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NUMBER 200/14

COLLEGE OF PHYSICIANS AND SURGEONS
OF SASKATCHEWAN
TO COUNCIL

FROM: Registrar

SUBJECT: **Possible Policy – Conscientious Objection to Providing Medical Care**

For Your Decision

M E M O R A N D U M

DATE: July 31, 2014
TO: Council
FROM: Bryan E. Salte
RE: Possible Policy or Guideline – Physicians who have an ethical objection to provide certain forms of medical services

1. Decision to be made

Council is asked to consider whether it will develop a policy or guideline for physicians who have an ethical objection to providing certain forms of care. If such a policy is to be developed, the Council will need to appoint a committee to develop the policy or guideline.

2. Background

Council has developed a policy on Unplanned Pregnancy which addresses physicians' ethical obligations in the context of an unplanned pregnancy. It provides the following guidance to physicians:

Any physician who is unable to be involved in the further care and management of any patient when termination of the pregnancy might be contemplated should inform the patient and make an expeditious referral to another available physician.

...

5) Will fully apprise the patient of the options she may pursue and provide her with accurate information relating to community agencies and services that may be of assistance to her in pursuing each option.

The issue of physician's ethical obligations in situations where a service requested by a patient conflicts with the physician's religious or moral beliefs seems to have gathered more attention recently.

Some of the issues which have resulted in controversy are:

- 1) Abortion;
- 2) Provision of birth control;

- 3) Legislation in Quebec dealing with assisted suicide;
- 4) Use of technology to identify the gender of a fetus;
- 5) Genetic testing.

That is not an exhaustive list, but provides some idea of the situations where ethical issues arise in the provision of such services.

3. Current Consultation in Ontario

The Ontario College of Physicians and Surgeons has a current policy *Physicians and the Ontario Human Rights Code* which partially addresses the issue above.

As part of its policy renewal cycle, it asked the question “Do you think a physician should be allowed to refuse to provide a patient with a treatment or procedure because it conflicts with the physician’s religious or moral beliefs?” At the date of this memo, 67% of the respondents (15,128) had responded “yes” and 33% (7,330) had responded “no”.

There has been some media attention to the issue and some quite strongly expressed views from different perspectives.

4. The work of the Conscientious Objections Working Group

I was part of a group that was formed with a grant to study and provide recommendations to Canadian Colleges of Physicians and Surgeons on the issue of physicians who have a conscientious objection to providing certain forms of medical care. The recommendations from the group are attached to this memo.

5. Discussion at the Western Registrars’ Meeting

The issue of conscientious objection was discussed at the most recent Western Registrars’ meeting attended by representatives of the Colleges of B.C., Alberta, Saskatchewan, Manitoba and Ontario.

I suggested that each of the Colleges consider whether the recommendations in the report of the conscientious objections working group are appropriate, and if so, to consider implementing them. I understood each College agreed to consider doing that.

My perspective is that if there can be a consistent position across Canada, it will greatly help in addressing this difficult issue, which many people feel very strongly about.

As a member of the conscientious objections working group which developed the recommendations I am not unbiased. However, I think that a document which generally follows what is in the document would be useful to establish expectations for physicians and guidance to the College when it deals with physicians who have ethical or moral objections to providing certain forms of care.

6. Attached documents

- 1) Draft policy statement developed by the Conscientious Objections Working Group which recommended Colleges adopt the draft policy (page 5)
- 2) Letter which I sent to Registrars of Canadian Colleges relating to the work of the Conscientious Objections Working Group, without the attached draft policy in paragraph 1) above (page 8)
- 3) Ontario's current policy *Physicians and the Ontario Human Rights Code* (page 10)
- 4) Alberta's Standard *Moral or Religious Beliefs Affecting Medical Care* (page 14)
- 5) Manitoba's standard *Members Moral or Religious Beliefs Not to Affect Medical Care* (page 15)
- 6) Saskatchewan College Document - *Guideline: Unplanned Pregnancy* (page 16)
- 7) Star Phoenix article addressing the Ontario consultation (page 19)
- 8) Article printed in the journal *Family Medicine* in 2011, *Conscientious Refusal in Family Medicine Residency Training* by Jennifer E. Frank, MD (page 21)

DRAFT

Policy Statement - Conscientious Refusal

This document is a policy of the College of Physicians and Surgeons of [location] and reflects the position of the College. It is expected that all members of the College will comply with it. Failure to do so will render members subject to College investigation and may result in disciplinary action being taken against them.

1. Purpose

This policy seeks to provide clear guidance to physicians and the public about the right of physicians to act in accordance with their conscience as well as obligations they have that may conflict with this right and concern the provision of health information, referrals, and health services. This policy also outlines a process for the public to make complaints against physicians who fail to meet these obligations.

2. Scope

This policy applies to all situations in which physicians are providing, or holding themselves out to be providing, health services.

3. Definitions

Freedom of conscience: for purposes of this policy, actions or thoughts that reflect one's deeply held and considered moral or religious beliefs.

Lawful excuse: a reason provided by law that relieves a person of a duty (e.g., physicians have a lawful excuse not to treat a patient who requests a procedure that will not achieve the goal that the patient seeks).

4. Principles

The College of Physicians and Surgeons has an obligation to serve and protect the public interest.

The Canadian medical profession as a whole has an obligation to ensure that people have access to the provision of legally permissible and publicly-funded health services.

Physicians have an obligation not to interfere with or obstruct people's access to legally permissible and publicly-funded health services.

Physicians have an obligation to provide health information, referrals, and health services to their patients in a non-discriminatory fashion.

Physicians have an obligation not to abandon their patients.

Physicians' freedom of conscience should be respected.

It is recognized that these obligations and freedoms can come into conflict. This policy establishes what the College expects physicians to do in the face of such conflict.

5. Obligations

5.1 Taking on new patients

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

- a. age;
- b. race, national/ethnic/Aboriginal origin, colour;
- c. sex, gender identity, or gender expression;
- d. religion or creed;
- e. family or marital status;
- f. sexual orientation;
- g. physical or mental disability;
- h. medical condition;
- i. socioeconomic status;
- j. engaging in activities perceived to contribute to ill health (e.g., smoking, drug or alcohol abuse); or
- k. requesting or refusing any particular publicly-funded health service.

The above obligation does not prevent physicians from making *bona fide* decisions, or exercising professional judgment, in relation to their own clinical competence. Physicians are always expected to practice medicine in keeping with their level of clinical competence to ensure that they safely deliver quality health care. If physicians genuinely feel on grounds of clinical incompetence that they cannot accept someone as a patient because they cannot appropriately meet that person's health care needs, then they should not do so and should explain to the person why they cannot do so.

The above obligation does not prevent physicians from making *bona fide* decisions to develop a specialist practice.

Where physicians know in advance that they will not provide specific services, but will provide only referrals (in accordance with s. 5.3), they must communicate this fact as early as possible and preferably in advance of the first appointment with an individual who wants to become their patient.

5.2 Providing information to patients

Physicians must provide their patients with the health information required to make legally valid, informed choices about medical treatment (e.g., diagnosis, prognosis, and treatment options, including the option of no treatment or treatment other than that recommended by the physician), even if the provision of such information conflicts with the physician's deeply held and considered moral or religious beliefs.

Physicians must not provide false, misleading, intentionally confusing, coercive, or materially incomplete information to their patients.

All information must be communicated by the physician in a way that is likely to be understood by the patient.

While informing a patient, physicians must not communicate or otherwise behave in a manner that is demeaning to the patient or to the patient's beliefs, lifestyle, choices, or values.

The obligation to inform patients may be met by delegating the informing process to another competent individual for whom the physician is responsible.

5.3 Providing referrals for health services

Physicians can decline to provide legally permissible and publicly-funded health services if providing those services violates their freedom of conscience. However, in such situations, they must make a referral to another health care provider who is willing and able to accept the patient and provide the service.

This obligation does not prevent physicians from refusing to refer patients where there exists a recognized lawful excuse (see s. 3).

While discussing a referral with a patient, physicians must not communicate, or otherwise behave in a manner that is demeaning to the patient or to the patient's beliefs, lifestyle, choices, or values.

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

5.4 Treating patients

When a referral to another health care provider is not possible without causing a delay that would jeopardize the patient's health or well-being, physicians must provide the patient with all health services that are legally permissible and publicly-funded and that are consented to by the patient or, in the case of an incompetent patient, by the patient's substitute decision-maker. This obligation holds even in circumstances where the provision of health services conflicts with physicians' deeply held and considered moral or religious beliefs.

This obligation does not prevent physicians from refusing to treat a patient where there exists a recognized lawful excuse (see s. 3).

6. Complaints Process

Upon notification of a complaint under this Policy (see Form 2 [to be developed]), the College will investigate, prosecute, and remedy breaches of the obligations set out in this Policy.

7. Penalties

Failure to meet the obligations set out in this policy constitutes professional misconduct. Physicians who violate this policy will be subject to discipline by the College.

I was a member of a group which met last year to address issues of conscientious objection in health care. There were four representatives from Colleges of Physicians and Surgeons - Andréa Foti from the Ontario College, Gus Grant from the Nova Scotia College, me, and a person whose name I did not record from the Collège des Médecins du Québec. There were representatives from the faculties of law, medicine and philosophy from academia and other invited individuals. It was funded through a research grant.

The goal of the group was to develop a policy that could be adopted by Canadian Colleges of Physicians and Surgeons to guide physicians who have a conscientious objection to providing certain forms of health care. While that is most frequently experienced in issues pertaining to reproduction i.e. birth control, abortion and emergency contraception, it can arise in a number of other situations as well, such as provision of blood products and end of life care.

At the recent Western Registrar's meeting the attendees appeared to have reached a consensus that the document developed by the working group, attached to this letter, should be considered for possible adoption by Canadian Colleges of Physicians and Surgeons.

Physician-assisted suicide, in particular, has the potential to challenge Colleges of Physicians and Surgeons to provide guidance to its members. I think that it will be much better for the Colleges and the physician members if the Colleges are prepared for the issue. If no policy is in place, and either the legislation in Quebec dealing with assisted suicide comes into effect, or the Supreme Court of Canada strikes down the prohibition against assisted suicide in the **Taylor** case, there will be an expectation that Colleges provide guidance to their members. The situation could have to be addressed on an urgent basis if there is no policy in place at the time.

I think it will be very helpful if all Colleges are able to adopt the same or a very similar document. My perspective is that the topic has the potential to be very controversial. My perspective is that ethical standards for medical practice should be very similar across Canada and that it should be possible for all of the Canadian Colleges to adopt a common approach. Any College that is an outlier, either because it has adopted a different position than other Colleges, or because it has not developed a policy, will potentially be placed in a difficult position.

The attached policy will be discussed by the Council of the College of Physicians and Surgeons of Saskatchewan at its upcoming meeting. The Council will be asked to consider adopting the policy in its current, or modified, form to guide physicians. I hope that a similar discussion will occur with all of the other Colleges.

If any College identifies what it perceives to be a deficiency in the document, dissemination of that perspective would be useful.

At the Western Registrar's meeting, there appeared to be a general consensus that the document was generally appropriate. There were two suggestions raised by attendees.

Firstly, one attendee suggested that it may be useful to include in the guidance document a statement that the physician can advise the patient that he or she has an ethical or religious

objection to providing a service to a patient or providing information about a service to a patient, but should not engage in a further discussion about what the physician's beliefs are that would interfere with providing that service or information.

Secondly, another attendee suggested that the document would better reflect the *Code of Ethics* if the obligation to inform patients was stated in positive terms rather than in negative terms. Currently the document states the following in section 5.2:

Physicians must provide their patients with the health information required to make legally valid, informed choices about medical treatment (e.g., diagnosis, prognosis, and treatment options, including the option of no treatment or treatment other than that recommended by the physician), even if the provision of such information conflicts with the physician's deeply held and considered moral or religious beliefs.

Physicians must not provide false, misleading, intentionally confusing, coercive, or materially incomplete information to their patients.

The *Code of Ethics* has two paragraphs of relevance:

21. *Provide your patients with the information they need to make informed decisions about their medical care, and answer their questions to the best of your ability.*
45. *Recognize a responsibility to give the generally held opinions of the profession when interpreting scientific knowledge to the public; when presenting an opinion that is contrary to the generally held opinion of the profession, so indicate.*

I would be interested in the perspective of the various Colleges whether, if the document was to be accepted as a guidance document for physicians it would be better stated if it was partially in positive terms which could state something like the following:

Information provided to patients must be accurate and unbiased. It should not be false, misleading, intentionally confusing, coercive, or materially incomplete."

I hope that this letter will begin a dialogue which will result in a similar guidance document being adopted by each College that addresses the issue of the obligations of physicians who have a moral, ethical or religious objection to providing certain forms of medical services or providing information about certain forms of medical services.

Sincerely yours,



Bryan E. Salte, B.Ed., LL.B.
Associate Registrar



Physicians and the Ontario *Human Rights Code*

APPROVED BY COUNCIL:	September 2008
PUBLICATION DATE:	December 2008
TO BE REVIEWED BY:	September 2013
KEY WORDS:	Discrimination, Moral or religious beliefs, Accommodation of disability
RELATED TOPICS:	Ending the Physician-Patient Relationship policy; The Practice Guide.
REFERENCE MATERIALS:	Ontario Human Rights Commission, <i>Policy and Guidelines on Disability and the Duty to Accommodate</i> ; Ontario Human Rights Commission, <i>Accommodating Persons with Disabilities</i> ; Ontario Human Rights Commission, <i>How Far Does the Duty to Accommodate Go?</i> ; Ontario Human Rights Commission, <i>Guide to the Human Rights Code</i> ; Canadian Medical Association, <i>Code of Ethics</i> .
LEGISLATIVE REFERENCES:	<i>Human Rights Code</i> , R.S.O. 1990, c.H.19.
COLLEGE CONTACT:	Physician Advisory Service

Physicians and the Ontario *Human Rights Code*

INTRODUCTION

Ontario's *Human Rights Code*¹ (the *Code*) articulates the right of every Ontario resident to receive equal treatment with respect to goods, services and facilities without discrimination based on a number of grounds, including race, age, colour, sex, sexual orientation, and disability.² This imposes a duty on all those who provide services in Ontario – which includes physicians providing medical services – to provide these services free from discrimination.

PURPOSE

The goal of this policy is to help physicians understand the scope of their obligations under the *Code* and to set out the College's expectation that physicians will respect the fundamental rights of those who seek their medical services.

SCOPE

This policy is applicable to all situations in which physicians are providing medical services.

POLICY

Physicians must comply with the *Code* when making any decision relating to the provision of medical services. This includes decisions to accept or refuse individuals as patients, decisions about providing treatment or granting referrals to existing patients, and decisions to end a physician-patient relationship.

While the College does not have the expertise or the authority to make complex, new determinations of human rights law, physicians should be aware that the College is obliged to consider the *Code* when determining whether physician conduct is consistent with the expectations of the profession. Compliance with the *Code* is one factor the College will consider when evaluating physician conduct.

This policy is divided into two sections, each of which addresses physicians' obligations under the *Code*. The first addresses physicians' obligations to provide medical services without discrimination. The second addresses physicians' obligations to accommodate the disabilities of patients or individuals who wish to become patients.

1. Providing medical services without discrimination

The *Code* requires that physicians provide medical services without discrimination.

This means that physicians cannot make decisions about

whether to accept individuals as patients, whether to provide existing patients with medical care or services, or whether to end a physician-patient relationship on the basis of the individual's or patient's race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, family status and/or disability.³

This does not prevent physicians from making decisions or exercising professional judgment in relation to their own clinical competence. Physicians are always expected to practice medicine in keeping with their level of clinical competence to ensure they provide patients with quality health care in a safe manner. If physicians feel they cannot appropriately meet the health care needs of a patient or an individual who wishes to become a patient, they are not required to accept that person as a patient or to continue to act as that patient's physician, provided they comply with other College policies in so doing.⁴

Guidelines

Although the Human Rights Commission and Tribunal have primary responsibility for interpreting and adjudicating human rights matters, the following guidance is intended to assist physicians in determining how to comply with the requirements of the *Code*. Physicians may also wish to seek guidance from a lawyer or the Canadian Medical Protective Association (CMPA).

i) Clinical Competence

As stated above, the duty to refrain from discrimination does not prevent physicians from making decisions in the course of practicing medicine that are related to their own clinical competence.

Where a physician is not able to accept an individual as a patient, provide a patient with treatment, or must end a physician-patient relationship for reasons related to his or her own clinical competence, the College offers the following as guidance.

Consider the Possibility of Referral

As a first step, physicians are encouraged to consider whether individuals or patients could be referred to other physicians for the elements of care that the physician is unable to manage directly.

Consult College Policies

If physicians decide that referral is not an option, and that they must end a physician-patient relationship for reasons

1 R.S.O. 1990, c.H.19.

2 Section 1 of the *Human Rights Code*, R.S.O. 1990, c. H.19 states, Every person has a right to equal treatment with respect to services, goods and facilities, without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, family status or disability. The Ontario Human Rights Commission's position is that the obligation not to discriminate on the basis of 'sex' includes an obligation not to discriminate on the basis of pregnancy, breastfeeding and gender identity.

3 *Human Rights Code*, R.S.O. 1990, c.H.19, section 1. This legal obligation is reflected in guidance contained in the Canadian Medical Association's *Code of Ethics*, paragraph 17.

4 See CPSO's policy *Ending the Physician-Patient Relationship*, and *The Practice Guide*.



related to clinical competence, they are expected to act in accordance with College expectations as set out in the *Ending the Physician-Patient Relationship* policy.

Clear Communication

The College expects physicians to communicate decisions they make to end a physician-patient relationship, refrain from providing a specific procedure, or to decline to accept an individual as a patient, and the reasons for the decision in a clear, straightforward manner. Doing so will allow physicians to explain the reason for their decision accurately, and thereby avoid misunderstandings.

Where a physician's clinical competence may restrict the type of patients the physician is able to accept, physicians should communicate these restrictions as soon as is reasonable. This will enable individuals to have a clear understanding as to whether the physician will be able to accept them as a patient, or whether it will be in their best interests to try to find another physician.

Where a physician's clinical competence may restrict the type of services or treatment he or she can provide, the physician should inform patients of any limitations related to clinical competence as soon as it is relevant. That is, the physician should advise the patient as soon as the physician knows the patient has a condition that he or she is not able to manage.

ii) Moral or Religious Beliefs

If physicians have moral or religious beliefs which affect or may affect the provision of medical services, the College advises physicians to proceed cautiously with an understanding of the implications related to human rights.

Personal beliefs and values and cultural and religious practices are central to the lives of physicians and their patients.

Physicians should, however, be aware that the Ontario Human Rights Commission or Tribunal may consider decisions to restrict medical services offered, to accept individuals as patients or to end physician-patient relationships that are based on physicians' moral or religious beliefs to be contrary to the *Code*.

Ontario Human Rights Code: Current Law

Within the *Code*, there is no defence for refusing to provide a service on the basis of one of the prohibited grounds. This

means that a physician who refuses to provide a service or refuses to accept an individual as a patient on the basis of a prohibited ground such as sex or sexual orientation *may* be acting contrary to the *Code*, even if the refusal is based on the physician's moral or religious belief.⁵

The law in this area is unclear, and as such, the College is unable to advise physicians how the Commission, Tribunal or Courts will decide cases where they must balance the rights of physicians with those of their patients.

There are some general principles, however, that Courts have articulated when considering cases where equality rights clash with the freedom of conscience and religion.⁶ They are as follows:

- There is no hierarchy of rights in the *Charter*; freedom of religion and conscience, and equality rights are of equal importance;⁷
- Freedom to exercise genuine religious belief does not include the right to interfere with the rights of others;⁸
- Neither the freedom of religion nor the guarantee against discrimination are absolute. The proper place to draw the line is generally between belief and conduct. The freedom to hold beliefs is broader than the freedom to act on them.⁹
- The right to freedom of religion is not unlimited; it is subject to such limitations as are necessary to protect public safety, order, health, morals, or the fundamental rights or freedoms of others;¹⁰
- The balancing of rights must be done in context. In relation to freedom of religion specifically, Courts will consider how directly the act in question interferes with a core religious belief. Courts will seek to determine whether the act interferes with the religious belief in a 'manner that is more than trivial or insubstantial.'¹¹ The more indirect the impact on a religious belief, the more likely Courts are to find that the freedom of religion should be limited.¹²

These principles appear to be generally applicable to circumstances in which a physician's religious beliefs conflict with a patient's need or desire for medical procedures or treatments. They are offered here to provide physicians with an indication of what principles may inform the decisions of Courts and Tribunals.

5 This could occur if the physician's decision to refuse to provide a service, though motivated by religious belief, has the effect of denying an individual access to medical services on one of the protected grounds. For example, a physician who is opposed to same sex procreation for religious reasons and therefore refuses to refer a homosexual couple for fertility treatment may be in breach of the *Code*.

6 *Canadian Charter of Rights and Freedoms*, Schedule B, *Canada Act 1982* (U.K.) 1982, c. 11, section 2(a).

7 *EGALE Canada Inc. v. Canada (Attorney General)* (2003), 13 B.C.L.R. (4th) 1 (B.C.C.A.), at paragraph 133.

8 *Trinity Western University v. British Columbia College of Teachers*, [2001] 1 S.C.R. 772 at p.33.

9 *Trinity Western University v. British Columbia College of Teachers*, [2001] 1 S.C.R. 772 headnote, and at para.36.

10 *R. v. Big M Drug Mart Ltd.*, [1985] 1 S.C.R. 295, at p 336-7; *Ross v. School District no. 15*, [1996] 1 S.C.R. 825 at p.868.

11 *Syndicat Northcrest v. Amselem*, [2004] 2 S.C.R. 551, at paragraphs 59-60.

12 *Ross v. School District no. 15*, [1996] 1 S.C.R. 825; In *Syndicat Northcrest v. Amselem*, [2004] 3 S.C.R. 698, the Court said that the religious belief must be interfered with in a manner that is more than trivial or insubstantial. (at paragraphs 59, 60)

PHYSICIANS AND THE ONTARIO *HUMAN RIGHTS CODE*

College Expectations

The College has its own expectations for physicians who limit their practice, refuse to accept individuals as patients, or end a physician-patient relationship on the basis of moral or religious belief.

In these situations, the College expects physicians to do the following:¹³

- Communicate clearly and promptly about any treatments or procedures the physician chooses not to provide because of his or her moral or religious beliefs.
- Provide information about all clinical options that may be available or appropriate based on the patient's clinical needs or concerns. Physicians must not withhold information about the existence of a procedure or treatment because providing that procedure or giving advice about it conflicts with their religious or moral beliefs.
- Treat patients or individuals who wish to become patients with respect when they are seeking or requiring the treatment or procedure. This means that physicians should not express personal judgments about the beliefs, lifestyle, identity or characteristics of a patient or an individual who wishes to become a patient. This also means that physicians should not promote their own religious beliefs when interacting with patients, nor should they seek to convert existing patients or individuals who wish to become patients to their own religion.
- Advise patients or individuals who wish to become patients that they can see another physician with whom they can discuss their situation and in some circumstances, help the patient or individual make arrangements to do so.

The College will consider the extent to which a physician has complied with this guidance, when evaluating whether the physician's behaviour constitutes professional misconduct.

2. Accommodation of disability

Legal Duty under the *Code*

Under the *Code*, the legal obligation not to discriminate includes a duty to accommodate short of undue hardship. The duty to accommodate is not limited to disability,¹⁴ however, the information provided in this section will focus on accommodation of disability only.

When physicians become aware that existing patients or individuals who wish to become patients have a disability which may impede or limit access to medical services, the *Code* requires physicians to take steps to accommodate the needs of these patients or individuals. The purpose in doing so is to eliminate or reduce any barriers or obstacles that disabled persons may experience.

While physicians have a legal duty to accommodate disability, there are limits to this duty. Physicians do not have to provide accommodation that will cause them undue hardship.¹⁵ Further explanation of 'undue hardship' is provided in the Human Rights Commission's *Policy and Guidelines on Disability and the Duty to Accommodate*.¹⁶

Guidelines for Accommodation of Disability

Guidance on the specific steps that may be required to fulfil the duty to accommodate disability can be found in the Ontario Human Rights Commission's *Policy and Guidelines on Disability and the Duty to Accommodate* (section 3.4).

There is no set formula for accommodating the needs of persons with disabilities.

Accommodation of persons with disabilities should be provided in a manner that is respectful of the dignity, autonomy and privacy of the person, if to do so does not create undue hardship.¹⁷

Physicians are advised to approach situations where accommodation is required on a case-by-case basis, and to tailor the nature of the accommodation to the needs of the individual before them.

Examples of accommodation may include taking steps to ensure that a guide dog can be brought into an examination room, or that patients are permitted to have a sign language interpreter present during a physician-patient encounter.

¹³ These points are consistent with the guidance provided by the General Medical Council in its document, *Personal Beliefs and Medical Practice*.

¹⁴ The Ontario Human Rights Commission has stated that the duty to accommodate could arise in relation to other enumerated or protected grounds in the *Code*.

¹⁵ *Human Rights Code*, R.S.O. 1990, c.H.19, section 17(2).

¹⁶ *Policy and Guidelines on Disability and the Duty to Accommodate*, Ontario Human Rights Commission, November 2000.

¹⁷ *Policy and Guidelines on Disability and the Duty to Accommodate*, Ontario Human Rights Commission, November 2000 (pp. 12, 13).



Moral or Religious Beliefs Affecting Medical Care Standard 29

Reissued: April 3, 2014¹

Standards of Practice of the College of Physicians & Surgeons of Alberta are the minimum standards of professional behavior and ethical conduct expected of all physicians registered in Alberta. Standards of Practice are enforceable under the *Health Professions Act* and will be referenced in the management of complaints and in discipline hearings. The College of Physicians & Surgeons of Alberta also provides **Advice to the Profession** to support the implementation of the Standards of Practice.

- (1) A physician must communicate clearly and promptly about any treatments or procedures the physician chooses not to provide because of his or her moral or religious beliefs.
- (2) A physician must not withhold information about the existence of a procedure or treatment because providing that procedure or giving advice about it conflicts with their moral or religious beliefs.
- (3) A physician must not promote their own moral or religious beliefs when interacting with patients.
- (4) When moral or religious beliefs prevent a physician from providing or offering access to information about a legally available medical or surgical treatment or service, that physician must ensure that the patient who seeks such advice or medical care is offered timely access to another physician or resource that will provide accurate information about all available medical options.

¹Replaces *Moral or Religious Beliefs Affecting Medical Care, Standard 27*, reissued January 9, 2014 (standard number change only)

Terms used in the Standards of Practice:

- *Physician* means any person who is registered or who is required to be registered as a member of this College. The College regulates physicians, surgeons and osteopaths.
- *Must* refers to a mandatory requirement.
- *May* means that the physician may exercise reasonable discretion.
- *Patient* includes, where applicable, the patient's legal guardian or substitute decision maker.



Effective May 1, 2014

STATEMENT

No. 181

Members Moral or Religious Beliefs Not to Affect Medical Care

1. A member must communicate clearly and promptly to a patient or prospective patient about any treatment or procedure that the member chooses not to provide because of his or her moral or religious beliefs.
2. A member must not withhold information about the existence of a procedure or treatment even if providing that procedure or treatment or giving advice about them conflicts with his or her moral or religious beliefs.
3. A member must not promote his or her own moral or religious beliefs when interacting with a patient.
4. If the moral or religious beliefs of a member prevent him or her from providing or offering access to information about a legally available medical treatment or procedure, the member must ensure that the patient who seeks that advice or medical care is offered timely access to another member or resource that will provide accurate information about all available medical options.

A statement is a formal position of the College with which members shall comply.



GUIDELINE: UNPLANNED PREGNANCY

An unplanned pregnancy is not necessarily an unwanted pregnancy.

Any physician who is unable to be involved in the further care and management of any patient when termination of the pregnancy might be contemplated should inform the patient and make an expeditious referral to another available physician.

In accepting responsibility for medically evaluating and counseling a patient in circumstances in which termination of the pregnancy might be contemplated, the responsible physician:

- 1) Will obtain a complete medical history, including inquiry as to the probability of sexual assault, and perform requisite examinations and investigations to:
 - a) Confirm the pregnancy.
 - b) Establish an accurate estimation of gestation based upon history, physical findings and when appropriate, ancillary investigations such as diagnostic ultrasound.
 - c) Identify abnormal findings related to the pregnancy or other concomitant pathology which might be relevant to the making of an informed decision to continue or to terminate the pregnancy.
 - d) Determine the Rh factor so that Rh Immunoglobulin may be given when appropriate.
 - e) Any other investigations as deemed necessary by the history.

- 2) Will advise the patient fully of all the findings derived from the history, physical exam and investigations and explain to the patient the medical significance of the findings. Such explanation ought to include sufficient information to assure that the patient has a reasonable understanding of the stage of fetal development which is consistent with her current gestational age at which the pregnancy might be terminated.

- 3) Will provide or arrange for, genetic counseling where medically indicated.

- 4) Will explore with the patient her response to the findings of 1), 2) and 3) above, and record this response in the patient's medical file.

- 5) Will fully apprise the patient of the options she may pursue and provide her with accurate information relating to community agencies and services that may be of assistance to her in pursuing each option.
 - a) With reference to the option of carrying the pregnancy to term, with plans to keep the child, the physician should apprise the patient of assistance that may be available through the Department of Social Services or other community-based support groups. If requested to do so, the physician should assist the patient in establishing contact with such groups.
 - b) With reference to the option of carrying the pregnancy to term, with plans to give up the child for adoption, the physician should arrange for early referral of the patient to the Department of Social Services and other government approved agencies to counsel and arrange for a variety of different types of adoption agencies.
 - c) With reference to the option of termination of the pregnancy, the physician should apprise the patient of the availability of abortion services in the province, or elsewhere, in accordance with any current law or regulation governing such services, and should ensure that the patient has the information needed to access such services or make the necessary referral. The patient should be provided the information regarding the nature of termination options, to the best of the physician's ability.
- 6) All physicians performing abortions are to take appropriate steps to ensure that the patient has been provided with information about all options, and ensure that the decision for termination of the pregnancy was made on the basis of informed consent. Informed consent requires that the patient be provided with reasonably detailed information regarding:
 - i) the precise nature of the intervention that is to be undertaken, and
 - ii) the manner in which the intervention will be conducted, and,
 - iii) the known immediate risks (i.e. uterine perforation, infection, hemorrhage) associated with the intervention and the known incidence of risks, and
 - iv) the known long-term risks (impact on future fertility, incidence of future spontaneous abortions, ectopic pregnancy and premature birth) and the known incidence of such risks, and
 - v) the known psychological risks, and
 - vi) the follow-up care plan, to include possible complications, contraception options and clear directions as to follow up with a physician.
- 7) The physician who performs the abortion, should be skilled, not only in the initiation of the abortion, but also in the recognition of incomplete and failed procedures, as well as complications such as uterine perforation, hemorrhage, infection and cervical laceration, and refer the patient as deemed necessary.
- 8) All termination of pregnancies should be performed in accredited facilities.

- 9) Regardless of which option the patient elects, the physician has a professional obligation to explore the patient's understanding of contraception options and to provide her with appropriate information and counseling which might reduce the risk of future unplanned or unwanted pregnancies.

- 10) Should there be difficulties in determining the maturity or capacity of the patient, the physician should use any other available resources such as the CPSS, CMPA, etc. to help in that respect.

Adopted by Council May 1991
Amended Feb 2011
To be Reviewed Feb 2014

Poll supports moral choice for doctors

Issue of refusing treatment

BY SHARON KIRKEY, POSTMEDIA NEWS JULY 24, 2014



An online poll conducted by the College of Physicians and Surgeons found 56 per cent of 14,000 respondents supported a doctor's right to refuse to provide treatment if it conflicts with
Photograph by: Adam Berry, Getty Images, Postmedia News

A slight majority of Canadians believe doctors should have the right to deny a patient a medical treatment based on moral or religious beliefs, the nation's biggest medical licensing authority is discovering.

More than 14,000 individuals have responded so far to an online poll conducted by the College of Physicians and Surgeons of Ontario as part of a review of its policy on doctors and Ontario's human rights code.

The unscientific "quick poll," open to the public and members of the profession, asks whether physicians "should be allowed to refuse to provide a patient with a treatment or procedure because it conflicts with the physician's religious or moral beliefs."

As of Wednesday, 14,207 individuals had voted. Of those, 56 per cent support allowing doctors to restrict medical care based on their personal beliefs while 43 per cent are opposed. One per cent said they "don't know." The college has received 742 comments as well on the discussion forum, and is inviting public feedback until Aug. 5 on its website (cpso.on.ca).

"This is clearly an issue of relevance to both the public and members of the profession," said college spokeswoman Kathryn Clarke, who called the amount of feedback "exceptional." The college last year began promoting its public consultations using Twitter and Facebook, in addition to its website and Dialogue magazine.

But the debate has also been stoked by recent headlines involving doctors in two major Canadian cities denying medical care based on religious grounds.

Last month, the Calgary Herald reported that a doctor working at a walk-in clinic was refusing to prescribe contraception due to her personal beliefs. A sign in the window at the Westglen Medical Centre informed patients that "the physician on duty today will not prescribe the birth control pill." Patients looking for the pill were instead provided with a list of other clinics willing to prescribe it.

In January, the Ottawa Citizen reported that three family doctors were refusing to provide birth control pills, or any form of artificial contraception, including the "morning after" pill, saying in letters to patients that doing so conflicts with their "medical judgment, professional ethical concerns and religious values."

On the College's discussion page, one member of the public wrote, "If I come to you for medical care, I expect to get the scientifically determined best care for my condition. If you can't or won't provide it because of your beliefs, find a new job."

One physician said he would never ask a patient "to act against her own conscience when making difficult choices about treatment. Who do you think you are to make me, because I have chosen a profession in the service of others, act against mine?" The College's current policy, approved in 2008, sets out a doctor's legal obligations under the Code as well as the college's expectations "that physicians will respect the fundamental rights of those who seek their medical services."

When it comes to moral or religious beliefs, the policy advises doctors to "proceed cautiously," warning that restricting medical services based on moral or religious beliefs may be "contrary to the Code."

Canadian ethicist Arthur Schafer said doctors and other health-care providers should be allowed to exercise "conscientious objection."

"They don't have to perform services that they think are unethical or that violate their sense of what the will of God is, if they're religious. But that's not an absolute right," said Schafer, director of the University of Manitoba's Centre for Professional and Applied Ethics.

What trumps that right are the life and health of the patient, he said. "That means that if you are the only physician in a remote, rural or northern area, and your refusal to provide a service will mean that the service will effectively not be available to them, you can't refuse."

In addition, he said a doctor who announces on a sign in his or her office a religious objection to the birth control pills isn't just refusing to provide a patient with a prescription they might get from another clinic across the street.

"She's saying, 'I have certain religious scruples and I don't believe in sex outside marriage and I don't believe in artificial birth control because my church teaches that it's wicked.'"

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Conscientious Refusal in Family Medicine Residency Training

Jennifer E. Frank, MD

BACKGROUND AND OBJECTIVES: Conscientious refusal among physicians to provide medical care is known to exist. The prevalence of conscientious refusal in residents and behaviors surrounding moral objections is largely unknown. The purpose of this study was to identify the prevalence of moral objections among family medicine residents and faculty members and to identify beliefs and actions surrounding conscientious refusal.

METHODS: A Web-based survey was e-mailed to residents and faculty in six family medicine residency programs. Those respondents identifying a moral objection were asked about their beliefs and practices regarding disclosure and referral.

RESULTS: A total of 154 physicians responded (44.9% response rate). The majority reported a moral objection to at least one procedure with abortion for gender selection eliciting the largest number of moral objections (79.2%). Of the 14 procedures identified, at least four respondents (2.6%) reported an objection. The majority believed that a physician with a moral objection has a duty to disclose his or her objection to colleagues, but the majority had not done so. Resident and faculty physicians were generally felt to have the same right to refuse. Fifty-five percent of all respondents reported having participated in morally objectionable care based on medical futility.

CONCLUSIONS: This study is the first to demonstrate the prevalence of moral objection to legally available medical procedures among family medicine residents and faculty. The survey responses demonstrate that conscientious objection exists and that there is support for physicians exercising moral objection in clinical practice, provided they engage in appropriate patient education and referral.

(Fam Med 2011;43(5):330-3.)

Conscientious objection, a term most closely associated with opposition to war, exists among health care professionals. Several widely publicized cases in which a physician or pharmacist refused to dispense a medication or perform a procedure for reasons of conscience have brought the issue to national prominence.^{1,2} While conscientious objection in medicine is

known to be present, what occurs in the interaction between a physician and patient at the moment a conflict of conscience arises is unknown. Behaviors surrounding conscientious refusal are largely unknown with anecdotal descriptions being the norm, usually in the context of a legal case.

Curlin et al conducted a nationwide survey of a random, stratified

sample of US physicians on attitudes and beliefs regarding religious beliefs and conscientious objection.³ Physicians were predominately male (74%), Caucasian (78%), and came from diverse geographical locations, practice types, and medical and surgical subspecialties. The majority (63%) scored moderate or high on a scale of intrinsic religiosity, with 50% of respondents identifying a Christian affiliation, 16% identifying a Jewish affiliation, 10% identifying no religious affiliation, and the remainder identifying another type of religious affiliation. Fifty-two percent of the physicians surveyed objected to abortion for failed contraception, 42% objected to prescribing birth control to adolescents without parental consent, and 17% objected to terminal sedation. Physicians in this survey were also queried about opinions regarding behaviors when a physician has a conscientious objection. Sixty-three percent of respondents believed it is ethical for the physician to describe his or her objection; 86% believed that the physician has an obligation to provide all the information about the requested procedure, and 71% believed the physician has an obligation to refer for the procedure.

A second survey of a random sample of primary care physicians was conducted by Lawrence and Curlin.⁴

From the Department of Family Medicine, University of Wisconsin

In this study, 61% of respondents were male, 44% were Asian, and 44% were Caucasian; they were fairly equally distributed among ages with a range of 26–60 years old, and 26% were family physicians, with the remaining 74% specializing in internal medicine. Interestingly, while 78% of respondents agreed that a physician should never do something he or she considered to be morally wrong, 57% agreed that physicians have an obligation to provide services to which they may morally object.⁴ When objections to legal medical procedures were identified, the majority of physicians did not believe they have an obligation to perform the procedure, but the majority did believe they have an obligation to refer. Sixty-eight percent of physicians objected to physician-assisted suicide, 44% objected to abortion for failed contraception, and 44% objected to abortion if the fetus had Down syndrome.

Residency training is a unique practice environment. A power differential exists between faculty and resident physicians potentially impacting a resident physician's comfort with or ability to articulate a moral opposition to a controversial practice. Practice attitudes and professional roles are still being developed by residents who are in what has been termed a "professional adolescence." Additionally, resident physicians are required to receive training in a specified group of patient care scenarios and medical procedures, which may make conscientious refusal difficult to reconcile with training requirements.

Research into conscientious objection in residency training is limited. Lazarus⁵ described the environment in an obstetrics and gynecology residency program surrounding the performance of or refusal to perform abortions. As has been described elsewhere,⁶ residents who declined to participate in abortions for moral reasons chose, in some cases, to extend their refusal to involvement in pre-procedure evaluation, ordering labs, or even interacting with the patient after the patient's intent to

obtain an abortion became known. Interestingly, only six of 20 residents and two of 24 faculty physicians elected to perform abortions in the residency program she describes.

Family medicine residency training provides a unique opportunity to explore the professional, legal, ethical, and practical issues surrounding conscientious objection. Family medicine is distinctive among specialties in encompassing nearly all controversial medical practices, including neonatal male circumcision, reproductive health, sexual medicine, end-of-life care, and transgender medicine. During residency training, resident physicians are both expected and required to practice full-scope family medicine, which includes comprehensive care of patients at all stages of life. While an attending family physician may select a practice that allows him or her to freely exercise his or her moral objections unencumbered, resident physicians do not enjoy the same freedom in choosing how they practice medicine. They are subject to attending oversight and required to participate in clinical activities in which they may be asked to provide a service to which they object. As trainees, their objections to medical procedures considered typical for a family physician to perform may interfere with an adequate training experience or may unfairly burden colleagues with increased workload. This paper reports results of a survey of attending and resident family physicians' beliefs about conscientious objection and practices when confronting this issue in their own clinical experience.

Methods

Sample

The University of Wisconsin Institutional Review Board determined that this research study was exempt from review. A quantitative study was conducted of resident and faculty physicians in the six family medicine residency programs in the University of Wisconsin Department of Family Medicine from June through

August 2008. A total of 343 resident and faculty physicians were invited to participate in an electronic Web-based survey. Three separate invitations were sent by e-mail to resident and faculty physicians with a link to the survey. Demographic information was not collected on study participants in an effort to preserve confidentiality among a relatively small group of physicians.

Survey Instrument

A Web-based survey (websurvey@UW) was used for the eight-item questionnaire. The Web-based survey was anonymous and voluntary, and all questions were optional to complete. The survey focused on prevalence of moral objection to 14 legally available medical procedures, practices, and prescriptions, behaviors and opinions regarding disclosure of moral objections, and beliefs regarding different requirements or allowances for resident physicians to exercise moral objection compared with attending physicians (survey available from corresponding author upon request). The survey questions were based in part on a previously published survey of physicians' beliefs regarding conscientious objection.³

Data Analysis

Descriptive frequency statistics were calculated on responses to each of the questions in the survey. Both absolute numbers of responses and percentages based on the total number of responses to each question were calculated.

Results

Survey Response Rate

A total of 154 respondents completed the survey, yielding an overall response rate of 44.9%. Survey respondents were not identified based on type of response, faculty or resident status, or any demographic data. Since no survey items required mandatory completion, not all questions received 154 responses. Survey questions received between 131 and 154 responses each.

Conscientious Objection to Specific Procedures

Each of the 14 procedures or prescriptions had at least four respondents (2.6%) who reported an objection. One procedure (performing or referring for an abortion for gender selection because of parental preference) solicited 122 respondents who identified a potential objection, representing 79.2% of total respondents. Aside from this one procedure, a minority of respondents (4–43, representing 2.6%–27.9%, respectively) identified an objection to the listed procedures and practices. Likewise, the majority of respondents identified “no objection” to 13 of 14 procedures and practices with a range from 91–147 respondents (59%–95.5%, respectively).

The respondents were also asked to identify whether residents should be allowed to refuse participation in these procedures and practices. With one exception, a larger number of respondents identified that a resident had a right to refuse than the number who volunteered a personal objection. Depending on the procedure, between 19 (12.3%) and 89 (57.8%) of respondents indicated a belief in the resident’s right to refuse, with performing an abortion for failed contraception generating the largest positive responses.

Behaviors Surrounding Conscientious Refusal

Twelve (13%) of the respondents who had at least one moral objection reported notifying their supervisor (medical director or program director) of their objection, with the majority (87%) reporting that they had not informed their supervisor of their objection. However, the majority of respondents (86.4%) believed that a physician with a moral objection was obligated to disclose the objection to practice colleagues. The majority of respondents with a moral objection (62/103 or 60.2%) did report having a plan to “inform, educate, and refer patients who request the objectionable procedure.”

Respondents were asked about their experience providing or refusing to provide care that they considered morally objectionable on the basis that the care was futile. Eighty-four of 147 respondents (57.1%) reported providing this type of care with 35/147 (23.8%) stating they had not done so. Twenty-eight (19%) reported never being in this specific clinical scenario. Twenty-seven of 151 (17.9%) respondents reported refusing to provide futile care on moral grounds with 91/151 never refusing (60.3%) and 33/151 (21.9%) never being in this clinical situation.

Obligation to Inform and Refer

The majority of respondents stated that a physician has an obligation to fully inform patients about (95.5%) and to refer patients for (90.2%) procedures to which he or she has a moral objection. Seventy percent of respondents felt that it is acceptable for a physician to explain the rationale behind his or her objection to the patient.

Clinical Scenario

Respondents were given a brief clinical scenario (Table 1). The majority of respondents (69.9%) reported that the attending and resident physician have the same right to refuse. Eighteen percent reported that the resident is more entitled to refuse, 5.9% reported the resident is less entitled to refuse, and 5.2% reported that neither physician has the right to refuse to perform the procedure.

Discussion

The majority of respondents report a moral objection to at least one legal medical procedure, although this is an outlier, with the majority of respondents reporting no objection to the remaining 13 procedures listed. This particular procedure (abortion for gender selection for parental preference) may elicit a strong emotional response among physicians who feel that it is an inappropriate reason for abortion. Each procedure listed elicited at the minimum four respondents with a potential objection, revealing that even common and widespread medical treatments and procedures (vasectomy, tubal ligation, treatment of sexual dysfunction in an unmarried person) are objectionable to a small minority of practicing physicians.

In general, there was support for resident refusal even among physicians who did not personally have an objection to a specified procedure or practice. This was further borne out in a hypothetical clinical scenario in which most survey respondents identified that a resident physician has an equal or stronger right to refuse than an attending physician. Despite the reliance on resident physicians to do much of the “front-line” work with patients and the recognition that broad training experiences are needed to become a competent family physician, resident and faculty family physicians do respect resident physicians’ ability to hold

Table 1: Hypothetical Scenario

Consider the following scenario. An attending physician and a second-year resident are rounding in the nursery on one of the residency program’s patients. One of the newborns is scheduled to have a circumcision performed that morning. The resident objects to neonatal circumcision on moral grounds and refuses to participate in the procedure.

- The resident is more entitled to refuse to participate in a morally objectionable procedure because his or her participation is not essential to the patient’s care.
- The resident is less entitled to refuse to participate in a morally objectionable procedure because he or she is a trainee.
- The resident has the same right to refuse to participate as the attending physician does because they are both physicians.
- Neither the resident nor the attending has the right to refuse to participate.
- Other, please specify

personal moral objections and to exercise their right to refuse.

In the presence of moral objections, disclosure to colleagues is seen as an obligation, but it is rarely done. More conversation around conscientious refusal needs to occur at all levels, including between learner and teacher, colleagues, and physicians and patients. Reasons for failure to disclose need to be elucidated to identify barriers. Given the prevalence of moral objections to legal medical procedures and prescriptions, medical students, residents, and faculty should discuss the ethics of conscientious refusal, methods for communication with peers, supervisors, and patients, and the requirement for legally and ethically sound plans of care.

Limitations

The response rate (44.9%) is one limitation of the survey since the majority of those invited to respond did not do so. This limits interpretation of the results and could indicate that those surveyed who had stronger beliefs (in one direction or the other) may have been more likely to respond. The results of this study are unique to the residents and faculty in the University of Wisconsin Department of Family Medicine and limit generalizability of the findings. No demographic data was obtained, making it impossible to determine if professional experience or current position is linked to beliefs or behaviors. It is also not possible to identify if specific characteristics (such as religious beliefs) are associated with moral objections as was identified previously.³

Since behaviors are self-reported, there may be bias inherent in the responses and error in recollection of clinical experiences. The complexity of the subject matter may also limit the respondents' ability to give a complete answer by requiring a yes or no response.

Conclusions

The appropriate response to the resident physician who voices a moral opposition to a controversial medical practice is still being defined. To promote ethical development in residency education, it is important to proceed through several steps. The first, which this study sought to address, is to define the prevalence of the issue. Clearly, if conscientious refusal is only a philosophical construct that does not play out in the interaction between a patient and physician, then it is not a high priority for resident education. If, however, moral objections to legal, medically appropriate, and available procedures, prescriptions, and practices does exist as demonstrated by this survey and others,^{3,4} it is imperative that an appropriate response is considered, debated, and finally defined.

Lazarus⁵ quantified the problem facing resident physicians and program directors who confront moral opposition. In her program, 17/20 residents volunteered that the policy regarding performing abortions was not stated when they interviewed for the program and that the policy should be clarified. Fifteen of the 20 residents desired further discussion on the ethical issues surrounding abortion policy.

While interesting, it is not sufficient to only define the issue. Further steps must explore how beliefs evolve into behaviors, how those behaviors play out in patient care, and how resident physicians can be educated to promote ethical behavior in the provision of care.

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CORRESPONDENCE: Address correspondence to Dr Frank, Theda Care Physicians, 1380 Tullar Road, Neenah, WI 54956. 920-727-3480. jennifer.frank@thedacare.org.

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POLICY - CONSCIENTIOUS REFUSAL

This document is a policy of the College of Physicians and Surgeons of Saskatchewan and reflects the position of the College.

1. Purpose

This policy seeks to provide clear guidance to physicians and the public about the obligations which physicians have to provide care to patients and how to balance those obligations with physicians' right to act in accordance with their conscience if they conflict.

2. Scope

This policy applies to all situations in which physicians are providing, or holding themselves out to be providing, health services.

3. Definitions

Freedom of conscience: for purposes of this policy, actions or thoughts that reflect one's deeply held and considered moral or religious beliefs.

Lawful excuse: a reason provided by law that relieves a person of a duty (e.g., physicians have a lawful excuse not to treat a patient who requests a procedure that will not achieve the goal that the patient seeks).

4. Principles

The College of Physicians and Surgeons has an obligation to serve and protect the public interest. The Canadian medical profession as a whole has an obligation to ensure that people have access to the provision of legally permissible and publicly-funded health services.

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

Physicians have an obligation to provide health information, referrals, and health services to their patients in a non-discriminatory fashion.

Physicians have an obligation not to abandon their patients.

In certain circumstances a physician will have a lawful excuse to refuse to provide a service requested by a patient.

Physicians' freedom of conscience should be respected.

It is recognized that these obligations and freedoms can come into conflict. This policy establishes what the College expects physicians to do in the face of such conflict.

5. Obligations

5.1 Taking on new patients

Physicians must not refuse to accept patients based on the following characteristics of, or conduct by, them:

- a. age;
- b. race, national/ethnic/Aboriginal origin, colour;
- c. sex, gender identity, or gender expression;
- d. religion or creed;
- e. family or marital status;
- f. sexual orientation;
- g. physical or mental disability;
- h. medical condition;
- i. socioeconomic status;
- j. engaging in activities perceived to contribute to ill health (e.g., smoking, drug or alcohol abuse); or
- k. requesting or refusing any particular publicly-funded health service.

The above obligation does not prevent physicians from making *bona fide* decisions, or exercising professional judgment, in relation to their own clinical competence. Physicians are always expected to practice medicine in keeping with their level of clinical competence to ensure that they safely deliver quality health care. If physicians genuinely feel on grounds of lack of clinical competence that they cannot accept someone as a patient because they cannot appropriately meet that person's health care needs, then they should not do so and should explain to the person why they cannot do so.

The above obligation does not prevent physicians from making *bona fide* decisions to develop a non-discriminatory focused practice.

Where physicians know in advance that they will not provide specific services, but will provide only referrals (in accordance with s. 5.3), they must communicate this fact as early as possible and preferably in advance of the first appointment with an individual who wants to become their patient.

5.2 Providing information to patients

Physicians must provide their patients with the health information required to make legally valid, informed choices about medical treatment (e.g., diagnosis, prognosis, and treatment options, including the option of no treatment or treatment other than that recommended by the physician), even if the provision of such information conflicts with the physician's deeply held and considered moral or religious beliefs.

Physicians must not provide false, misleading, intentionally confusing, coercive, or materially incomplete information to their patients.

All information must be communicated by the physician in a way that is likely to be understood by the patient.

While informing a patient, physicians must not communicate or otherwise behave in a manner that is demeaning to the patient or to the patient's beliefs, lifestyle, choices, or values.

Physicians must not promote their own moral or religious beliefs when interacting with a patient.

The obligation to inform patients may be met by delegating the informing process to another competent individual for whom the physician is responsible.

5.3 Providing referrals for health services

Physicians can decline to provide legally permissible and publicly-funded health services if providing those services violates their freedom of conscience. However, in such situations, they must make a timely referral to another health care provider who is willing and able to accept the patient and provide the service.

This obligation does not prevent physicians from refusing to refer patients where there exists a recognized lawful excuse (see s. 3).

While discussing a referral with a patient, physicians must not communicate, or otherwise behave in a manner that is demeaning to the patient or to the patient's beliefs, lifestyle, choices, or values.

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

5.4 Treating patients

When a referral to another health care provider is not possible without causing a delay that would jeopardize the patient's health or well-being, physicians must provide the patient with all health services that are legally permissible and publicly-funded and that are consented to by the patient or, in the case of an incompetent patient, by the patient's substitute decision-maker. This obligation holds even in circumstances where the provision of health services conflicts with physicians' deeply held and considered moral or religious beliefs.

This obligation does not prevent physicians from refusing to treat a patient where there exists a recognized lawful excuse (see s. 3).

Appendix "A"

Origin of the CPSS Draft Policy Conscientious Refusal

AI. Attempts to coerce physicians: abortion

- AI.1 Since the early 1970's, the Canadian Medical Association (CMA) has struggled repeatedly to resolve conflicts within the medical profession created by legalization of abortion. A prime source of conflict has been a continuing demand that objecting physicians be forced to provide or facilitate the procedure by referral. An early experiment with mandatory referral by objecting physicians was abandoned after a year because there was no ethical consensus to support it; there is no evidence that the policy was ever enforced.¹
- AI.2 A difficult compromise has emerged. Physicians are required to disclose personal moral convictions that might prevent them from recommending a procedure to patients, but are not required to refer the patient or otherwise facilitate abortion. The arrangement preserves the integrity of physicians who do not want to be involved with abortion, while making patients aware of the position of their physicians so that they can seek assistance elsewhere. The compromise has been used as a model for dealing with other morally contested procedures, like contraception.
- AI.3 Nonetheless, some activists, influential academics, powerful interests, state institutions and professional organizations have been working steadily to overthrow the compromise and compel objecting physicians and other health care workers to provide, participate in or facilitate abortion, contraception and related procedures. This was attempted, for example, in a guest 2006 editorial in the Canadian Medical Association Journal (CMAJ) by Professors Sanda Rodgers and Jocelyn Downie.² The editorial elicited a flood of protest. Dr. Jeff Blackmer, CMA Director of Ethics, reaffirmed Association policy that referral was not required,³ and the CMAJ declared the subject closed.

AII. Plans to coerce physicians: assisted suicide and euthanasia

- AII.1 Professor Downie was a member of the "expert panel" of the Royal Society of Canada that, in 2011, recommended legalization of euthanasia and assisted suicide. The panel conceded that health care workers might, for reasons of conscience or religion, object to killing patients or helping them kill themselves.
- AII.2 Professor Downie and her expert colleagues, including Professors Daniel Weinstock and Udo Schuklenk, recommended that such objectors should be compelled to refer patients to someone who would do so.⁴ They claimed that this was consistent with "[t]oday's procedural solution to this problem. . . in Canada as well as many other jurisdictions" with respect to conscientious objection to abortion and contraception ("certain reproductive health services"). Objecting physicians, they declared, are required "to refer assistance seekers to colleagues who are prepared to oblige them."⁵

- AII.3 It is not surprising that the authors did not cite a reference to support this assertion. In Canada, outside of Quebec, there is, in fact, no policy that objecting health care professionals should be compelled to refer for abortions or other morally contested procedures. Given the repudiation of her views by the CMA in 2006, Professor Downie must have been aware of that.
- AII.4 As the Supreme Court of Canada heard submissions in *Carter v. Canada* in October. Professor Downie was live-tweeting from the courtroom, while her Royal Society fellow panelist Udo Schuklenk watched the live webcast. The goal of forcing objecting physicians to participate in euthanasia and assisted suicide was on his mind.

I looked at the list of interveners in the case. There's a whole bunch of them, virtually all of whom are Christian activist groups, some more fundamentalist than others. Their presentations were by and large predictable. . . I suspect they are a last ditch attempt at keeping the SCC from declaring the part of the Criminal Code that criminalises assisted dying unconstitutional. The God folks also served other arguments such as the sanctity-of-life argument. . .

Then there was a lawyer representing groups called the Faith and Freedom Alliance and the Protection of Conscience Project. He didn't address the actual challenge but asked that the Court direct parliament to ensure that health care professionals would not be forced to assist in dying if they had conscientious objections. That, of course, is the case already today in matters such as abortion. However, this lawyer wanted to extend conscience based protections. Today health care professionals are legally required to pass the help-seeking patient on to a health care professional willing to provide the requested service. The lawyer wanted to strike out such an obligation. I am not a fan of conscientious objection rights anyway, so I hope the Court will ignore this. . . (Emphasis added)⁶

AIII. Plans to coerce physicians: the CRG Model Policy

- AIII.1 Jocelyn Downie and Daniel Weinstock, who, with Udo Schuklenk were members of the Royal Society "expert panel," are also part of the faculty of the "Conscience Research Group" (CRG). It is headed by Professor Carolyn McLeod and supported by research associate Jaquelyn Shaw and seven graduate students.⁷
- AIII.2 A central goal of the group is to entrench in medical practice a duty to refer for or otherwise facilitate contraception, abortion and other "reproductive health" services. As the involvement and arguments of Daniel Weinstock and Jocelyn Downie demonstrate, what is advocated by the "Conscience Research Group" equally applies to forcing physicians who are unwilling to kill patients or commit suicide to find a colleague who will.
- AIII.3 The Conscience Research Group advocates a coercive policy on conscientious objection written by three members of the Group, Downie, McLeod and Shaw. As a result of the negative response of physicians and the CMA to Professor Downie's 2006 CMAJ

editorial (AI.3), they decided to convince provincial Colleges of Physicians and Surgeons to adopt the CRG model:

We decided to proceed by way of regulatory bodies rather than the CMA for two main reasons: 1) the Colleges of Physicians and Surgeons, not the CMA, are the regulators of physicians, which means their policies have more force than CMA policies; and 2) in view of the reaction of the CMA to the editorial described earlier, we thought CMA policy reform was unlikely.⁸

AIII.4 This explanation was part of the introduction to the draft CRG policy, *A Model Conscientious Objection Policy for Canadian Colleges of Physicians and Surgeons* (below, right column).

AIV. Saskatchewan College replicates the CRG Model

AIV.1 On 16 January, 2015, the Council of the College of Physicians and Surgeons of Saskatchewan approved in principle a draft policy statement on conscientious objection and directed the Registrar to begin consultations about it.⁹

AIV.2 The draft document, *Conscientious Refusal*, is virtually identical to *A Model Conscientious Objection Policy for Canadian Colleges of Physicians and Surgeons*, the model proposed to Canadian Colleges by Professor Downie and her colleagues.

AIV.3 Nonetheless, the College's Associate Registrar, Bryan Salte, has denied that *Conscientious Refusal* "was taken" from from *A Model Conscientious Objection Policy for Canadian Colleges of Physicians and Surgeons*. He did acknowledge that the Conscience Research Group's proposal was "significant source" for the draft College policy.¹⁰

AIV.4 Very strictly speaking, this is true (See Appendix "B"). Nonetheless, the fact remains that the draft policy approved in principle by the College Council is virtually identical to a model policy proposed by activists whose goal is to force physicians unwilling to kill patients or to provide abortions to help to arrange for someone else to do so.

AIV.5 In the columns below, italicized text the sections of text in the Downie/McLeod/Shaw model that are identical to the College's proposed draft, while underlining of sections in the College's draft marks those parts that differ from the Conscience Research Group model.

**College of Physicians and Surgeons of
Saskatchewan**

Draft Policy- Conscientious Refusal

This document is a policy of the College of Physicians and Surgeons of Saskatchewan and reflects the position of the College.

1. Purpose

This policy seeks to provide clear guidance to physicians and the public about the obligations which physicians have to provide care to patients and how to balance those obligations with physicians' right to act in accordance with their conscience if they conflict.

2. Scope

This policy applies to all situations in which physicians are providing, or holding themselves out to be providing, health services.

3. Definitions

Freedom of conscience: for purposes of this policy, actions or thoughts that reflect one's deeply held and considered moral or religious beliefs.

**Jocelyn Downie, Carolyn McLeod and
Jacquelyn Shaw**

**Moving Forward with a Clear Conscience: A
Model Conscientious Objection Policy for
Canadian Colleges of Physicians and
Surgeons**

This document is a policy of the College of Physicians and Surgeons of [location] and reflects the position of the College. It is expected that all members of the College will comply with it. Failure to do so will render members subject to College investigation and may result in disciplinary action being taken against them.

1. Purpose

This policy seeks to provide clear guidance to physicians and the public about the right of physicians to act in accordance with their conscience as well as obligations they have that may conflict with this right and concern the provision of health information, referrals, and health services. This policy also outlines a process for the public to make complaints against physicians who fail to meet these obligations.

2. Scope

This policy applies to all situations in which physicians are providing, or holding themselves out to be providing, health services.

3. Definitions

Freedom of conscience: for purposes of this policy, freedom to act in ways that reflect one's deeply held and considered moral or religious beliefs.

**College of Physicians and Surgeons of
Saskatchewan**

Draft Policy- Conscientious Refusal

Lawful excuse: a reason provided by law that relieves a person of a duty (e.g., physicians have a lawful excuse not to treat a patient who requests a procedure that will not achieve the goal that the patient seeks).

4. Principles

The College of Physicians and Surgeons has an obligation to serve and protect the public interest. The Canadian medical profession as a whole has an obligation to ensure that people have access to the provision of legally permissible and publicly-funded health services.

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

Physicians have an obligation to provide health information, referrals, and health services to their patients in a non-discriminatory fashion.

Physicians have an obligation not to abandon their patients.

In certain circumstances a physician will have a lawful excuse to refuse to provide a service requested by a patient.

Physicians' freedom of conscience should be respected.

**Jocelyn Downie, Carolyn McLeod and
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Lawful excuse: a reason provided by law that relieves a person of a duty (e.g., physicians have a lawful excuse not to treat a patient who requests a procedure that will not achieve the goal the patient seeks).

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**College of Physicians and Surgeons of
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It is recognized that these obligations and freedoms can come into conflict. This policy establishes what the College expects physicians to do in the face of such conflict.

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5. Obligations

5. Obligations

5.1 Taking on new patients

5.1 Taking on new patients

Physicians must not refuse to accept patients based on the following characteristics of, or conduct by, them:

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

- a. age;
- b. race, national/ethnic/Aboriginal origin, colour;
- c. sex, gender identity, or gender expression;
- d. religion or creed;
- e. family or marital status;
- f. sexual orientation;
- g. physical or mental disability;
- h. medical condition;
- I. socioeconomic status;

- a. age;*
- b. race, national/ethnic/Aboriginal origin, colour;*
- c. sex, gender identity, or gender expression;*
- d. religion or creed;*
- e. family or marital status;*
- f. sexual orientation;*
- g. physical or mental disability;*
- h. medical condition;*
- I. socioeconomic status;*

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j. engaging in activities perceived to contribute to ill health (e.g., smoking, drug or alcohol abuse); or

k. requesting or refusing any particular publicly-funded health service.

The above obligation does not prevent physicians from making *bona fide* decisions, or exercising professional judgment, in relation to their own clinical competence. Physicians are always expected to practice medicine in keeping with their level of clinical competence to ensure that they safely deliver quality health care. If physicians genuinely feel on grounds of lack of clinical competence that they cannot accept someone as a patient because they cannot appropriately meet that person's health care needs, then they should not do so and should explain to the person why they cannot do so.

The above obligation does not prevent physicians from making *bona fide* decisions to develop a non-discriminatory focused practice.

Where physicians know in advance that they will not provide specific services, but will provide only referrals (in accordance with [s. 5.3](#)), they must communicate this fact as early as possible and preferably in advance of the first appointment with an individual who wants to become their patient.

**Jocelyn Downie, Carolyn McLeod and
Jacquelyn Shaw**

**Moving Forward with a Clear Conscience: A
Model Conscientious Objection Policy for
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Surgeons**

j. engaging in activities perceived to contribute to ill health (e.g., smoking, drug or alcohol abuse); or

k. requesting or refusing any particular publicly funded health service.

The above obligation does not prevent physicians from making bona fide decisions, or exercising professional judgment, in relation to their own clinical competence. Physicians are always expected to practice medicine in keeping with their level of clinical competence to ensure that they safely deliver quality health care. If physicians genuinely feel that they cannot accept someone as a patient because they cannot competently meet that person's health care needs, then they should not accept that person and should explain to him or her why they cannot do so.

The above obligation does not prevent physicians from making bona fide decisions to develop a specialist practice.

Where physicians know in advance that they will not provide specific services, but will provide only referrals (in accordance with [s. 5.3](#)), they must communicate this fact as early as possible and preferably in advance of the first appointment with an individual who wants to become their patient.

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5.2 Providing information to patients

5.2 Providing information to patients

Physicians must provide their patients with the health information required to make legally valid, informed choices about medical treatment (e.g., diagnosis, prognosis, and treatment options, including the option of no treatment or treatment other than that recommended by the physician), even if the provision of such information conflicts with the physician's deeply held and considered moral or religious beliefs.

Physicians must provide their patients with the health information required to make legally valid, informed choices about medical treatment (e.g., diagnosis, prognosis, and treatment options, including the option of no treatment or treatment other than that recommended by the physician), even if the provision of such information conflicts with the physician's deeply held and considered moral or religious beliefs.

Physicians must not provide false, misleading, intentionally confusing, coercive, or materially incomplete information to their patients.

Physicians must not provide false, misleading, intentionally confusing, coercive, or materially incomplete information to their patients.

All information must be communicated by the physician in a way that is likely to be understood by the patient.

All information must be communicated by the physician in a way that is likely to be understood by the patient.

While informing a patient, physicians must not communicate or otherwise behave in a manner that is demeaning to the patient or to the patient's beliefs, lifestyle, choices, or values.

While informing a patient, physicians must not communicate or otherwise behave in a manner that is demeaning to the patient or to the patient's beliefs, lifestyle, choices, or values.

Physicians must not promote their own moral or religious beliefs when interacting with a patient.



The obligation to inform patients may be met by delegating the informing process to another competent individual for whom the physician is responsible.

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College of Physicians and Surgeons of
Saskatchewan

Jocelyn Downie, Carolyn McLeod and
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5.3 Providing referrals for health services

5.3 *Providing referrals for health services*

Physicians can decline to provide legally permissible and publicly-funded health services if providing those services violates their freedom of conscience. However, in such situations, they must make a timely referral to another health care provider who is willing and able to accept the patient and provide the service.

Physicians can decline to provide legally permissible and publicly funded health services if providing those services violates their freedom of conscience. However, in such situations, they must make a referral to another health care provider who is willing and able to accept the patient and provide the service.

This obligation does not prevent physicians from refusing to refer patients where there exists a recognized lawful excuse (see [s. 3](#)).

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While discussing a referral with a patient, physicians must not communicate, or otherwise behave in a manner that is demeaning to the patient or to the patient's beliefs, lifestyle, choices, or values.

While discussing a referral with a patient, physicians must not communicate, or otherwise behave in a manner that is demeaning to the patient or to the patient's beliefs, lifestyle, choices, or values.

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

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

5.4 Treating patients

5.4 *Treating patients*

When a referral to another health care provider is not possible without causing a delay that would jeopardize the patient's health or well-being, physicians must provide the patient with all health services that are legally permissible

When a referral to another health care provider is not possible without causing a delay that would jeopardize the patient's health or well-being, physicians must provide the patient with all health services that are legally permissible

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Draft Policy- Conscientious Refusal

and publicly-funded and that are consented to by the patient or, in the case of an incompetent patient, by the patient's substitute decision-maker. This obligation holds even in circumstances where the provision of health services conflicts with physicians' deeply held and considered moral or religious beliefs.

This obligation does not prevent physicians from refusing to treat a patient where there exists a recognized lawful excuse (see [s. 3](#)).

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This obligation does not prevent physicians from refusing to treat a patient where there exists a recognized lawful excuse (see [s. 3](#)).

6. Complaints Process

Upon notification of a complaint under this Policy (see Form 2 [to be developed]), the College will investigate, prosecute, and remedy breaches of the obligations set out in this Policy.

7. Penalties

Failure to meet the obligations set out in this policy constitutes professional misconduct. Physicians who violate this policy will be subject to discipline by the College.

Notes:

1. A requirement that an objection physician "advise the patient of other sources of assistance," was introduced by the CMA General Council in June, 1977, and revoked the following year. Geekie D.A. "Abortion referral and MD emigration: areas of concern and study for CMA." *CMAJ*, January 21, 1978, Vol. 118, 175, 206 (<http://www.consciencelaws.org/archive/documents/cma-cmaj/1978-01-21-CMAJ-118-175-referral-geekie.pdf>) Accessed 2014-02-22;

- "Ethics problem reappears." *CMAJ*, July 8, 1978, Vol. 119, 61-62
2. In a guest 2006 editorial in the *Canadian Medical Association Journal*, Professors Sandra Rodgers of the University of Ottawa and Jocelyn Downie of Dalhousie University complained that "Islamic physicians refuse to provide abortion services and refuse to provide women with information or referrals needed to find help elsewhere." Rodgers S, Downie J. "Abortion: Ensuring Access." *CMAJ* July 4, 2006 vol. 175 no. 1 doi: 10.1503/cmaj.060548 (http://www.cmaj.ca/content/175/1/9.full) Accessed 2014-02-23
3. Blackmer J. "Clarification of the CMA's position on induced abortion." *CMAJ* April 24, 2007 vol. 176 no. 9 doi: 10.1503/cmaj.1070035 (http://www.cmaj.ca/content/176/9/1310.1.full) Accessed 2014-02-22.
4. Schuklenk U, van Delden J.J.M, Downie J, McLean S, Upshur R, Weinstock D. *Report of the Royal Society of Canada Expert Panel on End-of-Life Decision Making* (November, 2011) p. 101 (http://rsc-src.ca/sites/default/files/pdf/RSCEndofLifeReport2011_EN_Formatted_FINAL.pdf) Accessed 2014-02-23.
5. Schuklenk U, van Delden J.J.M, Downie J, McLean S, Upshur R, Weinstock D. *Report of the Royal Society of Canada Expert Panel on End-of-Life Decision Making* (November, 2011) p. 62 (http://rsc-src.ca/sites/default/files/pdf/RSCEndofLifeReport2011_EN_Formatted_FINAL.pdf) Accessed 2014-02-23.
6. Schuklenk U. "Supreme Court of Canada heard arguments in Charter challenge to assisted dying criminalisation." *Udo Schuklenk's Ethx Blog*, T, Thursday, October 16, 2014 (http://ethxblog.blogspot.ca/2014/10/supreme-court-of-canada-heard-arguments.html) Accessed 2015-02-22.
7. *Let their conscience be their guide? Conscientious refusals in reproductive health care.* (http://conscience.carolynmcleod.com/meet-the-team/) Accessed 2014-11-21.
8. Downie J, McLeod C, Shaw J. "Moving Forward with a Clear Conscience: A Model Conscientious Objection Policy for Canadian Colleges of Physicians and Surgeons." *Health Law Review*, 21:3, 2013, p. 29 (http://carolynmcleod.com/wp-content/uploads/2014/05/04_Downie-McLeod-Shaw.pdf) Accessed 2015-02-24.
9. College of Physicians and Surgeons of Saskatchewan, *Executive Summary of the 16 January, 2015 Council Meeting* (http://www.cps.sk.ca/cpsc/Physician_Summary/Activity_Viewer.aspx?SEQN=63103&Doc=MEETINGFUNC) Accessed 2015-02-22.
10. Weatherbe S. "'This is moral genocide': Canadian doctors blast plans to force them into helping patients procure abortion." *LifeSite News*, 17 February, 2015 (https://www.lifesitenews.com/news/this-is-moral-genocide-canadian-doctors-blast-plans-to-force-them-into-help?) Accessed 2015-02-22.

Appendix "B"

Development of the CPSS Draft Policy Conscientious Refusal

BI. Conscience Research Group (CRG)

- BI.1 The Conscience Research Group (CRG) was formed by Professor Carolyn McLeod of the University of Western Ontario with the assistance of a 2009 grant of over \$240,000.00 from the Canadian Institutes of Health Research (CIHR).¹ CIHR provided members of the group with another \$24,500.00 in grants between 2010 and 2012.²
- BI.2 The Group faculty includes euthanasia/assisted suicide advocates Jocelyn Downie and Daniel Weinstock. It is headed by Professor Carolyn McLeod and supported by research associate Jaquelyn Shaw and seven graduate students.³
- BI.3 A central goal of the Group is to entrench in medical practice a duty to refer for or otherwise facilitate contraception, abortion and other "reproductive health" services. The Group advocates a coercive model policy on conscientious objection that would apply to any legal, publicly funded procedure, including assisted suicide and euthanasia. They have been working to convince provincial Colleges of Physicians and Surgeons to enact the policy in order to achieve by force of law/regulation what they have been unable to achieve by persuasion (Appendix "A").

BII. CRG convenes meeting with College representatives

- BII.1 The Group organized a meeting in 2013 to advance their *Model Conscientious Objection Policy* (Appendix "A"). The meeting, which was funded by a research grant (presumably the CIHR granted noted above) included:
- Bryan Salte, LLB, Associate Registrar, College of Physicians and Surgeons of Saskatchewan
 - Andréa Foti, Manager- Policy Dept., College of Physicians and Surgeons of Ontario
 - Dr. Gus Grant, Registrar of the College of Physicians and Surgeons of Nova Scotia
 - A representative of the Collège des Médecins du Québec
 - ". . . representatives from the faculties of law, medicine and philosophy from academia and other invited individuals."⁴
- BII.2 The CRG authors appear to refer to this meeting in the introduction to their model policy:
- Feedback on the draft policy was also solicited from a number of relevant experts: academics who do research primarily in health law, biomedical ethics, medicine or other health professions; **physician regulatory body members**; and local community organizations dealing with women's health, sexual health, and the health of more marginalized populations (e.g. rural populations, street youth, First Nations). . . (Emphasis added)⁵
- BII.3 It is not unlikely that the various faculties were represented by CRG members, perhaps augmented by supportive colleagues.
- BII.4 The goal of the meeting "was to develop a policy that could be adopted by Canadian Colleges of Physicians and Surgeons to guide physicians who have a conscientious objection to providing certain forms of health care."

While that is most frequently experienced in issues pertaining to reproduction i.e. birth control, abortion and emergency contraception, it can arise in a number of other situations as well, such as the provision of blood products and end of life care.⁴

- BII.4 According to Byran Salte, participants at the meeting agreed upon the text of what he subsequently called the "draft policy statement developed by the Conscientious Objections Working Group."⁶ This was almost an exact duplicate of what the CRG published later in 2013 as its *Model Conscientious Objection Policy*. However, because Mr. Salte continued to use and refer to the text of the former, he could, strictly speaking, claim that the CPSS draft, *Conscientious Refusal* was not "taken from" that the CRG Model.

BIII. Meeting of Registrars of BC, Alberta, Saskatchewan, Manitoba and Ontario

- BIII.1 On 5 May, 2014,⁷ the "draft policy statement developed by the Conscientious Objections Working Group" was discussed during a meeting of the Registrars of the Colleges of BC, Alberta, Saskatchewan, Manitoba and Ontario. Associate Registrar Bryan Salte of Saskatchewan seems to have taken the lead:

I suggested that each of the Colleges consider whether the recommendations in the report of the conscientious objections working group are appropriate, and if so, to consider implementing them. I understood each College agreed to consider doing that.⁸

- BIII.2 According to Salte, the Registrars "appeared to have reached a consensus that the document developed by the working group. . . should be considered for possible adoption by Canadian Colleges of Physicians and Surgeons."⁴
- BIII.3 Of interest here is that the reported consensus included the Registrar of the College of Physicians and Surgeons of Ontario, one month *before* the Ontario College launched its public consultation on *Physicians and the Ontario Human Rights Code*.⁹
- BIII.4 However, the Registrar of the College of Physicians of BC made no reference to the discussion or consensus when reporting to the College Board at the end of the month,⁷ and the Registrar of the College in Alberta seems not to have reported the discussion or consensus at the College's quarterly Council meeting at the end of May.¹⁰ Neither was the discussion or consensus mentioned by Bryan Salte at the CPSS Council meeting at the end of June, though he made numerous other reports.¹¹

BIV. Controversy about Alberta physician declining to prescribe contraceptives

- BIV.1 On 2 July, 2014, the CPSS Registrar (or someone in her office) copied a newspaper article about a Calgary physician who was refusing to prescribe contraceptives for the

- information of College Council.¹² This appears to have been done in anticipation of the next Council meeting in September.
- BIV.2 It is noteworthy that the news reports were sparked by a patient who was offended by the physician's notice about her practice, not by someone who had been refused a birth control prescription, although this was not clear in the clipping selected.¹³ More significant, the final sentence in the story stated that CPSA policy required objecting physicians to "ensure the patient has access to another practitioner who will prescribe the drug." The statement erroneously implied a policy of mandatory referral for morally contested services.
- BIV.3 The Registrar of the Alberta College included the following remarks in a column sparked by the controversy. He referred, in particular, to two paragraphs of the College's policy on *Moral or Religious Beliefs Affecting Medical Care*:
2. A physician must not withhold information about the existence of a procedure or treatment because providing that procedure or giving advice about it conflicts with their moral or religious beliefs.
 4. When moral or religious beliefs prevent a physician from providing or offering access to information about a legally available medical or surgical treatment or service, that physician must ensure that the patient who seeks such advice or medical care is offered timely access to another physician or resource that will provide accurate information about all available medical options.¹⁴
- BIV.4 He went on to say:
- The first point I wish to make is that patients shouldn't be denied access to a medically necessary service. Numbers 2 and 4 (especially #4) of the standard emphasize that point. The physician in this case responded by altering her sign, giving prospective patients specific information as to where (and from whom) they could receive information about birth control including, if appropriate, a prescription for oral contraceptive pills.¹⁵
- BIV.5 This could be taken to imply that the policy means that a physician has a duty to refer for a morally contested service, and that the physician in question had complied with the policy. However, the Registrar had previously refused to assert that the policy implied such a duty, and strongly denied that the policy should be understood to imply a duty to refer for abortion.¹⁶

BV. Canadian Registrars advised to adopt uniform coercive policy

- BV.1 Associate Registrar Bryan Salte wrote to all Canadian Registrars of Colleges of Physicians and Surgeons, in July, 2014. Citing the consensus of the western registrars (BIII.2), he recommended that all Colleges in Canada adopt the "draft policy statement developed by the Conscientious Objections Working Group."

Physician-assisted suicide, in particular, has the potential to challenge

Colleges of Physicians and Surgeons to provide guidance to its members. . .

I think it will be very helpful if all Colleges are able to adopt the same or a very similar document. My perspective is that that topic has the potential to be very controversial. My perspective is that ethical standards for medical practice should be very similar across Canada, and that it should be possible for Canadian Colleges to adopt a common approach. Any College that is an outlier, either because it has adopted a different position than other Colleges, or because it has not developed a policy, will potentially be placed in a difficult position.⁴

- BV.2 Note that the concern voiced here is with the provision of assisted suicide (and, presumably, euthanasia), not with birth control or abortion. Obviously, if it is agreed that objecting physicians can be coerced to refer patients for euthanasia, it becomes difficult to explain why they should not be forced to refer patients for anything else.

BVI. Memo to College Council proposes policy on "ethical objection"

- BVI.1 On 31 July, 2014, Mr. Salte prepared a memo for College Council asking "whether it will develop a policy or guideline for physicians who have an ethical objection to providing certain forms of care."¹⁷
- BVI.2 He offered five examples of "issues which have resulted in controversy": abortion, birth control, assisted suicide, fetal sex identification and genetic testing. He identified himself as "part of a group that was formed with a grant to study and provide recommendations to Canadian Colleges of Physicians and Surgeons" concerning "physicians who have a conscientious objection to providing certain forms of medical care." He provided a copy of the "draft policy statement developed by the Conscientious Objections Working Group," a copy of his letter to the Registrars of Canadian Colleges and copies of Alberta, Saskatchewan, Manitoba and Ontario policies referring to similar issues.
- BVI.3 The policy documents were supplemented by a newspaper article about the Ontario consultation. It referred to the On-line poll conducted by the College of Physicians and Surgeons of Ontario, which was actually of doubtful value. However, the article concluded with an interview of ethicist Arthur Schafer, who insisted that objecting physicians have an obligation to refer patients to a colleague who will provide the services they refuse to provide.¹⁸
- BIV.4 Mr. Salte also included an article from an American professional journal, "Conscientious Refusal in Family Medicine Residency Training." The article described the results of a survey completed by 154 physicians in a university faculty, less than half of those polled. Like the article quoting Schafer, the conclusion of the journal article generally favoured the draft policy he was proposing:

This study is the first to demonstrate the prevalence of moral objection to legally available medical procedures among family medicine residents and faculty. The

survey responses demonstrate that conscientious objection exists and that there is support for physicians exercising moral objection in clinical practice, provided they engage in appropriate patient education and referral.¹⁹

BIV.5 However, the author added that the results were "unique to the residents and faculty in the University of Wisconsin Department of Family Medicine and limit generalizability of the findings" and that "the complexity of the subject matter may also limit the respondents' ability to give a complete answer by requiring a yes or no response."¹⁹

BVII. College Council approves formation of committee

BVII.1 At the College Council meeting on 19 September, 2014, Mr. Salte presented his report and the newspaper clipping about the Calgary physician (BIV.).

BVII.2 The Council approved the formation of a committee to study "Conscientious Objection to Providing Medical Care." Members of the committee were Mr. Salte, Council President Dr. Mark Chapelski, and public members Susan Halland and Marcel de la Gorgendiere. Dr. Susan Hayton of the Department of Academic Family Medicine of the University of Saskatchewan was also a committee member.²⁰ In January, 2014 she completed a Master's thesis on Accommodation of Religious and Cultural Differences in Medical School Training.²¹

BVIII. Committee meeting

BVIII.1 The committee met once; no minutes were kept.²² Dr. Chapelski was not present. Committee members were Registrar Karen Shaw, Associate Registrar Bryan Salte, Deputy Registrar Dr. Michael Howard-Tripp, Dr. Hayton, Susan Halland and Marcel de la Gorgendiere. The group agreed that the "draft policy statement developed by the Conscientious Objections Working Group" was generally satisfactory, but suggested minor changes for the sake of clarity. The only notable changes:

- Statements concerning disciplinary consequences were removed because they were thought superfluous.
- A statement to the effect that physicians should not promote their own beliefs was added.²³

BIX. Council approval in principle

BIX.1 Mr. Salte presented a report based on the committee meeting to Council, recommending that there should be a consultation about the document because of its "potentially contentious nature."²⁴ On 20 January, 2015, Council unanimously approved the policy in principle and authorized a consultation.²⁵

Notes:

1.

2009

Principal Investigator: MCLEOD, Carolyn W
Co-Investigators: BAYLIS, Françoise; DOWNIE, Jocelyn G; HICKSON, Michael W
Institution Paid: University of Western Ontario
Program: Operating Grant
Year/Month: 2009/09
Assigned PRC: HLE

Project Title:

Let Conscience Be Their Guide? Conscientious Refusals in Reproductive Health Care

Many bioethicists and health-policy makers are currently struggling with what to do about conscientious refusals by health care professionals to provide standard health care services, such as abortions. The proposed research addresses this complex moral and legal issue. Our team will conduct rigorous analyses of when conscientious refusals--in particular those that occur in reproductive health care--are morally and legally permissible, and of which policies and educational initiatives we need in Canada with respect to these refusals. Our practical aim is to encourage delivery of reproductive health care services that is appropriately respectful of conscience and that safeguards women's reproductive health.

Details:

CIHR Contribution:

\$240,296

CIHR Equipment:

\$0

Term Yrs/Mths.:

3 yrs 0 mth

Source: CIHR, *Funding Decisions Data*

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

Accessed 2015-02-23)

2.

2010

Principal Investigator: MCLEOD, Carolyn W
Co-Investigators:
Institution Paid: University of Western Ontario
Program: CIHR Café Scientifique Program
Year/Month: 2010/06
Assigned PRC: ***

Project Title:

The Spark of Conscience Inflames Debate: Conflicts of Conscience in Medicine

Conscientious refusal by health care professionals to provide standard health services, such as abortions, is a subject of intense debate in Canada and elsewhere. Recent discussion in the Canadian Medical Association Journal about refusals by physicians to participate in abortions revealed that the Canadian Medical Association lacks a coherent policy on conscientious objection. The CIHR Café Scientifique, "The Spark of Conscience Inflames Debate," will provide a public forum for deliberation on what the CMA policy ought to be. The panelists and moderator are all experts in areas of profound relevance to this issue: bioethics, health law, health policy, religion, and medicine.

Details:

CIHR Contribution:

\$3,000

CIHR Equipment: \$0
Term Yrs/Mths.: 1 yr 0 mth
Source: CIHR, *Funding Decisions Data*
(http://webapps.cihr-irsc.gc.ca/cfdd/db_search?p_language=E)
Accessed 2015-02-23)

2011

Principal Investigator: KANTYMIR, Lori
Co-Investigators: HICKSON, Michael W; MCLEOD, Carolyn W
Institution Paid: University of Western Ontario
Program: Dissemination Events - Priority Announcement: Ethics
Year/Month: 2011/02
Assigned PRC: KDE
Project Title: **Santa Clara Workshop on Conscientious Refusals in Health Care**
The Santa Clara Workshop on Conscientious Refusals will bring together a CIHR team of researchers studying conscientious refusals in health care in Canada with U.S. researchers and members of the U.S. public to discuss policy options. The workshop is structured to facilitate knowledge exchange between these groups by devoting Day 1 to public discussion and Day 2 to collaboration between expert researchers. The workshop will take an inter-disciplinary approach to the problem of conscientious refusals in health care, and will include presentations from expert researchers working in bioethics, medicine, philosophy, law, and religious studies.

Details:

CIHR Contribution: \$18,500
CIHR Equipment: \$0
Term Yrs/Mths.: 1 yr. 0 mth.
Source: CIHR, *Funding Decisions Data*
(http://webapps.cihr-irsc.gc.ca/cfdd/db_search?p_language=E)
Accessed 2015-02-23)

2012

Principal Investigator: SHAW, Jacquelyn
Co-Investigators:
Institution Paid: Dalhousie University (Nova Scotia)
Program: CIHR Café Scientifique Program
Year/Month: 2012/05
Assigned PRC: CAF
Project Title: **Liberation therapy aftercare, body modification, reproductive and other health services: can your healthcare provider refuse to treat you because it bothers his (or her) conscience?**
Conscientious objection has largely entered the public consciousness via the polarizing lens of debates on access to abortion services. Yet such debate reflects only the tip of a much larger iceberg of contexts in which healthcare providers conscientiously refuse to provide certain services. For example, what should be done about conscientious refusals of care to patients who engage in health-related activities of which a practitioner does not professionally approve (e.g., smoking, overeating, body modification, accessing unapproved therapies overseas)? These service

Details:

refusals may well be an expression of conscience on the part of healthcare professionals. However, they also risk denying individual patients access to healthcare services and they may in some cases be argued to be discriminatory. The challenging question before us is how we can create policies that permit genuinely conscience-based refusal opportunities, while also ensuring that patients receive adequate, non-discriminatory access to desired healthcare services. The panelists and moderator are experts in areas of relevance to the subject matter: i.e., bioethics, medicine, dentistry and health law and policy. We invite all members of the public, including health and legal professionals, to come to the Café Scientifique, where they can enjoy free refreshments, ask questions of expert panelists, share their own experiences, and weigh in on a matter of great importance to Canadian patients and providers today.

CIHR Contribution:

\$3,000

CIHR Equipment:

\$0

Term Yrs/Mths.:

1 yr 0 mth

Source: CIHR, *Funding Decisions Data*

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

Accessed 2015-02-23)

3. *Let their conscience be their guide? Conscientious refusals in reproductive health care.* (<http://conscience.carolynmcleod.com/meet-the-team/>) Accessed 2014-11-21

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

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

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

**"Draft policy statement developed by the
Conscientious Objections Working Group."**

**Jocelyn Downie, Carolyn McLeod and
Jacquelyn Shaw**

In certain circumstances a physician will have a lawful excuse to refuse to provide a service requested by a patient.



3. Definitions

Freedom of conscience: for purposes of this policy, *actions or thoughts* that reflect one's deeply held and considered moral or religious beliefs.

5.1 Taking on new patients

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

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

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

3. Definitions

Freedom of conscience: for purposes of this policy, freedom to act in ways that reflect one's deeply held and considered moral or religious beliefs.

5.1 Taking on new patients

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

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

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

7. College of Physicians and Surgeons of British Columbia, *Minutes of Board Meeting 30 May, 2014*, p. 2. The Registrar reported the date of the meeting and four agenda items, but did not mention the discussion concerning physician freedom of conscience.
(<https://www.cpsbc.ca/files/pdf/Minutes-Board-2014-05-30.pdf>) Accessed 2015-02-23.

8. Document 200/14, College of Physicians and Surgeons of Saskatchewan, *Report to Council from the Registrar*, 31 July, 2014, p. 3.
(<http://consciencelaws.org/archive/documents/cpss/2014-07-31-Report.pdf>)

9. "Physicians and the Ontario Human Rights Code." *Protection of Conscience Blog*, 4 June, 2014. (<http://consciencelaws.org/blog/?p=4921>)

10. College of Physicians and Surgeons of Alberta, *Council Highlights*, May, 2014.
(<http://www.cpsa.ab.ca/Libraries/council/meeting-highlights.pdf>) Accessed 2015-02-23.

11. College of Physicians and Surgeons of Saskatchewan, Agenda, Open Session and Executive Summary, Council Meeting 20-21 June, 2014
(http://www.cps.sk.ca/cpss/Physician_Summary/Activity_View.aspx?SEQN=51360&Doc=ME)

ETINGFUNC) Accessed 2015-02-23. He did provide a report on a Federation of Medical Regulatory Authorities, but the report is confidential.

12. Document 185/14, College of Physicians and Surgeons of Saskatchewan, "Alberta doctor refuses to prescribe birth control over her morality." Tristan Bronca, *The Medical Post*, 30 June, 2014.

(<http://www.consciencelaws.org/archive/documents/cpss/2014-07-02-CPSSCouncil-AltaDoctor.pdf>)

13. Leung M. "Calgary doctor refuses to prescribe birth control due to personal beliefs." *CTV News*, 28 June, 2014.

(<http://www.ctvnews.ca/canada/calgary-doctor-refuses-to-prescribe-birth-control-due-to-personal-beliefs-1.1890724>) (Accessed 2015-02-25)

14. College of Physicians and Surgeons of Alberta, *Moral or Religious Beliefs Affecting Medical Care*.

(<http://www.cpsa.ab.ca/Resources/StandardsPractice/medical-practice/moral-or-religious-beliefs-affecting-medical-care>) Accessed 2015-02-13.

15. College of Physicians and Surgeons of Alberta, "Trevor's Take on. . . Moral or Religious Beliefs Affecting Medical Care." *The Messenger*, 3 July, 2014

(<http://www.cpsa.ab.ca/Resources/the-messenger/trevors-take-on/trevors-take-on/2014/07/03/a-patient's-right-to-good-medical-care>) Accessed 2015-02-24.

16. Protection of Conscience Project Submission to the College of Physicians and Surgeons of Ontario Re: *Professional Obligations and Human Rights* (20 February, 2015) Appendix "B", BII.2.9

(<http://www.consciencelaws.org/publications/submissions/submissions-013-003-cpsa.aspx#BII.2.9>)

17. Document 200/14, College of Physicians and Surgeons of Saskatchewan, Memo from Bryan Salte to Council dated 31 July, 2014 Re: *Possible Policy or Guideline - Physicians who have an ethical objection to provide certain forms of medical services*.

(<http://www.consciencelaws.org/archive/documents/cpss/2014-07-31-Report.pdf>)

18. Document 200/14, College of Physicians and Surgeons of Saskatchewan, Memo from Bryan Salte to Council dated 31 July, 2014 Re: *Possible Policy or Guideline - Physicians who have an ethical objection to provide certain forms of medical services*. p. 19-20.

(<http://www.consciencelaws.org/archive/documents/cpss/2014-07-31-Report.pdf>)

19. Document 200/14, College of Physicians and Surgeons of Saskatchewan, Memo from Bryan Salte to Council dated 31 July, 2014 Re: *Possible Policy or Guideline - Physicians who have an ethical objection to provide certain forms of medical services*, p. 21-24.

(<http://www.consciencelaws.org/archive/documents/cpss/2014-07-31-Report.pdf>)

20. College of Physicians and Surgeons of Saskatchewan, *Minutes of Council Meeting*, 19 September, 2014.
(<http://www.consciencelaws.org/archive/documents/cpss/2014-09-19-20-CPSSCouncilMinutes.pdf>)
21. Hayton S. *Accommodation of Religious and Cultural Differences in Medical School Training*. A Thesis Submitted to the College of Graduate Studies and Research In Partial Fulfillment of the Requirements For the Degree of Master of Laws In the College of Law University of Saskatchewan Saskatoon (January, 2014)
(<http://ecommons.usask.ca/bitstream/handle/10388/ETD-2014-01-1446/HAYTON-THESIS.pdf?sequence=4>) Accessed 2015-02-24.
22. Document 23/15, College of Physicians and Surgeons of Saskatchewan, Memo to Council from Bryan Salte, Re: Draft Policy-Conscientious Objection (9 January, 2015), p. 2.
([http://www.consciencelaws.org/archive/documents/cpss/2015-01-09-Draft Conscientious Objection Policy.pdf](http://www.consciencelaws.org/archive/documents/cpss/2015-01-09-Draft%20Conscientious%20Objection%20Policy.pdf)) Email from the Office of the Registrar, College of Physicians and Surgeons of Saskatchewan, to the Administrator, Protection of Conscience Project, 24 February, 2015, 7:14 AM.
23. Document 23/15, College of Physicians and Surgeons of Saskatchewan, Memo to Council from Bryan Salte, *Re: Draft Policy-Conscientious Objection* (9 January, 2015), p. 2-3
([http://www.consciencelaws.org/archive/documents/cpss/2015-01-09-Draft Conscientious Objection Policy.pdf](http://www.consciencelaws.org/archive/documents/cpss/2015-01-09-Draft%20Conscientious%20Objection%20Policy.pdf))
24. Document 23/15, College of Physicians and Surgeons of Saskatchewan, Memo to Council from Bryan Salte, *Re: Draft Policy-Conscientious Objection* (9 January, 2015), p. 2
([http://www.consciencelaws.org/archive/documents/cpss/2015-01-09-Draft Conscientious Objection Policy.pdf](http://www.consciencelaws.org/archive/documents/cpss/2015-01-09-Draft%20Conscientious%20Objection%20Policy.pdf))
25. College of Physicians and Surgeons of Saskatchewan, *Minutes of Council Meeting*, 16 January, 2015, p. 11
(<http://www.consciencelaws.org/archive/documents/cpss/2015-01-16-CPSSCouncilMinutes.pdf>)

Appendix "C"

Interview of Associate Registrar, College of Physicians and Surgeons of Saskatchewan



Saskatchewan doctors could face discipline over assisted suicide

Global News, 13 February, 2015

(<http://globalnews.ca/news/1829394/saskatchewan-doctors-could-face-discipline-over-assisted-suicide/>) Accessed 2015-02-25

Re: CPSS Draft Policy *Conscientious Refusal*

Note: The interview was preceded by a video clip of an interview with a Saskatchewan physician unwilling to participate in or facilitate assisted suicide.

CI. 00:38

- CI.1 **Interviewer:** Now you heard him say he doesn't even want to refer a patient to another doctor willing to help a patient end their lives. Bryan, where are you at in coming up with the regulations for this?
- CI.2 **Salte:** Well, it's a fairly broad question. So if what you're asking is solely on the issue of, of what do we expect in terms of referring for what is at some point in time going to be a legal procedure, we currently have a draft policy that is being circulated for discussion, which applies much more broadly than just physician assisted death.
- CI.3 It deals with birth control and abortion and all of the other areas where there is a clash between physicians' personal values and the services which patients may wish.
- CI.4 So, at the moment, it's a draft policy that, uh, discusses how a physician tries to reconcile their own personal beliefs with the legal services which are available in Canada, despite the fact that their, those legal services may clash with the personal beliefs of the

- physician.
- CII. 01:32**
- CII.1 Interviewer: So your policy on conscience obligation says doctors have to refer even if they don't agree. What does this mean for doctors who don't want to?
- CIII. 01:42**
- CIII.1 **Salte:** Well, it means that if this becomes a policy, and it currently is a requirement, for example, in the case of an unwanted pregnancy, and it currently is the policy in other provinces in dealing with some of those issues.¹
- CIII.2 The issue of physician assisted dying is, of course a new issue.
- CIII.3 But, the expectation would be that, uh, physicians will follow the directions which come from the College of Physicians and Surgeons which are going to be established, of course, by their colleagues as part of the expectations of practice.
- CIII.4 So, if a physician feels that the directives are wrong, they will still, we would expect follow those directives despite the fact that they may not agree with them.
- CIV. 02:18**
- CIV.1 **Interviewer:** Do you think there is any room for a middle ground, or will doctors who disagree with assisted suicide end up being disciplined, could they lose their jobs . . . ?
- CV. 02:25**
- CV.1 **Salte:** Well, certainly, um, we try to avoid discipline whenever possible. But if there are physicians who engage in behaviour which is regarded as unacceptable or unprofessional, then that is a possible outcome.
- CV.2 Certainly, with any physician what we would try to do is we would work and see if there is some mutually acceptable solution.
- CV.3 But you speak about compromise. Um, there are those who, for example, take the position that physicians are compelled to provide legal procedures, and so there those who take the position that by saying physicians who are capable of providing birth control don't actually have to provide it, that already we have engaged in a compromise which is unacceptable.
- CV.4 So there is a broad range of, uh, of beliefs out there, there's a broad range of perspectives out there, and what, uh, the draft policy talks about is, in fact, a compromise between the extreme position, which would be that physicians are compelled to provide this service, on the one side, and the other extreme position which is physicians can simply refuse to discuss with their patients what is going to become a legal procedure.
- CVI. 03:26**
- CVI.1 **Interviewer:** So will you wait for the CMA to weigh in on this?

CVII. 03:29

CVII.1 **Salte:** Well, there's a lot of consultation that's going on. I was just at a national meeting and that was a fairly significant subject associated with it.

CVII.2 So the issue is going to be how do we come up with best guidance for physicians on a variety of issues and certainly physician assisted suicide or physician assisted death is one of those.

CVII.3 The other thing, of course, is that this is going to take some number of months to resolve itself, so nothing changes for the next 12 months, or unless the federal government introduces legislation more quickly than that. So, there is a period of time for us to try to get this right. It's not indefinite, but it's not next week either.

CVIII. 04:06

CVIII.1 **Interviewer:** How tough is this for you to deal with? You obviously have had a long career. Is this one of the biggest challenges you've ever faced?

CIX. 04:13

CIX.1 **Salte:** I wouldn't say it's one of the biggest, but it is a difficult challenge. Any time that you have people who believe very strong ethically about certain issues, and certainly we've dealt with that with birth control, we've dealt with that with abortion, we've dealt with that with the morning after pill, there's a variety of other areas that are right now such . . .

CIX.2 **Interviewer:** . . . Grey area.

CIX.3 **Salte:** Very grey areas. People feel very strongly about them and feel that, ethically, they believe that the other side is just completely wrong.

CIX.4 So trying to reconcile some of those and try to find ways where you can impose as little as possible upon the rights or obligations of some part of civilization, where at the same time imposing as little as possible upon the other side is a difficult compromise without question.

End 04:54

Notes

1. **Re: CIII.1 ". . . it is currently a requirement in the case of unwanted pregnancy."**

This is not the case. The policy in question is *Guideline on Unplanned Pregnancy*, adopted in 2011. It opens with the statement, "An unplanned pregnancy is not necessarily and unwanted pregnancy."

(http://www.cps.sk.ca/CPSS/Legislation__ByLaws__Policies_and_Guidelines/Legislation_Content/Policies_and_Guidelines_Content/Unplanned_Pregnancy.aspx)

Although, at the time, some of the major papers reported that the policy required objecting physicians to refer for abortion, this was incorrect.

The changes are intended to provide clarity, said Dr. Karen Shaw, the college's deputy registrar. They weren't prompted by any specific concerns, but were part of a regular review of college guidelines. The new guidelines were adopted at the council's most recent meeting on Friday.

"We didn't change the actual policy," she said. "It just made it clearer that people can state up front that they have difficulty with this and make a referral or they can assist the patient through all the steps they're comfortable with, until the point where they are more uncomfortable or the patient understands they're not willing to do the last step -which is to refer to someone they know will perform the abortion -but they must provide enough information."

Scissons H. "Abortion guidelines updated: Rules clarify protocol for doctors unwilling to terminate pregnancy." Saskatchewan Star Phoenix, 9 February, 2011

For a detailed explanation, see Appendix "E."

Re: CIII.1 "it currently is the policy in other provinces in dealing with some of those issues."
Only Quebec requires an objecting physician to refer a patient for a morally contested procedure.