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Submission to the College of Physicians and Surgeons of Saskatchewan

Re: *Conscientious Refusal*

5 March, 2015

Abstract

The policy *Conscientious Refusal* requires all physicians who object to a procedure for reasons of conscience to facilitate the procedure by referring patients to a colleague who will provide it, even if it is homicide or suicide. No evidence was provided to justify the policy. None of the arguments provided to Council justify the policy, nor do the principles included in the text.

Conscientious Refusal fails to recognize that the practice of medicine is a moral enterprise, that morality is a human enterprise, and that physicians, no less than patients, are moral agents.

The original text virtually copied by *Conscientious Refusal* was written by believers: by people who believe that whatever is "legally permissible and publicly-funded" is morally acceptable- including euthanasia, assisted suicide and abortion. It is an assertion of those beliefs and an authoritarian attempt to compel others to conform to them. It is a partisan document that is profoundly disrespectful of the moral agency of physicians, not a compromise.

Conscientious Refusal advances the dangerous idea that a learned or privileged class, a profession or state institutions can legitimately compel people to do what they believe to be wrong and punish them if they refuse. This is not a limitation of fundamental freedoms, but a serious violation of human dignity. It is also incoherent, because it posits the existence of a moral or ethical duty to do what one believes to be wrong.

The Associate Registrar has made it clear that those who refuse to do what the policy demands will be disciplined by the College or forced out of the medical profession. This clashes seriously with the approach taken by the Supreme Court of Canada, which has affirmed that public policy must make room for physicians whose “concept of the good life” precludes their participation in abortion, euthanasia, assisted suicide or other morally contested procedures.

The burden of proof was on the Associate Registrar and the appointed committee to prove beyond doubt that *Conscientious Refusal* is justified and that no less authoritarian alternatives are available. They failed to discharge that burden; neither has College Council discharged it. The policy should be withdrawn.

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I. Origin of the draft policy, *Conscientious Refusal*

I.1 The text of the draft policy, *Conscientious Refusal,* originates in a model conscientious objection policy drafted by members of the Conscience Research Group (CRG). The Group includes euthanasia/assisted suicide and abortion activists who are determined to force physicians who are unwilling to provide abortions, kill patients or help them commit suicide to find a colleague willing to do so. Having been unable to convince the Canadian Medical Association to adopt such a policy, they decided to convince provincial regulatory authorities to impose it (Appendix "A").

I.2 It appears that Saskatchewan Associate Registrar Bryan Salte was among the participants at a meeting convened by the Conscience Research Group in 2013 to further this objective. The proposed CRG policy was presented and discussed. Mr. Salte left the meeting with the text agreed upon by meeting participants, almost an exact duplicate of what the CRG published later in 2013 as its *Model Conscientious Objection Policy* (MCOP) (Appendix "B", BII.).

I.3 Subsequently, Mr. Salte appears to have taken on the project of convincing regulatory authorities to adopt what he called the "draft policy statement developed by the Conscientious Objections Working Group."

I.4 Mr. Salte appears to have led discussion of the subject at a meeting of the Registrars of British Columbia, Alberta, Saskatchewan, Manitoba and Ontario on 5 May, 2014. He said that there seemed to be a "consensus" among the Registrars that provincial Colleges should consider adopting the policy (Appendix "B", BIII). Two months later he wrote to all of the Registrars of Colleges of Physicians in Canada, providing them with a copy of it and urging them to do just that. He advised them that Saskatchewan's College Council would be considering the policy at its upcoming meeting (Appendix "B", BV). The Council was not meeting until September, so it is not certain that, at the time Mr. Salte wrote to the other Colleges, Council members were aware of what he had in store for them.

I.5 Making explicit reference to the possibility of the legalization of physician assisted suicide, and explicitly acknowledging that the subject was potentially "very controversial," Mr. Salte urged all Canadian Registrars to adopt a uniform policy - obviously, the one he was proposing to them, or one much like it. He argued that this was necessary to ensure that no College was placed in the difficult position of being an "outlier" on such a controversial subject (Appendix "B", BV).

I.6 Since the policy he was proposing would require physicians unwilling to kill patients or help them commit suicide to help find a colleague willing to do the killing, it seems obvious that his intention was to make this the ethical standard for medical practice throughout Canada. In the face of the historic opposition of the Canadian Medical Association and the controversy attending demands for compulsory referral, it is not surprising that Mr. Salte seems to have adopted the CRG strategy of suppressing opposition by a unilateral and monolithic exercise of regulatory power.

I.7 College Council discussed the memo provided by Mr. Salte at its September, 2014 meeting. The memo included a draft policy virtually identical to the CRG's *Model Conscientious Objection Policy.* (Appendix "B", Note 6)

I.8 It is significant that Mr. Salte took care to avoid identifying the Conscience Research Group as the ultimate source of the policy. Instead, he identified the participants in the meeting noted in I.2 as "the Conscientious Objections Working Group" - "a group that was formed with a grant to study and provide recommendations to Canadian Colleges of Physicians and Surgeons" concerning physician conscientious objection.[1] This was at least a misleading oversimplification, if not a misrepresentation.

I.9 The committee formed to study the question met once, and no minutes were kept. The committee added a sentence to *Conscientious Refusal* that warns physicians not to promote their moral or religious beliefs, and deleted references to discipline and complaints they considered superfluous. For the rest, the few textual differences that exist between *Conscientious Refusal* and MCOP are not significant (Appendix "A"). On 20 January, Council approved the policy in principle and authorized external consultation.

II. Content of the proposed policy

II.1 Conscientious Refusal is divided into several sections. The two sections of concern are "Principles" and "Obligations."

II.2 Under "Principles" one finds broad statements that purport to provide the foundation for the obligations that follow. However, some of the principles and some of the terminology used serves no purpose apart from providing a rhetorical pretext for the coercive and tendentious elements found later in the policy, and are, moreover, misleading with respect to the obligations of physicians.

II.3 The Obligations include some commonplace duties that are uncontroversial, others that require qualification if they are to be broadly acceptable, and purported obligations that are advanced in order to force objecting physicians to do what they believe to be wrong. These are disputed, and are the focus of this submission.

III. Focus of this submission

III.1 This submission focuses on two passages in *Conscientious Refusal*:

> **5.3 Providing referrals for health services**
> 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 make a timely referral to another health care provider who is willing and able to accept the patient and provide the service.
>
> **5.4 Treating patients**
> When a referral to another health care provider is not possible without causing a delay that would jeopardize the patient's health or well-being, physicians must provide the patient with all health services that are legally permissible and

> publicly-funded and that are consented to by the patient or . . . substitute decision maker. This obligations holds even in circumstances where the provision of health services conflicts with physicians' deeply held and considered moral or religious beliefs.

III.2 During an interview in February, 2015, Mr. Salte confirmed that, if the policy is adopted, physicians will be expected to do what they believe to be wrong, including referral for assisted suicide (Appendix "C", CIII.4). He made it clear that, if the policy is approved, physicians unwilling to comply could face discipline, including cancellation of their licenses to practice, since refusing to arrange for a colleague to help a patient commit suicide would be considered "unacceptable or unprofessional" (Appendix "C", CV.I).

III.3 This is a dangerous and extraordinarily authoritarian policy that is completely at odds with liberal democratic aspirations and Canadian traditions. The burden of proof was on Mr. Salte and the appointed committee to prove beyond doubt that it is justified and that no reasonable alternatives to the policy are available.

IV. Justification for the proposed policy

IV.1 Taking note of controversial ethical issues like abortion, contraception, assisted suicide, fetal sex selection and genetic testing, Mr. Salte observed that strong views "from different perspectives" had been expressed during a consultation underway in Ontario about *Physicians and the Human Rights Code*. He then asserted that the draft policy had the support of the Registrars of B.C., Alberta, Manitoba and Ontario.

> My perspective is that if there can be a consistent position across Canada, it will greatly help in addressing this difficult issue, which many people feel very strongly about.
>
> As a member of the conscientious objections working group which developed the recommendations I am not unbiased. However, I think that a document which generally follows what is in the document would be useful to establish expectations for physicians and guidance to the College when it deals with physicians who have ethical or moral objections to providing certain forms of care.[2]

IV.2 The argument was supported by a newspaper article quoting an ethicist who claimed that objecting physicians are obliged to refer for morally contested services (Appendix "B", BVI.3) and a paper from a professional journal reporting the results of a survey of opinions of 154 physicians in a Wisconsin faculty of medicine (Appendix "B", BVI.4).

IV.3 Mr. Salte also provided the newspaper article about the Calgary physician who was refusing to prescribe contraceptives, apparently as evidence supporting the argument. The article did not make clear that no patient had been denied contraception or had been unable to obtain it, and concluded with a sentence erroneously implying that the Alberta College of Physicians had a policy requiring objecting physicians to refer for morally contested procedures (Appendix "B", BIV).

IV.4 Attachments to the memo included policies of the Ontario,[3] Alberta[4] and Manitoba[5] Colleges of Physicians and the Saskatchewan College policy on Unplanned Pregnancy.[6] He extracted two sections of the Saskatchewan policy and highlighted them in the memo:

> Any physician who is unable to be involved in the further care and management of any patient when termination of the pregnancy might be contemplated should inform the patient and make and expeditious referral to another available physician.
>
> 5) Will fully apprise the patient of the options she may pursue and provide her with accurate information relating to community agencies and services that may be of assistance to her in pursuing each option.[7]

IV.5 The documents and quotes noted in IV.4 could create the impression that a policy of mandatory referral by objecting physicians existed elsewhere and was already the policy of the College in Saskatchewan with respect to abortion.

IV.6 Contrary to the impression that may have been created by Mr. Salte's memo, the policies he provided do not require an objecting physician to refer a patient to a colleague who will provide a morally contested service (Appendix "D", "E"). In this regard, it is disturbing to find that Mr. Salter later publicly made this claim, which is false (Appendix "C", CIII.1, CIII.1-note).

IV.7 Discounting the policies noted in IV.4, the argument and evidence presented by Mr. Salte can be summarized as follows.

Since

- people have strongly held ethical or moral convictions about killing developing infants *in utero*, helping people to commit suicide, killing fetuses for reasons of sex, genetic testing and provision of contraception; and
- by virtue of their strong convictions, some physicians are unwilling to do such things or to arrange for them to be done because they consider them evil, even if legal; and
- other people of equally strong convictions want physicians made to provide these services or arrange for them because they are legal, and are upset if they refuse; and
- less than half of physicians surveyed in a Wisconsin University believe that objecting physicians have an obligation to refer for morally contested procedures, and a Canadian ethicist agrees; and
- participants in closed meetings held in 2013 and 2014 also think physicians unwilling to provide morally contested services for reasons of conscience should be forced to facilitate them by referral or other means; and
- it is administratively prudent for regulators to adopt a uniform and consistent policy across the country;

therefore,

- physicians unwilling to kill developing infants *in utero*, kill people or help them to commit suicide, kill fetuses for reasons of sex, or unwilling to provide any other legal service for reasons of conscience are ethically obliged to help to arrange for the services to be provided by someone else, and should be punished if they refuse.

Hence, the policy *Conscientious Refusal* is justified.

IV.8 As noted in II, the policy includes principles that purport to justify the obligations *Conscientious Refusal* would impose.

IV.9 There is no indication that the Council had before it or asked for any other arguments, reasons or evidence before it when it approved *Conscientious Refusal* in principle. However, Mr. Salte subsequently claimed that the policy was a compromise (Appendix "C", CV.4).

V. The issues

V.1 Does the proposed policy adversely affect freedom of conscience or religion?

V.2 If the policy adversely affects freedom of conscience or religion, is it, nonetheless, justified by evidence provided to Council?

V.3 If the policy adversely affects freedom of conscience or religion, is it, nonetheless, justified by the arguments provided to Council?

V.4 If the policy adversely affects freedom of conscience or religion, is it, nonetheless, justified by the principles included in the policy?

V.5 Is the policy a compromise?

VI. Response to the issues

VI.1 Does the proposed policy adversely affect freedom of conscience or religion?

VI.1.1 To the extent that the policy requires some physicians to do what they believe to be wrong, the policy *Conscientious Refusal* adversely affects freedom of conscience or religion.

VI.1.2 Killing patients, helping patients commit suicide, and the killing of infants developing *in utero* are understood to be the subject of significant moral and ethical disagreement, both inside and outside the medical profession. While these procedures generate the most notable disagreement, moral and ethical disputes are entangled around other issues as well, such as contraception and eugenics. Mr. Salte's memo explicitly adverts to this. The existence of these controversies is one of the elements in his justification of the policy.

VI.1.3 The policy *Conscientious Refusal* affects physicians unwilling to kill patients or help them commit suicide for reasons of conscience or religion. Indeed, Mr. Salte has explicitly stated that the policy was developed with physician assisted suicide in mind (I.5, III.2). In addition, the policy is applicable to physicians who, for reasons of

conscience or religion, refuse to kill developing infants *in utero* or to provide other legal, publicly-funded services.

VI.1.4 *Conscientious Refusal* requires all such physicians to facilitate the services by referring patients to a colleague who will provide them. This is widely recognized as a form of morally significant participation (Appendix "F").

VI.1.5 The policy demands that physicians do what they believe to be wrong - even gravely wrong - even arranging homicide or suicide. Mr. Salte is clear that those who refuse to do what the policy demands will be disciplined by the College or forced out of the medical profession (Appendix "C", CV.1).

VI.1.6 **Conclusion:** The policy *Conscientious Refusal* will adversely affect freedom of conscience and religion.

VI.2 Is the policy justified by evidence provided to Council?

VI.2.1 Given the obligations of the College, it might be reasonable for Council to adopt *Conscientious Refusal* if it were demonstrated that the policy is necessary to ensure that medical practice in the province is safe, competent, ethical and safeguards the health of patients.

Evidence not provided

VI.2.2 Neither Mr. Salte nor the committee provided any evidence

- that anyone in Saskatchewan has ever been unable to access medical services because a physician has declined to provide or refer for a procedure for reasons of conscience; or
- that the health of anyone in Saskatchewan has ever been adversely affected because a physician has declined to provide or refer for a procedure for reasons of conscience; or
- that physicians who refuse to do what they believe to be wrong are guilty of unethical practice.

The evidence provided

VI.2.3 The only evidence provided to Council concerned a complaint by a woman about a Calgary physician who does not prescribe contraceptives. The woman who complained does not appear to have been her patient. She was simply angry because the physician was not prescribing contraceptives. There is no evidence that she was refused a prescription or that she or anyone else was unable to access contraceptives because of the physician's practice (Appendix "B", BIV).

VI.2.4 **Conclusion:** No evidence was provided to justify the policy.

VI.3 Is the policy justified by the arguments provided to Council?

VI.3.1 Given the obligations of the College, it might be reasonable for Council to adopt

Conscientious Refusal if it were provided with arguments demonstrating that the policy is necessary to ensure that medical practice in the province is safe, competent, ethical and safeguards the health of patients.

Arguments not offered

VI.3.2 Neither Mr. Salte nor the committee argued

- that medical practice in Saskatchewan will be unsafe unless *Conscientious Refusal* is adopted; or
- that *Conscientious Refusal* is necessary to ensure the competence of medical practice in Saskatchewan; or
- that anyone in Saskatchewan will be unable to access medical services if physicians decline to provide or refer for a procedure for reasons of conscience; or
- that the health of anyone in Saskatchewan will be at risk if physicians decline to provide or refer for a procedure for reasons of conscience, or
- that physicians who refuse to do what they believe to be wrong are guilty of unethical practice.

The argument offered

VI.3.3 The argument offered began with the reasonable observation that there are markedly different ethical or moral beliefs concerning legal and publicly funded (or soon to be legal and publicly funded) controversial procedures like assisted suicide, euthanasia and abortion, and conflicts are likely to arise between patients who want these services and physicians unwilling to provide them.

VI.3.4 However, this observation alone was merely descriptive of a present or anticipated state of affairs: a description of an "is." The mere fact of disagreement was not sufficient to justify the conclusion that objecting physicians *ought* to be forced to provide or refer for the services. Something more was needed. Mr. Salte offered something more in the form of appeals to authority, and appeal to consensus, and a claim that priority should be given to administrative convenience.

VI.3.5 **Appeals to authority**

VI.3.5.a Mr. Salte appealed to the authority of a single ethicist, Arthur Schafer, who believes that objecting physicians are obliged to help patients obtain morally contested procedures by referral (Appendix "B", BVI.3).

VI.3.5.b Mr. Salte appealed to the authority of the collective opinion of less than half the faculty of Family Medicine at the University of Wisconsin, as derived by a survey conducted in 2011 (Appendix "B", BVI.4).

VI.3.6. **Appeal to consensus**

VI.3.6.a Mr. Salte also appealed to the consensus of largely (and sometimes purposefully)

unidentified participants in closed meetings held in 2013 and 2014. He argued that the consensus arising from these meetings was that objecting physicians should be forced to help patients obtain legal and publicly funded services (which will now include euthanasia and assisted suicide) (Appendix "B", BII, BIII).

VI.3.7 **Claim of administrative convenience**

VI.3.7.a The final reason offered by Mr. Salte to adopt *Conscientious Refusal* was his concern that the failure to adopt a uniform and consistent policy across the country would prove to be troublesome for College administrators. In his view, "ethical standards for medical practice should be very similar across Canada, and that it should be possible for Canadian Colleges to adopt a common approach." (Appendix "B", BV.)

Response to the argument

VI.3.8. **Appeals to authority:**

VI.3.8.a An appeal to authority may be appropriate within a defined community in which the authority is recognized. Within Canada, a point of law may be settled by citing a ruling of the Supreme Court of Canada, for example. However, an appeal to authority on points of morality or ethics is not appropriate within a pluralist society composed of people and groups with different and sometimes opposing concepts of good and evil.

VI.3.8.b In this situation it is customary in Canada to adopt the advice of Madame Justice Bertha Wilson of the Supreme Court of Canada in *R v. Morgentaler* with respect to how the conscientious judgement of an individual should stand against that of the state. Her answer was that, in a free and democratic society, "the state will respect choices made by individuals and, to the greatest extent possible, will avoid subordinating these choices to any one conception of the good life," and that the state should not endorse and enforce "one conscientiously-held view at the expense of another."(VII.12)

VI.3.8.c With respect to Arthur Schafer's opinion, other ethicists disagree with him. Mr. Salte did not explain why he chose to ignore the opinions of ethicists who disagree with Mr. Schafer, nor did he explain why the College should endorse and enforce Mr. Schafer's view at the expense of those who disagree with him.

VI.3.8.d The same thing can be said with respect to the opinions of faculty members at the University of Wisconsin. In addition, the author of the paper provided by Mr. Salte cautioned that the research cannot be used in the way Mr. Salte would have it used. (Appendix "B", BVI.5).

VI.3.9 **Appeal to consensus**

VI.3.9.a Concerning the "consensus" of participants at the meetings described by Mr. Salte, it is not difficult to arrive at a consensus concerning a policy by excluding from discussion anyone likely to disagree with it.

VI.3.9.b The first of these meetings appears to have been organized and controlled by the CRG activists who meant to have their *Model Conscientious Objection Policy* adopted by the

Colleges. Invitations were probably sent to those known to be supportive or MCOP or those thought likely to agree with it, those known to disagree or likely to disagree with it being deliberately excluded.(Appendix "B", BII.).

VI.3.9.c The second meeting was limited to officials from different Colleges (Appendix "B", BIII.). Groups likely to be opposed to a policy of mandatory referral were not present, even if the meeting was not deliberately structured to exclude them.

VI.3.9.d Such a contrived "consensus" is certainly useful for the purpose of advancing an ideological position at the expense of the conscientiously-held views of others, and for subordinating them to the conception of the good life favoured by CRG activists and College administrators. However, a contrived and partisan consensus is not capable of justifying the suppression of the fundamental freedoms of physicians.

VI.3.10 **Administrative convenience**

VI.3.10.a While a uniform policy would obviously be much more convenient for administrators, Mr. Salte did not explain why either the CRG's *Model Conscientious Objection Policy* or its virtual clone, *Conscientious Refusal*, should be that policy.

VI.3.10.b Neither Mr. Salte nor the committee offered a single ethical argument to support the claim that *Conscientious Refusal* should be an 'ethical standard for medical practice.'

Summary

VI.3.11 Neither Mr. Salte nor the committee argued that *Conscientious Refusal* is necessary to ensure that medical practice in the province is safe, competent, ethical and safeguards the health of patients.

VI.3.12 Mr. Salte attempted to justify *Conscientious Refusal* by appealing to the authority of opinion of half of a Wisconsin University faculty and the opinion of a single ethicist. However, the former approach is invalid for empirical reasons, and the latter is unsatisfactory in a pluralist society.

VI.3.13 Mr. Salte's appeal to a contrived "consensus" is an unacceptable form of manipulation, not an adequate justification of the policy.

VI.3.14 Even if it is administratively convenient for Canadian regulators to adopt a common ethical standard for medical practice, neither Mr. Salte nor the committee offered a single argument to prove that *Conscientious Refusal* should be that standard.

Conclusion

VI.3.15 No argument was provided to Council that demonstrates that *Conscientious Refusal* is necessary to ensure that medical practice in the province is safe, competent, ethical, or to safeguard the health of patients. No argument was provided to prove that *Conscientious Refusal* should be an ethical standard of medical practice.

VI.4 Is the policy justified by the principles included in the policy?

VI.4.1 A number of the principles set out in *Conscientious Refusal* might, at first glance, seem to

justify the conclusion that physicians should be made to do what they believe to be wrong.

VI.4.2 **"The College of Physicians and Surgeons has an obligation to serve and protect the public interest."**

VI.4.2.a This obligation applies generally to every government or state institution.

VI.4.2.b The College serves and protects the public interest by attending to its statutory responsibilities. The responsibilities are described on the College website:

> Licensing properly qualified medical practitioners;
>
> Developing and ensuring the standards of practice in all fields of medicine;
>
> Investigating and disciplining of all doctors whose standards of medical care, ethical or professional conduct are questioned.

VI.4.2.c Since the assertion of "an obligation to serve and protect the public interest" applies to every government or state institution, and the College fulfils that obligation by properly discharging its statutory responsibilities, the reference to this principle either serves no purpose, or has been included to provide rhetorical pretext for the coercive elements found in the policy.

VI.4.2.d In any case, the public interest is neither served nor protected by the unjustified suppression of freedom of conscience and religion.

VI.4.3 **"The Canadian medical profession as a whole has an obligation to ensure that people have access to the provision of legally permissible and publicly-funded health services."**

VI.4.3.a Even if undisputed, it does not follow from this principle that every physician is obliged to provide or facilitate access to every legal, publicly-funded health service.

VI.4.4 **"Physicians have an obligation not to interfere with or obstruct a patient's right to access legally permissible and publicly-funded health services."**

VI.4.4.a Granted that physicians must not interfere with or obstruct a patient's access to legally permissible services, it does not follow that a physician is always legally or ethically obliged to facilitate access.

VI.4.4.b Moreover, the unwillingness of a physician to provide a service or facilitate access to it does not constitute obstruction or interference. Obstruction or interference both require some positive act. This point was made recently in the submission of the Justice Centre for Constitutional Freedoms to the College of Physicians and Surgeons of Ontario:

> To obstruct or hinder a person connotes an active intention. If a physician explains to a patient that the physician has a moral, ethical, or religious objection to a treatment or procedure, that physician is not "impeding" that patient's access to such medical services. Neither are those physicians who proactively take steps to notify potential patients that they do not provide certain controversial services.

There is no active intention to obstruct or hinder the patient from receiving such care, just an explanation that the physician cannot participate in providing it.

As an analogous example, if a customer were to go to a butcher to buy some pork chops and discover that the butcher is a devout Muslim or Jew who refuses to sell pork, and even refuses to direct customers to other butchers offering pork, that butcher is not "impeding" the potential customer's access to pork. Rather, the butcher is merely refusing to participate or facilitate the potential customer's purchase of pork.[8]

VI.4.5 **"Physicians have an obligation not to abandon their patients."**

VI.4.5.a Writing in the *New England Journal of Medicine*, two euthanasia advocates characterized refusal of physicians to provide euthanasia as patient abandonment, a violation of medical ethics.[9]

VI.4.5.b Testifying during the trial in *Carter v. Canada* as an expert witness in favour of legalization of physician assisted suicide, Professor Margaret Battin also linked refusal to provide such service as patient abandonment.[10] Professor Jocelyn Downie of Dalhousie University helped the lawyers who called Professor Battin to testify prepare their expert witnesses for the trial.[11]

VI.4.5.c Professor Downie was one of the ghost writers of *Conscientious Refusal.* She and fellow ghost writer Jaquelyn Shaw claim that a physician who "terminates a relationship without referral in a conscientious conflict" may be guilty of "patient abandonment."[12]

VI.4.5.d However, many will dispute the claim that a physician who refuses to kill a patient in the circumstances contemplated by the Supreme Court of Canada is guilty of "patient abandonment." A patient who asks a physician for assisted suicide or euthanasia is not abandoned because the physician offers effective remedial treatments or palliative care instead of a lethal injection.

VI.4.5.e Similarly, a physician does not abandon a patient because he offers treatment or care that the patient does not want. A pregnant woman who comes to a physician seeking an abortion is not abandoned because the physician declines to provide an abortion and offers obstetrical care. A patient who asks a physician for birth control is not abandoned because the physician offers assistance with Natural Family Planning rather than a prescription for birth control.

VI.4.5.f To characterize such situations as examples of "patient abandonment" reflects wordsmithing that deforms accepted principles in order to use them for a purpose for which they were never intended: to convince physicians that they have an ethical and legal obligation to kill patients or find someone who will, to justify the coercion of those who resist, and to provide an excuse to suppress freedom of conscience and religion in the medical profession.

VI.4.5.g Moving from ethics to law, in 2004, two Canadian academics, Professors Rebecca Cook and Bernard Dickens, claimed that failing to refer for abortion is a breach of fiduciary

duty and constitutes "negligence close to abandonment." However, their claims were unsupported by their own legal references (Appendix "G").

VI.4.6 **". . . legally permissible and publicly-funded . . ."**

VI.4.6.a Neither individual physicians nor the medical profession as a whole have an obligation to ensure that people have access to illegal health services. Any actual obligation can refer only to legal services.

VI.4.6.b Many kinds of elective surgery are not publicly funded. Diabetic supplies like insulin needles or pumps may not be publicly funded or may be publicly funded only after payment of an annual deductible. The fact that a health service is or is not "publicly-funded" has nothing to do with whether or not individual physicians or the medical profession as a whole have an obligation to ensure that people have access to it.

VI.4.6.c Physicians may not interfere with or obstruct a patient's right to access legally permissible services *whether or not* they are health services and *whether or not* they are publicly funded.

VI.4.6.d "Public funding" provides a benefit for a patient, but it confers no privileged status on a procedure, nor does "public funding" establish definitively that a procedure is morally or ethically acceptable, any more than "public funding" can establish that a war is justified.

VI.4.6.e The descriptors "legally permissible" and "publicly-funded" serve no purpose in this document apart from providing a rhetorical pretext for the coercive elements found in the policy.

VI.4.7 **". . . health services. . . health . . . well-being. . ."**

VI.4.7.a Following the legalization of abortion it quickly became obvious that the meaning of "health" was so elastic as to be meaningless for policy purposes unless more specifically defined; "well-being" is more elastic still.

VI.4.7.b In his submission to the Supreme Court of Canada in *Carter v. Canada*, counsel for the Canadian Medical Association explained that the concept of "the best interests of the patient" can be taken to mean that physicians should sometimes help patients commit suicide or kill them, on the one hand, or, on the other, that they should never do so. He told the Court that the medical profession is divided between two positions, "each defensible on the basis of established medical ethical considerations and compassion for the patient."[13]

VI.4.7.c The problem described by the CMA's lawyer arises because the question of whether or not a service is a health service or a procedure is a medical procedure is determined by an underlying philosophy. Only to the extent that the philosophy is actually shared can there be agreement on that point. It is not determined by the legality of the service or the procedure, nor is it determined by whether or not the service is publicly-funded.

VI.4.7.d For example, the fact that the Supreme Court of Canada has decided that physicians should be allowed to kill patients under certain circumstances does not oblige all

physicians to accept the view that killing patients is a "health service" or "medical procedure," any more than they are obliged to accept the legal fiction that an infant is not a human person until it has completely proceeded, alive, from the body of its mother. It is precisely for this reason that counsel for the CMA told the Court that "the law should offer protection to those physicians who choose to participate in physician assisted death if it is legalized, and those who do not."[14]

Summary

VI.4.8 Consistent with the ultimate origin of the policy with the Conscience Research Group, the principles set out and terminology used in *Conscientious Refusal* are apparently intended to convince physicians that they have an ethical and legal obligation to do what they believe to be wrong, to justify the coercion of those who resist, and to provide an excuse to suppress freedom of conscience and religion in the medical profession.

VI.4.9 However, the principles cannot be applied for this purpose unless they are tendentiously interpreted in accordance with the views of the Conscience Research Group and alternative philosophical or ethical viewpoints are ignored or disallowed.

VI.4.10 Neither Mr. Salte nor the committee has demonstrated that alternative philosophical or ethical viewpoints should be ignored or disallowed.

VI.4.11 At this point one returns again to the words of Madame Justice Bertha Wilson in *R v. Morgentaler*. In a free and democratic society, "the state will respect choices made by individuals and, to the greatest extent possible, will avoid subordinating these choices to any one conception of the good life," and that the state should not endorse and enforce "one conscientiously-held view at the expense of another."(VII.12)

Conclusion

VI.4.12 *Conscientious Refusal* is not justified by the principles included in the policy because there is no necessary connection between the principles and a policy requiring physicians to do what they believe to be wrong. Different philosophical or ethical approaches can be applied to qualify or interpret the principles, leading to the opposite conclusion.

VI.5 Is the policy a compromise?

VI.5.1 Interviewed after the draft policy was made public, Mr. Salte offered a further justification for *Conscientious Refusal*:

> So there is a broad range of beliefs out there, there's a broad range of perspectives out there, and what the draft policy talks about is, in fact, a compromise between the extreme position, which would be that physicians are compelled to provide this service, on the one side, and the other extreme position which is physicians can simply refuse to discuss with their patients what is going to become a legal procedure. (Appendix "C", CV.4)

VI.5.2 This is a false characterization of the opposite poles of the issue. Against the position that physicians are obliged to do something they believe to be wrong is the opposite

position that they are not obliged to do so. Merely talking about killing the patient is a different matter.

VI.5.3 However, for present purposes, consider the claim that forcing an objecting physician to help to arrange the killing of a patient by someone else is a compromise between two polar opposites: on the one hand, that physicians are morally obliged to kill patients in the circumstances defined by the Supreme Court, or, on the other, that physicians are not morally obliged to kill patients in those circumstances.

VI.5.4 To claim that killing patients in accordance with the Supreme Court ruling involves no moral judgement is absurd. Clearly, the (unspoken) premise is that killing patients in those circumstances is morally acceptable. If it is morally acceptable to kill them, then it must be morally acceptable to assist with the killing - by finding someone else to do it, for example. This is precisely the reasoning used by the trial court judge in *Carter.* Beginning with the premise that suicide can be morally acceptable, she agreed that it follows that assisting with suicide can be morally acceptable.[15]

VI.5.5 However, objecting physicians typically reject the premise that killing patients is morally acceptable even in the circumstances defined by the Supreme Court. They insist, to the contrary, that it is morally *unacceptable*. And, from the premise that it is morally unacceptable, it follows that it must be morally unacceptable to assist with it or arrange for it. This is entirely consistent with the reasoning of the trial judge in *Carter* and with widespread understanding of morally significant participation.

VI.5.6 To insist, despite this, that objecting physicians are obliged to help to arrange the killing of a patient according to the *Carter* protocol is not neutral with respect to the morality of killing. On the contrary: the unspoken premise that lies behind such a demand is that killing patients according to the *Carter* protocol is morally acceptable and that anyone who refuses to accept that premise is mistaken. To take the next step - to order an objecting physician to help to arrange a killing - is not a compromise between two opposite moral views about killing patients. It is a demand to conform to the opposite moral view.

VI.5.7 While the explanation offered here uses the examples of physician assisted suicide and euthanasia, it applies equally to other morally contested procedures, and it applies equally to disputes about the content of professional obligations.

VI.5.8 To describe this demand for submission as a “compromise” is, as Professor Jay Budziszewski says, "bad faith authoritarianism . . . a dishonest way of advancing a moral view by pretending to have no moral view."[16]

Conclusion

VI.5.9 *Conscientious Refusal* is not a compromise between opposite views about morally contested procedures or professional responsibilities. It is an assertion of a preference for one of the opposing views and an authoritarian attempt to compel others to conform to that preference, masked by the pretence of neutrality.

VII. Discussion

VII.1 One of the disturbing aspects of the story of the origin and development of *Conscientious Refusal* is what appears to be a pattern of concealment, selective disclosure, and false or misleading statements that all serve the purpose of supporting the policy.

VII.2 Further, one also finds explicit statements that the subject is controversial, which obviously imply the existence of contrary opinions. However, at no point does one find even a half-hearted effort to consider those opinions. For the purposes of policy development by College officials, contrary views either do not exist or are not worth examining.

VII.3 Finally, the documents considered in this submission disclosed that, since some time in 2013, officials of Colleges of Physicians in a number of provinces have been making plans behind closed doors to suppress freedom of conscience in the medical profession by enacting guidelines to force physicians to do what they believe to be wrong - even if that means participating in homicide or suicide. Saskatchewan physicians became aware of this only *after* the College Council had approved *Conscientious Refusal* in principle.

VII.4 It is thus appropriate to offer here a number of principles that have been ignored both by those who urged College Council to approve *Conscientious Refusal*, and by the ghost writers in the Conscience Research Group who provided the original text for the policy.

VII.5 Medicine is a moral enterprise.

VII.5.1 The practice of medicine is an inescapably moral enterprise precisely because physicians are always seeking to do some kind of good and avoid some kind of evil for their patients.[17] However, the moral aspect of practice as it relates to the conduct and moral responsibility of a physician is usually implicit, not explicit. It is normally eclipsed by the needs of the patient and exigencies of practice. But it is never absent; every decision concerning treatment is a moral decision, whether or not the physician specifically adverts to that fact.

VII.5.2 This point is frequently overlooked when a physician, for reasons of conscience, declines to participate in or provide a service or procedure that is routinely provided by his colleagues. They may be disturbed because they assume that, in making a moral decision about treatment, he has done something unusual, even improper. Seeing nothing wrong with the procedure, they see no moral judgement involved in providing it. In their view, the objector has brought morality into a situation where it doesn't belong, and, worse, it is his morality.

VII.5.3 In point of fact, the moral issue was there all along, but they didn't notice it because they have been unreflectively doing what they were taught to do in medical school and residency, and what society expects them to do. Nonetheless, in deciding to provide the procedure they also implicitly concede its goodness; they would not provide it if they did not think it was a good thing to do. What unsettles them is really not that the objector has taken a moral position on the issue, but that he has made an explicit moral judgement that

differs from their implicit one.

VII.5.4 Hence, the demand that physicians must not be allowed to act upon beliefs is unacceptable because it is impossible; one cannot act morally without reference to beliefs, and cannot practise medicine without reference to beliefs. Relevant here is a comment by Professor Margaret Somerville. "In ethics," she writes,"impossible goals are not neutral; they cause harm."[18]

VII.5.5 Once medicine is understood to be a moral enterprise, it becomes easier to understand why it is a mistake to think that moral or ethical views are unwelcome intruders upon the physician-patient relationship. Morality and ethics are actually intrinsic to it. Of course, some moral or ethical views may be erroneous, but that is a different matter that must be addressed by explaining *why* they are erroneous. It will not do to pretend, for example, that the claim that best medical practice in some circumstances means killing a patient does not involve at least implicit moral or ethical judgements.

VII.5.6 It is not possible here to adequately address the issues raised by *Conscientious Refusal* in relation to the practice of medicine, particularly since the policy is fixated on the provision of "legally permissible publicly-funded services" to the complete exclusion of any reference to the philosophy of medicine or ethical medical practice. It does not seem to recognize that providing palliative care is not functionally or morally equivalent to providing automotive repairs covered by Saskatchewan Government Insurance.

VII.6 Consider first the well being of the patient.

VII.6.1 Consistent with the practice of medicine understood as a moral enterprise, a physician first considers the well-being of the patient.[19] What constitutes or contributes to the "well-being" of a patient is largely determined by a competent patient, not by a physician, though a physician may well contribute to the patient's decision. However, it does not follow that a physician is always obliged to agree with the patient's decision or to give effect to it. What happens in the case of such disagreements is largely dependent upon patient and physician concerned and their respective evaluations of what is at stake. More relevant here is the obligation of the physician to offer the patient his best medical judgement about a recommended course of treatment or action, and, in so doing, select treatments that avoid or minimize health risks or adverse side effects.

VII.6.2 Sound medical judgement begins with and remains focussed on the patient and is exercised respectfully. It must be informed by correct science, avoiding or minimizing foreseeable risks or harm. It must seek a reasonably effective response to the needs of the patient, the anticipated benefits of which outweigh potential risks or harms. Medical judgement requires the reasonable exercise of discretion, which is shaped and refined by clinical wisdom born of experience. More could be added, but these elements are essential.

VII.6.3 Physicians are expected to provide patients with accurate information about all legal options available to them, the effectiveness of the methods, adverse effects or risks associated with each, benefits associated with each, and other information that someone

in the position of a patient would reasonably want to know. In some cases the physician might have to provide a great deal of information; in others, it may simply be a matter of filling in some gaps in what the patient knows.[20] In all cases, the physician must take care to present the information in a form comprehensible to the patient.[21]

VII.6.4 The physician must disclose whether or not he has religious, ethical or other conscientious convictions that generally preclude him from providing some services or treatments, even if medical judgement is central to his practice.[22] The reason for this is that the patient is entitled to be apprised of non-medical factors that may influence a physician's medical judgement and recommendations. The patient is also entitled to know whether or not the physician's medical evaluation of the treatment in question is consistent with the general view of the medical profession.[23]

VII.6.5 The physician should invite questions from the patient at different stages in the consultation to ensure that he has been correctly understood.[24] The goal is to ensure that the patient has sufficient information and understanding to make an informed decision about what kind of treatment she will accept. With respect to any reference to his conscientious convictions, unless the patient questions him, asks for further explanation, or otherwise indicates that she does not understand his position, the physician need not and probably should not expand upon the basis for his own position. To do so would likely invite the accusation that he is "preaching."

VII.6.6 Patient-centred medical practice is directed to ensuring good medical care, but good medical care is not provided by automatons. Medical schools do not manufacture made-to-order products that perform according to factory default settings, or finely machined cogs that keep health care delivery apparatus running smoothly. Medicine is a moral enterprise, morality is a human enterprise, and physicians, no less than patients, are moral agents. *Conscientious Refusal* was written from a very different perspective, and it has not been shown to be a morally or ethically superior perspective.

VII.7 Morality is a human enterprise.

VII.7.1 All public behaviour - how one treats other people, how one treats animals, how one treats the environment - is determined by what one believes. All beliefs influence public behaviour. Some of these beliefs are religious, some not, but all are beliefs. This applies no less to "secular" ethics than to religious ethics. A secular ethic may be independent of religion,[25] but it is not faith-free, nor is it beyond the influence of faith. On the contrary: a secular ethic, like any ethic, is faith-based. That human dignity exists - or that it does not - or that human life is worthy of unconditional reverence - or merely conditional respect - and notions of beneficence, justice and equality are not the product of scientific enquiry, but rest upon faith: upon beliefs about human nature, the meaning and purpose of life, the existence of good and evil.

VII.7.2 That everyone is a believer reflects the fact that the practice of morality is a human enterprise,[26] but it is not a scientific enterprise. The classic ethical question, "How ought I to live?" is not a scientific question and cannot be answered by any of the disciplines of natural science, though natural science can provide raw material needed for adequate

answers.

VII.7.3 Answers to the question, "How ought I to live?" reflect two fundamental moral norms; do good, avoid evil. These basics have traditionally been undisputed; the disputes begin with identifying or defining good and evil and what constitutes "doing" and "avoiding." Such explorations are the province of philosophy, ethics, theology and religion. Internationally, religion continues to be the principal means by which concepts of good and evil and right and wrong conduct are sustained and transmitted.

VII.7.4 Nonetheless, since the practice of morality is a human enterprise, reflections about morality and the development and transmission of ideas about right and wrong also occurs within culture and society outside the framework of identifiable academic disciplines and religions. In consequence, the secular public square is populated by people with any number of moral viewpoints, some religious, some not: some tied to particular philosophical or ethical systems, some not: but all of them believers. There is no reason to deny the freedom to act upon religious belief because it is religious: no reason, that is, apart from anti-religious bigotry.

VII.7.5 Further, since morality is a human enterprise, moral judgement is an essential activity of every human person, moral judgement necessarily involves some kind of individual or personal conviction, and maintaining one's personal moral integrity is the aspiration of anyone who wishes to live rightly. Thus, beliefs are "personal," in the sense that one personally accepts them and is committed to them.

VII.7.6 However, this does not mean that they are parochial, insignificant or erroneous. Christian, Jewish and Muslim beliefs, for example, are shared by hundreds of millions of people. They "personally" adhere to their beliefs, just as non-religious believers "personally" adhere to their non-religious beliefs. In neither case does the fact of this "personal" commitment provide grounds to set beliefs aside. Thus, it is important to recognize that pejorative or suspicious references to "personal" beliefs or "personal" values frequently reflect underlying and perhaps unexamined prejudices against them.

VII.7.7 *Conscientious Refusal* was written by believers: by people who believe that whatever is "legally permissible and publicly-funded" is morally acceptable, who believe that those who think differently are mistaken, and who believe that others should be compelled to conform to their faith in the moral infallibility of the law and ministers of finance. The policy is profoundly disrespectful of the moral agency of physicians.

VII.8 A secular public square includes religious belief.

VII.8.1 Consistent with these observations, the Supreme Court of Canada has recognized that, in Canadian law, "secular" must be understood to include religious belief. In his paper, *Seeing Through the Secular Illusion*,[27] Dr. Iain Benson emphasizes this by referring to an explanation supported by the full bench of the Court:

> In my view, Saunders J. below erred in her assumption that 'secular' effectively meant 'non-religious'. This is incorrect since nothing in the Charter, political or democratic theory, or a proper understanding of pluralism demands that

> atheistically based moral positions trump religiously based moral positions on matters of public policy. I note that the preamble to the Charter itself establishes that '... Canada is founded upon principles that recognize the supremacy of God and the rule of law'. According to the reasoning espoused by Saunders J., if one's moral view manifests from a religiously grounded faith, it is not to be heard in the public square, but if it does not, then it is publicly acceptable. The problem with this approach is that everyone has 'belief' or 'faith' in something, be it atheistic, agnostic or religious. To construe the 'secular' as the realm of the 'unbelief' is therefore erroneous. Given this, why, then, should the religiously informed conscience be placed at a public disadvantage or disqualification? To do so would be to distort liberal principles in an illiberal fashion and would provide only a feeble notion of pluralism. The key is that people will disagree about important issues, and such disagreement, where it does not imperil community living, must be capable of being accommodated at the core of a modern pluralism.[28]

VII.8.2 Thus, the Supreme Court of Canada has acknowledged that secularists, atheists and agnostics are believers, no less than Christians, Muslims, Jews and persons of other faiths. Neither a secular state nor a secular health care system (tax-paid or not) must be purged of the expression of religious belief. Whether or not they are state employees in law or as a matter of public policy, physicians may act upon religious beliefs when practising medicine. The Court has insisted that rational democratic pluralism must make room for all of them.

VII.8.3 This undercuts the reasoning sometimes offered by those who would suppress freedom of conscience and religion in the medical profession. Identifying physicians as "providers of secular public services"(emphasis added),[29] they erroneously presume that what is "secular" excludes religious belief. The public perpetuation of this error contributes significantly to anti-religious sentiments and a climate of religious intolerance.

VII.8.4 Further, the approach taken by the Supreme Court of Canada on this issue contradicts the position taken by those who argue that "moral beliefs" are not protected: that only specifically religious beliefs and practices are protected by law.[30] This reasoning would place atheists and agnostics "at a public disadvantage or disqualification" vis-à-vis religious believers, surely not an outcome consistent with the thinking of the Supreme Court.

VII.8.5 While the Supreme Court of Canada has recognized that religious believers and religious communities are part of the warp and woof of the Canadian social fabric, *Conscientious Refusal* is written as if this is inconsequential, inasmuch as it demands that physicians must participate in morally significant ways in procedures known to be contrary to the teaching of major religious groups. Thus, the policy is inimical to the presence of members of those groups in medical practice.

VII.9. Avoid authoritarian solutions.

VII.9.1 Making room in the public square for people motivated by different and sometimes opposing beliefs can lead to conflict, as the present consultation demonstrates. The

Supreme Court of Canada has warned that to single out and exclude religious belief in order to prevent or minimize such conflict would "distort liberal principles in an illiberal fashion."[31]

VII.9. 2 It is also dangerous. It overlooks the possibility that some secularists - like some religious believers - can be uncritical and narrowly dogmatic in the development of their ethical thinking, and intolerant of anyone who disagrees with them. They might see them as heretics who must be driven from the professions, from the public square, perhaps from the country: sent to live across the sea with their "own kind." University of Victoria law professor Mary Anne Waldron provides a reminder and a warning:

> Conflict in belief is an endemic part of human society and likely always will be. What has changed, I think, is the resurrection of the idea that we can and should compel belief through legal and administrative processes, or, if not compel the belief itself, at least force conformity. Unfortunately, that begins the cycle of repression that, if we are to maintain a democracy, we must break.[32]

VII.9. 3 On this point, it is essential to note that a secular ethic is not morally neutral.[33] The claim that a secular ethic is morally neutral - or that one can practise medicine in a morally "neutral" fashion- is not merely fiction. It is another example of "bad faith authoritarianism" identified by Professor J. Budziszewski.[16]

VII.9. 4 *Conscientious Refusal* illustrates another of the most common examples of "bad faith authoritarianism": the pretence that referral is an acceptable compromise that balances the respective "interests" of physicians and patients. While that may be the case for many physicians in many situations, it clearly is not the case when it is understood that referral or other forms of facilitation make a physician complicit in wrongdoing.[34]

VII.10. There is no duty to do what is believed to be wrong.

VII.10. 1 If it is legitimate to compel religious believers to do what they believe to be wrong, then it is equally legitimate to compel non-religious believers to do what they think is wrong. It would, in principle, establish a duty to do what is believed to be wrong for everyone.

VII.10. 2 For Andrei Marmor, "a duty to do what is wrong is surely an oxymoron,"[35] and most people would agree, as did Dr. John Williams, then Director of Ethics for the Canadian Medical Association. Speaking in 2002 of physicians who decline to provide or refer for contraceptives for religious reasons, he said, "[They're] under no obligation to do something that they feel is wrong."[36]

VII.10. 3 When discussion about difficulties associated with the exercise of freedom of conscience in health care is repeatedly characterized as "the problem of conscientious objection,"[37] it becomes clear that the underlying premise is that people and institutions ought to do what they believe to be wrong, and that refusal to do what one believes to be wrong requires special justification. This is exactly the opposite of what one would expect. Most people believe that we should not do what we believe to be wrong, and that refusing to do what we believe to be wrong is the norm. It is wrongdoing that needs special justification or excuse, not refusing to do wrong.

VII.10. 4 The inversion is troubling, since "a duty to do what is wrong" is being advanced by those who support the "war on terror." They argue that there is, indeed, a duty to do what is wrong, and that this includes a duty to kill non-combatants and to torture terrorist suspects.[38] The claim is sharply contested,[39] but it does indicate how far a duty to do what is wrong might be pushed. In Quebec - and now, in Saskatchewan - it is being pushed as far as requiring physicians to participate in killing patients, even if they believe it is wrong: even if they believe that it is homicide.[40]

VII.10. 5 This, perhaps, was what was troubling a member of the Council of the College of Physicians of Ontario when, in September, 2008, the Council was considering the final draft of Physicians and the Human Rights Code. He drew his colleagues' attention to a chilling *New England Journal of Medicine* article by Holocaust survivor, Elie Wiesel: "Without conscience."[41] It was about the crucial role played by German physicians in supporting Nazi horrors. "How can we explain their betrayal?" Wiesel asked. "What gagged their conscience? What happened to their humanity?"[42]

VII.10. 6 This reminder is a warning that the community must be protected against the temptation to give credence to the dangerous idea that is advanced by *Conscientious Refusal*: that a learned or privileged class, a profession or state institutions can legitimately compel people to do what they believe to be wrong - even gravely wrong - and punish them if they refuse.

VII.10. 7 Finally, *Conscientious Refusal* is incoherent because it purports to include a duty to do what one believes to be wrong in a code of ethics or ethical guidelines, the very purpose of which is to encourage physicians to act ethically and avoid wrongdoing.

VII.11 Forcing someone to do wrong is violation, not limitation.

VII.11.1 Attempts to suppress freedom of conscience and religion in the medical profession are often defended using a statement of the Supreme Court of Canada: "the freedom to hold beliefs is broader than the freedom to act on them."[43]

VII.11.2 The statement is certainly correct, and precedents can be cited for applying it. Oliver Cromwell applied the distinction to justify his suppression of the practice of Catholicism in Ireland.[44] However, it is doubtful that the Supreme Court of Canada intended its comment to be put to such use in a liberal democracy.

VII.11.3 The mantra, "the freedom to hold beliefs is broader than the freedom to act on them" is not wrong, but it is inadequate. It is simply not responsive to many of the questions about the exercise of freedom of conscience that arise in a society characterized by a plurality of moral and political viewpoints and conflicting demands. More refined distinctions are required. One of them is the distinction between perfective and preservative freedom of conscience, which reflects the two ways in which freedom of conscience is exercised: by pursuing apparent goods and avoiding apparent evils.[45]

VII.11.4 It is generally agreed that the state may limit the exercise of perfective freedom of conscience if it is objectively harmful, or if the limitation serves the common good. Although there may be disagreement about how to apply these principles, and restrictions

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

VII.11.5 If the state can legitimately limit perfective freedom of conscience by preventing people from doing what they believe to be good, it does not follow that it is equally free to suppress preservative freedom of conscience by forcing them to do what they believe to be wrong. There is a significant difference between preventing someone from doing the good that he wishes to do and forcing him to do the evil that he abhors.

VII.11.6 We have noted the danger inherent in the notion of a "duty to do what is wrong." Here we add that, as a general rule, it is fundamentally unjust and offensive to suppress preservative freedom of conscience by forcing people to support, facilitate or participate in what they perceive to be wrongful acts; the more serious the wrongdoing, the graver the injustice and offence. It is a policy fundamentally opposed to civic friendship, which grounds and sustains political community and provides the strongest motive for justice. It is inconsistent with the best traditions and aspirations of liberal democracy, since it instills attitudes more suited to totalitarian regimes than to the demands of responsible freedom.

VII.11.7 This does not mean that no limit can ever be placed on preservative freedom of conscience. It does mean, however, that even the strict approach taken to limiting other fundamental rights and freedoms is not sufficiently refined to be safely applied to limit freedom of conscience in its preservative form. Like the use of potentially deadly force, if the restriction of preservative freedom of conscience can be justified at all, it will only be as a last resort and only in the most exceptional circumstances.

VII.11.8 What is proposed by *Conscientious Refusal* is not a justified limitation of fundamental freedoms, but a serious violation of human dignity that remains unjustified by any evidence or argument advanced to support it.

VII.12 Accommodate different conceptions of "the good life."

VII.12.1 Madame Justice Bertha Wilson of the Supreme Court of Canada addressed the issue of freedom of conscience in the landmark 1988 case *R v. Morgentaler*. Madame Justice Wilson argued that "an emphasis on individual conscience and individual judgment . . . lies at the heart of our democratic political tradition."[46] Wilson held that it was indisputable that the decision to have an abortion "is essentially a moral decision, a matter of conscience."

> The question is: whose conscience? Is the conscience of the woman to be paramount or the conscience of the state? I believe. . . that in a free and democratic society it must be the conscience of the individual. Indeed, s. 2(a) makes it clear that this freedom belongs to "everyone", i.e., to each of us individually.[47]

VII.12.2 "Everyone" includes every physician. But, at this point in the judgement, Wilson was not discussing whether or not the conscience of a woman should prevail over that of an objecting physician, but how the conscientious judgement of an individual should stand

against that of the state. Her answer was that, in a free and democratic society, "the state will respect choices made by individuals and, to the greatest extent possible, will avoid subordinating these choices to any one conception of the good life."[48] This statement was affirmed unanimously in 1991 by a panel of five judges, and by the full bench of the Court in1996.[49]

VII.12.3 Wilson approved the principle that a human person must never be treated as a means to an end - especially an end chosen by someone else, or by the state. Wilson rejected the idea that, in questions of morality, the state should endorse and enforce "one conscientiously-held view at the expense of another," for that is "to deny freedom of conscience to some, to treat them as means to an end, to deprive them . . .of their 'essential humanity'."[50]

VII.12.4 Freedom of conscience was also mentioned by Justices Beetz and Estey in *Morgentaler* when considering the appointment of therapeutic abortion committees.

> Given that therapeutic abortions can only be performed in eligible hospitals and that the committee certifying the abortion must come from that hospital, this effectively contributes to the inaccessibility of the treatment. Nothing in the *Criminal Code* obliges the board of an eligible hospital to appoint therapeutic abortion committees. Indeed, a board is entitled to refuse to appoint a therapeutic abortion committee in a hospital that would otherwise qualify to perform abortions and boards often do so in Canada.
>
> **Given that the decision to appoint a committee is, in part, one of conscience and, in some cases, one which affects religious beliefs, a law cannot force a board to appoint a committee any more than it could force a physician to perform an abortion.** The defect in the law is not that it does not force boards to appoint committees, but that it grants exclusive authority to those boards to make such appointments. (Emphasis added)[51]

VII.12.5 Most recently, in *Carter v. Canada*, the full bench of the Court, affirming the words of Mr. Justice Beetz, stated, “a physician’s decision to participate in assisted dying is a matter of conscience and, in some cases, of religious belief (pp. 95-96).”[52]

VII.12.6 The plan to suppress freedom of conscience and drive dissenting physicians from the medical profession demonstrates that *Conscientious Refusal* clashes seriously with the approach taken in *Morgentaler* and affirmed in *Carter.* Public policy must make room for both hospitals and physicians whose “a concept of the good life” precludes their participation in abortion, euthanasia, assisted suicide or other morally contested procedures for reasons of conscience or religion.

VIII. Conclusions

VIII.1 *Conscientious Refusal* requires all physicians who object to a procedure for reasons of conscience to facilitate the procedure by referring patients to a colleague who will provide it, even if it is homicide or suicide. This is widely recognized as a form of morally

significant participation. Moreover, since this is known to be contrary to the teaching of major religious groups, the policy is inimical to the presence of members of those groups in medical practice. Thus, the policy adversely affects freedom of conscience and religion.

VIII.2 No evidence was provided to justify the policy. No argument was offered to demonstrate that *Conscientious Refusal* is necessary to ensure that medical practice in the province is safe, competent, ethical, or to safeguard the health of patients. None of the arguments provided to Council justify the policy, nor do the principles included in the text.

VIII.3 *Conscientious Refusal* fails to recognize that the practice of medicine is a moral enterprise, morality is a human enterprise, and physicians, no less than patients, are moral agents. The policy is profoundly disrespectful of the moral agency of physicians.

VIII.4 The original text virtually copied by *Conscientious Refusal* was written by believers: by people who believe that whatever is "legally permissible and publicly-funded" is morally acceptable- including euthanasia, assisted suicide and abortion. It is an assertion of those beliefs and an authoritarian attempt to compel others to conform to them. It is a partisan document that is profoundly disrespectful of the moral agency of physicians, not a compromise.

VIII.5 *Conscientious Refusal* advances the dangerous idea that a learned or privileged class or profession or state institutions can legitimately compel people to do what they believe to be wrong - even gravely wrong - and punish them if they refuse. This is not a limitation of fundamental freedoms, but a serious violation of human dignity that remains unjustified by any evidence or argument advanced to support it. It is also incoherent, because it purports to include a duty to do what one believes to be wrong in a code of ethics or ethical guidelines, the very purpose of which is to encourage physicians to act ethically and avoid wrongdoing.

VIII.6 The Associate Registrar has made it clear that those who refuse to do what the policy demands will be disciplined by the College or forced out of the medical profession. This clashes seriously with the approach taken by the Supreme Court of Canada, which has affirmed that public policy must make room for physicians whose "a concept of the good life" precludes their participation in abortion, euthanasia, assisted suicide or other morally contested procedures.

VIII.7 The burden of proof was on the Associate Registrar and the appointed committee to prove beyond doubt that *Conscientious Refusal* is justified and that no less authoritarian alternatives are available. They failed to discharge that burden; neither has College Council discharged it. The policy should be withdrawn.

Notes:

1. Document 200/14, College of Physicians and Surgeons of Saskatchewan, Memo from Bryan Salte to Council dated 31 July, 2014 Re: *Possible Policy or Guideline - Physicians who have an ethical objection to provide certain forms of medical services*, p. 3. (http://www.consciencelaws.org/archive/documents/cpss/2014-07-31-Report.pdf)

2. Document 200/14, College of Physicians and Surgeons of Saskatchewan, Memo from Bryan Salte to Council dated 31 July, 2014 Re: *Possible Policy or Guideline - Physicians who have an ethical objection to provide certain forms of medical services*, p. 4. (http://www.consciencelaws.org/archive/documents/cpss/2014-07-31-Report.pdf)

3. Document 200/14, College of Physicians and Surgeons of Saskatchewan, Memo from Bryan Salte to Council dated 31 July, 2014 Re: Possible Policy or Guideline - Physicians who have an ethical objection to provide certain forms of medical services, p. 10-13. (http://www.consciencelaws.org/archive/documents/cpss/2014-07-31-Report.pdf) (Physicians and the Ontario Human Rights Code [http://www.consciencelaws.org/archive/documents/cpso/2008-09-cpso-physicians-hrcode.pdf])

4. Document 200/14, College of Physicians and Surgeons of Saskatchewan, Memo from Bryan Salte to Council dated 31 July, 2014 Re: Possible Policy or Guideline - Physicians who have an ethical objection to provide certain forms of medical services, p. 14. (http://www.consciencelaws.org/archive/documents/cpss/2014-07-31-Report.pdf) (Moral or Religious Beliefs Affecting Medical Care [http://www.cpsa.ab.ca/Resources/StandardsPractice/medical-practice/moral-or-religious-beliefs-affecting-medical-care])

5. Document 200/14, College of Physicians and Surgeons of Saskatchewan, Memo from Bryan Salte to Council dated 31 July, 2014 Re: Possible Policy or Guideline - Physicians who have an ethical objection to provide certain forms of medical services, p. 15. (http://www.consciencelaws.org/archive/documents/cpss/2014-07-31-Report.pdf) (Members Moral or Religious Beliefs Not to Affect Medical Care [http://cpsm.mb.ca/cjj39alckF30a/wp-content/uploads/st181.pdf])

6. Document 200/14, College of Physicians and Surgeons of Saskatchewan, Memo from Bryan Salte to Council dated 31 July, 2014 Re: Possible Policy or Guideline - Physicians who have an ethical objection to provide certain forms of medical services, p. 16-18. (http://www.consciencelaws.org/archive/documents/cpss/2014-07-31-Report.pdf) (Guideline: Unplanned Pregnancy [http://www.cps.sk.ca/CPSS/Legislation__ByLaws__Policies_and_Guidelines/Legislation_Content/Policies_and_Guidelines_Content/Unplanned_Pregnancy.aspx])

7. Document 200/14, College of Physicians and Surgeons of Saskatchewan, Memo from Bryan Salte to Council dated 31 July, 2014 Re: Possible Policy or Guideline - Physicians who have an ethical objection to provide certain forms of medical services, p. 2.

(http://www.consciencelaws.org/archive/documents/cpss/2014-07-31-Report.pdf)

8. *In Defence of Charter Freedoms: A legal analysis of the constitutionality of the draft policy "Professional Obligations and Human Rights."* Justice Centre for Constitutional Freedoms, February, 2015, p. 6 (http://policyconsult.cpso.on.ca/wp-content/uploads/2015/02/JCCF-redacted.pdf) Accessed 2015-03-02

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10. *Carter v. Canada* (Attorney General) 2012 BCSC 886, para. 239 (http://www.canlii.org/en/bc/bcsc/doc/2012/2012bcsc886/2012bcsc886.html) Accessed 2015-02-28

11. *Carter v. Canada* (Attorney General) 2012 BCSC 886, para. 124 (http://www.canlii.org/en/bc/bcsc/doc/2012/2012bcsc886/2012bcsc886.html) Accessed 2015-02-28

12. Shaw, J. and Downie, J. "Welcome to the Wild, Wild North: Conscientious Objection Policies Governing Canada's Medical, Nursing, Pharmacy, and Dental Professions." *Bioethics*. doi: 10.1111/bioe.12057

13. Re: Joint intervention in *Carter v. Canada*: *Selections from oral submissions.* Supreme Court of Canada, 15 October, 2014. Harry Underwood (Counsel for the Canadian Medical Association)[227:29/491:20] to [229:29/491:20] (../law/commentary/legal073-009.aspx#Harry_Underwood)

14. Re: Joint intervention in Carter v. Canada: Selections from oral submissions. Supreme Court of Canada, 15 October, 2014. Harry Underwood (Counsel for the Canadian Medical Association)[229:29/491:20] (../law/commentary/legal073-009.aspx#Harry_Underwood)

15. Carter v. Canada (Attorney General) 2012 BCSC 886. Supreme Court of British Columbia, 15 June, 2012. Vancouver, British Columbia. (Hereinafter "Carter v. Canada") para. 339 (Accessed 2014-11-24) The judge uses the term "ethical," not "moral," and more frequently employs the former, but she treats them as synonyms when addressing the question, "Does the law attempt to uphold a conception of morality inconsistent with the consensus in Canadian society?" (para. 340-358) Moreover, witnesses on both sides do not typically distinguish between ethical and moral issues. See, for example, Dr. Shoichet (plaintiffs) at para. 75, Prof. Sumner (plaintiffs) at para. 237, Dr. Bereza (defendants) at para. 248, Dr. Preston (plaintiffs) at para. 262. The judge defines ethics as "a discipline consisting of rational inquiry into questions of right and wrong" and frames the question accordingly: " whether it is right, or wrong, to assist persons who request assistance in ending their lives and, if it is right to do so, in what circumstances." Carter v. Canada, para. 164. Most would see in this passage no way to distinguish between ethics and

moral philosophy.

16. "The question of neutrality has been profoundly obscured by the mistake of confusing neutrality with objectivity... neutrality and objectivity are not the same... objectivity is possible but neutrality is not. To be neutral, if that were possible, would be to have no presuppositions whatsoever. To be objective is to have certain presuppositions, along with the manners that allow us to keep faith with them." Budziszewski J., "Handling Issues of Conscience." *The Newman Rambler,* Vol. 3, No. 2, Spring/Summer 1999, P. 4. (http://www.consciencelaws.org/ethics/ethics007.aspx)

17. Maddock J.W. "Humanizing health care services. The practice of medicine as a moral enterprise." *J Natl Med Assoc*. 1973 November; 65(6): 501–passim. PMCID: PMC2609038 (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2609038/?page=1) Accessed 2014-02-18.

18. Somerville M. "Why are they throwing brickbats at God?" *MercatorNet*, 1 June, 2007 (http://www.mercatornet.com/articles/view/why_are_they_throwing_brickbats_at_god) Accessed 2014-08-03.

19. Canadian Medical Association, *Code of Ethics* (2004): Fundamental Responsibilities No. 1. (http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf) Accessed 2014-02-15.

20. Canadian Medical Association *Code of Ethics* (2004): "21. Provide your patients with the information they need to make informed decisions about their medical care, and answer their questions to the best of your ability." (http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf) Accessed 2014-02-22.

21. Murray B. "Informed Consent: What Must a Physician Disclose to a Patient?" *American Medical Association Journal of Ethics, Virtual Mentor*. July 2012, Volume 14, Number 7: 563-566. (http://virtualmentor.ama-assn.org/2012/07/hlaw1-1207.html) Accessed 2014-02-22.

22.Canadian Medical Association *Code of Ethics* (2004): "12. Inform your patient when your personal values would influence the recommendation or practice of any medical procedure that the patient needs or wants." (http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf) Accessed 2014-02-22.

23. Canadian Medical Association *Code of Ethics* (2004): "45. Recognize a responsibility to give generally held opinions of the profession when interpreting scientific knowledge to the public; when presenting an opinion that is contrary to the generally held opinion of the profession, so indicate." (http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf) Accessed 2014-02-22.

24. Canadian Medical Association *Code of Ethics* (2004): "22. Make every reasonable effort to communicate with your patients in such a way that information exchanged is understood." (http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf) Accessed 2014-02-22.

25. Singer P. *Practical Ethics* (2nd Ed.). Cambridge: Cambridge University Press, 1993, p. 3; Kreeft P. *Fundamentals of the Faith*. San Francisco: Ignatius Press, 1988, p. 74-80. On line (Chapter 11) as "The Uniqueness of Christianity." (http://www.catholiceducation.org/en/religion-and-philosophy/apologetics/the-uniqueness-of-christianity.html) Accessed 2015-03-05)

26. This presumption obviously underlies standard bioethics texts. See, for example, Beauchamp TL, Childress JF, *Principles of Biomedical Ethics* (7th ed) New York: Oxford University Press, 2013

27. Benson, I.T., "Seeing Through the Secular Illusion" (July 29, 2013). NGTT Deel 54 *Supplementum* 4, 2013. (http://ssrn.com/abstract=2304313) Accessed 2014-02-18.

28. *Chamberlain v. Surrey School District No. 36* [2002] 4 S.C.R. 710 (SCC), para. 137 (http://scc-csc.lexum.com/scc-csc/scc-csc/en/item/2030/index.do?r=AAAAAQALIm1hbmRhdG9yeSIAAAAAAAAB) Accessed 2014-08-03). Dr. Benson adds: "Madam Justice McLachlin, who wrote the decision of the majority, accepted the reasoning of Mr. Justice Gonthier on this point thus making his the reasoning of all nine judges in relation to the interpretation of 'secular.'" Benson I.T., "Seeing Through the Secular Illusion" (July 29, 2013). NGTT Deel 54 *Supplementum* 4, 2013. (http://ssrn.com/abstract=2304313) Accessed 2014-02-18.

29. *Submission of the Ontario Human Rights Commission to the College of Physicians and Surgeons of Ontario Regarding the draft policy, "Physicians and the Ontario Human Rights Code."* 15 August, 2008. (http://www.ohrc.on.ca/en/resources/submissions/physur) Accessed 2014-03-11, citing Norton K.C. "Letter to Ontario's Attorney General expressing concern about allowing public officials to refuse to marry same-sex couples." (http://www.ohrc.on.ca/en/news_centre/letter-ontarios-attorney-general-expressing-concern-about-allowing-public-officials-refuse-marry) Accessed 2014-03-11.

30. Submission of the Ontario Human Rights Commission to the College of Physicians and Surgeons of Ontario Regarding the draft policy, "Physicians and the Ontario Human Rights Code." 15 August, 2008. (http://www.ohrc.on.ca/en/resources/submissions/physur) Accessed 2014-03-11.

31. ". . . if, despite being a belief system, secularism is not excluded from the public square, then religious voices should not be excluded on that basis. The mistake is in taking a disjunctive (either secularism or religion) approach to a situation that requires a conjunctive (both this and that, secularism and religion) approach. We need all voices to be heard in the democratic public square." Somerville M. "Should religion be evicted from the public square?" *The Warrane Lecture* 2011. Kensington, NSW Australia: Warrane College, August, 2011, p. 12. (http://warrane.unsw.edu.au/f/publications/monographs/WarraneMonographNo22.pdf) Accessed 2014-08-02.

32. Waldron, MA, "Campuses, Courts and Culture Wars." *Convivium*, February/March 2014, p. 33

33. The distinction between ethics and morality is mainly a matter of usage. Recent trends identify ethics as the application of morality to a specific discipline, like medicine or law. In a broader and older sense, ethics is concerned with how man ought to live, while the study of morality focuses on ethical obligations. See the entry on "Ethics and Morality" in Honderich T. (Ed.) *The Oxford Companion to Philosophy* (2nd Ed.) Oxford: Oxford University Press, 2005.

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36. Mackay B. "Sign in office ends clash between MD's beliefs, patients' requests." *CMAJ* January 7, 2003 vol. 168 no. 1 (http://www.cmaj.ca/content/168/1/78.2.full) Accessed 2014-02-16.

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Human Rights Council, 23nd Session - June 3, 2013. Agenda Item 3: Presentation of Reports by the Special Rapporteur on Violence against Women. "Oral Statement: Center for Reproductive Rights." (http://issuu.com/acpdcanada/docs/statement_by_crr-sri__id_with_sr_on) Accessed 20-13-08-11.

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47. *R. v. Morgentaler* (1988)1 S.C.R 30 (Supreme Court of Canada) p. 176. (http://scc-csc.lexum.com/scc-csc/scc-csc/en/item/288/index.do) Accessed 2015-02-26.

48. *R. v. Morgentaler* (1988)1 S.C.R 30 (Supreme Court of Canada) p. 166. (http://scc-csc.lexum.com/scc-csc/scc-csc/en/item/288/index.do) Accessed 2015-02-26.

49. *R. v. Salituro*, [1991] 3 S.C.R. 654 (https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/820/index.do); *Québec (Curateur public) c. Syndicat national des employés de l'Hôpital St-Ferdinand,* [1996] 3 S.C.R. 211 (https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/1423/index.do) Accessed 2015-03-05.

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51. *R. v. Morgentaler* (1988)1 S.C.R 30 (Supreme Court of Canada) p. 95-96. (http://scc-csc.lexum.com/scc-csc/scc-csc/en/item/288/index.do) Accessed 2015-02-26.

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Appendix "A"

Origin of the CPSS Draft Policy Conscientious Refusal

AI. Attempts to coerce physicians: abortion

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

AI.2 A difficult compromise has emerged. Physicians are required to disclose personal moral convictions that might prevent them from recommending a procedure to patients, but are not required to refer the patient or otherwise facilitate abortion. The arrangement preserves the integrity of physicians who do not want to be involved with abortion, while making patients aware of the position of their physicians so that they can seek assistance elsewhere. The compromise has been used as a model for dealing with other morally contested procedures, like contraception.

AI.3 Nonetheless, some activists, influential academics, powerful interests, state institutions and professional organizations have been working steadily to overthrow the compromise and compel objecting physicians and other health care workers to provide, participate in or facilitate abortion, contraception and related procedures. This was attempted, for example, in a guest 2006 editorial in the Canadian Medical Association Journal (CMAJ) by Professors Sanda Rodgers and Jocelyn Downie.[2] The editorial elicited a flood of protest. Dr. Jeff Blackmer, CMA Director of Ethics, reaffirmed Association policy that referral was not required,[3] and the CMAJ declared the subject closed.

AII. Plans to coerce physicians: assisted suicide and euthanasia

AII.1 Professor Downie was a member of the "expert panel" of the Royal Society of Canada that, in 2011, recommended legalization of euthanasia and assisted suicide. The panel conceded that health care workers might, for reasons of conscience or religion, object to killing patients or helping them kill themselves.

AII.2 Professor Downie and her expert colleagues, including Professors Daniel Weinstock and Udo Schuklenk, recommended that such objectors should be compelled to refer patients to someone who would do so.[4] They claimed that this was consistent with "[t]oday's procedural solution to this problem. . . in Canada as well as many other jurisdictions" with respect to conscientious objection to abortion and contraception ("certain reproductive health services"). Objecting physicians, they declared, are required "to refer assistance seekers to colleagues who are prepared to oblige them."[5]

AII.3 It is not surprising that the authors did not cite a reference to support this assertion. In Canada, outside of Quebec, there is, in fact, no policy that objecting health care professionals should be compelled to refer for abortions or other morally contested procedures. Given the repudiation of her views by the CMA in 2006, Professor Downie must have been aware of that.

AII.4 As the Supreme Court of Canada heard submissions in *Carter v. Canada* in October. Professor Downie was live-tweeting from the courtroom, while her Royal Society fellow panelist Udo Schuklenk watched the live webcast. The goal of forcing objecting physicians to participate in euthanasia and assisted suicide was on his mind.

> I looked at the list of interveners in the case. There's a whole bunch of them, virtually all of whom are Christian activist groups, some more fundamentalist than others. Their presentations were by and large predictable. . . I suspect they are a last ditch attempt at keeping the SCC from declaring the part of the Criminal Code that criminalises assisted dying unconstitutional. The God folks also served other arguments such as the sanctity-of-life argument. . .
>
> Then there was a lawyer representing groups called the Faith and Freedom Alliance and the Protection of Conscience Project. He didn't address the actual challenge but asked that the Court direct parliament to ensure that health care professionals would not be forced to assist in dying if they had conscientious objections. That, of course, is the case already today in matters such as abortion. However, this lawyer wanted to extend conscience based protections. Today health care professionals are legally required to pass the help-seeking patient on to a health care professional willing to provide the requested service. The lawyer wanted to strike out such an obligation. I am not a fan of conscientious objection rights anyway, so I hope the Court will ignore this. . . (Emphasis added)[6]

AIII. Plans to coerce physicians: the CRG Model Policy

AIII.1 Jocelyn Downie and Daniel Weinstock, who, with Udo Schuklenk were members of the Royal Society "expert panel," are also part of the faculty of the "Conscience Research Group" (CRG). It is headed by Professor Carolyn McLeod and supported by research associate Jaquelyn Shaw and seven graduate students.[7]

AIII.2 A central goal of the group is to entrench in medical practice a duty to refer for or otherwise facilitate contraception, abortion and other "reproductive health" services. As the involvement and arguments of Daniel Weinstock and Jocelyn Downie demonstrate, what is advocated by the "Conscience Research Group" equally applies to forcing physicians who are unwilling to kill patients or commit suicide to find a colleague who will.

AIII.3 The Conscience Research Group advocates a coercive policy on conscientious objection written by three members of the Group, Downie, McLeod and Shaw. As a result of the negative response of physicians and the CMA to Professor Downie's 2006 CMAJ

editorial (AI.3), they decided to convince provincial Colleges of Physicians and Surgeons to adopt the CRG model:

> We decided to proceed by way of regulatory bodies rather than the CMA for two main reasons: 1) the Colleges of Physicians and Surgeons, not the CMA, are the regulators of physicians, which means their policies have more force than CMA policies; and 2) in view of the reaction of the CMA to the editorial described earlier, we thought CMA policy reform was unlikely.[8]

AIII.4 This explanation was part of the introduction to the draft CRG policy, *A Model Conscientious Objection Policy for Canadian Colleges of Physicians and Surgeons* (below, right column).

AIV. Saskatchewan College replicates the CRG Model

AIV.1 On 16 January, 2015, the Council of the College of Physicians and Surgeons of Saskatchewan approved in principle a draft policy statement on conscientious objection and directed the Registrar to begin consultations about it.[9]

AIV.2 The draft document, Conscientious Refusal, is virtually identical to A Model Conscientious Objection Policy for Canadian Colleges of Physicians and Surgeons, the model proposed to Canadian Colleges by Professor Downie and her colleagues.

AIV.3 Nonetheless, the College's Associate Registrar, Bryan Salte, has denied that Conscientious Refusal "was taken" from from *A Model Conscientious Objection Policy for Canadian Colleges of Physicians and Surgeons*. He did acknowledge that the Conscience Research Group's proposal was "significant source" for the draft College policy.[10]

AIV.4 Very strictly speaking, this is true (See Appendix "B"). Nonetheless, the fact remains that the draft policy approved in principle by the College Council is virtually identical to a model policy proposed by activists whose goal is to force physicians unwilling to kill patients or to provide abortions to help to arrange for someone else to do so.

AIV.5 In the columns below, italicized text the sections of text in the Downie/McLeod/Shaw model that are identical to the College's proposed draft, while underlining of sections in the College's draft marks those parts that differ from the Conscience Research Group model.

College of Physicians and Surgeons of Saskatchewan

Draft Policy- Conscientious Refusal

This document is a policy of the College of Physicians and Surgeons of Saskatchewan and reflects the position of the College.

1. Purpose

This policy seeks to provide clear guidance to physicians and the public about the obligations which physicians have to provide care to patients and how to balance those obligations with physicians' right to act in accordance with their conscience if they conflict.

2. Scope

This policy applies to all situations in which physicians are providing, or holding themselves out to be providing, health services.

3. Definitions

Freedom of conscience: for purposes of this policy, actions or thoughts that reflect one's deeply held and considered moral or religious beliefs.

Jocelyn Downie, Carolyn McLeod and Jacquelyn Shaw

Moving Forward with a Clear Conscience: A Model Conscientious Objection Policy for Canadian Colleges of Physicians and Surgeons

This document is a policy of the College of Physicians and Surgeons of [location] and reflects the position of the College. It is expected that all members of the College will comply with it. Failure to do so will render members subject to College investigation and may result in disciplinary action being taken against them.

1. Purpose

This policy seeks to provide clear guidance to physicians and the public about the right of physicians to act in accordance with their conscience as well as *obligations* they *have* that may conflict with this right and concern the provision of health information, referrals, and health services. This policy also outlines a process for the public to make complaints against physicians who fail to meet these obligations.

2. Scope

This policy applies to all situations in which physicians are providing, or holding themselves out to be providing, health services.

3. Definitions

Freedom of conscience: *for purposes of this policy,* freedom to act in ways *that reflect one's deeply held and considered moral or religious beliefs.*

College of Physicians and Surgeons of Saskatchewan	Jocelyn Downie, Carolyn McLeod and Jacquelyn Shaw
Draft Policy- Conscientious Refusal	**Moving Forward with a Clear Conscience: A Model Conscientious Objection Policy for Canadian Colleges of Physicians and Surgeons**
Lawful excuse: a reason provided by law that relieves a person of a duty (e.g., physicians have a lawful excuse not to treat a patient who requests a procedure that will not achieve the goal that the patient seeks).	***Lawful excuse:*** *a reason provided by law that relieves a person of a duty (e.g., physicians have a lawful excuse not to treat a patient who requests a procedure that will not achieve the goal the patient seeks).*
4. Principles	***4. Principles***
The College of Physicians and Surgeons has an obligation to serve and protect the public interest. The Canadian medical profession as a whole has an obligation to ensure that people have access to the provision of legally permissible and publicly-funded health services.	*The College of Physicians and Surgeons has an obligation to serve and protect the public interest. The Canadian medical profession as a whole has an obligation to ensure that people have access to the provision of legally permissible and publicly funded health services.*
Physicians have an obligation not to interfere with or obstruct a patient's right to access legally permissible and publicly-funded health services.	*Physicians have an obligation not to interfere with or obstruct people's access to legally permissible and publicly funded health services.*
Physicians have an obligation to provide health information, referrals, and health services to their patients in a non-discriminatory fashion.	*Physicians have an obligation to provide health information, referrals, and health services to their patients in a non-discriminatory fashion.*
Physicians have an obligation not to abandon their patients.	*Physicians have an obligation not to abandon their patients.*
In certain circumstances a physician will have a lawful excuse to refuse to provide a service requested by a patient.	
Physicians' freedom of conscience should be respected.	*Physicians' freedom of conscience should be respected.*

College of Physicians and Surgeons of Saskatchewan	Jocelyn Downie, Carolyn McLeod and Jacquelyn Shaw
Draft Policy- Conscientious Refusal	**Moving Forward with a Clear Conscience: A Model Conscientious Objection Policy for Canadian Colleges of Physicians and Surgeons**
It is recognized that these obligations and freedoms can come into conflict. This policy establishes what the College expects physicians to do in the face of such conflict.	*It is recognized that these obligations and freedoms can come into conflict. This policy establishes what the College expects physicians to do in the face of such conflict.*
5. Obligations	***5. Obligations***
5.1 Taking on new patients	***5.1 Taking on new patients***
Physicians must not refuse to accept patients based on the following characteristics of, or conduct by, them:	Even if doing so would violate their deeply held and considered moral or religious beliefs, *physicians must not refuse to* take on individuals as *patients based on the following characteristics of or conduct by them*:
a. age;	*a. age;*
b. race, national/ethnic/Aboriginal origin, colour;	*b. race, national/ethnic/Aboriginal origin, colour;*
c. sex, gender identity, or gender expression;	*c. sex, gender identity, or gender expression;*
d. religion or creed;	*d. religion or creed;*
e. family or marital status;	*e. family or marital status;*
f. sexual orientation;	*f. sexual orientation;*
g. physical or mental disability;	*g. physical or mental disability;*
h. medical condition;	*h. medical condition;*
I. socioeconomic status;	*I. socioeconomic status;*

College of Physicians and Surgeons of Saskatchewan Draft Policy- Conscientious Refusal	Jocelyn Downie, Carolyn McLeod and Jacquelyn Shaw Moving Forward with a Clear Conscience: A Model Conscientious Objection Policy for Canadian Colleges of Physicians and Surgeons
j. engaging in activities perceived to contribute to ill health (e.g., smoking, drug or alcohol abuse); or	*j. engaging in activities perceived to contribute to ill health (e.g., smoking, drug or alcohol abuse); or*
k. requesting or refusing any particular publicly-funded health service.	*k. requesting or refusing any particular publicly funded health service.*
The above obligation does not prevent physicians from making *bona fide* decisions, or exercising professional judgment, in relation to their own clinical competence. Physicians are always expected to practice medicine in keeping with their level of clinical competence to ensure that they safely deliver quality health care. If physicians genuinely feel on grounds of lack of clinical competence that they cannot accept someone as a patient because they cannot appropriately meet that person's health care needs, then they should not do so and should explain to the person why they cannot do so.	*The above obligation does not prevent physicians from making bona fide decisions, or exercising professional judgment, in relation to their own clinical competence. Physicians are always expected to practice medicine in keeping with their level of clinical competence to ensure that they safely deliver quality health care. If physicians genuinely feel that they cannot accept someone as a patient because they cannot* competently *meet that person's health care needs, then they should not* accept that person *and should explain to* him or her *why they cannot do so.*
The above obligation does not prevent physicians from making *bona fide* decisions to develop a non-discriminatory focused practice.	*The above obligation does not prevent physicians from making bona fide decisions to develop a specialist practice.*
Where physicians know in advance that they will not provide specific services, but will provide only referrals (in accordance with s. 5.3), they must communicate this fact as early as possible and preferably in advance of the first appointment with an individual who wants to become their patient.	*Where physicians know in advance that they will not provide specific services, but will provide only referrals (in accordance with s. 5.3), they must communicate this fact as early as possible and preferably in advance of the first appointment with an individual who wants to become their patient.*

College of Physicians and Surgeons of Saskatchewan	Jocelyn Downie, Carolyn McLeod and Jacquelyn Shaw
Draft Policy- Conscientious Refusal	**Moving Forward with a Clear Conscience: A Model Conscientious Objection Policy for Canadian Colleges of Physicians and Surgeons**
5.2 Providing information to patients	**5.2 Providing information to patients**
Physicians must provide their patients with the health information required to make legally valid, informed choices about medical treatment (e.g., diagnosis, prognosis, and treatment options, including the option of no treatment or treatment other than that recommended by the physician), even if the provision of such information conflicts with the physician's deeply held and considered moral or religious beliefs.	*Physicians must provide their patients with the health information required to make legally valid, informed choices about medical treatment (e.g., diagnosis, prognosis, and treatment options, including the option of no treatment or treatment other than that recommended by the physician), even if the provision of such information conflicts with the physician's deeply held and considered moral or religious beliefs.*
Physicians must not provide false, misleading, intentionally confusing, coercive, or materially incomplete information to their patients.	*Physicians must not provide false, misleading, intentionally confusing, coercive, or materially incomplete information to their patients.*
All information must be communicated by the physician in a way that is likely to be understood by the patient.	*All information must be communicated by the physician in a way that is likely to be understood by the patient.*
While informing a patient, physicians must not communicate or otherwise behave in a manner that is demeaning to the patient or to the patient's beliefs, lifestyle, choices, or values.	*While informing a patient, physicians must not communicate or otherwise behave in a manner that is demeaning to the patient or to the patient's beliefs, lifestyle, choices, or values.*
Physicians must not promote their own moral or religious beliefs when interacting with a patient.	
The obligation to inform patients may be met by delegating the informing process to another competent individual for whom the physician is responsible.	*The obligation to inform patients may be met by delegating the informing process to another competent individual for whom the physician is responsible.*

College of Physicians and Surgeons of Saskatchewan	Jocelyn Downie, Carolyn McLeod and Jacquelyn Shaw
Draft Policy- Conscientious Refusal	**Moving Forward with a Clear Conscience: A Model Conscientious Objection Policy for Canadian Colleges of Physicians and Surgeons**
5.3 Providing referrals for health services	***5.3 Providing referrals for health services***
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 make a timely referral to another health care provider who is willing and able to accept the patient and provide the service.	*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 make a referral to another health care provider who is willing and able to accept the patient and provide the service.*
This obligation does not prevent physicians from refusing to refer patients where there exists a recognized lawful excuse (see s. 3).	*This obligation does not prevent physicians from refusing to refer patients where there exists a recognized lawful excuse (see s. 3).*
While discussing a referral with a patient, physicians must not communicate, or otherwise behave in a manner that is demeaning to the patient or to the patient's beliefs, lifestyle, choices, or values.	*While discussing a referral with a patient, physicians must not communicate, or otherwise behave in a manner that is demeaning to the patient or to the patient's beliefs, lifestyle, choices, or values.*
When physicians make referrals for reasons having to do with their moral or religious beliefs, they must continue to care for the patient until the new health care provider assumes care of that patient.	*When physicians make referrals* to protect their own freedom of conscience*, they must continue to care for the patient until the new health care provider assumes care of that patient.*
5.4 Treating patients	***5.4 Treating patients***
When a referral to another health care provider is not possible without causing a delay that would jeopardize the patient's health or well-being, physicians must provide the patient with all health services that are legally permissible	*When a referral to another health care provider is not possible without causing a delay that would jeopardize the patient's health or well-being, physicians must provide the patient with all health services that are legally permissible*

College of Physicians and Surgeons of Saskatchewan	Jocelyn Downie, Carolyn McLeod and Jacquelyn Shaw
Draft Policy- Conscientious Refusal	**Moving Forward with a Clear Conscience: A Model Conscientious Objection Policy for Canadian Colleges of Physicians and Surgeons**
and publicly-funded and that are consented to by the patient or, in the case of an incompetent patient, by the patient's substitute decision-maker. This obligation holds even in circumstances where the provision of health services conflicts with physicians' deeply held and considered moral or religious beliefs.	*and publicly funded and that are consented to by the patient or, in the case of an incompetent patient, by the patient's substitute decision-maker. This obligation holds even in circumstances where the provision of health services conflicts with physicians' deeply held and considered moral or religious beliefs.*
This obligation does not prevent physicians from refusing to treat a patient where there exists a recognized lawful excuse (see s. 3).	*This obligation does not prevent physicians from refusing to treat a patient where there exists a recognized lawful excuse (see s. 3).*
	6. Complaints Process
	Upon notification of a complaint under this Policy (see Form 2 [to be developed]), the College will investigate, prosecute, and remedy breaches of the obligations set out in this Policy.
	7. Penalties
	Failure to meet the obligations set out in this policy constitutes professional misconduct. Physicians who violate this policy will be subject to discipline by the College.

Notes:

1. A requirement that an objection physician "advise the patient of other sources of assistance," was introduced by the CMA General Council in June, 1977, and revoked the following year. Geekie D.A. "Abortion referral and MD emigration: areas of concern and study for CMA." *CMAJ*, January 21, 1978, Vol. 118, 175, 206 (http://www.consciencelaws.org/archive/documents/cma-cmaj/1978-01-21-CMAJ-118-175-referral-geekie.pdf) Accessed 2014-02-22; "Ethics problem reappears." *CMAJ*, July 8, 1978, Vol. 119, 61-62 (../archive/documents/cma-cmaj/1978-07-08-CMAJ-119-61-62-referral-out.pdf) Accessed 2014-02-22. In 2000, during a telephone conversation with the Project Administrator, Dr. John R. Williams, then CMA Director of Ethics, confirmed that the Association did not require objecting physicians to refer for abortion. He explained that the CMA had once had a policy that required referral, but had dropped it because there was "no ethical consensus to support it." This was clearly a brief reference to the short-lived 1977 revision of the Code of Ethics and ensuing controversy.

2. In a guest 2006 editorial in the Canadian Medical Association Journal, Professors Sanda Rodgers of the University of Ottawa and Jocelyn Downie of Dalhousie University complained that "[s]ome physicians refuse to provide abortion services and refuse to provide women with information or referrals needed to find help elsewhere." Rodgers S. Downie J. "Abortion: Ensuring Access." *CMAJ* July 4, 2006 vol. 175 no. 1 doi: 10.1503/cmaj.060548 (http://www.cmaj.ca/content/175/1/9.full) Accessed 2014-02-23.

3. Blackmer J. "Clarification of the CMA's position on induced abortion." *CMAJ* April 24, 2007 vol. 176 no. 9 doi: 10.1503/cmaj.1070035 (http://www.cmaj.ca/content/176/9/1310.1.full) Accessed 2014-02-22.

4. Schuklenk U, van Delden J.J.M, Downie J, McLean S, Upshur R, Weinstock D. *Report of the Royal Society of Canada Expert Panel on End-of-Life Decision Making* (November, 2011) p. 101 (http://rsc-src.ca/sites/default/files/pdf/RSCEndofLifeReport2011_EN_Formatted_FINAL.pdf) Accessed 2014-02-23.

5. Schuklenk U, van Delden J.J.M, Downie J, McLean S, Upshur R, Weinstock D. *Report of the Royal Society of Canada Expert Panel on End-of-Life Decision Making* (November, 2011) p. 62 (http://rsc-src.ca/sites/default/files/pdf/RSCEndofLifeReport2011_EN_Formatted_FINAL.pdf) Accessed 2014-02-23.

6. Schuklenk U. "Supreme Court of Canada heard arguments in Charter challenge to assisted dying criminalisation." *Udo Schuklenk's Ethx Blog*, T, Thursday, October 16, 2014 (http://ethxblog.blogspot.ca/2014/10/supreme-court-of-canada-heard-arguments.html) Accessed 2015-02-22.

7. *Let their conscience be their guide? Conscientious refusals in reproductive health care.* (http://conscience.carolynmcleod.com/meet-the-team/) Accessed 2014-11-21.

8. Downie J. McLeod C. Shaw J. "Moving Forward with a Clear Conscience: A Model Conscientious Objection Policy for Canadian Colleges of Physicians and Surgeons." *Health Law Review*, 21:3, 2013, p. 29 (http://carolynmcleod.com/wp-content/uploads/2014/05/04_Downie-McLeod-Shaw.pdf) Accessed 2015-02-24.

9. College of Physicians and Surgeons of Saskatchewan, *Executive Summary of the 16 January, 2015 Council Meeting* (http://www.cps.sk.ca/cpss/Physician_Summary/Activity_Viewer.aspx?SEQN=63103&Doc=MEETINGFUNC) Accessed 2015-02-22.

10. Weatherbe S. "'This is moral genocide': Canadian doctors blast plans to force them into helping patients procure abortion." *LifeSite News*, 17 February, 2015 (https://www.lifesitenews.com/news/this-is-moral-genocide-canadian-doctors-blast-plans-to-force-them-into-help?) Accessed 2015-02-22.

Appendix "B"

Development of the CPSS Draft Policy Conscientious Refusal

BI. Conscience Research Group (CRG)

BI.1 The Conscience Research Group (CRG) was formed by Professor Carolyn McLeod of the University of Western Ontario with the assistance of a 2009 grant of over $240,000.00 from the Canadian Institutes of Health Research (CIHR).[1] CIHR provided members of the group with another $24,500.00 in grants between 2010 and 2012.[2]

BI.2 The Group faculty includes euthanasia/assisted suicide advocates Jocelyn Downie and Daniel Weinstock. It is headed by Professor Carolyn McLeod and supported by research associate Jaquelyn Shaw and seven graduate students.[3]

BI.3 A central goal of the Group is to entrench in medical practice a duty to refer for or otherwise facilitate contraception, abortion and other "reproductive health" services. The Group advocates a coercive model policy on conscientious objection that would apply to any legal, publicly funded procedure, including assisted suicide and euthanasia. They have been working to convince provincial Colleges of Physicians and Surgeons to enact the policy in order to achieve by force of law/regulation what they have been unable to achieve by persuasion (Appendix "A").

BII. CRG convenes meeting with College representatives

BII.1 The Group organized a meeting in 2013 to advance their *Model Concientious Objection Policy* (Appendix "A"). The meeting, which was funded by a research grant (presumably the CIHR granted noted above) included:

- Bryan Salte, LLB, Associate Registrar, College of Physicians and Surgeons of Saskatchewan
- Andréa Foti, Manager- Policy Dept., College of Physicians and Surgeons of Ontario
- Dr. Gus Grant, Registrar of the College of Physicians and Surgeons of Nova Scotia
- A representative of the Collège des Médecins du Québec
- ". . . representatives from the faculties of law, medicine and philosophy from academia and other invited individuals."[4]

BII.2 The CRG authors appear to refer to this meeting in the introduction to their model policy:

> Feedback on the draft policy was also solicited from a number of relevant experts: academics who do research primarily in health law, biomedical ethics, medicine or other health professions; **physician regulatory body members**; and local community organizations dealing with women's health, sexual health, and the health of more marginalized populations (e.g. rural populations, street youth, First Nations). . . (Emphasis added)[5]

BII.3 It is not unlikely that the various faculties were represented by CRG members, perhaps augmented by supportive colleagues.

BII.4 The goal of the meeting "was to develop a policy that could be adopted by Canadian Colleges of Physicians and Surgeons to guide physicians who have a conscientious objection to providing certain forms of health care."

> While that is most frequently experienced in issues pertaining to reproduction i.e. birth control, abortion and emergency contraception, it can arise in a number of other situations as well, such as the provision of blood products and end of life care.[4]

BII.4 According to Byran Salte, participants at the meeting agreed upon the text of what he subsequently called the "draft policy statement developed by the Conscientious Objections Working Group."[6] This was almost an exact duplicate of what the CRG published later in 2013 as its *Model Conscientious Objection Policy*. However, because Mr. Salte continued to use and refer to the text of the former, he could, strictly speaking, claim that the CPSS draft, *Conscientious Refusal* was not "taken from" that the CRG Model.

BIII. Meeting of Registrars of BC, Alberta, Saskatchewan, Manitoba and Ontario

BIII.1 On 5 May, 2014,[7] the "draft policy statement developed by the Conscientious Objections Working Group" was discussed during a meeting of the Registrars of the Colleges of BC, Alberta, Saskatchewan, Manitoba and Ontario. Associate Registrar Bryan Salte of Saskatchewan seems to have taken the lead:

> I suggested that each of the Colleges consider whether the recommendations in the report of the conscientious objections working group are appropriate, and if so, to consider implementing them. I understood each College agreed to consider doing that.[8]

BIII.2 According to Salte, the Registrars "appeared to have reached a consensus that the document developed by the working group. . . should be considered for possible adoption by Canadian Colleges of Physicians and Surgeons."[4]

BIII.3 Of interest here is that the reported consensus included the Registrar of the College of Physicians and Surgeons of Ontario, one month *before* the Ontario College launched its public consultation on *Physicians and the Ontario Human Rights Code*.[9]

BIII.4 However, the Registrar of the College of Physicians of BC made no reference to the discussion or consensus when reporting to the College Board at the end of the month,[7] and the Registrar of the College in Alberta seems not to have reported the discussion or consensus at the College's quarterly Council meeting at the end of May.[10] Neither was the discussion or consensus mentioned by Bryan Salte at the CPSS Council meeting at the end of June, though he made numerous other reports.[11]

BIV. Controversy about Alberta physician declining to prescribe contraceptives

BIV.1 On 2 July, 2014, the CPSS Registrar (or someone in her office) copied a newspaper article about a Calgary physician who was refusing to prescribe contraceptives for the information of College Council.[12] This appears to have been done in anticipation of the next Council meeting in September.

BIV.2 It is noteworthy that the news reports were sparked by a patient who was offended by the physician's notice about her practice, not by someone who had been refused a birth control prescription, although this was not clear in the clipping selected.[13] More significant, the final sentence in the story stated that CPSA policy required objecting physicians to "ensure the patient has access to another practitioner who will prescribe the drug." The statement erroneously implied a policy of mandatory referral for morally contested services.

BIV.3 The Registrar of the Alberta College included the following remarks in a column sparked by the controversy. He referred, in particular, to two paragraphs of the College's policy on *Moral or Religious Beliefs Affecting Medical Care*:

> 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.
>
> 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 must ensure that the patient who seeks such advice or medical care is offered timely access to another physician or resource that will provide accurate information about all available medical options.[14]

BIV.4 He went on to say:

> The first point I wish to make is that patients shouldn't be denied access to a medically necessary service. Numbers 2 and 4 (especially #4) of the standard emphasize that point. The physician in this case responded by altering her sign, giving prospective patients specific information as to where (and from whom) they could receive information about birth control including, if appropriate, a prescription for oral contraceptive pills.[15]

BIV.5 This could be taken to imply that the policy means that a physician has a duty to refer for a morally contested service, and that the physician in question had complied with the policy. However, the Registrar had previously refused to assert that the policy implied such a duty, and strongly denied that the policy should be understood to imply a duty to refer for abortion.[16]

BV. Canadian Registrars advised to adopt uniform coercive policy

BV.1 Associate Registrar Bryan Salte wrote to all Canadian Registrars of Colleges of

Physicians and Surgeons, in July, 2014. Citing the consensus of the western registrars (BIII.2), he recommended that all Colleges in Canada adopt the "draft policy statement developed by the Conscientious Objections Working Group."

> Physician-assisted suicide, in particular, has the potential to challenge Colleges of Physicians and Surgeons to provide guidance to its members. . .
>
> I think it will be very helpful if all Colleges are able to adopt the same or a very similar document. My perspective is that that topic has the potential to be very controversial. My perspective is that ethical standards for medical practice should be very similar across Canada, and that it should be possible for Canadian Colleges to adopt a common approach. Any College that is an outlier, either because it has adopted a different position than other Colleges, or because it has not developed a policy, will potentially be placed in a difficult position.[4]

BV.2 Note that the concern voiced here is with the provision of assisted suicide (and, presumably, euthanasia), not with birth control or abortion. Obviously, if it is agreed that objecting physicians can be coerced to refer patients for euthanasia, it becomes difficult to explain why they should not be forced to refer patients for anything else.

BVI. Memo to College Council proposes policy on "ethical objection"

BVI.1 On 31 July, 2014, Mr. Salte prepared a memo for College Council asking "whether it will develop a policy or guideline for physicians who have an ethical objection to providing certain forms of care."[17]

BVI.2 He offered five examples of "issues which have resulted in controversy": abortion, birth control, assisted suicide, fetal sex identification and genetic testing. He identified himself as "part of a group that was formed with a grant to study and provide recommendations to Canadian Colleges of Physicians and Surgeons" concerning "physicians who have a conscientious objection to providing certain forms of medical care." He provided a copy of the "draft policy statement developed by the Conscientious Objections Working Group," a copy of his letter to the Registrars of Canadian Colleges and copies of Alberta, Saskatchewan, Manitoba and Ontario policies referring to similar issues.

BVI.3 The policy documents were supplemented by a newspaper article about the Ontario consultation. It referred to the On-line poll conducted by the College of Physicians and Surgeons of Ontario, which was actually of doubtful value. However, the article concluded with an interview of ethicist Arthur Schafer, who insisted that objecting physicians have an obligation to refer patients to a colleague who will provide the services they refuse to provide.[18]

BIV.4 Mr. Salte also included an article from an American professional journal, "Conscientious Refusal in Family Medicine Residency Training." The article described the results of a survey completed by 154 physicians in a university faculty, less than half of those polled.

Like the article quoting Schafer, the conclusion of the journal article generally favoured the draft policy he was proposing:

> This study is the first to demonstrate the prevalence of moral objection to legally available medical procedures among family medicine residents and faculty. The survey responses demonstrate that conscientious objection exists and that there is support for physicians exercising moral objection in clinical practice, provided they engage in appropriate patient education and referral.[19]

BIV.5 However, the author added that the results were "unique to the residents and faculty in the University of Wisconsin Department of Family Medicine and limit generalizability of the findings" and that "the complexity of the subject matter may also limit the respondents' ability to give a complete answer by requiring a yes or no response."[19]

BVII. College Council approves formation of committee

BVII.1 At the College Council meeting on 19 September, 2014, Mr. Salte presented his report and the newspaper clipping about the Calgary physician (BIV.).

BVII.2 The Council approved the formation of a committee to study "Conscientious Objection to Providing Medical Care." Members of the committee were Mr. Salte, Council President Dr. Mark Chapelski, and public members Susan Halland and Marcel de la Gorgendiere. Dr. Susan Hayton of the Department of Academic Family Medicine of the University of Saskatchewan was also a committee member.[20] In January, 2014 she completed a Master's thesis on Accommodation of Religious and Cultural Differences in Medical School Training.[21]

BVIII. Committee meeting

BVIII.1 The committee met once; no minutes were kept.[22] Dr. Chapelski was not present. Committee members were Registrar Karen Shaw, Associate Registrar Bryan Salte, Deputy Registrar Dr. Michael Howard-Tripp, Dr. Hayton, Susan Halland and Marcel de la Gorgendiere. The group agreed that the "draft policy statement developed by the Conscientious Objections Working Group" was generally satisfactory, but suggested minor changes for the sake of clarity. The only notable changes:

- Statements concerning disciplinary consequences were removed because they were thought superfluous.
- A statement to the effect that physicians should not promote their own beliefs was added.[23]

BIX. Council approval in principle

BIX.1 Mr. Salte presented a report based on the committee meeting to Council, recommending that there should be a consultation about the document because of its"potentially contentious nature."[24] On 20 January, 2015, Council unanimously approved the policy in principle and authorized a consultation.[25]

Notes:

1.

2009

Principal Investigator:	MCLEOD, Carolyn W
Co-Investigators:	BAYLIS, Françoise; DOWNIE, Jocelyn G; HICKSON, Michael W
Institution Paid:	University of Western Ontario
Program:	Operating Grant
Year/Month:	2009/09
Assigned PRC:	HLE
Project Title:	**Let Conscience Be Their Guide? Conscientious Refusals in Reproductive Health Care**
Details:	Many bioethicists and health-policy makers are currently struggling with what to do about conscientious refusals by health care professionals to provide standard health care services, such as abortions. The proposed research addresses this complex moral and legal issue. Our team will conduct rigorous analyses of when conscientious refusals--in particular those that occur in reproductive health care--are morally and legally permissible, and of which policies and educational initiatives we need in Canada with respect to these refusals. Our practical aim is to encourage delivery of reproductive health care services that is appropriately respectful of conscience and that safeguards women's reproductive health.
CIHR Contribution:	$240,296
CIHR Equipment:	$0
Term Yrs/Mths.:	3 yrs 0 mth
	Source: CIHR, *Funding Decisions Data* (http://webapps.cihr-irsc.gc.ca/cfdd/db_search?p_language=E) Accessed 2015-02-23)

2.

2010

Principal Investigator:	MCLEOD, Carolyn W
Co-Investigators:	
Institution Paid:	University of Western Ontario
Program:	CIHR Café Scientifique Program
Year/Month:	2010/06
Assigned PRC:	***
Project Title:	**The Spark of Conscience Inflames Debate: Conflicts of Conscience in Medicine**
Details:	Conscientious refusal by health care professionals to provide standard health services, such as abortions, is a subject of intense debate in Canada and elsewhere. Recent discussion in the Canadian Medical Association Journal about refusals by physicians to participate in abortions revealed that the Canadian Medical Association lacks a coherent policy on conscientious objection. The CIHR Café Scientifique, "The Spark of Conscience Inflames Debate," will provide a public forum for deliberation on what the CMA policy ought to be. The panelists and moderator are all experts in areas of profound relevance to this issue: bioethics, health law, health policy, religion, and medicine.
CIHR Contribution:	$3,000

CIHR Equipment:	$0
Term Yrs/Mths.:	1 yr 0 mth **Source:** CIHR, *Funding Decisions Data* (http://webapps.cihr-irsc.gc.ca/cfdd/db_search?p_language=E) Accessed 2015-02-23)

2011

Principal Investigator:	KANTYMIR, Lori
Co-Investigators:	HICKSON, Michael W; MCLEOD, Carolyn W
Institution Paid:	University of Western Ontario
Program:	Dissemination Events - Priority Announcement: Ethics
Year/Month:	2011/02
Assigned PRC:	KDE
Project Title:	**Santa Clara Workshop on Conscientious Refusals in Health Care**
Details:	The Santa Clara Workshop on Conscientious Refusals will bring together a CIHR team of researchers studying conscientious refusals in health care in Canada with U.S. researchers and members of the U.S. public to discuss policy options. The workshop is structured to facilitate knowledge exchange between these groups by devoting Day 1 to public discussion and Day 2 to collaboration between expert researchers. The workshop will take an inter-disciplinary approach to the problem of conscientious refusals in health care, and will include presentations from expert researchers working in bioethics, medicine, philosophy, law, and religious studies.
CIHR Contribution:	$18,500
CIHR Equipment:	$0
Term Yrs/Mths.:	1 yr. 0 mth. **Source:** CIHR, *Funding Decisions Data* (http://webapps.cihr-irsc.gc.ca/cfdd/db_search?p_language=E) Accessed 2015-02-23)

2012

Principal Investigator:	SHAW, Jacquelyn
Co-Investigators:	
Institution Paid:	Dalhousie University (Nova Scotia)
Program:	CIHR Café Scientifique Program
Year/Month:	2012/05
Assigned PRC:	CAF
Project Title:	**Liberation therapy aftercare, body modification, reproductive and other health services: can your healthcare provider refuse to treat you because it bothers his (or her) conscience?**
Details:	Conscientious objection has largely entered the public consciousness via the polarizing lens of debates on access to abortion services. Yet such debate reflects only the tip of a much larger iceberg of contexts in which healthcare providers conscientiously refuse to provide certain services. For example, what should be done about conscientious refusals of care to patients who engage in health-related activities of which a practitioner does not professionally approve (e.g., smoking, overeating, body modification, accessing unapproved therapies overseas)? These service

refusals may well be an expression of conscience on the part of healthcare professionals. However, they also risk denying individual patients access to healthcare services and they may in some cases be argued to be discriminatory. The challenging question before us is how we can create policies that permit genuinely conscience-based refusal opportunities, while also ensuring that patients receive adequate, non-discriminatory access to desired healthcare services. The panelists and moderator are experts in areas of relevance to the subject matter: i.e., bioethics, medicine, dentistry and health law and policy. We invite all members of the public, including health and legal professionals, to come to the Café Scientifique, where they can enjoy free refreshments, ask questions of expert panelists, share their own experiences, and weigh in on a matter of great importance to Canadian patients and providers today.

CIHR Contribution: $3,000
CIHR Equipment: $0
Term Yrs/Mths.: 1 yr 0 mth
Source: CIHR, *Funding Decisions Data* (http://webapps.cihr-irsc.gc.ca/cfdd/db_search?p_language=E) Accessed 2015-02-23)

3. *Let their conscience be their guide? Conscientious refusals in reproductive health care.* (http://conscience.carolynmcleod.com/meet-the-team/) Accessed 2014-11-21

4. Letter from Bryan Salte to the Registrars of Colleges of Physicians and Surgeons in Canada. Redacted in Document 200/14, College of Physicians and Surgeons of Saskatchewan, *Report to Council from the Registrar*, 31 July, 2014, p. 8. (http://consciencelaws.org/archive/documents/cpss/2014-07-31-Report.pdf)

5. Downie J. McLeod C. Shaw J.,"Moving Forward with a Clear Conscience: A Model Conscientious Objection Policy for Canadian Colleges of Physicians and Surgeons." *Health Law Review*, 21:3, 2013, p. 29 (http://carolynmcleod.com/wp-content/uploads/2014/05/04_Downie-McLeod-Shaw.pdf) Accessed 2015-02-24

6. Document 200/14, College of Physicians and Surgeons of Saskatchewan, *Report to Council from the Registrar,* 31 July, 2014, p. 4: listed as the first of the attached documents, identifying the text reproduced on pages 5 to 7 of the report. (http://consciencelaws.org/archive/documents/cpss/2014-07-31-Report.pdf) The few differences between the documents are largely editorial and are compared below.

"Draft policy statement developed by the Conscientious Objections Working Group."	**Jocelyn Downie, Carolyn McLeod and Jacquelyn Shaw**
In certain circumstances a physician will have a lawful excuse to refuse to provide a service requested by a patient.	

3. Definitions

Freedom of conscience: for purposes of this policy, *actions or thoughts* that reflect one's deeply held and considered moral or religious beliefs.

5.1 Taking on new patients

Even if taking on certain individuals as patients would violate the physician's deeply held and considered moral or religious beliefs, physicians must not refuse to take people on based on the following characteristics of or conduct by them:

. . . If physicians genuinely feel *on grounds of lack of clinical competence* that they cannot accept someone as a patient because they cannot *appropriately* meet that person's health care needs, then they should not *do so* and should explain to *the person* why they cannot do so.

When physicians make referrals *for reasons having to do with their moral or religious beliefs*, they must continue to care for the patient until the new health care provider assumes care of that patient.

3. Definitions

Freedom of conscience: for purposes of this policy, freedom to act in ways that reflect one's deeply held and considered moral or religious beliefs.

5.1 Taking on new patients

Even if doing so would violate their deeply held and considered moral or religious beliefs, physicians must not refuse to take on individuals as patients based on the following characteristics of or conduct by them:

. . . If physicians genuinely feel that they cannot accept someone as a patient because they cannot competently meet that person's health care needs, then they should not accept that person and should explain to him or her why they cannot do so.

When physicians make referrals to protect their own freedom of conscience, they must continue to care for the patient until the new health care provider assumes care of that patient.

7. College of Physicians and Surgeons of British Columbia, *Minutes of Board Meeting 30 May, 2014,* p. 2. The Registrar reported the date of the meeting and four agenda items, but did not mention the discussion concerning physician freedom of conscience. (https://www.cpsbc.ca/files/pdf/Minutes-Board-2014-05-30.pdf) Accessed 2015-02-23.

8. Document 200/14, College of Physicians and Surgeons of Saskatchewan, *Report to Council from the Registrar*, 31 July, 2014, p. 3. (http://consciencelaws.org/archive/documents/cpss/2014-07-31-Report.pdf)

9. "Physicians and the Ontario Human Rights Code." *Protection of Conscience Blog*, 4 June, 2014. (http://consciencelaws.org/blog/?p=4921)

10. College of Physicians and Surgeons of Alberta, *Council Highlights*, May, 2014. (http://www.cpsa.ab.ca/Libraries/council/meeting-highlights.pdf) Accessed 2015-02-23.

11. College of Physicians and Surgeons of Saskatchewan, Agenda, Open Session and Executive Summary, Council Meeting 20-21 June, 2014 (http://www.cps.sk.ca/cpss/Physician_Summary/Activity_Viewer.aspx?SEQN=51360&Doc=ME

ETINGFUNC) Accessed 2015-02-23. He did provide a report on a Federation of Medical Regulatory Authorities, but the report is confidential.

12. Document 185/14, College of Physicians and Surgeons of Saskatchewan, "Alberta doctor refuses to prescribe birth control over her morality." Tristan Bronca, *The Medical Post*, 30 June, 2014.
(http://www.consciencelaws.org/archive/documents/cpss/2014-07-02-CPSSCouncil-AltaDoctor.pdf)

13. Leung M. "Calgary doctor refuses to prescribe birth control due to personal beliefs." *CTV News*, 28 June, 2014.
(http://www.ctvnews.ca/canada/calgary-doctor-refuses-to-prescribe-birth-control-due-to-personal-beliefs-1.1890724) (Accessed 2015-02-25)

14. College of Physicians and Surgeons of Alberta, *Moral or Religious Beliefs Affecting Medical Care*.
(http://www.cpsa.ab.ca/Resources/StandardsPractice/medical-practice/moral-or-religious-beliefs-affecting-medical-care) Accessed 2015-02-13.

15. College of Physicians and Surgeons of Alberta, "Trevor's Take on. . . Moral or Religious Beliefs Affecting Medical Care." *The Messenger*, 3 July, 2014
(http://www.cpsa.ab.ca/Resources/the-messenger/trevors-take-on/trevors-take-on/2014/07/03/a-patient's-right-to-good-medical-care) Accessed 2015-02-24.

16. Protection of Conscience Project Submission to the College of Physicians and Surgeons of Ontario Re: *Professional Obligations and Human Rights* (20 February, 2015) Appendix "B", BII.2.9
(http://www.consciencelaws.org/publications/submissions/submissions-013-003-cpso.aspx#BII.2.9)

17. Document 200/14, College of Physicians and Surgeons of Saskatchewan, Memo from Bryan Salte to Council dated 31 July, 2014 Re: *Possible Policy or Guideline - Physicians who have an ethical objection to provide certain forms of medical services.*
(http://www.consciencelaws.org/archive/documents/cpss/2014-07-31-Report.pdf)

18. Document 200/14, College of Physicians and Surgeons of Saskatchewan, Memo from Bryan Salte to Council dated 31 July, 2014 Re: *Possible Policy or Guideline - Physicians who have an ethical objection to provide certain forms of medical services*. p. 19-20.
(http://www.consciencelaws.org/archive/documents/cpss/2014-07-31-Report.pdf)

19. Document 200/14, College of Physicians and Surgeons of Saskatchewan, Memo from Bryan Salte to Council dated 31 July, 2014 Re: *Possible Policy or Guideline - Physicians who have an ethical objection to provide certain forms of medical services*, p. 21-24.
(http://www.consciencelaws.org/archive/documents/cpss/2014-07-31-Report.pdf)

20. College of Physicians and Surgeons of Saskatchewan, *Minutes of Council Meeting*, 19 September, 2014. (http://www.consciencelaws.org/archive/documents/cpss/2014-09-19-20-CPSSCouncilMinutes.pdf)

21. Hayton S. *Accommodation of Religious and Cultural Differences in Medical School Training.* A Thesis Submitted to the College of Graduate Studies and Research In Partial Fulfillment of the Requirements For the Degree of Master of Laws In the College of Law University of Saskatchewan Saskatoon (January, 2014) (http://ecommons.usask.ca/bitstream/handle/10388/ETD-2014-01-1446/HAYTON-THESIS.pdf?sequence=4) Accessed 2015-02-24.

22. Document 23/15, College of Physicians and Surgeons of Saskatchewan, Memo to Council from Bryan Salte, Re: Draft Policy-Conscientious Objection (9 January, 2015), p. 2. (http://www.consciencelaws.org/archive/documents/cpss/2015-01-09-Draft Conscientious Objection Policy.pdf) Email from the Office of the Registrar, College of Physicians and Surgeons of Saskatchewan, to the Administrator, Protection of Conscience Project, 24 February, 2015, 7:14 AM.

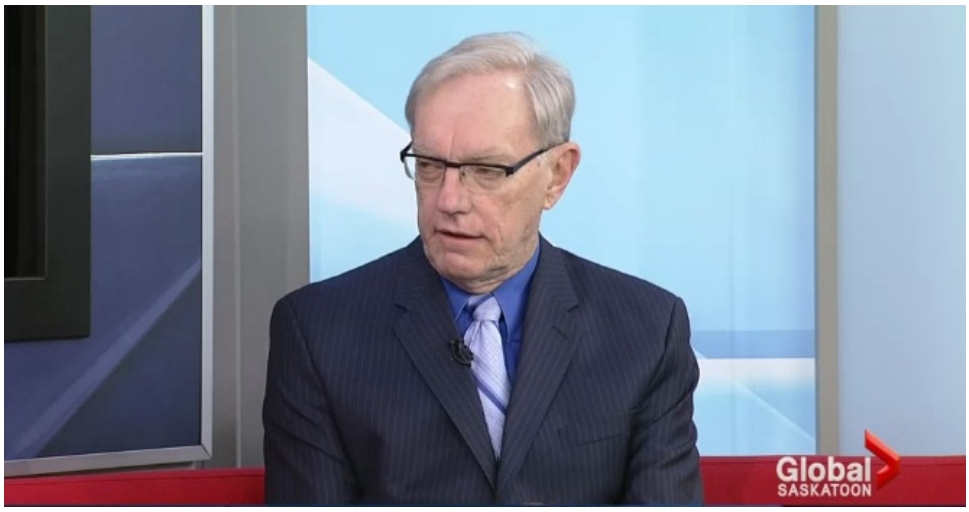
23. Document 23/15, College of Physicians and Surgeons of Saskatchewan,Memo to Council from Bryan Salte, *Re: Draft Policy-Conscientious Objection* (9 January, 2015), p. 2-3 (http://www.consciencelaws.org/archive/documents/cpss/2015-01-09-Draft Conscientious Objection Policy.pdf)

24. Document 23/15, College of Physicians and Surgeons of Saskatchewan, Memo to Council from Bryan Salte, *Re: Draft Policy-Conscientious Objection* (9 January, 2015), p. 2 (http://www.consciencelaws.org/archive/documents/cpss/2015-01-09-Draft Conscientious Objection Policy.pdf)

25. College of Physicians and Surgeons of Saskatchewan, *Minutes of Council Meeting*, 16 January, 2015, p. 11 (http://www.consciencelaws.org/archive/documents/cpss/2015-01-16-CPSSCouncilMinutes.pdf)

Appendix "C"

Interview of Associate Registrar, College of Physicians and Surgeons of Saskatchewan



Saskatchewan doctors could face discipline over assisted suicide
Global News, 13 February, 2015
(http://globalnews.ca/news/1829394/saskatchewan-doctors-could-face-discipline-over-assisted-suicide/) Accessed 2015-02-25

Re: CPSS Draft Policy *Conscientious Refusal*

Note: The interview was preceded by a video clip of an interview with a Saskatchewan physician unwilling to participate in of facilitate assisted suicide.

CI. 00:38

CI.1 **Interviewer:** Now you heard him say he doesn't even want to refer a patient to another doctor willing to help a patient end their lives. Bryan, where are you at in coming up with the regulations for this?

CI.2 **Salte:** Well, it's a fairly broad question. So if what you're asking is solely on the issue of, of what do we expect in terms of referring for what is at some point in time going to be a legal procedure, we currently have a draft policy that is being circulated for discussion, which applies much more broadly than just physician assisted death.

CI.3 It deals with birth control and abortion and all of the other areas where there is a clash between physicians' personal values and the services which patients may wish.

CI.4 So, at the moment, it's a draft policy that, uh, discusses how a physician tries to reconcile their own personal beliefs with the legal services which are available in Canada, despite the fact that their, those legal services may clash with the personal beliefs of the

physician.

CII. 01:32

CII.1 Interviewer: So your policy on conscience obligation says doctors have to refer even if they don't agree. What does this mean for doctors who don't want to?

CIII. 01:42

CIII.1 **Salte:** Well, it means that if this becomes a policy, and it currently is a requirement, for example, in the case of an unwanted pregnancy, and it currently is the policy in other provinces in dealing with some of those issues.[1]

CIII.2 The issue of physician assisted dying is, of course a new issue.

CIII.3 But, the expectation would be that, uh, physicians will follow the directions which come from the College of Physicians and Surgeons which are going to be established, of course, by their colleagues as part of the expectations of practice.

CIII.4 So, if a physician feels that the directives are wrong, they will still, we would expect follow those directives despite the fact that they may not agree with them.

CIV. 02:18

CIV.1 **Interviewer:** Do you think there is any room for a middle ground, or will doctors who disagree with assisted suicide end up being disciplined, could they lose their jobs . . .?

CV. 02:25

CV.1 **Salte:** Well, certainly, um, we try to avoid discipline whenever possible. But if there are physicians who engage in behaviour which is regarded as unacceptable or unprofessional, then that is a possible outcome.

CV.2 Certainly, with any physician what we would try to do is we would work and see if there is some mutually acceptable solution.

CV.3 But you speak about compromise. Um, there are those who, for example, take the position that physicians are compelled to provide legal procedures, and so there those who take the position that by saying physicians who are capable of providing birth control don't actually have to provide it, that already we have engaged in a compromise which is unacceptable.

CV.4 So there is a broad range of, uh, of beliefs out there, there's a broad range of perspectives out there, and what, uh, the draft policy talks about is, in fact, a compromise between the extreme position, which would be that physicians are compelled to provide this service, on the one side, and the other extreme position which is physicians can simply refuse to discuss with their patients what is going to become a legal procedure.

CVI. 03:26

CVI.1 **Interviewer:** So will you wait for the CMA to weigh in on this?

CVII. 03:29

CVII.1 **Salte:** Well, there's a lot of consultation that's going on. I was just at a national meeting and that was a fairly significant subject associated with it.

CVII.2 So the issue is going to be how do we come up with best guidance for physicians on a variety of issues and certainly physician assisted suicide or physician assisted death is one of those.

CVII.3 The other thing, of course, is that this is going to take some number of months to resolve itself, so nothing changes for the next 12 months, or unless the federal government introduces legislation more quickly than that. So, there is a period of time for us to try to get this right. It's not indefinite, but it's not next week either.

CVIII. 04:06

CVIII.1 **Interviewer:** How tough is this for you to deal with? You obviously have had a long career. Is this one of the biggest challenges you've ever faced?

CIX. 04:13

CIX.1 **Salte:** I wouldn't say it's one of the biggest, but it is a difficult challenge. Any time that you have people who believe very strong ethically about certain issues, and certainly we've dealt with that with birth control, we've dealt with that with abortion, we've dealt with that with the morning after pill, there's a variety of other areas that are right now such . . .

CIX.2 **Interviewer:** . . .Grey area.

CIX.3 **Salte:** Very grey areas. People feel very strongly about them and feel that, ethically, they believe that the other side is just completely wrong.

CIX.4 So trying to reconcile some of those and try to find ways where you can impose as little as possible upon the rights or obligations of some part of civilization, where at the same time imposing as little as possible upon the other side is a difficult compromise without question.

End 04:54

Notes

1. **Re: CIII.1 ". . . it is currently a requirement in the case of unwanted pregnancy."**
This is not the case. The policy in question is *Guideline on Unplanned Pregnancy*, adopted in 2011. It opens with the statement, "An unplanned pregnancy is not necessarily and unwanted pregnancy."
(http://www.cps.sk.ca/CPSS/Legislation__ByLaws__Policies_and_Guidelines/Legislation_Content/Policies_and_Guidelines_Content/Unplanned_Pregnancy.aspx)

Although, at the time, some of the major papers reported that the policy required objecting physicians to refer for abortion, this was incorrect.

> The changes are intended to provide clarity, said Dr. Karen Shaw, the college's deputy registrar. They weren't prompted by any specific concerns, but were part of a regular review of college guidelines. The new guidelines were adopted at the council's most recent meeting on Friday.
>
> "We didn't change the actual policy," she said. "It just made it clearer that people can state up front that they have difficulty with this and make a referral or they can assist the patient through all the steps they're comfortable with, until the point where they are more uncomfortable or the patient understands they're not willing to do the last step -which is to refer to someone they know will perform the abortion -but they must provide enough information."
> Scissons H. "Abortion guidelines updated: Rules clarify protocol for doctors unwilling to terminate pregnancy." Saskatchewan Star Phoenix, 9 February, 2011

For a detailed explanation, see Appendix "E."

Re: CIII.1 "it currently is the policy in other provinces in dealing with some of those issues."
Only Quebec requires an objecting physician to refer a patient for a morally contested procedure.

Appendix "D"

Ontario, Alberta, Manitoba and Saskatchewan College Policies

DI. Introduction

DI.1 The information in this Appendix is relevant to the documents provided by Mr. Salte in his memo to Council dated 31 July, 2014 (See IV: Justification for the proposed policy).

DII. College of Physicians and Surgeons of Ontario

DII.1 Physicians and the Ontario Human Rights Code (POHR) was adopted in 2008. An earlier draft was withdrawn because of the opposition and public controversy it provoked, centred on the following passages:

> . . .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. (p. 4)
>
> 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. (p. 6-7)[1]

DII.2 In POHR as adopted, these expectations were dropped. In the event that a patient wants a procedure that a physician is unwilling to provide for reasons of conscience, the physician is expected to advise the patient "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."[2]

DII.3 Contrary to the impression that may have been created by its inclusion in Mr. Salte's memo, this does not amount to a requirement to refer a patient to a physician who will provide a morally contested procedure. This conclusion is supported by the current attempt by a CPSO working group to convince the College Council to adopt a policy that does have such a requirement.

DIII. College of Physicians and Surgeons of Alberta

DIII.1 A copy of the CPSA policy document Moral or Religious Beliefs Affecting Medical Care[3] was provided by Mr. Salte.

DIII.2 Mr. Salte may have been unfamiliar with the development and meaning of the policy.

DIII.3 This provision is part of the Standards of Practice adopted by the CPSA following public consultation in 2008. The original draft Standards included a section concerning the termination of pregnancy which included the statement, "ensure that the patient. . . is offered access to available medical options." In its submission to the College, the Project warned that the wording was likely to be interpreted to impose a duty to refer for or otherwise facilitate procedures or services the physician believes to be wrong, and that

many objecting physicians would find that unacceptable.[4]

DIII.4 Consistent with this warning, the Registrar of the College later stated:

> Most respondents take exception with the draft, believing that the College will require physicians to refer patients for termination of pregnancy, or at the very least to be compliant in arranging a patient's abortion, contrary to the physician's personal beliefs. This is not true. . . .
>
> . . . The College's current policy (in place for the past decade) states:
>
> > While recognizing the varied personal convictions of physicians it must still be the responsibility of physicians to ensure that pregnant women who come to them for medical care are provided with or are offered access to information or assistance to enable them to make informed decisions on all available options for their pregnancies including termination.
>
> The points I wish to make are these: A Standard of Practice on this subject will not change the obligations of physicians that have been accepted by this College since 1991. The words are a little different, but the intent is not, as the principles underlying the standard have not changed over the past 20 years. (Emphasis in the original)[5]

DIII.5 The section concerning terminations of pregnancy was deleted from the final version of the Standards and the policy *Moral or Religious Beliefs Affecting Medical Care* adopted.

DIII.6 As a result of questions from physicians, the Project Administrator wrote to the Registrar of the College and was provided with the wording of the new policy, *Moral or Religious Beliefs Affecting Medical Care*. The Administrator asked the Registrar to confirm that he correctly understood the policy:

> I understand the expectation of referral . . . to hold in those cases in which a physician, for reasons of conscience, is unwilling to advise a patient that a procedure is legally available, or unwilling to explain precisely what is involved with the procedure, its purported risks and benefits, or provide other information a reasonable patient would need to have in order to decide whether or not to undergo an abortion (or assisted suicide, euthanasia, etc.).
>
> In such cases, the physician is expected to direct the patient to another physician or resource who is willing to provide this information. It seems clear from the wording of all of these passages that they are meant to ensure that a patient has all of the information necessary to make an informed decision about treatment options. None of these passages imply that there is a duty to refer patients in order to facilitate abortion (or assisted suicide, euthanasia, etc.).[6]

DIII.7 The Registrar responded:

> You are correct in your understanding that it is a physician's obligation to ensure

> his or her patient has the necessary information to make an informed decision. It would be unacceptable behaviour for a physician to deny a patient access to such information.[7]

DIII.8 An explanation of the policy to the same effect is available on the CPSA website.[8]

DIII.9 The correspondence and explanation make clear that the focus of the policy is the communication of information. If, for reasons of conscience, the physician cannot provide information about a treatment or service, the patient must be directed to a physician who can supply that information. Contrary to the impression that may have been created by its inclusion in Mr. Salte's memo, *Moral or Religious Beliefs Affecting Medical Care* does not require an objecting physician to refer a patient to a colleague who will provide a morally contested service.

DIV. College of Physicians and Surgeons of Manitoba

DIV.1 A copy of the CPSM policy document *Members Moral or Religious Beliefs Not to Affect Medical Care* was provided by Mr. Salte.[9]

DIV.2 The wording is virtually identical to the wording of policy of the Colleges of Alberta. It is directed to ensuring that patients have information about all available medical options, not to mandatory referral for a morally contested procedure.

DIV.3 This conclusion is supported by a review of the College's *Code of Conduct*:

> 8. Inform your patient when your personal morality would influence the recommendation or practise of any medical procedure that the patient needs or wants.[10]

DIV.4 This is virtually identical to section 12 of the CPSS *Code of Ethics*.[11]

DIV.5 Contrary to the impression that may have been created by its inclusion in Mr. Salte's memo, *Members Moral or Religious Beliefs Not to Affect Medical Care* does not require an objecting physician to refer a patient to a colleague who will provide a morally contested service.

DV. College of Physicians and Surgeons of Saskatchewan

DV.1 The first section of the policy quoted in Mr. Salte's memo (IV.4) appears to be directed at physicians who refuse to continue a relationship with a patient who 'might contemplate' abortion. Physicians who take this approach must be extremely rare - if any can be found at all - so it is doubtful that the situation would ever arise. And while one can arrive at more than one interpretation of this passage, there is no requirement that the "available physician" be an abortion provider. Thus, the passage should not be understood to require referral for abortion.

DV.2 Quoted in isolation, the second passage provided by Mr. Salte is potentially misleading. The policy goes on to state that the patient is to be advised "of the availability of abortion services in the province, or elsewhere," and that the physician "should ensure that the

patient has the information needed to access such services or make the necessary referral" (emphasis added).

DV.3 This does not require the physician to provide information that would direct a patient to an abortion provider, and, as the following comment by the then Deputy Registrar demonstrates, referral is clearly an alternative, not a requirement.

> The changes are intended to provide clarity, said Dr. Karen Shaw, the college's deputy registrar. They weren't prompted by any specific concerns, but were part of a regular review of college guidelines. The new guidelines were adopted at the council's most recent meeting on Friday.
>
> "We didn't change the actual policy," she said. "It just made it clearer that people can state up front that they have difficulty with this and make a referral or they can assist the patient through all the steps they're comfortable with, until the point where they are more uncomfortable or the patient understands they're not willing to do the last step -which is to refer to someone they know will perform the abortion -but they must provide enough information."[12]12

DV.4 When the *Guideline on Unplanned Pregnancy* was adopted in 2011, some of the major papers reported that the policy required objecting physicians to refer for abortion. This was incorrect, and the error was noted and the source of the confusion identified in an article that was sent to the Registrar of the College at the time (Appendix "E").

Notes

1. College of Physicians and Surgeons of Ontario, DRAFT: Physicians and the Ontario Human Rights Code (2008) (http://www.consciencelaws.org/archive/documents/cpso/2008-cpso-ohrc-app-a-consultation draft.pdf)

2. College of Physicians and Surgeons of Ontario, Physicians and the Ontario Human Rights Code (2008) (http://www.consciencelaws.org/archive/documents/cpso/2008-cpso-ohrc-app-a-consultation draft.pdf)

3. College of Physicians and Surgeons of Alberta, *Moral or Religious Beliefs Affecting Medical Care*. (http://www.cpsa.ab.ca/Resources/StandardsPractice/medical-practice/moral-or-religious-beliefs-affecting-medical-care) Accessed 2015-02-13.

4. *Protection of Conscience Project, Submission to the College of Physicians and Surgeons of Alberta Re: CPSA Draft Standards of Practice* (8 October, 2008), II.5 (http://www.consciencelaws.org/publications/submissions/submissions-007-001.aspx)

5. "Registrar's Report: Draft standard for termination of pregnancy." *The Messenger*, April, 2009, p. 3 (http://www.cpsa.ab.ca/Libraries/Res_Messenger/M150.pdf) Accessed 2015-02-12.

6. Letter from the Administrator, Protection of Conscience Project to the Registrar of the College of Physicians and Surgeons of Alberta, dated 17 August, 2009.

7. Letter from the Registrar of the College of Physicians and Surgeons of Alberta to the Administrator, Protection of Conscience Project, dated 24 August, 2009.

8. *The Messenger*, "Are you up to Standard? Moral or Religious Beliefs Affecting Medical Care." 5 December, 2013. (http://www.cpsa.ab.ca/Resources/the-messenger/StandardsPractice/standards-of-practice/2013/12/05/moral-or-religious-beliefs-affecting-medical-care) Accessed 2015-02-12.

9. College of Physicians and Surgeons of Manitoba, Statement: *Members Moral or Religious Beliefs Not to Affect Medical Care.* (http://cpsm.mb.ca/cjj39alckF30a/wp-content/uploads/st181.pdf) Accessed 2015-02-11.

10. College of Physicians and Surgeons of Manitoba, *Code of Conduct* (1 December, 2008) (http://www.cps.sk.ca/CPSS/Legislation__ByLaws__Policies_and_Guidelines/Legislation_and_Bylaws.aspx?Legislation_BylawsCCO=3) Accessed 2015-02-27.

11. College of Physicians and Surgeons of Manitoba, *Code of Conduct* (http://www.cps.sk.ca/CPSS/Legislation__ByLaws__Policies_and_Guidelines/Legislation_and_Bylaws.aspx?Legislation_BylawsCCO=3) Accessed 2015-02-27.

12. Scissons H. "Abortion guidelines updated: Rules clarify protocol for doctors unwilling to terminate pregnancy." *Saskatchewan Star Phoenix*, 9 February, 2011

Appendix "E"

College of Physicians and Surgeons of Saskatchewan

Re: Guideline: *Unplanned Pregnancy*

Note: The following article, which explains the origin of the guideline *Unplanned Pregnancy*, was posted on the Project website in March, 2011. A copy was mailed to the CPSS Registrar, Dr. Dennis Kendel.

Clarifying the Clarification

Sean Murphy

Reports in the *Toronto Sun* and *Edmonton Sun* in February, 2011, stated that the College of Physicians and Surgeons of Saskatchewan would henceforth require physicians who refuse to perform abortion to refer patients to other physicians to obtain the procedure.[1] These reports were false. The *National Post* highlighted the story with a headline to the same effect. Its story was more accurate, but still misleading.[2] The Protection of Conscience Project began receiving e-mails from concerned physicians and others as soon as the stories appeared.

The source of the problem was a revision to the College *Guideline for Unplanned Pregnancy* that incorporated a requirement for "referral" in certain circumstances. It was this new requirement that the big dailies appear to have misunderstood and used as the basis for their inaccurate headlines and stories. To be fair to reporters and editors, the wording of the revised *Guideline* lends itself to such misunderstanding.

The story begins in January of 2010, when the College Registrar identified the 1991 *Guideline* in a 185 page document listing College policies that might be in need of updating.[3] The Registrar listed policies in six categories, from those recommended for affirmation (Category 1) to those recommended for deletion (Category 6). The *Guideline for Unplanned Pregnancy* was placed in Category 5, the Registrar seeking the Council's direction about whether or not it should be retained.

During discussion, the Registrar commented that physicians response to patients with unplanned pregnancy may be governed by the physician's "values and beliefs." It is not clear from the minutes whether or not the comment was directed only at physicians who object to abortion; physicians who do not object to abortion are equally guided by "values and beliefs." In any case, a subcommittee consisting of three College Councillors was formed to review the Guideline. Reverend J. Fryters, a public representative, joined two physicians, Dr. A. Danilkewich and Dr. P. Hanekom, to undertake the review.[4] In June, 2010 the Council designated Dr. Hanekom chair of the subcommittee.[5]

Reporting to the Council in September, Dr. Hanekom requested clarification of the Council's opinion about maturity and consent capacity with respect to pregnant minors and the meaning of 'policy' and 'guideline.' He was advised that a 'policy' sends a stronger message to the profession than a guideline.[6]

On 19 November the subcommittee, now including Dr. Karen Shaw, provided a draft Guideline to Council that included two references to referral.

> 5 (c) With reference to the option of termination of the pregnancy, the physician should appraise the patient of the availability of abortion services in the province, or elsewhere, in accordance with any current law or regulation governing such services, and arrange for the necessary referral. Ideally the patient should be provided the information regarding the nature of termination options, to the best of the physician's ability. (emphasis added)
>
> 11) Any physician who is unable to be involved in the further care and management when termination of the pregnancy is considered, should reveal this to the patient and make an expeditious referral to another available physician. (emphasis added)[7]

The references to referral were challenged during discussion, and the guideline was returned to the subcommittee with instructions to provide a written discussion and submit a report to the Council at its February, 2011 meeting.[8]

A revised draft Guideline dated 12 January, 2011 was brought to the Council in February, but the subcommittee failed to deliver the expected written discussion or report. It was approved after further revisions, after which it made the news. For the most part, the 2011 Guideline replicates its 1991 predecessor and the changes are not substantive. This is consistent with a published comment by the Deputy Registrar that the College did not mean to change the policy, but to clarify it.[9]

It was the following new addition to the *Guideline* that triggered the inaccurate news stories and set off alarms among health care workers and others who find abortion morally objectionable:

> (Preamble) Any physician who is unable to be involved in the further care and management of any patient when termination of the pregnancy might be contemplated should inform the patient and make an expeditious referral to another available physician. (emphasis added)

The Preamble appears to be directed at physicians who refuse to continue a relationship with a patient who 'might contemplate' abortion. Physicians who take this approach must be extremely rare - if any can be found at all - so it is doubtful that the situation considered here would ever arise. And while one can arrive at more than one interpretation of this passage, there is no requirement that the "available physician" be an abortion provider. Thus, it would seem that the Preamble cannot be understood to imply a duty to refer for abortion.

Section 5 of the guideline can also be interpreted in different ways.

> 5) Will fully apprise the patient of the options she may pursue and provide her with accurate information relating to community agencies and services that may be of assistance to her in pursuing each option. (emphasis added)
>
> 5(c) With reference to the option of termination of the pregnancy, the physician should apprise the patient of the availability of abortion services in the province, or elsewhere, in accordance with any current law or regulation

> governing such services, and should ensure that the patient has the information needed to access such services or make the necessary referral. . . . (emphasis added)

In the Project's experience, objecting physicians are usually willing to indicate that abortion may be obtained from other physicians without the need for referral, and to suggest that the patient consult a phone book or seek assistance from the College of Physicians. However, some physicians are unwilling to provide contact information for an abortion provider, on the grounds that doing so would make them complicit in the abortion that followed.[10] The term "necessary referral" is confusing, since a referral is not necessary for abortion and is not required by the Canadian Medical Association.[11] Thus, whether or not this part of the *Guideline* is problematic hinges upon the meaning of "information needed to access."

The College policy *Performance of Abortion* is also relevant here because it specifies that a physician "who is unwilling to carry out the procedure in this instance, should advise the patient where the service may be obtained and, if requested to do so, assist the patient in establishing contact with such a physician or facility."[12] Since this passage contemplates refusal to perform an abortion in a particular instance, and not a global refusal to do so, it appears that this is directed at physicians whose refusal is grounded upon clinical competence, or upon clinical rather than moral judgement.

Nonetheless, it could be interpreted to apply to physicians who, while generally willing to provide abortions, have moral objections to doing so in particular cases. Dr. Henry Morgentaler, for example, who has been awarded the Order of Canada for the dedicated delivery of abortion service for decades, is unwilling to perform abortions after about 24 weeks gestation because he does not want to abort fetuses after they have become babies.[13] Other physicians may set lower gestational limits, and some may not be willing to provide abortions for sex selection or other social reasons. Of these, some may be unwilling to facilitate such abortions by assisting the patient in the manner indicated in the *Guideline*.

Happily, *Performance of Abortion* is one of the policies slated for review by the Council, with a recommendation that it be deleted.[14]14 Since much of it has been incorporated into the new Guideline on Unplanned Pregnancy, the deletion should have no adverse effects and will relieve the profession of an ambiguous and therefore potentially troublesome directive.

The fact that the *Guideline on Unplanned Pregnancy* was under review was not formally announced, nor was the draft published for comment from the profession and the public before it was approved. However, the review process can be described as reasonably transparent because the subject was discussed at Council meetings open to the public, and the College promptly responded to Project requests for copies of relevant documents after the story broke. The failure to consult the profession and the public before approving the Guideline seems to reflect a lack of awareness by College Councillors that referral for morally controversial procedures is a highly contentious issue.

It is unfortunate that an effort to clarify the *Guideline on Unplanned Pregnancy* has generated such confusion and that the *Guideline* itself is, on key points, less than clear. The Protection of Conscience Project suggests that concerned physicians and medical students contact the College directly and obtain a written explanation of the *Guideline*. In the meantime, they may take comfort in the fact that physicians who object to abortion for reasons of conscience - whether globally or, like

Dr. Morgentaler, selectively - can hardly be disciplined for failing to adhere to ambiguous directives or guidelines.

Notes

1. "Saskatchewan Updates Abortion Policy." *Edmonton Sun*, 9 February, 2011 (http://www.edmontonsun.com/life/healthandfitness/2011/02/09/17209346.html). *Toronto Sun*, 9 February, 2011 (http://www.torontosun.com/life/healthandfitness/2011/02/09/17209251.html) Accessed 2011-02-09.

2. Scissons, Hannah, and Boesveld, Sarah, "Anti-abortion Docs Must Provide Referrals." *National Post*, 9 February, 2011. (http://www.nationalpost.com/todays-paper/Anti+abortion+doctors+must+provide+referrals/4247767/story.html#ixzz1DUMkmyb0) Accessed 2011-02-09.

3. Registrar to Council, 2010-01-20, No. 20-10. Registrar's Review of All Current Council Policies.

4. Extract of minutes of Council meeting of 29 January, 2010, in e-mail dated 28 February, 2011, from the Associate Registrar, College of Physicians and Surgeons of Saskatchewan to the Project Administrator.

5. Extract of minutes of Council meeting of 25 June, 2010, in e-mail dated 28 February, 2011, from the Associate Registrar, College of Physicians and Surgeons of Saskatchewan to the Project Administrator.

6. Extract of minutes of Council meeting of 17 September, 2010, in e-mail dated 28 February, 2011, from Associate Registrar, College of Physicians and Surgeons of Saskatchewan to the Project Administrator.

7. To Council from Registrar, 15 November, 2011. Guideline: Unplanned Pregnancy. No. 256-10

8. Extract of minutes of Council meeting of 19 November, 2010, in e-mail dated 28 February, 2011, from Associate Registrar, College of Physicians and Surgeons of Saskatchewan to the Project Administrator.

9. Scissons, Hannah, "Abortion Guidelines Updated: Rules clarify protocol for doctors unwilling to terminate pregnancy." *Star Phoenix*, 9 February, 2011 (http://www.thestarphoenix.com/news/Abortion+guidelines+updated/4248285/story.html#ixzz1DUM1ust7) Accessed 2011-02-09.

10. Murphy, Sean, "The Problem of Complicity." *Protection of Conscience Project*. (http://www.consciencelaws.org/ethics/ethics082.aspx)

11. Canadian Medical Association, *Induced Abortion*. (15 December, 1988) (https://www.cma.ca/Assets/assets-library/document/en/advocacy/CMA_induced_abortion_PD88-06-e.pdf#search=induced%20abortion) Accessed 2015-03-04; Blackmer, Jeff, "Clarification of CMA's position concerning induced abortion." *CMAJ* • April 24, 2007; 176 (9) (http://www.cmaj.ca/cgi/content/full/176/9/1310) Accessed 2015-03-04.

12. Registrar to Council, 2010-01-20, No. 20-10. Registrar's Review of All Current Council Policies, p. 181.

13. Henry Morgentaler initially advocated unrestricted abortion during the first 12 weeks of pregnancy. In 1989 he was performing abortions on women 16 weeks pregnant, moving to 18 weeks by 1996. He noted in 2004 that he had "ethical problems" doing abortions from about 24 weeks, explaining, that he did not want to abort fetuses after they had become babies. [Canadian Press, "Quebec hopes to offer late term abortions." (http://www.ctv.ca/CTVNews/Canada/20040912/quebec_abortion_040911/) Accessed 2010-09-20; Dunphy, Catherine, *Morgentaler: A Difficult Hero*. Random House: Toronto, 1996, p. 62-64, 339.

14. "[T]he College does not attempt to 'micro manage clinical practice' in respect to other services so this policy would seem to be inconsistent with our usual approach to guiding clinical care." Registrar to Council, 2010-01-20, No. 20-10. Registrar's Review of All Current Council Policies, p. 181.

Appendix "F"

Morally Significant Participation

FI. Conscientious Refusal within the context of *Carter*

FI.1 The policy Conscientious Refusal was developed with assisted suicide in mind, and proposed following the ruling of the Supreme Court of Canada that orders the legalization of physician assisted suicide and physician administered euthanasia. It is thus appropriate to consider it within the context of assisted suicide and euthanasia, recognizing that discussion is equally applicable to other morally contested services.

FII. "The serious moral burdens of complicity"

FII.1 It is unlikely that a physician who refuses to personally kill a patient or provide an abortion for reasons of conscience will be prosecuted by state or professional authorities, since the practical competence of such a physician would be in doubt, and coercion of that kind would be politically unwise and counterproductive.

FII.2 On the other hand, physicians who object to euthanasia for reasons of conscience not only refuse to kill patients, but often refuse to do anything that they believe makes them morally responsible for the killing. This includes actions that support or facilitate it - such as encouraging or affirming a patient's desire to be killed, or helping to find someone to do it. As Holly Fernandez Lynch noted in her book, *Conflicts of Conscience in Health Care: An Institutional Compromise*, such actions impose "the serious moral burdens of complicity."[1]

FII.3 It is thus likely that most of the attacks on freedom of conscience resulting from Carter will be precipitated, not by a refusal to kill directly, but by refusal to participate indirectly in killing.

FII.4 Are such refusals reasonable? If so, what might reasonably be considered to be "indirect participation"?

FII.5 Answers to both questions are readily available from different sources, the first of which is Canada's *Criminal Code.* It is both convenient and appropriate to use it to demonstrate that the concept of indirect participation is reasonable, and to illustrate what kinds of actions can be considered indirect participation in killing.

FIII. "Parties" to killing

FIII.1 The *Code* describes anyone who participates in a crime as a "party to an offence." Applying *Code*'s definition of "party" to assisted suicide or lethally injecting a patient, "party" would include

- the physician who assists the suicide or injects the patient,[2]
- anyone who does or omits to do anything for the purpose of helping the physician

assist with the suicide or provide the lethal injection,[3]

- anyone who encourages, instigates, promotes or arranges it,[4]
- anyone who counsels, procures, solicits or incites a physician to provide it.[5]

FIII.2 But for the Supreme Court's ruling, the criminally culpable participants in assisted suicide or lethal injection would include (1) the injecting physician, (2) the pharmacist dispensing the drug and the nurse preparing the needle, (3) a family member or referring physician, and (4) the executive director of an institution or local authority who arranges for a willing physician to replace an objecting physician. Again, but for *Carter*, a plan to assist in a patient's suicide or lethally inject a patient would constitute a criminal conspiracy among all who agree to it, each of whom (like members of an institutional ethics committee) is a participant in a conspiracy.[6]

FIII.3 The *Criminal Code* is concerned with *criminal* complicity or *criminal* culpability, which are narrower concepts than moral complicity or culpability. Nonetheless, it demonstrates that the concept of indirect participation is well-recognized and undisputed. A physician who refuses to facilitate the killing of a patient because he does not want to be a culpable participant in the killing is acting well within well-established moral and legal norms reflected in our criminal law.

FIV. Participation in killing

FIV.1 While these references to criminal law are clear and convenient, it is appropriate to supplement them by reflecting on the concept of morally significant participation in killing within the context of medical ethics.

FIV.2 World Medical Association

FIV.2.1 In October, 2012, the World Medical Association (WMA) reaffirmed its position that physician must not "participate in capital punishment, in any way, or during any step of the execution process, including its planning and the instruction and/or training of persons to perform executions", adding that, they must not "facilitate the importation or prescription of drugs for execution" (emphasis added).[7]

FIV.2.2 The WMA did not define "participation." However, it is obvious that the statement reaffirmed was meant to include acts contributing even indirectly to an execution, and this was further emphasized by the additional proscription of "facilitating" drug importation or prescription.

FIV.3 American Medical Association

FIV.3.1 The policy of the American Medical Association forbids physician participation in capital punishment. We are not concerned here with the morality of capital punishment or even with the morality of physician participation in executions. What is of interest is the discussion of "participation," which is obviously intended to mean morally significant participation. The policy and supporting documents demonstrate that participation becomes morally significant to the extent to which one's actions contribute to and thus

make one complicit in what follows from them. With respect to participation in executions, this includes:

(1) an action which would directly cause the death of the condemned;

(2) an action which would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned;

(3) an action which could automatically cause an execution to be carried out on a condemned prisoner.

FIV.3.2 Among the actions identified by the AMA as "participation" in executions are

- prescribing or administering tranquillizers or other drugs as part of the procedure, directly or indirectly monitoring vital signs, rendering technical advice or consulting with the executioners, selecting injection sites;
- starting intravenous lines as a port for a lethal injection device;
- prescribing, preparing, administering, or supervising injection drugs or their doses or types;
- inspecting, testing, or maintaining lethal injection devices; and consulting with or supervising lethal injection personnel;
- attending or observing an execution, except at the request of the condemned, or in a non-professional capacity.

FIV.3.3 The attention paid to what others might consider insignificant participation is exemplified in the provision that permits physicians to certify death, providing that death has been pronounced by someone else, and by restrictions on the donation of organs by the deceased.[8]

FV. Participation in torture

FV.1 Recall that our interest here is not in the morality of capital punishment, euthanasia or assisted suicide, but in the meaning of morally significant participation. This interest can be pursued further by considering participation in torture.

FV.2 Extraordinary rendition

FV.2.1 In the weeks following the terrorist attacks on the United States in September, 2001, *Newsweek* columnist Jonathon Alter argued that it was time to think about torturing terrorist suspects who might have information about plans for such horrendous crimes. He acknowledged that physical torture was "contrary to American values," but argued that torture is appropriate in some circumstances, and proposed a novel 'compromise:' that the United States turn terrorist suspects who won't talk over to "less squeamish allies,"[9] a practice known as "extraordinary rendition." The allies would then do what Americans would not, without compromising American values.

FV.3 Maher Arar

FV.3.1 Less than a year later, Canadian citizen Maher Arar, returning home from Zurich through New York, was detained, interrogated and "rendered" to Syria by U.S. authorities.[10] In Syria he was imprisoned for almost a year, "interrogated, tortured and held in degrading and inhumane conditions."[11] A commission of inquiry was appointed to investigate the actions of Canadian officials because, unlike Jonathon Alter, most Canadians did not believe that referral to "less squeamish allies" could absolve one of moral responsibility for torture.

FV.3.2 Even though Mr. Arar's deportation to Syria was effected by the United States, and Syrian officials imprisoned and tortured him, the public and the government wanted to know whether or not Canadian officials had caused or contributed to what happened to Mr. Arar. The key issue was whether or not Canada was complicit in torture - even indirectly. The report of the Inquiry made this abundantly clear: "Canada should not inflict torture, nor should it be complicit in the infliction of torture by others."[12]

> If it is determined that there is a credible risk that the Canadian interactions would render Canada complicit in torture or create the perception that Canada condones the use of torture, then a decision should be made that no interaction is to take place (emphasis added).[13]

FV.4 Physician participation in torture

FV.4.1 Thus far, government officials. But the problem of complicity does not relate only to government officials. The Lancet, among others, has asked, "How complicit are doctors in the abuse of detainees?"[14] and other journal articles have explored the answer with some anxiety.[15]

FV.4.2 The Arar Inquiry and the alarm raised about physician complicity in torture make sense only if it is agreed that facilitating an act done by someone else makes one morally responsible for it: a participant in the act, as it were: in the words of the *Criminal Code*, a party to it. This is the principle underlying the prohibition of physician participation in capital punishment by the World Medical Association and American Medical Association, and it is also the basis for their prohibition of physician participation in torture.

FV.4.3 The WMA states that a physician must not "countenance, condone or participate in the practice of torture," "provide any premises, instruments, substances or knowledge to facilitate the practice of torture" and must not even be present "during any procedure during which torture or any other forms of cruel, inhuman or degrading treatment is used or threatened."[16]

FV.4.4 The AMA states that participation in torture includes, but is not limited to, "providing or withholding any services, substances, or knowledge to facilitate the practice of torture."[17] Similarly, the Canadian Medical Association opposes physician involvement in the punishment or torture of prisoners. The CMA states that physicians "should refuse to allow their professional or research skills to be used in any way" for such purposes.[18]

FVI. Participation in female genital cutting (mutilation)

FVI.1 Female genital cutting (also known as female circumcision) is a ritual practice that involves excising, infibulating or mutilating the labia majora, labia minora or clitoris, usually of girls four to eight years old. It is a criminal offence in Canada, a form of aggravated assault.[19]

FVI.2 Consistent with the criminal law, the College of Physicians and Surgeons of Ontario prohibits physicians from performing female genital cutting, and also forbids referral for the practice: "The performance of, or referral for, FGC/M procedures by a physician will be regarded by the College as professional misconduct."[20]20

FVI.3 This is formal acknowledgement by a state regulatory authority that facilitating an act - in this case by referral - makes one complicit in it. Indeed, the policy makes no distinction between performance and referral; both amount to professional misconduct.

FVI.4 It might be argued that the College prohibition of referral merely reflects the criminal prohibition of aiding or abetting (discussed above). However, ethical misconduct is distinct from criminal law; the College was free to draw the attention of physicians to the law against female genital cutting without also declaring it to be professional misconduct.

FVI.5 Moreover, while the policy document cautions physicians about legal issues, it introduces the topic within the context of adverse health outcomes, and the principles that inform the policy concern the practice of medicine, the physician-patient relationship and the duty to act in the patient's best interests. This is a professional ethical framework, not a mere re-statement of the criminal law.

FVI.6 Finally, criminal rules of evidence require proof beyond reasonable doubt for conviction, so various factors, such as the absence of a key witness, may preclude criminal prosecution for referral for genital cutting. However, the standard of proof in disciplinary proceedings is proof on the balance of probabilities, so that charge of professional misconduct for referral may proceed even if criminal prosecution does not take place. In that case, the criminal law on parties to offences would not be applicable, though it could, as here, serve as a reference to illustrate the underlying principles. Instead a conviction for professional misconduct for referral would have to rely on the concept of morally significant participation discussed above.

FVII. Refusing to participate

FVII.1 It is reasonable to hold that the kind of action involved in helping a patient to access assisted suicide or euthanasia amounts to participation in the sense intended by various medical authorities in policies that forbid physician participation in capital punishment, torture or female genital cutting. Refusing to participate, even indirectly, in conduct believed to involve serious ethical violations or wrongdoing is not aberrant behaviour. On the contrary: it is the response expected of physicians by professional bodies and regulators in order to avoid physician complicity in such procedures.

Notes

1. Fernandez-Lynch, Holly, *Conflicts of Conscience in Health Care: An Institutional Compromise*. Cambridge, Mass.: The MIT Press, 2008, p. 229

2. *Criminal Code* (R.S.C., 1985, c. C-46) (Hereinafter "CC"), Section 21(a). (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-6.html#h-5) Accessed 2015-03-05.

3. Often referred to as "aiding." CC, Section 21(b). (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-6.html#h-5) Accessed 2015-03-05.

4. The *Code* uses the word "abet." CC, Section 21(c) (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-6.html#h-5) ; *R. v. Greyeyes*, [1997] 2 S.C.R. 825, at para. 26. (http://scc-csc.lexum.com/scc-csc/scc-csc/en/item/1537/index.do) Accessed 2015-03-05.

5. CC, Section 22 (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-6.html#h-5) Accessed 2015-03-05.

6. *R v. Papalia* (1979) 2 S.C.R. 256 (http://scc-csc.lexum.com/scc-csc/scc-csc/en/item/4459/index.do) ; CC, Section 465 (http://laws-lois.justice.gc.ca/eng/acts/C-46/page-228.html#docCont) Accessed 2015-03-05.

7. World Medical Association, "WMA Resolution to Reaffirm the WMA's Prohibition of Physician Participation in Capital Punishment." Adopted by the 63rd General Assembly of the World Medical Association, Bangkok, Thailand, October 2012. (http://www.wma.net/en/30publications/10policies/c23/index.html) Accessed 2015-03-05.

8. American Medical Association, Resources- Medical Ethics: *Opinion 2.06 - Capital Punishment.* (http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion206.page?) Accessed 2015-03-05.

9. Alter, Jonathon, "Time to Think About Torture." *Newsweek*, 5 November, 2001, p. 45.

10. Wikipedia, "Maher Arar." (http://en.wikipedia.org/wiki/Maher_Arar) Accessed 2015-03-05.

11. *Commission of Inquiry into the Actions of Canadian Officials in Relation to Maher Arar, Report of the Events Relating to Maher Arar: Analysis and Recommendations*. (hereinafter, "*Arar Inquiry: Analysis and Recommendations*") p. 9. (http://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/maher_arar/07-09-13/www.ararcommission.ca/eng/AR_English.pdf) Accessed 2015-03-05.

12. *Arar Inquiry: Analysis and Recommendations*, p. 346. (http://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/maher_arar/07-09-13/www.ararcommission.ca/eng/AR_English.pdf) Accessed 2015-03-05.

13. *Arar Inquiry: Analysis and Recommendations*, p. 199. (http://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/maher_arar/07-09-13/www.ararcommission.ca/eng/AR_English.pdf) Accessed 2015-03-05.

14. Editorial, "How complicit are doctors in the abuse of detainees?" *The Lancet*, Vol 364, August 21, 2004, p. 725-729

15. Miles, Steven H., "Abu Ghraib: its legacy for military medicine." *The Lancet*, Vol 364, August 21, 2004, p. 725-729; Lifton, Robert Jay, "Doctors and Torture." *N Engl J Med* 351;5

16. WMA Declaration of Tokyo - *Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment*. Adopted by the 29th World Medical Assembly, Tokyo, Japan, October 1975 and editorially revised by the 170th WMA Council Session, Divonne-les-Bains, France, May 2005 and the 173rd WMA Council Session, Divonne-les-Bains, France, May 2006 (http://www.wma.net/en/30publications/10policies/c18/) Accessed 2015-03-05

17. American Medical Association, *Policy E.2.067: Torture*. (http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2067.page) Accessed 2015-03-05.

18. Canadian Medical Association Policy resolution BD80-03-99 - *Treatment of prisoners*. Status: Approved, 1979-Dec-08. Last Reviewed, 2004-Feb-28: Still relevant.

19. . CC, Section 268(3).(http://laws-lois.justice.gc.ca/eng/acts/C-46/page-133.html#docCont) Accessed 2015-03-05.

20. College of Physicians and Surgeons of Ontario, Policy Statement #2-11, *Female Genital Cutting (Mutilation)*. Reviewed and updated November, 2004, September 2011. (http://www.cpso.on.ca/cpso/media/uploadedfiles/policies/policies/policyitems/female_circ.pdf) Accessed 2015-03-05.

Appendix "G"

Notes on Referral, Abandonment and Fiduciary Duty

GI. 'Referral and abandonment'

GI.1 In 2004 an exchange of letters in the *Journal of the Society of Obstetrics and Gynaecology Canada* between a physician and Professors Cook and Dickens prompted the Administrator of the Protection of Conscience Project to write to the Journal. He challenged the Cook/Dickens claim that Canadian courts require that physicians who refuse to provide abortions for reasons of conscience have an obligation to refer patients for the procedure. He noted that the only authority they cited to support their avowal that courts "continue" to demand referral was a less than contemporary ruling in *Zimmer v. Ringdove*, a 23 year old case from the Alberta Court of Appeal.[1]

GI.2 The published letter from the Project pointed out that *Zimmer* addressed the failure to obtain informed consent to silver nitrate sterilization and failure to provide adequate follow-up care, not referral. Professors Cook and Dickens countered that the Administrator had misrepresented legal cases because he had failed to consider "historical background jurisprudence" that shapes court decisions.

GI.3 Summarizing what they believed to be the "continuing relevance of the *Zimmer* case," they claimed that failure to refer for abortion is "negligence close to abandonment."

> [T]he "failure to provide adequate follow-up care" that Mr. Murphy acknowledges consisted in the defendant physician's *failure to refer* his patient to another physician who could facilitate *the abortion she wanted*. The Court found that this failure was negligence close to abandonment . . . a wilful failure or refusal to refer . . . may justify an award of aggravated or exemplary damages. (emphasis added)[2]

GI.4 However, they cited no authorities to support their understanding of the case. Moreover, the rulings followed and referred to by the Court of Appeal in *Zimmer* were about informed consent, not freedom of conscience.[3]

GI.5 The only relevant "historical background jurisprudence" appears to be the earlier decision of the trial court in *Zimmer*, and this did not assist Cook and Dickens. The failure to provide adequate follow-up care had two elements - not one, as the authors implied. The first was the physician's failure "to follow his patient's progress by conducting regular medical examinations during the summer of 1973," an omission the trial judge found to be "inconsistent with good clinical practice" that contributed to the fact that her pregnancy was not detected earlier.[4]

GI.6 The second element was not the "failure to refer" alleged by the authors; the physician did *not* refuse or fail to refer the patient for abortion. In fact, she understood from him that she should have an abortion as soon as possible.[5] Nor was the issue a refusal to refer "for the abortion *she* wanted" (emphasis added). It was, rather, his decision to refer the

woman for an abortion in Seattle rather than Edmonton. He testified that he advised her to get an abortion in Seattle to avoid the delay involved in Edmonton, where, he said, it was then necessary to obtain a psychiatric report to justify the procedure. He also believed that the suction procedure used in Seattle would be less traumatic for the patient than the saline method employed in Edmonton.[6]

GI.7 The key fact noticed by the Court in ruling against the physician was that he "made no attempt to secure an abortion for the respondent in a hospital in Edmonton" (by, for example, referring her to a colleague) and thus failed "to display the degree of care and concern dictated by the situation."[7]

GI.8 The trial judge had noted the same thing, and was sceptical of the physician's evidence:

> I cannot find that the [physician] made any effort to get medical and hospital care in Edmonton for the abortion and in this respect his attitude appears to have been casual. He failed to do everything he could for the welfare of his patient, and I cannot accept as true his statement to Mrs. Zimmer that she would have to be declared mentally unsound before she could be admitted to hospital in Edmonton for an abortion . . . At least. . . he should have consulted another gynaecologist in Edmonton before suggesting that she go to Seattle.[8]

GI.9 In other words, having told the patient that she should get an abortion as soon as possible, he was expected to at least attempt to secure an abortion for the patient in Edmonton at the earliest opportunity. Rather than making such an attempt, he based his advice to go to Seattle on an untested assumption about the availability of the procedure. The patient took his advice and went to Seattle, but she was found to be too far along for suction. A saline abortion was performed, and "Mrs. Zimmer was left to abort in a hotel room, unattended my medical personnel." Thus,

> [T]he respondent underwent a more painful and emotionally distressing experience than was necessary in the circumstances. Her suffering would have been substantially reduced if the appellant had discharged his duty by arranging hospital care.[9]

GI.10 A review of *Zimmer* suggests that one can argue that a physician who urgently recommends a procedure to a patient has a duty to do all that he reasonably can to help the patient obtain it, but *Simmer* does not speak to a case in which a physician, for reasons of conscience, refuses to recommend a procedure at all.

GII. Fiduciary duty

GII.1 Professors Cook and Dickens' second legal claim, that the fiduciary duties of physicians requires them to subordinate their conscientious convictions to those of their patients, rested upon a more recent Supreme Court of Canada case, *McInerney v. MacDonald.* But *McInerney*[10] had absolutely nothing to do with conflicts of conscience. It concerned the duty of a physician to release a patient's medical records to her upon request.

GII.2 While the court noted that the fiduciary relationship between physician and patient obliged the physician to disclose the records, the nature of fiduciary relationships was not discussed at length. Moreover, the Supreme Court ruled that fiduciary relationships and obligations are "shaped by the demands of the situation"; they are not governed by a "fixed set of rules and principles". Mr. Justice La Forest, writing for the court, stated, "A physician-patient relationship may properly be described as 'fiduciary' for some purposes, but not for others."[11]

GII.3 In other words, that the physician patient relationship is fiduciary for the purpose of disclosing patient records does not imply that it is fiduciary for the purpose of suppressing the conscientious convictions of the physician.

GII.4 Finally, the court in *McInerney* accepted the characterization of the physician-patient relationship as "the same . . . as that which exists in equity between a parent and his child, a man and his wife, an attorney and his client, a confessor and his penitent, and a guardian and his ward."[12] Pursuing the analogy, no one has ever suggested that the fiduciary obligations of parents, husbands, attorneys, confessors, and guardians require them to sacrifice their own integrity to the "desires" of others. *McInerney* does not even remotely imply that physicians have such a duty.

This discussion is taken from Murphy S. "Postscript for the *Journal of Obstetrics and Gynaecology Canada*: *Morgentaler* vs. Professors Cook and Dickens." *Protection of Conscience Project* (2005) (http://www.consciencelaws.org/law/commentary/legal030-001.aspx)

Notes

1. *Zimmer v. Ringrose* (1981), 124 Dominion Law Reports (3d) 215 (Alberta Court of Appeal)

2. Cook RJ, Dickens BM, Access to emergency contraception [letter] J.Obstet Gynaecol Can 2004; 26(8):706.

3. *Riebl v. Hughes* (1980), 114 DLR (3rd) 1, (1980) 2 SCR 880, 14 CCLT 1, 33 NR, 361; *Hopp v. Lepp* (1980), 112 DLR (3d) 67, (1980) 2 SCR 192, (1980) 4 WWR 645, 22 AR 361, 13 CCLT 66, 32 NR 145, followed; *Trogun v. Fruchtman* (1973), 207 NW 2d 297; *Downer v. Veilleux* (1974), 322 A. 2d 82, referred to.

4. *Zimmer v. Ringrose* (1981), 124 DLR (3d) 225-226 (Alberta Court of Appeal); *Zimmer v. Ringrose* (1978), 89 Dominion Law Reports (3d) 657 (Alberta Supreme Court)

5. *Zimmer v. Ringrose* (1981), 124 DLR (3d) 219 (Alberta Court of Appeal); *Zimmer v. Ringrose* (1978), 89 DLR (3d) 649 (Alberta Supreme Court)

6. *Zimmer v. Ringrose* (1981), 124 DLR (3d) 219 (Alberta Court of Appeal); *Zimmer v. Ringrose* (1978), 89 DLR (3d) 649 (Alberta Supreme Court)

7. *Zimmer v. Ringrose* (1981), 124 DLR (3d) 226 (Alberta Court of Appeal)

8. *Zimmer v. Ringrose* (1978), 89 DLR (3d) 657-658 (Alberta Supreme Court)

9. *Zimmer v. Ringrose* (1981), 124 DLR (3d) 226 (Alberta Court of Appeal); *Zimmer v. Ringrose* (1978), 89 DLR (3d) 657 (Alberta Supreme Court)

10. McInerney v. MacDonald (1992), 93 Dominion Law Reports (4th) 415 (Supreme Court of Canada)

11. Recalling an earlier case (*Canson Enterprises Ltd. v. Boughton & Co.* [1991] 3 S.C.R. 534),

12. Quoting LeBel, J. in *Henderson v. Johnston*, [1956] O.R. 789 at p. 799.