College of Physicians and Surgeons of Ontario
80 College Street
Toronto, Ontario
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Attn: Policy Department

February 20, 2015

Dear Policy Secretariat:

RE: Professional Obligations and Human Rights Draft Policy

The CPSO has invited feedback from all stakeholders in regard to its revised Physicians and the Ontario Human Rights Code draft policy, renamed Professional Obligations and Human Rights. The draft policy seeks to outline physicians’ legal obligations, College expectations regarding patients’ fundamental rights, and most significantly in our view, it severely restricts and limits the ability of physicians to practice medicine in accordance with sincerely held religious beliefs or conscientious convictions.

We have several concerns with the draft policy. First, the CPSO fails to meet its own Charter and human rights obligations to respect and accommodate the religious beliefs of its members. Second, the policy minimizes and diminishes freedom of religion in an unjustifiable manner. Third, the policy fails to incorporate recent and longstanding jurisprudence that explicitly recognizes and obliges protection of physicians’ freedom of conscience and religious belief in the practice of medicine.

(1) CPSO fails to meet its own Charter obligations

As a regulatory body, the CPSO must act in a Charter- and human rights- compliant manner. In other words, any policy or regulation it enacts must recognize the Charter rights and freedoms of the physicians who operate under its authority and in so regulating it must adhere to Charter principles.

Instead of addressing ways in which the CPSO can and will meet its Charter and human rights obligations to accommodate doctors, the draft policy instead responds to a perceived tension between physicians’ Charter freedoms and patient care in a way that clearly and substantially interferes with physicians’ Charter rights and freedoms and is thus problematic.

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1 Dore v Barreau du Quebec, 2012 SCC 12
2 It is the CPSO that is obliged to examine and thoroughly consider accommodation of physicians’ religious beliefs to the point of undue hardship. It is not the duty of the individual physician. See Dichmont v Newfoundland and Labrador (Government Services and Lands), 2015 NLTD(G) 14, para 96
The CPSO, as an arm of the state must remain neutral on matters of religion, not favouring one religion over another nor favouring either religion or the absence of it. Religiously informed moral consciences have not been – nor should they be – purged from the public sphere; the state does not have a secularizing mission. Moreover, the Charter exists to protect the citizen from the power of the state (and its administrative agents) and to preclude the state from enforcing citizens to comply with its moral judgments.

(2) Policy Minimizes Freedom of Religion & Conscience

Contrary to the effect of the draft policy, religion as a protected freedom is more than the right to privately think or believe certain principles. The Supreme Court has explained that

The purpose of s.2(a) is to ensure that society does not interfere with profoundly personal beliefs that govern one’s perception of oneself, human nature, and in some cases, a higher or different order of being. These beliefs, in turn, govern one’s conduct and practices.

While the beliefs themselves are personal, the application of those beliefs to one’s conduct and practices are not limited to the private sphere. There is no requirement for physicians, lawyers or other self-regulated professionals to “leave those beliefs at the door of the church, synagogue, temple, mosque or meeting hall”.

Rather, freedom of religion includes the right to entertain beliefs of one’s own choosing, the right to declare those beliefs openly and without fear of hindrance or reprisal, and, inter alia, the right to manifest those beliefs by worship, practice, teaching and dissemination.

Religion encompasses

...deeply held personal convictions or beliefs connected to an individual’s spiritual faith and integrally linked to one’s self-definition and spiritual fulfillment, the practices of which allow individuals to foster a connection with the divine or with the subject or object of that spiritual faith.

For Ontarians generally and physicians specifically, deeply held personal convictions are essential to navigating the complex ethical dilemmas that arise in healthcare, particularly around reproductive technologies and end-of-life care. In light of the Supreme Court’s recent decision in Carter v Canada

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3 *TWU v NSBS*, 2015 NSSC 25 at para 19
4 *TWU v NSBS* at para 19
5 *TWU v NSBS* at para 10
7 *TWU v NSBS* at para 258
8 *R v Big M Drug Mart* [1985] 1 SCR 295 at 336-337
9 *Syndicat Northcrest v Amselem*, 2004 SCC 47 at para 39
(Attorney General),

legalizing physician-assisted suicide, questions surrounding end-of-life care and the ability of physicians to practice in accordance with their religious beliefs is essential.

The meaning of life and the ethical and moral implications of purposely ending a life cannot be flippantly characterized as a “trivial or insubstantial” interference with religious belief.

(3) Specific Ways in Which the Policy Violates Physicians’ Charter Rights

As outlined above, the CPSO, as a regulatory body subject to the Charter must protect to the fullest extent possible the religious freedom and conscientious rights of the physicians under its delegated governmental authority. In this regard the policy utterly fails. It claims to recognize those freedoms but then immediately thereafter requires physicians to violate them. Particularly offensive are the effective referral requirement, the urgent care provision and the lack of strong protections for conscientious objection.

Effective Referral (Lines 156-164)

The “effective referral” requirement states:

Where physicians are unwilling to provide certain elements of care due to their moral or religious beliefs, an effective referral to another health care provider must be provided to the patient. An effective referral means a referral made in good faith, to a non-objecting, available, and accessible physician or other health-care provider. [emphasis added]

The “effective referral” requirement demands physicians participate in morally objectionable procedures such as abortion or assisted suicide. An “effective referral” obliges a physician to refer to a non-objecting, available and accessible physician or health-care provider, meaning the referral must result in the procedure or aspect of care being carried out to completion. That makes the referring physician an active participant in what that physician believes is morally wrong.

For example, if a patient requests assisted suicide, the draft policy mandates a referral from an objecting physician that will result in that patient’s death. Even the Canadian Medical Association (a neutral party) has acknowledged that its membership is divided on the issue of physician-assisted suicide. One can safely presume that the difference of opinion arises from differing and deeply held personal convictions about the propriety of actively and purposely causing the death of a human being.

It is curious that the referral obligations for physicians objecting on religious or moral grounds are significantly greater than those who cannot provide the care for reasons of clinical competence. In this scenario, the physician is simply obliged to provide a referral. There is no duty to ensure the referral is “effective” or that the referee is “non-objecting, available and accessible”. Why should there be a

10 Carter v Canada (Attorney General), 2015 SCC 5 [Carter]
11 Indeed, if “sexual behaviour” can be found by the courts to be “an expression of one’s ‘fundamental loyalty to disloyalty to God ... which is of ultimate importance in Christian faith’” it is difficult to argue that the very essence of life would be of less value. See TWU v NSBS at para 38.
12 Carter at para 131
greater burden placed on physicians with a religious belief, a Charter protected right, than clinical competence?

And how is it that a regulatory body with a mandate to protect its members' Charter rights can propose a policy that so explicitly violates those rights?

**Urgent Care (Lines 168-169)**

Under the heading “Protecting Patient Safety” the policy adds:

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

While the footnote to the latter mandate suggests this expectation is consistent with providing care in health emergencies, the statement indicates otherwise. The “suffering” language is particularly problematic in light of the Carter decision.

The Carter decision held that physician-assisted suicide is permissible where (1) the person affected clearly consents and (2) the person has a grievous and irremediable medical condition (including illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.\(^\text{13}\)

Who defines “suffering” as written in the draft policy? Is “otherwise necessary” defined from the patient’s perspective? Is “deterioration” akin to “enduring suffering” or “irremediable medical condition”? Does “imminent harm” include suicide? Can a physician then intervene to prevent an assisted suicide from taking place?

This section of the draft is vague, ill-defined and raises more questions that it does answers as to the expectations of physicians. However, worse than being simply vague, this section appears to demand physicians practice medicine in ways that are offensive to and in violation of religious beliefs.

**Right to Conscientiously Object**

This month - February 2015 - the Supreme Court confirmed that physicians have a right to conscientiously object to the provision of certain medical care. The Carter decision stated that “nothing in the declaration of invalidity [of provisions prohibiting physician-assisted suicide] would compel physicians to provide assistance in dying.”\(^\text{14}\) In making this statement, the Supreme Court also reaffirmed the applicability of an exemption principle as regards abortion:

> What follows [from the declaration of invalidity] is in the hands of the physicians’ colleges, Parliament, and the provincial legislatures. However, we note – as did Beetz J. in addressing the topic of physician participation in abortion in R v. Morgentaler – that a

\(^{13}\) Carter at paras 4, 127 [emphasis added]

\(^{14}\) Carter at para 132 [emphasis added]
The physician’s decision to participate in assisted dying is a matter of conscience and, in some cases, of religious belief (pp. 95-96).\textsuperscript{15}

In other words, the Supreme Court was cautioning Parliament, colleges and legislatures that any regulatory or legislative scheme developed to govern physician-assisted suicide must protect and exempt physicians from participation.

**Conclusion**

In its current format, the draft policy utterly fails to accord with the mandate from the Supreme Court that physicians cannot be compelled to participate in medical care that conflicts with their religious beliefs. It fails to recognize the Charter and human rights protections the CPSO is obliged to protect. We therefore ask the CPSO to reconsider and rewrite the Policy in a manner that respects those rights and freedoms.

\textsuperscript{15} Ibid