Protection of Conscience Project
www.consciencelaws.org

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Submission to the Provincial/Territorial Expert Advisory Group on Physician-Assisted Dying

Re: *Implementing Carter v. Canada*

23 September, 2015

I. Introduction

I.1 The Protection of Conscience Project is a non-profit, non-denominational initiative that advocates for freedom of conscience among health care workers. It does not take a position on the acceptability of morally contested procedures. For this reason, almost half of the questions in the *Written Stakeholder Submission Form* are outside the scope of the Project's interests.

I.2 The completed *Written Stakeholder Submission Form* is in Appendix "A" of this submission. The responses are numbered for reference purposes.

II. Scope of this submission

II.1 The responses in the *Written Stakeholder Submission Form* (Appendix "A") are supplemented, in some cases, by additional comments in Part III. A protection of conscience policy is suggested in Appendix "B."

III. Additional comments on numbered responses

III.1 Role of Physicians (Response 11)

III.1.1 While the Quebec euthanasia kits are to include two courses of medication in case the first does not work,[1] insufficient attention has been paid to the fact that euthanasia and assisted suicide drugs do not always cause death as expected.[2]

III.1.2 Physicians willing to perform euthanasia as well as to assist in suicide should disclose and discuss options available in the event that a lethal injection or prescribed drug does not kill the patient.

III.1.3 Physicians willing to prescribe lethal drugs but unwilling to provide euthanasia by lethal injection should consider what they may be expected to do if a prescribed drug incapacitates but does not kill a patient.

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III.1.4 The possibility of this complication provides another reason for insisting that the physician who approves assisted suicide or euthanasia should be the one to administer the lethal medication or to be present when it is ingested. Expecting other health care workers to deal with this complication is likely to increase the likelihood of conflict in what will be an already emotionally charged situation.

III.2 Conscientious Refusal by Healthcare Providers (Responses 15, 16)

III.2.1 Conscientious refusal within the context of exemptions from criminal prosecution

The Netherlands

III.2.1.1 Consensual homicide and assisted suicide continue to be prohibited by the *Penal Code* in the Netherlands. The Dutch *Termination of Life on Request and Assisted Suicide (Review Procedures) Act* does not actually authorize either physician-assisted suicide or euthanasia, but provides a defence to criminal charges for physicians who adhere to its requirements.[3] In this respect, it is analogous to the provisions of the Canadian *Criminal Code* on therapeutic abortion from 1969 to 1988, and to the exemptions offered in the *Carter* decision.

III.2.1.2 One of the requirements of the Dutch law is that the physician must believe that the patient's request is "well-considered." Another is that the physician must believe that the patient's suffering is "lasting and unbearable." A physician who did not actually believe one or both of these things and who killed a patient or helped a patient commit suicide or aided or abetted either act would have no defence to a charge of murder or assisted suicide.

III.2.1.3 Physicians who object to euthanasia and assisted suicide for reasons of conscience usually do not believe that a request for either can be "well-considered." Moreover, they may not believe that a patient's suffering is "lasting and unbearable," particularly if the suffering can be relieved. On both points, the available defence requires actual belief; doubt is insufficient to provide a defence to a criminal charge.

III.2.1.4 Since the legal prohibition of homicide and assisted suicide is not displaced in such circumstances, there can be no obligation on the part of objecting physicians to provide or refer for euthanasia or physician-assisted suicide. They have no obligation to commit or cooperate in the commission of a criminal offence.

Canada

III.2.1.5 Unlike the Supreme Court's 1988 *Morgentaler* decision, which struck down the abortion law entirely, the *Carter* decision did not invalidate murder and assisted suicide laws altogether, but only to the extent that the laws prevent homicide and assisted suicide by

physicians in accordance with the guidelines laid down by the Court.

III.2.1.6 Thus, a physician accused of failing to follow the *Carter* guidelines is still liable to be charged for murder or assisted suicide, just as, prior to 1969, physicians who provided an abortion under guidelines based on the case of *R. v. Bourne* were liable to be charged if the abortion was not necessary to preserve the life of the mother.[4]

III.2.1.7 The *Carter* guidelines include requirements that an eligible patient must be competent, clearly consent, have a "grievous and irremediable medical condition" and experience "enduring suffering that is intolerable to the individual."[5] In addition to moral considerations, an objecting physician may not be satisfied that one or more of these conditions has been met.

III.2.1.8 As in the case of the Netherlands, the legal prohibition of homicide and assisted suicide is not displaced in such circumstances. There can thus be no obligation on the part of objecting physicians to provide or refer for euthanasia or physician-assisted suicide if they are not satisfied that all of the conditions providing a defence to a charge of culpable homicide or assisting suicide have been met. They have no obligation to commit or cooperate in the commission of a criminal offence. On the contrary: they are obliged by law to refuse.

III.2.2 Suggested policy on physician exercise of freedom of conscience

III.2.2.1 Appendix "B" provides a policy concerning the exercise of freedom of conscience by physicians that, in the Project's experience, would be acceptable to most objecting physicians. It can be modified to apply to other health care workers. It is consistent with

- the *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999);
- the Canadian Medical Association *Code of Ethics* (2004);
- the Canadian Medical Protective Association publication, *Consent: A guide for Canadian physicians* (2006).

III.2.2.2 The policy provides seven alternative responses for objecting physicians, reflecting the fact that different ethical, moral or religious traditions may take different approaches to the issue of complicity in morally contested acts. Further, within some traditions, the facts of a particular case may influence the moral judgement of a physician.

III.2.2.3 The policy's provisions concerning providing information to patients and two of the proposed alternatives [Appendix "B", III.6(e) and III.6(f)] are consistent with guidance recently approved at the recent Annual General Council of the Canadian Medical

Association with respect to assisted suicide and euthanasia: that physicians should "provide complete information on all options and advise on how to access a separate, central information, counselling, and referral service."

III.2.2.4 CMA guidance noted in III.2.2.3 does not preclude the other alternatives in the suggested policy for reasons given by the Association to the Supreme Court of Canada:

> The CMA's purpose, in developing and setting policy, is not to override individual judgment or to mandate a standard of care.[6]
>
> The CMA's policies are not meant to mandate a standard of care for members or to override an individual physician's conscience.[7]

III.2.2.5 None of the responses obstruct patient access to services. Some responses involve deliberate of facilitation of the services. It is up to the physician to decide which response to choose in each case.

Notes:

1. Ubelacker S. "Quebec MDs to get euthanasia guide to prepare for legalized assisted death: Unclear whether other provinces and territories will adopt a similar practice."*The Canadian Press*, 1 September, 2015 (http://www.cbc.ca/news/canada/montreal/quebec-mds-to-get-euthanasia-guide-to-prepare-for-legalized-assisted-death-1.3212081) Accessed 2015-09-03.

2. Groenewoud JH, van der Heide A. Onwuteaka-Philipsen BD Willems DL van der Maas PJ, van der wal G., "Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands." *N Engl J Med* 2000; 342:551-556 February 24, 2000

3. Netherlands, *Termination of Life on Request and Assisted Suicide (Review Procedures) Act* (http://www.eutanasia.ws/documentos/Leyes/Internacional/Holanda Ley 2002.pdf) Accessed 2015-07-24).

4. *R. v. Bourne* (1939) 1KB 687

5. *Carter v. Canada (Attorney General)*, 2015 SCC 5, paragraph 127 (https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/14637/index.do) Accessed 2015-02-07.

6. In the Supreme Court of Canada (On Appeal from the Court of Appeal of British Columbia) *Affidavit of Dr. Chris Simpson, Motion for Leave to Intervene by the Canadian Medical Association* (5 June, 2014), para. 17 (https://www.cma.ca/Assets/assets-library/document/en/advocacy/EOL/Supreme-Court-Affidavit-Carter-Case.pdf) Accessed 2015-06-22.

7. In the SCC on appeal from the BCCA, *Factum of the Intervener, The Canadian Medical Association* (27 August, 2014), para. 9
(http://www.consciencelaws.org/archive/documents/carter/2014-08-27-cma-factum.pdf)

Appendix "A"

Written Stakeholder Submission Form

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Tel: 604-485-9765 E-mail: protection@consciencelaws.org

CANADIAN PROVINCIAL/TERRITORIAL
EXPERT ADVISORY GROUP ON PHYSICIAN-ASSISTED DYING
WRITTEN STAKEHOLDER SUBMISSION FORM

NAME OF ORGANIZATION:	Protection of Conscience Project
CORRESPONDING AUTHOR:	Sean Murphy, Administrator
CONTACT INFORMATION:	protection@consciencelaws.org 7120 Tofino St., Powell River, BC V8A 1G3
DATE:	22 September, 2015

BACKGROUND

In February 2015, the Supreme Court of Canada struck down the federal law prohibiting physician-assisted dying (PAD). The ruling applies to a competent adult who:

- Clearly consents to the termination of life; and
- Has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition

The court gave governments one year to consider the development of new laws and practices for physician-assisted dying.

In July 2015, the federal government established an external panel to inform its legislative response to the Supreme Court of Canada's decision. The primary focus of the Federal Expert Panel's work is to provide advice to the federal government on possible amendments to the Criminal Code. In August 2015, eleven provinces and territories established the Provincial/Territorial Expert Advisory Group on Physician-Assisted Dying (the "Advisory Group").

As provinces and territories have the primary responsibility for health care, including regulating physicians and health care institutions, provincial and territorial governments must consider whether regulatory or other changes are needed over the coming months in response to the Supreme Court's decision. The Advisory Group will provide advice on the development of laws, policies, practices and safeguards for provinces and territories to consider in advance of physician-assisted dying becoming legal in Canada.

Your organization's input and feedback will be considered as part of the Advisory Group's deliberations.

INSTRUCTIONS

The Advisory Group is seeking input on the following questions. Your organization's responses will be used by the Advisory Group to inform its advice to the provincial and territorial governments on physician-assisted dying, with a focus on the needs of patients and their families as well as health institutions and regulatory bodies.

Please answer all questions relevant to your organization's interests. **If your organization does not have a position or opinion on a particular issue, please feel free to leave that section blank.** Please limit your response to each question to 1000 characters (or approximately 200 words). If your organization has developed specific guidance (e.g., policy, guidelines) for its staff or members related to the implementation of PAD, you may attach it to your reply email. Please send the completed template and attachment to PADadvisorygroup@ontario.ca by **September 24, 2015**.

Please note that all information collected by the Advisory Group is governed by Ontario's *Freedom of Information and Protection of Privacy Act* and may be subject to disclosure in accordance with that Act. In addition, comments or documents provided to the Advisory Group may be shared with provinces and territories participating in the work of the Advisory Group and will be treated as public information that may be used and disclosed by the Advisory Group without the consent of the author, or the organization on whose behalf the submission is made. As such, please ensure that you do not include any personal information about identifiable individuals in your responses to this template.

The information collected will be considered by the Advisory Group in developing recommendations for provinces and territories to consider as they develop their responses to the Supreme Court's decision on physician-assisted dying. If you have any questions about how the Advisory Group will collect, use and disclose the information that you are providing, please contact Alicia Neufeld at Alicia.Neufeld@ontario.ca.

QUESTIONNAIRE

QUESTIONS	FEEDBACK
GENERAL	
What are your organization's thoughts on the Supreme Court of Canada's decision in *Carter v. Canada (Attorney General)*?	1) The Project's concern is that the decision should not be interpreted to subvert freedom of conscience by being used as an excuse to compel individuals to do what they believe to be wrong, or by punishing, discriminating against or otherwise disadvantaging those who refuse.

In general, should provinces and territories develop new legislation or regulations to govern the provision of physician-assisted dying (PAD) or should the regulation of PAD be left to regulatory bodies (e.g., professional colleges) and/or individual physicians and patients?	2) Neither. The Carter decision provides an exemption to criminal prosecution, which is federal jurisdiction. The law that details the terms of the exemption should, in the first instance, take the form of amendments to the Criminal Code re: homicide, suicide etc. Once the criminal law is clear, provinces and regulators can work within that common framework. This should reduce legal uncertainties or conflicts likely to exacerbate difficulties in ensuring protection for freedom of conscience. (See Response 4.)
ELIGIBILITY CRITERIA	
In the Supreme Court of Canada's decision, it was determined that, in certain circumstances, a "competent adult" must not be prohibited from accessing PAD. • **What should the definition of "adult" be?** • **Should the competency requirement apply at the time of request for PAD or at the time of provision of the assistance, or both?** *See Appendix 1 for additional information.*	3) Outside the scope of Project interests.

The Supreme Court of Canada's decision limits PAD to those who have a "grievous and irremediable medical condition". • **What does "grievous and irremediable medical condition" mean to your organization?** • **Should the term "grievous and irremediable medical condition" be defined in the provincial/territorial legislation or regulation?** • **Should specific medical conditions be defined in law or should it be determined in each case by the patient and their physician? If the medical conditions should be defined in law, what medical conditions should be included?** *See Appendix 2 for additional information.*	4) Generally speaking, the greater the range of circumstances in which euthanasia or assisted suicide may be provided, the greater the temptation to suppress or restrict freedom of conscience, and the greater the likelihood of conflicts of conscience. For this reason, from the Project perspective, it would be best to have the term "grievous and irremediable medical condition" defined by statute, and the definition should be as narrow as possible, consistent with the Carter ruling. Since the Carter ruling deals with criminal law, the definition should be included in a section of the Criminal Code setting out the circumstances in which the exemption from criminal prosecution applies.
PROCEDURAL SAFEGUARDS TO ENSURE ELIGIBILITY CRITERIA ARE MET	
The Supreme Court of Canada's decision limits PAD to a competent adult person who "clearly consents to the termination of life". • **What processes should be put in place to ensure that the consent to PAD is informed? (e.g., what information should have to be provided to the patient? Who should provide the information?)** *See Appendix 3 for additional information.*	5) Outside the scope of Project interests.

What processes should be put in place to ensure that the consent to PAD is voluntary?	6) Outside the scope of Project interests.
What processes should be put in place to ensure that the person requesting PAD is competent? For example: • **Who should conduct the competency assessment(s)?** • **Should an assessment by a psychiatrist or psychologist be required in any or all cases? If some, which ones?)**	7) Outside the scope of Project interests.

How many physicians should be required to confirm that the eligibility criteria have been met? Must they be from any particular specialities? Must they be independent of one another? If so, what should be the definition of independent for these purposes?	8) In general, the fewer the number of physicians who have to be involved in each case, the less the likelihood of conflicts of conscience arising, and the less the pressure to suppress freedom of conscience.
Should a waiting period (sometimes called a "cooling off period") be established between the request and the provision of PAD? If so, how long should the waiting period be? Should the waiting period vary based on the medical condition?	9) Outside the scope of Project interests.

What should be the formal requirements for a patient's request for PAD? (e.g., should requests be written or can they be oral? Should witnesses be required?)	10) Outside the scope of Project interests.
ROLE OF PHYSICIANS	
What is the appropriate role of physicians in physician-assisted dying? For example: • **Should a physician's role be to actively administer the medication that causes death if requested to do so by a patient who meets the eligibility criteria?** • **If an eligible patient prefers, and has the ability, should a physician's role be to prescribe the lethal medication which the patient would then administer themselves?** • **Should physicians always remain with the patient until the time of death?**	11) The Carter ruling seems to exempt only physicians from prosecution, but the exemption would presumably extend to anyone who is a party to the act. The following should reduce the likelihood and extent of conflicts of conscience. The physician who approves assisted suicide or euthanasia should personally administer or provide the lethal drug, and should remain with the patient until death ensues. Should the lethal drugs not act as expected (for example: incapacitate the patient but not cause death), this physician will be responsible for responding to the situation as per the instructions of the patient received during discussions preliminary to the act. This physician should personally notify next of kin if the next of kin is unaware that the patient has been killed or helped to commit suicide. None of this should be delegated to anyone else.

ROLE OF OTHER HEALTH CARE PROVIDERS	
What is the appropriate role of non-physician regulated health care professionals in the provision of PAD?	12) If they are involved, it should be only as self-identified volunteers. A requirement for complicity in killing patients or assisting with suicide should not be a requirement for employment, education, etc.
Should non-physician regulated health care professionals (e.g., Registered Nurse, Nurse Practitioner) acting under directives from a physician be allowed to fulfil a request for PAD?	13) See Responses 11 and 12

What is the appropriate role of non-regulated health workers in the provision of PAD?	14) See Responses 11, 12 and 13.
CONSCIENTIOUS REFUSALS BY HEALTHCARE PROVIDERS	
Should physicians have the right to refuse to provide PAD for reasons of conscience? If yes: • **What continuing obligations, if any, do they have to the patient?** • **Does the right to refuse include the right to refuse to provide an effective referral for PAD?** *See Appendix 4 for additional information.*	15) According to the text of the Carter ruling, the unequivocal answer to this answer is "Yes." That the panel should even ask this question is strongly suggestive of bias inconsistent with the ruling. Physicians have an obligation to provide continuity of care with respect to other aspects/kinds of treatment. They have NO obligation to provide an "effective referral" if they believe that doing so makes them unacceptably morally complicit in homicide or suicide. See Submission, Part III.2 and Appendix "B"

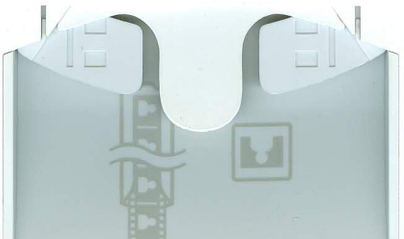
Should non-physician regulated health care professionals (e.g., Registered Nurse, Nurse Practitioner, Pharmacist, etc.) have the right to refuse to participate in the provision of PAD for reasons of conscience? • **If so, under what circumstances?**	16) According to the Carter ruling, the unequivocal answer to this answer is "Yes." Only physicians are explicitly exempted from prosecution if they kill patients or help them commit suicide within the terms of the ruling, and the ruling explicitly states that they are not obliged to do so. Nothing in the ruling suggests that other health care workers have a duty to participate. That the panel should even ask this question is strongly suggestive of bias inconsistent with the ruling. Other health care workers may refuse to participate under all circumstances in which they believe that what is required of them makes them unacceptably morally complicit in homicide or suicide. They are obliged to provide continuity of care with respect to other aspects/kinds of treatment. They have NO obligation to find substitutes if they believe that doing so makes them unacceptably morally complicit in homicide or suicide. See Submission, Part III.2 and Appendix "B"
ROLE OF INSTITUTIONS	
What is the appropriate role of health care institutions (e.g., hospitals, hospices, long-term care facilities, etc.) in making PAD services available to patients?	17) Institutions that do not wish to be involved in killing patients or helping them to commit suicide should not be obliged to do so, nor obliged to allow it on their premises, nor obliged to arrange for it by other institutions.

On what issues in particular does your organization feel that health institutions need specific guidance – through legislation, regulation, or guidelines – for the implementation of PAD services?	18) Accommodation of those unwilling to be involved in killing patients or helping them to commit suicide. They should identify employees willing to respond to family members whose loved ones have been killed or helped to commit suicide without their knowledge. Employees should not be put in the position of having to defend or support something they believe to be wrong. This is distinct from the obligation of the attending physician in these circumstances to personally notify the next of kin (See Response 11).
Should health care institutions be required to provide PAD at their facility? If yes, please explain why. If no, under what circumstances and what responsibility should the institution have to ensure patients have access to PAD?	19) No. An objecting institution should notify a patient of its policy at the time of admission and advise the patient that the services may be obtained elsewhere. After admission, it should transfer the patient and/or records as requested by the patient or the patient's agent.

What should be the responsibility of the health care institution to the patient when a physician within the facility refuses to provide PAD for reasons of conscience and/or provide an effective referral for PAD in a case where the requesting patient meets the eligibility criteria?	20) First, see response 19. The following arrangements would reduce the likelihood of conflicts of conscience. If the institution wishes to provide euthanasia and/or assisted suicide, the institution should provide patients/patient agents with information about how to obtain the services should the attending physician refuse to do so. The information could be provided by designated willing hospital employees. Alternatively, some provinces (like Nova Scotia) have patients rights advocates who are independent of institutions who might be willing to provide the information.
ACCESS	
What barriers to access do you foresee that will need to be addressed in implementing PAD? In what ways do you think these barriers could or should be reduced? **Where access to PAD is limited by these barriers, what steps should be taken to facilitate access for patients seeking the service?**	21) It appears that only a minority of physicians are willing to provide even where this has been legal for years. It also appears most people don't want to be involved in homicide or suicide. To avoid adverse effects on freedom of conscience, those who want to provide the services should identify themselves to medical regulators and/or others or to a central agency so that they can be contacted easily by anyone seeking the services.

What unique implementation issues, if any, do you foresee for PAD in rural or remote settings? How should they be addressed?	22) See response 21. Otherwise, outside the scope of Project interests.
How could and should provincial/territorial governments ensure equitable access to PAD?	23) Outside the scope of Project interests.

If it is determined that a patient is ineligible for PAD, should the patient have a right to appeal that decision? If so, what process should be used and to whom should the appeal be directed?	24) Outside the scope of Project interests.
SETTINGS	
In what health care settings should PAD be provided? *See Appendix 5 for additional information.*	25) Outside the scope of Project interests.



If it is determined that a patient is ineligible for PAD, should the patient have a right to appeal that decision? If so, what process should be used and to whom should the appeal be directed?	24) Outside the scope of Project interests.
SETTINGS	
In what health care settings should PAD be provided? *See Appendix 5 for additional information.*	25) Outside the scope of Project interests.

If PAD were provided at home, what implementation issues would this raise? How should they be addressed?	26) Outside the scope of Project interests.
Are there other implementation issues related to the settings in which PAD might be provided that need to be addressed?	27) Outside the scope of Project interests

CASE REVIEW AND OVERSIGHT	
What reporting (including documentation) should be required of the physician following the provision of PAD? How should this reporting be done? Who should receive the reports? *See Appendix 6 for additional information.*	28) Reports should not involve falsification of the cause of death or classification of the death as natural causes. Requirements for deception make conflicts of conscience more likely among a broader range of people not otherwise implicated in euthanasia and assisted suicide.
Should there be a review of each case of PAD? If yes: • **Should it be undertaken before or after the assistance is provided?** • **Who should undertake the review?** • **What standards (e.g., clinical, professional, legal) should be used in the review?** • **To whom should the reviewer(s) report any findings of non-compliance with the standards?** **If there should be no review, why not?**	29) See Response 28. Beyond that, outside the scope of Project interests.

Should an oversight body be established? If yes: • **Should it be national or provincial/territorial?** • **Should it be administered by government or by regulatory bodies?** • **What role and responsibilities should it have?** • **What should its composition be, in terms of the number of members and their backgrounds?** • **What should be its obligations for public reporting and quality improvement?** • **What other considerations are relevant to an oversight system, process, or body?**	30) Outside the scope of Project interests.
ADDITIONAL SUPPORTS	
What, if any, educational materials should be developed for and provided to physicians and other health care providers? Who should be responsible for developing these materials (e.g., provincial/territorial governments, professional bodies, provincial Colleges of Physicians and Surgeons)?	31) Outside the scope of Project interests.

Should an independent organization be established to support physician practice (e.g., information, training) and/or facilitate patient access to PAD services? • **If so, who should establish it? What should it be tasked to do?** • **If not, what organization(s) should assume this responsibility?**	32) In the Project's experience, most of those unwilling to provide or facilitate euthanasia or assisted suicide would be willing to provide information to patients about the kind of agency described below. This would minimize pressure adverse to freedom of conscience in health care. Establish an agency that does not arrange for euthanasia or assisted suicide that would provide information to make patients aware of their legal options, assist them in making an informed decision, and provide information about services nearest them. The Ministry of the Attorney General /Justice in each province should be responsible. The 24/7 free Brydges Counsel telephone service maintained in every jurisdiction for prisoners in custody anywhere in Canada (including remote areas) could easily be used at least as an initial portal for this purpose. All that would be required is instruction and resources for the lawyers manning the phones.
What other resources should be developed to support physicians and other health care providers in relation to PAD?	33) Outside the scope of Project interests.

What resources should be developed to support patients and their families/caregivers in relation to PAD?	34) See Response 32.
ADDITIONAL INPUT	
Is there anything else, not covered above, that your organization considers relevant to the implementation of PAD? Please use this space or attach additional comments to your e-mail response.	35) See balance of submission.

Appendix "B"

Physician Exercise of Freedom of Conscience and Religion

I. Introduction

I.1 To minimize inconvenience to patients and avoid conflict, physicians should develop a plan to meet the requirements of Parts II and III for services they are unwilling to provide for reasons of conscience or religion.

II. Providing information to patients

II.1 This Part highlights points of particular interest within the context of the exercise of freedom of conscience. It is not an exhaustive treatment of the subject of informed consent.

II.2 In exercising freedom of conscience and religion, physicians must provide patients with sufficient and timely information to make them aware of relevant treatment options so that they can make informed decisions about accepting or refusing medical treatment and care.

- Canadian Medical Association *Code of Ethics* (2004) para. 21[1]
- CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) I.4[2]
- Canadian Medical Protective Association, *Consent: A guide for Canadian physicians* (4th ed) (May, 2006): Disclosure of information; Standard of disclosure.[3]

II.3 Sufficient information is that which a reasonable patient in the place of the patient would want to have, including diagnosis, prognosis and a balanced explanation of the benefits, burdens and risks associated with each option.

- Canadian Medical Association *Code of Ethics* (2004) para. 21[1]
- CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) I.7[2]
- Canadian Medical Protective Association, *Consent: A guide for Canadian physicians* (4th ed) (May, 2006): Standard of disclosure; Some practical considerations - (1), (2). (4), (5)[3]

II.4 Information is timely if it is provided as soon as it will be of benefit to the patient.

Timely information will enable interventions based on informed decisions that are most likely to cure or mitigate the patient's medical condition, prevent it from developing further, or avoid interventions involving greater burdens or risks to the patient.

II.5 Relevant treatment options include all legal and clinically appropriate procedures, services or treatments that may have a therapeutic benefit for the patient, whether or not they are publicly funded, including the option of no treatment or treatments other than those recommended by the physician.

- Canadian Medical Association *Code of Ethics* (2004) para. 23[4]

II.6 Physicians whose medical opinion concerning treatment options is not consistent with the general view of the medical profession must disclose this to the patient.

- Canadian Medical Association *Code of Ethics* (2004) para.45[5]

II.7 The information provided must be responsive to the needs of the patient, and communicated respectfully and in a way likely to be understood by the patient. Physicians must answer a patient's questions to the best of their ability.

- Canadian Medical Association *Code of Ethics* (2004) para. 21,[1] 22[6]
- CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) I.4[2]
- Canadian Medical Protective Association, *Consent: A guide for Canadian physicians* (4th ed) (May, 2006): Standard of disclosure; Some practical considerations - (3)[3]

II.8 Physicians who are unable or unwilling to comply with these requirements must promptly arrange for a patient to be seen by another physician or health care worker who can do so.

III. Exercising freedom of conscience or religion

III.1 In exercising freedom of conscience and religion, physicians must adhere to the requirements of Part II (Providing information to patients).

III.2 In general, and when providing information to facilitate informed decision making, physicians must give reasonable notice to patients of religious, ethical or other conscientious convictions that influence their recommendations or practice or prevent them from providing certain procedures or services. Physicians must also give reasonable notice to patients if their views change.

- Canadian Medical Association *Code of Ethics* (2004) para. 12,[7] 21[1]
- CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical*

Conflicts Involving Health Care Providers and Persons Receiving Care (1999) I.16[2]

III.3 Notice is reasonable if it is given as soon as it would be apparent to a reasonable and prudent person that a conflict is likely to arise concerning treatments or services the physician declines to provide, erring on the side of sooner rather than later. In many cases - but not all - this may be prior to accepting someone as a patient, or when a patient is accepted.

III.4 In complying with these requirements, physicians should limit discussion related to their religious, ethical or moral convictions to what is relevant to the patient's care and treatment, reasonably necessary for providing an explanation, and responsive to the patient's questions and concerns.

III.5 Physicians who decline to recommend or provide services or procedures for reasons of conscience or religion must advise affected patients that they may seek the services elsewhere, and provide information about how to find other service providers. Should the patient do so, physicians must, upon request, transfer the care of the patient or patient records to the physician or health care provider chosen by the patient.

- Canadian Medical Association *Code of Ethics* (2004) para. 21[1]
- (CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) II.10[2]

III.6 Alternatively, in response to a patient request, physicians may respond in one of the following ways, consistent with their moral, ethical or religious convictions:

a) by arranging for a transfer of care to another physician able to provide the service; or

b) by providing a formal referral to someone able to provide the service; or

c) by providing contact information for someone able to provide the service; or

d) by providing contact information for an agency or organization that will refer the patient to a service provider; or

e) by providing contact information for an agency or organization that provides information the patient may use to contact a service provider; or

f) by providing non-directive, non-selective information that will facilitate patient contact with other physicians, heath care workers or sources of information about the services being sought by the patient.

III.7 A physician's response under III.5 or III.6 must be timely. Timely responses will enable interventions based on informed decisions that are most likely to cure or mitigate the

patient's medical condition, prevent it from developing further, or avoid interventions involving greater burdens or risks to the patient.

III.8 In acting pursuant to III.5 or III.6, physicians must continue to provide other treatment or care until a transfer of care is effected, unless the physician and patient agree to other arrangements.

- Canadian Medical Association *Code of Ethics* (2004) para. 19,[8] 21[1]
- CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) I.16, II.11[2]

III.9 Physicians unwilling or unable to comply with these requirements must promptly arrange for a patient to be seen by another physician or health care worker who can do so.

III.10 Physicians who provide medical services in a health care facility must give reasonable notice to a medical administrator of the facility if religious, ethical or other conscientious convictions prevent them from providing certain procedures or services, and those procedures or services are or are likely to be provided in the facility. In many cases - but not all - this may be when the physician begins to provide medical services at the facility.

IV. Reminder: treatments in emergencies

IV.1 Physicians must provide medical treatment that is within their competence when a patient is likely to die or suffer grave injury if the treatment is not immediately provided, or immediately arrange for the patient to be seen by someone competent to provide the necessary treatment.

- Canadian Medical Association *Code of Ethics* (2004) para. 18[9]

IV.2 Physicians who fail to provide or arrange for medical treatment in such circumstances may be liable for negligence or malpractice.

Notes

1. Canadian Medical Association *Code of Ethics* (2004): "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."
(http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf) Accessed 2015-09-22

2. *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) (Canadian Medical Association, Canadian Healthcare Association, Canadian Nurses' Association, Catholic Health Association of Canada)

(http://www.consciencelaws.org/background/policy/associations-001.aspx)

3. Canadian Medical Protective Association, *Consent: A guide for Canadian physicians* (4th ed) (May, 2006) (https://www.cmpa-acpm.ca/-/consent-a-guide-for-canadian-physicians#disclosure) Accessed 2015-09-15

4. Canadian Medical Association *Code of Ethics* (2004): "23. Recommend only those diagnostic and therapeutic services that you consider to be beneficial to your patient or to others. . ." (http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf) Accessed 2015-09-22

5. Canadian Medical Association *Code of Ethics* (2004): "45. Recognize a responsibility to give 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." (http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf) Accessed 2015-09-22

6. Canadian Medical Association *Code of Ethics* (2004): "22. Make every reasonable effort to communicate with your patients in such a way that information exchanged is understood." (http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf) Accessed 2015-09-22

7. Canadian Medical Association *Code of Ethics* (2004): "12. Inform your patient when your personal values would influence the recommendation or practice of any medical procedure that the patient needs or wants." (http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf) Accessed 2015-09-22

8. Canadian Medical Association *Code of Ethics* (2004): "19. Having accepted professional responsibility for a patient, continue to provide services until they are no longer required or wanted; until another suitable physician has assumed responsibility for the patient; or until the patient has been given reasonable notice that you intend to terminate the relationship." (http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf) Accessed 2015-09-22

9. Canadian Medical Association *Code of Ethics* (2004): "18. Provide whatever appropriate assistance you can to any person with an urgent need for medical care. " (http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf) Accessed 2015-09-22