March 2015

COUNCIL BRIEFING NOTE

TOPIC: Professional Obligations and Human Rights – Consultation Report & Revised Draft Policy

FOR DECISION

ISSUE:

- The draft *Professional Obligations and Human Rights* policy was released for external consultation between December 2014 and February 2015.
- Council is provided with a report on the consultation and the proposed revisions made to the draft policy in response to the feedback received.
- Council is asked whether the revised draft policy can be approved as a policy of the College.

BACKGROUND:

- A Working Group was struck to lead the review of the College's current *Physicians and the Ontario Human Rights Code* policy (attached as Appendix 1).
- The policy, which was first approved by Council in September 2008, articulates physicians' existing legal obligations under the Ontario *Human Rights Code* (the "*Code*"), and the College's expectation that physicians will respect the fundamental rights of those who seek their medical services.
- Of particular interest among physician members, organizational stakeholders, members of the public and media, is the section of the policy that addresses the College's expectations in circumstances where physicians limit the services they provide on moral or religious grounds. Such objections are commonly referred to as "conscientious objections".
- The policy review process was informed by an extensive research review, which included: a comprehensive literature review with particular emphasis on conscientious objection in the health services context; a jurisdictional comparison of positions taken by key external stakeholders, including those of other regulators within Canada and internationally; a broad preliminary consultation on the current policy; and a public poll of a representative sample of Ontarians.

- Based on research undertaken, feedback received through the preliminary consultation, and public polling results, the Working Group developed a draft policy entitled *Professional Obligations and Human Rights*.

- The draft policy was approved for external consultation at the December 2014 meeting of Council.

CURRENT STATUS:

- Council is provided with a report on the consultation, and a summary of revisions undertaken in response to the feedback received.

A. Report on Consultation

Consultation process

- The consultation was held from December 10, 2014 to February 20, 2015.

- Invitations to participate in the consultation were sent via email to a broad range of stakeholders, including the entire CPSO membership and key stakeholder organizations. In addition, a general notice was posted on the CPSO's website, Facebook page, and announced via Twitter. It was also published in *Dialogue* and *Noteworthy* (the CPSO's public e-newsletter).

- Stakeholders were given the option of submitting their feedback in writing, via email or regular mail, via a brief online survey, or by posting comments to a consultation-specific discussion page.

Number of responses

- In total, 3105 submissions have been received in response to this consultation. This includes 2208 comments either submitted by mail or posted to the online discussion page, and 897completed online surveys.

- Responses are tabulated as of the Council material submission date of February 11, 2015. An updated consultation report, including the final count of responses, will be provided at the March 2015 meeting of Council.

- Approximately 78% of responses are from members of the public, 14% from physicians or health care practitioners, 7% from "other" or "anonymous" and <1% from organizations[1].

[1] The organizational respondents to date are as follows: Christian Medical and Dental Society (CMDS); Renfrew Victoria Hospital - Regional Assault Program; Immanuel United Reformed Church; Alliance for Life Ontario; Queenship of Mary Community; Catholic Organization for Life and Family; Catholic Civil Rights League; Pro Life Movement; Canadian Disability Alliance; and Saskatchewan Pro-Life Association. Some organizations provided feedback through the online survey as well as in written form.

Summary of Feedback Received

- The majority of consultation respondents indicate that the draft policy clearly articulates physicians' legal obligations under the Ontario *Human Rights Code*, and the College's expectations of physicians who limit the health services they provide due to clinical competence, or due to their personal values and beliefs.

- As in the preliminary consultation, feedback focuses predominantly on the section of the draft policy that addresses the College's expectations in circumstances where physicians limit the services they provide on moral or religious grounds.

- The vast majority of consultation respondents are proponents of freedom of conscience, and argue that physicians should not have to provide services that conflict with their moral and/or religious beliefs.

- A vocal minority of consultation respondents argue the opposite perspective: that patient access to care should not be impacted by an individual physician's moral and/or religious beliefs.

- An overview of feedback received is provided below. The feedback is organized by section of the draft policy.

The Duty to Accommodate

- Respondents recommended that the draft policy content on the Duty to Accommodate be augmented by including examples of circumstances where a physician's legal duty to accommodate would be limited due to the "undue hardship" the accommodation would cause.

Limiting Health Services for Legitimate Reasons

i) Clinical Competence

- Respondents commented that this section should expressly state that clinical competence and/or scope of practice must not be used as a means of unfairly refusing patients with complex care needs.

ii) Moral or Religious Beliefs

Respecting Patient Dignity

- Several respondents expressed concern with the draft policy requirement that physicians, who are unwilling to provide certain elements of care due to their moral or religious beliefs, inform their patients that the objection is due to personal and not clinical reasons. Respondents who expressed this concern argue that a clear line cannot be drawn between the two.

Ensuring Access to Care

- The draft policy requires that physicians, who are unwilling to provide certain elements of care due to their moral or religious beliefs, refer the patient to another health care provider. The vast majority of consultation respondents, who are also supportive of conscientious objection, are opposed to this requirement as they consider a referral to be morally equivalent to providing the treatment/procedure in question.

- Some respondents recommended that the referral requirement in the draft policy be expanded to permit referrals to an agency or resource. The prospect of referring to an agency was considered more palatable to some, from a moral perspective, as compared to providing a referral to an individual physician/health care provider.

- Several respondents were of the opinion that a referral should not be necessary where a treatment/procedure is publically available and accessible by self-referral.

- Respondents also recommended that the draft policy include examples of an effective referral, particularly what is meant by an “available” and “accessible” physician or other health-care provider.

iii) Protecting Patient Safety

- Many respondents expressed concern with the requirement in the draft policy that physicians provide care that is urgent or otherwise necessary to prevent imminent harm, suffering, and/or deterioration, even where that care conflicts with their religious or moral beliefs. Those respondents felt the scope of this requirement was overbroad.

- Respondents recommended that further detail around the degree/type of harm, suffering and/or deterioration that would trigger this requirement be included in the draft policy.

B. Revisions in Response to Feedback

- All feedback has been carefully reviewed by the Working Group.

- The Working Group has made revisions to the draft policy in response to the feedback. A track changes version of the draft policy, highlighting the specific revisions made, is attached as **Appendix 2**. A clean copy of the draft policy is attached as **Appendix 3.**

Key Revisions and Additions

1. In order to enhance the clarity and flow of the draft policy, minor editorial changes have been proposed.

2. In order to ensure the language used throughout the draft policy mirrors that of the Ontario *Human Rights Code*, the term "equitable" has been replaced with "equal" in instances where the *Code* is directly referenced.

3. A footnote has been added to the Clinical Competence section of the draft policy to indicate that physicians must not use clinical competence or scope of practice as a means of unfairly refusing patients with complex health care needs or patients who are perceived to be otherwise difficult. This expectation originates from the College's *Accepting New Patients* policy.

4. The requirement that physicians provide care that is urgent or otherwise necessary to prevent imminent harm, suffering, and/or deterioration, even where that care conflicts with their religious or moral beliefs, has been revised. This language has been revised to clearly signal that the requirement applies only in emergency situations, which was the Working Group's original intention.

5. Despite objection from consultation participants, the Working Group has elected to maintain the requirement that physicians, who are unwilling to provide certain elements of care due to their moral or religious beliefs, refer the patient to another health care provider. This requirement has been expanded to allow physicians to also refer the patient to an agency that will coordinate and/or provide the treatment/service to which the physician objects.

    Rationale:

    - The Working Group is of the opinion that the referral requirement strikes an appropriate balance between patient and physician rights; reflects the expectations of the Ontario public; and is consistent with the positions of other medical regulators in Canada.

    - The draft policy protects patient rights by ensuring that patients are not prevented from accessing care that is clinically indicated and legally available because a physician objects to that care on moral or religious grounds.

    - Physicians' right to freedom of conscience and religion is respected by not requiring physicians to provide care that is clinically indicated and legally available but contrary to their religious or moral beliefs, except in emergency situations.

- In May 2014, the College commissioned a public opinion poll of a representative sample of Ontarians to capture public sentiment on conscientious objection.

- The polling results indicated that Ontarians believe that physicians who object to providing care on moral or religious grounds should be required to:
    - Provide patients with information about treatment or procedure options (94%)
    - Identify another physician who will provide the treatment, and advise the patient to contact them (92%)
    - Make/coordinate the referral (87%)

- The expectations that are outlined in the draft policy to ensure patient access to care are in line with the positions of a number of other Canadian medical regulators:

    - *Quebec:* Where physicians' personal convictions prevent them from prescribing or providing professional services that may be appropriate, the physician must offer to help the patient find another physician.

    - *Saskatchewan:* The expectations outlined in the draft policy, including the referral requirement, align with the position taken by the College of Physicians and Surgeons of Saskatchewan (CPSS) in their draft policy titled Conscientious Refusal. This draft policy has been approved in principle by the CPSS Council, and an external consultation is underway.

    - *Alberta, Manitoba and New Brunswick*: Patients must be offered timely access to another physician or resource that will provide accurate information about all available medical/surgical options to which the physician objects on moral or religious grounds.

<u>Substantive comments that were not incorporated into the draft policy</u>

1. The Working Group considered feedback received on the perceived challenge of categorizing an objection as either personal or clinical. After careful review, the Working Group determined that it is possible to distinguish clinical objections from those that are personal, and therefore elected to leave this section of the policy unchanged.

2. The Working Group decided not to qualify the referral expectation in circumstances where the treatment/service to which the physician objects may be available to the patient through self-referral. This decision was made to avoid placing the onus on the patient, and to ensure timely access to care.

ADDITIONAL CONSIDERATIONS:

- Council will receive an update on feedback received from the date of drafting this briefing note to the end of the consultation period at the March 2015 meeting. Any further revisions to the draft policy that are proposed by the Working Group to address this feedback will also be reported to Council at that time.

- In order to provide further elaboration on key policy concepts, the Working Group has elected to develop a companion FAQ document. This document will include:

    - Circumstances where physicians may legitimately limit their practice due to their own clinical competence;
    - Examples of how physicians can satisfy the "effective referral" requirement, where they choose to limit the services they provide on moral or religious grounds;
    - Circumstances that would require physicians to provide emergency treatment, despite the fact that the treatment may conflict with their religious or moral beliefs;
    - An explanation for the membership that non-compliance with the policy will be considered in accordance with the College's duty to serve and protect the public interest;
    - Elaboration upon what is meant by "promoting religious beliefs";
    - Examples of circumstances where a physician's legal duty to accommodate may be limited due to the "undue hardship" the accommodation would cause; and
    - The impact, if any, of the Supreme Court of Canada's decision that *Criminal Code* provisions prohibiting physician assisted death are invalid on expectations set out in the policy.[2]

NEXT STEPS:

- Should Council approve the draft policy, as revised, it will be published in *Dialogue* and will replace the current version of the *Physicians and the Ontario Human Rights Code* policy on the CPSO website.

[2] A summary of the Supreme Court of Canada's decision in *Carter v. Canada (Attorney General)*, 2015 SCC 5, will be provided to Council in a separate briefing note under items for information.

- All stakeholders who responded to the consultation will receive a copy of the new policy, along with a letter thanking them for their participation.

DECISIONS FOR COUNCIL:

1. Does Council have any feedback on the revised draft *Professional Obligations and Human Rights* policy?

2. Does Council approve the revised draft *Professional Obligations and Human Rights* policy?

DATE: February 12, 2015

Attachments:

Appendix 1: Current Policy, Physicians and the Ontario Human Rights Code
Appendix 2: Revised Draft Policy, Professional Obligations and Human Rights (with track changes)
Appendix 3: Revised Draft Policy, Professional Obligations and Human Rights

Professional Obligations and Human Rights

INTRODUCTION

The fiduciary nature of the physician-patient relationship requires that physicians act in their patients' best interests. In doing so, physicians must strive to create and foster an environment in which the rights, autonomy, dignity and diversity of all patients, or those seeking to become patients, are respected. This goal is achieved, in part, by fulfilling the obligations under the *Ontario Human Rights Code*[1] (the "*Code*"), which entitles every Ontario resident to ~~equitable~~ equal treatment with respect to services, including health services, without discrimination.

This policy articulates physicians' professional and legal obligations to provide health services without discrimination. This includes a duty to accommodate individuals who may face barriers to accessing care. The policy also sets out the College's expectations for physicians who limit the health services they provide due to clinical competence or because of their personal values and beliefs.

PRINCIPLES

The key values of professionalism articulated in the College's *Practice Guide* – compassion, service, altruism and trustworthiness – form the basis for the expectations set out in this policy. Physicians embody these values and uphold the reputation of the profession by, among other things:

1. Acting in the best interests of their patients, and ensuring that all patients, or those seeking to become patients, receive equitable access to care. This is especially important with respect to vulnerable and/or marginalized populations;
2. Communicating effectively and respectfully with patients, or those seeking to become patients, in a manner that supports their autonomy in decision-making, and ensures they are informed about their medical care;
3. Properly managing conflicts, especially where the physician's values differ from those of their patients, or those seeking to become patients. The patient's best interests must remain paramount;
4. Participating in self-regulation of the medical profession by complying with the expectations set out in this policy.

PURPOSE

This policy sets out the legal obligations under the *Code* for physicians to provide health services without discrimination, as well as the College's professional and ethical expectations of physicians in meeting those obligations. This policy also sets out physicians' duty to accommodate individuals who may face barriers to accessing care. Finally, this policy outlines physicians' rights to limit the health services they provide for legitimate reasons while upholding their fiduciary duty to their patients.

[1] *Human Rights Code*, RSO 1990, c H.19.

POLICY

Human Rights, Discrimination and Access to Care

The *Code* articulates the right of every Ontario resident to receive ~~equitable~~ equal treatment with respect to services, goods and facilities, without discrimination on the grounds of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.[2] The *Code* requires that all those who provide services in Ontario, including physicians providing health services, do so free from discrimination.

Discrimination may be described as an act, decision or communication that results in the unfair treatment of a person or group by either imposing a burden on them, or denying them a right, privilege, benefit or opportunity enjoyed by others. Discrimination may be direct and intentional. Alternatively, discrimination may be entirely unintentional, where rules, practices or procedures appear neutral, but may have the effect of disadvantaging certain groups of people. The *Code* provides protection from all forms of discrimination based on the above protected grounds, whether intentional or unintentional.[3]

Physicians must comply with the *Code*, and the expectations of the College, when making any decision relating to the provision of health services. This means that physicians cannot discriminate, either directly or indirectly, based on a protected ground under the *Code* when, for example:

- Accepting or refusing individuals as patients;
- Providing existing patients with healthcare or services;
- Providing information or referrals to existing patients or those seeking to become patients; and/or
- Ending the physician-patient relationship.

The Duty to Accommodate

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

The *Code* requires physicians to take reasonable steps to accommodate the needs of existing patients, or those seeking to become patients, where a disability[4] or other personal circumstance may impede or

[2] *Human Rights Code*, RSO 1990, c H.19, s 1.

[3] As adapted from the Human Rights Commission of Ontario's definition of 'discrimination'.

[4] Section 1 of the *Human Rights Code*, RSO 1990, c H.19 defines "disability" as follows:

> (a) any degree of physical disability, infirmity, malformation or disfigurement that is caused by bodily injury, birth defect or illness and, without limiting the generality of the foregoing, includes diabetes mellitus, epilepsy, a brain injury, any degree of paralysis, amputation, lack of physical co-ordination, blindness or visual impediment, deafness or hearing impediment, muteness or speech impediment, or physical reliance on a guide dog or other animal or on a wheelchair or other remedial appliance or device, (b) a condition of mental impairment or a developmental disability,

limit their access to care. The purpose in doing so is to eliminate or reduce any barriers or obstacles that they may experience.

The College expects physicians to comply with their duty to accommodate as set out in the *Code*, and to make accommodations in a manner that is respectful of the dignity, autonomy and privacy of the person.

Examples of accommodation may include: enabling access for those with mobility limitations, permitting a guide dog to accompany a patient into the examination room, ensuring that patients with hearing impairment can be assisted by a sign-language interpreter, being considerate of older patients that may face unique communication barriers, and/or providing reasonable flexibility around scheduling appointments where patients have family-related needs.[5]

While physicians have a legal, professional and ethical duty to accommodate, there are limits to this duty. Physicians do not have to accommodate beyond the point of undue hardship, where excessive cost, ~~or~~ health or safety concerns would result. The duty to accommodate is also limited where it significantly interferes with the legal rights of others.[6]

Limiting Health Services for Legitimate Reasons

The duty to refrain from discrimination does not prevent physicians from limiting the health services they provide for legitimate reasons.[7] Physicians, for instance, may be unable to provide care that is clinically indicated and within the standard of care, if that care is outside of their clinical competence. Also, physicians may be unwilling to provide care that is contrary to their moral or religious beliefs.

While physicians may limit the health services they provide as discussed below, they must do so in a manner that respects patient dignity and autonomy, upholds their fiduciary duty to the patient, and does not impede equitable access to care for existing patients, or those seeking to become patients.

The following sections set out physicians' rights and obligations in these circumstances.

i) Clinical Competence

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. Physicians are expected to provide patients with quality health care in a safe manner. If physicians feel they cannot appropriately

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(c) a learning disability, or a dysfunction in one or more of the processes involved in understanding or using symbols or spoken language,
(d) a mental disorder, or
(e) an injury or disability for which benefits were claimed or received under the insurance plan established under the *Workplace Safety and Insurance Act, 1997*.

[5] Ontario Human Rights Commission, *Submission Regarding College of Physicians and Surgeons Policy Review: Physicians and the Ontario Human Rights Code,* (Ontario: August 1, 2014).

[6] Further explanation of 'undue hardship' is provided in the Human Rights Commission's *Policy and Guidelines on Disability and the Duty to Accommodate*.

[7] For more information see the College's *Accepting New Patients* and *Ending the Physician-Patient Relationship* policies.

meet the health care needs of an existing patient, or those who wish to become patients, they are not required to provide that specific health service or to accept that person as a patient. However, physicians must comply with the *Code*, and College expectations, in so doing. Any decision to limit health services provided on the basis of clinical competence must be made in good faith[8].

Where clinical competence may restrict the type of services or treatments provided, or the type of patients a physician is able to accept, the College requires physicians to inform patients of this as soon as is reasonable. The College expects physicians to communicate this information in a clear and straightforward manner to ensure that individuals or patients understand that their decision is based on an actual lack of clinical competence rather than discriminatory bias or prejudice. This will lessen the likelihood of misunderstandings.

In order to protect patients' best interests and to ensure that existing patients, or those seeking to become patients, are not abandoned, the College requires physicians to provide a referral to another appropriate health care provider for the elements of care the physician is unable to manage directly.

ii) Moral or Religious Beliefs

The *Canadian Charter of Rights and Freedoms* (the *"Charter"*) protects the right to freedom of conscience and religion.[9] Although physicians have this freedom under the *Charter*, the Supreme Court of Canada has determined that no rights are absolute. The right to freedom of conscience and religion can be limited, as necessary, to protect public safety, order, health, morals, or the fundamental rights and freedoms of others.[10]

Where physicians choose to limit the health services they provide for moral or religious reasons, this may impede access to care ~~resulting in a violation of patient rights under the *Charter* and~~in a manner that violates patient rights under the *Charter* and *Code*.[11] The courts have determined that there is no hierarchy of rights; all rights are of equal importance.[12] Should a conflict arise, the aim of the courts is to respect the importance of both sets of rights to the extent possible.

The balancing of rights must be done in context.[13] In relation to freedom of religion specifically, courts will consider ~~how directly~~the degree to which the act in question interferes with a sincerely held 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. The less direct the impact on a religious belief, the less

[8] As stated in the College's *Accepting New Patients* policy, "Clinical competence and scope of practice must not be used as a means of unfairly refusing patients with complex health care needs or patients who are perceived to be otherwise difficult."

[9] *Canadian Charter of Rights and Freedoms,* Part I of the *Constitution Act, 1982,* being Schedule B to the *Canada Act 1982* (UK), 1982, c 11, s 2(a).

[10] *R. v Big M Drug Mart Ltd.*, [1985] 1 SCR 295 at para 95.

[11] *R. v Morgentaler*, [1988] 1 SCR 30 at pp 58-61, and see also the *Code*.

[12] *Dagenais v Canadian Broadcasting Corp.,* [1994] 3 SCR 835 at p 839.

[13] Ontario Human Rights Commission, *Policy on Competing Human Rights,* (Ontario: Jan 26, 2012).

likely courts are to find that freedom of religion is infringed.[14] Conduct that would potentially cause harm to and interfere with the rights of others would not automatically be protected.[15]

While the *Charter* entitles physicians to limit the health services they provide on moral or religious grounds, this cannot impede, either directly or indirectly, access to care for existing patients, or those seeking to become patients. Therefore, the College requires physicians who choose to limit the health services they provide on moral or religious grounds to do so in a manner that:

i. Respects patient dignity;
ii. Ensures access to care; **and**
iii. Protects patient safety.

i. *Respecting Patient Dignity*

Where physicians are unwilling to provide certain elements of care due to their moral or religious beliefs, physicians must communicate their objection directly and with sensitivity to existing patients, or those seeking to become patients, and inform them that the objection is due to personal and not clinical reasons.

In the course of communicating their objection, physicians must not express personal judgments about the beliefs, lifestyle, identity or characteristics of existing patients, or those seeking to become patients. This includes not refusing or delaying treatment because the physician believes the patient's own actions have contributed to their condition. Furthermore, physicians must not promote their own religious beliefs when interacting with patients, or those seeking to become patients, nor attempt to convert them.

ii. Ensuring Access to Care

Physicians must provide information about all clinical options that may be available or appropriate to meet patients' clinical needs or concerns. Physicians must not withhold information about the existence of any procedure or treatment because ~~the procedure~~ it conflicts with their religious or moral beliefs.

Where physicians are unwilling to provide certain elements of care due to their moral or religious beliefs, an effective referral to another health care provider must be provided to the patient. An effective referral means a referral made in good faith, to a non-objecting, available, and accessible physician, ~~or~~ other health-care provider, or agency.[16] The referral must be made in a timely manner to reduce the risk of adverse clinical outcomes. Physicians must not impede access to care for existing patients, or those seeking to become patients.

The College expects physicians to proactively maintain an effective referral plan for the frequently requested services they are unwilling to provide.

[14] *Syndicat Northcrest v Amselem,* [2004]2 SCR 551 at paras 59-61.
[15] *Syndicat Northcrest v Amselem*, [2004] 2 SCR 551 at para 62.
[16] In the hospital setting, referral practices may vary in accordance with hospital policies and procedures.

iii. Protecting Patient Safety

Physicians must provide care in an emergency, where it is necessary ~~situation that is urgent or otherwise necessary~~ to prevent imminent harm, ~~suffering, and/or deterioration,~~ even where that care conflicts with their religious or moral beliefs.[17]

[17] This expectation is consistent with the College's *Providing Physician Services during Job Actions* policy. For further information specific to providing care in health emergencies, please see the College's *Physicians and Health Emergencies* policy.

Professional Obligations and Human Rights

INTRODUCTION

The fiduciary nature of the physician-patient relationship requires that physicians act in their patients' best interests. In doing so, physicians must strive to create and foster an environment in which the rights, autonomy, dignity and diversity of all patients, or those seeking to become patients, are respected. This goal is achieved, in part, by fulfilling the obligations under the *Ontario Human Rights Code*[1] (the "*Code*"), which entitles every Ontario resident to equal treatment with respect to services, including health services, without discrimination.

This policy articulates physicians' professional and legal obligations to provide health services without discrimination. This includes a duty to accommodate individuals who may face barriers to accessing care. The policy also sets out the College's expectations for physicians who limit the health services they provide due to clinical competence or because of their personal values and beliefs.

PRINCIPLES

The key values of professionalism articulated in the College's *Practice Guide* – compassion, service, altruism and trustworthiness – form the basis for the expectations set out in this policy. Physicians embody these values and uphold the reputation of the profession by, among other things:

1. Acting in the best interests of their patients, and ensuring that all patients, or those seeking to become patients, receive equitable access to care. This is especially important with respect to vulnerable and/or marginalized populations;
2. Communicating effectively and respectfully with patients, or those seeking to become patients, in a manner that supports their autonomy in decision-making, and ensures they are informed about their medical care;
3. Properly managing conflicts, especially where the physician's values differ from those of their patients, or those seeking to become patients. The patient's best interests must remain paramount;
4. Participating in self-regulation of the medical profession by complying with the expectations set out in this policy.

PURPOSE

This policy sets out the legal obligations under the *Code* for physicians to provide health services without discrimination, as well as the College's professional and ethical expectations of physicians in meeting those obligations. This policy also sets out physicians' duty to accommodate individuals who may face barriers to accessing care. Finally, this policy outlines physicians' rights to limit the health services they provide for legitimate reasons while upholding their fiduciary duty to their patients.

[1] *Human Rights Code*, RSO 1990, c H.19.

POLICY

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The *Code* articulates the right of every Ontario resident to receive equal treatment with respect to services, goods and facilities, without discrimination on the grounds of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.[2] The *Code* requires that all those who provide services in Ontario, including physicians providing health services, do so free from discrimination.

Discrimination may be described as an act, decision or communication that results in the unfair treatment of a person or group by either imposing a burden on them, or denying them a right, privilege, benefit or opportunity enjoyed by others. Discrimination may be direct and intentional. Alternatively, discrimination may be entirely unintentional, where rules, practices or procedures appear neutral, but may have the effect of disadvantaging certain groups of people. The *Code* provides protection from all forms of discrimination based on the above protected grounds, whether intentional or unintentional.[3]

Physicians must comply with the *Code*, and the expectations of the College, when making any decision relating to the provision of health services. This means that physicians cannot discriminate, either directly or indirectly, based on a protected ground under the *Code* when, for example:

- Accepting or refusing individuals as patients;
- Providing existing patients with healthcare or services;
- Providing information or referrals to existing patients or those seeking to become patients; and/or
- Ending the physician-patient relationship.

The Duty to Accommodate

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

The *Code* requires physicians to take reasonable steps to accommodate the needs of existing patients, or those seeking to become patients, where a disability[4] or other personal circumstance may impede or

[2] *Human Rights Code*, RSO 1990, c H.19, s 1.
[3] As adapted from the Human Rights Commission of Ontario's definition of 'discrimination'.
[4] Section 1 of the *Human Rights Code*, RSO 1990, c H.19 defines "disability" as follows:

> (a) any degree of physical disability, infirmity, malformation or disfigurement that is caused by bodily injury, birth defect or illness and, without limiting the generality of the foregoing, includes diabetes mellitus, epilepsy, a brain injury, any degree of paralysis, amputation, lack of physical co-ordination, blindness or visual impediment, deafness or hearing impediment, muteness or speech impediment, or physical reliance on a guide dog or other animal or on a wheelchair or other remedial appliance or device,
> (b) a condition of mental impairment or a developmental disability,

limit their access to care. The purpose in doing so is to eliminate or reduce any barriers or obstacles that they may experience.

The College expects physicians to comply with their duty to accommodate as set out in the *Code*, and to make accommodations in a manner that is respectful of the dignity, autonomy and privacy of the person.

Examples of accommodation may include: enabling access for those with mobility limitations, permitting a guide dog to accompany a patient into the examination room, ensuring that patients with hearing impairment can be assisted by a sign-language interpreter, being considerate of older patients that may face unique communication barriers, and/or providing reasonable flexibility around scheduling appointments where patients have family-related needs.[5]

While physicians have a legal, professional and ethical duty to accommodate, there are limits to this duty. Physicians do not have to accommodate beyond the point of undue hardship, where excessive cost, health or safety concerns would result. The duty to accommodate is also limited where it significantly interferes with the legal rights of others.[6]

Limiting Health Services for Legitimate Reasons

The duty to refrain from discrimination does not prevent physicians from limiting the health services they provide for legitimate reasons.[7] Physicians, for instance, may be unable to provide care that is clinically indicated and within the standard of care, if that care is outside of their clinical competence. Also, physicians may be unwilling to provide care that is contrary to their moral or religious beliefs.

While physicians may limit the health services they provide as discussed below, they must do so in a manner that respects patient dignity and autonomy, upholds their fiduciary duty to the patient, and does not impede equitable access to care for existing patients, or those seeking to become patients.

The following sections set out physicians' rights and obligations in these circumstances.

i) Clinical Competence

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. Physicians are expected to provide patients with quality health care in a safe manner. If physicians feel they cannot appropriately

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(c) a learning disability, or a dysfunction in one or more of the processes involved in understanding or using symbols or spoken language,
(d) a mental disorder, or
(e) an injury or disability for which benefits were claimed or received under the insurance plan established under the *Workplace Safety and Insurance Act, 1997*.

[5] Ontario Human Rights Commission, *Submission Regarding College of Physicians and Surgeons Policy Review: Physicians and the Ontario Human Rights Code,* (Ontario: August 1, 2014).

[6] Further explanation of 'undue hardship' is provided in the Human Rights Commission's *Policy and Guidelines on Disability and the Duty to Accommodate*.

[7] For more information see the College's *Accepting New Patients* and *Ending the Physician-Patient Relationship* policies.

meet the health care needs of an existing patient, or those who wish to become patients, they are not required to provide that specific health service or to accept that person as a patient. However, physicians must comply with the *Code*, and College expectations, in so doing. Any decision to limit health services provided on the basis of clinical competence must be made in good faith[8].

Where clinical competence may restrict the type of services or treatments provided, or the type of patients a physician is able to accept, the College requires physicians to inform patients of this as soon as is reasonable. The College expects physicians to communicate this information in a clear and straightforward manner to ensure that individuals or patients understand that their decision is based on an actual lack of clinical competence rather than discriminatory bias or prejudice. This will lessen the likelihood of misunderstandings.

In order to protect patients' best interests and to ensure that existing patients, or those seeking to become patients, are not abandoned, the College requires physicians to provide a referral to another appropriate health care provider for the elements of care the physician is unable to manage directly.

ii) Moral or Religious Beliefs

The *Canadian Charter of Rights and Freedoms* (the *"Charter"*) protects the right to freedom of conscience and religion.[9] Although physicians have this freedom under the *Charter*, the Supreme Court of Canada has determined that no rights are absolute. The right to freedom of conscience and religion can be limited, as necessary, to protect public safety, order, health, morals, or the fundamental rights and freedoms of others.[10]

Where physicians choose to limit the health services they provide for moral or religious reasons, this may impede access to care in a manner that violates patient rights under the *Charter* and *Code*.[11] The courts have determined that there is no hierarchy of rights; all rights are of equal importance.[12] Should a conflict arise, the aim of the courts is to respect the importance of both sets of rights to the extent possible.

The balancing of rights must be done in context.[13] In relation to freedom of religion specifically, courts will consider the degree to which the act in question interferes with a sincerely held religious belief. Courts will seek to determine whether the act interferes with the religious belief in a manner that is more than trivial or insubstantial. The less direct the impact on a religious belief, the less likely courts

[8] As stated in the College's *Accepting New Patients* policy, "Clinical competence and scope of practice must not be used as a means of unfairly refusing patients with complex health care needs or patients who are perceived to be otherwise difficult."

[9] *Canadian Charter of Rights and Freedoms,* Part I of the *Constitution Act, 1982,* being Schedule B to the *Canada Act 1982* (UK), 1982, c 11, s 2(a).

[10] *R. v Big M Drug Mart Ltd.*, [1985] 1 SCR 295 at para 95.

[11] *R. v Morgentaler*, [1988] 1 SCR 30 at pp 58-61, and see also the *Code*.

[12] *Dagenais v Canadian Broadcasting Corp.,* [1994] 3 SCR 835 at p 839.

[13] Ontario Human Rights Commission, *Policy on Competing Human Rights,* (Ontario: Jan 26, 2012).

are to find that freedom of religion is infringed.[14] Conduct that would potentially cause harm to and interfere with the rights of others would not automatically be protected.[15]

While the *Charter* entitles physicians to limit the health services they provide on moral or religious grounds, this cannot impede, either directly or indirectly, access to care for existing patients, or those seeking to become patients. Therefore, the College requires physicians who choose to limit the health services they provide on moral or religious grounds to do so in a manner that:

i. Respects patient dignity;
ii. Ensures access to care; **and**
iii. Protects patient safety.

i. *Respecting Patient Dignity*

Where physicians are unwilling to provide certain elements of care due to their moral or religious beliefs, physicians must communicate their objection directly and with sensitivity to existing patients, or those seeking to become patients, and inform them that the objection is due to personal and not clinical reasons.

In the course of communicating their objection, physicians must not express personal judgments about the beliefs, lifestyle, identity or characteristics of existing patients, or those seeking to become patients. This includes not refusing or delaying treatment because the physician believes the patient's own actions have contributed to their condition. Furthermore, physicians must not promote their own religious beliefs when interacting with patients, or those seeking to become patients, nor attempt to convert them.

ii. Ensuring Access to Care

Physicians must provide information about all clinical options that may be available or appropriate to meet patients' clinical needs or concerns. Physicians must not withhold information about the existence of any procedure or treatment because it conflicts with their religious or moral beliefs.

Where physicians are unwilling to provide certain elements of care due to their moral or religious beliefs, an effective referral to another health care provider must be provided to the patient. An effective referral means a referral made in good faith, to a non-objecting, available, and accessible physician, other health-care provider, or agency.[16] The referral must be made in a timely manner to reduce the risk of adverse clinical outcomes. Physicians must not impede access to care for existing patients, or those seeking to become patients.

The College expects physicians to proactively maintain an effective referral plan for the frequently requested services they are unwilling to provide.

[14] *Syndicat Northcrest v Amselem,* [2004]2 SCR 551 at paras 59-61.
[15] *Syndicat Northcrest v Amselem*, [2004] 2 SCR 551 at para 62.
[16] In the hospital setting, referral practices may vary in accordance with hospital policies and procedures.

iii. Protecting Patient Safety

Physicians must provide care in an emergency, where it is necessary to prevent imminent harm, even where that care conflicts with their religious or moral beliefs.[17]

[17] This expectation is consistent with the College's *Providing Physician Services during Job Actions* policy. For further information specific to providing care in health emergencies, please see the College's *Physicians and Health Emergencies* policy.