9 March, 2015 NUMBER 38/15

COLLEGE OF PHYSICIANS AND SURGEONS

OF SASKATCHEWAN

TO COUNCIL

FROM: Registrar

SUBJECT: Policy on Conscientious Objection

For Your Decision

M E M O R A N D U M

DATE: March 9, 2015

TO: Council

FROM: Bryan E. Salte

RE: Draft Policy – Conscientious Objection

1. Decision Required

This memo has been prepared based upon the feedback which the College has received to the draft policy.

As a result of the feedback, the committee has agreed to meet on Thursday, March 17. A further report from the committee which developed the draft policy may be forthcoming.

However, based upon the current draft that is part of this memorandum, and which was approved in principle by the Council, I suggest that Council make one of the following decisions:

1) To approve the policy without changes;
2) To approve the principles of the policy but make whatever changes the Council thinks is appropriate;
3) To approve the principles of the policy but send the policy back for rewrite based upon specific directions relating to change;
4) To decide not to adopt a policy on conscientious objection.

In addition, if the Council concludes that it continues to support the policy in general, the Council may wish to consider whether there is something different about physician assisted death that should result in it being addressed differently than other issues of conscientious objection.

That issue is also addressed in discussing the feedback from CMPA and the comments of Dr. Hayton at the end of this memorandum.

2. Results of the Feedback

Email messages were sent to every Saskatchewan physician inviting comment on the policy. Additionally, the policy and an opportunity to comment were posted on the website to allow physicians and members of the public to comment.

The SMA has a proposed response which will be reviewed by the Board for final approval. I have advised the SMA that, provided they have the response to me more than one week prior to the Council meeting, it will be distributed.

The draft policy resulted in the type of response that I had expected. Various groups encouraged their supporters to write to the College expressing opposition to the policy. Some groups provided template letters with responses that could be sent to the College. The source of the template letters appears to have been Catholic and Right to Life Groups.

There were in excess of 4,400 responses received. Most were members of the public, not physicians. While the number of responses received is fewer than the 14,000 responses received by the Ontario College when it considered (and adopted) a similar policy, that was a very significant return.

Almost all of the feedback was opposed to the policy.

3. Common themes:

One thing that I found personally disappointing was that very few of the responses commented at all about patients, patient interests, or the fiduciary obligations of physicians towards their patients.

While physician responses referred to aspects of the *Code of Ethics*, and used that as support for the position that they should have an absolute right not to refer a patient to another provider, none of the responses mentioned two specific statements in the *Code of Ethics* which address a physician's obligation to provide information to a patient so that the patient can make an informed decision:

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.

22. Make every reasonable effort to communicate with your patients in such a way that information exchanged is understood.

Many of the responses appeared to be based upon a general objection to abortion, birth control or physician assisted dying. From my perspective, relatively few of the responses addressed in a thoughtful way how to reconcile the interests of patients with the conscientious objections of physicians.

The most common concerns expressed as I interpret them were:

1) Many physicians feel that referring a patient for a service which that physician finds morally objectionable is, itself, ethically wrong. Compelling physicians to make a referral to a practitioner who can provide a service which the referring physician finds morally objectionable breaches the conscience rights of the physician.
2) A number of physicians and members of the public stated that moral judgments are inextricably linked with the provision of good medical care and compelling physicians to act contrary to their conscience is inconsistent with good medical care.
3) A number of respondents referred to a "slippery slope" associated with physician assisted dying.
4) Several responses suggested that the draft policy is not sufficiently clear on the difference between a physician who refuses to provide a particular service based upon clinical grounds and a physician who refuses to provide a particular service based upon a conscientious objection to the treatment.
5) A number of responses take issue with the requirement of the policy that physicians must provide health services if referral to another health care provided is not possible and refusing to do so would cause a delay that would jeopardize the patient's health or well-being. In addition to those responses which ignore the statement that the obligation only exists if "refusing to do so would cause a delay that would jeopardize the patient's health or well-being", a number of responses suggest that the policy is open to abuse as it is not sufficiently specific as to what would constitute "a delay that would jeopardize the patient's health or well-being".

6) Related to that is the concern expressed by some undergraduate medical students that the policy requires a referral to a provider who can provide the service. Finding providers may be difficult as, for example, there are a limited number of physicians who provide abortions, although there are a larger number of physicians who can provide appropriate counseling about abortion, even if they do not themselves perform abortions.

4. Specific concerns

1) A few persons expressed concern about the effect that the policy would have on faith-based institutions.
2) Dr. Fitzpatrick (page 121) criticizes the policy from two perspectives:
   a) He states that it is reasonable for a policy to mandate that a patient be provided all relevant information respecting a medical service for the patient, but that should not extend to making a referral to a provider who will provide the service.
   b) He states that the tone of the document is unnecessarily adversarial, rather than enforcing the relationship between the physician and the patient.
3) Pat and Donna Rogal express the concern that doctors working in faith-based institutions or who share a religious faith with a patient should not be prohibited from discussion religion with or praying with their patient.

5. Specific suggestions for changes to the policy:

1) CMPA provided several comments about the wording of the policy. CMPA did not address the merits of the policy.
   a) CMPA first commented that both the College Guideline on Physician Patient Relationships and the draft policy on Conscientious Objection state that a physician should not refuse to accept a patient based upon discriminatory grounds. CMPA questioned why there is a difference in the two lists of prohibited grounds.

      The Guideline on Physician Patient Relationships reproduces the CMA Code of Ethics, which states:

> 17. In providing medical service, do not discriminate against any patient on such grounds as age, gender, married status, medical condition, national or ethnic origin, physical or mental disability, political affiliation, race, religion, sexual orientation, or socioeconomic status. This does not abrogate the physician's right to refuse to accept patients for legitimate reasons.

The draft policy on Conscientious Objection states:

> 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.

b) CMPA thinks that there is a potential ambiguity when two paragraphs begin with the words "The above obligation" and suggests that the second paragraph would be clearer if it instead began with the phrase "The duty of a physician not to refuse to accept a patient based on the characteristics identified does not prevent …"

The paragraphs currently follow the list of prohibited grounds of discrimination and state:

> 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.

CMPA suggests that the second paragraph be amended to read:

The duty of a physician not to refuse to accept a patient based on the characteristics identified does not prevent physicians from making *bona fide* decisions to develop a non-discriminatory focused practice.

c) CMPA thinks that the statement about a physician's obligation to provide information is too broadly stated, as physicians are not required to discuss what might be clearly regarded as unconventional therapies. CMPA recommends that this paragraph be amended to state that physicians are only required to provide their patients with information regarding **reasonable** treatment alternatives.

If the recommendation is adopted, the paragraph which currently reads:

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.

will be changed to read:

Physicians must provide their patients with the health information required to make legally valid informed choices about medical treatment (e.g., diagnosis, prognosis, and reasonable treatment options) even if even if the provision of such information conflicts with the physician's deeply held and considered moral or religious beliefs.

d) CMPA suggests that the reference to a lawful excuse can be removed from both 5.3 and 5.4 as potentially confusing to physicians. The letter from CMPA states:

Both sections 5.3 and 5.4 include a paragraph that states: "This obligation does not prevent physicians from refusing to refer patients where there exists a recognized lawful excuse (see s. 3)". In our view, these paragraphs may be challenging for physicians to understand. We therefore recommend that the College consider removing these paragraphs, particularly as the concept is already captured in section 4 of the Policy, which states that "[i]n certain circumstances a physician

will have a lawful excuse to refuse to provide a service requested by a patient."

Comment from Bryan Salte – This is the comment from CMPA with which I strongly disagree. I don't agree that the concept of "recognized lawful excuse" is adequately captured in section 4, as that states that "**In certain circumstances** a physician will have a lawful excuse to refuse to provide a service requested by a patient", without stating in what circumstances that may occur.

Additionally, one of the concerns from some of the respondents appears to be that the policy will unduly interfere with clinical decision making if a physician refuses to provide a medical service based upon clinical judgment. Some respondents stated their concern that this allowed patients to compel a physician to refer them to another provider, even if the physician believed that the treatment was inappropriate for clinical reasons. The draft policy is intended make it clear that a referral to another practitioner is not necessary if that decision is based upon clinical judgment.

If there is a potential lack of clarity, I think that the solution is not to remove the paragraphs from the policy, but to clarify those statements so that it is clear that the expectations of the policy address conscientious objection and not clinical decision-making.

The paragraphs currently read (the relevant sentences in red font)

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).

If the concern is the potential confusion caused by the term "recognized lawful excuse", it may be better to state something like:

This obligation does not prevent physicians from refusing to refer patients based upon the physician's clinical judgment that the health service would not be clinically appropriate for the patient or where there exists another recognized lawful excuse (see s. 3).

- and -

This obligation does not prevent physicians from refusing to treat a patient based upon the physician's clinical judgment that the health service would not be clinically appropriate for the patient or where there exists another recognized lawful excuse (see s. 3).

e) CMPA comments about physician assisted dying and the policy in the following terms:

As you know, subsequent to your letter enclosing the Guideline and Policy, the Supreme Court of Canada released its decision in *Carter v. Canada (Attorney General).* The Court unanimously and expressly affirmed a physician's freedom of conscience to refuse to participate in physician-assisted dying: "In our view, nothing in the declaration of invalidity which we propose to issue would compel physicians to provide assistance in dying" .

As currently worded, section 5.4 states that physicians must provide a patient with all health services that are legally permissible and publicly-funded and

that are consented to by the patient or his or her substitute decision maker, regardless of any moral or religious objections, if a referral to another healthcare provider is not possible without causing a delay that would jeopardize the patient's health or well-being. Once physician-assisted dying becomes lawful in Canada, the College will want to ensure that section 5.4 conforms with the principles set out in the *Carter* decision, as well as any legislative changes that may be introduced at the federal or provincial level.

Comment from Bryan Salte – I have suggested in the introduction to this document that the Council may wish to consider whether to consider whether there is something about physician assisted dying that is different.

While I think it unlikely that the Government of Canada will establish a regulatory regime to address physician assisted dying, that may occur. If it does not occur at the federal level, it could occur at the provincial level.

Council may wish to consider whether it will defer discussion of a physician's responsibility if patient requests assistance in dying to a time when it is clearer whether there will be legislation to further regulate it, and if there will be, what that legislation will state.

f) CMPA comments that the College may wish to consider whether to add a provision relating to ending the physician-patient relationship.

We note that while the Policy addresses the issue of conscientious objections in respect of most aspects of a physician-patient relationship *(i.e.* taking on new patients, providing information to patients, providing referrals for health services, and treating patients), the Policy does not address this issue in the context of ending the physician-patient relationship. Some Colleges in other provinces have addressed this issue in their guidelines and policies.2 The College may wish to consider addressing this issue in the Policy to ensure that physicians are clear on the *College's* expectations in this regard.

The policy to which the CMPA refers is the CPSO policy Physicians and the Ontario Human Rights Code. It is currently under review, with the consultation period closed.

That states the following:

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 polices in so doing.

Comment from Bryan Salte – I am not convinced that trying to combine additional concepts in this policy is likely to be helpful. This policy is intended to address a physician's obligations if a physician has a conscientious objection to providing a form of treatment. That is related to, but different than, a physician's obligation to comply with human rights requirements.

Council can consider whether the policy should address whether a physician can end a doctor-patient relationship based upon a patient's request for a medical service to which the physician has a conscientious objection.

6. Comments from Dr. Hayton (member of the committee)

The suggestions that I have are that we should:

1. Try to meet again before the Council meeting

2. Contemplate strengthening the wording with respect to the difference between a physician who refuses to provide a particular service based upon clinical grounds and a physician who refuses to provide a particular service based upon a conscientious objection to the treatment.

3. Think about changing the wording from "referral to a provider who can provide the service" to something that ensures that the physician will refer to another physician or

organization/care provider that will take over management of the patient in this situation (as long as this doesn't delay the patient's health or well-being).

4. I don't agree that the wording that talks about ensuring that the patient's health or well-being is not compromised is too vague. I think it will be impossible to create wording for every eventuality. This is something that will need to be assessed on a case-by-case basis and is something that I think most physicians actually can work out for themselves. For abortion, for example, physicians recognize that there are time limits surrounding this issue and it will be readily apparent that certain decisions/or refusals to manage care will delay "treatment" and compromise choice/access to care.

5. I agree with the CMPA suggestions a/b/c and I agree with Bryan that suggestion 'd' should not be followed and that we should leave the "recognized lawful excuse" in the various components of the policy.

6. I think that we should consider re-evaluating this document with respect to physician-assisted dying once we see what Parliament or the Provincial Legislature will do with respect to creating any sort of legislation. Perhaps we should say that this current document does not apply to PAS and will be re-evaluated within the year in light of whatever the governments/Colleges of P &S come up with for policing of this new reality. I continue to believe that patients should have autonomy with respect to their medical decisions, but the boundaries of this whole area are very grey at the moment - what will comprise a "recognized lawful excuse" to not send a patient for PAS....that you think that they are well and not imminently dying, for example?

7. With respect to whether a physician can end a physician-patient relationship based on request for a medical procedure that the physician has a conscientious objection to - I'm inclined to say "no". I would like to discuss this in more detail at a meeting rather than by email.

8. As I outlined in my previous response to this policy, I think that there is plenty of case law supporting the concept that freedom of conscience and freedom of religion can and should be limited in circumstances where the rights of other individuals are compromised. Physicians are in a fiduciary relationship with their patients and are gatekeepers to access to medical care. In my opinion, it is our job to give patients good medical advice and support and to allow them to make their own decisions about their

healthcare thereafter (even if we don't agree with their decisions - which is often the case for both small and large decisions).

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7. The effect of the Charter:

Several responses stated that compelling physicians to provide a referral to a provider who can provide the service is a breach of physicians' freedom of religion.

The Ontario College adopted a policy on March 7. From the media coverage it appears that the policy was adopted in the form circulated for feedback. The documents states:

> 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 a procedure or treatment because the procedure 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. 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.

Charter rights are not absolute and are subject to other interests that must be recognized:

Section 1 of the **Charter** states:

> The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

I contacted the Ontario College to see if they obtained a legal opinion whether the provision adopted in Ontario is consistent with the **Charter**. The Ontario College did not obtain an outside legal opinion. The lawyer assigned to assist with the legal issues related to the policy is in a hearing but I anticipate being contacted next week.

I don't consider myself an expert in **Charter** law, but I am generally familiar with **Charter** principles and have argued **Charter** cases previously.

I think that there are a number of good arguments which can be used to support the position that physicians can be required to ensure that patients receive medical care to which they are entitled in Canada. Physicians have a fiduciary relationship with patients, a monopoly on providing medical services and the power in an inherently unbalanced power relationship.

A College policy which states that physicians are not allowed to refuse to provide assistance to a patient seeking a medical service seems to me to be a "reasonable limit prescribed by law as can be demonstrably justified in a free and democratic society".

8. Attached Documents

1) The Draft Policy Approved by the Council (page 15)
2) CMPA's response to the consultation request (page 18)
3) The submission by the Christian Medical and Dental Society (page 23)
4) Submissions by physicians approving of the draft policy (page 71)
5) Response by U of S Students and Dr. Harding (page 86)
6) Submissions by physicians objecting to the draft policy (page 109)
7) Letter from the AMA Council on Ethical and Judicial Affairs (page 135)
8) Response from the Abortion Right Coalition of Canada (there are a number of links in the document for those who wish to read information which the Coalition states support their position (page 138)
9) Response from the Justice Centre for Constitutional Freedoms (page 145)
10) Response from the Christian Legal Fellowship (page 162)
11) Submission from former counselor Rev. Fryters, with Bryan Salte's comments (page 172)
12) Five standard letters sent by multiple respondents (page 180)
13) Miscellaneous Negative Responses from Members of the Public (page 190)
14) The draft policy from the Ontario College of Physicians and Surgeons which was considered on March 7. The policy was adopted which appears to have been unchanged from the draft (page 308)

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).