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Submission to the College of Physicians and Surgeons of Saskatchewan

Re: *Conscientious Objection*

7 August, 2015

Abstract

Conscientious Objection is unacceptable because it attacks the character and competence of objecting physicians, and it nullifies their freedom of conscience by compelling them to arrange for patients to obtain services to which they object.

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. In the absence of such evidence, the limits proposed in *Conscientious Objection* are neither reasonable nor demonstrably justified.

Conscientious Objection 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. The principles can be applied to force physicians to facilitate morally contested procedures only if they are ideologically interpreted in order to impose one world view at the expense of others. The Supreme Court of Canada has unanimously affirmed that such an approach is unacceptable.

It is unrealistic to believe that the approach taken in *Conscientious Objection* will not be taken with respect to physician administered euthanasia and physician assisted suicide. The disclaimer to the contrary is ill-advised and misleading. A policy on conscientious objection should be sufficiently flexible to apply to direct or indirect participation in killing patients or helping them commit suicide. If Council is uncertain how this can be done, it should postpone policy development concerning conscientious objection until after the *Carter* decision comes into force in 2016.

Alternatively, if the College believes that some kind of guidance should be provided with respect to this contentious issue, the Project offers an alternative that protects physician freedom of conscience and religion but does not obstruct patient access to services, including euthanasia and assisted suicide.

Revision Date: 2015-10-28

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I. Introduction

I.1 *Conscientious Objection* was preceded by two earlier versions of the policy. The Protection of Conscience Project made submissions about both.

- *Conscientious Refusal*, approved in principle by College Council on 20 January, 2015[1] (hereinafter "*CR No. 1*").
    - Project Submission (5 March, 2015)[2] (hereinafter "*Project Submission-CR No. 1*")
- *Conscientious Refusal*, a revision of *CR No. 1* re-submitted to Council on 20 March, 2015 (hereinafter "*CR No. 2*")[3]
    - Project Submission (5 June, 2015)[4] (hereinafter "*Project Submission-CR No. 2*")

I.2 For the most part, comments made about *CR No. 1* and *CR No. 2* in the two previous Project submissions are applicable to *Conscientious Objection* and remain valid. Some of them are incorporated into this submission.

I.3 *Conscientious Objection* is unacceptable because, in its attempt to ensure patient access to services - itself an entirely acceptable goal - it attacks the character and competence of objecting physicians and it nullifies physician freedom of conscience and religion. In particular:

- it attacks the character and competence of objecting physicians by prohibiting them from communicating with their patients about morally contested services; and
- it nullifies physician freedom of conscience and religion by compelling them to arrange for patients to obtain morally contested services.

II. Overview of this submission

II.1 This submission first briefly addresses the College's attempt to limit physician freedom of conscience and religion through *Conscientious Objection*. The Project submits that the proposed limitations are not justified (Part III).

II.2 It next deals with the principles that are offered to support the policy. The Project submits that the policy can be justified only by an unacceptably narrow ideological interpretation of the principles (Part IV: Appendix "A").

II.3 The Project submits that it is unrealistic to believe that the provisions of *Conscientious Objection* will not be applied to euthanasia and assisted suicide, and that the disclaimer indicating that it does not apply should be deleted (Part V: Appendix "B").

II.4 This submission offers an alternative to Section 5 of *Conscientious Objection* that simplifies the policy, is consistent with establish legal and ethical expectations and which permits the exercise of physician freedom of conscience and religion without obstructing patient access to services, including euthanasia and assisted suicide (Part VI: Appendix

"C").

II.5 Detailed arguments relevant to each part of the submission have been provided in the related appendices.

III. Limitation of fundamental freedoms

III.1 By means of *Conscientious Objection,* College Council intends to limit the fundamental freedoms of conscience and religion.

III.2 According to the *Canadian Charter of Rights and Freedoms*, freedoms of conscience and religion can be subjected "only to such *reasonable* limits prescribed by law as can be *demonstrably justified* in a free and democratic society."[5] (Emphasis added)

III.3 As the state regulator of the practice of medicine in Saskatchewan, the College is obliged to adhere to the *Saskatchewan Human Rights Code* and the *Charter of Rights and Freedoms* with respect to the accommodation of freedom of conscience and religion. The general rule is that the exercise of freedom of conscience and religion by physicians must be accommodated by the College to the point of undue hardship.[6]

III.4 When the Council approved *Conscientious Objection* in principle in June, 2015, despite extensive consultation, it had no evidence that anyone in Saskatchewan had ever been unable to access medical services, and no evidence that the health of anyone in Saskatchewan had ever been adversely affected because a physician had declined to provide or refer for a procedure for reasons of conscience. In the absence of such evidence, the limits proposed in *Conscientious Objection* are neither reasonable nor demonstrably justified.

IV. *Conscientious Objection* - 1. Purpose | 2. Principles

IV.1 *Conscientious Objection* refers to a number of important and well-established principles: the fiduciary duty of physicians, their duty of non-abandonment, patient autonomy, principles of informed consent and decision-making, equity, and respect for human dignity and freedom of conscience. Other principles found in *Conscientious Objection* - various formulations of continuity of care and non-obstruction - have force to the extent that they reflect these fundamental principles.

IV.2 Nonetheless, these principles did not prevent the Canadian Medical Association (CMA) from developing and maintaining its long-standing position that unwilling physicians should not be forced to facilitate procedures to which they object for reasons of conscience. The authors of *Conscientious Objection* avoided any reference to this, and deliberately omitted the key section of the CMA *Code of Ethics* that might have brought it to mind (Appendix "A", A1).

IV.3 *Conscientious Objection* is not justified by the principles included in the policy because, as the history of the CMA position indicates, 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 different conclusions. The principles can be applied to force physicians to facilitate morally contested procedures only if they are ideologically interpreted - only if the criticism, qualifications and distinctions like those provided in Appendix "A" are ignored or disallowed (Appendix "A", A2 to A13).

IV.4 This appears to explain why *Conscientious Objection* deliberately excludes reference to the most relevant section of the CMA *Code of Ethics* and the CMA's historical rejection of mandatory referral by objecting physicians. *Conscientious Objection* is intended to impose a particular world view and to suppress others, notably the world view that generated the very principles it cites.

IV.5 *Conscientious Objection* thus fails to meet the standard unanimously affirmed by the Supreme Court of Canada. 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, further, that the state should not endorse and enforce "one conscientiously-held view at the expense of another."[7]

V. *Conscientious Objection* - 2. Scope

V.1 The disclaimer

V.1.1 *Conscientious Objection* includes the following disclaimer:

> This policy does not apply to physician-assisted death or physicians' conscientious objection related to a potential physician-assisted death. The College recognizes that this is currently an issue which is in a state of development and may be revisited by the College at a later time.

V.1.2 Associate Registrar Bryan 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.[8]

V.1.3 Committee member Dr. Susan Hayton explicitly supported this position, noting that "the boundaries of this whole area are very grey at the moment."[9]

V.2 Dissecting the disclaimer

V.2.1 However, the disclaimer is inconsistent with

- the opinion of the Canadian Medical Protective Association (Appendix "B", B2);
- the origin of the policy and previous statements by the Associate Registrar and others

(Appendix "B", B3);

- previous arguments associating the provision of abortion/contraception with the provision of euthanasia/assisted suicide (Appendix "B", B4).

V.2.2 Moreover, 11 of the 16 principles in *Conscientious Objection* are as supportive of euthanasia and assisted suicide as they are of abortion and contraception, and a number of them have already been put forward as reasons to compel physician involvement in assisted suicide and euthanasia (Appendix "B", B5).

V.2.3 Finally, the reasons offered by Mr. Salte and Dr. Hayton to support the disclaimer are completely unsatisfactory. It appears that the disclaimer has been added to the policy either to secure passage of the policy by defusing opposition that has been amplified by the pending legalization of assisted suicide and euthanasia. Alternatively, at least some committee members may have realized that if the College can force physicians to do what they believe to be wrong with respect to abortion and contraception, it can force physicians to do what they believe to be wrong with respect to killing patients and helping them commit suicide (Appendix "B", B6).

V.3 Summary

V.3.1 If the policy *Conscientious Objection* can be used force physicians to do what they believe to be wrong with respect to abortion, contraception and other morally contested procedures, it can be used to force physicians to do what they believe to be wrong with respect to killing patients and helping them commit suicide. This conclusion is entirely consistent with opinion of the CMPA, the origin and development of the policy, the known views of the Associate Registrar, and the principles proposed in the policy itself.

V.3.2 The reasons offered by Mr. Salte and Dr. Hayton are entirely unsatisfactory, since they appear to have been offered either as a tactic to blunt the overwhelming opposition to the policy or because at least some committee members recognized the issue noted in V.3.1.

V.3.3 The Project submits that it is unrealistic to believe that *Conscientious Objection* 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. Including the disclaimer is thus ill-advised and misleading.

V.4 Recommendations

V.4.1 If College Council is determined to enact a policy on conscientious objection, it should ensure that it 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.

V.4.2 If Council is uncertain how this can be done, it should postpone policy development concerning conscientious objection until after the *Carter* decision comes into force in 2016.

V.4.3 Alternatively, if the College believes that some kind of guidance should be provided with

respect to this contentious issue, the Project offers an alternative in Part VI that protects physician freedom of conscience and religion but does not obstruct patient access to services, including euthanasia and assisted suicide.

VI. *Conscientious Objection* - 5. Physician obligations

VI.1 **5.1 Taking on new patients:** The provisions concerning taking on new patients are generally satisfactory, but a qualification is needed with respect to the meaning of "discrimination."

VI.2 While it is agreed that physicians should not engage in unlawful discrimination, it must be understood that conscientious objectors are not discriminating on the basis of the sex, marital status or "group status" of the patient. They are concerned to avoid moral complicity in wrongdoing. It seems highly unlikely that a physician would refuse to accept a patient for reasons of conscience or religion.

VI.3 It is unnecessary and unrealistic to require physicians to notify *every* patient before or when the patient is accepted of *all* services that they will not provide for reasons of conscience or religion. It makes more sense to insist on notification when there is actually some reason to believe that it is advisable to do so to avoid inconvenience to the patient or conflict.

VI.4 It is reasonable to expect that physicians will develop plans to minimize inconvenience and conflict that might arise in relation to their refusal to provide services for reasons of conscience or religion. However, this would seem to be better addressed in the section of the policy dealing with obligations related to the exercise of freedom of conscience and religion.

VI.5 Accordingly, the Project recommends moving the last paragraph of sub-section 5.1 (Taking on new patients) and concluding the sub-section as follows:

> **5.1 Taking on new patients**
>
> Physicians must give notice of religious, ethical or other conscientious convictions that influence their recommendations or practice or prevent them from providing certain procedures or services if it appears that a conflict is likely to arise in relation to someone applying to be accepted as patient. In such circumstances, the provisions of 5.3 (5) apply.

VI.6 **5.2 Providing information to patients:** The requirement in this sub-section that physicians provide information even if doing so violates their religious or moral convictions is inflammatory and unnecessary. So, too, is the accusation implied by reference to the provision of false, misleading, intentionally confusing, coercive, or materially incomplete information.

VI.7 It has not been the experience of the Project that objecting physicians are unwilling to provide information sufficient to fulfil the requirements of informed medical decision-making. Accordingly, what is proposed is a revision of the sub-section to focus on that

goal.

VI.8 Since all physicians are expected to provide information sufficient to fulfil the requirements of informed medical decision making, and since providing information for that purpose is not generally understood to involve wrongdoing, there is no need to refer to the exercise of freedom of conscience or religion in this context.

VI.9 Where indicated, the following adopts, modifies and/or expands upon provisions of *Conscientious Objection*.

5.2 Providing information to patients

1) To minimize inconvenience to patients and avoid conflict, physicians should develop a plan to meet the requirements of subsections 5.2 and 5.3 for services they are unwilling to provide for reasons of conscience or religion.

2) In exercising freedom of conscience and religion, physicians must adhere to the requirements of 5.2 (Providing information to patients).

3. Physicians must provide patients with sufficient and timely information to make them aware of relevant treatment options so that they can make informed decisions about accepting or refusing medical treatment and care. [Canadian Medical Association *Code of Ethics* (2004) para. 21[10]] [(CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) I.4[11]]

4. Sufficient information includes diagnosis, prognosis and a balanced explanation of the benefits, burdens and risks associated with each option. [Canadian Medical Association *Code of Ethics* (2004) para. 21[10]] [(CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) I.7[11]] [CPSS, *Conscientious Objection* (draft)]

5. Information is timely if it is provided as soon as it will be of benefit to the patient. Timely information will enable interventions based on informed decisions that are most likely to cure or mitigate the patient's medical condition, prevent it from developing further, or avoid interventions involving greater burdens or risks to the patient.

6. Relevant treatment options include all legal and clinically appropriate procedures, services or treatments that may have a therapeutic benefit for the patient, whether or not they are publicly funded, including the option of no treatment or treatments other than those recommended by the physician. [Canadian Medical Association *Code of Ethics* (2004) para. 23[12]][CPSS, *Conscientious Objection* (draft)]

7. A physician whose medical opinion concerning treatment options is not consistent with the general view of the medical profession must disclose this to the patient.[Canadian Medical Association *Code of Ethics* (2004) para.45[13]]

> 8. The information must be responsive to the needs of the patient and communicated respectfully and in a way likely to be understood by the patient. Physicians must answer a patient's questions to the best of their ability. [Canadian Medical Association *Code of Ethics* (2004) para. 21,[10] 22[14]] [(CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) I.4[11]] [CPSS, *Conscientious Objection* (draft)]
>
> 9. Physicians who are unable or unwilling to comply with these requirements must promptly arrange for a patient to be seen by another physician or health care worker who can do so.

VI.10 **Exercise of freedom of conscience and religion:** *Conscientious Objection* clearly presumes that, by virtue of moral opposition to a service, a physician cannot be trusted and must be forced to refer patients seeking a morally contested service to a purportedly "unbiased" party who can be trusted to act honestly.

VI.11 This is not an attack on freedom of conscience. It is, however, an attack on the character and competence of objecting physicians. Solely on the basis of their beliefs, it implies that they are unacceptably biased and effectively prohibits objecting physicians from communicating with their patients about morally contested procedures.

VI.12 The assumption underlying the demand is that a physician who has a moral viewpoint is incapable of properly communicating with a patient. But *all* physicians have moral viewpoints. *Conscientious Objection* simply exchanges one kind of 'bias' for another. If the College is to be fair and consistent, the 'bias' of physicians who do *not* object to a procedure should be nullified in the same way.

VI.13 Such a policy would do nothing more than 'protect' patients from one kind of alleged 'bias' by exposing them to another. It would only inconvenience patients and provide them with no better care.

VI.14 The problems with this approach were thoroughly canvassed in "*Project Submission-CR No. 2*. Medicine is a moral enterprise, and the College fairly and consistently control for or eliminate the exercise of *bona fide* moral judgement 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.

VI.15 That appears to be mindset that has caused the problem with this part of *Conscientious Objection*. It 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."[7]

VI.16 The expectation that an objecting physician should advise patients that they can see a different physician or seek the service elsewhere conforms to the spirit of the motion and is respectful of patient autonomy. A patient-initiated transfer of care seems

unproblematic and is the procedure used to accommodate objecting physicians in jurisdictions where assisted suicide and/or euthanasia are legal.

VI.17 A demand that an objecting physician help a patient obtain a morally contested service is unacceptable for the reason given by Dr. Charles Bernardin, the President of the Collège des Médecins du Québec. Speaking at a legislative committee hearing into what later became Quebec's euthanasia law, Dr. Bernardin explained:

> [I]f you have a conscientious objection and it is you who must undertake to find someone who will do it, at this time, your conscientious objection is [nullified]. It is as if you did it anyway. / [Original French] Parce que, si on a une objection de conscience puis c'est nous qui doive faire la démarche pour trouver la personne qui va le faire, à ce moment-là, notre objection de conscience ne s'applique plus. C'est comme si on le faisait quand même. [15]

VI.18 However, it is important to recognize that the response of objecting physicians when faced with a patient request for assistance will vary according to the beliefs and moral reasoning of the physician and the particular facts of each case.

VI.19 Hence, the Project alternative offers physicians a choice from among a range of responses that do not obstruct patient access to services.

5.3 Exercise of freedom of conscience and religion

1) To minimize inconvenience to patients and avoid conflict, physicians should develop a plan to meet the requirements of subsections 5.2 and 5.3 for services they are unwilling to provide for reasons of conscience or religion.

2) In exercising freedom of conscience and religion, physicians must adhere to the requirements of 5.2 (Providing information to patients).

3) In general, and when providing information to facilitate informed decision making, physicians must give patients reasonable notice of religious, ethical or other conscientious convictions that influence their recommendations or practice or prevent them from providing certain procedures or services. Physicians must also give reasonable notice to patients if their views change. [Canadian Medical Association *Code of Ethics* (2004) para. 12,[16] 21[10]] [(CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) I.16[11]]

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

5) In complying with these requirements, physicians should limit discussion related to their religious, ethical or moral convictions to what is relevant to the patient's care and treatment, reasonably necessary for providing an explanation,

and responsive to the patient's questions and concerns.

6) A physician who declines to recommend or provide services or procedures for reasons of conscience or religion must advise affected patients that they may seek the services elsewhere. Should the patient do so, a physician must, upon request, transfer the care of the patient or patient records to the physician or health care provider chosen by the patient. [Canadian Medical Association *Code of Ethics* (2004) para. 21[10]] [(CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) II.10[11]]

7) In other cases, in response to a patient request, a physician may respond in one of the following ways:

a) by providing a formal referral; or

b) by arranging for a transfer of care to another physician; or

c) by providing contact information for someone who is able to provide the service or procedure; or

d) by providing contact information for an agency or organization that facilitates the service or procedure; or

e) by providing non-directive, non-selective information that will facilitate patient contact with other physicians, heath care workers or sources of information about the services being sought by the patient.

8) In acting pursuant to (5) or (6) above, a physician must continue to provide other treatment or care until a transfer of care is effected, unless the physician and patient agree to other arrangements. [Canadian Medical Association *Code of Ethics* (2004) para. 19,[17] 21[10]][(CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) I.16, II.11[11]]

9) A physician unwilling or unable to comply with these requirements must promptly arrange for a patient to be seen by another physician or health care worker who can do so.

VI.20 Necessary treatments to prevent harm: The Project has not encountered physicians unwilling to provide medical treatment that is urgently needed to prevent serious harm to patients. However, in the event that such an allegation is made, the issues are likely to be contested and complex. Hence, the Project alternative uses simplified terminology that is consistent with existing ethical and legal expectations, and cautions physicians to be mindful of their civil liability for malpractice or negligence.

5.4 Necessary treatments to prevent harm to patients

1) Physicians must provide medical treatment that is within their competence when a patient is likely to suffer serious harm if the treatment is not immediately provided, or immediately arrange for the patient to be seen by someone competent to provide the necessary treatment. [Canadian Medical Association *Code of Ethics*

(2004) para. 18[18]]

2) Physicians who fail to provide medical treatment in such circumstances may be civilly liable for negligence or malpractice, whether or not the failure results from their moral or religious beliefs.

VI.20 There is no need to refer to the possibility of investigation or discipline by the College, since the conduct of physicians who fail to conform to the norm established in 5.4(1) is subject to review by the College as a matter of course, whether or not moral or religious beliefs of a physician were contributory.

Notes

1. College of Physicians and Surgeons of Saskatchewan, *Policy-Conscientious Refusal* (20 January, 2015) (http://www.consciencelaws.org/archive/documents/cpss/2015-01-20-cpss-policy.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. Protection of Conscience Project, Submission to the College of Physicians and Surgeons of Saskatchewan Re: *Conscientious Refusal*, 5 June, 2015 (http://www.consciencelaws.org/publications/submissions/submissions-015-001-cpss.aspx)

5. Government of Canada, Justice Laws Website, *Constitution Act, Part I, Canadian Charter of Rights and Freedoms*, Section 1. (http://laws-lois.justice.gc.ca/eng/const/page-15.html) Accessed 2015-08-03

6. "In Defence of Charter Freedoms: A legal analysis of the 'Policy - *Conscientious Refusal*.'" Submission to the College of Physicians and Surgeons of Saskatchewan by the Justice Centre for Constitutional Freedoms (March, 2015) (http://www.jccf.ca/wp-content/uploads/2013/01/In-Defence-of-Charter-Freedoms-A-legal-analysis-of-the-constitutionality-of-the-Policy-Conscientious-Refusal.pdf) Accessed 2015-08-07

7. The statement was made by Madame Justice Bertha Wilson in *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), affirmed unanimously in 1991 by a panel of five judges in *R. v. Salituro* [1991] 3 S.C.R. 654, (https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/820/index.do) (Accessed 2015-08-05) and again unanimously affirmed by the full bench of the Court in *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.

8. 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)

9. 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)

10. 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 2015-08-07

11. *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) (Canadian Medical Association, Canadian Healthcare Association, Canadian Nurses' Association, Catholic Health Association of Canada) (http://www.consciencelaws.org/background/policy/associations-001.aspx)

12. Canadian Medical Association *Code of Ethics* (2004): "23. Recommend only those diagnostic and therapeutic services that you consider to be beneficial to your patient or to others. . ." (http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf) Accessed 2015-08-07

13. 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 2015-08-07

14. 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 2015-08-07

15. *Consultations*: College of Physicians of Quebec (Tuesday 17 September 2013 - Vol. 43 no. 34), T#154 (http://www.consciencelaws.org/background/procedures/assist009-001.aspx#154)

16. 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 2015-08-07

17. Canadian Medical Association *Code of Ethics* (2004): "19. Having accepted professional responsibility for a patient, continue to provide services until they are no longer required or wanted; until another suitable physician has assumed responsibility for the patient; or until the

patient has been given reasonable notice that you intend to terminate the relationship." (http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf) Accessed 2015-08-07

18. Canadian Medical Association *Code of Ethics* (2004): "18. Provide whatever appropriate assistance you can to any person with an urgent need for medical care. " (http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf) Accessed 2015-08-07

Appendix "A"

Conscientious Objection- "Purpose" and "Principles" Comment and critique

A1. Introduction

A1.1 Notably absent from the principles is any reference to a key section of the Canadian Medical Association (CMA) *Code of Ethics:*

> 12. Inform your patient when your personal values would influence the recommendation or practice of any medical procedure that the patient needs or wants.[1]

A1.2 This does not impose a duty on an objecting physician to help the patient obtain the morally contested service elsewhere. Moreover, in 1978, after a trial of one year, the CMA abolished a requirement to that effect because there was no ethical consensus to support it, and has maintained that position for almost forty years.[2] The College was aware of this because this information was provided in Appendix "B" of the Project's first submission.

A1.3 There is no reference to this key statement, and the long-standing position of the CMA does not appear anywhere in *Conscientious Objection*. However, the draft policy quotes four other sections of the CMA *Code of Ethics* verbatim: three under "Purpose" in the third and fourth bulleted sub-sections, and one under "Obligations" in sub-section 5.1 ("Taking on new patients").

A1.4 All of this indicates that the omission of section 12 and the long-standing position of the CMA was deliberate.

A1.5 16 other principles are offered in two different sections of *Conscientious Objection* for the purpose of justifying the policy.

A1.6 One principle - that physicians may have legitimate clinical reasons to refuse to provide a service requested by a patient - is a truism that does not require comment. The remainder are considered below, grouped together when appropriate.

A2. "The fiduciary relationship between a physician and a patient." (1. Purpose)

A2.1 Some writers assert that the fiduciary duties of physicians requires them to subordinate their conscientious convictions to those of their patients. Professors R.J. Cook and B.M. Dickens have made this claim,[3] citing the Supreme Court of Canada case, *McInerney v. MacDonald*.[4]

A2.2 However, *McInerney* 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, and the nature of fiduciary relationships was not discussed at length. Moreover, the 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."[5] 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.

A2.3 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."[6] 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.[7]

A3. "Patient autonomy." (1. Purpose)

A3.1 The description of the problem as a conflict of autonomy between patient and physician actually precludes a successful resolution by appealing to the principle giving rise to the conflict in the first place. Lawyer Iain Benson explains:

> Yes, the patient or "client" has his or her autonomy; but so, too, does the practitioner. There is no good reason (except perhaps one grounded in an anti-religious bias) to advocate that a patient's autonomy should trump the autonomy of the professional health-care worker just because the two views conflict. What is needed . . . is an examination of how to accommodate conscience and religious views within the contemporary technocratic and often implicitly anti-religious paradigm of certain aspects of modern medicine.
>
> The real issue, where there is a conflict of views between people regarding involvement with a procedure or drug, is not settled by reference to one person's "autonomy" but by reference to another principle, that of "justice" (defined as "rendering a person their due"). For it is there, in the order of justice, that competing claims must be reconciled in a manner that accords with the rule of law (including professional ethics and respect for professional disagreement), the provision of health-care and the developed understanding of a civil society.[8]

A4. "A patient's right to continuity of care." (1. Purpose)

"Patients should not be disadvantaged or left without appropriate care due to the personal beliefs of their physicians." (1. Purpose)

" Physicians have an obligation not to abandon their patients." (4. Principles)

A4.1 The first point to note here is a problem that is found repeatedly in *Conscientious Objection*: the question-begging assumption that a morally contested service or procedure is "appropriate" or "care" or "health care" or "health service" or "medical treatment" that contributes to a patient's "well-being." An objecting physician may well

deny that it is either health care, health service or medical treatment, and will invariably deny that it is "appropriate," if not absolutely, then in particular cases.

A4.2 This is most evident as a result of the *Carter* ruling. 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" or "medical treatment" or "care" 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.

A4.3 Similarly, 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.

A4.4 Likewise, 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.

A4.5 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 do what they believe to be wrong 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.

A4.6 Moving from ethics to law, Professors Cook and Dickens also claimed that failing to refer for abortion is a breach of fiduciary duty and constitutes "negligence close to abandonment." However, as noted in *Project Submission-CR No. 1*, their claims are unsupported by their own legal references.[9]

A5. "A patient's right to information about their care." (1. Purpose)

"Physicians have an obligation to provide full and balanced health information, referrals and health services to their patients in a non-discriminatory fashion." (4. Principles)

A5.1 With respect to "care", "health information", and "health services" see A4.

A5.2 It is agreed that patients have a right to full and balanced information so that they can make informed decisions about medical treatment and care. However, the reference to non-discrimination suggests that the College may not correctly understand the reasoning of objecting physicians.

A5.3 Certainly, it would be improper for a physician to refuse to provide services or treatment to patients because of his race, ethnic origin, religious beliefs, etc. But conscientious objectors are concerned to avoid moral complicity in wrongdoing, not with the sex, marital status or "group status" of the patient. Objections, if they arise, are, for example, to abortion, even though only women can have abortions: to premarital sex, even though only unmarried persons can have premarital sex: to the amputation of healthy body parts, even though only apotemnophiliacs are likely to request such surgery.

A5.4 Further, personal characteristics may be relevant to moral judgement. For example: a 20 year old man may not be faulted morally or legally for having sexual intercourse, and a friend may have no objection to making his apartment available for that purpose. However, the friend might well refuse the favour if the prospective bedmate were a nine year old girl rather than a nineteen year old woman, or if the would-be Lothario were cheating on his wife. Age and marital status may both be important factors in the friend's moral evaluation of the act and his decision to avoid complicity in it, even though age and marital status are "personal characteristics."

A5.5 Objecting physicians should not be threatened with discipline for exercising this kind of rationally comprehensive moral reasoning. It would be absurd and profoundly offensive to assert that physicians who refuse to be complicit in adultery, premarital sex, the mutilation or amputation of healthy body parts or the killing of human embryos or fetuses are acting like bigots.

A6. "Physicians should not intentionally or unintentionally create barriers to patient care." (1. Purpose)

"Physicians have an obligation not to interfere with or obstruct a patient's right to access legally permissible and publicly-funded health services." (4. Principles)

A6.1 With respect to "care" and "health services," see A4.

A6.2 Patients do not have a right to access *illegal* services. The only right that can exist is with respect to *legal* services.

A6.3 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 legal health service is *not* "publicly-funded" does not mean that physicians may interfere with or obstruct access to it.

A6.4 "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.

A6.5 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.

A6.6 Objecting physicians act to preserve their own integrity, not to control the conduct of patients. Thus, it is agreed that physicians who refuse to provide a treatment for reasons of conscience are not entitled to prevent patients from obtaining the treatment elsewhere.

A6.7 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 legally or ethically obliged to help a patient obtain a procedure or service to which the physician objects for reasons of conscience.

A6.8 Nor does it follow that refusal to help a patient obtain a morally contested service amounts to obstruction, interference, or creates a "barrier," any more than the refusal of a vegetarian restaurant to serve meat obstructs or interferes with customers' access to meat or creates a "barrier" to a customer who wants a roast beef sandwich.

A6.9 Obstruction or interference or the erection of barriers requires some positive act. It does not include refusal to do what one believes to be wrong.

A7. "The College has a responsibility to impose reasonable limits on a physician's ability to refuse to provide care where those limits are appropriate." (1. Purpose)

A7.1 With respect to "care," see A4.

A7.2 It is unlikely that objecting physicians and those who would suppress their freedom of conscience would agree about what counts as "reasonable" or "appropriate" limits.

A7.3 The primary legal responsibility of the College with respect to physician freedom of conscience and religion is to accommodate and minimally impair the exercise of both.

A8. "Medical care should be equitably available to patients whatever the patient's situation, to the extent that can be achieved." (1. Purpose)

A8.1 With respect to "medical care," see A4.

A8.2 Leaving aside disputes about whether or not a service constitutes medical care or treatment, "equitable" refers to a just distribution or share of something that is owed.

A8.3 Since justice is intrinsic to the concept of equity, justice is essential to achieving it. However, to force someone to do what he believes to be wrong is, as a rule, a grievous violation of the human person, not a mere limitation of freedom. It denies to the human person the freedom essential for a moral agent and treats him as a thing, not a person: a mere instrument or tool to serve the interests of another. It is not a demand for equitable service, but demand for servitude.

A8.4 Hence, the admirable goal of making services equitably available cannot be achieved by forcing physicians to do what they believe to be wrong.

A9. "The College of Physicians and Surgeons has an obligation to serve and protect the public interest." (4. Principles)

A9.1 This obligation applies generally to every government or state institution.

A9.2 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.

A9.3 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.

A9.4 In any case, the public interest is neither served nor protected by the unjustified suppression or restriction of freedom of conscience and religion. See A6 and A7.

A10. "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." (4. Principles)

A10.1 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.

A10.2 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.

A10.3 "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.

A10.4 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.

A10.5 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.

A10.6 Even if otherwise undisputed, it does not follow from this principle that an individual physician is obliged to provide or facilitate access to legal, publicly-funded services to which he objects for reasons of conscience.

A11. "Physicians' freedom of conscience should be respected." (4. Principles)

A11.1 The primary legal responsibility of the College with respect to physician freedom of conscience and religion is to accommodate and minimally impair the exercise of both, not merely to respect it.

A12. "Physicians' exercise of freedom of conscience to limit the health services that they provide should not impede, either directly or indirectly, access to legally permissible and publicly-funded health services." (4. Principles)

A12.1 For "health services," see A4. For "legally permissible and publicly funded," see A6 and A10.

A12.2 To "interfere with," "obstruct" and "create barriers," this statement adds "impede." The multiplication terms adds nothing of substance to the policy.

A12.3 The comments made in A6 are applicable here. Refusal to help a patient obtain a morally contested service no more "impedes" the patient than a refusal to help someone campaign for office "impedes" an electoral candidate.

A12.4 To "intentionally or unintentionally" this statement adds "either directly or indirectly." Refusing to do what one believes to be wrong is an intentional act that may have direct or indirect effects on others. It does not follow that refusing to do what one believes to be wrong is improper or illicit, or that it entitles the College to suppress the exercise of freedom of conscience.

A12.5 The increasingly restrictive demands and the multiplication of terms is indicative of a mindset determined to suppress any exercise of freedom of conscience that might, in the least, inconvenience a patient.

A13. "Physicians' exercise of freedom of conscience to limit the services that they provide to patients should be done in a manner that respects patient dignity, facilitates access to care and protects patient safety." (4. Principles)

A13.1 With respect to "care," see A4.

A13.2 It is agreed that the exercise of freedom of conscience should not compromise patient dignity or safety.

A13.3 However, it is unacceptable to demand that someone who objects to a procedure for reasons of conscience must, nonetheless, "facilitate access"to that procedure, since that would effectively nullify the exercise of freedom of conscience. Objecting physicians may not obstruct access, but they should not be required to facilitate it.

A14. Summary

A14.1 *Conscientious Objection* refers to a number of important and well-established principles: the fiduciary duty of physicians, their duty of non-abandonment, patient autonomy, principles of informed consent and decision-making, equity, and respect for human dignity and freedom of conscience. Other principles found in *Conscientious Objection* -

various formulations of continuity of care and non-obstruction - have force to the extent that they reflect these fundamental principles.

A14.2 Nonetheless, these principles did not prevent the CMA from developing and maintaining its long-standing position that unwilling physicians should not be forced to facilitate procedures to which they object for reasons of conscience. The authors of *Conscientious Objection* avoided any reference to this, and deliberately omitted the related section of the CMA *Code of Ethics* that might have brought it to mind.

A14.3 *Conscientious Objection* is not justified by the principles included in the policy because, as the history of the CMA position indicates, 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 different conclusions. The principles can be applied to force physicians to facilitate morally contested procedures only if they are ideologically interpreted - only if the criticism, qualifications and distinctions like those provided here are ignored or disallowed.

A14.4 That explains why *Conscientious Objection* deliberately excludes reference to section 12 of the CMA *Code of Ethics* and the CMA's historical rejection of mandatory referral by objecting physicians. *Conscientious Objection* is intended to impose a particular world view and to suppress others, notably the world view that generated the very principles it cites.

A14.5 In its attempt to impose particular world view at the expense of others, *Conscientious Objection* fails to meet the standard unanimously affirmed by the Supreme Court of Canada. 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, further, that the state should not endorse and enforce "one conscientiously-held view at the expense of another."[10]

Notes

1. Canadian Medical Association, *Code of Ethics* (2004) (http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf) Accessed 2015-08-05

2. Murphy S. "'NO MORE CHRISTIAN DOCTORS,' Appendix 'F': The Difficult Compromise- Canadian Medical Association, Abortion and Freedom of Conscience." (http://www.consciencelaws.org/background/procedures/birth002-F.aspx) *Protection of Conscience Project.*

3. Cook RJ, Dickens BM, "In Response". *J.Obstet Gyanecol Can*, February, 2004; 26(2)112.

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

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

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

7. For an analysis of subsequent arguments made by Cook and Dickens on this point, see Murphy S. "Postscript for the Journal of Obstetrics and Gynaecology Canada: *Morgentaler* vs. Professors Cook and Dickens." *Protection of Conscience Project.* (http://www.consciencelaws.org/law/commentary/legal030-001.aspx)

8. Benson IT. "'Autonomy', 'Justice' and the Legal Requirement to Accommodate the Conscience and Religious Beliefs of Professionals in Health Care." *Protection of Conscience Project.* (http://consciencelaws.org/law/commentary/legal004.aspx)

9. Submission CR No. 1, Appendix "G": *Notes on Referral, Abandonment and Fiduciary Duty*. (http://www.consciencelaws.org/publications/submissions/submissions-014-008-cpss.aspx)

10. The statement was made by Madame Justice Bertha Wilson in *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), affirmed unanimously in 1991 by a panel of five judges in *R. v. Salituro* [1991] 3 S.C.R. 654, (https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/820/index.do) (Accessed 2015-08-05) and again unanimously affirmed by the full bench of the Court in *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.

Appendix B

Scope of *Conscientious Objection*
Purported non-applicability of policy to assisted suicide, euthanasia

B1. Disclaimer

B1.1 *Conscientious Objection* includes the following disclaimer:

> This policy does not apply to physician-assisted death or physicians' conscientious objection related to a potential physician-assisted death. The College recognizes that this is currently an issue which is in a state of development and may be revisited by the College at a later time.

B1.2 Associate Registrar Bryan 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.[1]

B1.3 Committee member Dr. Susan Hayton explicitly supported this, noting that "the boundaries of this whole area are very grey at the moment."[2]

B2. Disclaimer inconsistent with opinion of the CMPA

B2.1 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."

B2.2 The CMPA understood this would include providing euthanasia and assisted suicide once *Carter* came into effect.[3]

B2.3 This requirement has been substantially reproduced in *Conscientious Objection*:

> When it is not possible to arrange for another physician or health care provider to provide a necessary treatment without causing a delay that would jeopardize the patient's health or well-being, physicians must provide the necessary treatment even if providing that treatment conflicts with their conscience or religious beliefs. (5.4b)

B3. Disclaimer inconsistent with policy origin, previous statements

B3.1 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.

B3.2 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.[4] 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.

B3.3 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."[5]

B3.4 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.[6]

B3.5 *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."[7]

B3.6 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.

B4. Disclaimer inconsistent with links between abortion and euthanasia

B4.1 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.[8]

B4.2 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.

B4.3 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 (B3.4). After the *Carter* decision, he again explicitly associated abortion and birth control with euthanasia and physician assisted suicide (B3.5).

B5. Principles support coercion of physicians to facilitate euthanasia

B5.1 *Conscientious Objection* purports to base its claims concerning physician obligations on 16 principles, listed in "Purpose" and "Principles."

B5.2 11 of the 16 principles are supportive of physician participation in euthanasia and assisted suicide, and a number have already been put forward as reasons to compel physician involvement in both.

B5.3 "The fiduciary relationship between a physician and a patient." (1. Purpose)

B5.3.1 "Fiduciary duty" is 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."[9]

B5.3.2 Assisted suicide and euthanasia advocates argue that the procedures are in the "best interests" of some patients.

B5.3.3 The trial judge in *Carter v. Canada*[10] 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)

B5.3.4 In justifying her ruling in favour of physician assisted suicide, the trial 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)

B5.4 "Patient autonomy." (1. Purpose)

B5.4.1 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."[11]

> 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.[12]

B5.4.2 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.8 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.[13]

B5.4.3 The Canadian Medical Association draft framework, *Principles-Based Approach to Assisted Dying in Canada*, offers guidelines for the implementation of physician-assisted suicide and euthanasia in accordance with the *Carter* decision. It includes the following "foundational principle" supportive of physician involvement in homicide and assisted suicide in the circumstances contemplated by the ruling:

> Respect for patient autonomy: Competent adults are free to make decisions about their bodily integrity. . .[14]

B5.5 "A patient's right to continuity of care." (1. Purpose)
"Patients should not be disadvantaged or left without appropriate care due to the personal beliefs of their physicians." (1. Purpose)
" Physicians have an obligation not to abandon their patients." (4. Principles)

B5.5.1 Whether or not lethal injection can be properly classified as a form of "care" is a dispute that has not been ended by *Carter*. Leaving that aside, health care workers who refuse to provide or facilitate euthanasia and assisted suicide may be accused of abandoning their patients.[15]

B5.5.2 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.[16]

B5.5.3 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,[17] co-author of the CRG policy largely copied in *CR No. 1*.

B5.5.4 Dr. David Grube of Oregon is a member of a euthanasia activist group who has helped about 30 patients commit suicide. Responding to reports that physicians are reluctant to lethally inject patients, he said, "[Y]ou have to realize we're no longer able to cure now; these are people who can't be healed," he said, "and we can't abandon them."[18]

B5.5.5 *Conscientious Objection* paraphrases euthanasia/assisted suicide advocate Dr. Derryk Smith, who, in responding to a strong statement against mandatory referral by CMA President Dr. Chris Simpson, said, "Patients seeking assisted dying should not be denied access to medical care just because of the beliefs of their doctor." [19]

B5.6 "Physicians should not intentionally or unintentionally create barriers to patient care." (1. Purpose)
"Physicians have an obligation not to interfere with or obstruct a patient's right to access legally permissible and publicly funded health services." (4. Principles)
"Physicians' exercise of freedom of conscience to limit the health services that they provide should not impede, either directly or indirectly, access to legally permissible and publicly-funded health services." (4. Principles)

B5.6.1 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."[20]

B5.6.2 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.[21]

B5.6.3 The premise of *Conscientious Objection*- is that it is 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." However, most physicians prescribe contraceptives, birth control is widely available, and the premise is unsupported by any evidence.

B5.6.4 In contrast, only a minority of physicians provide euthanasia and assisted suicide even where the procedures have been legal for years.[22] If one accepts the reasoning of *Conscientious Objection*, it is even *more* necessary to force objecting physicians to help find someone willing to kill a patient or assist in suicide than there is to force them to refer for contraception.

B5.7 "Medical care should be equitably available to patients whatever the patient's situation, to the extent that can be achieved." (1. Purpose)

B5.7.1 The Canadian Medical Association draft framework, *Principles-Based Approach to Assisted Dying in Canada*, offers guidelines for the implementation of physician-assisted suicide and euthanasia in accordance with the Carter decision. It includes the following "foundational principle" supportive of physician involvement in homicide and assisted

suicide in the circumstances contemplated by the ruling:

> Equity: To the extent possible, all those who meet the criteria for medical aid in dying should have access to this intervention. . .[14]

B5.8 "The College has a responsibility to impose reasonable limits on a physician's ability to refuse to provide care where those limits are appropriate." (1. Purpose)

B5.8.1 The Royal Society of Canada panel of "experts" argued that physicians or other health care workers unwilling to provide euthanasia or assisted suicide "are duty-bound to refer them in a timely fashion to a health care professional who will." The panel described this as a 'limitation' on freedom.[23]

B5.9 "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." (1. Purpose)

B5.9.1 This principle is identical to statements found in the policy proposed by the Conscience Research Group (CRG), from which *CR No. 1* was taken. As noted in B3.1 and B3.2, the CRG included euthanasia activists who 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. This statement in the CRG policy is meant to apply to *all* "legally permissible and publicly funded health services" - including euthanasia and assisted suicide.

B5.9.2 As noted in B3.1, the CMPA took note of that a demand that objecting physicians must provide "all health services that are legally available and publicly funded" would include providing euthanasia and assisted suicide once *Carter* came into effect. Logically, a requirement "to ensure . . . access to the provision of legally permissible and publicly-funded health services" must entail the provision of euthanasia and assisted suicide.

B6. Unsatisfactory reasons offered to support the disclaimer

B6.1 Questioning the reasons

B6.1.1 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*.

B6.1.2 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 (B3.3). He did not *then* express concern that "the ethical implications of physician assisted dying [had] not been fully explored." Why not?

B6.1.3 Again, when Mr. Salte proposed that the College adopt a policy on "ethical objection," he included assisted suicide among the list of controversial services (B3.4). 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?

B6.1.4 *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 (B3.5, B3.6). Why so bold then, so cautious now?

B6.2 Answering the questions

B6.2.1 The timing of the shift in attitude suggests answers to these questions. 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 drafting the policy were confronted by overwhelming opposition to *CR No. 1*.[24]

B6.2.2 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.

B6.2.3 Alternatively, the disclaimer may indicate that at least some committee members realized 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."[25]

Notes

1. 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)

2. 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)

3. 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)

4. 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.

5. 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)

6. 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)

7. "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)

8. 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.

9. 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)

10. *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

11. 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.

12. 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.

13. 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.

14. Canadian Medical Association, *Principles-Based Approach to Assisted Dying in Canada* (Backgrounder) (https://www.cma.ca/Assets/assets-library/document/en/advocacy/EOL/care-at-the-end-of-life-cma-framework-june2015-e.pdf) (Accessed 2015-07-21)

15. 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

16. *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

17. *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

18. Kirkey S., "How to end a life? Canada can look abroad for guidance as it seeks best method for assisted suicide." *National Post*, 10 April, 2015
(http://news.nationalpost.com/news/canada/canadian-politics/how-to-end-a-life-canada-can-look-abroad-for-guidance-as-it-seeks-best-method-for-assisted-suicide) Accessed 2015-07-04

19. "DWD responds to CMA statement on assisted dying." Dying with Dignity, 6 March, 2015
(https://www.dyingwithdignity.ca/2015/03/06/dwd-responds-to-cma-statement-on-assisted-dying.php) Accessed 2015-03-06

20. 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

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

22. 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)

23.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. 61
(http://rsc-src.ca/sites/default/files/pdf/RSCEndofLifeReport2011_EN_Formatted_FINAL.pdf) Accessed 2014-02-23.

24. 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)

25. 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 "C"

Conscientious Objection - 5. Physician Obligations Comment and Critque

This appendix contains three principal sections:

C1: A suggested alternative to Section 5 of *Conscientious Objection*, presented as a whole;

C2: A side-by-side comparison of *Conscientious Objection* with the Project alternative to identify the similarities and differences, with references to explanations in C3;

- Table A: 5.1 Taking on new patients (Ref. C3.1, C3.2)
- Table B: 5.2 Providing information to patients (Ref. C3.3 to C3.8)
- Table C: 5.3 Exercise of freedom of conscience and religion (Ref. C3.9 to C3.18)
- Table D: 5.4 Necessary treatments to prevent harm to patients (Ref: C3.19)

C3: Commentary corresponding to the tables in C2.

C1. 5. Obligations (Project alternative)

5.1 Taking on new patients

(To replace the 2nd last paragraph) Physicians must give notice of religious, ethical or other conscientious convictions that influence their recommendations or practice or prevent them from providing certain procedures or services if it appears that a conflict is likely to arise in relation to someone applying to be accepted as patient. In such circumstances, the provisions of 5.3 (5) apply.

5.2 Providing information to patients

1. Physicians must provide patients with sufficient and timely information to make them aware of relevant treatment options so that they can make informed decisions about accepting or refusing medical treatment and care. [Canadian Medical Association *Code of Ethics* (2004) para. 21[1]] [(CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) I.4[2]]

2. Sufficient information includes diagnosis, prognosis and a balanced explanation of the benefits, burdens and risks associated with each option. [Canadian Medical Association *Code of Ethics* (2004) para. 21[1]] [(CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) I.7[2]] [CPSS, *Conscientious Objection* (draft)]

3. Information is timely if it is provided as soon as it will be of benefit to the patient. Timely information will enable interventions based on informed decisions that are most likely to cure or mitigate the patient's medical condition, prevent it from developing further, or avoid interventions involving greater burdens or risks to the patient.

4. Relevant treatment options include all legal and clinically appropriate procedures, services or

treatments that may have a therapeutic benefit for the patient, whether or not they are publicly funded, including the option of no treatment or treatments other than those recommended by the physician. [Canadian Medical Association *Code of Ethics* (2004) para. 23[3]][CPSS, *Conscientious Objection* (draft)]

5. A physician whose medical opinion concerning treatment options is not consistent with the general view of the medical profession must disclose this to the patient. [Canadian Medical Association *Code of Ethics* (2004) para.45[4]]

6. The information must be responsive to the needs of the patient and communicated respectfully and in a way likely to be understood by the patient. Physicians must answer a patient's questions to the best of their ability. [Canadian Medical Association *Code of Ethics* (2004) para. 21, 22[1,5]] [(CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) I.4[2]] [CPSS, *Conscientious Objection* (draft)]

7. Physicians who are unable or unwilling to comply with these requirements must promptly arrange for a patient to be seen by another physician or health care worker who can do so.

5.3 Exercise of freedom of conscience and religion

1) To minimize inconvenience to patients and avoid conflict, physicians should develop a plan to meet the requirements of subsections 5.2 and 5.3 for services they are unwilling to provide for reasons of conscience or religion.

2) In exercising freedom of conscience and religion, physicians must adhere to the requirements of 5.2 (Providing information to patients).

3) In general, and when providing information to facilitate informed decision making, physicians must give patients reasonable notice of religious, ethical or other conscientious convictions that influence their recommendations or practice or prevent them from providing certain procedures or services. Physicians must also give reasonable notice to patients if their views change. [Canadian Medical Association *Code of Ethics* (2004) para. 12[6]][Canadian Medical Association *Code of Ethics* (2004) para. 21[1]] [(CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) I.16[2]]

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

5) In complying with these requirements, physicians should limit discussion related to their religious, ethical or moral convictions to what is relevant to the patient's care and treatment, reasonably necessary for providing an explanation, and responsive to the patient's questions and concerns.

6) A physician who declines to recommend or provide services or procedures for reasons of conscience or religion must advise affected patients that they may seek the services elsewhere. Should the patient do so, a physician must, upon request, transfer the care of the patient or patient records to the physician or health care provider chosen by the patient. [Canadian Medical Association *Code of Ethics* (2004) para. 21[1]] [(CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) II.10[2]]

7) In other cases, in response to a patient request, a physician may respond in one of the following ways: a) by providing a formal referral; or

b) by arranging for a transfer of care to another physician; or

c) by providing contact information for someone who is able to provide the service or procedure; or

d) by providing contact information for an agency or organization that facilitates the service or procedure; or

e) by providing non-directive, non-selective information that will facilitate patient contact with other physicians, heath care workers or sources of information about the services being sought by the patient.

8) In acting pursuant to (5) or (6) above, a physician must continue to provide other treatment or care until a transfer of care is effected, unless the physician and patient agree to other arrangements. [Canadian Medical Association *Code of Ethics* (2004) para. 19[7]][Canadian Medical Association *Code of Ethics* (2004) para. 21[1]] [(CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) I.16, II.11[2]]

9) A physician unwilling or unable to comply with these requirements must promptly arrange for a patient to be seen by another physician or health care worker who can do so.

5.4 Necessary treatments to prevent harm to patients

1) Physicians must provide medical treatment that is within their competence when a patient is likely to suffer serious harm if the treatment is not immediately provided, or immediately arrange for the patient to be seen by someone competent to provide the necessary treatment. [Canadian Medical Association *Code of Ethics* (2004) para. 18[8]]

2) Physicians who fail to provide medical treatment in such circumstances may be civilly liable for negligence or malpractice, whether or not the failure results from their moral or religious beliefs.

C2. *Conscientious Objection* and Project alternative compared

Table A. ***Conscientious Objection*** **5.1 Taking on new patients**	**C3#**	**Table A.** ***Project Alternative*** **5.1 Taking on new patients**
(2nd last paragraph) . . . Where physicians know in advance that they will not provide specific services, but will only arrange for the patient to obtain the necessary information from another source or arrange for the patient to obtain access to a medical treatment from another source (in accordance with paragraphs 5.2 or 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.	3.1	Physicians must give notice of religious, ethical or other conscientious convictions that influence their recommendations or practice or prevent them from providing certain procedures or services if it appears that a conflict is likely to arise in relation to someone applying to be accepted as patient. In such circumstances, the provisions of 5.3 (5) apply. **[From 5.3 Exercise of freedom of conscience and religion]** 5) In complying with these requirements, physicians should limit discussion related to their religious, ethical or moral convictions to what is relevant to the patient's care and treatment, reasonably necessary for providing an explanation, and responsive to the patient's questions and concerns.
(Last paragraph) The College expects physicians to proactively maintain an effective plan to meet the requirements of paragraph 5.2 and 5.3 for the frequently requested services they are unwilling to provide.	3.2	**[From 5.3 Exercise of freedom of conscience and religion]** 1) To minimize inconvenience to patients and avoid conflict, physicians should develop a plan to meet the requirements of subsections 5.2 and 5.3 for services they are unwilling to provide for reasons of conscience or religion.

Table B. ***Conscientious Objection*** **5.2 Providing information to patients**	**C3#**	**Table B.** ***Project Alternative*** **5.2 Providing information to patients**
Physicians must provide their patients with full and balanced health information required to make legally valid, informed choices about medical treatment (e.g., diagnosis, prognosis, and clinically appropriate 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.	3.3	1. Physicians must provide patients with sufficient and timely information to make them aware of relevant treatment options so that they can make informed decisions about accepting or refusing medical treatment and care. 2. Sufficient information includes diagnosis, prognosis and a balanced explanation of the benefits, burdens and risks associated with each option. 3. Information is timely if it is provided as soon as it will be of benefit to the patient. Timely information will enable interventions based on informed decisions that are most likely to cure or mitigate the patient's medical condition, prevent it from developing further, or avoid interventions involving greater burdens or risks to the patient. 4. Relevant treatment options include all legal and clinically appropriate procedures, services or treatments that may have a therapeutic benefit for the patient, whether or not they are publicly funded, including the option of no treatment or treatments other than those recommended by the physician. 5. A physician whose medical opinion concerning treatment options is not consistent with the general view of the medical profession must disclose this to the patient. 6. The information must be responsive to the needs of the patient and communicated respectfully and in a way likely to be understood by the patient. Physicians must answer a patient's questions to the best of their ability.

Table B. ***Conscientious Objection*** **5.2 Providing information to patients**	**C3#**	**Table B.** ***Project Alternative*** **5.2 Providing information to patients**
		7. Physicians who are unable or unwilling to comply with these requirements must promptly arrange for a patient to be seen by another physician or health care worker who can do so.
The obligation to inform patients may be met by arranging for the patient to obtain the full and balanced health information required to make a legally valid, informed choice about medical treatment from another source, provided that arrangement is made in a timely fashion and the patient is able to obtain the information without undue delay. That obligation will generally be met by arranging for the patient to meet and discuss the choices of medical treatment with another physician or health care provider who is available and accessible and who can meet these requirements. The physician has the obligation to ensure that an arrangement which does not involve the patient meeting and discussing choices of medical treatment with another physician or health care provider is effective in providing the information required by this paragraph.	3.4	**[From 5.2 Providing information to patients]** 7. Physicians who are unable or unwilling to comply with these requirements must promptly arrange for a patient to be seen by another physician or health care worker who can do so.
Physicians must not provide false, misleading, intentionally confusing, coercive, or materially incomplete information to their patients.	3.5	**[From 5.2 Providing information to patients]** 1. Physicians must provide patients with sufficient and timely information to make them aware of relevant treatment options . . 2. Sufficient information includes diagnosis, prognosis and a balanced explanation of the benefits, burdens and risks associated with each option. 4. Relevant treatment options include all legal and clinically

Table B. ***Conscientious Objection*** **5.2 Providing information to patients**	**C3#**	**Table B.** ***Project Alternative*** **5.2 Providing information to patients**
		appropriate procedures, services or treatments that may have a therapeutic benefit for the patient, whether or not they are publicly funded, including the option of no treatment or treatments other than those recommended by the physician. 5. A physician whose medical opinion concerning treatment options is not consistent with the general view of the medical profession must disclose this to the patient.
All information must be communicated by the physician in a way that is likely to be understood by the patient.	3.6	**[From 5.2 Providing information to patients]** 6. The information must be responsive to the needs of the patient and communicated respectfully and in a way likely to be understood by the patient. Physicians must answer a patient's questions to the best of their ability.
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.	3.7	**[From 5.2 Providing information to patients]** 6. The information must be responsive to the needs of the patient and communicated respectfully . . .
Physicians must not promote their own moral or religious beliefs when interacting with a patient.	3.8	**[From 5.3 Exercise of freedom of conscience and religion]** 5) In complying with these requirements, physicians should limit discussion related to their religious, ethical or moral convictions to what is relevant to the patient's care and treatment, reasonably necessary for providing an explanation, and responsive to the patient's questions and concerns.

Table C. ***Conscientious Objection*** **5.3 Providing or arranging access to health services**	**C3#**	**Table C.** ***Project Alternative*** **5.3 Exercise of freedom of conscience and religion**
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:	3.9	1) To minimize inconvenience to patients and avoid conflict, physicians should develop a plan to meet the requirements of subsections 5.2 and 5.3 for services they are unwilling to provide for reasons of conscience or religion. 2) In exercising freedom of conscience and religion, physicians must adhere to the requirements of 5.2 (Providing information to patients)
a) make an arrangement for the patient to obtain the full and balanced health information required to make a legally valid, informed choice about medical treatment as outlined in paragraph 5.2; and,	3.10	3) In general, and when providing information to facilitate informed decision making, physicians must give patients reasonable notice of religious, ethical or other conscientious convictions that influence their recommendations or practice or prevent them from providing certain procedures or services. Physicians must also give reasonable notice to patients if their views change. 4) Notice is reasonable if it is given as soon as it would be apparent to a reasonable and prudent person that a conflict is likely to arise concerning treatments or services the physician declines to provide, erring on the side of sooner rather than later. In many cases - but not all - this may be prior to accepting someone as a patient, or when a patient is accepted.
	3.11	5) In complying with these requirements, physicians should limit discussion related to their religious, ethical or moral convictions to what is relevant to the patient's care and treatment, reasonably necessary for providing an explanation, and responsive to the patient's questions and concerns.

Table C. ***Conscientious Objection*** **5.3 Providing or arranging access to health services**	**C3#**	**Table C.** ***Project Alternative*** **5.3 Exercise of freedom of conscience and religion**
b) make an arrangement that will allow the patient to obtain access to the health service if the patient chooses.	3.12	6) A physician who declines to recommend or provide services or procedures for reasons of conscience or religion must advise affected patients that they may seek the services elsewhere. Should the patient do so, a physician must, upon request, transfer the care of the patient or patient records to the physician or health care provider chosen by the patient.
Those obligations will generally be met by arranging for the patient to meet with another physician or other health care provider who is available and accessible and who can either provide the health service or refer that patient to another physician or health care provider who can provide the health service.	3.13	7) In other cases, in response to a patient request, a physician may respond in one of the following ways: a) by providing a formal referral; or b) by arranging for a transfer of care to another physician; or c) by providing contact information for someone who is able to provide the service or procedure; or d) by providing contact information for an agency or organization that facilitates the service or procedure; or e) by providing non-directive, non-selective information that will facilitate patient contact with other physicians, heath care workers or sources of information about the services being sought by the patient.
	3.14	8) In acting pursuant to (6) or (7) above, a physician must continue to provide other treatment or care until a transfer of care is effected, unless the physician and patient agree to other arrangements.
If it is not possible to meet the obligations of paragraphs a)	3.15	9) A physician unwilling or unable to comply with these

Table C. ***Conscientious Objection*** **5.3 Providing or arranging access to health services**	**C3#**	**Table C.** ***Project Alternative*** **5.3 Exercise of freedom of conscience and religion**
or b), the physician must demonstrate why that is not possible and what alternative methods to attempt to meet those obligations will be provided.		requirements must promptly arrange for a patient to be seen by another physician or health care worker who can do so.
This obligation does not prevent physicians from refusing to arrange for the patient to obtain access to the health service based upon the physician's clinical judgment that the health service would not be clinically appropriate for the patient. If the physician refuses to arrange for the patient to obtain access to a health service based upon the physician's clinical judgment, the physician should provide the patient with a full explanation for the reason not to do so.	3.16	
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.	3.17	**[From 5.2 Providing information to patients]** 6. The information must be responsive to the needs of the patient and communicated respectfully . . . **[From 5.3 Exercise of freedom of conscience and religion]** 5) In complying with these requirements, physicians should limit discussion related to their religious, ethical or moral convictions to what is relevant to the patient's care and treatment, reasonably necessary for providing an explanation, and responsive to the patient's questions and concerns.
When physicians decline to provide a health service 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.	3.18	**[From 5.3 Exercise of freedom of conscience and religion]** 8) In acting pursuant to (6) or (7) above, a physician must continue to provide other treatment or care until a transfer of care is effected, unless the physician and patient agree to other arrangements.

Table D. ***Conscientious Objection*** **5.4 Necessary treatments to prevent harm or provide care to patients**	**C3#**	**Table D.** ***Project Alternative*** **5.4 Necessary treatments to prevent harm to patients**
Physicians must provide medical treatment for a patient if treatment is necessary to avoid harming the patient's health or well-being. Accordingly: a) Physicians must provide care in an emergency, where it is necessary to prevent imminent harm, even if providing that treatment conflicts with their conscience or religious beliefs. b) When it is not possible to arrange for another physician or health care provider to provide a necessary treatment without causing a delay that would jeopardize the patient's health or well-being, physicians must provide the necessary treatment even if providing that treatment conflicts with their conscience or religious beliefs. Physicians must provide medical treatment for a patient within the physician's competency where the patient's chosen medical treatment must be provided within a limited time to be effective and it is not reasonably possible to arrange for another physician or health care provider to provide that treatment.	3.19	1) Physicians must provide medical treatment that is within their competence when a patient is likely to suffer serious harm if the treatment is not immediately provided, or immediately arrange for the patient to be seen by someone competent to provide the necessary treatment. 2) Physicians who fail to provide or arrange for medical treatment in such circumstances may be civilly liable for negligence or malpractice, whether or not the failure results from their moral or religious beliefs.

C3. Commentary corresponding to the tables in C2

Table A
5.1 Taking on new patients

C3.1 It would be improper for a physician to refuse to accept a patient because of race, ethnic origin, religious beliefs, etc. However, conscientious objectors are not concerned with the sex, marital status or "group status" of the patient. They are concerned to avoid moral complicity in wrongdoing. Objections, if they arise, are, for example, to abortion, even though only women can have abortions: to premarital sex, even though only unmarried persons can have premarital sex: to the amputation of healthy body parts, even though only apotemnophiliacs are likely to request such surgery.

Since objections are specific to procedures or services, and simply accepting a patient does not involve wrongdoing, it seems highly unlikely that a physician would refuse to accept a patient for reasons of conscience or religion.

It is unnecessary and unrealistic to require physicians to notify *every* patient before or when the patient is accepted of *all* services that they will not provide for reasons of conscience or religion. For example: there would seem to be no reason for physicians opposed to contraception to notify a 60 year old woman that they will not prescribe birth control pills. It makes more sense to insist on notification when there is actually some reason to believe that it is advisable to do so to avoid inconvenience to the patient or conflict.

C3.2 It is reasonable to expect that physicians will develop plans to minimize inconvenience and conflict that might arise in relation to their refusal to provide services for reasons of conscience or religion.

This would seem to be better addressed in the section of the policy dealing with obligations related to the exercise of freedom of conscience and religion, so the provision is found there in the Project alternative.

Table B
5.2 Providing information to patients

C3.3 Provisions in this paragraph have been distributed among the 7 paragraphs in the Project alternative, and somewhat modified.

In the Project alternative,

- the reference to "*balanced* health information" is connected specifically to a balanced account of benefits, burdens and risks associated with the various treatment options, which is its correct meaning;
- "full" information becomes "sufficient" information in the Project alternative because, in reality, "full" information might well be overwhelming and unhelpful. "Sufficient" is defined so as to capture what was likely meant by "full";

- a specific requirement that information be "timely" (with a definition) is added.

Note that the essential element of "timely" information is its benefit to the patient. It is not always beneficial to present an "options menu" to a patient at the first opportunity. In the case of a patient who has lost both legs in a motor vehicle accident, it would probably not be beneficial to present the options of assisted suicide and euthanasia the day after surgery. Subject to the other elements in the definition of "timely," timing must be left to the discretion of physicians.

The reference to physicians' beliefs is deleted in the Project alternative because the provision of information in the manner indicated here is expected of all physicians, and it has not been the experience of the Project that objecting physicians are unwilling to provide information sufficient to fulfil the requirements of informed medical decision-making. Instead, the Project alternative proposes that physicians who are unable or unwilling to provide information sufficient to fulfil the requirements of informed medical decision-making must arrange for the patient to see someone who can.

C3.4 Since the goal in this situation is to provide timely information sufficient to ensure informed medical decision making, the Project alternative recommends that the patient be "promptly" directed to another physician or health care worker. This avoids the need for the physician to ensure that a non-physician/health care "source" provides the information as required.

C3.5 The requirements in the Project alternative preclude the provision of false, misleading, intentionally confusing, coercive, or materially incomplete information and lack the offensive implications of the statement in *Conscientious Objection*.

C3.6 The Project alternative emphasizes the importance of ensuring that the information is responsive to the needs of the patient.

C3.7 It is sufficient to require respectful communication, which necessarily excludes communication or conduct that is demeaning to the patient or to the patient's beliefs, lifestyle, choices, or values.

Note that a patient may feel that his beliefs, lifestyle, choices or values are demeaned for no other reason than that the physician refuses to provide or facilitate a service because he believes it is wrong. However, that cannot justify the suppression or restriction of physician freedom of conscience.

C3.8 Granted that physicians should not use clinical encounters as an opportunity for proselytizing, some discussion of religious or moral issues may well be necessary within the context of conscientious objection. The Project alternative proposes practical guidelines that take this into account, while accomplishing what was likely intended in *Conscientious Objection*.

Table C
5.3 Exercise of freedom of conscience and religion

C3.9 In this sub-section, the first paragraph of the Project alternative, following *Conscientious*

Objection, includes the expectation that physicians will develop plans to minimize inconvenience and the possibility of conflict.

The second paragraph sets out the expectation that physicians exercising freedom of conscience and religion must provide patients with sufficient and timely information concerning their medical care.

C3.10 *Conscientious Objection,* like *CR No. 2*, clearly 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. Accordingly, the policy demands that such untrustworthy physicians must be forced to refer patients seeking a morally contested service to a purportedly "unbiased" party who can be trusted to act honestly.

As the Project pointed out in *Project Submission-CR No. 2*, this is not an attack on freedom of conscience. It is, however, an attack on the character and competence of objecting physicians. Solely on the basis of their beliefs, it implies that they are unacceptably biased and effectively prohibits objecting physicians from communicating with their patients about morally contested procedures.

The assumption underlying the demand is that a physician who has a moral viewpoint is incapable of properly communicating with a patient. But *all* physicians have moral viewpoints. To be against euthanasia is to have a moral viewpoint; to be in favour of euthanasia is to have a moral viewpoint. *Conscientious Objection* simply exchanges one kind of 'bias' for another.

To be fair and consistent, the College 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.

Even then, however, the purported 'problem' remains. Such a policy would do 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.

However, this would be ludicrous. 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.

The solution proposed in the Project alternative is simple. All physicians should be expected to to provide information sufficient to fulfil the requirements of informed medical decision-making. When applicable, and in accordance with the CMA *Code of Ethics*, physicians must disclose and give reasonable notice of religious, ethical or other conscientious convictions that influence their recommendations or practice or prevent them from providing certain procedures or services.

Only physicians who are unable or unwilling to do this should be required to refer patients to a colleague or health care worker who can do so.

C3.11 As noted in C3.8, physicians should not use clinical encounters as an opportunity for proselytizing, but some discussion of religious or moral issues may well be necessary within the context of conscientious objection. The Project alternative proposes practical guidelines that take this into account.

C3.12 A requirement that an objecting physician must "make an arrangement that will allow the patient to obtain access" to a morally contested service amounts to a demand that the physician help the patient to do what the physician believes to be wrong. This is unacceptable because it nullifies freedom of conscience.

The Project alternative adopts the language and approach of a resolution at the 1971 CMA General Council concerning abortion:

> 4. That faced with a request for an abortion, a physician whose moral or religious beliefs prevent him from recommending and/or performing this procedure should so inform the patient *so that she may consult another physician.*[9] (Emphasis added)

The expectation that an objecting physician should advise patients that they can see a different physician or seek the service elsewhere conforms to the spirit of the motion and is respectful of patient autonomy. The transfer of records pursuant to a patient-initiated transfer of care does not, in the Project's experience, present a problem for objecting physicians. A patient-initiated transfer of care is the procedure used to accommodate objecting physicians in jurisdictions where assisted suicide and/or euthanasia are legal.

C3.13 A patient may not initiate a transfer of care, but may ask the objecting physician for other assistance. It is important to recognize that the response of objecting physicians will vary according to the beliefs and moral reasoning of the physician and the particular facts of each case. Hence, the Project alternative offers physicians a choice from among a range of responses that do not obstruct patient access to services.

"Non-directive, non-selective information" refers to what is sometimes called "generic" or "non-specific" information that a patient can use to get further information about how or where to obtain a morally contested service, the provision of which is not perceived by objecting physicians to make them morally culpable participants in what they believe to be wrongdoing.

C3.14 Like *Conscientious Objection*, the Project alternative expects an objecting physician to provide continuity of care, but, unlike *Conscientious Objection*, specifies that this does not include the morally contested procedure. The alternative also recognizes that the patient and physician may agree to other arrangements.

C3.15 Only physicians unwilling or unable to comply with these requirements are required by the Project alternative to promptly arrange for the patient to be seen by a physician or health care worker who can comply with them.

C3.16 The Project alternative makes no reference to clinical judgement since there does not appear to be any dispute that physicians cannot be expected to provide or facilitate procedures or services contrary to their clinical judgement.

C3.17 The Project alternative includes an expectation of respectful communication. As noted in C3.7, a patient may feel that his beliefs, lifestyle, choices or values are demeaned for no other reason than that the physician refuses to provide or facilitate a service because he believes it is wrong. However, that cannot justify the suppression or restriction of physician freedom of conscience.

C3.18 Like *Conscientious Objection*, the Project alternative expects an objecting physician to provide continuity of care, but, unlike *Conscientious Objection*, specifies that this does not include the morally contested procedure. The alternative also recognizes that the patient and physician may agree to other arrangements.

Table D
5.4 Necessary treatments to prevent harm to patients.

C3.19 Activists determined to suppress physician freedom of conscience frequently employ vague terminology for that purpose, such as purported risks to "health" or "well-being" and the tendentious classification of morally contested procedures like euthanasia as "medical treatment."

To avoid or at least minimize these problems, the Project alternative uses simplified and more restricted terminology that is consistent with existing ethical and legal expectations.

The Project has not encountered physicians unwilling to provide medical treatment that is urgently needed to prevent serious harm to patients. However, in the event that such an allegation is made, the issues are likely to be contested and complex. Hence, the Project alternative simply cautions physicians to be mindful of their civil liability for malpractice or negligence.

Notes

1. 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 2015-08-07

2. *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) (Canadian Medical Association, Canadian Healthcare Association, Canadian Nurses' Association, Catholic Health Association of Canada) I.4 (http://www.consciencelaws.org/background/policy/associations-001.aspx)

3. Canadian Medical Association *Code of Ethics* (2004): "23. Recommend only those diagnostic and therapeutic services that you consider to be beneficial to your patient or to others. . ."
(http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf) Accessed 2015-08-07

4. 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 2015-08-07

5. 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 2015-08-07

6. 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 2015-08-07

7. Canadian Medical Association *Code of Ethics* (2004): "19. Having accepted professional responsibility for a patient, continue to provide services until they are no longer required or wanted; until another suitable physician has assumed responsibility for the patient; or until the patient has been given reasonable notice that you intend to terminate the relationship." (http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf) Accessed 2015-08-07

8. Canadian Medical Association *Code of Ethics* (2004): "18. Provide whatever appropriate assistance you can to any person with an urgent need for medical care. " (http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf) Accessed 2015-08-07

9. "Canadian Medical Association 104th Annual Meeting, Halifax, Nova Scotia." *CMAJ* Volume 104(12) 1132-1134, June 19, 1971 (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1931049/pdf/canmedaj01621-0080.pdf) Accessed 2015-06-17