] An audit conducted by Policy staff in September 2016 showed that the number reported in 2014/2015 (6710 submissions) was incorrect.

required a simple, straightforward question that could be answered with either a yes or no response. It did not allow for a nuanced examination of the policy issues. The results of the quick poll were therefore considered in that light.

63. In keeping with the College's consultation practices, all stakeholder feedback was posted publicly on the College's website. A copy of this written feedback, including both online comments and letters/emails, is included in the Applicants' Application Record as **Exhibit "E" to the Affidavit of Larry Worthen** (beginning at vol. 3, p. 585). I am advised by staff in the Policy department, and I believe, that one submission received at the College by email (Response #853 on the College's Wordpress page) was omitted from the Affidavit of Larry Worthen. This is attached to this affidavit as **Exhibit "N"**. A comprehensive report of survey results is attached to this affidavit as **Exhibit "O"**.

64. The substantive themes that emerged during the preliminary consultation period concerned the following:

i. *Human Rights Code* obligations, including the duty to accommodate; and

ii. Conscientious objection, access to care, and patient referrals.

65. With respect to physicians' obligations under the *Human Rights Code*, there was general support for the College expectation that physicians provide health services free from discrimination.

66. The majority of feedback received focused on the issue of conscientious objection and what should happen if physicians choose to limit the care they provide on moral or religious grounds. As it was in 2008, the feedback on this issue was divided. The majority of consultation respondents expressed their support for freedom of conscience, and the idea that physicians

should not be required to provide services that conflict with their moral and/or religious beliefs. A minority of respondents took the opposite view and argued that physicians should not be permitted to refuse to provide medical services for reasons relating to their moral and/or religious beliefs.

67. A majority of consultation respondents disagreed with the idea that physicians should be required to provide a referral for those services they deem to be objectionable. Several respondents argued that providing a referral would make the physician 'complicit' in the treatment or service to which the physician asserted a conscientious objection. A small minority of respondents expressed the opposing view: they were in support of a referral requirement in this context, and recommended that the College consider developing stronger and/or clearer language regarding physicians' responsibility to facilitate patient care.

68. The OHRC provided feedback as part of the preliminary external consultation and made several suggestions for revisions. The OHRC suggested the new policy should:

- Reference the new Code grounds of gender identity and gender expression and clarify that the ground "creed" includes religious and other creed-based beliefs and practices and also protects people who have no creed;
- Clarify that *prima facie* discrimination under the Code might happen where physicians limit their services because of moral or religious beliefs unless there is a legitimate reason in the circumstances;
- Rephrase the competing rights principles with regard to the OHRC's Policy on Competing Human Rights and emphasize the aim to respect the importance of both sets of rights;

- For physicians who limit services because of moral or religious beliefs, clarify their duties to patients under the CPSO's *Practice Guide* and under its policy on *Physicians and Health Emergencies*;
- Clarify that physicians who limit their services because of moral or religious beliefs must make sure patients get the services they need in a timely way including referrals to other physicians when appropriate and necessary;
- Require physicians who limit their services in settings such as hospitals, clinics and shared service practices, to inform administrators or fellow physicians accordingly to prevent any potential discriminatory impact on patients;
- Clarify that organizations such as hospitals, clinics and professional associations also have a duty to accommodate physicians, not just patients; and that the duty to accommodate covers creed and other grounds, not just disability; and
- Clarify that the duty to accommodate might be limited by undue hardship because of cost, health or safety, or when there is significant interference with the legal rights of others.

The letter from the OHRC is attached to this affidavit as **Exhibit "P"**.

ii. Public polling

69. In addition to the preliminary external consultation, a poll of Ontario residents was conducted between May 8 and May 19, 2014. The primary purpose of this poll was to capture public sentiment on the issue of conscientious objection in the health services context. The report of the May 2014 public opinion poll, prepared by the Strategic Counsel, a public polling and market research firm, is attached to this affidavit as **Exhibit "Q"**.

70. The polling results are based on 800 survey completions using an online panel of adult Ontario residents. The results can be generalized to the online population of Ontario, which represents approximately 84% of the adult population. Findings are accurate to +/-3.5%, at the

95% level of confidence. The polling methodology was designed to ensure that the results were as representative as possible of the views of the Ontarians, and accounted for a variety of demographic factors including the role played by religion in the respondent's life.

71. Specific issues covered in the poll included whether physicians should be allowed to refuse to provide a treatment or procedure on religious or moral grounds, what actions should be required of a physician who refuses to provide a treatment or procedure on religious or moral grounds, and other questions relating to respondents' experience of physicians' moral and religious beliefs within the health care system.

72. The poll showed that a substantial majority of Ontarians believed that physicians should not be allowed to refuse to provide treatment on religious or moral grounds. An overwhelming majority believed that if physicians object to providing care, they should be required to provide information about options, identify another physician to provide care, and make the referral for the patient. Key highlights from the polling results are as follows:

- 71% of the Ontario public believed that a physician should not be allowed to refuse to provide a treatment or procedure because it conflicts with the physicians' religious or moral beliefs; and
- Ontarians believed that physicians who object to providing care on moral or religious grounds should be required to do the following:
    - Provide the patient with information about treatment or procedure options (94%);
    - Identify another physician who will provide the treatment, and advise the patient to contact them (92%); and
    - Make/co-ordinate the referral (87%)

73. These figures were similar for Ontarians among all demographic groups. 34% of survey respondents indicated that religion played "a large role" or "somewhat of a role" in their lives. Even among these "very" or "somewhat" religious individuals, a majority (56%) believed a physician does not have the right to refuse to provide a treatment or procedure on religious or moral grounds. Only 34% of "very" or "somewhat" religious individuals supported physicians' right to refuse to provide treatment or a procedure, with 10% being undecided. Similarly, a majority of those who reported that they were "very" or "somewhat" religious agreed that if physicians refuse to provide treatment, they should be required to provide information about all treatment options and provide a referral.

iii. Comparative jurisdictional review

74. The College conducted a comprehensive jurisdictional review of the positions of other regulators and stakeholders on the subjects covered by the *Physicians and the Ontario Human Rights Code* policy. This jurisdictional review involved identifying the guiding policy documents for regulators/stakeholders and comparing their positions with respect to discrimination in the provision of medical services and conscientious objection on the part of medical service providers.

75. The jurisdictional review included:

- All Canadian provincial medical regulators;
- Ontario regulated health profession regulators/other stakeholders:

  (Ontario College of Pharmacists; College of Nurses of Ontario; College of Midwives of Ontario; Society of Obstetricians & Gynecologists of Canada; Canadian Medical Association); and
- International medical regulators or associations:

(General Medical Council, U.K.; Medical Council of New Zealand; General Medical Council, Australia; Australian Medical Association; Australian Medical Students' Association, American Medical Association; American College of Obstetricians and Gynecologists; American Academy of Pediatrics; American College of Emergency Physicians).

A chart summarizing the results of the jurisdictional comparison (for the jurisdictions with relevant policies in place) is attached to this affidavit as **Exhibit "R".** The following policies, standards, guidelines and articles (referred to in the summary chart) are attached to this affidavit as **Exhibit "S"**:

- British Columbia – *Professional Standards & Guidelines: Access to Medical Care*;
- Alberta – *Professional Standard: Moral or Religious Beliefs Affecting Medical Care*;
- Manitoba – *Statement: Members Moral or Religious Beliefs Not to Affect Medical Care*;[2]
- Quebec – *Legal, Ethical and Organizational Aspects of Medical Practice in Québec: Conscientious Objection*;
- New Brunswick – *Guidelines: Moral Factors and Medical Care*;
- Ontario College of Pharmacists – *Position Statement: Refusal to Fill for Moral or Religious Reasons*;
- Ontario College of Nurses – *Practice Standard: Ethics*;
- Ontario College of Midwives – *Code of Ethics*;
- Society of Obstetricians & Gynecologists of Canada – *Guidelines: Adopted FIGO Guidelines (Professional and Ethical Responsibilities Concerning Sexual and Reproductive Rights)*;
- Canadian Medical Association:
    - *Code of Ethics*;

[2] The jurisdictional review chart incorrectly refers to the title of the Manitoba policy as "Discrimination in Access to Physicians", however the policy reviewed by staff and summarized in the chart was entitled "*Members Moral or Religious Beliefs Not to Affect Medical Care*".

- *Policy: Care at the End of Life*;
- *Policy: Induced Abortion*;

- General Medical Council, U.K. – *Personal beliefs and medical practice*;
- Medical Council of New Zealand – *Good Medical Practice*;
- General Medical Council, Australia – *Good Medical Practice: A Code of Conduct for Doctors in Australia: Decisions About Access to Medical Care (s. 2)*;
- Australian Medical Association – *Conscientious Objection to the Termination of Pregnancy: Information for GPs*;
- Australian Medical Students' Association – *Policy: Conscientious Objection and Access to Care*;
- American Medical Association – *Article, Virtual Mentor: Legal Protection for Conscientious Objection by Health Professionals*;
- American College of Obstetricians and Gynecologists – *The Limits of Conscientious Refusal in Reproductive Medicine*;
- American Academy of Pediatrics – *Policy: Physician Refusal to Provide Information or Treatment on the Basis of Claims of Conscience*;
- American College of Emergency Physicians – *Policy Compendium*. [Note – only the relevant section of this document (pp. 129-130) is attached as an exhibit to this affidavit.]

76. In brief, the jurisdictional review showed that Canadian medical regulators recognized physicians' freedom of conscience and religion, and upheld physicians' right to refuse to provide health services and/or procedures for reasons of conscience or religion. However, regulators also articulated certain ethical and professional expectations that flow from asserting that right. Specifically, where a physician objects to providing health services and/or procedures for reasons of conscience or religion, Canadian medical regulators expect physicians to take positive action to assist patients and to connect them with a willing care provider.

77. For instance, in British Columbia, physicians who object to providing health services for reasons of conscience or religion must offer assistance and not abandon the patient. In Alberta, Manitoba and New Brunswick, objecting physicians were required to ensure that patients are offered timely access to another physician or resource that will provide accurate information about all available medical options. In Quebec, objecting physicians must offer to help the patient find another physician.

78. In March 2015, the Registrar of the College, Dr. Rocco Gerace, wrote to Canadian medical regulators to ask about their policies on moral/religious beliefs, and whether their policies required physicians asserting a conscientious objection to refer the patient to a colleague. Dr. Gerace made this inquiry in his role as the Federation of Medical Regulatory Authorities of Canada (FMRAC) Observer on the Canadian Medical Association's Committee on Ethics. The Colleges in Alberta, Saskatchewan, Manitoba, Quebec and New Brunswick all indicated that they interpreted their policies as requiring physicians to make a referral to a colleague, in the face of a conscientious objection. With the exception of Saskatchewan, the policies of these Colleges in March 2015 were the same policies in place during the development of the *Professional Obligations and Human Rights* policy in 2014/2015. Dr. Gerace's summary of the responses he received, titled "Conscientious Objections, March 2015", is attached to this affidavit as **Exhibit "T".**

79. The policies or guidance documents of other Ontario regulated health professions also recognized members' freedom of conscience and religion, while articulating a range of positive obligations flowing to the professional from the assertion of a conscientious objection. The College of Pharmacists stated that objecting pharmacists have a responsibility to participate in a system designed to respect a patient's right to receive pharmacy products and services.

Individual objecting pharmacists must ensure an alternate source to enable the patient to obtain the service or product that they need. Any alternate means must minimize inconvenience or suffering to the patient. The College of Nurses stated that if a nurse objects to providing care, she must arrange for another caregiver to take over. If no other caregiver can be found, the nurse must provide the immediate care required. In some circumstances, the nurse may have to leave a particular place of employment to adhere to her personal values. The College of Midwives stated that while midwives may assert a conscientious objection, they may not refuse to attend in the course of labour notwithstanding any objection. If for any reason a midwife finds herself unable to provide care, she must assist clients to find appropriate alternate care.

80. Policy staff also conducted a review of select international medical regulators, namely the General Medical Council in the United Kingdom, the Medical Council of New Zealand, and the Australian Medical Council. Policies or guidance documents from these regulators recognize physicians' right to refuse to provide medical treatments or procedures to which they conscientiously object, and also set out certain professional expectations that flow to objecting physicians as a result of asserting this right. Broadly speaking, the international medical regulators surveyed require that objecting physicians take positive steps to ensure that the conscientious objection does not impede the patient's access to care. This means either ensuring that the patient has sufficient information to seek the care of a willing provider, and/or taking positive steps to facilitate the patient's access to a willing provider.

81. For instance, the U.K. General Medical Council required physicians, who have a conscientious objection to a treatment or procedure, to tell patients that they have the right to discuss their condition and treatment options with a non-objecting practitioner. The GMC also states that physicians must ensure that the patient has sufficient information to make these

arrangements. If, however, it is not practical for a patient to arrange to see another practitioner, the objecting physician must arrange for another suitably qualified colleague to advise, treat or refer the patient.

82. The Medical Council of New Zealand required that physicians who have a conscientious objection to providing certain health services must explain their position to the patient, and tell them about their right to see another doctor. The patient must have sufficient information to seek out alternative care.

83. The Australian Medical Council required physicians to inform patients of their conscientious objection, and to not allow personal moral or religious views to deny patients access to medical care.

iv. Academic and legal research

84. The College conducted a comprehensive literature review on the topics of freedom of conscience and religion, conscientious objection, the limits of conscientious objection, and the nature and content of fiduciary duties.

85. The College also conducted legal research that was conducted focused on relevant case law involving human rights and the balancing of rights. This included *McInerney v MacDonald*, [1992] 2 S.C.R. 138; *R. v Big M. Drug Mart Ltd.*, [1985] 1 S.C.R. 295; *R. v Morgentaler*, [1988] 1 S.C.R. 30.; *Dagenais v Canadian Broadcasting Corp.*; and [1994] 3 S.C.R. 835, *Syndicat Northcrest v. Amselem*, [2004] 2 S.C.R. 551. The College also reviewed the Ontario Human Rights Commission document, *Policy on Competing Human Rights*, which is attached to this affidavit as **Exhibit "U"**.

b) Working Group develops draft policy

86. A Working Group was struck in the summer of 2014 to review and update the 2008 *Physicians and the Ontario Human Rights Code* policy. The Working Group was chaired by Dr. Marc Gabel and also included other Council members: Dr. Barbara Lent, Dr. John Watts, and Ms. Debbie Giampietri. College staff and a College Medical Advisor[3] provided the Working Group with support.

87. Dr. Gabel is a Toronto general practitioner practising in psychotherapy. He received a B.A. from Cornell University, an M.D. from Downstate Medical Centre, New York and a Master of Public Health from UCLA, with a special interest in tropical Medicine. Dr. Gabel has practiced in the United States, Asia and Canada. His practice has included pediatrics, public health, general practice and psychotherapy. He served as an assessor for the College for eight years, after which he was elected to the College's Council, where he served for more than eight years as well as serving as a Chair of the College's Discipline Committee for three years. Dr. Gabel served as President of the College from 2013-2014.

88. Dr. Barbara Lent is a family physician based in London, Ontario. Starting in 1979, she practiced in a private office setting, and then, in 1994, she moved her practice to a community-based academic clinic in a socially disadvantaged neighbourhood, where she supervised medical students and family medicine residents. She served as Associate Dean of Equity and Professionalism at the Schulich School of Medicine & Dentistry at Western University from 2004-2010. Dr. Lent has participated actively in several local, provincial and national committees addressing gender and equity issues. She has served on the College Council as the

[3] Medical Advisors are physicians employed by the College with expertise in different practice areas, who provide advice, information and support to College Committees and departments. The Medical Advisor assigned to the Working Group was a specialist in haematology and medical oncology.

academic representative for Western University since 2010, and has participated on numerous College committees, including the Discipline, Registration and Education Committees.

89. Dr. John Watts is a Professor Emeritus in the Department of Pediatrics at McMaster University and practiced as a neonatologist at McMaster Children's Hospital. He trained in internal medicine and pediatrics, and has served as the Director of the Neonatal Intensive Care Unit and as the Chief of the Neonatal Division in Hamilton, Ontario. He is a Past President of the Canadian Pediatric Society, as well as Past President of the Canadian Bioethics Society. Dr. Watts' research interests include ethics, particularly with respect to research in children, overviews of clinical trials, and respiratory disease and palliative care in newborns and children. He has published more than 40 peer-reviewed papers and seven book chapters. He also teaches clinical ethics at McMaster University. Dr. Watts served as a member of the Council from 2005 to 2015, and currently serves as a member of the College's Discipline, Fitness to Practise and Registration Committees.

90. Ms. Debbie Giampietri has served as a public member of Council appointed by the provincial government since 2011. Within the College, she serves on the Discipline, Fitness to Practice and Quality Assurance Committees. Ms. Giampietri has a B.A. from York University. Ms. Giampietri works in project management at JLG Management Consulting Ltd.

91. At its first meeting on August 7, 2014, the Working Group was provided with an overview of the current policy and reviewed the key themes emerging from the preliminary consultation and public polling results. A draft of the PowerPoint Presentation presented at the August 7, 2014 Working Group meeting is attached to this affidavit as **Exhibit "V"**.

92. At its second meeting on September 3, 2014, the Working Group was presented with the results of research into relevant issues and a jurisdictional review. The Working Group considered consultation feedback, including the survey report, and the public polling results. The Working Group also considered the outcomes of a sampling of cases that raised human rights issues, considered by the Inquiries, Complaints and Reports Committee of the College ("ICRC"), the body at the College which considers the results of all investigations into physicians' care and conduct. The following documents and presentations before the Working Group at the September 3, 2014, meeting are attached as exhibits to this affidavit:

- Jurisdictional Review Chart (**Exhibit "R"**);
- Organizational Feedback Chart and selected organizational submissions, including the submission of the Applicants, the Christian Medical and Dental Society of Canada and the Canadian Federation of Catholic Physician Societies (**Exhibit "W"**);
- PowerPoint Presentation: Human Rights Jurisdictional Review (**Exhibit "X"**)
- PowerPoint Presentation: Human Rights Consultation Feedback (**Exhibit "Y"**).

93. Following this meeting, an initial draft of the policy was developed by the Policy Department, at the direction of the Working Group ("Working Group Draft Policy"). The Working Group's direction with respect to the development of the draft policy was informed by the results of the literature and legal review; the jurisdictional survey and the feedback received during the consultation, including the view expressed by those opposing and supporting a referral requirement; and the submissions of expert stakeholders including the OHRC, the OMA and other organizations. The direction provided by the Working Group was also informed by the polling results, which showed that a majority of Ontarians, including those who identified as religious, favoured requiring objecting physicians to provide a referral.

94. In directing the development of the draft policy, the Working Group had as its primary focus the protection of the public interest, and how it viewed the public interest in this context. The Working Group sought to explicitly recognize physicians' freedom of conscience and religion while also highlighting the correlative duty of physicians not to abandon their patients. Central to the expectations outlined in the draft policy was the foundational principle that physicians, as professionals, have fiduciary obligations to their patients, and that there is a power imbalance between physicians and their patients.

95. The draft policy drew from the articulation in the *Practice Guide* of the social contract between the medical profession and the public. The *Practice Guide* characterizes the social contract as follows:

> [I]n return for a monopoly over the practice of medicine, professional autonomy and the privilege of self-regulation, the profession has made a commitment to competence, integrity, altruism and the promotion of the public good within its domain. The social contract is reflected in the ethical tenets of the profession, the legislation governing the profession, and the standards of practice for physicians.

The *Practice Guide* goes on to note that individual physicians "uphold the social contract through their commitment to their profession, their medical practice, and their patients."

96. The draft policy was also informed by the fact that physicians perform an essential public service, for a multicultural and multidimensional society, and are subject to human rights legislation. While acknowledging and affirming physicians' *Charter*-protected rights and freedoms, the draft policy also acknowledged that no rights under the *Charter* are absolute.

97. The Working Group considered that it was in the public interest to balance physicians' freedom of conscience and religion with patient access to care. It recognized that an integral aspect of regulating the practice of medicine in the public interest is ensuring that the College

upholds Canadian and Ontario law, including the rights and freedoms guaranteed by the *Charter*, and the obligations of physicians under the *Human Rights Code*. The Working Group also considered that it was in the public interest to ensure that the public has access to physicians from the wide range of backgrounds and beliefs that comprise the population of Ontario. The Working Group acknowledged that physicians' deeply held values are integral to their lives. Finally, the Working Group accepted that the value of altruism expressed in the *Practice Guide* does not mean that physicians must sacrifice their health or other important aspects of their life for their patients. Rather, it means that when providing care to a patient, a physician should always put that patient first. Thus, in considering physicians' right to assert a conscientious objection, the draft policy sought to affirm physicians' freedom of conscience and religion while still ensuring the public interest was protected and served in accordance with the College's duty.

98. In addition to the interest of physicians and patients, the Working Group also considered the importance of maintaining public confidence in the College as a protector and promoter of the public interest. In light of the power imbalance between physicians and patients, the College must ensure that patients feel the College is protecting their ability to access the public health care system. The Working Group also considered this in light of the obligations of physicians under the Ontario *Human Rights Code*.

99. The draft policy thus represented an attempt to recognize and balance all of these elements: physicians' *Charter*-protected freedom of conscience and religion; the duties physicians owe to patients as fiduciaries; the role of a physician as a provider of a public service and gatekeeper of access to health services; the values and duties of medical professionalism, including the commitments arising from the social contract; the wide range of religious beliefs or moral views that could be held by physicians in our multicultural society, and the equally wide

range of religious beliefs or moral views that could be held by the patients seeking assistance from those physicians; the expectations of the public for how an ethical and professional physician should act; the fact that the services or procedures to which physicians may have an objection are publicly funded and legally available; and the fact that a conscientious objection is based on physicians' personal conscience or religious beliefs and not on elements that would inform a clinical decision about the suitability of a patient's choice of a treatment or procedure.

100. At its third meeting on October 6, 2014, the Working Group was presented with the Working Group Draft Policy, which incorporated the Working Group's direction and deliberations to date. The Working Group discussed the draft and provided feedback. The Working Group sought to ensure that the policy was grounded in key values of professionalism, as articulated in the *Practice Guide*, and that it set out physicians' legal obligations under the Ontario *Human Rights Code* and the College's professional expectations of members. At this meeting, a new working policy title was proposed: "*Professional Obligations and Human Rights*". The following documents and presentations were before the Working Group at the October 6, 2014 meeting, and are attached as exhibits to this affidavit:

- Draft policy (Working Group Draft Policy) (**Exhibit "Z"**);
- PowerPoint Presentation (**Exhibit "AA"**).

101. The Working Group Draft Policy preserved much of the content of the 2008 *Physicians and the Ontario Human Rights Code* policy. Many of the revisions integrated into the Working Group Draft Policy represented an attempt to restructure the 2008 policy in keeping with drafting conventions of the Policy Department, to enhance clarity of the expectations for physicians and to provide further detail around physicians' professional and legal obligations and the manner in

which their obligations are to be fulfilled, in light of feedback received during the preliminary consultation.

102. In particular, the Working Group Draft Policy clarified the nature of the duties or positive obligations that arise when physicians assert a conscientious objection. Whereas the 2008 *Physicians and the Ontario Human Rights Code* policy stated the College's expectation that physicians should "Advise patients or individuals who wish to become patients that they can see another physician with whom they can discuss their situation and in some circumstances, help the patient or individual make arrangements to do so," the Working Group Draft Policy clarified that physicians are expected to provide an "effective referral". The Working Group felt it essential to clarify and be explicit about what positive actions the College expected physicians to take in the face of a conscientious objection.

103. Similarly, although the *Physicians and the Ontario Human Rights Code* policy was silent on the issue of what is required of an objecting physician in an emergency situation if the required care conflicts with their conscience or religious beliefs, the Working Group Draft Policy clarified the College's existing expectations in such situations. The expectation outlined in the Working Group Draft Policy was drawn from the guiding principles expressed in the *Practice Guide*, in particular its articulation of medicine's foundational values of compassion, service, altruism and trustworthiness, principles which require that physicians act in the best interest of patients and ensure that the patient is not abandoned or placed at risk of harm.

104. The Working Group Draft Policy included a number of key revisions, as compared to the 2008 *Physicians and the Ontario Human Rights Code* policy. One of these revisions was a restructuring of the section of the policy dealing with moral and religious beliefs. This section of

the 2008 policy was retitled *Conscience or Religious Beliefs*, and reframed to emphasize the following core requirements of professionalism: (1) Respecting Patient Dignity; (2) Ensuring Access to Care; and (3) Protecting Patient Safety.

105. As part of *Ensuring Access to Care*, the draft required that physicians who are unwilling to provide certain elements of care due to their moral or religious beliefs facilitate access to care by providing an "effective referral" to another health-care provider. The policy defined an "effective referral" as one that is made in good faith, to a non-objecting, available, and accessible physician or other health-care provider. The explicit definition of "effective referral" was included to ensure clarity, assist with compliance, and ultimately to ensure patient access to care, in keeping with the College's mandate to protect and serve the public interest.

106. As part of *Protecting Patient Safety*, the Working Group Draft Policy required physicians to provide care that is urgent or otherwise necessary to prevent harm, suffering, and/or deterioration even where that care conflicts with their religious or moral beliefs. The 2008 policy was silent on the College's expectations when an objecting physician was confronted with a patient who required emergency care. The Working Group Draft Policy elected to address this issue, making explicit the College's expectations that physicians should provide care in an emergency, even if that care is contrary to their conscience or religious beliefs.

107. The Working Group's decision to include an explicit provision regarding emergency care was informed, in part, by the well-publicized case of Savita Halappanavar, a woman who died of septicemia in Ireland in 2012 after physicians refused to provide her with an emergency abortion. A CBC News story outlining the details of that case is attached to this affidavit as **Exhibit "BB"**.

108. In relation to conscientious objections, both the Working Group Draft Policy and the 2008 *Physicians and the Ontario Human Rights Code* policy attempted to express the duty of a physician not to abandon the patient. The key distinction between the 2008 policy and the Working Group Draft Policy is that the Working Group Draft Policy made the content of the duty of non-abandonment more explicit and clear. Such clarity was intended to ensure that the College's expectations could be well understood by all and that the College could ensure and evaluate compliance.

109. The Working Group Draft Policy also clarified the 2008 policy by explicitly grounding the College expectations in the key values of professionalism as articulated in the *Practice Guide*, particularly physicians' fiduciary duty to prioritize patient interests and to facilitate equitable access to care. The Working Group Draft Policy emphasized that these professional obligations are applicable in all circumstances.

110. The Working Group Draft Policy, revised in keeping with the Working Group's feedback, was presented to the Senior Management Team ("SMT") on October 15, 2014. SMT is composed of all College senior management (Directors, Associate Directors and the Registrar). The group meets weekly, and may review draft policies prior their being forwarded to the Executive Committee.

111. SMT recommended that the *Protecting Patient Safety* section of the draft policy, which addressed providing care in emergency situations, be amended to include the word "imminent":

> Physicians must provide care that is urgent or otherwise necessary to prevent <u>imminent</u> harm, suffering, and/or deterioration, even where that care conflicts with their religious or moral beliefs.

The Working Group was advised of the revision suggested by SMT, and did not express any concerns. The Working Group Draft Policy, with the revision proposed by SMT, was then sent to the Executive Committee for consideration.

c) Draft policy approved for external consultation

112. The Executive Committee considered the Working Group Draft Policy, as revised by SMT ("2014 Draft Policy"), at its meeting on November 4, 2014. It was provided with a summary of the research, including the positions of other regulators with regard to the issue of conscientious objection, the feedback received during the preliminary consultation, and the results of the public polling conducted. The Briefing Note considered by the Executive Committee on November 4, 2014, including appendices, is attached as **Exhibit "CC"** to this affidavit.

113. The Executive Committee approved forwarding the 2014 Draft Policy to Council with a recommendation that it be released for external consultation. The Proceedings of the Executive Committee, dated November 4, 2014, are attached to this affidavit as **Exhibit "DD"**.

114. On December 4, 2014, the 2014 Draft Policy was presented to Council. Council voted to engage in an external consultation regarding the draft. The Briefing Note considered by Council, including appendices, is attached to this affidavit as **Exhibit "EE"**. The Council Minutes for December 4 & 5, 2014, are attached to this affidavit as **Exhibit "FF"**.

d) External consultation and outreach

i. Ongoing informal consultation

115. While policies are in development, the College occasionally uses external presentations and events as opportunities to conduct outreach and solicit feedback in addition to, or at times outside of, formal consultation periods.

116. On November 14, 2014, Dr. Marc Gabel engaged in a policy session at the College's annual Chiefs and Presidents Day, an event at which 23 leaders from the College and Ontario hospitals discussed issues of common interest. Dr. Gabel outlined the contents of the College's existing policy, *Physicians and the Ontario Human Rights Code*, and discussed feedback received during the preliminary consultation related to whether physicians should be required to provide referrals. Participants then discussed whether, in their hospitals, there were policies in place to address situations where physicians were unwilling to perform procedures on moral or religious grounds, and how the inclusion of a referral requirement would impact hospital practices. Participants were advised of the upcoming external consultation, and were asked to participate when it took place. The PowerPoint Presentation used at the November 14, 2014, Chiefs and Presidents Day Event is attached to this affidavit as **Exhibit "GG"**.

117. On November 21, 2014, Dr. Gabel conducted a policy session at the annual Future Leaders Day, an event attended by approximately 25 physicians who wish to become involved with the College as peer assessors, opinion providers or committee members. The session was titled "Physicians' Right to Refuse", and was structured as an interactive debate. Participants engaged in a debate exploring the tension that can arise between physician and patient rights in the context of physicians' religious or moral objections to providing medical care or treatment. At the conclusion of the session, Dr. Gabel outlined the review process taking place for the 2008 *Physicians and the Ontario Human Rights Code* policy, and encouraged participants to provide

feedback on the new draft policy when the consultation period launched. The two PowerPoint Presentations used in this session are attached to this affidavit as **Exhibits "HH"** and **"II"**.

ii. External consultation

118. On December 10, 2014, the external consultation was launched. The consultation continued until February 20, 2015. The 2014 Draft Policy which formed the basis of the consultation is attached as Appendix 2 to the Council Briefing Note of December 4, 2014 **(Exhibit "EE")**.

119. Invitations to participate in the consultation were sent by email to a broad range of stakeholders, including the entire College membership and key stakeholder organizations. In addition, a general notice was posted on the College's website and Facebook page, and was announced on Twitter. It was also published in *Dialogue* and *Patient Compass* (formerly *Noteworthy*). Stakeholders were given the option of submitting their feedback in writing, via email or regular mail, via a brief online survey, or by posting comments to a consultation-specific discussion page. The consultation invitations and notices are attached to this affidavit as **Exhibits "JJ"**

120. Stakeholder feedback was posted publicly on the College's website as it was received, throughout the consultation, in accordance with the College's Posting Guidelines. A copy of this written feedback (both letter mail/email and online comments) is attached to this affidavit as **Exhibit "KK"**. The College's Posting Guidelines are attached to this affidavit as **Exhibit "LL"**. A comprehensive report of survey results is attached to this affidavit as **Exhibit "MM"**.

121. I am advised by staff in the Policy department, and I do believe, that, in total, 9262 submissions were received in response to this consultation.[4] This includes 7475 comments either submitted by mail or posted to the online discussion page, and 1787 completed or partially completed online surveys. Of the written responses, 5958 were signatories to form letters received by mail or email. Approximately 89% of responses were from members of the public, 6% from physicians, 4% from "other" or "anonymous" and 0.4% from organizations. An alphabetical list of organizational respondents, prepared by Policy staff in October 2016, is attached to this affidavit as **Exhibit "NN"**. In addition, list of organizations which completed the survey, prepared by Policy staff in October 2015, is attached to this affidavit as **Exhibit "OO".**

122. The majority of consultation respondents indicated that the 2014 Draft Policy clearly articulated physicians' legal obligations under the Ontario *Human Rights Code*, and the College's expectations of physicians who limit the health services they provide due to clinical competence, or due to their personal values and beliefs. As in the preliminary consultation, the feedback focused predominantly on the section of the draft policy addressing the College's expectations in circumstances where physicians limit the services they provide on moral or religious grounds. The majority of consultation respondents expressed the view that physicians should not have to provide services that conflict with their moral and/or religious beliefs. A minority of consultation respondents argued the opposite perspective: that patient access to care should not be impacted by an individual physician's moral and/or religious beliefs.

123. The feedback relating to limiting health services for reasons related to moral or religious beliefs can be summarized as follows:

[4] An audit conducted by Policy staff in September 2016 showed that the number reported in 2015 (9287 submissions) was incorrect.

124. Respecting Patient Dignity: Several respondents expressed concern with the draft policy requirement that physicians who are unwilling to provide certain elements of care due to their moral or religious beliefs inform their patients that the objection is due to personal and not clinical reasons. Respondents who expressed this concern argue that a clear line cannot be drawn between the two.

125. Ensuring Access to Care: The majority of consultation respondents were opposed to the requirement to provide an effective referral, which they articulated as being morally equivalent to providing the treatment/procedure in question. Some respondents recommended that the effective referral requirement in the draft policy be expanded to permit referrals to an agency or resource. The prospect of referring to an agency was considered more palatable to some, from a moral perspective, as compared to providing a referral to an individual physician/health care provider. Several respondents were of the opinion that a referral should not be necessary where a treatment/procedure is publically available and accessible by self-referral. Respondents also recommended that the draft policy include examples of an effective referral, particularly what is meant by an "available" and "accessible" physician or other health-care provider.

126. Protecting Patient Safety: Many respondents expressed concern with the requirement in the draft policy that physicians provide care that is urgent or otherwise necessary to prevent imminent harm, suffering, and/or deterioration, even where that care conflicts with their religious or moral beliefs. Those respondents felt the scope of this requirement was overbroad. Respondents recommended that further detail around the degree/type of harm, suffering and/or deterioration that would trigger this requirement be included in the draft policy.

127. The OHRC provided feedback during the external consultation. It expressed approval for the 2014 Draft Policy, stating that the policy "better reflects the legal principles set out in decisions by the courts and in the OHRC's Policy on Competing Human Rights." The OHRC further stated:

> More specifically, the CPSO's draft policy will help physicians understand the scope of their legal obligations under Ontario's Human Rights Code, and sets out the CPSO's expectation that physicians will respect the fundamental rights of those who seek their medical services. At the same time, it acknowledges a physician's right to freedom of conscience and religion. The draft policy recognizes that no right is absolute; the core of a right is more protected than the periphery; rights can be limited by the rights and freedoms of others; and that the aim is to respect the importance of both sets of rights. The draft policy effectively strives to achieve this balance of rights.

The letter from the OHRC to the College, dated February 19, 2015, is attached to this affidavit as **Exhibit "PP"**.

128. The College of Physicians & Surgeons of Alberta ("CPSA") also provided feedback during the formal external consultation. The CPSA stated that it "strongly support[ed]" the draft policy. The letter from the CPSA to the College, dated February 19, 2015, is attached to this affidavit as **Exhibit "QQ"**.

129. A positive response was also received from the Sherbourne Health Centre, Rainbow Health Ontario and the LGBTQ Parenting Network, organizations with many years' experience advocating for the elimination of discrimination against the LGBTQ community. These organizations explicitly supported the effective referral requirement in the draft policy. Their joint submission is attached to this affidavit as **Exhibit "RR".**

130. The College received further positive feedback regarding its inclusion of the "effective referral" requirement from a team of leading academics in the areas of health care ethics and law, who had received a grant from the Canadian Institutes of Health Research to investigate the permissibility of conscientious refusals by health care professionals to provide health care services. The team was led by Principal Investigator Dr. Carolyn McLeod, a Professor in the Department of Philosophy at Western University, who has published widely on ethical issues concerning women's reproductive health and on conscientious refusals by health care professionals, and included as cosignatories Francoise Baylis, a Professor and Canada Research Chair in Bioethics and Philosophy at Dalhousie University, and Jocelyn Downie, a Professor in the Faculties of Law and Medicine at Dalhousie University and Fellow of both the Royal Society of Canada and the Canadian Academy of Health Sciences. The team led by Dr. McLeod conducted research on the nature and value of conscience; the impact that conscientious refusals can have on patients, especially women, who are denied care; and moral and legal limits on permissible refusals. In 2013, Dr. McLeod et. al. published a model policy on conscientious refusals, entitled "Moving Forward With a Clear Conscience: A Model Conscientious Objection Policy for Canadian Colleges of Physicians and Surgeons", which attached to this affidavit as **Exhibit "SS"**.

131. The team led by Dr. McLeod provided feedback both during the preliminary consultation on the *Physicians and the Ontario Human Rights Code* policy in August 2014 and during the consultation on the 2014 Draft Policy in February 2015. In their submission regarding the 2014 Draft Policy they stated that they were "pleased that the draft Policy includes the requirement that physicians who refuse to provide access to services, goods and facilities because of their moral or religious beliefs provide "effective referrals." The submissions of Dr. McLeod et. al. to

the preliminary consultation and the consultation on the 2014 Draft Policy are attached to this affidavit as **Exhibit "TT"**.

e) Revision and approval of policy

132. Staff in the Policy Department reviewed the consultation feedback as it was received. Although a large number of responses were received, the feedback was thematically consistent with feedback received in the preliminary consultation addressing the same themes or variations on the themes outlined above. A summary of the feedback was presented to the Working Group at its January 19, 2015 meeting. The Working Group discussed the feedback received and decided to make revisions in response to the feedback. The Working Group also discussed the list of topics to be covered in a "frequently asked questions" ("FAQ") document to be prepared in respect of the policy. The following documents and presentations were before the Working Group on January 19, 2015, and are attached as exhibits to this affidavit:

- Human Rights Consultation Feedback: Key Themes (**Exhibit "UU"**)
- PowerPoint Presentation: Human Rights Working Group: Feedback: Formal Consultation (**Exhibit "VV"**)

133. At its meeting on January 19, 2015, the Working Group decided to implement the following revisions to the 2014 Draft Policy:

- A footnote was added to the Clinical Competence section of the policy. The footnote indicates that, in keeping with the College's *Accepting New Patients* policy, physicians must not use clinical competence or scope of practice as a means of unfairly refusing patients with complex health care needs or patients who are perceived to be otherwise difficult; and
- The requirement that physicians provide care that is urgent or otherwise necessary to prevent imminent harm, suffering, and/or deterioration, even where that care conflicts

with their religious or moral beliefs, was revised. This language was narrowed to clearly signal that the requirement applies only in emergency situations.

134. In consideration of the concerns of those who objected to the effective referral requirement, the Working Group clarified this section of the policy to indicate that physicians who refer a patient to an agency that would co-ordinate and/or provide the treatment/service to which the physician objected would meet the requirement for an effective referral. However, it decided it was important to maintain the requirement for an effective referral, which in its view lay at the core of the physician's professional obligations.

135. Throughout the policy review process, the Working Group considered the feedback of those opposed to the requirement of an effective referral, and considered whether any alternatives to that requirement would achieve the Working Group's objectives. The Working Group first considered whether it could retain the section of the 2008 *Physicians and the Ontario Human Rights Code* policy dealing with moral and religious beliefs. The Working Group concluded that this would not sufficiently protect patient access to care. The 2008 policy did not clearly articulate the type of conduct or positive action the College expected from physicians who asserted a conscientious objection. The Working Group believed that in the absence of a clear articulation of the physician's duty of non-abandonment, there was a real risk that patients would be left without access to the health care services to which they were entitled, and the goals of the policy would be frustrated.

136. Another option the Working Group explored was requiring patients to assume responsibility for finding a non-objecting physician, for example, through a "self-referral" approach. The Working Group concluded this option was not acceptable given that the policy was intended to apply to a range of services provided by physicians across the province. Very

few procedures can be accessed directly by the patient, without a referral from a physician. The self-referral model also did not account for the experiences of patients in smaller, non-urban settings, who may have difficulty identifying a non-objecting physician given the limited range of providers or options for accessing care. The Working Group was also concerned about the impact of requiring self-referral on the population generally, given the disproportionate burden it would impose on vulnerable and marginalized groups, including the homeless, mentally ill individuals and individuals dealing with addiction, and individuals with linguistic or cultural barriers. The Working Group concluded that the "self-referral" option unfairly and inappropriately imposed on patients the burden of managing a physician's conscientious objections.

137. The Working Group further considered whether, instead of "requiring" an effective referral, it could simply "advise" or "recommend" that physicians make an effective referral, or whether it could require physicians to provide a referral only "when necessary". The Working Group rejected this option, reasoning that if permissive language such as "advise" or "recommend" were used in relation to an effective referral, objecting physicians would interpret the policy language as signalling that an effective referral was entirely optional, and the decision as to whether or not to provide an effective referral was at their own discretion. The Working Group was concerned that this permissive language would therefore result in objecting physicians not providing an effective referral, thereby frustrating the Working Group's objectives. The Working Group's assessment of this option was directly informed by the College's extensive experience both in policy development in general, and with implementation of the 2008 *Physicians and the Ontario Human Rights Code* policy in particular. In the College's experience, if policy expectations are not stated using mandatory language such as "must" or

"require", some physicians will conclude that compliance is optional. Likewise, requiring referrals only "when necessary" left it up to the physician's sole discretion to decide whether a referral was necessary, and would create a risk that patients would not receive the required referral. Further, the Working Group felt that physicians are often not in the position to know whether a referral is necessary, in the circumstances of a particular patient, to ensure that the patient receives access to care. The Working Group was therefore concerned that requiring effective referrals only "when necessary" would unfairly impact patients, as whether a patient received an effective referral would depend not on their need for a referral, but on whether their physician chose to provide one.

138. Although the Working Group elected to retain the requirement for an effective referral, it did change the definition of "effective referral", in response to stakeholder feedback. The 2014 Draft Policy stated that an effective referral must be made to a physician or health care provider. Based directly on consultation feedback, the Working Group changed the policy to reflect that an effective referral could also be made to an agency, which some stakeholders had indicated was more compatible with their conscience or religious beliefs.

139. The Working Group concluded that providing an effective referral to an agency in addition to either a physician or health care provider would be acceptable. However, the Working Group felt it was important to include all three receptors to an effective referral (physician, health care provider and agency), as it reasoned that agencies do not exist to coordinate referrals for all health care services, and they do not provide services in all communities, particularly in rural or Northern Ontario. In the view of the Working Group, it was imperative that the College's policy response to physicians' assertion of a conscientious objection ensure that all Ontario patients would receive an effective referral and thereby access

to health care services, and that no patients would be abandoned based solely on their place of residence or the type of care they required.

140. Ultimately the Working Group concluded that the possible alternatives to the requirement of an effective referral did not meet the objectives of ensuring patient access to care, did not account for the realities of clinical practice, and would not reflect the expectations of the public or the values of the profession, including the fiduciary duty physicians owe to patients. The Working Group was of the opinion that the effective referral requirement struck an appropriate balance between physician and patient rights, while ensuring patient access to care was not impeded. Further, the Working Group noted that the public polling conducted to capture public sentiment on conscientious objection (the results of which are discussed above) indicated that the vast majority of Ontarians (87%), including individuals who identified as religious, supported a referral requirement.

141. The Working Group also decided to maintain the expectation that physicians are required to provide emergency care where it is necessary to prevent imminent harm, even where the care conflicts with their conscience or religious beliefs The Working Group felt this expectation was an important element needed to ensure patient safety, and recognized that the policy requirement was sufficiently narrow as to only require physicians to act and provide care when patient health and safety were in jeopardy.

142. The Working Group forwarded the revised draft ("Revised Draft Policy") to the Executive Committee for consideration. At its meeting of February 3, 2015, the Executive Committee was provided with a summary of the feedback received to date. The Executive Committee recommended that the Revised Draft Policy be forwarded to Council for final

approval. In making the recommendation to forward the Revised Draft Policy to Council, the Executive Committee agreed with the opinion of the Working Group that the "effective referral" requirement should be maintained, as it appropriately reflected physicians' professional obligations, including the fiduciary duty owed to patients, and that the Revised Draft Policy struck an appropriate balance between physician and patient rights, while ensuring that patient access to care is not impeded. The Briefing Note (including appendices) considered by the Executive Committee at its February 3, 2015 meeting is attached to this affidavit as **Exhibit "WW"**. The Executive Committee Minutes are attached to this affidavit as **Exhibit "XX"**.

143. On March 6, 2015, the Revised Draft Policy was brought forward to Council for final approval. The presentation to Council outlined the new expectations set out in the Revised Draft Policy, in particular the requirement that objecting physicians provide patients with an effective referral to another physician, healthcare provider or agency, and the requirement that physicians provide care in an emergency that is necessary to prevent imminent harm. An "effective referral" was defined as meaning one that is made in good faith, to a non-objecting, available and accessible healthcare provider. Council was also presented with a companion FAQ document, which outlined how to satisfy the "effective referral" requirement and clarified the circumstances that would require physicians to provide emergency treatment, even if the care is contrary to physicians' conscience or religion.

144. The presentation to Council provided a summary of the consultation feedback, including feedback that was received following the Executive Committee meeting up to the consultation deadline of February 20, 2015. Specifically, Council was informed of the key themes expressed by stakeholders with respect to conscientious objection and the effective referral requirement, and the responses received from the Ontario Human Rights Commission (in support of the

policy) and the Ontario Medical Association (which called for a retraction of the policy). In addition, Council was presented with the results of the public opinion poll commissioned by the College and the jurisdictional review. The Briefing Note, with appendices, is attached to this affidavit as **Exhibit "YY"**. The PowerPoint Presentation presented to Council, including draft speaking notes, is attached to this affidavit as **Exhibit "ZZ"**.

145. Council voted to approve the Revised Draft Policy as a policy of the College, entitled *Professional Obligations and Human Rights,* by a vote of 23 in favour and 3 against. The Council Minutes are attached to this affidavit as **Exhibit "AAA"**.

f) Publication of *Professional Obligations and Human Rights* policy

146. Following Council's approval of the *Professional Obligations and Human Rights* policy, the new policy was published on the College website and in *Dialogue*. The companion FAQ document was posted to the College website. The published version of the *Professional Obligations and Human Rights* policy is attached as Appendix B to **Exhibit "AAA"**. The companion FAQ document is attached to this affidavit as **Exhibit "BBB"**.

147. The new policy was promoted in *Dialogue*, *Patient Compass* and *Council Update*. The articles from *Dialogue* and *Patient Compass* are attached to this affidavit as **Exhibits "CCC"** and **"DDD".** The *Council Update* is included in the Applicants' Application Record as **Exhibit "D" to the affidavit of Larry Worthen** (vol. 3, p. 531).

148. On June 6, 2016, the Executive Committee approved publication of a Fact Sheet developed by the Policy Department, entitled "Ensuring Access to Care: Effective Referral" ("Fact Sheet"). The Fact Sheet was prepared at the direction of the working group responsible for the development of the College's *Medical Assistance in Dying* policy. The Fact Sheet provided

further information on what is meant by an "effective referral" and provided guidance on the steps that physicians must take in making an effective referral. It also provided examples of ways in which a physician can satisfy the effective referral requirement, and invited physicians to contact the College's Physician Advisory Services for advice on specific situations. The Fact Sheet was developed as a companion document to both the *Physician Assisted Death* policy (replaced on June 21, 2016 by the *Medical Assistance in Dying* policy) and the *Professional Obligations and Human Rights* policies. It was published on the College website, including as a reference on the Policy webpages dedicated to both policies. The Fact Sheet is attached to this affidavit as **Exhibit "EEE"**. The Minutes of Proceeding of the Executive Committee for June 6, 2016, are attached to this affidavit as **Exhibit "FFF"**.

V. Current Policies of Other Canadian and Ontario Regulators

149. In October 2016, staff in the Policy Department reviewed the websites of Canadian medical regulators and several Ontario regulated health colleges to identify the policies that were currently in place governing the issue of conscientious objection in the context of health care services generally (as opposed to specific policies dealing with Medical Assistance in Dying). Staff advised me, and I do believe, that the medical regulatory authorities of British Columbia, Alberta, Saskatchewan, Manitoba, Quebec, New Brunswick, Prince Edward Island and the Yukon have policies in place governing this issue, as do the Ontario Colleges of Pharmacists, Nurses and Midwives. Policy staff were unable to find any specific policies in place to deal with conscientious objections to provision of health care services generally at the medical regulatory authorities in Nova Scotia, Newfoundland and Labrador, the Northwest Territories and Nunavut.

150. Staff advised me, and I do believe, that the policies of the Colleges of Physicians and Surgeons of British Columbia, Quebec and New Brunswick, and the policy of the Ontario College of Nurses, remain the same as those in effect at the time the College's *Professional Obligations and Human Rights* policy was adopted. These were reviewed during the development of the College's policy in 2014/2015, and are attached as **Exhibit "S" to this affidavit** and **Exhibit "J" to the affidavit of Larry Worthen**. These documents are entitled as follows:

- British Columbia – *Professional Standards and Guidelines: Access to Medical Care*;
- Quebec – *Code of Ethics of Physicians*;
- New Brunswick – *Guideline: Moral Factors and Medical Care*;
- Ontario College of Nurses – *Practice Standard: Ethics.*

151. Staff advised me, and I do believe, that the Colleges of Physicians and Surgeons of Alberta, Saskatchewan, Manitoba and Prince Edward Island; the Yukon Medical Council; and the Ontario Colleges of Midwives have adopted new or revised policies on this issue, subsequent to the College's adoption of the *Professional Obligations and Human Rights* policy. In addition to updating its *Code of Ethics,* the Ontario College of Pharmacists also adopted a new guideline dealing with conscientious objections specifically, to supplement the existing provisions in its *Code of Ethics*. These documents are attached as exhibits to either this affidavit, or the affidavit of Larry Worthen, as follows:

- Alberta – *Standard of Practice: Conscientious Objection* (**Exhibit "GGG" to this affidavit**);
- Saskatchewan – *Policy: Conscientious Objection* (**Exhibit "J" to the affidavit of Larry Worthen**);

- Manitoba – *By-Law 11: Standard of Practice: Conscience-Based Objections* **(Exhibit "GGG" to this affidavit)**;
- Prince Edward Island – *Policy: Conscientious Objection* **(Exhibit "GGG" to this affidavit)**;
- Yukon – *Moral or Religious Beliefs Affecting Medical Care* **(Exhibit "GGG" to this affidavit)**
- Ontario College of Midwives – *Code of Ethics* **(Exhibit "GGG" to this affidavit)**
- Ontario College of Pharmacists:
    - *Code of Ethics* **(Exhibit "GGG" to this affidavit)**
    - *Guideline: Professional Obligations when Declining to Provide a Pharmacy Product or Service due to Conscience or Religion* **(Exhibit "GGG" to this affidavit)**

152. I have reviewed the policies currently in place in other Canadian provinces and territories. These policies take different approaches to physicians' objections to providing care or treatment on the basis of conscience or religion. Although the wording of the policies in each province/territory differs, the policies, generally, have consistent overarching principles and goals: that physicians have a duty not to abandon their patients, that they should ensure patients receive continuity of care, and that physicians must act in a manner that facilitates patient access to legally available health care services. Several require that physicians provide patients with a referral to a colleague, or, stated alternatively, that physicians take positive action to connect the patient with a willing care provider.

153. Like Ontario, Quebec explicitly requires that the physician connect the patient with a willing care provider. Quebec's *Code of Ethics of Physicians*, s. 24, states:

A physician must, where his personal convictions prevent him from prescribing or providing professional services that may be appropriate, acquaint his patient with such convictions; he must also advise him of the possible consequences of not receiving such professional services.

The physician must then offer to help the patient find another physician.

154. Alberta's *Standard of Practice: Conscientious Objection* states:

When Charter freedom of conscience and religion prevent a regulated member from providing or offering access to information about a legally available medical or surgical treatment or service, the regulated member must ensure that the patient who seeks such advice or medical care is offered timely access to:

a) a regulated member who is willing to provide the medical treatment, service or information; or

b) a resource that will provide accurate information about all available medical options.

155. New Brunswick's *Guideline: Moral Factors and Medical Care*, Prince Edward Island's *Policy: Conscientious Objection to Provision of Service*, and the Yukon's *Standard of Practice: Moral or Religious Beliefs Affecting Medical Care*, are identical and state:

1. A physician must communicate clearly and promptly about any treatments or procedures the physician chooses not to provide because of his or her moral or religious beliefs.

2. A physician must not withhold information about the existence of a procedure or treatment because providing that procedure or giving advice about it conflicts with their moral or religious beliefs.

3. A physician must not promote their own moral or religious beliefs when interacting with patients.

4. When moral or religious beliefs prevent a physician from providing or offering access to information about a legally available medical or surgical treatment or service, that physician should ensure that the patient who seeks such advice or medical care is offered

timely access to another physician or resource that will provide accurate information about all available medical options.

156. As noted above, when the College's Registrar, Dr. Gerace, contacted Canadian medical regulatory authorities in March 2015 to inquire about their policies on conscientious objection, Alberta and New Brunswick both indicated that they interpreted their policies as requiring physicians to make a referral to a colleague, in the face of a conscientious objection.

157. Finally, Saskatchewan's *Policy: Conscientious Objection* states:

> Physicians can decline to provide legally permissible and publicly-funded health services if providing those services violates their freedom of conscience. However, in such situations, they must:
>
> a) make an arrangement for the patient to obtain the full and balanced health information required to make a legally valid, informed choice about medical treatment as outlined in paragraph 5.2; and,
>
> b) make an arrangement that will allow the patient to obtain access to the health service if the patient chooses.
>
> Those obligations will generally be met by arranging for the patient to meet with another physician or other health care provider who is available and accessible and who can either provide the health service or refer that patient to another physician or health care provider who can provide the health service.

158. I have also reviewed the policies in place at the Ontario Colleges of Pharmacists, Nurses and Midwives. These Colleges have stringent guidelines in place requiring that an objecting member arrange for the patient/client to receive access to a non-objecting member.

159. The *Code of Ethics* of the Ontario College of Pharmacists, s. 2.13, states:

> Members must, in circumstances where they are unwilling to provide a product or service to a patient on the basis of moral or religious grounds, ensure the following:

i. that the member does not directly convey their conscientious objection to the patient;

ii. that the member participates in a system designed to respect the patient's right to receive products and services requested;

iii. that there is an alternative provider available to enable the patient to obtain the requested product or service, which minimizes inconvenience or suffering to the patient.

160. The College of Pharmacist's *Guideline: Professional Obligations when Declining to Provide a Pharmacy Product or Service due to Conscience or Religion* that members must not impede a patient's access to care. The obligation to ensure that there is an alternative provider available to the patient means that "an effective referral meaning, a referral made in good faith, to a non-objecting, available, and accessible alternate provider in a timely manner must be provided to the patient."

161. The Ontario College of Nurses *Practice Standard: Ethics* states, at p. 6:

> When a client's wish conflicts with a nurse's personal values, and the nurse believes that she/he cannot provide care, the nurse needs to arrange for another caregiver and withdraw from the situation.
>
> If no other caregiver can be arranged, the nurse must provide the immediate care required. If no other solution can be found, the nurse may have to leave a particular place of employment to adhere to her/his personal values.

162. The Ontario College of Midwives *Code of Ethics* states that midwives must:

8. Openly acknowledge to clients and health care practitioners any conscientious objection or conflict of interest, which may affect professional practice or the client's right to informed choice.

9. Consult or transfer care in accordance with the standards of practice of the profession.

10. Assist clients to find appropriate alternate care if for any reason the midwife is unable to provide care.

11. Attempt to provide the best possible care under any circumstance. A midwife may not refuse to attend or abandon a client in active labour.

163. I have also reviewed information, and do believe, that the American College of Cardiology (ACC), the American Geriatrics Society (AGS), the American Academy of Hospice and Palliative Medicine (AAHPM); the American Heart Association (AHA), the European Heart Rhythm Association (EHRA), and the Hospice and Palliative Nurses Association (HPNA) have all endorsed a statement adopting principles very similar to the College's requirement that physicians provide an effective referral, if they assert a conscientious objection to providing care or treatment. This information is contained in a document titled *HRS Expert Consensus Statement on the Management of Cardiovascular Implantable Electronic Devices (CIEDs) in patients nearing end of life or requesting withdrawal of therapy* (the "Consensus Statement"), which is attached to this affidavit at **Exhibit "HHH"**.

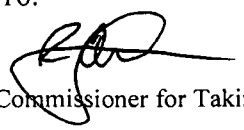
164. The Consensus Statement outlines the rights and responsibilities of physicians, nurses and other health care providers ("clinicians") when participating in the deactivation of a dying patient's Cardiovascular Implantable Electronic Device ("CIED" – this includes devices such as a pacemaker or implantable defibrillator). The Consensus Statement outlines the legal, ethical and religious principles which underlie withdrawal of life-sustaining therapies, including device deactivation, in patients who have made this decision and provides a management scheme to guide clinicians in assisting a patient who has made such a request.

165. The Consensus Statement deals with the religious and moral objections of clinicians to participating in device deactivation, at p. 1013. Like the College's *Professional Obligations and*

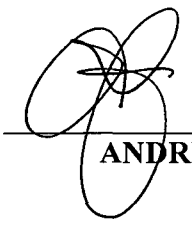
Human Rights policy, the Consensus Statement indicates that clinicians should not be compelled to carry out the medical treatment they object to (in this case, device deactivation). If this is the case:

> [T]he clinician should inform the patient of his/her preference not to perform CIED deactivation. However, as described in the AMA code of ethics, the clinician should not impose his/her values on the patient, and must state their objection in a way to avoid causing the patient emotional distress. Further, s/he must not abandon the patient, but rather, the clinician and patient should work to achieve a mutually agreed-upon care plan. If such a plan cannot be achieved, then the primary clinician should involve a second clinician who is willing to comanage the patient and provide legally permissible care and procedures including CIED deactivation. If there is difficulty identifying another clinician, the hospital administration and/or ethics committee should be contacted to help identify a willing clinician and resolve the issue.

SWORN before me at the City of Toronto, in the Province of Ontario, this 18th day of October, 2016.)



A Commissioner for Taking Affidavits, etc.



ANDRÉA FOTI