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PROJECT TEAM
Human Rights Specialist
Rocco Mimmo, LLB, LLM
Ambrose Centre for Religious Liberty,
Sydney, Australia

Administrator
Sean Murphy

Submission to the College of Physicians and Surgeons of Saskatchewan

Re: *Conscientious Refusal (as revised)*

5 June, 2015

Abstract

Council has been given no evidence that anyone in Saskatchewan has ever been unable to access medical services 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.

The conclusion that objecting physicians "should not be obligated to provide a referral to a physician who will ultimately potentially provide the service" is entirely satisfactory. It is a tacit admission that such a policy would be an unacceptable assault on freedom of conscience.

Conscientious Refusal as revised attempts to nullify the alleged 'bias' of physicians who object to a procedure for reasons of conscience by requiring them to refer patients to a non-objecting colleague. This proposal is not sound, since, if it is to be applied fairly and consistently, the 'bias' of physicians who do *not* object to a procedure should be nullified in the same way. This would simply exchange one kind of alleged 'bias' for another, inconvenience patients and provide them with no better care.

The more sensible course is to require all physicians to provide patients with sufficient information to satisfy the requirements of informed medical decision making. Physicians must advise patients at the earliest reasonable opportunity of services or procedures they decline to recommend or provide for reasons of conscience, advise affected patients that they may approach other physicians, heath care workers or community organizations, and ensure that they have sufficient information to do so. They must not promote their own moral or religious beliefs when interacting with a patient.

Physicians unwilling to abide by these requirements must promptly arrange for a patient to be seen by another physician or health care worker who is able to do so.

If the College is determined to enact a policy on conscientious refusal, it should ensure that the policy adopted is sufficiently flexible to accommodate physicians with respect to all procedures or services. Otherwise, Council should reject *Conscientious Refusal* as revised and postpone policy development until after the *Carter* decision comes into force in 2016.

Revision Date: 5 June, 2015

7120 Tofino St., Powell River, British Columbia, Canada V8A 1G3
Tel: 604-485-9765 E-mail: protection@consciencelaws.org

Table of Contents

I. Revision of draft policy - *Conscientious Refusal* 1

II. Focus of this submission 1

III. Section 5.3 2
III.1 Deletion of requirement to refer for a morally contested service. 2
III.2 Section 5.3 Imposition of requirement to refer patients for information. 2

IV. Section 5.3: Suggested modification (See Appendix "A") 5

V. Section 2: Scope 6
V.1 Purported non-applicability of policy to assisted suicide and euthanasia. 6
V.2 Disclaimer inconsistent with origin of policy and previous statements.. 7
V.3 Disclaimer inconsistent with association of abortion/birth control and euthanasia/assisted suicide.. 8
V.4 Dissecting the disclaimer. 8
V.5 Explaining the disclaimer. 9
V.6 Disposing of the disclaimer. 9

VI. Summary 10

Appendix "A" - Ontario College briefing materials 15
A1. Introduction. 15
A2. Citation of *Conscientious Refusal* (*CR No.1*). 15
A3. Reasonable apprehension of bias. 15
A4. Tunnel Vision at the College of Physicians. 17

Appendix "B" - Providing Information 23
Introduction. 23
Clarifications. 23
Sufficient information. 23
Relevant options.. 23
Disclosure. 23
Advance notice 24
Respectful/non-demeaning communication.. 24

Appendix "C" - *Conscientious Refusal* and assisted suicide/euthanasia 27
C1. Introduction. 27
C.2 Euthanasia/assisted suicide supported by principles 27
C2.2 Fiduciary duty. 27
C2.3 Patient autonomy. 27
C2.4 Continuity of care/ left without appropriate care.. 28

C2.5 Intentional or unintentional barriers to care/disadvantage/equitable access. . 28
C2.6 Reasonable limits. 29

I. Revision of draft policy - *Conscientious Refusal*

I.1 The original text of *Conscientious Refusal*, approved in principle by College Council on 20 January, 2015 (hereinafter "*CR No. 1*"), was released for public consultation that generated "a very significant return" of over 4,400 responses, almost all of which opposed the policy.[1] The first Protection of Conscience Project submission was made during this consultation.[2]

I.2 *CR No. 1* was revised and re-submitted to Council on 20 March, 2015. This submission concerns the revised text of *CR No. 1* (hereinafter "*Conscientious Refusal* as revised").[3]

I.3 The Project's first submission noted that neither Mr. Salte nor the committee had 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.

I.4 Since Mr. Salte would surely have drawn Council's attention to any evidence on either of these points produced by the consultation, it appears that the "very significant return" produced no evidence that such problems exist in Saskatchewan.

I.5 Council was provided with information from the College of Physicians and Surgeons of Ontario concerning its new policy, *Professional Obligations and Human Rights*, including the briefing note provided to the Ontario College Council by its working group.[4] Council is cautioned that the Ontario College briefing note is "deficient, erroneous and seriously misleading." (Appendix "A")

II. Focus of this submission

II.1 The primary focus of this second submission is on three elements in *Conscientious Refusal* as revised:

Section 5.3

- Deletion of the requirement to refer for a morally contested service
- Imposition of a requirement to refer patients for information

Section 2: Scope

- Non-applicability to assisted suicide and euthanasia

II.2 This submission notes that the deletion of the requirement to refer for a morally contested service is entirely satisfactory and warrants emphasis.

II.3 The imposition of a requirement to refer for information does not, strictly speaking, have a direct adverse effect on the fundamental freedoms of physicians, but it is problematic

for other reasons relevant to the exercise of freedom of conscience and the expectations of the Supreme Court of Canada. For this reason, this submission treats this requirement at greater length and recommends an alternative approach to ensure that patients receive information necessary for medical decision making, without compromising physician freedom of conscience.

II.4 This submission argues that the disclaimer that *Conscientious Refusal* as revised will not apply to "physician assisted death" (i.e., physician administered euthanasia and physician assisted suicide) is misleading and ill-advised. If the College is determined to enact a policy on conscientious refusal, it should ensure that the policy adopted is sufficiently flexible to accommodate physicians who are unwilling to do what they believe to be wrong, not excluding direct or indirect participation in killing patients or helping them commit suicide. If Council is uncertain how this can be done, it should reject *Conscientious Refusal* as revised and postpone policy development until after the *Carter* decision comes into force in 2016.

III. Section 5.3

III.1 Deletion of requirement to refer for a morally contested service

III.1.1 The revised policy no longer requires that a physician unwilling to provide a service for reasons of conscience must facilitate the procedure by referral to a colleague who will.

III.1.2 The revision is consistent with the committee's conclusion that objecting physicians "should not be obligated to provide a referral to a physician who will ultimately potentially provide the service."[5]

III.1.3 This is a tacit admission that the original demand that objecting physicians must provide what the College of Physicians and Surgeons of Ontario calls "effective referral" was an assault on freedom of conscience, not a compromise.

III.1.4 The deletion of the demand for referral is entirely satisfactory and the committee's conclusion is highly significant.

III.2 Section 5.3 Imposition of requirement to refer patients for information

III.2.1 Instead of a demand to facilitate a morally contested service by referral, the revised policy imposes the following requirement when patients seek a service to which a physician objects for reasons of conscience:

> . . . in such situations, [the physician] must make a timely referral to another physician or other health care provider who can meet the expectations of paragraph 5.2, who is willing and able to accept the patient, and if the patient decides to receive a clinically appropriate health service, that physician can either provide that treatment or refer the patient to another physician or health care provider who can provide that treatment.

III.2.2 Paragraph 5.2, to which this passage refers, concerns the expectation that physicians will

provide patients with the "full and balanced" (Section 4) information needed to make informed decisions about medical treatment. The accompanying memo to College Council included a practical example of what is intended by the revision:

> A physician with an ethical objection to referring a patient for an abortion would not be obligated to refer a patient to an obstetrician who will perform an abortion. Rather, the physician would be obligated to refer the patient to another physician who can have an informed discussion with the patient about abortion and, if the patient after that discussion chooses to have a therapeutic abortion, refer the patient to an obstetrician willing to perform the abortion.[6]

III.2.3 The revision presumes that, by virtue of moral opposition to a service, a physician must be hopelessly prejudiced, duplicitous, disrespectful and incapable of providing full and balanced information. In light of Paragraph 5.2, the revision implies that physicians morally opposed to a service (like abortion) will

- fail to advise a patient of its availability; and/or
- fail to advise a patient of diagnosis, prognosis, and clinically appropriate treatment options; and/or
- provide false, misleading, intentionally coercive or materially incomplete information; and/or
- fail to communicate in a manner likely to be understood by a patient; and/or
- communicate or otherwise behave in a manner that demeans the patient or the patient's beliefs, lifestyle, choices or values; and/or
- promote their own religious beliefs.

III.2.4 This is not an attack on freedom of conscience. It is, however, an attack on the character and competence of objecting physicians. This confirms one of the central points made in the Project's first submission to Council: medicine is an inescapably moral enterprise.

> . . . [E]very decision concerning treatment is a moral decision, whether or not the physician specifically adverts to that fact. [VII.5.1]
>
> . . . 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. . . [VII.5.4]
>
> . . . Morality and ethics are actually intrinsic to [the practice of medicine]. 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.5.5]

III.2.5 Nor will it do to pretend that the claim that best medical practice means providing an abortion does not involve at least an implicit moral or ethical judgement. On the contrary: the revised policy is not an ethically or morally neutral statement. It demonstrates that committee members believe that abortion (for example) is morally or ethically acceptable and may be provided. Recall one of the conclusions reached about the original policy in the Project's first submission:

> *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.[VI.5.9]

III.2.6 The revised policy does not compel objecting physicians to conform to the committee's ethical viewpoint, but, solely on the basis of their beliefs, it effectively prohibits them from communicating with their patients about morally contested procedures. This demonstrates that the above conclusion was correct, and that the policy, even as revised, continues to advance moral or ethical views masked by the pretence of neutrality.

III.2.7 While Project Advisor Jay Budziszewski calls this "bad faith authoritarianism,"[7] it may be more appropriate, in this case, to describe it as merely unreflective authoritarianism. It is possible that committee members are so intent upon the 'bias' they perceive in those with whom they disagree that they are unaware that they are similarly biased by their own moral/ethical viewpoint.

III.2.8 Nonetheless, suppose that College Council believes that it should nullify the 'bias' of physicians who object to a procedure for reasons of conscience by prohibiting them from communicating with their patients about morally contested procedures, requiring them, instead, to refer patients to a non-objecting colleague.

III.2.9 However, if this approach is sound, the College must go a step further. It must also nullify the 'bias' of physicians who do *not* object to a procedure. It must also prohibit physicians who do *not* object to abortion (for example) from communicating with their patients about it, and require them to refer patients to colleagues who *do* object to it.

III.2.10 As this exercise demonstrates, this approach is not sound. It does nothing more than 'protect' patients from one kind of alleged 'bias' by exposing them to another. Of course, this outcome could be avoided by allowing physicians who do *not* object to abortion (for example) to communicate with their patients about it, on the condition that they *then* refer the patient to a colleague who *does* object to abortion, and vice-versa. The respective physician 'biases' would then cancel each other out.

III.2.11 However, this is also unsatisfactory. It would, at a minimum, inconvenience patients, delay treatments, provide no better outcomes, double the costs of providing health care and antagonize physicians on all sides of any issue.

III.2.12 To repeat: this approach is not sound. The assumption underlying the recommendation is that a physician who has a moral viewpoint is incapable of properly communicating with

a patient. But all physicians have moral viewpoints. Thus, if applied as now written, the policy would simply exchange one kind of 'bias' for another. If applied fairly and consistently, the results would be ludicrous.

III.2.13 The committee's recommendation is not sound because medicine is a moral enterprise, yet the committee would have the College control for or eliminate the exercise of *bona fide* moral judgement. The College cannot do that fairly and consistently without grotesquely deforming medical practice. It can only do it unfairly and inconsistently by an authoritarian suppression of moral viewpoints selected arbitrarily, or selected on the basis of their unpopularity with those in positions of power and influence.

III.2.14 Such selective authoritarianism by medical regulators is a practice that squarely contradicts the repeated and eventually unanimous assertion of the full bench of the Supreme Court of Canada: 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."[8]

III.2.15 The recommended requirement to refer for information is offensive to objecting physicians for the same reasons that it would be offensive if it were applied to non-objecting physicians, but it does not, strictly speaking, immediately and adversely affect the exercise of freedom of conscience or religion.

III.2.16 However, the mindset perpetuated by such a policy is inimical to fundamental freedoms because its natural tendency is in the direction of oppression, as illustrated by developments in the College of Physicians and Surgeons of Ontario between 2008 and 2015. It is also inconsistent with the expectations of the Supreme Court of Canada concerning the accommodation of different world views. For these reasons (in addition to those noted in III.2.10 to 13) the Project recommends that the requirement for referral for information be modified.

IV. Section 5.3: Suggested modification (See Appendix "A")

IV.1 Physicians must provide patients with sufficient information to make them aware of relevant treatment options so that they can make informed decisions about accepting or refusing medical treatment and care. The information must be communicated respectfully and in a way likely to be understood by the patient.[9]

IV.2 Physicians must disclose whether or not their religious, ethical or other conscientious convictions influence their recommendations or practice or prevent them from providing certain procedures or services.[10] If medical judgement rather than moral/religious conviction is the primary consideration, it is still prudent to disclose pertinent religious or moral beliefs. The patient is also entitled to know whether or not the physician's medical opinion is consistent with the general view of the medical profession.[11]

IV.3 Physicians should inform patients of treatments or services that they will not provide for reasons of conscience, and notify them when their views change. Notice should be given as soon as it would be apparent to a reasonable and prudent person that a conflict is likely

to arise concerning treatments or services the physician declines to provide, erring on the side of sooner rather than later. In many cases - but not all - this may be when a patient is accepted. The same holds true for notification of patients when a physician's views change significantly.

IV.4 Physicians must not promote their own moral or religious beliefs when interacting with a patient. Unless the patient questions the physician, asks for further explanation, or otherwise indicates a lack of understanding, a physician need not and probably should not expand upon the basis for his conscientious convictions.

IV.5 A physician who declines to recommend or provide services or procedures for reasons of conscience must advise affected patients that they may seek the services elsewhere, and ensure that they have sufficient information to approach other physicians, heath care workers or community organizations.

IV.6 Physicians who are unable or unwilling to comply with this section must promptly arrange for a patient to be seen by another physician or health care worker who can comply with this section.

V. Section 2: Scope

V.1 Purported non-applicability of policy to assisted suicide and euthanasia

V.1.1 College Council has been asked to include a disclaimer in *Conscientious Refusal* as revised. The disclaimer states that the policy will not apply to "physician assisted death or physicians' conscientious objection related to a potential physician assisted death"[12] (i.e., physician administered euthanasia and physician assisted suicide).

V.1.2 The ostensible reason for this is "that this is currently an issue which is in a state of development and may be revisited by the College at a later time."[13]

V.1.3 Mr. Salte offered a more detailed explanation:

> There is considerable uncertainty associated with physician-assisted death following the *Carter* decision. There may be legislation by the Federal or Provincial Government which addresses the issue before February 2016 when the *Carter* decision will come into effect if no new legislation is passed. The ethical implications of physician-assisted death have not been fully explored.
>
> The situation of physician-assisted death can be revisited later, when it is clearer whether there will be legislation that addresses the issue and, if there will be, what the legislation will state.[14]

V.1.4 Committee member Dr. Susan Hayton explicitly supported this, noting that "the boundaries of this whole area are very grey at the moment."[15]

V.1.5 However, this disclaimer is inconsistent with the origin of the policy and with previous statements by its proponents (V.2). It is also inconsistent with previous arguments associating the provision of abortion/contraception with the provision of

euthanasia/assisted suicide (V.3). Further, almost all of the principles introduced into the revised policy are as supportive of euthanasia and assisted suicide as they are of abortion and contraception (Appendix "C").

V.2 Disclaimer inconsistent with origin of policy and previous statements

V.2.1 The policy first proposed by Mr. Salte originated with the Conscience Research Group (CRG) and was virtually identical to it. The slightly modified text, approved in principle by College Council in January, 2015 as *Conscientious Refusal* (hereinafter "*CR No.1*") was also a nearly verbatim copy of the CRG policy.

V.2.2 The CRG includes two euthanasia activists. One of them - Professor Jocelyn Downie - co-wrote the CRG policy largely replicated in *CR No. 1*. They were and are of the view that health care workers unwilling to kill patients or help them kill themselves should be forced to find someone else willing to do so.[16] Thus, the CRG policy is meant to apply to *all* "legally permissible and publicly funded health services" - which, beginning in 2016, will include euthanasia and assisted suicide.

V.2.3 Consistent with this, when, in 2014, Mr. Salte urged the registrars of all Canadian Colleges of Physicians and Surgeons to adopt a uniform coercive policy of the kind he and the CRG were proposing, he did not refer to abortion or contraception. Instead, he wrote, "Physician-assisted suicide, in particular, has the potential to challenge Colleges of Physicians and Surgeons to provide guidance to its members."[17]

V.2.4 Further, when - with a virtual clone of the CRG group's text in his back pocket, so to speak - Mr. Salte proposed that the College adopt a policy on "ethical objection," he identified assisted suicide as one of a list of "issues which have resulted in controversy" - the others being abortion, birth control, fetal sex identification and genetic testing.[18]

V.2.5 After the *Carter* decision, anticipating the legalization of physician administered euthanasia and physician assisted suicide, Mr. Salte stated publicly that *CR No. 1* was intended to apply "broadly,"not only to "birth control and abortion," but "all other areas," not excluding physician assisted suicide and euthanasia. He explicitly confirmed that doctors who disagree with assisted suicide could "end up being disciplined," and "could . . . lose their jobs."[19]

V.2.6 The statement is not surprising. Mr. Salte's willingness to discipline and dismiss physicians who refuse to participate in killing patients or helping them to commit suicide reflects an attitude entirely faithful to the source of the policy. It is also consistent with his explicit association of assisted suicide with the policy from the very beginning, and his linking of assisted suicide with abortion and birth control. Mr. Salte has said nothing to indicate that his attitude will be any different once the *Carter* decision comes into effect.

V.2.7 The Canadian Medical Protective Association (CMPA) took note of the *CR No. 1* requirement that objecting physicians actually provide "all health services that are legally available and publicly funded" if referral were not possible or would cause a delay jeopardizing a patient's "health or well being." The CMPA understood this would

include providing euthanasia and assisted suicide once *Carter* came into effect.[20]

V.3 Disclaimer inconsistent with association of abortion/birth control and euthanasia/assisted suicide

V.3.1 It has been noted that the policy first proposed by Mr. Salte and *CR No.1* are nearly verbatim copies of the CRG policy, produced by a group including two euthanasia activists, one of whom co-wrote the CRG policy. They argue that health care workers unwilling to kill patients or help them kill themselves should be forced to find someone else willing to do so *because* (they claim) *it is agreed* that health care workers who refuse to provide abortion and birth control can and should be compelled to refer patients to someone who will.[21]

V.3.2 It should be obvious that this claim is sharply contested, but it demonstrates clearly that arguments supporting a policy of coerced participation in abortion and birth control also support a policy of coerced participation in euthanasia and assisted suicide.

V.3.3 Consistent with this, when Mr. Salte proposed that the College adopt a policy on "ethical objection," he explicitly associated assisted suicide with abortion, birth control, fetal sex identification and genetic testing when indicating the potential scope of the policy (V.2.4). After the *Carter* decision, he again explicitly associated abortion and birth control with euthanasia and physician assisted suicide (V.2.5).

V.4 Dissecting the disclaimer

V.4.1 The reasons offered to support the disclaimer are unsatisfactory.

V.4.2 In the first place, almost every one of the principles that has been added to Section 1 of the revised policy has already been used to support demands that physicians should be forced to facilitate euthanasia and assisted suicide (Appendix "C"). Certainly, arguments based on those principles are disputed. However, one would have to be hopelessly naive, boundlessly optimistic or simply disingenuous to suggest that the principles *cannot* or *will* not be used to support coerced involvement in euthanasia and assisted suicide.

V.4.3 Second, when Mr. Salte proposed the coercive policy in July, 2014, it was well known that the Supreme Court of Canada might well legalize physician assisted suicide and euthanasia. That possibility had become a widespread prediction by the time the committee returned *CR No. 1* to Council for approval in principle in January, 2015, but there was no reference to the "very grey" areas later discovered by Dr. Hayton. And Mr. Salte continued to advocate for the coercive policy even *after* the ruling in *Carter*.

V.4.4 Recall that, when Mr. Salte urged the registrars of all Canadian Colleges to adopt a policy forcing objecting physicians to refer for morally contested procedures, he specifically noted to its importance in relation to physician-assisted suicide (V.2.3). He did not *then* express concern that "the ethical implications of physician assisted dying [had] not been fully explored." Why not?

V.4.5 Again, when Mr. Salte proposed that the College adopt a policy on "ethical objection," he included assisted suicide among the list of controversial services (V.2.4). He did not *then*

suggest that the College wait to see "whether there will be legislation that addresses the issue and, if there will be, what the legislation will state." Why not?

V.4.6 *After* the Supreme Court of Canada ordered the legalization of euthanasia and physician assisted suicide, Mr. Salte stated publicly that *CR No. 1* was intended to apply "broadly," to all areas of practice, not excluding physician assisted suicide and euthanasia. He did not *then* worry that there was "considerable uncertainty associated with physician-assisted death." He did not then say, "This is currently an issue which is in a state of development." On the contrary, he defended the proposition that physicians should be disciplined or fired if they refuse to at least help to find someone willing to kill patients or help them commit suicide (V.2.5, V.2.6). Why so bold then, so cautious now?

V.5 Explaining the disclaimer

V.5.1 The timing of the shift in attitude suggests an answer. All of the concerns about "ethical implications," "grey areas," "considerable uncertainty," and lack of legislation arose suddenly in March, 2015 - that is, just after Mr. Salte and the committee were confronted by overwhelming opposition to *CR No. 1*.

V.5.2 The introduction of the disclaimer could be seen as a mere tactical withdrawal: an attempt to secure passage of the policy, at least in some form, by defusing opposition that has been amplified by the pending legalization of assisted suicide and euthanasia. Supporters of *CR No. 1* may simply be prepared to wait, expecting to have an easier time imposing a policy that will force physicians to do what they believe to be wrong once physicians and the public have become as comfortable with assisted suicide and euthanasia as they are with abortion and contraception.

V.5.3 On the other hand, a less Machiavellian explanation is available. The disclaimer may indicate that committee members have begun to realize that if the College can force physicians to do what they believe to be wrong with respect to abortion and contraception, there would seem to be no reason why the College should not also be able to force physicians to do what they believe to be wrong with respect to killing patients and helping them commit suicide. That would explain Mr. Salte's suggestion that the Council "may wish to consider whether there is something different about physician assisted death that should result in it being addressed differently than other issues of conscientious objection."[22]

V.6 Disposing of the disclaimer

V.6.1 Mr. Salte appears to be inviting College Council to declare that objecting physicians need not facilitate euthanasia and physician assisted suicide because killing patients is morally contentious, but objecting physician must facilitate abortion, contraception, fetal sex selection (and perhaps other procedures) because they are morally acceptable and contrary views are erroneous.

V.6.2 Council should decline the invitation because declarations of that kind are beyond its competence, and enacting policies that give effect to such dogmatic positions would be an abuse of its authority. For the same reasons, it would be unacceptable to propose a policy

to limit the exercise of freedom of conscience with respect to some procedures or services and not others.

V.6.3 In view of V.2, V.3. V.4 and Appendix "B," it is unrealistic to believe that *Conscientious Refusal* as revised will not be applied to physician administered euthanasia and physician assisted suicide, either directly, after a certain length of time, or indirectly, as a paradigm for further policy development.

V.6.4 Including the disclaimer in the policy is thus misleading and ill-advised. If the College is determined to enact a policy on conscientious refusal, it should ensure that the policy adopted is sufficiently flexible to accommodate physicians who are unwilling to do what they believe to be wrong, not excluding direct or indirect participation in killing patients or helping them commit suicide. If Council is uncertain how this can be done, it should reject *Conscientious Refusal* as revised and postpone policy development until after the *Carter* decision comes into force in 2016.

VI. Summary

VI.1 A public consultation that produced a very significant return" produced no 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.

VI.2 The revised policy has withdrawn the demand that physicians unwilling to provide a service for reasons of conscience must facilitate the procedure by referral to a colleague who will. This is entirely satisfactory. It is also a tacit and significant admission that compelling physicians to facilitate services to which they object for reasons of conscience is an unacceptable assault on freedom of conscience. The statement, "Objecting physicians should not be obligated to provide a referral to a physician who will ultimately potentially provide the service" should be included in the text of the policy itself.

VI.3 *Conscientious Refusal* as revised effectively prohibits objecting physicians from communicating with their patients about morally contested procedures. It presumes that, by virtue of moral opposition to a service, a physician must be hopelessly prejudiced, duplicitous, disrespectful and incapable of providing full and balanced information. The suggested revision provides clear and convincing evidence that the College committee continues to advance moral and ethical views masked by the pretence of neutrality.

VI.4 The committee's recommendation would have the College control for or eliminate the exercise of *bona fide* moral judgement. The College can only do that unfairly and inconsistently by an authoritarian suppression of moral viewpoints selected arbitrarily, or because they are unpopular. Such selective authoritarianism contradicts direction from the Supreme Court of Canada that requires accommodation of different world views.

VI.5 Physicians who, for reasons of conscience, are unable or unwilling to provide patients with sufficient information to satisfy the requirements of informed medical decision

making must promptly arrange for a patient to be seen by another physician or health care worker who is able to do so.

VI.6 Physicians should inform patients of treatments or services that they will not provide for reasons of conscience as soon as it appears that a conflict is likely to arise. The same holds true for notification of patients when a physician's views change significantly.

VI.7 A physician who declines to recommend or provide services or procedures for reasons of conscience must advise affected patients that they may, if they wish, approach other physicians, heath care workers or community organizations to obtain the services, and ensure that they have sufficient information to do so.

VI.8 It is unrealistic to believe that a policy concerning the exercise of freedom of conscience will not be applied to euthanasia and assisted suicide. If the College is determined to enact a policy on conscientious refusal, it should ensure that the policy adopted is sufficiently flexible to accommodate physicians with respect to all procedures or services. Otherwise, Council should reject *Conscientious Refusal* as revised and postpone policy development until after the *Carter* decision comes into force in 2016.

Notes

1. Salte BE. *Memorandum to Council re: Policy on Conscientious Objection*, 9 March, 2015 (CPSS No. 38/15) p. 3.
(http://www.consciencelaws.org./archive/documents/cpss/2015-03-09-38_15.pdf)

2. Protection of Conscience Project, Submission to the College of Physicians and Surgeons of Saskatchewan Re: *Conscientious Refusal*, 5 March, 2015
(http://www.consciencelaws.org/publications/submissions/submissions-014-001-cpss.aspx)

3. Salte BE. *Memorandum to Council re: Draft Policy- Conscientious Objection*, 20 March, 2015 (CPSS No. 73/15) p. 10-17.
http://www.conscience.laws.org/archive/documents/cpss/2015-03-20-73_15.pdf)

4. Salte BE. *Memorandum to Council re: Draft Policy- Conscientious Objection*, 23 March, 2015 (CPSS No. 75/15) p. 4-11.
(http://www.consciencelaws.org/archive/documents/cpss/2015-03-23-75_15-cpso.pdf

5. Salte BE. *Memorandum to Council re: Draft Policy- Conscientious Objection*, 20 March, 2015 (CPSS No. 73/15) p. 5.
http://www.conscience.laws.org/archive/documents/cpss/2015-03-20-73_15.pdf)

6. Salte BE. *Memorandum to Council re: Draft Policy- Conscientious Objection*, 20 March, 2015 (CPSS No. 73/15) p. 7.
http://www.conscience.laws.org/archive/documents/cpss/2015-03-20-73_15.pdf)

7. "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)

8. *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. *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.

9. 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)

10. 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)

11. 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)

12. *Policy: Conscientious Refusal*-2: Scope. In Salte BE. *Memorandum to Council re: Draft Policy, Conscientious Objection*, 20 March, 2015 (CPSS No. 73/15) , p. 10-11, 14-15 (http://www.consciencelaws.org/archive/documents/cpss/2015-03-20-73_15.pdf)

13. *Policy: Conscientious Refusal-2*: Scope. In Salte BE. *Memorandum to Council re: Draft Policy, Conscientious Objection*, 20 March, 2015 (CPSS No. 73/15) , p. 10-11, 14-15. (http://www.consciencelaws.org/archive/documents/cpss/2015-03-20-73_15.pdf)

14. Salte BE. *Memorandum to Council re: Draft Policy- Conscientious Objection,* 20 March, 2015 (CPSS No. 73/15), p. 5. http://www.conscience.laws.org/archive/documents/cpss/2015-03-20-73_15.pdf)

15. Salte BE. *Memorandum to Council re: Policy on Conscientious Objection*, 9 March, 2015 (CPSS No. 38/15) p. 12. (http://www.consciencelaws.org./archive/documents/cpss/2015-03-09-38_15.pdf)

16. Professor Jocelyn Downie and Professor Daniel Weinstock are members of the faculty of the "Conscience Research Group" (CRG), the ulitmate source of the policy first proposed by Mr. Salte (See Protection of Conscience Project *Submission to the College of Physicians and Surgeons of Saskatchewan Re: Conscientious Refusal*, Appendices "A" and "B." (http://www.consciencelaws.org/publications/submissions/submissions-014-002-cpss.aspx) With Udo Schuklenk and others, they were members of a Royal Society of Canada panel of "experts" who recommended that health care workers unwilling to provide euthanasia or assisted suicide should be compelled to refer patients to someone who would do so. See 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. Referring to the Supreme Court of Canada hearing in Carter, Shcuklenk noted the Project's joint intervention asking the Court to "direct parliament to ensure that health care professionals would not be forced to assist in dying if they had conscientious objections." He commented, "I am not a fan of conscientious objection rights anyway, so I hope the Court will ignore this." 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.

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

18. Salte B. *Memorandum to Council re: Possible Policy or Guideline - Physicians who have an ethical objection to provide certain forms of medical services*, 31 July, 2014 (CPSS No. 200/14) (http://www.consciencelaws.org/archive/documents/cpss/2014-07-31-Report.pdf)

19. "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 2015-05-30. Annotated transcription at Protection of Conscience Project, *Submission to the College of Physicians and Surgeons of Saskatchewan, Re: Conscientious Refusal*, Appendix "C": Interview of Associate Registrar, College of Physicians and Surgeons of Saskatchewan Re: CPSS Draft Policy *Conscientious Refusal*, CI.2, CI.3; CIII.2 to CIII.4, CIV.1, CV.1 (http://www.consciencelaws.org/publications/submissions/submissions-014-004-cpss.aspx)

20. Salte BE. *Memorandum to Council re: Policy on Conscientious Objection*, 9 March, 2015 (CPSS No. 38/15) p. 9-10. (http://www.consciencelaws.org./archive/documents/cpss/2015-03-09-38_15.pdf)

21. 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.

22. Salte BE. *Memorandum to Council re: Policy on Conscientious Objection*, 9 March, 2015 (CPSS No. 38/15) p. 1.
(http://www.consciencelaws.org./archive/documents/cpss/2015-03-09-38_15.pdf)

Appendix "A"
Ontario College briefing materials

A1. Introduction

A1.1 The Council of the College of Physicians and Surgeons of Ontario (CPSO) was provided with a briefing note by the working group that drafted *Professional Obligations and Human Rights*. The briefing note helped to convince the Council to approve the policy.

A1.2 However, a review of the briefing materials shows them to be deficient, erroneous and seriously misleading. Moreover, it appears to have been physically impossible for the working group to have considered the results of the second public consultation before preparing the briefing materials.

A1.3 This suggests that the Saskatchewan College Council should give little weight to the CPSO briefing note and not rely upon the information it provides without independently verifying it, if possible.

A2. Citation of *Conscientious Refusal* (*CR No.1*)

A2.1 One of the reasons offered by the working group to justify the policy, including a requirement for compulsory referral, was that it aligned with "the position taken by the College of Physicians and Surgeons of Saskatchewan (CPSS) in their draft policy titled *Conscientious Refusal*" and had been "approved in principle by the CPSS Council."

A2.2 This was clearly premature, since *Conscientious Refusal* no longer aligns with the Ontario policy, and the withdrawal of the requirement for referral supports the view that the CPSO requirement of "effective referral" is unacceptable. (III.1)

A3. Reasonable apprehension of bias

A3.1 The Christian Medical and Dental Society and the Canadian Federation of Catholic Physicians' Societies have filed an application in the Ontario Superior Court of Justice asking for an injunction against enforcement of the CPSO policy, *Professional Obligations and Human Rights*.[1]

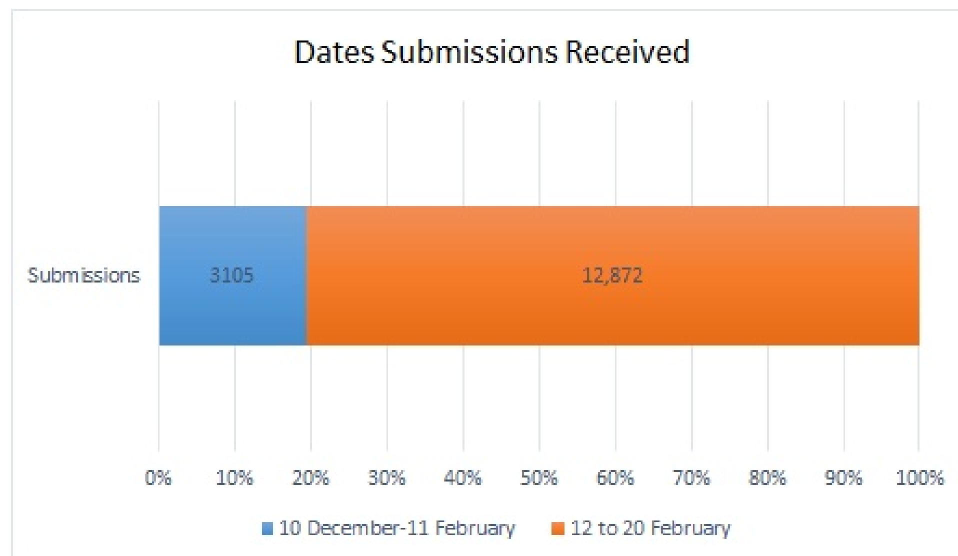
A3.2 According to the application, the CPSO acknowledged that it had received 15,977 submissions during the second consultation concerning the policy, which ended on 20 February, 2015. The great majority of submissions opposed the policy.

A3.3 While the consultation ended on 20 February, a working group wrote the final version of the policy by 11 February, at least nine days *before* the consultation closed. This is one of the factors that gives rise to concern about what the CMDS application calls either "actual bias" or "a reasonable apprehension of bias" on the part of the working group.

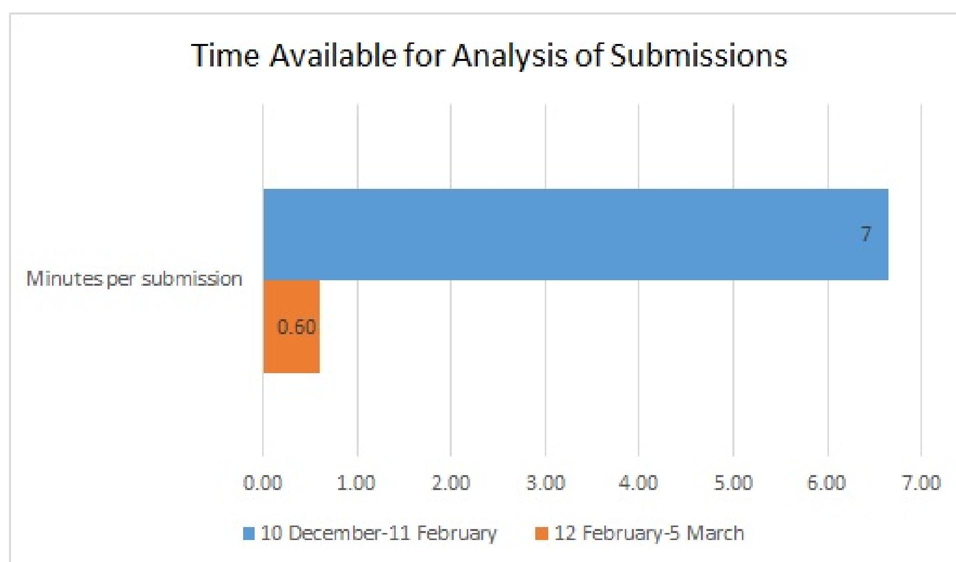
A3.4 On this point, the statistics provided by the CPSO are of interest.

A3.5 According to the briefing note supplied to the College Council,[2] by 11 February, 2015 the

College had received 3,105 submissions. This means that 12,872 submissions were received from 12 to 20 February inclusive. In other words, over 80% of the submissions in the second consultation were received *after* the final version of the policy had been written.



A3.6 Moreover, allowing sufficient time to receive feedback is only the beginning. Having received them, one would expect that a working group seriously interested in feedback would allow sufficient time to review and analyse the submissions.



A3.7 During the 64 days of consultation ending 11 February, the College received an average of almost 50 submissions per day. There were 43 working days during that period. Assuming someone spent eight full hours every working day reading the submissions, it

would have taken one person about seven minutes to review each one.

A3.8 However, the College received an average of one submission every minute of every hour of the last nine days of consultation ending 20 February. With 16 working days available from 12 February to 5 March inclusive, the day before the Council meeting, one person reading eight hours a day would have had no more than 36 seconds to review each submission.

A3.9 This demonstrates that it is highly unlikely that the CPSO briefing note can be safely relied upon by the Saskatchewan College.

A4. Tunnel Vision at the College of Physicians*

A4.1 The College of Physicians and Surgeons of Ontario has adopted a policy requiring physicians who have moral or ethical objections to a procedure to make an "effective referral" of patients to a colleague who will provide it, or to an agency that will arrange for it.[3] In 2008, amidst great controversy,[4] the Australian state of Victoria passed an abortion law with a similar provision.[5]

A4.2 After the law passed, a Melbourne physician, morally opposed to abortion, publicly announced that he had refused to provide an abortion referral for a patient. This effectively challenged the government and medical regulator to prosecute or discipline him. They did not. The law notwithstanding, no one dared prosecute him for refusing to help a woman 19 weeks pregnant obtain an abortion because she and her husband wanted a boy, not a girl.

A4.3 They obtained the abortion without the assistance of the objecting physician,[6] and they could have done the same in Ontario. College Council member Dr. Wayne Spotswood, himself an abortion provider, told Council that everyone 15 or 16 years old knows that anyone refused an abortion by one doctor "can walk down the street" to obtain the procedure elsewhere.[7]

A4.4 So why did the College working group that drafted the demand for "effective referral" urge College Council to adopt a policy that so clearly has the potential to make the College look ridiculous?

A4.5 Moreover, why did the working group push for a policy of "effective referral" despite having no evidence that even a single person in Ontario has ever been unable to access medical services because of conscientious objection by a physician?[8]

A4.6 Why did the working group supply Council with deficient, erroneous and seriously misleading briefing materials[9] - falsely implying, for example, that the Australian Medical Association supports "effective referral" by objecting physicians?[10]

A4.7 Having selected the American Medical Association for purposes of policy comparison, why did the working group fail to cite any AMA policy document in its December briefing materials,[11] and then, in March, leave out[12] the fact that AMA policy does *not* require "effective referral"?[13] If AMA policy was relevant in 2014, why was it irrelevant

in 2015?

A4.8 College consultation policy states that it "does not review any content of any feedback for accuracy."[14] Why, then, did the working group intervene in the second public consultation discussion forum, trying to stifle contributors' criticism by offering a purportedly 'correct' interpretation of the policy?[15]

A4.9 Why did the working group make *final* revisions to the draft policy nine days *before* the second public consultation closed, dismissing opposition that was overwhelming even then?[16]

A4.10 Four months elapsed between the end of the first public consultation and the working group's first report and recommendations to Council.[17] In contrast, Council was asked to pass the policy two *weeks* after the close of the second consultation.[18] Why the rush?

A4.11 And why did the working group wait until the day before the meeting to supply Council members with an explanation of the new policy?[19] Why has it not, even yet, published a report of the second on-line survey like that provided during the first?

A4.12. Lack of knowledge, lack of foresight, poor judgement, poor research, human error and carelessness might explain these problems, but for one disturbing fact. Almost every one of the errors, omissions, and deficiencies and every active intervention or decision made by the working group favoured its "effective referral" policy.

A4.13 What we seem to have here is not merely a series of unfortunate events, but a pattern of conduct strongly suggestive of a narrow and fixed ideological bias.

A4.14 Why such an impractical policy? Why insist upon it when there is no evidence to support it? Why the deficiencies, errors and misleading statements? Why finalize the policy nine days *before* the consultation ended? Why call for an immediate decision about a controversial policy affecting fundamental freedoms, without time for reflection - without even a complete accounting of the second consultation?

A4.15 The most cogent answer is that the working group, if not blinded by ideological extremism, had an exceptionally bad case of tunnel vision.

A4.16 Tunnel vision explains why the working group thought it a concession to allow a physician to refer a woman seeking a sex-selective abortion to an "agency" that would arrange for it rather than a physician who would provide it.

A4.17 Exceptionally bad tunnel vision accounts for the suggestion by the chairman of the working group and the president of the College that doctors opposed to abortion can avoid compromising their beliefs by sending patients with unwanted pregnancies to abortion clinics.[20]

A4.18 But there is yet no satisfactory explanation for the policy's central message: that ethical medical practice requires physicians to do what they believe to be unethical. Even the worst imaginable case of tunnel vision cannot account for that kind of incoherent authoritarianism.

A4.19 The working group failed to provide any evidence that the suppression of fundamental freedoms entailed by *Professional Obligations and Human Rights* was justified, and that no less restrictive means were available to achieve the legitimate objectives of the College. Despite this - and without seriously considering any of the foregoing questions - College Council approved the policy. If this is not the best possible example of blind faith by institutional decision makers, it will do until a better one comes along.

A4.20 Having failed to consider these questions before approving *Professional Obligations and Human Rights*, it appears that College Council will soon have the opportunity to consider them again. Indeed, the Council may be compelled to *answer* them - not in the closely controlled and congenial environment of its own offices, but in open court during a lawsuit launched by the Christian Medical Dental Society. That will likely be the beginning of a long trek to the Supreme Court of Canada, one that could have been avoided had College Council properly discharged its responsibilities.

A4.21 Certainly, the College is obliged "to protect and serve the public interest."[21] But the public interest is served by civility, restraint, tolerance, accommodation of divergent views and respect for fundamental freedoms. That requires broad-mindedness and evidence-based decision-making, not tunnel vision and blind faith.

*This appeared as an op-ed column in the *National Post* on 13 April, 2015. It is reproduced here in numbered paragraphs, with the notes not published with the column. (http://news.nationalpost.com/full-comment/sean-murphy-tunnel-vision-at-the-college-of-physicians)

Notes

1. Ontario Superior Court of Justice, Between the Christian Medical and Dental Society of Canada *et al* and College of Physicians and Surgeons of Ontario, *Notice of Application*, 20 March, 2015. Court File 15-63717 (http://consciencelaws.org/archive/documents/cpss/2015-03-20-cmds-notice.pdf)

2. Salte BE. *Memorandum to Council re: Draft Policy- Conscientious Objection*, 23 March, 2015 (CPSS No. 75/15) p. 4-11. (http://consciencelaws.org/archive/documents/cpss/2015-03-06-revised-policy.pdf)

3. College of Physicians and Surgeons of Ontario, *Professional Obligations and Human Rights* (http://www.cpso.on.ca/Policies-Publications/Policy/Professional-Obligations-and-Human-Rights) Accessed 2015-03-22

4. Letter from Dr. Mark Hobart to Mr. Edward O'Donohue, Chairperson, Scrutiny of Acts and Regulation Committee, Parliament of Victoria, dated 7 June, 2011. (http://www.parliament.vic.gov.au/images/stories/committees/sarc/charter_review/submissions/68_-_North_Sunshine_Surgery.pdf) Accessed 2015-02-19.

5. Murphy S. "State of Victoria, Australia demands referral, performance of abortions: Abortion Law Reform Act 2008." *Protection of Conscience Project*

(http://www.consciencelaws.org/repression/repression051.aspx)

6. Rolfe P. "Melbourne doctor's abortion stance may be punished." *Herald Sun*, 28 April, 2013 (http://www.heraldsun.com.au/news/victoria/melbourne-doctors-abortion-stance-may-be-punished/story-e6frf7kx-1226631128438) Accessed 2015-02-19; Devine M. "Doctor risks his career after refusing abortion referral." *Herald Sun*, 5 October, 2013 (http://www.perthnow.com.au/news/doctor-risks-his-career-after-refusing-abortion-referral/story-e6frg12c-1226733458187) Accessed 2015-02-19.

7. Swan M. "UPDATED: Ontario doctors must refer for abortions, says College of Physicians." *The Catholic Register*, 6 March, 2015 (http://www.catholicregister.org/item/19833-ontario-doctors-must-refer-for-abortions-says-college-of-physicians) Accessed 2015-03-10

8. Protection of Conscience Project, Submission to the College of Physicians and Surgeons of Ontario Re: *Professional Obligations and Human Rights* (20 February, 2015), Appendix "D"(http://www.consciencelaws.org/publications/submissions/submissions-013-005-cpso.aspx)

9. 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": Unreliability of Jurisdictional Review by College Working Group. (http://www.consciencelaws.org/publications/submissions/submissions-013-003-cpso.aspx)

10. 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": Unreliability of Jurisdictional Review by College Working Group- BII.3 (Australia) (http://www.consciencelaws.org/publications/submissions/submissions-013-003-cpso.aspx#BII.3)

11. It quoted a single sentence referring generally to AMA policy from an article about conscientious objection among pharmacists. 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": Unreliability of Jurisdictional Review by College Working Group- BII.5.1 (USA) (http://www.consciencelaws.org/publications/submissions/submissions-013-003-cpso.aspx#BII.5)

12. Council Briefing Note- Topic: *Professional Obligations and Human Rights- Consultation Report and Revised Draft Policy* (March, 2015). In Meeting of Council, March 6, 2015, p 60-67.(http://www.cpso.on.ca/CPSO/media/documents/Council/Council-Materials_Mar2015.pdf) Accessed 2015-03-23

13. Letter from the AMA Council of Ethical and Judicial Affairs to the College of Physicians and Surgeons of Ontario, 18 February, 2015 (http://policyconsult.cpso.on.ca/wp-content/uploads/2015/02/CEJA-to-CPSO_Redacted.pdf)

Accessed 2015-03-23

14. College of Physicians and Surgeons of Ontario, *The Consultation Process and Posting Guidelines*. (http://www.cpso.on.ca/Footer-Pages/The-Consultation-Process-and-Posting-Guidelines) Accessed 2015-03-22

15. Murphy S. "A watchdog in need of a leash." *Protection of Conscience Project Blog*, 3 February, 2015. (http://www.consciencelaws.org/ethics/ethics042.aspx)

16. College of Physicians and Surgeons of Ontario, *Meeting of Council 6 March, 2015*, p. 61. (http://www.cpso.on.ca/CPSO/media/documents/Council/Council-Materials_Mar2015.pdf) Accessed 2015-03-23

17. The first consultation closed on 5 August, 2014. The meeting occurred 4-5 December, 2014.

18. The second consultation closed 20 February, 2015. Council was asked to pass the policy on 6 March, 2015.

19. Swan M. "UPDATED: Ontario doctors must refer for abortions, says College of Physicians." *The Catholic Register*, 6 March, 2015 (http://www.catholicregister.org/item/19833-ontario-doctors-must-refer-for-abortions-says-college-of-physicians) Accessed 2015-03-10

20. Weatherbe S. "Doctors who oppose abortion should leave family medicine: Ontario College of Physicians." *LifeSite News*, 19 December, 2014 (https://www.lifesitenews.com/news/doctors-who-oppose-abortion-should-leave-family-medicine-ontario-college-of?) Accessed 2015-02-26.

21. College of Physicians and Surgeons of Ontario, *About the College: Self Regulation and the Practice of Medicine* (http://www.cpso.on.ca/About-Us) Accessed 2015-03-22

Appendix "B"
Providing Information

Introduction

B.1 It seems to be common ground that physicians have an ethical obligation to provide patients with sufficient information to make them aware of relevant treatment options so that they can make informed decisions about accepting or refusing medical treatment and care. It is also agreed that information must be communicated respectfully, in a way likely to be understood by the patient, and in a manner that does not provoke justifiable concern about "preaching" or attempting to "convert" the patient to his opinion. Finally, it is agreed that, whenever possible, physicians should inform patients, in advance, of treatments or services that they will not provide for reasons of conscience.

B.2 Some further qualifications are needed.

Clarifications

Sufficient information

B.3 The requirement that physicians will provide patients with sufficient information in comprehensible form necessarily precludes statements that are "false, misleading, intentionally confusing, coercive or materially incomplete."

Relevant options

B.4 Relevant options will, of necessity, be legal and clinically appropriate. It does not follow that every possible legal and clinically appropriate option must be presented at the first opportunity, in the absence of questions or other indications from the patient.

B.5 For example, while woman who is pregnant might want an abortion or might want to put the child up for adoption, it would be insensitive, when confirming a diagnosis of pregnancy, to say, "You can have the child, put it up for adoption or have an abortion. Which would you prefer?" That would be College-centred practice, not patient-centred practice.

B.6 Similarly, it would be insensitive, when advising a patient of a diagnosis of paraplegia, to present the relevant treatment options of euthanasia or assisted suicide, even though he has become legally entitled to the procedures under the terms of *Carter*.

Disclosure

B.7 The physician must disclose whether or not his religious, ethical or other conscientious convictions influence his recommendations or practice or prevent him from providing certain procedures or services.[1] If medical judgement rather than moral/religious conviction is his primary consideration, it is still prudent to disclose pertinent religious or moral beliefs.[2] 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 contraceptive(s) in question is consistent with the general view of the medical profession.[3]

B.8 Disclosure and discussion related to it ought to be limited to what is relevant to the patient's care and treatment. This should not be interpreted so strictly as to prevent a dialogue that is responsive to the needs of the patient.

Advance notice

B.9 Questions sometime arise about when such disclosures should be made. Holly Fernandez-Lynch insists that physicians fully disclose their objections to patients when they first accept them, reiterate them if they become relevant to treatment options, and notify patients if their views change.[4]

B.10 However, inflexible notification protocols do not serve the interests of either patients or physicians. For example: it would probably be unnecessary for a physician who accepts a 55 year old single woman as a patient to begin their professional relationship by disclosing objections to abortion, and it could well be unsettling for the patient if her medical history includes abortion. And, while it is possible that the woman might, six months after being accepted as a patient, ask for an embryo transplant, it does not follow that the mere possibility of such a request imposes a duty on the physician to disclose moral objections to artificial reproduction at their first consultation.

B.11 Similarly, it would likely be imprudent for a physician whose patient has just become paraplegic to give notice of an objection to euthanasia and assisted suicide simply because the patient has become legally entitled to the procedures under the terms of *Carter*.

B.12 Interests of patients and physicians are better served by open and continuing communication. On the part of the physician, this involves a special responsibility to be attentive to the spoken and unspoken language of the patient, and to respond in a caring and truthful manner. Within this context, it is reasonable to suggest that a physician should disclose his position when it would be apparent to a reasonable and prudent person that a conflict is likely to arise concerning treatments or services he declines to provide, erring on the side of sooner rather than later. In many cases - but not all - this may, indeed, be when a patient is accepted. The same holds true for notification of patients when a physician's views change significantly.

Respectful/non-demeaning communication

B.13 The requirement that physicians will be respectful in communication necessarily precludes communication or behaviour that demeans the patient or the patient's beliefs, lifestyle, choices or values. However, when a physician complies with disclosure requirements (B.7), patients will likely realize that a physician believes that a service or procedure is immoral. They may thus "feel judged" or "demeaned" by the physician, even if the physician's judgement pertains to the morality of the procedure rather than the personal culpability of the patient. Physicians should not be harassed or disciplined

because they have complied with disclosure requirements and the patient resents or is angered by their beliefs.

Notes

1. 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)

2. Guidelines typically require disclosure when a recommendation or practice is or would likely be influenced by a belief. However, a physician's decision or recommendation may be justified solely on medical grounds without reference to beliefs. The practical difficulty in a practice and disciplinary environment hostile to religious belief is that a failure to disclose a belief may invite the adverse inference that the physician failed to disclose beliefs that were 'really' shaping his decision making, especially if the medical grounds are contested by establishment opinion.

College of Physicians and Surgeons of Ontario, *Physicians and the Ontario Human Rights Code* (2008). "Communicate clearly and promptly about any treatments or procedures the physician chooses not to provide because of his or her moral or religious beliefs."(http://www.cpso.on.ca/Policies-Publications/Policy/Physicians-and-the-Ontario-Human-Rights-Code) Accessed 2014-02-22

3. 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)

4. Fernandez-Lynch H. *Conflicts of Conscience in Health Care: An Institutional Compromise.* Cambridge, Mass.: The MIT Press, 2008, p. 217-219, 222

Appendix "C"
Conscientious Refusal and assisted suicide/euthanasia

C1. Introduction

C1.1 *Conscientious Refusal* as revised states that it will not apply to "physician assisted death or physicians' conscientious objection related to a potential physician assisted death"[1] (i.e., physician administered euthanasia and physician assisted suicide).

C1.2 However, almost all of the principles introduced into the revised policy have already been used in support of euthanasia and assisted suicide .

C.2 Euthanasia/assisted suicide supported by principles

C2.1 *Conscientious Refusal* as revised by the drafting committee now includes an introductory paragraph that identifies the principles upon which it is based.

C2.2 Fiduciary duty

C2.2.1 The first principle identified in *Conscientious Refusal* as revised is "the fiduciary relationship between a physician and a patient." This is also addressed in the first line of the College of Physicians and Surgeons of Ontario (CPSO) policy provided to College Council: "The fiduciary nature of the physician-patient relationship requires that physicians act in their patients' best interests."[2]

C2.2.2 Assisted suicide and euthanasia advocates argue that the procedures are in the "best interests" of some patients.

C2.2.3 The trial judge in *Carter v. Canada*[3] acknowledged that physicians are expected to act in the "best interests" of patients (para. 311) and, when summarizing arguments in favour of euthanasia and assisted suicide, stated:

> Individuals may experience such suffering (physical or existential), unrelievable by palliative care, that it is in their best interests to assist them in hastened death. Physicians are required to respect patient autonomy, to act in their patients' best interests and not to abandon them. Where those principles co-exist, assistance in hastened death may be ethically permitted. (para. 315e)

C2.2.4 In justifying her ruling in favour of physician assisted suicide, the trail judge referred to "a strong consensus that if physician-assisted dying were ever to be ethical, it would be only be with respect to those patients, where clearly consistent with the patient's wishes and best interests, and in order to relieve suffering." (para. 358)

C2.3 Patient autonomy

C2.3.1 "Patient autonomy" is the second principle identified. Appeals to patient autonomy are central to the arguments of euthanasia and assisted suicide advocates. The Royal Society of Canada panel of "experts" asserted that, though not exclusive, "the value of individual

autonomy or self-determination . . . should be seen as paramount."[4]

> The commitment to autonomy, which as we have seen is a cornerstone of our constitutional order, thus quite naturally yields a *prima facie* right to choose the time and conditions of one's death, and thus, as a corollary, to request aid in dying from medical professionals.[5]

C2.3.2 The panel appealed to patient autonomy to justify its demand that health care workers unwilling to kill patients or help them kill themselves should be forced to refer patients to someone who would do so.[6] The *Carter* plaintiffs, seeking legalization of physician assisted suicide and euthanasia, quoted extensively from the panel's discussion of autonomy and "wholeheartedly" embraced its report.[7]

C2.4 Continuity of care/ left without appropriate care

C2.4.1 *Conscientious Refusal* as revised refers to a patient's right "to continuity of care" and insists that patients "should not be . . . left without appropriate care due to the personal beliefs of their physicians."

C2.4.2 Leaving aside disputes about whether or not lethal injection can be properly classified as a form of "care" - disputes that have not been ended by *Carter* - this assertion seems to be based on the principle of non-abandonment.

C2.4.3 Health care workers who refuse to provide or facilitate euthanasia and assisted suicide may be accused of abandoning their patients.[8]

C2.4.4 Testifying during the trial in *Carter*, Professor Margaret Battin stated that "non-abandonment" is a "core value" or "norm of practice" for physicians.

> Physicians are under an ethical obligation to try to respond to autonomous requests from their patients, especially when those requests revolve around extremes of suffering in those who are otherwise dying. . .
>
> The nature of the patient's suffering and why it is intolerable to the patient must also be understood by the physician, who then is obliged to try to respond as a matter of mercy and in fulfilment of his or her commitment not to abandon the dying patient. . . for the physician to offer assistance in dying, it must be the patient's choice and it must also be done to help the patient avoid suffering that is either intolerable or about to be so.[9]

C2.4.5 Professor Battin was called by the plaintiffs to help to make the case for legalization of physician assisted suicide and euthanasia. Plaintiff witnesses were prepared to testify with the help of Professor Jocelyn Downie,[10] co-author of the CRG policy largely copied in *CR No. 1*.

C2.5 Intentional or unintentional barriers to care/disadvantage/equitable access

C2.5.1 *Conscientious Refusal* as revised warns physicians against erecting "barriers to care" or disadvantaging patients.

C2.5.2 Dr. James Downar, a euthanasia advocate, has said that conscientious objection within the context of killing patients or helping them commit suicide "can serve as a barrier."[11]

C2.5.3 What constitutes a "barrier" or "disadvantage" is a polemical issue. In Ontario, for example, Facebook crusaders believe that an unacceptable "barrier" or "disadvantage" exists if a patient has to drive around the block or cross the street to obtain birth control pills.[12]

C2.5.4 Most physicians prescribe contraceptives, and birth control is widely available. In contrast, only a minority of physicians provide euthanasia and assisted suicide even where the procedures have been legal for years.[13] If it is said to be necessary to force objecting physicians to help patients obtain birth control in order to ensure patient "access" or to prevent "disadvantage" or "barriers it care," it would seem that there will be an even greater need to force objecting physicians to help find someone willing to kill a patient or assist in suicide.

C2.6 Reasonable limits

C2.6.1 *Conscientious Refusal* as revised states that "reasonable limits on a physician's ability to refuse to provide care are appropriate unless there is a good legal reason that the patient's interests should not be accommodated."

C2.6.2 Since a physician can only provide treatment that is legal in the circumstances of a particular patient, there can never be "a good legal reason" not to accommodate a patient's interests.

C2.6.3 Purged of its needless polemical convolutions, the statement amounts to this: that a physician's exercise of freedom of conscience is always subject to reasonable limits.

C2.6.4 As illustrated by the report of the Royal Society of Canada panel of "experts," euthanasia and assisted suicide advocates interpret this to mean that physicians unwilling to kill patients can be compelled to find someone else to do the killing.

Notes

1. *Policy: Conscientious Refusal*-2: Scope. In Salte BE. *Memorandum to Council re: Draft Policy, Conscientious Objection*, 20 March, 2015 (CPSS No. 73/15) , p. 10-11, 14-15. (http://www.conscience.laws.org/archive/documents/cpss/2015-03-20-73_15.pdf)

2. College of Physicians and Surgeons of Ontario Policy Statement #2-15, *Professional Obligations and Human Rights*, Sept. 2008 (Reviewed and updated March, 2015) p. 1. In Salte BE. *Memorandum to Council re: Draft Policy, Conscientious Objection*, 20 March, 2015 (CPSS No. 73/15) , p. 18-25 (http://www.conscience.laws.org/archive/documents/cpss/2015-03-20-73_15.pdf)

3. *Carter v. Canada (Attorney General)* 2012 BCSC 886. Supreme Court of British Columbia, 15 June, 2012. Vancouver, British Columbia. (http://www.courts.gov.bc.ca/jdb-txt/SC/12/08/2012BCSC0886cor1.htm) Accessed 2015-05-31

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. 41 (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. 45 (http://rsc-src.ca/sites/default/files/pdf/RSCEndofLifeReport2011_EN_Formatted_FINAL.pdf) Accessed 2014-02-23.

6. 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.

7. In the Supreme Court of British Columbia, between Lee Carter, Hollis Johnson, Dr. William Shoichet and the British Columbia Civil Liberties Association and Gloria Taylor (Plaintiffs) and the Attorney General of Canada and Attorney General of British Columbia (Defendants), *Written Submissions of the Plaintiffs*, dated 1 December, 2011, para 66 (http://www.dyingwithdignity.ca/database/files/library/Plaintiffs_Written_Submissions.pdf) Accessed 2015-06-02.

8. Angell M., Lowenstein E. Letter re: Redefining Physicians' Role in Assisted Dying. N Engl J Med 2013; 368:485-486 January 31, 2013 DOI: 10.1056/NEJMc1209798 (http://www.nejm.org/doi/full/10.1056/NEJMc1209798) Accessed 2015-05-31

9. *Carter v. Canada (Attorney General)* 2012 BCSC 886. Supreme Court of British Columbia, 15 June, 2012. Vancouver, British Columbia, para. 239-240 (http://www.courts.gov.bc.ca/jdb-txt/SC/12/08/2012BCSC0886cor1.htm) Accessed 2015-05-31

10. *Carter v. Canada (Attorney General)* 2012 BCSC 886. Supreme Court of British Columbia, 15 June, 2012. Vancouver, British Columbia, para. 124 (http://www.courts.gov.bc.ca/jdb-txt/SC/12/08/2012BCSC0886cor1.htm) Accessed 2015-05-31

11. Grant K. "Canadian doctors drafting new rules in case doors open to assisted suicide." *Globe and Mail*, 5 February, 2015 (http://www.theglobeandmail.com/news/national/canadian-doctors-drafting-new-rules-in-case-doors-open-to-assisted-suicide/article22798448/) Accessed 2015-06-01

12. Murphy S. "'NO MORE CHRISTIAN DOCTORS!' Crusade against NFP-only physicians." *Protection of Conscience Project.* (http://www.consciencelaws.org/background/procedures/birth002.aspx)

13. Murphy S. "Redefining the Practice of Medicine: Euthanasia in *Quebec-An Act Respecting End-of-Life Care* (June, 2014) Appendix "C": Statistics

(http://www.consciencelaws.org/law/commentary/legal068-012.aspx)