Protection of Conscience Project
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ADVISORY BOARD

PROJECT TEAM

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Submission to the College of Physicians and Surgeons of Ontario

Re: *Professional Obligations and Human Rights*

Abstract

This submission includes a cautionary note about the potential implications of human rights law for practitioners providing euthanasia/assisted suicide for some eligible patients but not for others. However, it is primarily concerned with provisions of *Professional Obligations and Human Rights* (*POHR*) and *Advice to the Profession: Professional Obligations and Human Rights* (*Advice: POHR*) demanding "effective referral." This policy of compulsory collaboration in perceived wrongdoing requires physicians unwilling to provide a procedure they consider unethical/immoral/harmful — including killing their patients — to arrange for it to be provided by someone else.

The effective referral provision in *POHR* attacks currently unpopular but plausible comprehensive world views that operationalize credal concepts of the human person foundational to health care. This has serious adverse consequences for civil liberties and medical practice.

POHR arbitrarily and erroneously states that clinical reasons cannot justify conscientious objection. Nonetheless, practitioners who refuse to provide or refer for apparently inefficacious or medically contra-indicated procedures seem entitled to defend their refusal as an exercise of freedom of (professional) opinion guaranteed by the *Charter of Rights*. Those who believe that causing harm to another person is immoral may, in addition, defend their refusal as an exercise of freedom of conscience. On these points, a 2019 Ontario Court of Appeal decision favourable to the College was not decisive.

Objecting practitioners are typically willing to work cooperatively with patients and others in relation to patient access to services as long as cooperation does not involve collaboration: an act that establishes a causal connection to or de facto support for the services to which they object. They are usually willing to provide patients with information to enable informed decision-making and contact with other health care practitioners. The distinctions between cooperation and collaboration and providing information vs. providing a service enable an approach that accommodates both patients and practitioners.

However, the College is clearly confused about such critical distinctions, since *POHR* does not even correctly apply its own definition of effective referral. The policy demonstrates hypocrisy and moral partisanship in relation to the moral/ethical significance of referral. Among other things, it invites the erroneous inference that refusal to make an effective referral for euthanasia/

suicide amounts to patient abandonment. Ultimately, physicians who refuse to refer may be forced to leave medicine or confine their practice to specialties suggested by the College (eg., hair restoration), adversely affecting access to health care and even patient safety.

Finally, a policy requiring unwilling citizens to collaborate in doing what they believe to be wrong — even killing people — and punish or disadvantage them if they refuse is dangerous and especially repugnant. It stands in violent contradiction to the solicitude for human life, dignity and freedom that ought to characterize a democratic society. This issue was not argued or even considered by the trial court or Ontario Court of Appeal in rulings on CPSO policy.

The Project recommends that the College adopt a single protection of conscience policy in line with "the basic theory of the *Charter*" affirmed by the Supreme Court of Canada and applicable to all services and procedures. This submission includes an example of such a policy. However, should current policy structure be maintained, specific recommendations are made for revisions to *POHR* that correct problematic elements of the policy.

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Introduction

The Project does not take a position on the acceptability of morally contested procedures. The Project's interest is confined to the exercise of freedom of conscience by practitioners who refuse to do what they believe to be unethical or immoral. Thus, much of the policy *Professional Obligations and Human Rights*[1] (*POHR*) and *Advice to the Profession: Professional Obligations and Human Rights*[2] (*Advice:POHR*) is outside the scope of this submission.

I. Freedom of conscience: physicians at the coal face

Foundations of medical practice

I.1 Evidence-based medical practice is possible because a human being has a recognizable, intelligible and ordered constitution. Disease, injury, and other pathologies disrupt that constitution. Disruptions sufficient to cause death may well be visible or detectable as things that ought not to be there: blockage of the coronary artery or lethal fentanyl levels in the blood. Sometimes fatal disruptions are not detectable: cardiac arrhythmias, for example. They may be inferred as a cause of death from other evidence.

I.2 Such inferences, like conclusions reached from direct observations, depend upon a foundational premise: that humans have a nature. However, the accepted view within the medical profession is that humans are more than bags of skin containing functional interdependent organ systems. The focus of medical practice is typically said to be the human person, a "who", not just a "what." In any case, the practice of medicine depends upon a credal concept of the human person — "credal" in a general sense that includes both religious and non-religious belief.

I.3 Current controversies about freedom of conscience reflect fundamental disagreement about the nature of the human person. Reasoning from different beliefs about what a human person is leads to different moral or ethical conclusions — sometimes radically different conclusions.

I.4 Is *in vitro* fertilization a good idea — or not? A good idea in some circumstances, but not in others? Is reconfiguring a boy to make him look like a girl an enlightened application of surgical and pharmaceutical technology? Or a form of unethical human experimentation? Is it in a patient's "best interests" to be lethally injected? These questions (and others) cannot be answered at all without a credal concept of the nature of the human person. That is what determines not only what counts as harmful or beneficial, but the approach to every moral or ethical problem in medicine.[3] It also underlies College policy and law — such as the definition of "disability" in Ontario's *Human Rights Code* [*POHR*, note 6].[4]

I.5 For historical reasons, a Judeo-Christian concept of the human person informed the development and interpretation of western medical ethics and law until the latter part of the twentieth century; credal concepts of the human person are also foundational in Islamic and Chinese traditions.[5,6,7] These are now being displaced. Changing credal concepts of the human person that have informed the profession of medicine for millennia must work a sea change in the nature of medical practice, which is uniquely and inextricably bound up with it. This is why physicians are at the coal face in the continuing and growing controversy about freedom of conscience in health care.

I.6 It is also the reason why this submission, except when citing or quoting College policy or other sources, frequently refers to services, procedures or treatment: not to *health* services, *medical* procedures, or *care*. For example, euthanasia by lethal injection is accurately described in this submission as a service, procedure or treatment. To call it a *health* service,

medical procedure or *care* gives normative force to underlying beliefs or assumptions that are disputed. Uncritically accepting such beliefs prejudices discussion, legal reasoning and policy from the outset.

Undermining the foundations

I.7 This was dramatically demonstrated when counsel for the plaintiffs in *Carter v Canada (Attorney General)* [*Carter*] told the Supreme Court of Canada that euthanasia and assisted suicide are "at the *core* of health care."[8] To accept the premise that killing patients is a *core* element in health care and enact policies that enforce that premise reflects state imposition of a biopolitical ideology that has serious consequences for civil liberties and medical practice.

> As a matter of principle, one must distinguish what is demonstrably necessary to preserve a free and democratic society from what may be necessary to enforce a biopolitical ideology. The difference is significant but can be difficult to discern. . . [Euthanasia/assisted suicide] ideology is grounded upon metaphysical, philosophical and moral premises that can be rationally contested but cannot be empirically validated. Among these is the dogmatic claim that a human being can be better off dead. In a free and democratic society, it ought to be unacceptable to force physicians to profess this article of faith, or to demonstrate practical adherence to it by killing or facilitating the killing of a patient. . .[9]

I.8 This point is more striking in relation to euthanasia and assisted suicide, but it applies to all morally contested procedures.

> Patients request an intervention, including euthanasia, because they believe it is not harmful, is beneficial, or is in their best interests. Physicians may reasonably disagree. If, despite this, physicians are compelled to futher a patient's request, the concepts of benefit, harm and best interest become irrelevant. All that remains is the demand of the patient, backed by the power of the state to ensure compliance.
>
> This treats physicians as mere technicians or state functionaries, as cogs in a state machine delivering services upon demand, not as responsible moral agents who, like their patients, must form and act upon judgements about benefits and harms. It imposes a form of servitude that is incompatible with human equality, dignity and personal and professional integrity.[10]

I.9 With respect to professional integrity, grave concern has been expressed that what is described here as the state imposition of a biopolitical ideology is displacing the traditional responsibility of the medical profession "to make considered medical determinations based on evidence, unique knowledge and expertise" and amounts to "a stunning reversal of the central role of the medical and legal concept of the standard of care."[11]

A foundation for rational moral pluralism in medical practice

I.10 The position of the Project is supported by what the Supreme Court of Canada has unanimously affirmed as"the basic theory"of the *Canadian Charter of Rights and Freedoms,*[12,13] originally proposed by Justice Bertha Wilson in *R v Morgentaler*.[14]

I.11 Justice Wilson affirmed that the *Charter* is predicated upon a particular understanding of the individual, who is *not* "a mere cog in an impersonal machine in which his or her values, goals and aspirations are subordinated to those of the collectivity."[15] She rejected the idea that, in questions of morality, the state should endorse and enforce "one conscientiously-held view at the expense of another," for that is "to deny freedom of conscience to some, to treat them as means to an end, to deprive them . . .of their 'essential humanity'."[16] She insisted that "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."[17]

I.12 Justice Wilson's affirmation of tolerance and respect is especially relevant to the College's demand that unwilling physicians collaborate in services they find morally and clinically objectionable. Contrary to the College's claims and Justice Wilson's urging, *POHR* does not accommodate freedom of conscience "to the greatest extent possible." Instead, it is designed to suppress currently unpopular but plausible comprehensive world views that operationalize credal concepts of the human person foundational to the practice of medicine.

I.13 The Project urges the College to adopt the approach advocated by Justice Wilson. By accepting the recommendations in this submission, the College can begin to develop a form of rational moral pluralism that enables physicians to discharge their obligations to patients with integrity, notwithstanding deep and persisting differences in comprehensive world views.[18]

II. General expectations and human rights

II.1 *POHR* states that physicians "must not discriminate, either directly or indirectly, based on a protected ground under the *Code*" when providing "health care or services" or "information or referrals." [*POHR,* para. 2(b), (c)]. "Disability" is one of the protected grounds. It receives special attention in the policy, but *POHR* does not provide the full definition. [*POHR,* para. 3, note 6]

II.2 As defined in the *Human Rights Code*, a disability is

> (a) any degree of physical disability, infirmity, malformation or disfigurement that is caused by bodily injury, birth defect or illness and, without limiting the generality of the foregoing, includes diabetes mellitus, epilepsy, a brain injury, any degree of paralysis, amputation, lack of physical co-ordination, blindness or visual impediment, deafness or hearing impediment, muteness or speech impediment, or physical reliance on a guide dog or other animal or on a wheelchair or other remedial appliance or device,
>
> (b) a condition of mental impairment or a developmental disability,
>
> (c) a learning disability, or a dysfunction in one or more of the processes involved in understanding or using symbols or spoken language,
>
> (d) a mental disorder, or
>
> (e) an injury or disability for which benefits were claimed or received under the insurance plan established under the Workplace Safety and Insurance Act, 1997; ("handicap")[19]

II.3 Euthanasia and assisted suicide (EAS) are now available for treatment of many of the disabilities listed in (a) and will become available for mental disorders (d) in two years.

II.4 In May, 2016, Professor Amir Attaran of the University of Ottawa offered a striking analysis of the application of laws like Ontario's *Human Rights Code* to medical practice in relation to EAS service.[20]

II.5 In brief, Prof. Attaran argued that physicians cannot refuse to personally provide euthanasia and assisted suicide except for reasons of clinical competence.

> I do not wish to be misunderstood as arguing that doctors cannot refer patients for medical reasons. A doctor who lacks the skills, facilities or ability to care for a patient can (and often, must) refer that patient to someone better able to help. But the fact that the physician's duty of care sometimes requires referrals does not mean that referral can be used as a tool of segregation, so as to discriminate against patients to whom one objects for whatever reason, and the case law is clear about this.[21]

II.6 "Depriving disabled persons of a routinely available medical service without justification is illegal," he wrote.[22]

> For example, if a doctor willingly prescribes pain-relieving drugs to alleviate suffering—for arthritis, back pain, cancer, stomach ulcer, *et cetera* — but selectively refuses to prescribe seco-barbital or pentobarbital to a patient who lawfully chooses to die, that differential denial of service (i.e.,prescribing vs. not prescribing) needs a satisfactory justification, or it is discriminatory and illegal.[23]

II.7 Further, he asserted that, contrary to College policy, human rights law *prohibits* effective referral as a means of avoiding the personal provision of EAS service. He found support for this position in a British Columbia case involving a physician who provided artificial insemination in his practice. He refused to provide it for a lesbian couple because of liability concerns and referred them to another practitioner for the service.

> The Court's reasoning shows the problem with an "effective referral" defence, for instead of helping Dr. Korn, the Court took the evidence of referrals <u>against</u> him. By denying his patients medical services and instead referring them to other, willing doctors, Dr. Korn had tacitly conceded two things: (i) that the sought-after treatment was within the ordinary medical standard of care, and (ii) that his personal, considered refusal to provide that standard of care to lesbians was taken conscientiously, and was therefore intentionally discriminatory. [24] (emphasis in original)

II.8 Prof. Attaran's first example was poorly chosen, since it compared patients doubtfully eligible for EAS with someone clearly eligible. However, the BC case parallels that of practitioners who provide EAS service for some legally eligible patients (terminally ill) but not for others (blind, deaf or paralyzed patients). This differential treatment arguably discriminates on the basis of disability.

II.9 If that is so, it would seem that practitioners who provide EAS service to *someone* eligible cannot refuse to provide it to *anyone* legally eligible. Further, according to Prof. Attaran, they cannot escape the obligation by making an effective referral. This is likely to become a more serious issue in two years, when EAS service becomes available as treatment for mental illness.

II.10 The Project does not accept Prof. Attaran's claim that an effective referral must be construed as evidence of discrimination, nor does it accept his argument in relation to objecting practitioners who refuse to provide a contested service to *anyone*. However, his argument may apply to practitioners willing to provide EAS for some eligible patients but not others. It thus seems appropriate to include guidance on this issue in *POHR*.

III. Limiting services: general

Clinical competence

III.1 *POHR* acknowledges that physicians may legitimately refuse to provide services if they lack clinical competence [*POHR*, para. 5,6]. It adds that physicians who decline to provide a service for this reason must notify patients as soon as possible [POHR, para. 7] and must provide an effective referral. It implies that failure to do so amounts to abandonment [*POHR*, para. 8].

III.2 No difficulty arises from the perspective of freedom of conscience when the only issue is clinical competence in relation to a service or procedure that the physician believes is in a patient's best interests. Facilitating or arranging for the service to be provided by someone else is then a natural extension of the physician's responsibilities to the patient and is consistent with the physician's professional and personal moral integrity. Effective referral in this situation becomes an obligation, and refusing or failing to make an effective referral can be characterized as abandonment.

Clinical judgement

III.3 *POHR* does not address refusals based on clinical judgement that a treatment or procedure is inefficacious or medically contraindicated. The omission warrants brief comment.

Inefficacious treatment

III.4 Evidence may establish that a treatment is inefficacious before it can be shown to be harmful, so it is irresponsible to provide inefficacious treatment simply because a physician or patient believes it may help. This is demonstrated by the diethylstilbostrol (DES) debacle. American physicians continued to write hundreds of thousands of DES prescriptions for pregnant women throughout the 1960's even though a definitive 1953 study had demonstrated that DES had no therapeutic value in pregnancy.[25,26] Evidence ultimately established that DES was especially harmful to "DES daughters" exposed to the drug *in utero*. [27,28]

III.5 On the other hand, evidence may be insufficient to prove or disprove the efficacy of a treatment, notwithstanding anecdotal claims. This is especially true when efficacy can only be demonstrated by long term research. Practitioners who refuse to provide or to make effective referrals for a treatment because evidence of efficacy is insufficient are acting in a manner consistent with their ethical obligations.

Medical contraindication

III.6 For the purpose of this submission, treatment is medically indicated if it is known or reasonably believed to be likely to provide therapeutic benefits that outweigh harm that may be associated with it. It is medically contraindicated if it is known or reasonably believed to be likely to cause harm disproportionate to its therapeutic benefits.

III.7 The burden imposed by a treatment is relevant to a patient's decision about accepting it, but

burden is not relevant to a practitioner's decision about whether or not a treatment is medically indicated. On the other hand, evaluation of risk necessarily enters into the decisions of both physician and patient.

III.8 As in the case of efficacy, evidence may not be sufficient to establish that a treatment is either indicated or contraindicated, and practitioners who refuse to provide or refer for this reason cannot be accused of acting improperly.

III.9 Beyond this, a decision about whether X is medically indicated or contraindicated depends upon what is known about X, the facts of a particular case (especially those unique to an individual patient), and a practitioner's knowledge and experience. This much is generally acknowledged, and it may be thought to account for disagreements among practitioners about whether or not X is medically indicated. While this is true as far as it goes, it does not go far enough.

III.10 The decision that X is medically indicated/contraindicated is also inextricably bound up with a practitioner's beliefs about what is beneficial or harmful. That, in turn, depends upon a credal concept of the human person explicit or implicit in a practitioner's comprehensive world view [Part I]. This is true of *all* practitioners — believers or not, objectors or not.

III.11 All practitioners who conclude that a treatment is medically contraindicated because it is harmful are obligated to refuse to provide or facilitate that treatment on the basis of clinical judgement. It would seem that they are entitled to defend their refusal as an exercise of freedom of (professional) opinion guaranteed by the *Charter of Rights*.[29] Hence, *POHR* is incorrect in asserting that refusal in such circumstances cannot be based on clinical grounds. Those who believe that causing harm to another person is immoral may, in addition, defend their refusal as an exercise of freedom of conscience.[30]

IV. Limiting services: conscience

Introduction

IV.1 The decision of the Ontario Court of Appeal in the challenge to the College demand for effective referral[31] was not the last word on the subject, notwithstanding the College's frequent citation of the ruling in defence of the policy requiring effective referral by objecting practitioners. The case was argued and decided in relation to freedom of religion, not freedom of conscience. We await a challenge in an actual case based squarely on freedom of conscience and arguments not yet judicially considered.

IV.2 The College claims that practitioners have a fiduciary obligation to provide services or procedures to which they object for reasons of conscience or religion, or to arrange for them to be provided by someone else. In support of this claim the College cites the Ontario Court of Appeal decision noted above, but this attributes weight to the decision that it does not have.

IV.3 In the first place, the trial court did not even mention fiduciary duty, finding, instead, that the requirement for physicians to place patients' interests before their own (by making an "effective referral") arose as a consequence of practising medicine "in a single payor, publicly funded healthcare system which is structured on the basis of patient-centered care."[32]

IV.4 The Court of Appeal, apart from noting the reference to fiduciary duty in CPSO policy,[33] made only a single passing reference to the fiduciary nature of the physician-patient relationship.[34] It cited only two cases on that point, *McInerney v. MacDonald*[35] and *Norberg v. Wynrib*,[36] without further elaboration. Neither case was remotely concerned with the exercise of freedom of conscience by physicians. Moreover, the Court overlooked passages and citations in both cases that do not support and arguably contradict the CPSO's position.

IV.5 The preceding paragraphs have given more attention to the law on fiduciary duty than is apparent in the cursory references by the Ontario Court of Appeal. The Court did not even attempt a serious examination of fiduciary duty, so the College's citation of the ruling on this point should be given no weight.

Conscience

Respect, access and safety [*POHR*, para. 9]

IV.6 *POHR* requires that practitioners who refuse to provide services or procedures for reasons of conscience "must do so in a manner that respects patient dignity, ensures access to care, and protects patient safety." The reference to safety refers to the obligation to provide treatment in medical emergencies [*POHR,* para. 17].

IV.7 The experience of the Project is that objecting physicians normally treat patients respectfully, though refusal itself is sometimes misunderstood or deliberately misconstrued as a disrespectful act. They also recognize the obligation to provide emergency medical treatment.

IV.8 Controversy arises in relation to what is meant by ensuring access to services. Objecting physicians typically respect patient autonomy by providing information necessary to enable informed decision-making and contact with other health care practitioners so that patients can obtain the services they want. However, many objecting physicians are unwilling to collaborate in what they believe to be unethical or immoral procedures by referral or other means.

IV.9 This part of the submission addresses policy expectations about respect for patients, access to services (except effective referral) and patient safety. Effective referral is addressed in Part V.

Respecting patient dignity

Notification of objections [*POHR*, para. 10]

IV.10 The expectation that physicians will personally advise patients of their objections in a sensitive manner is entirely in keeping with the intentions of objecting physicians made known to the Project.

IV.11 That objections are in all cases "due to personal and not clinical reasons" is incorrect [Part III.3-11]. Objecting physicians may have both clinical and ethical/moral objections to a contested service. Where both reasons exist, it is appropriate to inform the patient of both. Indeed: to withhold clinical reasons would seem to violate the requirements of informed medical decision-making.

Do not express personal moral judgements, promote own beliefs [*POHR*, para. 11]

IV.12 Refusal to provide or collaborate in a service for reasons of conscience obviously manifests a moral or ethical judgement. Moreover, practitioners are expected to advise patients of their objections. Objecting practitioners must not be accused of wrongfully expressing personal moral judgements simply because they refuse to do what they believe to be wrong and explain this their patients.

IV.13 Some patient beliefs or habits (which can be understood as aspects of a lifestyle) may have adverse effects upon their health (anti-vaccination beliefs, diet, exercise, alcohol consumption and drug use, etc.). The current text of *POHR* could be understood to prevent physicians from legitimately engaging patients on such issues.

Ensuring access to care

IV.14 One of the reasons given for insisting upon effective referral is that some patients who want a service may be so isolated and burdened by illness, physical or mental disability or language barriers that they are unable to connect with service providers without help. In its focus on patient autonomy, rights and choice, *POHR* fails to identify common ground that affords an opportunity to accommodate both patients and objecting physicians.

IV.15 Patients who are so debilitated or circumstantially handicapped that they are unable to contact health care personnel or obtain medical treatment are clearly at risk and in need of assistance

in all circumstances, not just in relation to accessing morally contested services. Physicians encountering such patients should recognize this problem and respond to it in all situations out of concern for patient welfare and safety. This can be done by finding a responsible and reliable person who can help patients overcome circumstantial handicaps, enabling them to obtain necessary assistance and navigate the health care system. The helper could be a family member, friend, social worker, outreach worker, etc. In the Project's experience, objecting physicians would likely do this in any case. See further discussion on this point below (Part V.12 - V.15).

Providing information [*POHR*, para. 12-13]

IV.16 In the Project's experience, objecting physicians are willing to provide information necessary to enable informed decision making, so the expectation that they will provide information on all treatment options — including procedures/services to which they object — is not normally problematic. However, this is subject to two qualifications in relation to euthanasia and assisted suicide, discussed in the Project's submission on College policy *Medical Assistance in Dying.*[37]

IV.17 Generally speaking, what information should be provided and the point at which it ought to be provided must be guided by and responsive to the circumstances and expressed interests of each patient. This should be left to the good judgement individual practitioners based on of knowledge of and interaction with their patients. For example, it would be insensitive to gratuitously suggest the options of abortion and adoption to every pregnant woman in the absence of some indication by the patient of at least ambivalence about her pregnancy.

Do not impede access [*POHR*, para. 15]

IV.18 To "impede access" is unacceptable if that means some positive act of interference, such as discouraging other health care providers from seeing the patient, or some wrongful act, like misleading a patient or refusing to release medical records belonging to a patient. On the other hand, practitioners who simply refuse to help patients find someone willing to do what they believe to be wrong or harmful are no more impeding patients than colleagues who refuse to help patients find someone willing to provide virginity certificates or sell organs.

Protecting patient safety

Ensure safety [*POHR*, para. 17]

IV.19 The reminder that physicians must provide treatment "in an emergency, where it is necessary to prevent imminent harm," notwithstanding conscientious convictions to the contrary, warrants comment.

IV.20 The duty of physicians to intervene to prevent imminent death or serious injury is universally accepted. National codes of ethics variously articulate the circumstances that trigger the obligation. Usually, like the Canadian Medical Association's *Code of Ethics and Professionalism*, they refer only generically to emergencies.[38] Sometimes they specify imminent threats to life, limbs or organs[39] or immediate action needed to prevent death,

disability or severe suffering.[40]

IV.21 Consistent with this, the Canadian Medical Protective Association (CMPA) indicates that the obligation to act in an emergency is limited to situations in which there is "demonstrable severe suffering or an imminent threat to the life or health of the patient" and "undoubted necessity" to proceed immediately to prevent "prolonged suffering. . . or imminent threats to life, limb or health."[41]

IV.22 On the other hand, the concept of "emergency" can be stretched for marketing purposes (as in "emergency" contraception) or for other reasons. For example, Canadian EAS practitioners attempting euthanasia in patients' homes who are unable to obtain IV access or provide "intraosseous infusion emergently" are advised to call 911 for ambulance personnel to help, or to transport the patient so that the IV can be inserted by hospital emergency ward staff. [42]

IV.23 The vague reference to "harm" is also open to ideological abuse, since, during heated disputes about morally contested interventions, there is likely to be no agreement about what counts as harm [Part I].

IV.24 Finally, legalization of euthanasia and assisted suicide has implications for the accepted obligation to provide treatment to prevent imminent death. This can now be interpreted to include transplanting organs obtained by EAS (or purchase or executions) in order to prevent the imminent death of a recipient. Physicians may have principled objections to the means by which the organs are obtained and/or grave moral reservations about inducing people to opt for euthanasia or assisted suicide or supporting the organ trade. Providing explicitly for this situation in the policy would encourage advance planning to avoid last-minute conflicts in critical circumstances.

Issues

IV.25 The assertion that conscientious objection cannot be based on clinical reasons is erroneous.

IV.26 The caution against expressing personal moral judgement is overbroad and thus open to ideological abuse at the expense of objecting practitioners.

IV.27 The caution against criticizing patient beliefs or lifestyles may make physicians reluctant to engage patients about beliefs or habits that may adversely affect their health.

IV.28 The term "impeding access" is overbroad and thus open to ideological abuse at the expense of objecting practitioners.

IV.29 The policy fails to recognize that appropriate reflection and caution may be required in presenting some treatment options.

IV.30 *POHR*'s vague reference to potential "harm" is insufficient to describe a medical medical emergency.

Recommendations

IV.31 The College should have a single general policy that addresses the exercise of freedom of

conscience by physicians that can be applied to all procedures or services. Appendix "A" offers such a policy.

IV.32 Within the context of the current policy structure, POHR should be amended to the following effect:

> 10. Where physicians object to providing ~~certain elements of care~~ *a service* for reasons of conscience or religion, they **must** communicate their ~~objection~~ *reasons* directly and with sensitivity to existing patients, or those seeking to become patients. ~~and inform them that the objection is due to personal and not clinical reasons.~~
>
> *11.* In the course of communicating their ~~objection~~ *reasons*, physicians must not ~~express personal moral judgements about~~ *criticize or denigrate* the beliefs, lifestyle, identity, or characteristics of existing patients or those seeking to become patients. This includes not delaying treatment because the physician beliefs the patient's own actions have contributed to their condition. *This should not be understood to preclude respectful discussion of beliefs or habits that may adversely affect a patient's health.*
>
> *13.* Physicians **must not** withhold information about the existence of any procedure or treatment because it conflicts with their conscience or religious beliefs, *subject to the following considerations:*
>
> > *i) Absent an inquiry or expression of interest from a patient, practitioners should not suggest assisted suicide or medical assistance in dying as treatment options. This does not preclude suggesting euthanasia alone.*
> >
> > *ii) What information is clinically relevant to informed decision making and the point at which it ought to be provided must be guided by and responsive to the facts in each case and expressed interests of each patient.*
>
> 15. Physicians **must not** ~~impede access to care~~ *interfere with access to services* for existing patients or those seeking to become patients.
>
> 17. Physicians must provide ~~care in an emergency, where it is necessary to prevent imminent harm~~, *an intervention when a patient is imminently likely to suffer death or serious permanent injury if the intervention is not immediately provided,* even where ~~that care~~ *the intervention* conflicts with their conscience or religious beliefs, *unless the intervention has been or is likely to be facilitated by causing the death or serious permanent injury of another person.*

V. Effective referral

Policy specifics

V.1 The policy states that physicians who refuse to provide a service for reasons of conscience or religion must make an "effective referral" to allow patients to access the service they refuse to provide [*POHR*, para. 14].

V.2 Further information about effective referral is provided in *Advice: POHR*. To make an effective referral is to "take positive action to ensure the patient is connected in a timely manner to a non-objecting, available and accessible physician. . . health care professional or agency that provides the service or connects the patient directly with a health care professional who does."

V.3 *Advice: POHR* explains that an effective referral need not involve a referral "in the formal clinical sense,"and that objecting practitioners may delegate a reliable person to make the effective referral.

V.4 The policy specifies that the referral must be "timely," so that patients will not experience "adverse clinical outcomes"[*POHR*, para. 14(b)]. Examples of adverse outcomes are being prevented from obtaining treatment (like "emergency contraception" or an abortion) and being prevented from exploring euthanasia/assisted suicide. The latter refers to the possibility that a patient might become incapacitated before EAS can be approved and provided. [*Advice: POHR*].

V.5 *Advice:POHR* emphasizes that objecting practitioners must "ensure" that the patient is connected directly to a practitioner who provides the contested service, or to an agency that provides it or will connect the patient to someone who does.

V.6 Neither *POHR* nor *Advice:POHR* link refusal to make an effective referral to abandonment. However, the College made that connection in applying *POHR* to its policy on euthanasia and assisted suicide.[43]

V.7 *POHR* requires objecting physicians to "proactively maintain an effective referral plan for frequently requested services they are unwilling to provide." [*POHR*, para. 16]

Discussion

V.8 The link between the principle of non-abandonment and the demand for effective referral invites the unwarranted inference that refusing to provide an effective referral amounts to patient abandonment. There is no necessary connection between the two. A practitioner does not abandon a patient by offering treatments a patient refuses to accept, nor does a practitioner abandon a patient by refusing to make an effective referral for treatments a patient wants but which the practitioner considers to be ineffective or harmful (Part III.4 – 11). It would be more to the point to remind practitioners of a continuing obligation to provide services unrelated to the service they decline to provide.

V.9 Practitioners who object to a procedure for reasons of conscience will not personally provide the procedure. Some may be willing to make effective referrals because they believe that effective referral absolves them of moral responsibility for a procedure provided by another person. However, others refuse to make effective referrals because they believe that referral makes them complicit in what they consider to be an immoral act.

V.10 The Canadian Medical Association (CMA) has drawn the College's attention to these distinctions and the need to respect them in policy-making in relation to euthanasia and assisted suicide. The CMA's argument is applicable to all other morally contested services:

> For the majority of physicians who will choose not to provide assistance in dying, referral is entirely morally acceptable; it is not a violation of their conscience. For others, referral is categorically morally unacceptable; it implies forced participation procedurally that may be connected to, or make them complicit in, what they deem to be a morally abhorrent act. In other words, referral respects the conscience of some, but not others. . .
>
> It is the CMA's strongly held position that there is no legitimate justification to respect one notion of conscience (i.e. the right not to participate in assisted dying), while wholly discounting another because one may not agree with it. As such, in seeking an approach that achieves an appropriate balance, the CMA sought to articulate a duty that achieves an ethical balance between conscientious objection and patient access in a way that respects differences of conscience. It is the CMA's position that the only way to authentically respect conscience is to respect differences of conscience.[44]

V.11 Objecting practitioners are typically willing to work cooperatively with patients and others in relation to patient access to services as long as cooperation does not involve an act that establishes a causal connection to or *de facto* support for the services to which they object. This enables an approach that accommodates both patients and practitioners. Again, the CMA:

> The argument that only mandatory referral puts patients' interests first or respects patient autonomy − and that not making a referral does not − is fundamentally erroneous. There are many ways to conceptualize a physician's positive obligations to her patient that do not require the imposition of a duty to refer and thus uphold conscience rights. . .
>
> . . . articulating a physician's positive obligations of what she ought to do if she declines to provide or participate in an act on grounds of deeply held beliefs does not *de facto* translate to making a referral. It is the CMA's position that there is no logical or ethical basis for this argument.[45]

V.12 In the Project's experience, objecting practitioners will provide patients with information that enables them to make informed decisions and that facilitates patient contact with other health

care service providers or agencies. This approach allows these practitioners avoid any positive action causally connected to contested services, while patients remain free to pursue them.

V.13 On the other hand, objecting practitioners are likely to refuse to do something that they believe implies their support for or establishes a causal connection to perceived wrongdoing. Thus, they would provide contact information for health care providers or services generally, but may refuse to direct patients specifically to someone who provides the contested service, or to an agency that delivers it.

V.14 So, for example, these practitioners would direct patients to Telehealth Ontario, but not to an abortion clinic or the MAiD Care Coordination Service (CCS). All three services can connect patients to providers, but abortion clinics are devoted to providing abortion and the CCS is dedicated to providing euthanasia and assisted suicide. In contrast, Telehealth facilitates access to all services. There is no significant practical difference for the patient, but there is a significant ethical difference for the practitioners.

V.15 This applies also when objecting practitioners connect patients to responsible and reliable persons who can address problems of isolation and neglect and help them obtain necessary services (see IV.14-15). It is possible the helpers (like Telehealth) might help a patient obtain services objecting physicians decline to provide. However, in the Project's experience, objecting physicians would not consider this possibility a reason to refuse to make a connection for patients needing this kind of support.

V.16 To sum up, practitioners who refuse to provide effective referrals are willing to cooperate with measures taken to accommodate practitioner freedom of conscience and patient access to services, but not to collaborate in services to which they object for reasons of conscience. The difference between cooperation and collaboration is illustrated by one of the four examples of "effective referral" the College offers in *Advice:POHR* (paraphrased below):

> a) The objector/delegate contacts provider and arranges for the patient to be seen or transferred.
>
> b) The objector/delegate contacts an agency that delivers the contested service, like a abortion clinic or the Ontario Care Coordination Service.
>
> c) A practice group in a hospital, clinic or family practice identifies patients seeking a contested service through a triage system and connects them with a non-objecting practitioner.
>
> d) A practice group identifies a provider/facilitator with whom an objecting practitioner connects the patient.

V.17 Example (c) may involve cooperation, but it does not entail collaboration. Someone in the group *other than* the objecting practitioner takes "positive action" to connect the patient with a non-objecting practitioner. Example (c) illustrates acceptable accommodation of freedom of conscience precisely because (contrary to the College's assertion) it does *not* fit the College's definition of effective referral.

V.18 Effective referral as defined by the College demands that the objecting practitioner — not the patient or another team member — personally take positive action to *ensure* the patient connects with a provider or delivery service. A referral that is not *effective* in facilitating access to a contested service is not an "*effective* referral."

V.19 Objecting physicians who refuse to provide effective referrals reasonably hold that doing something *effective* to facilitate wrongdoing is collaboration that makes them morally culpable for wrongdoing. The validity of this position can be verified by considering effective referral for euthanasia/assisted suicide had the Supreme Court not ordered legalization of the procedures in *Carter*.[46]

V.20 But for the *Carter* decision, practitioners providing an effective referral for euthanasia/ assisted suicide could be charged for murder or assisted suicide if patients were killed, or conspiracy to commit murder or assisted suicide if they were not. Similarly, many objecting physicians hold that by effective referral for euthanasia/assisted suicide they are morally implicated in grave wrongdoing: homicide/suicide. With respect to conclusions of criminal and moral culpability for referring patients to others for lethal injection, the reasoning is identical.

V.21 The *Carter* decision changed the law on murder and assisted suicide by making exemptions in defined circumstances, but it did not change the reasoning that underpins the law on criminal responsibility or parties to offences. The reasoning that supports the law against aiding or abetting murder is exactly the same reasoning applied by practitioners who refuse to provide effective referral for euthanasia. It is, moreover, reasoning that the College understands, accepts and applies in prohibiting female genital mutilation by physicians – *and referral* for the procedure. College policy states:

> The *Criminal Code* prohibits the performance of ***or referral*** for FGC/M (see Sections 268(3), 21-22 and 273.3(1)) (emphasis added)[47]

The *Criminal Code* does *not* mention referral, but the College correctly states that the *Code* prohibits referral, because the College recognizes that to refer for FGC/M is to aid or abet FGC/M, and aiding or abetting FGC/M is a crime.

V.22 This demonstrates that the College's assertion that effective referral does not "signal" endorsement or support for the procedures [*Advice:POHR*] is either disingenuous or the product of badly muddled wishful thinking. An objecting practitioner's conclusion that referral for X involves moral culpability because it aids or abets X is exactly the same reasoning the College applies when it asserts that referral for FGC/M involves criminal responsibility because it aids or abets FGC/M. It is thus reasonable for practitioners to hold that aiding or abetting X by effective referral makes them morally responsible collaborators in X, or in arranging for X, even if, ultimately, X is not provided.

V.23 The absurdity of the claim that making an effective referral cannot be understood to involve endorsement or support for a contested procedure is underlined by the requirement that objecting physicians maintain an "effective referral plan." In other words, those convinced, for example, that killing their patients is gravely wrong must, nonetheless, carefully map out

how they will ensure that their patients can be killed. But for *Carter*, evidence of deliberation of this kind would support a conviction for first degree murder. (On the other hand, developing a plan to accommodate patients without violating one's personal or professional integrity is highly recommended by the Project.)

V.24 While *Carter* means that euthanasia and assisted suicide in circumstances defined by law are no longer criminal offences, the ruling does not affect the legitimacy and reasonable plausibility of a moral/ethical/religious belief that it is gravely wrong or contrary to good medical practice to deliberately kill people or help them to commit suicide, even if the law approves. Having this belief is not currently a reason to exclude someone from health care professions.

V.25 Further, based on the preceding discussion, practitioners having this belief may reasonably conclude that they *must* refuse to make an effective referral for euthanasia/assisted suicide because collaboration in killing their patients would be gravely immoral.

V.26 The College position is that the freedom to hold this belief is broader than the freedom to act upon it: that practitioners who refuse to collaborate in killing their patients should be excluded from medical practice, or at least removed from any form of medical practice in which they may receive an EAS request (moving, for example, to hair restoration).[48] This has serious practical implications for access to health care. For example, it would now require these practitioners to leave general practice and terminate all clinical Covid 19 pandemic activities. In two years, only practitioners willing to provide or collaborate in euthanasia and assisted suicide as treatment for mental illness will be able to continue in psychiatric practice.

V.27 Driving physicians unwilling to collaborate in killing patients from medical practice also has implications for patient safety. Joseph Arvay, chief counsel for the *Carter* plaintiffs, lauded physician's unwillingness to harm their patients as an outstanding virtue that made them ideal euthanasia practitioners. "[I]t is an irrefutable truth," he told the Supreme Court of Canada, "that all doctors believe it is their professional and ethical duty to do no harm."

> Which means, in almost every case, that they will want to help their patients live, not die. It is for the very reason that we advocate only physician assisted dying and not any kind of assisted dying because we know physicians will be reluctant gatekeepers, and only agree to it as a last resort.[49]

Excluding physicians unwilling to collaborate in killing their patients from medical practice would thus seem to weaken what one of Canada's most prominent EAS advocates described as the most fundamental safeguard for patients.

Issues

V.28 In applying *POHR* to *Medical Assistance in Dying,* the College invites the erroneous inference that refusal to make an effective referral for euthanasia/assisted suicide or other contested procedures amounts to patient abandonment.

V.29 *Professional Obligations and Human Rights* demonstrates either confusion or hypocrisy and

moral partisanship and in relation to the moral/ethical significance of referral. It favours practitioners willing to do or collaborate in doing what they believe to be wrong/unethical and disadvantages and threatens practitioners who refuse.

V.30 The College's demand that objecting practitioners unwilling to collaborate in what they believe to be wrong/unethical should leave the profession or confine their practice to specialties like hair restoration may adversely affect access to health care and even patient safety.

V.31 Finally, that the state can require unwilling citizens to collaborate in doing what they believe to be wrong — even killing people — and punish or disadvantage them if they refuse is a dangerous and especially repugnant idea. It stands in violent contradiction to the solicitude for human life, dignity and freedom that ought to characterize a democratic society. This issue was not argued or even considered by the trial court or Ontario Court of Appeal in rulings on CPSO policy.[50,51]

Recommendations

V.32 The College should have a single general policy that addresses the exercise of freedom of conscience by physicians that can be applied to all procedures or services. Appendix "A" offers such a policy.

Appendix "A"

Recommended General Policy

The Project recommends the following general policy applicable to all procedures or services. Relevant provisions of *Professional Obligations and Human Rights* are noted in the text to facilitate comparison.

Conscience, Religion, Clinical Judgement and Access to Services

Definitions

"health care personnel" and "health care provider" include a member of a profession included in Schedule 1 of the *Regulated Health Professions Act*, 1991, S.O. 1991, c. 18.

"patient" includes persons seeking to be accepted as patients and persons lawfully designated to make a decision on the care to be provided to patients unable to express a decision.

Introduction

To minimize inconvenience to patients and avoid conflict, physicians should develop a plan to respond to requests for services they are unwilling to provide for reasons of conscience, religion or clinical judgement in accordance with this policy. [*POHR* para. 16]

A1. General

A1.1 Physicians may encounter patients who are isolated or burdened by illness, physical or mental disability, language barriers, etc. and unable to connect with health care personnel or obtain medical treatment or other necessary services. Patients so debilitated or circumstantially handicapped are clearly at risk.

A1.2 In all such cases, physicians should connect the patient to a responsible and reliable person who can address problems of isolation and neglect, help patients overcome circumstantial handicaps and enable them to obtain necessary assistance and navigate the health care system. The helper could be a family member, friend, social worker, outreach worker, etc.

A2. Notice

A2.1 Physicians must give reasonable and timely notice to patients of religious, ethical or other conscientious convictions that influence their recommendations or practice or prevent them from providing certain procedures or services so that patients may consult or seek services from other health care personnel. Physicians must also give reasonable notice to patients if their views change.[52,53] [*POHR* para. 9, 10]

a) 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. [*POHR*

para. 9,10]

b) Notice is timely if it is provided as soon as it will be of benefit to the patient. Timely notice 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. [*POHR* para. 9, 14(a), (b)]

c) 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. Physicians must not criticize or denigrate the beliefs, lifestyle, identity, or characteristics of patients. This should not be understood to preclude respectful discussion of beliefs or habits that may adversely affect a patient's health. [*POHR* para. 11]

A2.2 Physicians who provide medical services in a health care facility must give reasonable notice to the facility of religious, ethical or other conscientious convictions that prevent them from providing procedures or services that are or are likely to be provided in the facility. In many cases - but not all - this may be when the physician begins to provide medical services at the facility. [*POHR* note 3]

A3. Informed decision making

A3.1 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 treatment or services.[54,55,56,57] [*POHR* para. 9, 12, 13]

a) Sufficient information is that which a reasonable patient in the place of the patient would want to have, including diagnosis, prognosis and a balanced explanation of the benefits, burdens and risks associated with each option.[58,59,60,61][*POHR* para. 12, 13]

b) 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.[POHR para. 9, 14(a), (b)]

c) 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.[62,63] [*POHR* para. 9, 12, 13]

d) Physicians whose medical opinion concerning treatment options is not consistent with the general view of the medical profession must disclose this to the patient.[64]

e) The information provided 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.[65,66,67,68] [*POHR* para. 10]

f) 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. [*POHR* para. 9]

A4. Declining to provide services

A4.1 Physicians who decline to recommend or provide services or procedures for reasons of conscience, religion or clinical judgement must advise affected patients that they may seek the services elsewhere and provide information about how to contact other service providers. [*POHR* para. 9, 15]

A4.2 If the patient appears to be unable to contact other service providers without assistance, physicians must ensure that the patient is connected with a family member or other responsible person who can assist. [See A.1] [*POHR* para. 9, 14, 15]

A4.3 When appropriate, physicians must communicate to a person in authority a patient's request for a complete transfer of care so that the person in authority can facilitate the transfer; [*POHR* para. 9, 14, 15]

A4.4 Physicians must, upon request by a patient or person in authority, transfer the care of the patient or patient records to a physician or health care provider chosen by the patient.[69,70] [*POHR* para. 9, 14, 15]

A4.5 In addition, upon a patient's request or enquiry, physicians may, if consistent with their conscientious convictions and clinical judgement,

a) arrange for the patient to be seen by a someone able and willing to provide the service; or

b) arrange for a transfer of care to health care personnel willing to provide the service; or

c) provide contact information for a person, agency or organization that provides or facilitates the service; or

d) enable patient contact with health care personnel or services in the community or in institutional settings who will ensure that the patient has access to all available treatment options, including services the physician declines to provide.[*POHR* para. 9, 14, 15]

A4.6 Physicians unwilling or unable to comply with these requirements must promptly arrange for a patient to be seen by a physician or other health care provider who can do so. [*POHR* para. 9, 14, 15]

A5. Continuity of care

A5.1 Physicians must continue to provide services unrelated to the services they decline to provide unless a physician and patient agree to other arrangements.[71,72]

A6. Non-abandonment

A6.1 When a patient is imminently likely to suffer death or permanent, serious physical injury if an intervention is not immediately provided, physicians must

a) provide the intervention if it is within their competence and no competent and willing health care personnel are available; or

b) immediately arrange for available, competent and willing health care personnel to provide the intervention,

unless the intervention is facilitated by a service or procedure provided by health care personnel deliberately causing the death or serious permanent injury of another person.[73] [*POHR*, para. 17]

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