ADVICE TO THE PROFESSION:
HUMAN RIGHTS IN THE PROVISION OF HEALTH SERVICES

Advice to the Profession companion documents are intended to provide physicians with additional information and general advice in order to support their understanding and implementation of the expectations set out in policies. They may also identify some additional best practices regarding specific practice issues.

The *Human Rights in the Provision of Health Services* policy articulates physicians' legal and professional obligations regarding the provision of health services, including complying with accessibility and human rights legislation. The policy also sets out physicians' professional obligations where health services are limited for clinical competence/scope of practice reasons and health services conflict with their conscience or religious beliefs. The key values of professionalism articulated in the College's *Practice Guide* — compassion, service, altruism and trustworthiness — and physicians' obligations under the accessibility and human rights legislation form the basis for the expectations in the policy. This *Advice* document is intended to help physicians understand and interpret their obligations, and provide guidance around how these obligations may be effectively discharged.

For definitions of key terms/concepts related to this policy and *Advice*, see the College's Equity, Diversity, and Inclusion Glossary.

Providing Health Services

Why has the College referenced cultural humility, cultural safety, anti-racism, and anti-oppression in the policy?

The College recognizes the vast amount of literature that indicates a patient's racial/ethnic/cultural background, their sexual orientation and/or gender identity, their socio-economic status, and where they live are often the primary determinants of that patient's health. Those who are from racialized or marginalized groups are more likely to have difficulties accessing care and experience poorer health outcomes.[1]

The College has made a commitment to examine how we, as an organization, can better fulfill our mandate by bringing equity, diversity, and inclusion (EDI) to our processes and policies, and to address all forms of discrimination. Many other medical organizations have also identified EDI and anti-discrimination as priorities, including the following:

[1] University of Toronto, Family & Community Medicine. (2020). Family Medicine Report: Caring for Our Diverse Populations. Retrieved from: https://www.dfcm.utoronto.ca/sites/default/files/university_of_toronto_family_medicine_report_-_caring_for_our_diverse_populations.pdf

- Federation of Medical Regulatory Authorities of Canada;
- Royal College of Physicians and Surgeons of Canada (they have also published resources, including a poster, Examining 'Cultural Safety');
- College of Family Physicians of Canada (they have also published resources, including the CanMEDS–Family Medicine Indigenous Health Supplement); and
- Canadian Medical Protective Association (they have also published a resource on Cultural Safety).

The College believes it is important to set out expectations and guidance for physicians on these fundamental concepts, as creating and fostering a safe, inclusive, and accessible environment for patients will help improve the patient's experience, the quality of the physician-patient relationship, the care provided, and health outcomes. We recognize that these concepts may be new for some physicians and therefore have provided some specific examples and resources for educational purposes below.

What steps can I take to create and foster a safe, inclusive, and accessible environment in which the rights, autonomy, dignity, and diversity of all patients are respected and where my patients' needs are met?

Some specific examples may include, but are not limited to:

- Being aware of your assumptions, beliefs, and privilege and minimizing any biases[2] when providing care;
- Learning about your patient's lived experience, racial/ethnic/cultural background, values/beliefs/worldview, sexual orientation and/or gender identity, and socioeconomic status and respecting patients for who they are;
- Communicating and collaborating effectively with patients and/or others they wish to involve in their care to help ensure treatment plans address patients' specific needs;
- Incorporating a trauma/violence-informed approach to care;[3] and
- Identifying and addressing any barriers (e.g., communication, physical environment) that may be preventing or limiting patients' access to health services.

A list of resources is provided at the end of this document to help physicians create and foster a safe, inclusive, and accessible environment. Further information and resources can also be found on the College's Equity, Diversity, and Inclusion webpage.

[2] For more information, see the College's *eDialogue* article on Implicit Bias in Health Care.
[3] For more information, see EQUIP Health Care's Trauma- and Violence-Informed Care Tool.

Does the concept of "professionalism" include advocating for a safe, inclusive, and accessible environment in which the rights, autonomy, dignity, and diversity of all patients are respected?

Yes. The College recognizes that the concept of medical professionalism includes adopting the role of health advocate. This may include advocating for individual patient health care needs, advancing policies that promote the health and well-being of the public, and/or promoting a safe health care system.

For example, advocacy can range from helping a specific patient access a service, to challenging the structures (e.g., policies, programs, etc.) that perpetuate inequities in the health care system and actively being anti-racist.

The policy says that physicians must not promote their own spiritual, secular, or religious beliefs when interacting with patients or impose these beliefs on patients. What does this mean? Does this mean that physicians can never discuss spiritual, secular, or religious beliefs with their patients?

No. The College recognizes that patients' spiritual, secular, and religious beliefs can play an important role in the decisions they make about health care, and can offer comfort if patients are faced with difficult news about their health. It is appropriate for physicians to inquire about and/or discuss patients' spiritual, secular, and religious beliefs when those are relevant to patient decision-making, or where it will enable the physician to suggest supports and resources that may assist the patient.

However, as noted in the policy, physicians must not express personal moral judgments about the patient's beliefs, promote their own spiritual, secular, or religious beliefs when interacting with patients, or impose these beliefs on patients. This means, for example, that physicians cannot imply their beliefs are superior to the patient's, attempt to influence the patient's beliefs, or attempt to convert patients to the physician's own beliefs.

When discussing spiritual, secular, or religious beliefs, physicians will need to focus on the patient's beliefs, rather than focusing on their own beliefs, and allow patients to guide the discussion about their beliefs. This may help physicians avoid appearing as though they are attempting to influence the patient's beliefs.

Does the Accessibility for Ontarians with Disabilities Act, 2005 (AODA) apply to physicians, and how does the AODA relate to the Ontario Human Rights Code (the Code)?

Yes. The *AODA* applies to organizations with at least one employee, including organizations that provide health-care services (e.g., physicians' offices, clinics,

hospitals, etc.). Physicians are required to comply with the *AODA* standards[4] regarding accessibility for patients with disabilities that are applicable to their particular office,[5] as well as any policies that have been developed in accordance with *AODA* in their workplace. Physicians are also required to comply with the *Code*.

The human rights principles of the *Code* help to inform and guide how *AODA* standards are to be met. The *AODA* standards do not limit or replace the requirements of the *Code* or any other law. While the *Code* and the *AODA* work together, they have some important differences:

- Under the *Code*, service providers have a duty to accommodate persons with disabilities. Accommodation is a reactive and individualized adaptation or adjustment made to provide a person with a disability with equitable and non-discriminatory opportunities for participation.
- The *AODA* sets general accessibility standards that organizations must meet in a number of different areas, such as information and communication standards and customer service standards. Accessibility is the degree to which persons with disabilities can access a device, service, or environment without barriers. Accessibility is also a process – it is the proactive identification, removal or reduction, and prevention of barriers to persons with disabilities.
- While all organizations with more than one employee are required to comply with the *AODA*, the types of accessibility accommodations that must be provided depend on the number of employees in the organization. On the other hand, the *Code*, requires that organizations comply with their duty to accommodate to the point of undue hardship. Undue hardship is based on excessive cost or health or safety concerns – not the size of the organization.[6]

What is the duty to accommodate set out in the Code and what does this duty look like?

The legal, professional, and ethical obligation to provide services free from discrimination includes a duty to accommodate. The duty to accommodate is fundamental to providing fair treatment to patients and reflects the fact that each person has different needs and requires different solutions to gain equal access to care.

[4] See the Ontario government's website for more information on the accessibility standards.
[5] Physicians can use the Ontario government's Accessibility Standards Checklist to help them identify which requirements apply to their office. For example, requirements under the Information and Communication Standards may include ensuring that the physician's office can communicate with patients in accessible ways (e.g., in accessible formats, provide communication supports upon request, etc.).
[6] For more information, see the Ontario Human Rights Commission's eLearning series, Working Together: The *Code* and the *AODA*.

Examples of accommodation may include, but are not limited to: permitting a service dog to accompany a patient into the examination room, using interpreters to overcome communication barriers, ensuring signage reflects diverse family configurations (e.g., families with two mothers or two fathers), and/or creating forms to accommodate patients' gender identity and expression.[7]

What happens if I cannot accommodate a patient because it would cause undue hardship?

Physicians have a duty to accommodate patients but at times, the accommodation process may result in not being able to meet a patient's needs because it would subject the physician to undue hardship. When this occurs, physicians do not have an obligation to refer the patient to another health-care professional who can accommodate them. However, if physicians are aware of another health-care professional who is available and able to accommodate the patient, they can try connecting the patient to them.

What are "service animals" and "support animals" and are physicians required to allow them?

The *AODA* Customer Service Standards defines an animal as a "service animal" for a person with a disability if:

- the animal can be readily identified as one that is being used by the person for reasons relating to the person's disability, as a result of visual indicators such as the vest or harness worn by the animal; or
- the person provides documentation[8] from a regulated health professional confirming that the person requires the animal for reasons relating to the disability.[9]

A "support animal" (also commonly referred to as an "emotional support animal") is not defined in the *AODA* or the *Code*.

Physicians are required to allow service animals and may be required to allow support animals under the *Code* if support animals are required as a form of accommodation for patients with disabilities, subject to undue hardship.

How do I determine if the reason(s) for a patient's request to receive care from a physician with a particular social identity is discriminatory?

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[7] For more information on accommodation, see the Ontario Human Rights Commission's A policy primer: Guide to developing human rights policies and procedures and the Human Rights Legal Support Centre's Understanding the Duty to Accommodate resources.

[8] See the College's *Third Party Medical Reports* policy for general expectations that would apply to providing third party medical reports, including documentation for a service and/or support animal, and the *Advice to the Profession: Third Party Medical Reports* for guidance on this issue.

[9] See the Ontario government's website for more information about service animals.

Physicians will need to use their professional judgment to determine whether the patient's request is discriminatory (e.g., racist, sexist, ageist, heterosexist, etc.). In order to make this determination, physicians will need to explore the reason(s) for the patient's request.

At times, it may be obvious that the reason(s) for a patient's request is discriminatory because the patient uses disrespectful or derogatory language (e.g., they use a racial slur). Physicians must not be spoken to in this manner as physicians are entitled to a workplace that is free from violence, harassment, and discrimination. Guidance on how to navigate discriminatory requests is provided in the next question and answer below.

In other instances, it may be difficult for physicians to evaluate the patient's reason(s) where the patient is not overtly discriminatory and just does not feel comfortable disclosing the true reason(s) for their request (e.g., a woman may not disclose that they are requesting a woman physician because they were sexually assaulted by a man). In these circumstances, physicians may presume that personal preference requests are likely based on past experiences, cultural norms, etc. and therefore are not discriminatory for the purposes of this policy.

Requests are also not discriminatory when patients are seeking an ethically or clinically appropriate form of concordance (e.g., based on race/ethnicity/culture, language, gender, etc.). For example, patients who are members of racial or ethnic minority groups may request a physician of the same race or ethnicity because of a history of discrimination or other negative experiences with the health care system that have resulted in mistrust. In such cases, the literature recognizes that physician-patient concordance is associated with greater trust, comprehension, and satisfaction and other critical patient-centered outcomes. It is important for physicians to sensitively explore the reason(s) for the patient's request in order determine which requirements apply to the specific circumstances.

How do I navigate patient requests to receive care from a physician with a particular social identity when the reason(s) for their request are perceived to be discriminatory (e.g., racist, sexist, ageist, heterosexist, etc.)?

Physicians do not have to accommodate the patient's discriminatory request. This position supports the right of physicians to be free from violence, harassment, and discrimination in their workplace. As discussed in the College's *eDialogue* article on Treating Patient Bias, physicians do suffer harm (e.g., emotional exhaustion, fear, self-doubt, and increased cynicism) after encounters with patients who are discriminatory towards them and this can lead to physician burnout and negatively impact patient care.

Once a patient's emergent or urgent medical needs are met, one of the factors that physicians will need to consider when determining whether to treat the patient's other needs is safety (of the physician and patient). Some physicians may be harmed and/or

may not feel safe caring for the patient, and it would not be in anyone's best interest for physicians to care for a patient in these circumstances.

When determining whether it is in both parties' best interest to care for the patient, it would also be prudent to take the patient's capacity into account. Patients who are incapable (e.g., due to a severe mental illness, neurocognitive or neurodevelopmental disorder, substance intoxication, delirium, etc.) may not be cognitively aware of what they are saying or doing and therefore physicians may be more willing to care for patients in these circumstances. In fact, professionalism requires physicians to accept a broad range of human behaviour in response to illness or incapacity and physicians will have to use their professional judgment to determine when that behaviour crosses the line and becomes unsafe.

Where physicians determine that it would be unsafe or not in both parties' best interest to care for the patient and they decide to end the physician-patient relationship, they will have to comply with the expectations set out in the College's *Ending the Physician-Patient Relationship* policy.

Health Services that Conflict with Physicians' Conscience or Religious Beliefs

Can physicians practise in accordance with their conscience or religious beliefs?

Yes. However, physicians' freedom of conscience and religion must be balanced against patients' right to access health services.

The *Canadian Charter of Rights and Freedoms* protects the right to freedom of conscience and religion,[10] but this right is not absolute. The right to freedom of conscience and religion can be limited, as necessary, to protect public safety, order, health, morals, or the fundamental rights and freedoms of others.[11]

The balancing of rights must be done in context.[12] In relation to freedom of religion specifically, courts will consider the degree to which the act in question interferes with a sincerely held religious belief and will seek to determine whether the act interferes with the religious belief in a manner that is more than trivial or insubstantial. The less direct the impact on a religious belief, the less likely courts are to find that freedom of religion is infringed, and conduct that would potentially cause harm to and interfere with the rights of others would not automatically be protected.[13] The Court of Appeal for Ontario has confirmed that where an irreconcilable conflict arises between a physician's

[10] *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act*, 1982, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11, s 2(a).
[11] *R. v. Big M Drug Mart Ltd.*, [1985] 1 S.C.R. 295 at para 95.
[12] Ontario Human Rights Commission, Policy on Competing Human Rights, (Ontario: Jan 26, 2012).
[13] *Syndicat Northcrest v. Amselem*, [2004] 2 S.C.R. 551 at paras 59-61.

interest and a patient's interest, physicians' professional obligations and fiduciary duty require that the interest of the patient prevails.[14]

As such, the College has set out expectations for physicians whose conscience or religious beliefs conflict with certain health services in a manner that would impact patient access to those health services and has done so in such a way that it accommodates the rights of these physicians to the greatest extent possible, while ensuring that patients obtain access to that care.

What does an effective referral involve?

An effective referral involves taking the following steps:

1. **The physician must take positive action to connect a patient with another physician, health-care professional, or agency.** The physician can take these steps themselves or assign the task to someone else (i.e., their designate), so long as this other person complies with the College's expectations.

2. **The effective referral must be made to a non-objecting physician, health-care professional, or agency that is available and accessible to the patient.** The physician, health-care professional, or agency to which the effective referral is made cannot have conscientious or religious beliefs that would impact patient access to the service, treatment, or procedure, must be operating and/or accepting patients, and must be in a location that is reasonably physically accessible to the patient or accessible via virtual care, where appropriate.

3. **The effective referral must be made in a timely manner, so that the patient will not experience an adverse clinical outcome due to a delay in making the effective referral.** A patient would experience an adverse outcome due to a delay if, for example, the patient is no longer able to access the service, treatment, or procedure (e.g., for time sensitive matters such as emergency contraception, an abortion, or where a patient wishes to explore medical assistance in dying); their clinical condition deteriorates; or their untreated pain or suffering is prolonged.

An effective referral *does not:*

- necessarily require that the physician make a clinical referral , unless it is required in order for a patient to access the service, treatment, or procedure;

- require that the physician assess the patient or determine whether the patient is a suitable candidate, or eligible, for the service, treatment, or procedure;

[14] *Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario,* 2019 ONCA 393 at para. 187.

- guarantee that the patient will receive the service, treatment, or procedure as they may not ultimately choose that particular clinical option or be a suitable candidate, or eligible, for it; or
- require that the physician endorse or support the service, treatment, or procedure.

What are some examples of an effective referral?

Physicians will need to consider the patient's particular circumstances and use their professional judgement to determine what action to take. Some patients may need more assistance than others in accessing the service, treatment, or procedure. Physicians will also need to consider whether the service, treatment, or procedure can be accessed by the patient directly, or whether a clinical referral is required (e.g., to access a specialist). Even where patients can access services directly, many patients will require their physicians' assistance in doing so.

The following are examples of positive actions physicians can take, but these examples are not exhaustive and the action required to confirm a connection is made will depend on the specific circumstances.

- The physician or their designate contacts a non-objecting, available, and accessible physician or other health-care professional and arranges for the patient to be seen.
- The physician or their designate makes a clinical referral to a non-objecting, available, and accessible physician or other health-care professional where a clinical referral is required in order to access the service, treatment, or procedure (e.g., a fertility specialist).
- A physician or their designate partially transfers[15] the patient's care to a non-objecting, available, and accessible physician or other health-care professional with whom the patient can explore all options in which they have expressed an interest. This other physician or health-care professional could make a clinical referral if it is required in order to access the service, treatment, or procedure.
- The physician or their designate connects the patient with an agency charged with facilitating referrals for the service, treatment, or procedure, and arranges for the patient to be seen at that agency. For instance, in the medical assistance in dying (MAID) context, the physician or their designate would contact Ontario's

[15] In this situation, the physician would only transfer the care that they choose not to provide for reasons of conscience or religion. This partial transfer of care is not equivalent to ending the physician-patient relationship. The College's *Ending the Physician-Patient Relationship* policy states that physicians must not end the physician-patient relationship solely because the patient wishes to explore a care option that the physician chooses not to provide for conscience or religious reasons.

Care Coordination Service (CCS). The CCS would then connect the patient with a willing provider of MAID-related services.

- In appropriate circumstances (e.g., where the patient does not need assistance), the physician or their designate provides the patient with contact information for a non-objecting, available, and accessible physician, other health-care professional, or agency.
- A practice group in a hospital, clinic, or family practice model identifies patient queries or needs through a triage system. The patient is directly matched with a non-objecting physician in the practice group with whom the patient can explore all options in which they have expressed an interest.
- A practice group in a hospital, clinic, or family practice model identifies a point person who will facilitate an effective referral or who will provide the services, treatment, or procedure to the patient. The physician with conflicting beliefs or their designate connects the patient with that point person.

Regardless of which positive actions were taken, physicians or their designates will have to confirm that they were effective (i.e., the patient was connected).

What steps are involved in meeting the requirement to confirm that the patient was connected?

Given the physician's fiduciary duty to the patient and the professional responsibilities that flow from that duty, the onus falls on the physician or their designate to confirm the patient was connected, unless the patient has indicated that they prefer to reach out to the physician or their designate if they have any issues being connected. To that end, it is important for the physician or their designate to clarify with the patient how the confirmation will be obtained or provided.

Physicians will have to consider the patient's particular circumstances and use their professional judgment to determine what steps are required to confirm that the patient was connected. For example, physicians or their designate could confirm the patient was connected by contacting the patient directly, or the physician, health-care professional, or agency they connected the patient to. It would be prudent for the physician or their designate to obtain the patient's express consent regarding the manner in which they would like the physician or their designate to follow-up.

What further action do I need to take if I learn that the patient was not connected?

If physicians learn that their patient was not connected, they are required to take further action to provide an effective referral. In doing so, physicians may need to take a more active step to connect their patient. For example, if the first action they took was to provide the patient with a contact number for a non-objecting, available, and accessible physician, the next action they may need to take is to directly contact another physician,

health-care professional, or agency on the patient's behalf and arrange for them to be seen.

Does the expectation to provide patients with an effective referral apply in faith-based hospitals and hospices?

Yes. Physicians are required to comply with the expectations set out in the College's policy. This means that physicians would be required to provide patients with access to information and care, including an effective referral, for the services, treatments, and procedures that are not provided in the faith-based hospital or hospice.

Can I end the physician-patient relationship because my patient wishes to explore a care option that conflicts with my conscience or religious beliefs?

No. The College's *Ending the Physician-Patient Relationship* policy states that physicians must not end the physician-patient relationship solely because the patient wishes to explore a care option that conflicts with the physician's conscience or religious beliefs.

I am a primary care provider and my patient is exploring a health service that conflicts with my conscience or religious beliefs. Do I have to continue managing the other elements of their care?

Yes. As noted above, you cannot end the physician-patient relationship solely because the patient is exploring a health service that conflicts with your conscience or religious beliefs. Physicians have an obligation to continue to offer comprehensive and continuous care to meet their patients' other needs and are required to do so in a manner that does not impose their own religious beliefs on patients.

For example, patients who are seeking MAID may still require comprehensive care, including managing the symptoms that have led to their desire to explore MAID, and you have an obligation to ensure the continuity of that care is provided. If the patient's natural death is not reasonably foreseeable, the physician or nurse practitioner who is exploring MAID with the patient may also need your assistance to treat the patient's medical condition by means other than MAID.

Where do I go if I have questions or concerns about whether a physician has complied with their obligations?

You may bring any questions or concerns regarding physicians' compliance with the obligations set out in this policy to the College. You may also raise any concerns regarding physicians' compliance with their legal obligations under the *Code* to the Ontario Human Rights Commission and Tribunal. College processes are separate from the Ontario Human Rights Commission and Tribunal processes.

Resources

- Call it Out: Racism, Racial Discrimination, and Human Rights
- The College of Family Physicians of Canada: Indigenous Health Committee Resources
- Royal College of Physicians and Surgeons of Canada: Indigenous Health
- San'yas Anti-Racism Indigenous Cultural Safety and Training Program
- EQUIP Health Care Trauma- and Violence-Informed Care Resources
- Action Canada for Sexual Health and Rights: A Handbook for health care providers working with clients from diverse communities
- Never in the Room: A Forum Theatre Presentation in Partnership with Ontario Association of Interval and Transition Houses (OAITH) on ending violence against older women in Ontario
- Ontario Association of Interval and Transition Houses (OAITH): Training Portal[16]
- Ontario Association of Interval and Transition Houses (OAITH): Beneath the Iceberg Video Guide
- Rainbow Health Ontario: Education & Training
- Creating An Inclusive Space
- Obesity Guideline Addresses Root Drivers
- Cultural Religious Competence in Clinical Practice
- Religious Diversity: Practical Points for Health Care Providers

[16] These courses are designed for people working in violence against women shelters in Ontario and for all others who work in the violence against women sector or in roles that involve supporting or advocating for women who have experienced violence.