Protection of Conscience Project
www.consciencelaws.org

ADVISORY BOARD
Dr. Shahid Athar, MD
Clinical Associate Professor of Medicine & Endocrinology, Indiana School of Medicine, Indianapolis, Indiana, USA

J. Budziszewski, PhD
Professor, Departments of Government & Philosophy, University of Texas, (Austin) USA

Abdulaziz Sachedina,PhD
Dept. of Religious Studies, University of Virginia, Charlottesville, Virginia, USA

Roger Trigg, MA, DPhil
Academic Director, Centre for the Study of Religion in Public Life, Kellogg College, University of Oxford, United Kingdom

Lynn D. Wardle, JD
Professor of Law,J. Reuben Clark Law School,Brigham Young University, Salt Lake City, Utah, USA

PROJECT TEAM

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

Administrator
Sean Murphy

Revision Date: 2016-02-06

Submission to the College of Physicians and Surgeons of Nova Scotia

Re: *Standard of Practice: Physician-Assisted Death*

6 February, 2016

Abstract

The Project considers the proposed standard of practice satisfactory with respect to the accommodation of physician freedom of conscience and respect for the moral integrity of physicians. Neither direct nor indirect participation in euthanasia and assisted suicide is required.

The Project offers simple and uncontroversial recommendations to avoid conflicts of conscience associated with failed assisted suicide and euthanasia attempts and urgent situations.

The standard does not adequately address the continuing effects of criminal law. The College has no basis to proceed against physicians who, having the opinion that a patient does not fit one of the criteria specified by *Carter*, refuse to do anything that would entail complicity in homicide or suicide. College policies and expectations are of no force and effect to the extent that they are inconsistent with criminal prohibitions.

While the standard is satisfactory with respect to freedom of conscience, the fundamental freedoms of physicians in Nova Scotia will remain at risk as long as the College Registrar and others persist in the attitude and intentions demonstrated in his presentation to the Special Joint Committee on Physician Assisted Dying.

TABLE OF CONTENTS

I. Outline of the submission

I.1 The Project does not take a position on the acceptability of euthanasia and physician-assisted suicide. For this reason, much of the *Standard of Practice: Physician Assisted Death* (SPPAD) is outside the scope of this submission.

I.2 From the perspective of freedom of conscience, the Project considers SPPAD satisfactory. In particular, accommodation of physician freedom of conscience and respect for the moral integrity of physicians is reflected by the fact that effective referral is recommended, but not required. This is consistent with the position of the Canadian Medical Association in its recent submission to the College of Physicians and Surgeons of Ontario.[1]

I.3 The first issue raised in this submission concerns failed assisted suicide and euthanasia attempts and urgent situations, which can cause conflicts that can adversely affect patients, families and objecting health care providers. Simple and uncontroversial recommendations are offered to avoid these problems. (Part II)

I.4 The submission next points out the legal effect of *Carter v. Canada* with respect to the law on homicide, suicide, parties to offences, counselling offences and conspiracy, and that counselling (recommending) suicide remains a criminal offence. In some circumstances this will limit the power of the College to enforce demands for physician participation. (Part III)

I.5 Some remarks by the Registrar of the College made in his appearance before the Special Joint Committee on Physician Assisted Dying are addressed in Part IV.

II. Avoiding foreseeable conflicts

II.1 Failed assisted suicide and euthanasia

II.1.1 Euthanasia and assisted suicide drugs do not always cause death as expected.[2] As will be seen presently, this issue appears to have legal implications with respect to a physician's criminal responsibility, and also implications for physician freedom of conscience.

II.1.2 A 2014 survey of Canadian Medical Association members indicated that more physicians were willing to participate in assisted suicide (27%) than euthanasia (20%).[3,4,5,6,]

II.1.3 However, a physician who agrees to help a patient commit suicide would seem to have accepted an obligation to do something that will result in the patient's death, and to do it according to accepted standards. This obligation seems implicit in the agreement.

II.1.4 In the case of a failed physician-assisted suicide that incapacitates a patient, it is likely that the responsible physician will be expected to fulfil his commitment to help bring about the death of the patient by providing a lethal injection or finding someone willing to do so. The expectation would be stronger if the patient had sought assisted suicide to avoid the kind of incapacitation caused by the failed suicide attempt.

II.1.5 Here the issue of physicians willing to assist in suicide but unwilling to provide euthanasia becomes acute. Those willing to assist with suicide but not euthanasia may

be reluctant or unwilling to ask another colleague to kill the patient.

II.1.6 Moreover, the *Carter* ruling limits the provision of euthanasia to *competent* patients. Thus, to ask physicians to kill a patient who has been rendered *incompetent* by a colleague's failed attempt would seem to expose them to prosecution for first degree murder or, at least, assisted suicide. Even the legal position of an administering physician faced with a patient incapacitated by the first course of medication seems doubtful.

II.2 Urgent situations

II.2.1 It is often assumed that, since euthanasia and assisted suicide require extensive preliminary consultation and preparation before they can be authorized, they can never be urgently required.

II.2.2 That presumption is challenged by testimony taken by the Quebec legislative committee studying what later became the province's euthanasia law (*An Act Respecting End of Life Care*). Representatives of the College of Pharmacists of Quebec agreed that the provision of euthanasia would not seem to involve "the same urgency" as other kinds of procedures, and that arrangements could normally be made to accommodate conscientious objection by pharmacists because the decision could be anticipated.[7] However, they also stated that situations may evolve more quickly than expected, and that (for example) palliative sedation might be urgently requested as a result of respiratory distress precipitated by sudden bleeding.[8]

II.2.3 The pharmacist representatives distinguished between making a decision that euthanasia or assisted suicide should be provided - a decision which might take days or weeks - and a decision that a drug should be urgently provided to deal with an unanticipated and critical development in a patient's condition.[9]

II.2.4 Under the terms of the *Carter* ruling and the draft policy, it is possible that a responsible physician might agree to provide euthanasia or assisted suicide on a given date and time, to accommodate (for example) the desire of geographically distant family members to be present at the patient's death. Given the number of Nova Scotians working outside the province, this is likely to occur at some point. Between the time that decision is made and the appointed time, however, a sudden deterioration of the patient's condition may cause the patient to ask for immediate relief from pain or suffering by euthanasia or assisted suicide.

II.2.5 No problem will arise if the responsible physician is immediately available to fulfil the request. However, there is likely to be a problem if the responsible physician is absent or unavailable, and other physicians willing to kill the patient or assist in suicide cannot be conveniently found. This situation is more likely to arise if the originally appointed time for euthanasia/assisted suicide is some days later than the decision to provide the procedure.

II.3 Project recommendations

II.3.1 Physicians should not undertake to provide assisted suicide unless they are also willing to provide euthanasia.

II.3.2 In all cases, the responsible physician should, as part of the informed consent discussion preliminary to decision making, advise the patient of the possibility that the drugs might not cause death and discuss the options available.

II.3.3 Immediately prior to administering or providing the lethal medication, the responsible physician should obtain written direction from the patient as to what action should be taken if the prescribed or administered drugs fail to cause death. (NB. In the case of patients incapacitated by failed euthanasia/assisted suicide, it is *not* known if this would be legally sufficient to invoke the exemption from prosecution provided by *Carter*.)

II.3.4 The responsible physician should personally administer the lethal drug or be personally present when it is ingested, and remain with the patient until death ensues.

II.3.5 A responsible physician who has agreed to provide euthanasia or assisted suicide must be continuously available to do so from the time the agreement is made to the time that the procedure is performed, unless the patient withdraws the request.

II.3.6 A responsible physician who has agreed to provide euthanasia or assisted suicide must also arrange for a second responsible physician to provide the procedure in the event that he is unable to be continuously present or is unable to act.

II.3.7 The second responsible physician must be continuously available to act in the place of the primary responsible physician.

III. SPPAD and criminal law

III.1 The draft standard states:

> The effect of the *Carter* decision is that after February 6, 2016, it will be a legal for a physician to assist an adult patient to die if specified criteria have been met. (Introduction, para. 1)

III.2 While this statement is accurate as far as it goes, it fails to correctly assess the legal effect of *Carter v. Canada* with respect to the law on homicide, suicide, parties to offences, counselling offences and conspiracy and fails to acknowledge that counselling (recommending) suicide remains a criminal offence.

III.3 *Carter* did not entirely strike down murder and assisted suicide laws, and it left the law against counselling suicide intact. Physicians can be charged for murder, manslaughter, or administering a noxious substance if they fail to follow the *Carter* guidelines (Appendix A2.6); if they recommend suicide to patients they can be charged for counselling suicide (Appendix A2.5). Moreover, *Carter* did not touch laws on parties to offences, counselling offences and conspiracy, which apply to effective referral. (Appendix A2.7)

III.4 In view of this, the College has no basis to proceed against any physician who, having the opinion that a patient does not fit one of the criteria specified by *Carter*, refuses to do anything that would entail complicity in homicide or suicide, including effective referral. College policies and expectations are of no force and effect to the extent that they are inconsistent with criminal prohibitions.

IV. Remarks of the Registrar

IV.1 The Registrar before the Special Joint Committee on Physician Assisted Dying

IV.1.1 In his appearance before the Special Joint Committee on Physician Assisted Dying, on 2 February, 2016, Registrar Dr. Douglas Grant made the following remarks:

> The next question is perhaps the most contentious, and that is what are the responsibilities of professionals or physicians conflicted by conscience, and by whom should these responsibilities be mandated. We have a history to confront. I refer to our country's experience with abortion and access to contraception where conscientiously objecting physicians faced and continue to face the same question. On many occasions, whether through silence or obfuscation, **physicians chose and continue to choose not to assist** women to access a legal and medical service that runs counter to their personal beliefs. I respectfully disagree with the submission to this committee of Dr. Jeffrey Blackmer of the CMA. As a regulator, I submit it is naive to think that access to physician assisted death will not be an issue whether for reasons of conscience or geography. (Emphasis added)
>
> The provincial colleges are not in unanimous agreement on the question of conscience and whereas it's unfortunate that there is not a unified pan-Canadian approach, this alone should not invite federal legislation. The professional and ethical obligations of a physician in this difficult situation are clearly within the objects of provincial legislation. The colleges, through FMRAC, should work toward consistency, both to establish the physician's obligations and to establish the disciplinary consequences that might flow from a breach of those obligations.[10]

IV.2 The Registrar, the Conscience Research Group and "effective referral"

IV.2.1 These comments are consistent with the agenda of the Conscience Research Group (CRG). The Group includes euthanasia/assisted suicide and abortion activists who are determined to force physicians who are unwilling to provide abortions, kill patients or help them commit suicide to find a colleague willing to do so. Having failed to convince the Canadian Medical Association to adopt such a policy, they decided to convince provincial regulatory authorities to impose it. (Appendix "B")

IV.2.2 Dr. Grant became involved with the Conscience Research Group in 2013, when he participated in a meeting called to discuss a policy intended to suppress physician freedom of conscience and religion. Representatives from Colleges of Physicians and Surgeons in Saskatchewan, Ontario and Quebec also attended (Appendix BIV.).

IV.2.3 The Collège des Médecins du Québec was, at that time, the only regulator that required objecting physicians to refer patients for morally contested procedures. The Ontario College subsequently adopted the CRG inspired policy of "effective referral" for morally contested procedures other than euthanasia and assisted suicide, which almost immediately resulted in a constitutional challenge.[11] Predictably, it recently extended the policy of "effective referral" to euthanasia and assisted suicide.[12] Saskatchewan attempted but failed to impose a virtual clone of the CRG policy.[13] The policy

ultimately adopted there may yet lead to a lawsuit against the Saskatchewan College.[14]

IV.3 The Registrar's intentions

IV.3.1 It is clear from the history of the Conscience Research group and from the Registrar's statement to the Special Joint Committee that persistent lobbying to force objecting physicians to facilitate abortion and contraception by referral have been an ongoing dress rehearsal for the power play now being acted out.

IV.3.2 The Registrar's remarks about the lack of unanimity among Colleges of Physicians indicate that he will continue to try to impose the repressive policy of the Conscience Research Group. This will have practical consequences in Nova Scotia.

IV.3.3 When appearing before the Special Joint Committee, Dr. Jeff Blackmer of the Canadian Medical Association said that he was already hearing from physicians planning to move from one province to another in order to be able to practise in accordance with their convictions.[15] This suggests that physicians will leave Nova Scotia if Dr. Grant is ultimately successful in imposing his views.

IV.3.4 The Registrar appears to recognize this. The development of the "unified pan-Canadian approach" he advocates is clearly intended to impose a repressive regime across the country, so that objecting physicians unwilling to conform will have to leave medical practice or leave the country, and only those willing to do what they believe to be gravely wrong will be able to become physicians anywhere in Canada.

IV.4 The Registrar's complaint

IV.4.1 This is apparent from the Registrar's complaint to the committee. He did not complain that objecting physicians were actually obstructing patients or preventing them from obtaining morally contested services, nor did he offer any evidence to that effect (which, as Registrar, he could have produced, if it existed). Instead, he complained that objecting physicians "chose and continue to choose not to assist" patients.

IV.4.2 The reason for this is that objecting physicians are concerned to maintain their own personal and professional integrity. They cannot control the choices their patients make, nor prevent patients from acting upon those choices, but they may refuse to help patients do what they believe to be wrong. For example, they may refuse to help find someone willing to kill a patient or assist with suicide.

IV.4.3 In contrast, the Registrar intends to actively prevent objecting physicians from making or acting upon what he considers to be unacceptable choices. Those fond of labels might say that he is not "pro-choice," or that he is an "anti-choice." In any case, by his own account, he is less respectful of the freedom of objecting physicians than they are of the freedom of their patients.

IV.5 An ethic of servitude, not service

IV.5.1 The Registrar asks what responsiblities physicians have when they ecounter conflicts of conscience. His answer is implied in his presentation to the Committee and by his collaboration with the Conscience Research Group. He expects them to do what they are told to do by the patient, or by the College, or by the state. He expects them to 'follow orders', as it were, even if they believe doing so is wrong - even gravely wrong -

even if it means arranging for someone to be killed.

IV.5.2 The Registrar has accepted the argument of the Conscience Research Group that physicians have an ethical obligation to do what they believe to be unethical; that the essence of "professionalism" is a willingness to do what one believes to be wrong. This is incoherent. Moreover, his reference to "disciplinary consequences" makes clear his intention to punish those who refuse to do what they believe to be wrong, including those who refuse to be parties to homicide and suicide. This is dangerous.

IV.5.3 The best traditions of the practice of medicine, like the best traditions of liberal democracy, are associated with an ethic of service. The Registrar and the Conscience Research Group propose to replace this with an ethic of servitude. This is unacceptable.

V. Conclusion

V.1 The Project considers SPPAD satisfactory with respect to the accommodation of physician freedom of conscience and respect for the moral integrity of physicians. However, it should include reference to continuing effects of criminal law, and it would be prudent to address failed assisted suicide/euthanasia attempts and urgent situations.

V.2 The fundamental freedoms of physicians in Nova Scotia will remain at risk as long as the College Registrar and others persist in the attitude and intentions demonstrated in his presentation to the Special Joint Committee on Physician Assisted Dying.

Notes

1. Canadian Medical Association, *Submission to the College of Physicians and Surgeons of Ontario - Consultation on CPSO Interim Guidance on Physician-Assisted Death* (13 January, 2016) (http://www.consciencelaws.org/background/policy/associations-013.aspx) Accessed 2016-02-02.

2. Groenewoud JH, van der Heide A. Onwuteaka-Philipsen BD Willems DL van der Maas PJ, van der wal G., "Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands." N Engl J Med 2000; 342:551-556 February 24, 2000.

3. Moore E. "Doctor is hoping feds will guide on assisted suicide legislation." Edson Leader, 12 February, 2015. (http://www.edsonleader.com/2015/02/12/doctor-is-hoping-feds-will-guide-on-assisted-suicide-legislation) Accessed 2015-07-16.

4. Rich, P. "Physician perspective on end-of-life issues fully aired." Canadian Medical Association, 19 August, 2014 (https://www.cma.ca/En/Pages/Physician-perspective-on-end-of-life-issues-fully-aired.aspx) Accessed 2015-06-22.

5. Ubelacker S. "Medical professionals try to answer burning questions on doctor-assisted death." Associated Press, 13 February, 2015 (http://www.1310news.com/2015/02/13/medical-professionals-try-to-answer-burning-questions-on-doctor-assisted-death/) Accessed 2015-07-04.

6. Kirkey S. "How far should a doctor go? MDs say they 'need clarity' on Supreme Court's assisted suicide ruling." National Post, 23 February, 2015 (http://news.nationalpost.com/news/canada/how-far-should-a-doctor-go-mds-say-they-need-clarity-on-supreme-courts-assisted-suicide-ruling) Accessed 2015-07-04.

7. Consultations & hearings on Quebec Bill 52, College of Pharmacists of Quebec: Dianne Lamarre, Manon Lambert. Tuesday 17 September 2013 - Vol. 43 no. 34, T#49, T#58 (http://www.consciencelaws.org/background/procedures/assist009-005.aspx#049; http://www.consciencelaws.org/background/procedures/assist009-005.aspx#058).

8. Consultations & hearings on Quebec Bill 52, College of Pharmacists of Quebec: Dianne Lamarre, Manon Lambert. Tuesday 17 September 2013 - Vol. 43 no. 34, T#33 (http://www.consciencelaws.org/background/procedures/assist009-005.aspx#033).

9. Consultations & hearings on Quebec Bill 52, College of Pharmacists of Quebec: Dianne Lamarre, Manon Lambert. Tuesday 17 September 2013 - Vol. 43 no. 34, T#76, T#87, T#88 (http://www.consciencelaws.org/background/procedures/assist009-005.aspx#076) (http://www.consciencelaws.org/background/procedures/assist009-005.aspx#087) (http://www.consciencelaws.org/background/procedures/assist009-005.aspx#088).

10. Special Joint Committee on Physician Assisted Dying (PDAM), Meeting No. 10 (2 February, 2016). Webcast: Dr. Douglas Grant (19:30:08 to 19:31:50) (http://parlvu.parl.gc.ca/XRender/en/PowerBrowser/PowerBrowserV2/20160202/-1/24406?useragent=Mozilla/5.0 (Windows NT 6.1; WOW64; Trident/7.0; SLCC2; .NET CLR 2.0.50727; .NET CLR 3.5.30729; .NET CLR 3.0.30729; Media Center PC 6.0; .NET4.0C; .NET4.0E; InfoPath.3; GWX:DOWNLOADED; rv:11.0) like Gecko) Accessed 2016-02-05.

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

12. College of Physicians and Surgeons of Ontario, *Interim Guidance on Physician Assisted Death* (January, 2016) (http://www.cpso.on.ca/Policies-Publications/Policy/Interim-Guidance-on-Physician-Assisted-Death) Accessed 2016-02-05.

13. 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

14. Christian Medical and Dental Society, "Sask MDs, doctors' groups critical of CPSS decision." *News Release*, 19 June, 2015 (http://www.newswire.ca/news-releases/sask-mds-doctors-groups-critical-of-cpss-decision-517966881.html) Accessed 2016-02-05.

15. Dr. Blackmer: I have phone calls every day from people saying, "I live in this province. I think I'm going to move to this province because I like their rules better and they coincide

better with my own moral views." Special Joint Committee on Physician Assisted Dying, Evidence, Wednesday, 27 January, 2016. (http://www.parl.gc.ca/HousePublications/Publication.aspx?Language=e&Mode=1&Parl=42&Ses=1&DocId=8075735) Accessed 2016-02-05.

Appendix "A"

Supreme Court of Canada.
Carter v. Canada (Attorney General), 2015 SCC 5

A1. Carter criteria for euthanasia and physician assisted suicide

A1.1 In February, 2015, the Supreme Court of Canada struck down the criminal law to the extent that it prohibits physician assisted suicide and euthanasia in circumstances defined by the Court.[1]

A1.2 The ruling requires that physician assisted suicide and euthanasia be limited to competent adults who clearly consent to the procedure.[2] The use of the present tense suggests that consent cannot be established by an advance directive or provided by a substitute medical decision maker if the patient is otherwise unable to express valid consent.[3]

A1.3 According to Carter, the condition need not be terminal, but the patient must have "a grievous and irremediable medical condition (including an illness, disease or disability)."[4] The word "including" used here means that assisted suicide and euthanasia may be provided not only for "illness, disease or disability," but for other medical conditions - frailty, for example.[5]

A1.4 While the Court notes that "minor medical conditions" would not qualify[6] and that the medical condition must be "grievous," these are vague terms. Moreover, the Court does not specify whether it is the patient or the physician who determines that a condition is grievous. The medical condition must be "irremediable"; in oral argument, the appellants suggested this could be understood as "incurable."[7] However, the Court further states that individuals are entitled to refuse any treatments they find unacceptable,[8] so the ruling actually means that even treatable and curable medical conditions can be considered irremediable and incurable if the patient refuses treatment.

A1.5 Mental illness is a medical condition, and some kinds of mental illness are thought not to affect decisional capacity or competence. In passing, the Court remarks that the parameters they would propose in the reasons would not apply to "persons with psychiatric disorders."[9] However, the parameters actually laid out do not explicitly exclude mental illness, so, on this point, the ruling is ambiguous.

A1.6 Finally, the medical condition must cause "enduring suffering that is intolerable to the individual."[10] The Court does not specify that the suffering must be physical. Since it acknowledges the distinction between physical and psychological suffering[11] and pain and suffering,[12] the reference to intolerable suffering can be understood to mean both. Although the ruling does not say so, it is generally understood that suffering is subjectively assessed by the individual experiencing it.

A2. *Carter* and the criminal law

A2.1 If all of these criteria are met, a physician who kills a patient or helps him commit suicide cannot be charged for murder or assisted suicide or any other offence. However,

Carter did not entirely strike down murder and assisted suicide laws. They were invalidated only to the extent that they prevent homicide and assisted suicide by physicians adhering to the Court's guidelines.

A2.2 In the absence of legislation, the appropriate historical reference point for understanding the legal effect of *Carter* is the period between the 1938 case of R. v. Bourne and Canada's 1969 abortion law reform. Bourne was an English case that established a defence for physicians who provided abortions deemed necessary to preserve the life of the mother.[13]

A2.3 Though this condition was broadly construed, physicians were still liable to prosecution if the abortion were shown not to be required for that purpose. In 1967, CMA representatives told a parliamentary committee that "uncertainty about transgression of the law" was one of the reasons the Association supported reform of the abortion law.[14] Physicians wanted more than a defence to a charge. They wanted positive assurance that they would not be prosecuted.

A2.4 That assurance came when the Supreme Court of Canada struck down the abortion law entirely in the *Morgentaler* case. Physicians cannot be charged for providing abortions no matter what the circumstances.

A2.5 However, even with legislation - but particularly without it - it is difficult to see how physicians who are parties to homicide and suicide can entirely avoid some "uncertainty about transgression of the law." In the first place, the law against counselling suicide still stands [241(a) *Criminal Code*], so, while physicians may assist with suicide under the *Carter* guidelines, they can be charged if they recommend it.

A2.6 Second, as a matter of public policy, complete immunity from prosecution for murder or manslaughter can be safely guaranteed only for public executioners acting in the course of their duties. Thus, while the *Carter* ruling means that the state cannot prevent qualified patients from obtaining therapeutic homicide and suicide from physicians, it also means that physicians who fail to follow the *Carter* guidelines can be charged for first or second degree murder,[15,16] or manslaughter,[17] or administering a noxious substance.[18]

A2.7 Further, in such cases it would be a crime to conspire with the physician,[19] to do or omit to do anything for the purpose of aiding the physician,[20] to abet the physician,[21] or to counsel, procure, solicit or incite a physician to violate the *Carter* guidelines,[22] even if a patient is not ultimately killed.[23] Thus, anyone who deliberately participates in or facilitates euthanasia or assisted suicide by "effective referral" or similar means is liable to be charged unless the act is exempted by *Carter* from prosecution.

A2.8 The ruling itself is limited to the constitutional validity of the criminal law. It does not impose a legal duty on the state or upon anyone else to pay for euthanasia or assisted suicide or to provide or participate in them.

A3. *Carter* and freedom of conscience and religion

A3.1 That is essentially what the judges themselves acknowledge in *Carter*.

> In our view, nothing in the declaration of invalidity which we

> propose to issue would compel physicians to provide assistance in dying. The declaration simply renders the criminal prohibition invalid. What follows is in the hands of the physicians' colleges, Parliament, and the provincial legislatures (para. 132). (Emphasis added)

A3.2 Note that the Court here referred to "physicians" (plural), not "a physician" (singular). This passage indicates that striking down the criminal prohibition did not, in the Court's view, create any obligation on the part of physicians (individually or collectively) to provide assisted suicide or euthanasia. The statement is limited to providing - doing the killing or providing the lethal prescription.

A3.3 However, the Court included the broader term - participation - as it continued:

> . . . we note - as did Beetz J. in addressing the topic of physician participation in abortion in R. v. Morgentaler -- that a physician's decision to participate in assisted dying is a matter of conscience and, in some cases, of religious belief (pp. 95-96). In making this observation, we do not wish to pre-empt the legislative and regulatory response to this judgment. Rather, we underline that the Charter rights of patients and physicians will need to be reconciled (para. 132). (Emphasis added)

A3.4 To suggest that this reconciliation is to be accomplished by forcing unwilling physicians to become parties to homicide and suicide is inconsistent with the comments of Justice Beetz in *Morgentaler*, cited with approval by the full bench of the Court in *Carter*:

> Nothing in the *Criminal Code* obliges the board of an eligible hospital to appoint therapeutic abortion committees. Indeed, a board is entitled to refuse . . . in a hospital that would otherwise qualify to perform abortions, and boards often do so in Canada. Given that the decision to appoint a committee is, in part, one of conscience, and, in some cases, one which affects religious beliefs, a law cannot force a board to appoint a committee any more than it could force a physician to perform an abortion.[24] (Emphasis added)

A3.5 Note that Justice Beetz, while distinguishing between appointing a committee and performing an abortion, nonetheless considered both acts to involve judgements of conscience and religious belief, and the legal suppression of one to be the equivalent of the legal suppression of the other.

A3.6 Therapeutic abortion committees did not provide abortions. In fact, members of therapeutic abortion committees were prohibited from doing so.[25] The committees facilitated abortions by authorizing them. The refusal of boards to approve the formation of such committees was a refusal to become part of (participate in) a chain of causation culminating in abortion, even if not every case brought to a committee resulted in abortion.

A3.7 Thus, Justice Beetz' comments, affirmed by *Carter*, are authority for the proposition that the state is not only precluded from forcing individuals or institutions to provide

morally contested procedures, but also precluded from forcing them to participate indirectly by referral or other forms of causal facilitation.

A3.8 At the very least, this passage indicates that the suppression or restriction of freedom of conscience or religion by compelling indirect participation in a morally contested procedure is legally equivalent to compelling direct participation, a conclusion wholly consonant with the law on criminal responsibility and civil liability. The same constitutional standard applies, whether the state means to force unwilling physicians to kill patients themselves, or to force them to arrange for patients to be killed by someone else.

A3.9 Put another way, compelling indirect participation in a morally contested act is not a constitutionally valid 'solution' for the 'problem' that arises from being unable to compel direct participation.

A3.10 The Court's statement that "the *Charter* rights of patients and physicians will need to be reconciled" is not, as some seem to think, a warrant for the suppression of freedom of conscience and religion among health care workers.

A3.11 The *Charter* right of patients clearly established by *Carter* is a legal right not to be impeded or obstructed by the state in seeking euthanasia and assisted suicide in accordance with the Court's guidelines from willing physicians, except to the extent that impediments or obstructions can be demonstrably justified in a free and democratic society.

A3.12 The *Charter* right of physicians clearly established by *Carter* is their legal right not to be to impeded or obstructed by the state in providing euthanasia and assisted suicide in accordance with the Court's guidelines, except to the extent that impediments or obstructions can be demonstrably justified in a free and democratic society.

A3.13 Any additional rights claims are derived by reading into the ruling what the judges either did not address, or purposefully and expressly left out.

Notes

1. *Carter v. Canada* (Attorney General), 2015 SCC 5, para. 132. (Hereinafter "Carter") (https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/14637/index.do) Accessed 2015-06-27.

2. *Carter*, para. 4, 127, 147

3. This interpretation has been adopted by others. The College of Physicians and Surgeons of Alberta recently released a policy on euthanasia and assisted suicide that states, "PAD cannot be provided to patients who lack the capacity to make the decision, including when consent can only be provided by an alternate decision maker, is known by patient wishes or is provided through a personal directive." (Emphasis in the original). College of Physicians and Surgeons of Alberta, Physician Assisted Death (December, 2015) (http://www.cpsa.ca/standardspractice/advice-to-the-profession/pad/) Accessed 2015-12-18

4. *Carter*, para. 4, 127, 147

5. Cimons M. "Frailty Is a Medical Condition, Not an Inevitable Result of Aging (Op-Ed)." Livescience, 29 November, 2013. (http://www.livescience.com/41602-frailty-is-medical-condition.html) Accessed 2015-06-28.

6. *Carter*, para. 111

7. "We are limiting our case to people whose condition is irremediable, or incurable if you want to use that language, because it, assisted dying should only be allowed in the most serious cases. And not just because somebody wants to. It's because their condition is not going to get any better." Supreme Court of Canada, Webcast of the Hearing on 2014-10-15, 35591, Lee *Carter*, et al. v. Attorney General of Canada, et al (British Columbia) (Civil) (By Leave). Joseph Arvay, Oral Submission, 113:35/491:20 - 114:50/491:20 (http://www.scc-csc.ca/case-dossier/info/webcastview-webdiffusionvue-eng.aspx?cas=35591&urlen=http://www4.insinc.com/ibc/mp/md/open_protected/c/486/1938/201410150500wv150en,001&urlfr=http://www4.insinc.com/ibc/mp/md/open_protected/c/486/1940/201410150500wv150en,001&date=2014-10-15) Accessed 2015-06-28

8. *Carter*, para. 127

9. *Carter*, para. 111

10. *Carter*, para. 4, 127, 147

11. *Carter*, para 40 , 64

12. *Carter*, para. 68

13. *R. v Bourne* (1939) 1KB 687

14. "'We don't like being lawbreakers,' Dr. Aitken told the committee in partial explanation of the C.M.A's motivation in supporting the move to expunge the Criminal Code's prohibition of abortion. Dr. Gray commented that while he knew of no doctor having been prosecuted for performing an abortion openly in a hospital, there was still the uncertainty about transgression of the law. Dr. Cannell reported there were 262 therapeutic abortions performed in Canadian hospitals between 1954 and 1965." Waring G. "Report from Ottawa." CMAJ Nov. 11, 1967, vol. 97, 1233

15. *Criminal Code* (R.S.C., 1985, c. C-46) (Hereinafter "CC"), Section 229 (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-114.html); Section 231(1) (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-115.html) (Accessed 2014-07-25)

16. CC, Section 229 (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-114.html); Section 231(7) (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-115.html) (Accessed 2014-07-25)

17. CC, Section 232(1) (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-116.html) (Accessed 2014-07-25)

18. CC, Section 245. (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-119.html) (Accessed 2014-07-25)

19. CC. Section 465. (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-225.html)(Accessed 2014-07-25)

20. CC, Section 21(b). (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-6.html)(Accessed 2014-07-25)

21. CC, Section 21(c). (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-6.html) (Accessed 2014-07-25)

22. CC, Section 22 (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-6.html)(Accessed 2014-07-25)

23. CC, Section 464. (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-224.html) (Accessed 2014-07-25)

24. *R. v. Morgentaler* (1988) 1 S.C.R.95-96 (Supreme Court of Canada) (http://scc-csc.lexum.com/scc-csc/scc-csc/en/item/288/index.do) Accessed 2015-06-28.

25. CC, Section 287(4)a. (http://laws-lois.justice.gc.ca/eng/acts/C-46/page-152.html?texthighlight=abortion#s-287.) Accessed 2015-06-27

Appendix "B"

Conscience Research Group

B1. Attempts to coerce physicians: abortion

B1.1 Since the early 1970's, the Canadian Medical Association (CMA) has struggled repeatedly to resolve conflicts within the medical profession created by legalization of abortion. A prime source of conflict has been a continuing demand that objecting physicians be forced to provide or facilitate the procedure by referral. An early experiment with mandatory referral by objecting physicians was abandoned after a year because there was no ethical consensus to support it; there is no evidence that the policy was ever enforced.[1]

B1.2 A difficult compromise emerged. Physicians are required to disclose personal moral convictions that might prevent them from recommending a procedure to patients, but are not required to refer the patient or otherwise facilitate abortion. The arrangement preserves the integrity of physicians who do not want to be involved with abortion, while making patients aware of the position of their physicians so that they can seek assistance elsewhere. The compromise has been used as a model for dealing with other morally contested procedures, like contraception.

B1.3 Nonetheless, some activists, influential academics, powerful interests, state institutions and professional organizations have been working steadily to overthrow the compromise and compel objecting physicians and other health care workers to provide, participate in or facilitate abortion, contraception and related procedures. This was attempted, for example, in a guest 2006 editorial in the Canadian Medical Association Journal (CMAJ) by Professors Sanda Rodgers and Jocelyn Downie.[2] The editorial elicited a flood of protest. Dr. Jeff Blackmer, CMA Director of Ethics, reaffirmed Association policy that referral was not required,[3] and the CMAJ declared the subject closed.

B2. Plans to coerce physicians: assisted suicide and euthanasia

B2.1 Professor Downie was a member of the "expert panel" of the Royal Society of Canada that, in 2011, recommended legalization of euthanasia and assisted suicide. The panel conceded that health care workers might, for reasons of conscience or religion, object to killing patients or helping them kill themselves.

B2.2 Professor Downie and her expert colleagues, including Professors Daniel Weinstock and Udo Schuklenk, recommended that such objectors should be compelled to refer patients to someone who would do so.[4] They claimed that this was consistent with "[t]oday's procedural solution to this problem. . . in Canada as well as many other jurisdictions" with respect to conscientious objection to abortion and contraception ("certain reproductive health services"). Objecting physicians, they declared, are required "to refer assistance seekers to colleagues who are prepared to oblige them."[5]

B2.3 It is not surprising that the authors did not cite a reference to support this assertion. In Canada, outside of Quebec, there is, in fact, no policy that objecting health care

professionals should be compelled to refer for abortions or other morally contested procedures. Given the repudiation of her views by the CMA in 2006, Professor Downie must have been aware of that.

B2.4 As the Supreme Court of Canada heard submissions in *Carter v. Canada* in October. Professor Downie was live-tweeting from the courtroom, while her Royal Society fellow panelist Udo Schuklenk watched the live webcast. The goal of forcing objecting physicians to participate in euthanasia and assisted suicide was on his mind.

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

B3. Plans to coerce physicians: the CRG Model Policy

B3.1 Jocelyn Downie and Daniel Weinstock, who, with Udo Schuklenk were members of the Royal Society "expert panel," are also part of the faculty of the "Conscience Research Group" (CRG). The Conscience Research Group (CRG) was formed by Professor Carolyn McLeod of the University of Western Ontario with the assistance of a 2009 grant of over $240,000.00 from the Canadian Institutes of Health Research (CIHR).[7] CIHR provided members of the group with another $24,500.00 in grants between 2010 and 2012.[8] The Group is supported by research associate Jaquelyn Shaw and eight graduate students.[9]

B3.2 A central goal of the group is to entrench in medical practice a duty to refer for or otherwise facilitate contraception, abortion and other "reproductive health" services. As the involvement and arguments of Daniel Weinstock and Jocelyn Downie demonstrate, what is advocated by the "Conscience Research Group" equally applies to forcing physicians who are unwilling to kill patients or commit suicide to find a colleague who will.

B3.3 The Conscience Research Group advocates a coercive policy on conscientious objection written by three members of the Group, Downie, McLeod and Shaw. As a result of the

negative response of physicians and the CMA to Professor Downie's 2006 CMAJ editorial (B1.3), they decided to convince provincial Colleges of Physicians and Surgeons to adopt the CRG model:

> We decided to proceed by way of regulatory bodies rather than the CMA for two main reasons: 1) the Colleges of Physicians and Surgeons, not the CMA, are the regulators of physicians, which means their policies have more force than CMA policies; and 2) in view of the reaction of the CMA to the editorial described earlier, we thought CMA policy reform was unlikely.[10]

B4. CRG convenes meeting with College representatives

B4.1 The Group organized a meeting in 2013 to advance their *Model Concientious Objection Policy* (Appendix "A"). The meeting, which was funded by a research grant (presumably the CIHR granted noted above) included:

- Bryan Salte, LLB, Associate Registrar, College of Physicians and Surgeons of Saskatchewan
- Andréa Foti, Manager- Policy Dept., College of Physicians and Surgeons of Ontario
- Dr. Gus Grant, Registrar of the College of Physicians and Surgeons of Nova Scotia
- A representative of the Collège des Médecins du Québec
- ". . . representatives from the faculties of law, medicine and philosophy from academia and other invited individuals."[11]

B4.2 The CRG authors appear to refer to this meeting in the introduction to their model policy:

> Feedback on the draft policy was also solicited from a number of relevant experts: academics who do research primarily in health law, biomedical ethics, medicine or other health professions; **physician regulatory body members**; and local community organizations dealing with women's health, sexual health, and the health of more marginalized populations (e.g. rural populations, street youth, First Nations). . . (Emphasis added)[10]

B4.3 It is not unlikely that the various faculties were represented by CRG members, perhaps augmented by supportive colleagues.

B4.4 The goal of the meeting "was to develop a policy that could be adopted by Canadian Colleges of Physicians and Surgeons to guide physicians who have a conscientious objection to providing certain forms of health care."

> While that is most frequently experienced in issues pertaining to reproduction i.e. birth control, abortion and emergency contraception, it can arise in a number of other situations as well, such as the provision of blood products and end of life care.[11]

B4.4 According to Byran Salte, participants at the meeting agreed upon the text of what he subsequently called the "draft policy statement developed by the Conscientious Objections Working Group." This was almost an exact duplicate of what the CRG published later in 2013 as its *Model Conscientious Objection Policy*.[12]

Notes

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

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

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

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

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

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

Accessed 2015-02-22.

7.

2009

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

8.

2010

Principal Investigator:	MCLEOD, Carolyn W
Co-Investigators:	
Institution Paid:	University of Western Ontario
Program:	CIHR Café Scientifique Program
Year/Month:	2010/06
Assigned PRC:	***
Project Title:	**The Spark of Conscience Inflames Debate: Conflicts of Conscience in Medicine**
Details:	Conscientious refusal by health care professionals to provide standard health services, such as abortions, is a subject of intense debate in Canada and elsewhere. Recent discussion in the Canadian Medical Association Journal about refusals by physicians to participate in abortions revealed that the Canadian Medical Association lacks a coherent policy on conscientious objection. The CIHR Café Scientifique, "The Spark of Conscience Inflames Debate," will provide a public forum for deliberation on what the CMA policy ought to be. The panelists and moderator are all experts in areas of profound relevance to this issue: bioethics, health law, health policy, religion, and medicine.
CIHR Contribution:	$3,000
CIHR Equipment:	$0
Term Yrs/Mths.:	1 yr 0 mth
	Source: CIHR, *Funding Decisions Data*

(http://webapps.cihr-irsc.gc.ca/cfdd/db_search?p_language=E)
Accessed 2015-02-23)

2011

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

2012

Principal Investigator:	SHAW, Jacquelyn
Co-Investigators:	
Institution Paid:	Dalhousie University (Nova Scotia)
Program:	CIHR Café Scientifique Program
Year/Month:	2012/05
Assigned PRC:	CAF
Project Title:	**Liberation therapy aftercare, body modification, reproductive and other health services: can your healthcare provider refuse to treat you because it bothers his (or her) conscience?**
Details:	Conscientious objection has largely entered the public consciousness via the polarizing lens of debates on access to abortion services. Yet such debate reflects only the tip of a much larger iceberg of contexts in which healthcare providers conscientiously refuse to provide certain services. For example, what should be done about conscientious refusals of care to patients who engage in health-related activities of which a practitioner does not professionally approve (e.g., smoking, overeating, body modification, accessing unapproved therapies overseas)? These service refusals may well be an expression of conscience on the part of healthcare professionals. However, they also risk denying individual patients access to healthcare services and they may in some cases be argued to be discriminatory. The challenging question before us is how we can create policies that permit genuinely conscience-based refusal opportunities, while also ensuring that patients receive adequate, non-

	discriminatory access to desired healthcare services. The panelists and moderator are experts in areas of relevance to the subject matter: i.e., bioethics, medicine, dentistry and health law and policy. We invite all members of the public, including health and legal professionals, to come to the Café Scientifique, where they can enjoy free refreshments, ask questions of expert panelists, share their own experiences, and weigh in on a matter of great importance to Canadian patients and providers today.
CIHR Contribution:	$3,000
CIHR Equipment:	$0
Term Yrs/Mths.:	1 yr 0 mth
	Source: CIHR, *Funding Decisions Data* (http://webapps.cihr-irsc.gc.ca/cfdd/db_search?p_language=E) Accessed 2015-02-23)

9. *Let their conscience be their guide? Conscientious refusals in reproductive health care.* (http://conscience.carolynmcleod.com/meet-the-team/) Accessed 2016-02-05.

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

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

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

"Draft policy statement developed by the Conscientious Objections Working Group."	**Jocelyn Downie, Carolyn McLeod and Jacquelyn Shaw**
In certain circumstances a physician will have a lawful excuse to refuse to provide a service requested by a patient.	
3. Definitions	**3. Definitions**
Freedom of conscience: for purposes of this policy, *actions or thoughts* that reflect one's deeply held and considered moral or religious beliefs.	**Freedom of conscience:** for purposes of this policy, freedom to act in ways that reflect one's deeply held and considered moral or religious beliefs.

5.1 Taking on new patients

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

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

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

5.1 Taking on new patients

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

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

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