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Submission to the Canadian Medical Association 2018 Revision of the CMA *Code of Ethics*

Executive Summary

The CMA Code of Ethics Revision Task Force has proposed a substantial revision to the Association's *Code of Ethics*. The Project applauds the emphasis placed by the Task Force on the moral agency of both patients and physicians, on human dignity, and on the importance of integrity and freedom of conscience in medical practice.

However, the 2018 Revision adds a requirement quite inconsistent with that emphasis: that physicians provide a formal referral or initiate a transfer of care to facilitate procedures to which they object for reasons of conscience. This reverses the CMA's longstanding position against mandatory referral. It contradicts recently developed CMA policy, and it is inconsistent with a significant CMA position statement concerning freedom of conscience. Finally, it imposes a form of servitude that is offensive to human dignity, violates freedom of conscience and illicitly discriminates against physicians in a manner the CMA itself has rejected.

It is preferable to take a broad and principled approach that keeps the focus on the nature and importance of freedom of conscience, avoiding entanglement in controversies about the acceptability of morally contested procedures. The Project proposes a serviceable *Code of Ethics* provision and stand-alone policy of this type that draws on past CMA statements, key elements of its submission to the CPSO on effective referral, and the revised CMA Medical Assistance in Dying policy. This ought to be fully acceptable, since the elements of the policy have already been considered and agreed upon by the Association.

Incidentally, the Project recommends deletion of a reference to torture incorporated into 2018 revision. Deleting the reference would not compromise patient interests nor detract from the revision, and would avoid potentially troublesome distractions.

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I. Seeking reconciliation

Introduction

I.1 The Protection of Conscience Project advocates for the support and protection of the human dignity of health care workers, reflected in their moral agency, integrity and the exercise of freedom of conscience. This submission concerns a substantial revision to the Canadian Medical Association's *Code of Ethics* proposed by the CMA Code of Ethics Revision Task Force, parts of which will affect the dignity, moral agency integrity and freedom of conscience of physicians. The narrow focus of the submission should not be understood to imply a lack of appreciation for what the Task Force has accomplished, nor disagreement with aspects of the Revision that the submission does not address.

Praise for the 2018 Revision

I.2 The Project applauds the 2018 Revision's assertion that "the patient-physician relationship is at the heart of medical practice"and is a reciprocal relationship entailing recognition "that the physician and patient are each moral agents." (App. "A" Ref 037) Likewise, the Project strongly endorses a number of other elements of the Revision: the emphasis on moral courage (App. "A" Ref 020) the stress on what ethical and professional practice "*ought* to be"(App. "A" Ref 004-005), insistence that physicians must practise "with integrity"(App. "A" Ref. 027), and the expectation that physicians will "respect and promote the inherent dignity and equal worth of all persons and refuse to participate in or support practices that violate basic human rights." (App. "A" Ref 024) The Project recommends reinforcing these admirable elements in the 2018 Revision by retaining clause 7 of the 2004 Code: "Resist any influence or interference that could undermine your professional integrity." (App. "A" Ref 029).

I.3 The Project also commends the Task Force for proposing a new clause that reinforces the obligation to act according to one's conscience, bearing in mind one's responsibilities to colleagues and patients:

> **C2.** Act according to your conscience, and respect differences of conscience among your colleagues; always respond to a patient's medical request regardless of your moral commitments. (App. "A" Ref 049)

Problematic elements

I.4 These important and praiseworthy elements of the 2018 Revision are unfortunately undermined by a change to the protection of conscience provision in the current (2004) Code:

> **2004 *Code***
> 12. Inform your patient when your personal values would influence the recommendation or practice of any medical procedure that the patient needs or wants.
>
> **2018 Revision**
> C3. Inform the patient when your deeply held values may influence the

> recommendation, provision or practice of any medical procedure or intervention that the patient needs or requests, but never abandon the patient. (App "A" Ref 050) The duty of non-abandonment requires providing the patient with complete information on all clinical options available <u>and</u>*, when necessary, a formal referral or a direct transfer of care*. It also includes the transfer of the patient's records when requested by the patient. [emphasis added] (App "A" Ref 051)

I.5 The text, as written, asserts an obligation to provide information necessary to enable informed decision-making. This is not problematic. However, it imposes an additional obligation to refer and initiate a transfer of care to facilitate provision of a morally contested service.

I.6 This is not optional; it is not a case of providing information *or* making a referral. Whatever the intentions of the Task Force, the text states that referral or direct transfer must be provided "when necessary" — whatever that might mean. For many objecting physicians, this is unacceptable because they consider referral or initiating a transfer of care makes them complicit in the perceived wrongdoing that follows, and that it can never be "necessary" to do what they believe to be wrong.

I.7 If "when necessary" means "when required by law or regulation," this is equally unacceptable to many objecting physicians, as evidenced by the ongoing constitutional challenge to the demand for effective referral by the College of Physicians and Surgeons of Ontario. Their position is that "ethics trumps law," a legitimate ethical stance acknowledged by the CMA.[1]

I.8 The claim that the duty of non-abandonment imposes an obligation upon physicians to refer or initiate a direct transfer of care to facilitate procedures to which they object for reasons of conscience is tendentious. It is inconsistent with the 2018 Revision's emphasis on the moral agency and integrity of physicians. As currently written, 2018 Revision C3 codifies an unacceptable form of moral partisanship that has been explicitly rejected by the CMA. It is ethically incoherent, and thus incapable of sustaining trust in the profession. It contradicts CMA norms and policies, and — contrary to the intentions of the Task Force — would undermine the dignity, moral agency, integrity and freedom of conscience of physicians.

The codification of moral partisanship

I.9 2018 Revision C3 requires all physicians to facilitate a procedure or intervention by making a formal or informal referral, or by initiating a direct transfer of care, even if they believe that the procedure is morally unacceptable: sex selective abortion, for example.

I.10 Some physicians who object to sex selective abortion may be willing to refer patients or initiate a transfer of care because they believe that doing so absolves them of moral responsibility for the procedure. Others, however, would refuse, because they believe that referral makes them complicit in wrongdoing. Even academics who demand that objecting physicians be forced to refer for abortion admit this is a rationally defensible position.

I.11 In 2006, Carolyn McLeod admitted that referral is not a compromise. Being forced to refer,

she said, would put objecting physicians "at serious risk of losing moral integrity through self-betrayal," with profound consequences for their "psychological health and agency."[2] However, by 2008, concerned that "the pro-life side" was winning the intellectual argument on mandatory referral,[3] she proposed a new argument "to ensure that [physicians] do not get protections for refusal to refer."[4] She again admitted that requiring effective referral was not a compromise.[5] She nonetheless insisted that objecting physicians should be forced to refer for abortion because, she said, "abortions *are* morally permissible."[6] Objecting physicians "ought not to be able to follow their consciences when the voice of their conscience misleads them."[7]

I.12 Five years later, she and Lori Kantymir insisted that "referrals are *not* appropriate when the objection itself is morally justified": that "conscientious objections by healthcare professionals that *are* morally justified should *not* be followed up by referrals."[8] However, they insisted upon compulsory referral for most abortions because — in their view — most abortions *are* morally acceptable[9] — though not sex-selective abortions.[10] At this stage, however, they were also supporting a model conscientious objection policy co-authored by McLeod[11] that replaced the need for moral justification with the criterion of public funding.[12]

I.13 McLeod's obvious moral partisanship in advocating compulsory referral (except, perhaps, for sex selective abortion) is to be expected in politics and is not out of place in academic discourse, but it does not belong in the CMA *Code of Ethics*. The current wording of 2018 Revision C3 writes such partisanship into the *Code*. It favours the moral viewpoint of physicians willing to refer, and discounts that of physicians who believe that referral is morally objectionable. The CMA has denounced this approach as illicitly discriminatory (Part III.18), a view the Project shares.

Ethical incoherence

I.14 Moral partisanship is not diminished by the caveat, "when necessary." 2018 Revision C3 deals strictly with ethical/moral conflicts, not with clinical decisions about whether a particular intervention is functionally *necessary* to accomplish a specific therapeutic goal. The Revision asserts that some physicians, must, "when necessary," do what they believe to be wrong.

I.15 It is simply incoherent to include an ethical obligation to do what one believes to be unethical in a code of ethics (II.10-11). An expectation that some physicians must do what they believe to be wrong — even if only "when necessary" — would naturally undermine trust in the medical profession, an outcome completely at odds with the goals of the 2018 Revision[13] and the intentions of the CMA.[14] Consider the adverse effects of an expectation

- that lawyers who believe bribery is wrong must, "when necessary," arrange for someone to be bribed to secure some benefit for a client;
- that state officials who believe that torture is wrong must, "when necessary," arrange for someone to be tortured to ensure public safety;
- that people who believe that lying is wrong must, "when necessary," lie to preserve the reputation of a political party, church, school, profession or other institution.

What is "necessary"?

I.16 Moreover, when necessity is defined by the 'ethics of the profession,' or by law or public policy even in democratic states, the idea that professionalism involves a duty to do what one believes to be wrong "when necessary" is not only contentious, but decidedly ill-advised. This is demonstrated by sorry history of physician support and complicity in laws like the *Alberta Sterilization Act*, which Emily Murphy praised as a compassionate way to deal with "the human wreckage . . . dumped from foreign lands" in Canada.[15]

I.17 The Canadian Medical Association supported the thinking behind such legislation.[16],[17] It welcomed an address on "The Quality of the Human Stock" at its annual banquet in 1934[18] and published a favourable account of the operation of the Alberta Eugenics Board.[19] Two years later the *Canadian Medical Association Journal* (CMAJ) featured a lengthy essay on the superiority of the Aryan/Nordic Race[20] by a strong public supporter of Nazi racial policies.[21]

I.18 Alberta physicians eventually sterilized 2,822 people upon the authorization of the Alberta Eugenics Board.[22] When the *Sterilization Act* and Board were abolished in 1972, the government of the day denounced the program that had operated for 44 years — with the cooperation of the medical establishment — as a "reprehensible and intolerable" violation of "fundamental human rights."[23]

I.19 In 1996, the Alberta Court of Queens Bench found that the Eugenics Board "routinely operated outside the law," and that, as late as the early 1960's, physicians cooperating with the Board not only performed sterilizations not authorized by the statute, but performed medically unnecessary appendectomies, castrations, hysterectomies, oophorectomies and biopsies of testicular tissue, behaviour the judge described as "unlawful, offensive and outrageous."[24]

I.20 Nonetheless, Dr. Margaret Thompson, a former Eugenics Board member who was excoriated by the trial judge for, among other things, encouraging the use of trainees with Down Syndrome as "medical guinea pigs," had "no regrets" about her activities as a board member. Asserting that ethics "never stands still," she defended her decisions as "a very reasonable approach to a very difficult problem."[25] It should be noted that Dr. Thompson was not an outlier in the medical community. She had a particularly distinguished career,[26] and was eulogized in 2014 as "one of Canada's most respected geneticists, a pioneer in genetic counselling and a devoted researcher into the causes of certain diseases."[27]

I.21 It is very doubtful that any of the physicians who played a prominent role in giving effect to the Eugenics Board's decisions believed that they were doing anything wrong. On the contrary, as Dr. Thompson's explanation indicates, it is very likely that they thought it "necessary," and that they were "moving with the times" — a notion typically associated with revisions to the CMA *Code of Ethics*.[28], [29]

I.22 However, the pages of the CMAJ reveal that, in trying to move with the times, one can become a prisoner of one's own time, shackled by established ideas about what is "necessary," for example. Consistent with the Task Force's insight that the workplace must

not only be physically and psychologically safe, but "conducive to challenging the *status quo,*" (2018 Revision C43, App A, Ref 120) the Project recommends that the requirement that physicians do what they believe to be wrong "when necessary" be struck from the Revision.

Contradiction of CMA norms and policies

I.23 The CMA has, for almost fifty years, insisted that physicians must not be forced to do what they believe to be wrong by being compelled to facilitate procedures or interventions to which they object for reasons of conscience (Part II). The current wording of 2018 Revision C3 reverses that position, bringing into question CMA assurances to objecting physicians, and undermining resolutions passed by CMA General Councils (Parts II.4, III.3-4, III.11-12).

I.24 Finally, the requirement for referral or physician-initiated transfer of care contradicts a foundational CMA statement concerning freedom of conscience (Part IV.14-21), as well as the revised CMA policy, *Medical Assistance in Dying* (Part V).

Servitude, not service

I.25 As the Revision states, physicians, like patients, are moral agents (App. "A" Ref 037). Neither physicians nor patients act improperly when they insist that the conscience that guides their own actions must be their own and not someone else's. If patients' convictions are sufficient to justify their decisions to seek a particular service, it does not follow that their convictions are sufficient to justify forcing physicians to assist them. A right to choose for oneself is not equivalent to a right to coerce others. The practice of medicine entails service, not servitude.

I.26 In *R v Morgentaler*, Justice Bertha Wilson approved the principle that a human person must never be treated as a means to an end - especially an end chosen by someone else, or by the state. Wilson rejected the idea that, in questions of morality, the state should endorse and enforce "one conscientiously-held view at the expense of another," for that is "to deny freedom of conscience to some, to treat them as means to an end, to deprive them . . .of their 'essential humanity'."[30]

I.27 To use physicians as means to ends they reject as morally unacceptable demands the submission of intellect, will and conscience, reducing them to the status of things, to tools to be used by others, to a form of servitude that cannot be reconciled with principles of equality. Following Justice Wilson, it is an assault on human dignity that deprives physicians of their essential humanity.[31] It is impossible to reconcile such a policy with any acceptable notion of professionalism.

Seeking reconciliation

I.28 The current text of 2018 Revision C3 is unsatisfactory, but it can be rewritten to reconcile it with the CMA's longstanding commitment to physician freedom of conscience, and with the obvious desire of the Task Force to emphasize the moral agency and integrity of physicians in a revised *Code of Ethics*. Moreover, this can be done by drawing almost exclusively on CMA sources, so that a rewritten and satisfactory text remains almost entirely in the CMA's

own words. The balance of this submission seeks this reconciliation.

Notes

1. Dr. Jeff Blackmer, CMA's Vice President of Medical Professionalism, considering CMA policy options if euthanasia and assisted suicide were legalized, said, "One of the options would have been to say our policy is unchanged. We could say ethics trumps the law." Kirkey S. Canadian doctors want freedom to choose whether to help terminal patients die: CMA to revisit issue of doctor-assisted death after delegates pass motion supporting physician's right to 'follow their conscience'. canada.com [Internet] 2014 Aug 19 [cited 2018 Mar 24]. Available from http://o.canada.com/news/national/canadian-doctors-want-freedom-to-choose-whether-to-help-terminal-patients-die.

2. McLeod C. Demanding Referral in the Wake of Conscientious Objection to Abortion. In: Cohen JC, Keelan JE editors. Comparative Program on Health Law and Society, Lupina Foundation Working Papers Series 2004–2005. Toronto: University of Toronto, Munk Centre for International Studies [Internet]; 2006 [cited 2018-03-18]; 130-138 at 132 (emphasis added). Available from http://munkschool.utoronto.ca/cphs/wp-content/uploads/2012/11/CPHS2004_WorkingPapers1.pdf.

3. McLeod C. Referral in the Wake of Conscientious Objection to Abortion. Hypatia 2008; 23(4): 30-47. doi: 10.1111/j.1527-2001.2008.tb01432.x, at 30.

4. *Ibid*, 31.

5. *Ibid*, 32–35, 42.

6. *Ibid,* 42.

7. *Ibid,* 40.

8. Kantymir L, McLeod C. Justification for Conscience Exemptions in Health Care. Bioethics 2014; 28(1):16-23 at p. 18 [emphasis added]. doi: 10.1111/bioe.12055.

9. *Ibid* (noting that a pro-life panel might excuse someone from providing abortion "on the grounds that abortions are immoral, which is (arguably) false, at least about most abortions," at 22).

10. *Ibid* (arguing it would be unfair to deny exemption to providing sex selective abortion, at 21).

11. Downie J, McLeod C, Shaw J. Moving Forward with a Clear Conscience: A Model Conscientious Objection Policy for Canadian Colleges of Physicians and Surgeons. Health L Rev 2013; 21(3): 28-32.

12. “Legally permissible and publicly funded health services” is the term used, but “legally permissible” is superfluous because there can be no duty to do something illegal, and illegal health services would not be publicly funded. The policy cites physicians’ fiduciary obligations, but those pertain to all health services, many of which are *not* publicly funded. Since compulsory referral is demanded only for publicly funded services, it is public funding alone that trumps freedom of conscience.

13. Fostering “patient and public trust,”(App. “A” Ref 002) “the trustworthiness of the profession” (App. “A” Ref 015) “reciprocal trust” (App. “A” Ref 037-038).

14. Speaking last year, the Chair of the CMA Medical Ethics Committee warned that this is “a critical juncture for the medical profession” because “the public is losing faith . . . losing trust in physicians.” He was optimistic that “being ethical, being professional” and the planned revision of the *Code of Ethics* would help restore public trust in the profession. Canadian Medical Association. Medical professionalism — New Code of Ethics. YouTube [Internet] 2017 Aug 21 [cited 2018-03-17] (10:20 - 11:26); Available from https://youtu.be/tIeduTDVuL0.

15. She noted that surgically sterilizing a male took only about the same time needed to execute “unhappy degenerates” who broke the law because of their hereditary defects. Murphy E. Sterilization of the Insane. The Vancouver Sun. 1932 Sep; Heritage Community Foundation. Alberta On-Line Encyclopedia [Internet] The Famous Five: Heroes for Today. [cited 2018-03-29] Available from:
http://www.abheritage.ca/famous5/achievements/reading/sterilization_insane.html.

16. The Problem of the Feebleminded Can Med Assoc J [Internet] 1923 Jun [cited 2018-Mar 24]; 13(6): 444-445. Available from:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1707222/?

17. Eugenics and the Medical Profession. Can Med Assoc J [Internet] 1927 Dec [cited 2018 Mar 24]; 17(12): 1526-1528. Available from:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC407753/.

18. Wallace RG. The Quality of the Human Stock. Can Med Assoc J (Special Article) [Internet] 1934 Oct [cited 2018 Mar 24]; 31(4): 427-430. Available at:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC403580/.

19. Association notes - The Sixty-fifth Annual Meeting of the Canadian Medical Association (June, 1934). Can Med Assoc J [Internet] 1934 Oct [cited 2018 Mar 24]; 31(4): 433-436 at 435. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC403584/.

20. Campbell CG. The Lessons of Racial History. Can Med Assoc J (Special Article) [Internet] 1936 Jul [cited 2018 Mar 24]; 35(1): 80-84. Available from:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1561696/.

21. The year before the article appeared in the *Canadian Medical Association Journal*, Campbell had presented papers at the International Congress for the Scientific Investigation of Population Problems in Berlin, where he asserted that "Germany has set a pattern which other nations must follow" and toasted Adolph Hitler as "a great leader." See Praise for the Nazis. Time. 1935 Sep 9; at 21. Quoted in Lombardo PA. "The American Breed": Nazi Eugenics and the Origins of the Pioneer Fund. Albany Law Review [Internet] 2002 [cited 2018 Mar 26] 65(3):743-830 at 770, 773-774. Available from: https://www.academia.edu/836113/The_American_Breed_Nazi_Eugenics_and_the_Origins_of_the_Pioneer_Fund_2002_.

22. McLaren A. Our Own Master Race: Eugenics in Canada, 1885-1945. Toronto: McClelland & Stewart; 1990, at 159. Cited in Caufield T, Robertson G. Eugenic Policies in Alberta: From the Systematic to the Systemic. Alberta Law Review [Internet]1996 [cited 2018-Mar 26]) 35(1): 59-79 at 61. Available from: https://www.albertalawreview.com/index.php/ALR/article/view/1063/1053.

23. Reports of the Debates of the 17th Legislative Assembly of Alberta, 1st Session [Internet] 1972 May 31 [cited 2018 Mar 25]; 3945. Available at http://www.assembly.ab.ca/Documents/isysquery/4ab03327-0068-424b-8e5f-49d35dea124c/1/doc/19720531_1430_01_han.pdf#xml=http://www.assembly.ab.ca/Documents/isysquery/4ab03327-0068-424b-8e5f-49d35dea124c/1/hilite/.

24. *Muir v. Alberta*, 1996 CanLII 7287 (AB QB) [Internet] [cited 2018 Mar 24]. Available from: http://canlii.ca/t/1p6lq. The judge referred specifically to the evidence of geneticist Dr. Margaret Thompson, who was active on the Board from 1960 to 1962, during which period illegal sterilizations were authorized and unnecessary appendectomies were performed: "Dr. Thompson's evidence demonstrates that the operations of the Board, initiated on a purported scientific rationale, degenerated into unscientific practices. The decisions of the Board were not made according to the standards imposed on them by the legislation, but because the members of the Board, like Dr. Thompson, thought that it was socially appropriate to control reproduction of 'these people.'"

25. Cairney R. "Democracy was never intended for degenerates": Alberta's flirtation with eugenics comes back to haunt it. CMAJ [Internet] 1996 Sept 15 [cited 2018 Mar 25]; 155(6): 789-792 at 792. Available from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1335257/.

26. Dr. Thompson was awarded the Order of Canada in 1988 for her pioneering work in medical genetics and genetic counselling. The Canadian College of Medical Geneticists memorializes her in an annual Founders' Award for Career Achievement as one of seven "visionary men and women" who founded the College in 1976. Canadian College of Medical Geneticists [Internet] 2018 Founders' Award for Career Achievement [cited 2018 Mar 25]. Available from: https://www.ccmg-ccgm.org/about/award-information/founders-4.html. In 2011, the College authorized the Dr. Margaret Thompson Trainee Award in her honour. *Ibid*, Dr. Margaret Thompson Trainee Award [cited 2018 Mar 25]. Available from:

https://www.ccmg-ccgm.org/91-members/awards/148-trainee-awardees.html.

27. Csillag R. Gifted scientist Margaret Thompson had a lasting impact on health care. Globe and Mail [Internet] 2014 Dec 14 [updated 2017 Mar 25] [cited 2018 Mar 25]. Available from: https://www.theglobeandmail.com/news/national/gifted-scientist-margaret-thompson-had-a-lasting-impact-on-health-care/article22078694/.

28. In 1970, with "a new spirit of daring . . . alight in the land," incoming President Dr. D.L. Kippen, observed, "What we're seeing now is a more liberal attitude in society in general, and the doctors are moving with the times." The Physician and the Liberal Society: Understanding in Winnipeg. Can Med Assoc J [Internet] 1970 Jul 18 [cited 2018 Mar 14]; 103(2): 193, 195, 198-201, 204-209, 212-219 at 193, 195. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1930397/.

29. Canadian Medical Association, *Medical professionalism — New Code of Ethics*. YouTube (21 August, 2017) (https://youtu.be/tIeduTDVuL0) 26 Accessed 2018-03-17 Canadian Medical Association. Medical professionalism — New Code of Ethics. YouTube [Internet] 2017 Aug 21 [cited 2018-03-17] (Dr. Atul Kapur [3:11-4:26]; Dr. Tim Holland [4:34-5:17]. Available from https://youtu.be/tIeduTDVuL0.

30. *R. v. Morgentaler* (1988)1 SCR 30 at 179 [Internet] [cited 2018 Mar 18]. Available from: http://scc-csc.lexum.com/scc-csc/scc-csc/en/item/288/index.do.

31. Murphy S, Genuis SJ. Freedom of Conscience in Health Care: Distinctions and Limits. Bioethical Inquiry [Internet] 2013 [cited 2018 Mar 18] 10:347. Available from: https://doi.org/10.1007/s11673-013-9451-x.

II. CMA against mandatory referral

II.1 The demand for referral or physician-initiated transfer of care in 2018 Revision C3 reverses the CMA's longstanding position that it is unacceptable to compel physicians to make referrals for procedures to which they object for reasons of conscience. This position has been maintained for almost fifty years.

The first CMA "conscience clause"

II.2 In 1970 the CMA adopted a major revision of its *Code of Ethics*. It included the following statement, obviously made necessary by the reform of the abortion law the year before:

> **Personal morality**
> 15. An ethical physician will, when his personal morality prevents him from recommending some form of therapy which might benefit the patient, acquaint the patient with these factors.[1]

II.3 Abortion was not mentioned, however, because the ethics committee believed abortion was "like any other surgical procedure."[2]

II.4 The following year the CMA General Council declared that abortion could be justified on "non-medical social grounds." It approved nine further resolutions concerning abortion, two of particular significance to this submission:

> 4. That faced with a request for an abortion, a physician whose moral or religious beliefs prevent him from recommending and/or performing this procedure *should so inform the patient so that she may consult another physician*. (emphasis added)
>
> 7. That physicians or other health personnel *should not be required to participate in the termination of a pregnancy*; and that a patient should not be forced to have a pregnancy terminated (emphasis added).[3]

II.5 Immediately following liberalization of the abortion law, the number of abortions rose from about 300 in 11 years[4] to over 11,000 in one year,[5] reflecting the difference between therapeutic abortions performed to preserve the life of the mother and elective abortions provided for non-medical reasons.[6] Dramatic yearly increases in abortion rates continued for a decade. The broadened grounds for abortion and continuing increases in the abortion rate[5,7,8] increased the likelihood of conscientious objection to the procedure and of conflict between patients and physicians. It also brought raging controversy.

1977-78: The first referral controversy

II.6 At the General Council in 1977, the ethics committee recommended that the protection of conscience provision be amended by adding a requirement that an objecting physician should advise patients of their right to seek another opinion. This was met with a counter-proposal from the floor that they should be required to "advise the patient of other sources of assistance."[9]

II.7 In support of the counter-proposal it was argued that "compassion is the basis of ethics," of professionalism and of medical practice, and that the profession has a responsibility to patients "who should not be abandoned in any regard." Hence, a physician who disagrees with "a particular form of therapy" must not "abandon" the patient.[9]

II.8 The amendment was adopted, and a serious conflict erupted almost immediately. It was widely interpreted to mean that objecting physicians were obliged to refer for abortion, notwithstanding the assurance of the Director of Communications to the contrary.[10] The General Secretary defended the change on the grounds that physicians must not "abandon the patient or impede her from obtaining help from other sources of assistance.[11] The accusation of "abandonment" was strenuously rejected as at least an exaggeration.[12] An objecting physician insisted that "[n]o patient has the right to anything other than what a physician can in his conscience do," and protested that it was "intolerable that the CMA is telling me I may not follow my conscience in this most serious matter."[13] Even physicians who appear to have been willing to provide or refer for abortions feared that their objecting colleagues would be pressured to become morally complicit in what they considered to be murder.[14]

II.9 After a year of controversy, the 1977 amendment was struck out and the previous wording restored.[15] Apart from minor editorial changes and renumbering, the policy has remained intact since that time. This is the policy 2018 Revision C3 proposes to change (I.4).

No ethical obligation to do what is believed to be wrong

II.10 Dr. John R. Williams was Director of Ethics for the World Medical Association from 2003 to 2006 and the author of the *World Medical Association Medical Ethics Manual*.[16] In 2000, when he was CMA Director of Ethics, he advised the Project Administrator that the Association did not require objecting physicians to refer for abortion. He explained that the CMA had once had a policy to that effect, but had dropped it because there was "no ethical consensus to support it." This was clearly a brief reference to the short-lived 1977 revision of the *Code of Ethics.*

II.11 Two years later, speaking of physicians who decline to provide or to refer for contraceptives for religious reasons, Dr. Williams pithily expressed the ethical basis for the CMA position. He said, "[They're] under no obligation to do something that they feel is wrong."[17] Similarly, a 2003 annotation of the CMA *Code of Ethics* for the Canadian Psychiatric Association, commenting on the protection of conscience provision, stated the obvious: "A code of ethics can never require someone to carry out what he believes to be an immoral act."[18]

2006-2008: reaffirmation of the policy

II.12 In a guest 2006 editorial in the *Canadian Medical Association Journal* [19]and in a response to criticism of the editorial,[20] two law professors asserted that objecting physicians have an obligation to refer patients for abortion. Dr. Jeff Blackmer, then CMA Executive Director of Ethics, reaffirmed Association policy that referral was not required.[21]

II.13 Two years later, the Ontario Human Rights Commission (OHRC) tried to convince the College of Physicians and Surgeons of Ontario to suppress physician freedom of conscience

and religion because "doctors, as providers of services that are not religious in nature, must essentially 'check their personal views at the door' in providing medical care."[22]

II.14 The College produced a draft document to that effect, but the 25,000 member Ontario Medical Association asked that the document be withdrawn, stating, "We believe that it should never be professional misconduct for an Ontarian physician to act in accordance with his or her religious or moral beliefs."[23,24]

II.15 A generally hostile response forced the College to delete the most objectionable language in the draft policy, which became *Physicians and the Ontario Human Rights Code*. Dr. Bonnie Cham, Chair of the CMA Ethics Committee, reaffirmed the Associations support for "the identifiable minority" of physicians who do not agree with abortion, and observed that there is still "a minority who would not refer" for abortion.[25]

1978-2018: forty years later, no ethical consensus

II.16 It is noteworthy that, in 2018, we hear the same arguments made in 1978. Advocates of compulsory referral accuse objecting physicians of patient abandonment, claiming that refusal to refer impedes or obstructs access and demonstrates lack of compassion. Physicians who refuse to refer insist that helping a patient to commit suicide is not compassionate. They argue that physicians are not guilty of abandonment because a patient, refusing the treatments they offer, tries to compel them to do what they cannot do in good conscience.

II.17 In addition, forty years after the first explosive referral controversy, there is still no ethical consensus that physicians should be compelled to do what they believe to be wrong. Nor is there a consensus that a code of ethics can impose an obligation to do what one believes to be unethical. As the Canadian Psychiatric Association recognized in 2003, that is an incoherent proposition.

1978-2018: forty years later, no evidence

II.18 Finally, after forty years there appears to be no empirical evidence that patients have been unable to access physician services because objecting physicians have been unwilling to refer or otherwise facilitate morally contested procedures.

II.19 For example: in 2017, the College of Physicians and Surgeons of Ontario could not produce a single example of a complaint by a patient unable to access services because of conscientious objection or refusal to refer in 25 years.[26]

II.20 According to discipline notices published by the College of Physicians and Surgeons of British Columbia, between January, 2006 and November, 2015, 80 physicians were disciplined as a result of complaints of professional misconduct. None of these involved conscientious objection by a physician. The same is true of complaints against 57 physicians disciplined for professional misconduct between March 2008 and February, 2018.[27]

II.21 Documents produced by the College of Physicians and Surgeons of British Columbia in response to an access to information request by the Project included enquiries received by the

College concerning access to medical services. Over a 27 month period beginning in December, 2012, the College received 44 enquiries for which information was available. The largest single group (10 of 44) involved allegations that physicians had refused to accept patients who were elderly, disabled or had challenging medical needs. The next largest (7 of 44) alleged that physicians were refusing to treat injuries sustained in accidents because they involved ICBC,Worksafe or other insurances claims. None of the enquiries concerned conscientious objection by a physician.[28]

II.22 The documents disclosed only one concern about patient abandonment: "The abandonment of patients at the end of their lives by physicians . . . who refuse to make house calls and insist that if the patients cannot come to the office they cannot prescribe for them."[29]

Conclusion

II.23 There being no new and persuasive argument in favour of suppressing physician freedom of conscience with respect to referral, no consensus that it is proper to compel physicians to do what they believe to be wrong, and no empirical evidence demonstrating that the suppression of physician freedom of conscience is necessary to ensure patient access to services, there is no reason to reverse the CMA's longstanding policy against compelling physicians to refer for procedures to which they object for reasons of conscience.

Notes

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26. Answering Physicians Top 5 Legal Questions [Internet] Canadian Physicians for Life Conference Series. 2017 [cited 2018 Mar 29] (Video: 11:18-12:35). Available from: http://consciencelaws.org/blog/?p=8081. The Dawson case mentioned by the speakers occurred in 2002. It concerned a physician who, for religious reasons, refused to prescribe contraception to unmarried patients. The patients involved were able to access contraception from other sources.

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III. CMA on physician freedom of conscience

1988-2012: from abortion to euthanasia

III.1 In 1988, after the Supreme Court of Canada struck down all legal restrictions on abortion, the CMA revisited its policies on the procedure. The protection of conscience provision in the *Code of Ethics* remained unchanged, and the Association stressed that there should be no discrimination against objecting physicians, "particularly for doctors training in obstetrics and gynecology, and anesthesia."[1]

III.2 While this reaffirmed the CMA's commitment to protect physician freedom of conscience, it does not appear that the foundation for the commitment was explored or developed over the next 25 years, even in the face of increasingly strident claims that ultimately led to a recommendation that objecting physicians should be forced to refer patients for euthanasia.[2]

2012-2014: 'neutrality' and conscience

III.3 This issue suddenly came to the fore in 2012 when a ruling by a British Columbia Supreme Court judge struck down the prohibition of physician assisted suicide and euthanasia.[3] When the CMA Annual General Council convened in August, 2013, an appeal of the *Carter* decision was in progress, and a euthanasia bill had been introduced in the Quebec legislature. Council proceedings reflected "deep divisions within the medical community."[4] The Council did, however, resolve to support "the right of any physician to exercise conscientious objection when faced with a request for medical aid in dying." (DM 5-22)[5]

III.4 CMA officials spent much of 2014 studying euthanasia and assisted suicide, and in August presented the General Council with a resolution affirming CMA support for both physicians unwilling to participate in the procedures, and those willing to do so, should they be legalized.[6] This was explained by CMA officials as a commitment to neutrality and support for physician freedom of conscience.[7], [8], [9]

III.5 However, when the executive revised the policy in December, it formally approved physician assisted suicide and euthanasia as "end of life care" and promised to support patient access to "the full spectrum" of such care, subject only to the law. The policy did not exclude minors, the incompetent or the mentally ill, nor did it indicate that the procedures should be provided only to the terminally ill or those with uncontrollable pain. It referred directly only persons suffering from "incurable diseases."[10] The Directors thus formally committed the Association to support euthanasia and assisted suicide not only for competent adults, but for any patient group and for any reason approved by the courts or legislatures.

III.6 From a protection of conscience perspective, the first practical problem with this was that actual support for euthanasia and assisted suicide within the medical profession — to the extent that it had been evaluated at all — was highly volatile. Roughly contemporaneous *optimistic* estimates suggested that 6% to 29% of physicians were willing to provide the procedures, depending upon the condition of the patient; 63% to 78% would refuse, again dependent upon the condition of the patient. Of physicians willing to *consider* providing the

services, the number dropped by almost 50% in the case of non-terminal illness, and by almost 80% in the case of purely psychological suffering (i.e., in the absence of pain).[11] The Association's unconditional support for euthanasia and assisted suicide potentially exposed large number of physicians to demands that could generate serious conflicts of conscience.

III.7 The second problem was that the policy was not neutral.[12] By classifying euthanasia and assisted suicide as "end of life care," the CMA executive effectively made participation in euthanasia and assisted suicide normative for the medical profession. Once the Supreme Court of Canada ordered legalization of the procedures,[13] the refusal to provide assisted suicide and euthanasia in the circumstances set out in *Carter* became an exception to professional obligations that had to be justified or excused. This is why, since *Carter*, public discourse has largely centred on whether or under what circumstances physicians and institutions should be *allowed* to *refuse* to provide or participate in homicide and suicide.

III.8 Certainly, the new policy also stated that the CMA supported the right of physicians to "follow their conscience" when deciding whether or not to *provide* euthanasia, and that physicians "should not be compelled to *participate*," a broader term that could encompass referral. However, it characterized the protection of conscience provision in the *Code of Ethics* (2004 paragraph 12) as defending only "physician *autonomy*," not physician moral agency and personal integrity. In addition, it added a qualifying statement: "However, there should be no undue delay in the provision of end of life care." This could be (and later was) understood to justify limiting freedom of conscience for objecting physicians in order to ensure patient access to the services.

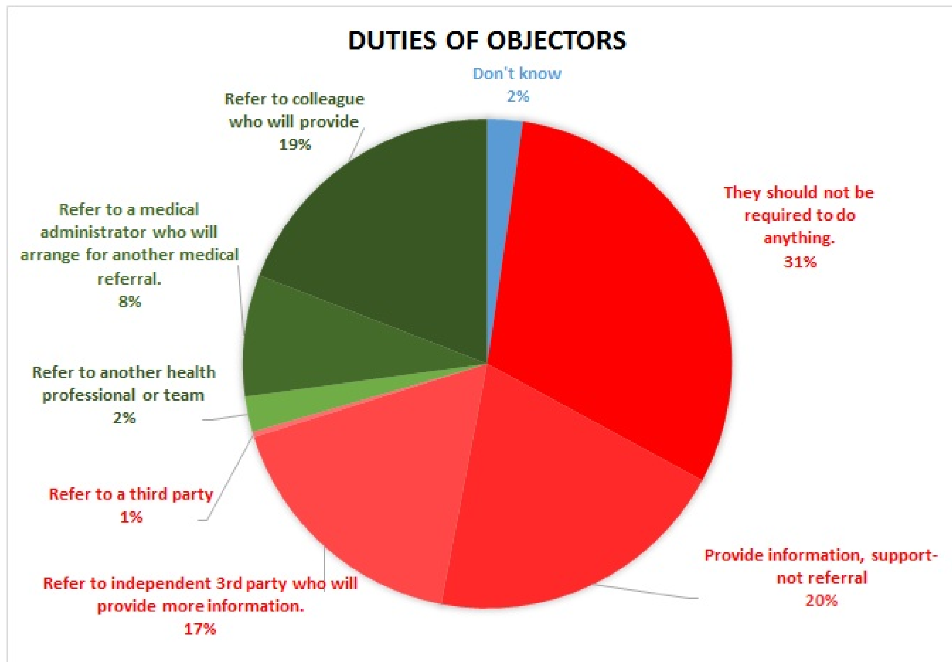
2015: the *Carter* maelstrom

III.9 Thus, when the Supreme Court ruled in *Carter*, the CMA was ready to proceed with implementing euthanasia and assisted suicide, but it was quite unprepared mount a cogent, articulate and persuasive defence of physician freedom of conscience. This disadvantage was compounded when the federal government did virtually nothing for five months following the ruling, then called (and lost) an election, and left the CMA other stakeholders scrambling to develop policies responsive to the *Carter* ruling without any direction as to what changes would be made to the criminal law.

III.10 The result was a policy and regulatory maelstrom that lasted several months. During this time, CMA officials, struggling to develop practice standards and guidelines in response to *Carter*, were also caught between activists demanding that physicians be compelled to refer for the procedures, and physicians and physician groups, galvanized by the *Carter* ruling, adamantly opposed to providing or facilitating euthanasia or assisted suicide. Under the circumstances, it is not surprising that there was some waffling by CMA officials on the issue of referral.

III.11 By the time the Annual General Council convened in August, 2015, only about 19% of CMA members believed that physicians should be required to refer patients to someone who would provide euthanasia or assisted suicide. Almost 70% were opposed to the idea. About 31% thought objecting physicians should not be require to do anything, but about 27% believed

that they should provide information and support, or refer to a third party who could provide information.



Source: Murphy S. "A uniquely Canadian approach" to freedom of conscience in health care*:* Provincial-Territorial Experts recommend coercion to ensure delivery of euthanasia and assisted suicide. App. D2.2.3. Protection of Conscience Project (2016).

III.12 The Council ultimately approved a resolution later adopted by the CMA Board of Directors. It stated that physicians were not obliged to fulfill requests for or participate in euthanasia or assisted suicide, and should not be discriminated against for refusing to do so. It required objecting physicians to provide patients with complete information on "all options," and advise them "how they can access any separate central information, counseling, and referral service."[14]

III.13 This was a development of the basic framework provided by the *Code of Ethics.* It was, however, a largely pragmatic response guided by a general notion of "striking a balance" between patient and physician autonomy or rights. It was specific to euthanasia and assisted suicide, and it was unsupported by principled ethical or philosophical rationale. It is unlikely that more than this could have been achieved in the circumstances.

2016: The CMA and "effective referral"

III.14 The first CMA statement addressing the subject of physician freedom of conscience at a foundational level was a 2016 submission to the College of Physicians and Surgeons of Ontario in response to its demand that objecting physicians facilitate euthanasia and assisted suicide by an "effective referral."[15] Important elements of this statement were incorporated into the new CMA *Medical Assistance in Dying* policy and are evident in the 2018 revised

draft of the CMA *Code of Ethics*.

III.15 The first and most important element is the recognition of physicians as moral agents.

> It is in fact in a patient's best interests and in the public interest for physicians to act as moral agents, and not as technicians or service providers devoid of moral judgement. At a time when some feel that we are seeing increasingly problematic behaviours, and what some view as a crisis in professionalism, medical regulators ought to be articulating obligations that encourage moral agency, instead of imposing a duty that is essentially punitive to those for whom it is intended and renders an impoverished understanding of conscience.

III.16 The statement does not neglect the interests of patients seeking access to euthanasia and assisted suicide, noting that the CMA wishes to protect physician freedom of conscience "without in any way impeding or delaying patient access." However, it insists that this can be accomplished by adopting a two-pronged strategy: by asking physicians to fulfil "a duty that is widely morally acceptable," yet allows them " to act as moral agents," and by requiring the community to accept its responsibility to ensure access, "rather than placing the burden of finding services solely on individual physicians."

III.17 The third significant point is recognition that the central concern of objecting physicians is their individual moral responsibility to avoid complicity in perceived wrongdoing. This is sometimes misconstrued or misrepresented as a desire to control the conduct of their patients, and it is too often passed over because it can be a painful reminder of the essential point of disagreement between objecting physicians and non-objecting colleagues.

III.18 Fourth, the statement recognizes that the exercise of freedom of conscience is a fundamental freedom for everyone, not just for those whose moral judgement conforms to a dominant viewpoint, or to one's own. This is implied in its discussion of effective referral. Some physicians who refuse to provide assisted suicide or euthanasia have no objection to referring a patient to a colleague willing to provide the service. Others find referral "categorically morally unacceptable" because they believe that referral makes them complicit in grave wrongdoing. The statement characterizes a demand for "effective referral" as illicit discrimination, not a solution, because it "respects the conscience of some, but not others."

> It is the CMA's strongly held position that there is no legitimate justification to respect one notion of conscience . . . the CMA [seeks] to articulate a duty that achieves an ethical balance between conscientious objection and patient access in a way that respects differences of conscience. It is the CMA's position that the only way to authentically respect conscience is to respect differences of conscience.

III.19 Finally, citing the Supreme Court of Canada, the statement also emphasizes the fiduciary nature of the patient-physician relationship: the physician's obligation "to protect and further their patients' best interests." However, it adds that physicians' fiduciary obligations do not "in any way" entail an obligation to violate their own moral integrity.

III.20 The Project has strongly supported this position for years. However, something more must be added to this. The dominant view is that "the interests" or "best interests" of patients are determined by the patients themselves — not by physicians — even if physicians assist them in deciding what those interests are. Once patients have identified their interests, the argument goes, physicians have a fiduciary duty to serve those interests, by, for example, referring a patient for a desired procedure. This is erroneous.

III.21 Granted that patients are entitled to determine what they believe to be in their best interests, physicians who disagree have no obligation to serve those interests. As a matter of law, a fiduciary is not a servant.[16] Fiduciaries have a duty *not* to act under dictation, even the dictation of a beneficiary,[17] and must exercise their *own* judgement.[18] The law does not allow beneficiaries (patients) to turn fiduciaries (physicians) into "puppets."[19] These are important legal principles that apply to all aspects of clinical and professional judgement, not just to the exercise of freedom of conscience.

Conclusion

III.22 The CMA's support for physician freedom of conscience has been expressed by resolutions at successive General Councils. In addition, available statistics indicate that the great majority of CMA members have been opposed to compelling objecting physicians to refer for morally contested services, but seem to agree that there is an obligation to provide information and to help patients contact other physicians or health care providers, though not specifically with providers of contested services.

III.23 Like the 2018 Revision, the CMA's first statement addressing physician freedom of conscience at a foundational level emphasizes physician moral agency and integrity. However, it strongly denounces the imposition of effective referral, describing it as illicitly discriminatory. This ought to preclude acceptance of the proposal for referral and physician-initiated transfer of care in the current text of 2018 Revision C3.

Notes

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12. Contrast the position of the CMA with that of the Royal New Zealand College of General Practitioners, which explicitly declined to endorse euthanasia or assisted suicide, while recognizing that individual practitioners might participate if they wished to do so. The Royal New Zealand College of General Practitioners. Submission to the Justice Committee re: End of Life Choice Bill [Internet] 2018 Mar 6 [cited 2018 Mar 15]. Available from: https://oldgp16.rnzcgp.org.nz/assets/2018-03-06-RNZCGP-submission-to-Justice-Committee-End-of-Life-Choice-Bill.pdf.

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16. Canadian Aero Service Ltd. v. O'Malley, [1974] SCR 592, 1973 CanLII 23 (SCC) [Internet][cited 2018 Mar 29] ("their positions . . .charged them with initiatives and with responsibilities far removed from the obedient role of servants. It follows that O'Malley and Zarzycki stood in a fiduciary relationship to Canaero . . ." at 606). Available from: https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/2717/index.do.

17. United Kingdom, Law Commission. Report No. 350. Fiduciary Duties of Investment Intermediaries. Williams Lea Group for HM Stationery Office [Internet] 2014 [cited 2018 Mar 29] at para 3.53, note 107, citing Selby v Bowie (1863) 8 LT 372; Re Brockbank [1948] Ch 206. Available at http://lawcom.gov.uk/app/uploads/2015/03/lc350_fiduciary_duties.pdf.

18. *Ibid*, notes 109–110, citing Thomas G. Thomas on Powers. 2nd ed. Oxford: Oxford University Press; 2012, at para 10.60; Finn P. Fiduciary Obligations. 1st ed. Sydney: Law Book Co; 1977, at para 44; Mowbray J et al. Lewin on Trusts. 18th ed. London: Sweet & Maxwell; 2007, at para 29-89.

19. *Ibid*, para 3.51 note 105, quoting Finn P. *supra* note 18 at para 42.

IV. CMA Policy: *Medical Assistance in Dying*

IV.1 In May, 2017, the CMA issued *Medical Assistance in Dying*, a revised policy on euthanasia and assisted suicide reflecting the experience of the Association.[1] Here one finds the principles enunciated in the submission to the CPSO developed and applied. The document addresses the circumstances of both patients and physicians in a more or less integrated manner, appropriately reflecting the nature of the subject. For analytical purposes, this submission deals with them separately.

Physicians as moral agents

IV.2 The moral agency of physicians is implicitly acknowledged and supported by the CMA goal of "creating an environment in which practitioners are able to adhere to their moral commitments."[2] The policy is meant to ensure "protection of physicians' freedom of conscience (or moral integrity) in a way that respects differences of conscience."[3]

IV.3 Consistent with this goal, the CMA states that it supports "the right of all physicians to follow their conscience" whether that takes the form of "conscientious participation" or "conscientious objection,"[4] whether their decisions follow from "reasons of moral commitments to patients and for any other reasons of conscience."[5]

IV.4 The sensitive issue of complicity in perceived wrongdoing (see III.17) is not discussed, but the CMA addresses it indirectly by insisting that physicians must be free to exercise freedom of conscience in relation to "any or all aspects"[6] of the procedures, which encompass eligibility assessment and patient decision-making.[7] Reflecting various forms of complicity, physicians are not required "to provide . . . or to otherwise participate . . . or to refer the patient" to a practitioner who will provide the services.[8]

IV.5 As in the submission to the CPSO (see III.18), here the CMA insists that physicians' moral integrity must be protected by ensuring that they are "able to follow their conscience without discrimination," including discrimination in "general employment or contract opportunities" or in "evaluations and training advancement" in learning environments.[9]

IV.6 Finally, consistent with the submission to the CPSO (see III.16) the CMA asserts that the community has an obligation "to enable physicians to adhere to [their] moral commitments" by implementing "an easily accessible mechanism" to facilitate patient access to services.[10]

IV.7 Granted the critical importance of fostering the moral agency and integrity of physicians, the CMA acknowledges that exercise of freedom of conscience is not unlimited. Physicians must "never abandon or discriminate against [patients]", nor "impede or block access," nor make acceptance or retention of patients conditional upon their agreement not to request certain services.[11]

Patient dignity

IV.8 The CMA does not articulate a rationale for the limits it sets on the exercise of physician freedom of conscience (IV.7), but it is readily discerned in the document's references to

patients. These are premised upon recognition of the centrality of the nature of the human person and human dignity.

IV.9 Speaking of patients, the CMA asserts that "persons have inherent dignity regardless of their circumstances," that "services ought to be delivered, and processes and treatments ought to be applied, in ways that strive to preserve and enhance dignity," and that it is critical to "maintain the integrity of personhood." For these reasons, patients must be "free to make informed choices and autonomous decisions about their bodily integrity, their personal aims and their care that are consistent with their personal values and beliefs."[12]

IV.10 Unfortunately, this holistic vision is impoverished when it is reduced to one of its parts: "respect for autonomy." The Project submits that the foundational ethical consideration for the practice of medicine — and one that does take priority — is respect for the inherent dignity of human person. This entails the support and protection of patients' moral agency, personal integrity, and legitimate autonomy.

IV.11 Once this is understood, the rationale for the duty of non-abandonment and the obligation to support vulnerable patients not only becomes clear, but is substantially reinforced. So, too, is the obligation to respect the moral agency of patients by not frustrating or impeding its exercise through misuse of power or influence, or by obstruction.

Equality of patients and physicians

IV.12 Much of *Medical Assistance in Dying* is necessarily concerned with the application of ethical considerations and practical matters specific to the delivery of the services. However, its strong defence of the moral agency of physicians and its determined assertion of the need to respect and support the inherent dignity of patients illuminates another foundational principle: the essential equality patients and physicians as human persons.

IV.13 The document considers the moral agency and moral integrity of physicians — but not their dignity; it emphasizes the dignity and bodily integrity of patients — but not their moral agency or moral integrity. In fact, everything that the CMA says in *Medical Assistance in Dying* about the moral agency and integrity of physicians applies equally to patients, and everything it says about the dignity of patients applies equally to physicians.

IV.14 This explains why, on the one hand, physicians are told that they may refuse to provide or participate in any way, but may not "impede or block access," while, on the other, patients have the right to request the service, but this "does not compel individual physicians to provide it."

Guidelines reflect the foundations

IV.15 With these foundational elements in place, the guidelines for the conduct of physicians who object to euthanasia and assisted suicide can be better understood and more accurately interpreted. The first point to note is that "patient" must be understood to include a patient's agent or designated medical decision maker.

IV.16 Second, the requirement that physicians "should inform their patients of the fact and

implications of their conscientious objection" helps patients and physicians who have different views arrange their relationship in a way that accommodates the moral agency of each.

IV.17 Physicians are not obliged to fulfill a patient's request for euthanasia or assisted suicide by providing or otherwise participating in it, or to facilitate it by referring the patient to someone who will do so. Provision, participation and referral are all possible, but not obligatory, thus preserving the moral integrity of all physicians, regardless of their position on the issue. This is fully consistent with the CMA submission to the CPSO and its warning against illicit discrimination.

IV.18 Apart from this, objecting physicians are obliged to respond to a patient request. This reflects the need to respect the person and dignity of patients by acknowledging their requests, taking them seriously, and providing information that they need to exercise their moral agency and give effect to their decisions. It explains the requirement to provide complete information, including information about how to access an appropriate health care network.

IV.19 The expectation that objecting physicians will facilitate a direct transfer of care upon the request of the patient cannot be understood to require objecting physicians to facilitate euthanasia or assisted suicide by *initiating* either a transfer of care by finding a willing provider. This would make no sense in light of the policy's statement that referral is not required, since physician-initiated direct transfer of care would entail the same kind of complicity entailed by referral.

IV.20 Instead, the transfer of care envisioned in the case of an objecting physician who also finds referral unacceptable must be patient-initiated, not physician-initiated. The transfer would be made after the patient — not the physician — has identified an individual or institution. The transfer would be required even if the person or institution selected will or is likely to provide euthanasia or assisted suicide. On the one hand, this safeguards the integrity of objecting physicians because they do not provide the impetus in favour of the intervention, nor do they participate in identifying a willing provider. On the other, it enables patients to exercise and give effect to their moral agency; they are entitled to find a different physician willing to manage all or part of their care, and an objecting physician cannot prevent them from doing so.

IV.21 Similarly, the expectation that objecting physicians will provide the clinical records reflects the fact that the information in the records belongs to the patients. They are entitled to direct its disclosure to serve their purpose, and a physician who has expressed disagreement with that purpose is not entitled to do more. The situation is analogous to that of a trustee who is obliged to transfer an inheritance to an heir who has reached the age of majority, whether or not the trustee believes the heir will make good use of it.

Notes

1. Canadian Medical Association. Policy: Medical Assistance in Dying [Internet]. 2017 May [cited 2018 Mar 12]. Available from: https://www.cma.ca/Assets/assets-library/document/en/advocacy/policy-research/cma-policy-medical-assistance-in-dying-pd17-03-

e.pdf.

2. *Ibid,* Rationale, para 1.

3. *Ibid,* Addressing adherence to moral commitments, para 1.

4. *Ibid,* Rationale, para 4.

5. *Ibid,* Relevant foundational considerations (3) Respect for freedom of conscience.

6. *Ibid,* Relevant foundational considerations (3) Respect for freedom of conscience.

7. *Ibid,* Glossary: What medical assistance in dying MAID encompasses (1).

8. *Ibid,* Addressing adherence to moral commitments, a(I).

9. *Ibid,* Relevant foundational considerations (3) Respect for freedom of conscience.

10. *Ibid,* Relevant foundational considerations (3) Respect for freedom of conscience.

11. *Ibid,* Addressing adherence to moral commitments (d).

12. *Ibid,* Relevant foundational considerations (1) Respect for autonomy.

V. Reconciling obligations

Avoiding entanglement: the need for a broad and principled approach

V.1 For almost fifty years, the CMA has repeatedly expressed its commitment to support and protect of physician freedom of conscience. However, until quite recently, no attempt was made to clearly and systematically articulate the foundations of that commitment.

V.2 Further, though the protection of conscience provision in the *Code of Ethics* has, from the beginning, been expressed in general rather than procedure-specific terms, all of the statements issued by the CMA concerning freedom of conscience, including the most recent, have been a result of controversies associated with specific procedures, notably abortion and euthanasia.

V.3 A significant shortcoming of procedure-specific policy-making and legislation is that it is not responsive to the challenges created by technological developments in medicine. For example, a policy or law that prevents coercion with respect to abortion does not apply to artificial reproduction, eugenic practices or human experimentation.

V.4 Moreover, when policies are developed in the midst of controversies about specific procedures, the issue of freedom of conscience is frequently obscured by partisan debates about the acceptability of the procedures themselves. Opposing sides in such debates may well come to see such policies merely as strategic weapons to be turned to ideological advantage. Carolyn McLeod's campaign "to ensure that [physicians] do not get protections for refusal to refer" is a classic example (I.11-I.12).

V.5 This is why conscience policies developed in relation to specific procedures tend to foster and entrench a morally partisan viewpoint, whether the viewpoint is that of a dominant majority or a powerful minority. It tends to lead to the kind of discrimination rejected by the CMA (III.18), either by allowing conscientious objection to some procedures, but not others, or by imposing discriminatory limits on the exercise of freedom of conscience: by, for example, allowing physicians to refuse to refer for euthanasia, but forcing them to refer for artificial reproduction.

V.6 For all of these reasons, it is preferable to take a broad and principled approach that keeps the focus on the nature and importance of freedom of conscience, avoiding entanglement in controversies about the acceptability of morally contested procedures.

Avoiding authoritarian "neutrality"

V.7 It is equally important to reject attempts to impose authoritarian solutions masked by a pretence of neutrality. For example, a theory of social contract professionalism that has attained dogmatic status may be applied by those in power to "resolve" moral issues by subordinating them to purportedly neutral "professional" obligations. This approach is exemplified by Udo Schuklenk and Julian Savulecu, who assert that "professionalism" precludes conscientious objection.[1],[2]

V.8 Notice that, from 1970 until 2004, the CMA *Code of Ethics* claimed to delineate "the standard of ethical behaviour expected of Canadian physicians" and that the *Code* and other CMA policies could "provide a common ethical framework for Canadian physicians." Reference to "a common ethical framework" has disappeared in the 2018 Revision, which now refers only to "a platform for a shared purpose and identity" and "a common understanding of what it means to be a medical professional and the profession's shared goals." (App "A" Ref 009). Further, the 2018 Revision states that physicians act with integrity only if they act "in accordance with professional expectations." (App. "A" Ref 019)

V.9 Taken together, these changes could be taken to mean that "professional expectations" override the moral agency and moral integrity of physicians. This is not a neutral claim, and it would contradict the emphasis place on moral agency and integrity elsewhere in the Revision and in CMA policy statements on effective referral and euthanasia. Further, physicians may disagree profoundly about whether participation in a given morally contested procedure exemplifies professional commitment or professional corruption: euthanasia is only the most recent and obvious example. Hence, an attempt to regulate the exercise of freedom of conscience by demanding conformity to a theory of professionalism will generate illicit discrimination and exacerbate rather than resolve conflict within the profession.

A stand-alone protection of conscience policy

V.10 Assuming one avoids entanglement in disputes about the acceptability of procedures/interventions, as well as authoritarian "neutrality," a serviceable protection of conscience policy must include a number of basic features:

a) protection of the moral agency and integrity of physicians by ensuring that they are not compelled to do what they believe to be wrong, including referral;

b) non-discrimination concerning physician judgements of conscience, both as to the acceptability of a procedure/intervention and decisions about participation or non-participation;

c) an expectation that physicians will provide patients with timely notice of deeply held beliefs that may influence their recommendation or provision of procedures/interventions the patient may request;

d) an expectation that physicians will provide information necessary to enable a patient to make informed decisions and exercise moral agency;

e) an expectation that physicians will provide information to allow patient access to other physicians, health care providers or the local, regional or provincial health care system, though not specifically with providers of contested services.

A stand-alone protection of conscience policy in the CMA's own words

V.11 These basic features are included in the revised CMA *Medical Assistance in Dying* policy and referenced in the CMA submission to the CPSO on effective referral. A protection of conscience policy that is generally acceptable in relation to euthanasia and assisted suicide

ought to be applicable in other situations. There is no principled reason to suggest otherwise.

V.12 Thus, a serviceable stand-alone policy on physician freedom of conscience can be drafted by drawing on past CMA statements, key elements of its submission to the CPSO on effective referral, and the revised CMA *Medical Assistance in Dying* policy. This ought to be fully acceptable to the Association, since the elements of the policy have already been considered and agreed upon. Part VI of this submission demonstrates how this can be done.

Notes

1. Schuklenk, U. Why medical professionals have no moral claim to conscientious objection accommodation in liberal democracies. J Med Ethics 2017;43:234-240.

2.Savulescu J, Schuklenk U. Doctors Have no Right to Refuse Medical Assistance in Dying, Abortion or Contraception. Bioethics. 2017;31(3):162-170. doi:10.1111/bioe.12288.

VI. In the CMA's words: a policy on physician freedom of conscience

Introduction

VI.1 Since 1970, the CMA's *Code of Ethics* has taken a general approach, leaving detailed discussion of particular issues to CMA policy statements. The 2018 revision includes more explanatory material than has been customary, and significantly develops some statements made in the 2004 version (such as sections concerning privacy/confidentiality and responsibilities to oneself).

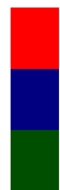
VI.2 The model proposed here is consistent with the approach taken in the 2018 revision and its predecessors. 2018 Revision C3 remains a general statement, and a supplementary policy statement drawn from CMA sources provides more detailed guidance.

VI.3 The 2018 Revision C3 and supplementary policy below are comprised almost entirely of *verbatim* or only slightly modified passages from important CMA position statements, as can be seen from the colour coding of the text. Virtually everything here has *already* been approved by the CMA.

VI.4 What is proposed here is limited to what is known to be acceptable to the CMA, and presented almost entirely in the CMA's words. A more comprehensive policy drawn from CMA and CMPA sources ("CMA Plus") is provided in Part VII.

VI.5 The exercise of freedom of conscience is presumed to occur within the ethical framework reflected in other parts of the *Code*, such as the fundamental commitments discussed in revision Section B.

Sources



2018 Draft CMA *Code of Ethics*

CMA Policy: *Medical Assistance in Dying*

CMA *Submission to the College of Physicians and Surgeons of Ontario*

CMA Code of Ethics (2018)

C3. Give patients timely notice of deeply held beliefs or values that may influence the recommendation, provision or practice of any medical procedure or intervention that the patient needs or requests. You are not obligated to fulfil a patient's request for procedures/interventions to which you object for reasons of conscience, nor to participate in providing them by referral to a provider. However, you must respond to requests by providing patients with complete information on all treatment options available, including the procedure/intervention to which you object, and advise them how to access a provincial or regional health care network or equivalent to obtain

further information, referral or services. Upon the request of the patient, you must transfer patient records to a physician or institution identified by the patient, while continuing to provide other aspects of care, or transfer the care of the patient to a physician or institution identified by the patient, continuing other aspects of care until the transfer has been effected. You must not impede or block access to procedures/interventions to which you object, and you must not make acceptance or retention of patients conditional upon their agreement not to request such procedures/interventions.

Supplementary Guidelines

Physicians' ethical norms and duties, arising from long-standing traditions that entail moral commitments to preserve and protect life, have not changed. The practice of medicine is an inescapably moral enterprise, and physicians exercise moral agency in making every treatment decision, whether or not they advert to the fact.

It is in fact in a patient's best interests and in the public interest for physicians to act as moral agents, and not as technicians or service providers devoid of moral judgement. At a time when some feel that we are seeing increasingly problematic behaviours, and what some view as a crisis in professionalism, we ought to be articulating obligations that encourage moral agency, instead of imposing a duty that is essentially punitive to those for whom it is intended and renders an impoverished understanding of conscience.

Hence, the CMA supports the right of all physicians to follow their conscience when deciding whether or not to provide or otherwise participate in procedures or interventions requested by patients.

Foundational considerations

Respect for freedom of conscience: The CMA believes that physicians must be able to follow their conscience without discrimination when deciding whether or not to provide or participate in procedures/interventions requested by patients. The CMA supports physicians who, for reasons of moral commitments to patients and for any other reasons of conscience, provide or facilitate legal procedures/interventions or refuse to do so. To enable physicians to adhere to such moral commitments without causing undue delay for patients requesting procedures/interventions, health systems will need to implement mechanisms that allow patients to easily obtain direct access to them. It is a responsibility of the community to ensure access, rather than placing the burden of finding services solely on individual physicians. Further, the CMA believes that physicians' general employment or contract opportunities should not be influenced by their conscientious decisions to participate in, or not participate in, the delivery of procedures/interventions. The right of patients to seek procedures/interventions does not compel individual physicians to provide or facilitate them. Learners should be equally free to follow their conscience without risk to their evaluations and training advancement.

Fiduciary obligations: The physician as fiduciary has long been ensconced in ethics and law on the view that the patient-physician relationship hinges on the physician's duty to act, among other fiduciary duties, to protect and further their patients' best interests. The fiduciary nature of the patient-physician relationship has been described as "the most fundamental characteristic of the doctor-patient relationship" by Madame Justice McLachlin in *Norberg v. Wynrib* (1992). However,

the physician's fiduciary obligation does not in any way mean that the physician must violate her moral integrity, in such a way that referral does for some objecting physicians.

Additional considerations: physician duties

Duty of non-abandonment: Physicians have an obligation to respond to patient requests for procedures/interventions, regardless of how their moral commitment is expressed. Patients should never be abandoned and must always be supported by their physician and other members of their care team. There should be no undue delay in providing access to procedures/interventions, either from a clinical, system or facility perspective.

Addressing adherence to moral commitments

CMA's position on conscientious participation and conscientious objection aims to harmonize two legitimate considerations: (1) effective patient access to a legally permissible medical service and (2) protection of physicians' freedom of conscience (or moral integrity) in a way that respects differences of conscience.

For the majority of physicians who will choose not to provide a procedure/intervention referral is entirely morally acceptable; it is not a violation of their conscience. For others, referral is categorically morally unacceptable; it implies forced participation procedurally that may be connected to, or make them complicit in, what they deem to be a morally abhorrent act. In other words, to make referral mandatory respects the conscience of some, but not others. It is the CMA's strongly held position that there is no legitimate justification to respect one judgement of conscience (such as the right not to participate in assisted dying), while wholly discounting another because one may not agree with it.

VII. CMA Plus: physician exercise of freedom of conscience

Introduction

VII.1 In Part VI a protection of conscience policy was proposed using almost entirely the CMA's words. In this Part a more comprehensive policy is offered, based largely on CMA sources.

General

VII.2 It is in a patient's best interests and in the public interest for physicians to act as moral agents, and not as technicians or service providers devoid of moral judgement. While physicians must act in accordance with their conscientious convictions or moral commitments, they must always demonstrate respect for their patients by responding to their enquiries, requests or needs by providing information and appropriate support.

Supporting sources:

- Canadian Medical Association, *Submission to the College of Physicians and Surgeons of Ontario* (16 January, 2016)[1]

- Canadian Medical Association *Code of Ethics* (2018 Revision), C2 (App "A" Ref 049; + Ref 017, 019, 020, 037)

- Canadian Medical Association, *Induced Abortion* (1988)[2]

- Canadian Medical Association, *Medical Assistance in Dying* (2017)[3],[4],[5],[6]

- Canadian Medical Association, *Principles-based Recommendations for a Canadian Approach to Assisted Dying* (2015)[7], [8]

Providing information to patients*

VII.3 Physicians must provide patients with sufficient and timely information, responsive to their needs or enquiries, to make them aware of relevant treatment options so that they can make informed decisions about accepting or refusing medical treatment and care.

Supporting sources:

- Canadian Medical Association *Code of Ethics* (2018 Revision) (App "A" C-IntroF, Ref 057, C8 Ref 063)

- Canadian Medical Association *Code of Ethics* (2004) para. 21[9]

- Canadian Medical Association, *Medical Assistance in Dying* (2017)[10]

- Canadian Medical Association, *Principles-based Recommendations for a Canadian Approach to Assisted Dying* (2015)[11],[12]

- Canadian Medical Protective Association, *Consent: A guide for Canadian physicians* (4th ed) (June, 2016): Disclosure of information; Standard of disclosure.[13]

- CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) I.4[14]

VII.4 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.

Supporting sources:

- Canadian Medical Association *Code of Ethics* (2018 Revision) (App "A" C8 Ref 063)

- Canadian Medical Association *Code of Ethics* (2004) para. 21[9]

- Canadian Medical Association, *Medical Assistance in Dying* (2017)[10]

- Canadian Medical Association, *Principles-based Recommendations for a Canadian Approach to Assisted Dying* (2015)[11,12]

- Canadian Medical Protective Association, *Consent: A guide for Canadian physicians* (4th ed) (June, 2016): Standard of disclosure.[13]

- CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) I.7[14]

VII.5 Information is timely if it 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.

VII.6 Relevant treatment options include all legal and clinically appropriate procedures/interventions/services 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.

Supporting sources:

- Canadian Medical Association *Code of Ethics* (2004) para. 23[15]

- Canadian Medical Protective Association, *Consent: A guide for Canadian physicians* (4th ed) (June, 2016): Some practical considerations about informed consent (4, 5)[13]

VII.7 Physicians whose medical opinion concerning a procedure/intervention/service is not consistent with the general view of the medical profession must disclose this to the patient.

Supporting sources:

- Canadian Medical Association *Code of Ethics* (2018 Revision) C31 (App "A" Ref 102)

- Canadian Medical Association *Code of Ethics* (2004) para. 45[16]

VII.8 The information provided must be 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.

Supporting sources:

- Canadian Medical Association *Code of Ethics* (2018 Revision) C4, (App "A" Ref 052)

- Canadian Medical Association *Code of Ethics* (2004) para. 21,[9] 22[17]

- Canadian Medical Protective Association, *Consent: A guide for Canadian physicians* (4th ed) (June, 2016): Patient Comprehension[13]

- CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) I.4[14]

VII.9 Physicians who are unable or unwilling to provide this information must promptly arrange for a patient to be seen by another physician or health care worker who can do so.

Exercising freedom of conscience

VII.10 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/interventions/services. Physicians must also give reasonable notice to patients if their views change.

Supporting sources:

- Canadian Medical Association *Code of Ethics* (2018 Revision), C3 (App "A" Ref 050)

- Canadian Medical Association *Code of Ethics* (2004) para. 12,[18] 21[9]

- Canadian Medical Association, *Induced Abortion* (1988)[19]

- Canadian Medical Association, *Medical Assistance in Dying* (2017)[20]

- CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) I.16[14]

VII.11 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 procedures/interventions/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.

VII.12 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.

VII.13 Physicians who decline to recommend or provide a procedure/intervention/service for reasons of conscience or religion are not required to provide it, or to otherwise participate in it, or to refer or direct the patient to a physician or a medical administrator who will provide it, or to arrange a transfer for care for that purpose. However, they must advise affected patients that they may seek the procedure/intervention/service elsewhere, and provide information about how to find other physicians or health care providers. Should the patient identify an alternative physician or provider, physicians must, upon the patient's request, effect transfer of care or patient records to the physician or provider chosen by the patient.

Supporting sources:

- Canadian Medical Association *Code of Ethics* (2018 Revision) (App "A" Ref 051)

- Canadian Medical Association *Code of Ethics* (2004) para. 21[9]

- Canadian Medical Association, *Medical Assistance in Dying* (2017)[21],[22]

- Canadian Medical Association, *Principles-based Recommendations for a Canadian Approach to Assisted Dying* (2015)[8]

- CMA, CHA, CNA, CHAC- *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) II.10[14]

VII.14 A physician's response under VII.13 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.

VII.15 In acting pursuant to VII.13, 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.

Supporting sources:

- Canadian Medical Association *Code of Ethics* (2004) para. 19[23]

- Canadian Medical Association, *Medical Assistance in Dying* (2017)[22]

- 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[14]

VII.16 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/interventions/services that 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.

Supporting sources:

- Canadian Medical Association, *Medical Assistance in Dying* (2017)[24]

VII.17 Physicians must not impede or block access to procedures/interventions/services to which they objection, nor make acceptance or retention of patients conditional upon their agreement not to request such procedures/interventions/services.

Supporting sources:

- Canadian Medical Association, *Medical Assistance in Dying* (2017)[19]

No discrimination

VII.18 To enable physicians to adhere to such moral commitments without causing undue delay for patients requesting procedures/interventions/services, health systems will need to implement mechanisms that allow patients to easily obtain direct access to them.

Supporting sources:

- Canadian Medical Association, *Medical Assistance in Dying* (2017)[25]

VII.19 It is a responsibility of the community to ensure access, rather than placing the burden of finding services solely on individual physicians or patients.

Supporting sources:

- Canadian Medical Association, *Submission to the College of Physicians and Surgeons of Ontario* (16 January, 2016)[26]

VII.20 Physicians' general employment or contract opportunities should not be influenced by their conscientious decisions to participate in, or not participate in, the delivery of procedures/interventions/services.

Supporting sources:

- Canadian Medical Association, *Medical Assistance in Dying* (2017)[27]

- Canadian Medical Association, *Induced Abortion* (1988)

VII.21 Learners must be free to follow their conscience without risk to their evaluations and training advancement.

Supporting sources:

- Canadian Medical Association, *Medical Assistance in Dying* (2017)[28]

- Canadian Medical Association, *Induced Abortion* (1988)[29]29

Notes

* All references to "patients" include substitute medical decision-makers.

1. "It is in fact in a patient's best interests and in the public interest for physicians to act as moral agents, and not as technicians or service providers devoid of moral judgement. At a time when some feel that we are seeing increasingly problematic behaviours, and what some view as a crisis in professionalism, we ought to be articulating obligations that encourage moral agency, instead of imposing a duty that is essentially punitive to those for whom it is intended and renders an impoverished understanding of conscience." Canadian Medical Association. Submission to the College of Physicians and Surgeons of Ontario [Internet]. 2016 Jan. Available from: http://consciencelaws.org/background/policy/associations-013.aspx.

2. "A physician should not be compelled to participate in the termination of a pregnancy." Canadian Medical Association. Policy: Induced abortion [Internet]. 1988 Dec 15 [cited 2018 Mar 15]. Available from: https://www.cma.ca/Assets/assets-library/document/en/advocacy/CMA_induced_abortion_PD88-06-e.pdf#search=induced%20abortion.

3. "Rationale: . . .The CMA supports the right of all physicians to follow their conscience when deciding whether to provide or otherwise participate in assistance in dying as per the legislation governing medical assistance in dying. The CMA equally supports conscientious participation in and conscientious objection to assistance in dying by physicians." Canadian Medical Association. Policy: Medical Assistance in Dying [Internet]. 2017 May [cited 2018 Mar 12]. Available from: https://www.cma.ca/Assets/assets-library/document/en/advocacy/policy-research/cma-policy-medical-assistance-in-dying-pd17-03-e.pdf.

4. "Relevant Foundational Considerations, 3. Respect for freedom of conscience: The CMA believes that physicians must be able to follow their conscience without discrimination when deciding whether or not to provide or participate in assistance in dying. The CMA supports physicians who, for reasons of moral commitments to patients and for any other reasons of conscience, will not participate in decisional guidance about, eligibility assessments for, or provision of medical assistance in dying." Canadian Medical Association. Policy: Medical Assistance in Dying [Internet]. 2017 May [cited 2018 Mar 12]. Available from: https://www.cma.ca/Assets/assets-library/document/en/advocacy/policy-research/cma-policy-medical-assistance-in-dying-pd17-03-e.pdf.

5. "Relevant Foundational Considerations, 5. Duty of non-abandonment: Physicians have an obligation to respond to a request for assistance in dying, regardless of how their moral commitment is expressed. Patients should never be abandoned and must always be supported by their physician and other members of their care team." Canadian Medical Association. Policy: Medical Assistance in Dying [Internet]. 2017 May [cited 2018 Mar 12]. Available from: https://www.cma.ca/Assets/assets-library/document/en/advocacy/policy-research/cma-policy-medical-assistance-in-dying-pd17-03-e.pdf.

6. "Relevant Foundational Considerations, 1. Respect for autonomy: The CMA upholds the importance of respect for decisional autonomy by competent patients — such persons are free to make informed choices and autonomous decisions about their bodily integrity, their personal aims and their care that are consistent with their personal values and beliefs." Canadian Medical Association. Policy: Medical Assistance in Dying [Internet]. 2017 May [cited 2018 Mar 12]. Available from: https://www.cma.ca/Assets/assets-library/document/en/advocacy/policy-research/cma-policy-medical-assistance-in-dying-pd17-03-e.pdf.

7. "Foundational Principle (6) Dignity: All patients, their family members or significant others should be treated with dignity and respect at all times, including throughout the entire process of care at the end of life." Canadian Medical Association. Principles-based Recommendations for a Canadian Approach to Assisted Dying [Internet]. 2015; A2-1 to A2-6 at A2-2. Available from: http://www.consciencelaws.org/archive/documents/cma-cmaj/2015-10-09-CMA%20Framework.pdf.

8. "Section 5.2: . . . physicians are expected to provide the patient with complete information on all options available to them, including assisted dying, and advise the patient on how they can access any separate central information, counseling, and referral service." Canadian Medical Association. Principles-based Recommendations for a Canadian Approach to Assisted Dying [Internet]. 2015; A2-1 to A2-6 at A2-6. Available from: http://www.consciencelaws.org/archive/documents/cma-cmaj/2015-10-09-CMA%20Framework.pdf.

9. "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." Canadian Medical Association. Code of Ethics [Internet] 2004 [cited 2018 Mar 24]. Available from: http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf.

10. ". . .physicians are obligated to, regardless of their beliefs: I. provide the patient with complete information on all options available, including assistance in dying; . . ." Canadian Medical Association. Policy: Medical Assistance in Dying [Internet]. 2017 May [cited 2018 Mar 12]. Available from: https://www.cma.ca/Assets/assets-library/document/en/advocacy/policy-research/cma-policy-medical-assistance-in-dying-pd17-03-e.pdf.

11. "Section 1.2: The attending physician must disclose to the patient information regarding their health status, diagnosis, prognosis, the certainty of death upon taking the lethal medication, and alternatives, including comfort care, palliative and hospice care, and pain and symptom control." Canadian Medical Association. Principles-based Recommendations for a Canadian Approach to Assisted Dying [Internet]. 2015; A2-1 to A2-6 at A2-3. Available from: http://www.consciencelaws.org/archive/documents/cma-cmaj/2015-10-09-CMA%20Framework.pdf.

12. "Section 5.2: . . . physicians are expected to provide the patient with complete information on all options available to them, including assisted dying, and advise the patient on how they can

access any separate central information, counseling, and referral service." Canadian Medical Association. Principles-based Recommendations for a Canadian Approach to Assisted Dying [Internet]. 2015; A2-1 to A2-6 at A2-6. Available from: http://www.consciencelaws.org/archive/documents/cma-cmaj/2015-10-09-CMA%20Framework.pdf.

13. Canadian Medical Protective Association. Consent: A guide for Canadian physicians. 4th ed. [Internet] 2016 Jun [cited 2018 Mar 23]. Available from https://www.cmpa-acpm.ca/-/consent-a-guide-for-canadian-physicians.

14. Canadian Medical Association, Canadian Healthcare Association, Canadian Nurses' Association, Catholic Health Association of Canada. Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care [Internet]. 1999. Available from: http://www.consciencelaws.org/background/policy/associations-001.aspx.

15. "23. Recommend only those diagnostic and therapeutic services that you consider to be beneficial to your patient or to others. . ." Canadian Medical Association. Code of Ethics [Internet] 2004 [cited 2018 Mar 24]. Available from: http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf.

16. "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."Canadian Medical Association. Code of Ethics [Internet] 2004 [cited 2018 Mar 24]. Available from: http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf.

17. "22. Make every reasonable effort to communicate with your patients in such a way that information exchanged is understood." Canadian Medical Association. Code of Ethics [Internet] 2004 [cited 2018 Mar 24]. Available from: http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf.

18. "12. Inform your patient when your personal values would influence the recommendation or practice of any medical procedure that the patient needs or wants." Canadian Medical Association. Code of Ethics [Internet] 2004 [cited 2018 Mar 24]. Available from: http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf.

19. " A physician whose moral or religious beliefs prevent him or her from recommending or performing an abortion should inform the patient of this so that she may consult another physician." Canadian Medical Association. Policy: Induced abortion. [Internet] 1988 Dec 15 [cited 2018 Mar 15]. Available from: https://www.cma.ca/Assets/assets-library/document/en/advocacy/CMA_induced_abortion_PD88-06-e.pdf#search=induced%20abortion.

20. "Addressing Adherence to Moral Commitments, (d) Physicians are expected to act in good faith. They are expected to never abandon or discriminate against a patient requesting assistance in dying and to not impede or block access to a request for assistance in dying. Physicians should inform their patients of the fact and implications of their conscientious objection. No physician may require a patient to make a commitment not to seek assistance in dying as a condition of acceptance or retention of the patient." Canadian Medical Association. Policy: Medical Assistance in Dying [Internet]. 2017 May [cited 2018 Mar 12]. Available from: https://www.cma.ca/Assets/assets-library/document/en/advocacy/policy-research/cma-policy-medical-assistance-in-dying-pd17-03-e.pdf.

21. "Addressing Adherence to Moral Commitments, (a) . . physicians who choose not to provide or otherwise participate in assistance in dying are: I. not required to provide it, or to otherwise participate in it, or to refer the patient to a physician or a medical administrator who will provide assistance in dying to the patient. . ." Canadian Medical Association. Policy: Medical Assistance in Dying [Internet]. 2017 May [cited 2018 Mar 12]. Available from: https://www.cma.ca/Assets/assets-library/document/en/advocacy/policy-research/cma-policy-medical-assistance-in-dying-pd17-03-e.pdf.

22. "Addressing Adherence to Moral Commitments, (a). . .physicians are obligated to, regardless of their beliefs: I. provide the patient with complete information on all options available, including assistance in dying; ii. advise the patient on how to access any separate central information, counselling and referral service; and iii. transfer care of the patient to another physician or another institution, if the patient requests it, for the assessment and treatment of the patient's medical condition and exploration of relevant options. The duty of non-abandonment still applies in all other aspects of the patient's care." Canadian Medical Association. Policy: Medical Assistance in Dying [Internet]. 2017 May [cited 2018 Mar 12]. Available from: https://www.cma.ca/Assets/assets-library/document/en/advocacy/policy-research/cma-policy-medical-assistance-in-dying-pd17-03-e.pdf.

23. "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." Canadian Medical Association. Code of Ethics [Internet] 2004 [cited 2018 Mar 24]. Available from: http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf.

24. "Additional Considerations: Physician Duties, 6. Duty to support interdisciplinary teams: The CMA advocates that physicians work within, and support other members of, interdisciplinary teams, pay close attention to the impacts of participation and non-participation in medical assistance in dying on their non-physician colleagues, and demonstrate solidarity with their team members as they navigate new legal and ethical territory together." Canadian Medical Association. Policy: Medical Assistance in Dying [Internet]. 2017 May [cited 2018 Mar 12]. Available from: https://www.cma.ca/Assets/assets-library/document/en/advocacy/policy-research/cma-policy-medical-assistance-in-dying-pd17-03-e.pdf.

25. "Relevant Foundational Considerations, 3. Respect for freedom of conscience: . . . To enable physicians to adhere to such moral commitments without causing undue delay for patients pursuing this intervention, health systems will need to implement an easily accessible mechanism to which patients can have direct access. . ." Canadian Medical Association. Policy: Medical Assistance in Dying [Internet]. 2017 May [cited 2018 Mar 12]. Available from: https://www.cma.ca/Assets/assets-library/document/en/advocacy/policy-research/cma-policy-medical-assistance-in-dying-pd17-03-e.pdf.

26. ". . .it is a responsibility of the community to ensure access, rather than placing the burden of finding services solely on individual physicians." Canadian Medical Association. Submission to the College of Physicians and Surgeons of Ontario [Internet]. 2016 Jan. Available from: http://consciencelaws.org/background/policy/associations-013.aspx.

27. "Relevant Foundational Considerations, 3. Respect for freedom of conscience: . . . Further, the CMA believes that physicians' general employment or contract opportunities should not be influenced by their decisions to participate in, or not participate in, any or all aspects of medical assistance in dying with patients. . . " Canadian Medical Association. Policy: Medical Assistance in Dying [Internet]. 2017 May [cited 2018 Mar 12]. Available from: https://www.cma.ca/Assets/assets-library/document/en/advocacy/policy-research/cma-policy-medical-assistance-in-dying-pd17-03-e.pdf.

28. "Relevant Foundational Considerations, 3. Respect for freedom of conscience: . . . Learners should be equally free to follow their conscience without risk to their evaluations and training advancement." Canadian Medical Association. Policy: Medical Assistance in Dying [Internet]. 2017 May [cited 2018 Mar 12]. Available from: https://www.cma.ca/Assets/assets-library/document/en/advocacy/policy-research/cma-policy-medical-assistance-in-dying-pd17-03-e.pdf.

29. "No discrimination should be directed against doctors who do not perform or assist at induced abortions. Respect for the right of personal decision in this area must be stressed, particularly for doctors training in obstetrics and gynecology, and anesthesia. No discrimination should be directed against doctors who provide abortion services."Canadian Medical Association. Policy: Induced abortion. [Internet] 1988 Dec 15 [cited 2018 Mar 15]. Available from: https://www.cma.ca/Assets/assets-library/document/en/advocacy/CMA_induced_abortion_PD88-06-e.pdf#search=induced%20abortion.

VIII. Postscript: torture

VIII.1 The 2018 revision incorporates and revises 2004 paragraph 9:

> **2004 Code**
> 9. Refuse to participate in or support practices that violate basic human rights.
>
> **2018 Revision**
> B2. . . . Respect and promote the inherent dignity and equal worth of all persons and refuse to participate in or support practices that violate basic human rights; *never participate in or facilitate torture*. [Emphasis added]

VIII.2 The addition of the reference to torture is instructive because it implies that moral responsibility attaches not only to direct participation in an act, but also to indirect forms of facilitation. This is precisely the reason why physicians who object to a procedure for reasons of conscience may be unwilling to provide an effective referral for it.

VIII.3 Nonetheless, the reference is out of keeping with the general approach that has been characteristic of CMA *Codes of Ethics* since 1970, and superfluous because torture is a criminal offence in Canada and prohibited by international law. The CMA has been on record as opposing torture since 1979,[1]1 and there is no evidence that Canadian physicians are participating or likely to participate in torture.

VIII.4 Moreover, it is odd to insist that physicians must not participate in or facilitate torture, while remaining silent about capital punishment. The current state of criminal law precludes physician participation in both, so if the *Code of Ethics* is to speak to one, one would expect it to speak to the other.

VIII.5 Thus, proscribing physician involvement in torture while remaining silent about capital punishment could be construed as an indication of neutrality concerning physician participation in executions. This, in turn, could be linked to euthanasia, given the similarity of the procedures and drugs used for euthanasia and execution by lethal injection.[2] On the other hand, for this very reason, adding a reference to capital punishment to the *Code of Ethics* could be as problematic as remaining silent about it.

VIII.6 Finally, the legal ban on euthanasia and assisted suicide was described by counsel for the claimants in the Carter case as "tantamount to torture."[3] The same argument was made in the Supreme Court of Appeal South Africa in 2016.[4] It requires little imagination to see that an otherwise inexplicable reference to torture in the *Code of Ethics* could be turned against physicians who refuse to participate in euthanasia or assisted suicide, just as a reference to capital punishment could be turned against physicians who provide the services.

VIII.7 In sum, the added reference to torture in the *Code of Ethics* is unnecessary. It is not responsive to present or reasonably foreseeable circumstances in Canada, and is likely to generate troublesome distractions. It seems prudent to delete it.

Notes

1. Canadian Medical Association. Policy resolution BD80-03-99: Treatment of prisoners [Internet]. 1979 Dec 8; Reviewed 2017 Mar 4 [cited 2018 Mar 30]. Available from: http://policybase.cma.ca/dbtw-wpd/exec/dbtwpub.dll?AC=GET_RECORD&XC=/dbtw-wpd/exec/dbtwpub.dll&BU=http%3A%2F%2Fpolicybase.cma.ca%2Fdbtw-wpd%2FCMAPolicy%2FPublicB.htm&TN=PubPol&SN=AUTO19500&SE=1280&RN=1&MR=20&TR=0&TX=1000&ES=0&CS=1&XP=&RF=Public%3E+TableDE&EF=&DF=Display%3E+English&RL=0&EL=0&DL=1&NP=3&ID=&MF=wpengmsgcmapolicypublicB.ini&MQ=&TI=0&DT=&ST=0&IR=431&NR=0&NB=0&SV=0&SS=0&BG=&FG=000000&QS=Staff&OEX=ISO-8859-1&OEH=ISO-8859-1.

2. Standard euthanasia guidelines direct the use of a drug (thiopental, propofol, phenobarbital) to induce an artificial coma, followed by the administration of a neuromuscular blocker (rocuronium, altracurium, cisatracurium) to cause respiratory arrest and death by anoxia. In Quebec, this is preceded by the administration of a drug (midazolam) to induce anxiolysis (minimal sedation that reduces anxiety). [See Royal Dutch Medical Association, Royal Dutch Pharmacists Association. Guidelines for the Practice of Euthanasia and Physician-Assisted Suicide. 2012; at 13–13; Collège des médecins du Québec. Medical Aid in Dying: 11/2015 Practice Guidelines. 2015; at 42–48.] Executions by lethal injection (in practice, infusion) parallel euthanasia procedures in using a drug (thiopental, pentobarbital, midazolam, propofol) to induce an artificial coma, followed by a neuromuscular blocker (rocuronium, pancuronium, vercuronium) to cause respiratory arrest, but a third drug (potassium chloride) is then used to cause cardiac arrest. [See Glossip et al v Gross et al, 576 US __ (2015), 135 S Ct 2736 (2015) at p 3–8. See also Krol D. The Drugs Used in Execution by Lethal Injection. Forbes [Internet] 2014 May 1 [cited 2018 Mar 13]. Available from: https://www.forbes.com/sites/davidkroll/2014/05/01/the-pharmacology-and-toxicology-of-execution-by-lethal-injection/#4a7fa2a47103.

3. Keller J. Euthanasia Ban Like Torture, BC Appeal Court Hears. Huffington Post [Internet] 2013 Mar 20 [cited 2018 Mar 10]. Available from: http://www.huffingtonpost.ca/2013/03/20/euthanasia-ban-torture-bc_n_2917348.html.

4. Pilane P. "Denying the right to day may be state-sanctioned torture, legal body says." Bhekisisa [Internet]. 2016 Nov 3 [cited 2018 Mar 10]. Availalbe from: http://bhekisisa.org/article/2016-11-03-00-denying-the-right-to-die-may-be-state-sanctioned-tortured-legal-body-says.

Appendix "A"

References in green provided for convenience by the Protection of Conscience Project

Ref.	2004 CMA Code of Ethics	2018 CMA Draft Code of Ethics
1	**2004-Intro-1.** This Code has been prepared by the Canadian Medical Association as an ethical guide for Canadian physicians, including residents, and medical students.	**2018-Intro-1.** The *CMA Code of Ethics and Professionalism* articulates the ethical and professional commitments and responsibilities of the medical profession.
2		**2018-Intro-2.** The Code guides high standards of practice in the interests of patients and the public to foster patient and public trust in physicians and the profession.
3		**2018-Intro-3.** The Code is founded on and affirms the core commitments to which the profession aspires and reflects the contemporaneous and changing landscape of medical practice.
4	**2004-Intro-2.** Its focus is the core activities of medicine –such as health promotion, advocacy, disease prevention, diagnosis, treatment, rehabilitation, palliation, education and research.	**2018-Intro-4.** In this Code, ethical practice is understood as a process of active and reflective inquiry and decision-making concerning what a physician's and the profession's practice is and ought to be.
5	From 2004-Intro-6.	**2018-Intro-5.** Ethical practice involves reflection on the reasons for a physician's actions, what a physician's actions ought to be, situations where existing rules, norms or guidelines are insufficient or are in tension, and a consideration of multiple perspectives in decision-making.
6		**2018-Intro-6.** The Code is not intended to provide specific guidance; it is a vehicle to guide ethical decision-making and ethical practice.
7	**2004-Intro-3.** It is based on the fundamental principles and values of medical ethics, especially compassion, beneficence, non-maleficence, respect for persons, justice and accountability.	**2018-Intro-7.** In this Code, medical ethics concerns the virtues, values and principles that ought to guide the medical profession, while professionalism is the embodiment or enactment of responsibilities arising from those norms through behaviours, standards and competencies.
8	From 2004-46.	**2018Intro-8.** Each physician has a continuing responsibility to merit the privilege of professional-led regulation and support its institutions through enacting the commitments and responsibilities outlined in the Code.
9	**2004-Intro-4.** The Code, together with CMA policies on specific topics, constitutes a compilation of guidelines that can provide a common ethical framework for Canadian physicians.	**2018-Intro-9.** The Code provides a platform for a shared purpose and identity, by articulating a common understanding of what it means to be a medical professional and the profession's shared goals.

Appendix "A"

References in green provided for convenience by the Protection of Conscience Project

Ref.	2004 CMA Code of Ethics	2018 CMA Draft Code of Ethics
10	**2004-Intro-5.** Physicians should be aware of the legal and regulatory requirements that govern medical practice in their jurisdictions.	**2018-Intro-10.** Physicians should be aware of legal and regulatory requirements that govern medical practice in their jurisdiction.
11	**2004-Intro-6.** Physicians may experience tension between different ethical principles, between ethical and legal or regulatory requirements, or between their own ethical convictions and the demands of other parties.	See Intro-5.
12	**2004-Intro-7.** Training in ethical analysis and decision-making during undergraduate, postgraduate and continuing medical education is recommended for physicians to develop their knowledge, skills and attitudes needed to deal with these conflicts.	Deleted.
13	**2004-Intro-8.** Consultation with colleagues, regulatory authorities, ethicists, ethics committees or others who have relevant expertise is also recommended.	Deleted.
14		**A. Virtues exemplified by the medical profession**
15		**A-Intro.** Trust is the cornerstone of the patient–physician relationship and of medical professionalism and is central to providing the highest standard of care. By exemplifying the following, interconnected virtues in practice, physicians strive to enhance the trustworthiness of the profession:
16		**COMPASSION**. A compassionate physician recognizes suffering, understands and feels something of the unique circumstances of the patient, and is motivated to act, and does act, to alleviate suffering.
17		**HONESTY.** An honest physician is straightforward and forthright, respects the truth and does their best to find out the truth, to preserve it, and to communicate it sensitively.

Appendix "A"

References in green provided for convenience by the Protection of Conscience Project

Ref.	2004 CMA Code of Ethics	2018 CMA Draft Code of Ethics
18		**HUMILITY**. A physician who acts with humility understands the limits of their own knowledge and skills and is careful not to overstep them by recognizing the experiential knowledge of patients and communities and the limits of scientific knowledge, and seeks the skills, experience, and wisdom of colleagues when necessary.
19		**INTEGRITY.** A physician who acts with integrity demonstrates consistency of intentions and actions, and acts in a truthful manner, in accordance with professional expectations.
20		**MORAL COURAGE.** A physician who acts with moral courage communicates and does what they believe to be right and true even in the face of adverse consequences.
21	**Fundamental Responsibilities**	**B. FUNDAMENTAL COMMITMENTS OF THE MEDICAL PROFESSION**
22	**1.** Consider first the well-being of the patient. (See also Intro-3.)	**B1. Commitment to beneficence** *Promote* the well-being of, and take steps to prevent harm to, patients; *take actions* that serve the best interests of patients and communities through the provision of appropriate care and treatment across the care continuum — from prevention to palliation.
23	**2.** Practise the profession of medicine in a manner that treats the patient with dignity and as a person worthy of respect.	**B2. Commitment to patient dignity and autonomy** *Tr*eat all patients with dignity and as persons worthy of respect. *Practise* medicine in a manner that recognizes patients as autonomous, self-determining persons capable of choice and that preserves the dignity and autonomy of those who cannot choose for themselves.
24	Moved from 2004-9.	*Respect and promote* the inherent dignity and equal worth of all persons and refuse to participate in or support practices that violate basic human rights; never participate in or facilitate torture.

Appendix "A"

References in green provided for convenience by the Protection of Conscience Project

Ref.	2004 CMA Code of Ethics	2018 CMA Draft Code of Ethics
25	**3.** Provide for appropriate care for your patient, even when cure is no longer possible, including physical comfort and spiritual and psychosocial support.	Deleted.
26	**4.** Consider the well-being of society in matters affecting health. (See also 2004-Intro-3)	**B3. Commitment to justice** *Promote* the well-being of communities, populations, and society by: ensuring the fair and equitable distribution of resources, improving access to care, reducing health disparities and inequities; and through resource stewardship, social accountability, health care advocacy and leadership in system change.
27	**5.** Practise the art and science of medicine competently, with integrity and without impairment. (See also 2004-15, 47)	**B4. Commitment to professional integrity and professional competence** *Practise* the art and science of medicine competently, safely and with integrity. *Engage* in lifelong learning to maintain and advance your professional knowledge and skills, know when to apply new knowledge and recognize that acting beyond one's expertise can have harmful consequences. *Provide* high-quality patient care and have a view to continuous quality improvement at the practice and system levels.
28	**6.** Engage in lifelong learning to maintain and improve your professional knowledge, skills and attitudes.	See B7.
29	**7.** Resist any influence or interference that could undermine your professional integrity.	Deleted.
30	**8.** Contribute to the development of the medical profession, whether through clinical practice, research, teaching, administration or advocating on behalf of the profession or the public.	**B5. Commitment to professional excellence** *Contribute* to the development of the medical profession through clinical practice, research, teaching, mentorship, leadership, administration or advocacy on behalf of the profession or the public. *Cultivate* strong connections and relationships between, and meaningful interactions with, colleagues, including physicians in all specialties and other health professionals.

Appendix "A"
References in green provided for convenience by the Protection of Conscience Project

Ref.	2004 CMA Code of Ethics	2018 CMA Draft Code of Ethics
31	**9.** Refuse to participate in or support practices that violate basic human rights.	Added to the end of B2.
32	**10.** Promote and maintain your own health and wellbeing.	**B6. Commitment to self-care and support for colleagues** *Maintain* personal health and well-being, including exhibiting self-awareness and managing personal influences as well as professional demands for a sustainable practice throughout the career life cycle. *Value* and *promote* a professional culture that recognizes, supports and responds effectively to colleagues in need, including cultivating training and practice environments where physicians are empowered and encouraged to seek help and are supported in their maintenance of physical, mental and social well-being.
33	See 2004-6.	**B7. Commitment to inquiry and reflection** *Value and enable* active and reflective inquiry, and collective reflection and self-reflection, to further medical science and facilitate ethical decision-making. *Foster* curiosity and exploration to further your professional development and insight and be open to new knowledge, technologies, ways of practising, and learning from others.
34		**C. PROFESSIONAL RESPONSIBILITIES**
35	**Responsibilities to the Patient**	**PHYSICIANS AND PATIENTS**
36	**General Responsibilities**	**Patient-physician relationship**
37		**C-IntroA**. The patient–physician relationship is at the heart of the practice of medicine. It is characterized by reciprocal trust, need and understanding, and centres on a process of deliberation that recognizes that the physician and patient are each moral agents.
38		**C-IntroB.** Physicians and their patients build relationships of trust that enable open and honest dialogue and foster the patient's willingness to share deeply personal information, often in conditions of vulnerability.

Appendix "A"

References in green provided for convenience by the Protection of Conscience Project

Ref.	2004 CMA Code of Ethics	2018 CMA Draft Code of Ethics
39		**C-IntroC.** Physicians owe a duty of loyalty to the patient by protecting and furthering the interests of the patient using the physician's expertise, knowledge and appropriate clinical judgement.
40	**11.** Recognize and disclose conflicts of interest that arise in the course of your professional duties and activities, and resolve them in the best interest of patients.	Moved to C19.
41	**12.** Inform your patient when your personal values would influence the recommendation or practice of any medical procedure that the patient needs or wants.	Moved to C3.
42	**13.** Do not exploit patients for personal advantage.	Moved to C19.
43	**14.** Take all reasonable steps to prevent harm to patients; should harm occur, disclose it to the patient.	Deleted.
44	**15.** Recognize your limitations and, when indicated, recommend or seek additional opinions and services.	See B4.
45	**16.** In determining professional fees to patients for non-insured services, consider both the nature of the service provided and the ability of the patient to pay, and be prepared to discuss the fee with the patient.	Deleted.
46	**Initiating and Dissolving a Patient-Physician Relationship**	In the context of the patient–physician relationship:
47	**17.** In providing medical service, do not discriminate against any patient on such grounds as age, gender, marital 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 a patient for legitimate reasons.	**C1.** Accept the patient without discrimination (such as on the basis of age, disability, gender identity or expression, genetic characteristics, language, marital and family status, medical condition, national or ethnic origin, political affiliation, race, religion, sex, sexual orientation or socioeconomic status).
48	**18.** Provide whatever appropriate assistance you can to any person with an urgent need for medical care.	Moved to C6.

Appendix "A"
References in green provided for convenience by the Protection of Conscience Project

Ref.	2004 CMA Code of Ethics	2018 CMA Draft Code of Ethics
49		**C2.** Act according to your conscience, and respect differences of conscience among your colleagues; always respond to a patient's medical request regardless of your moral commitments.
50	Moved from 2004-12.	**C3.** Inform the patient when your deeply held values may influence the recommendation, provision or practice of any medical procedure or intervention that the patient needs or requests, but never abandon the patient.
51	**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.	**C3.** The duty of non-abandonment requires providing the patient with complete information on all clinical options available and, when necessary, a formal referral or a direct transfer of care. It also includes the transfer of the patient's records when requested by the patient.
52	See 2004-22.	**C4.** Communicate accurately and honestly with the patient in a way that can be understood and applied.
53	**20.** Limit treatment of yourself or members of your immediate family to minor or emergency services and only when another physician is not readily available; there should be no fee for such treatment.	Deleted.
54	**Communication, Decision Making and Consent**	**Decision making**
55		**C-IntroD.** Medical decision-making is ideally a deliberative process that engages the patient in shared decision-making informed by the patient's experience and values and the physician's clinical judgment.
56		**C-IntroE.** This deliberation involves discussion with the patient and, with consent, the patient's family members and significant others, and other health care professionals and experts involved in the patient's care.
57		**C-IntroF.** The physician provides appropriate medical information and helps the patient navigate available therapeutic options to determine the best course of action for the patient. In the process of shared decision-making:

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Ref.	2004 CMA Code of Ethics	2018 CMA Draft Code of Ethics
58	**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.	See C8.
59	**22.** Make every reasonable effort to communicate with your patients in such a way that information exchanged is understood.	See C4.
60	**23.** Recommend only those diagnostic and therapeutic services that you consider to be beneficial to your patient or to others. If a service is recommended for the benefit of others, as for example in matters of public health, inform your patient of this fact and proceed only with explicit informed consent or where required by law.	**C5.** Recognize that inappropriate use or overuse of treatments or resources can lead to ineffective, and at times harmful, patient care.
61	Moved from 2004-18.	**C6.** Provide whatever appropriate assistance you can to any person with an emergency need for medical care.
62	Moved from 2004-40	**C7.** When involved in research, obtain the informed consent of the research participant, and advise prospective participants that they have the right to decline participation or withdraw from the study at any time, without impacting their ongoing care.
63		**C8.** Practise shared decision-making and empower patients to gain the knowledge and understanding necessary to improve their health and make informed choices, including by having a full discussion of the relevant harms and benefits.
64	**24.** Respect the right of a competent patient to accept or reject any medical care recommended.	**C9.** Respect the values and decisions of a competent patient to accept or reject any medical care or treatment recommended.
65	**25.** Recognize the need to balance the developing competency of minors and the role of families in medical decision-making. Respect the autonomy of those minors who are authorized to consent to treatment.	**C10.** Recognize the need to balance the developing competency of minors and the role of families or caregivers in medical decision-making.
66	**26.** Respect your patient's reasonable request for a second opinion from a physician of the patient's choice.	Moved to C12.

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Ref.	2004 CMA Code of Ethics	2018 CMA Draft Code of Ethics
67	**27.** Ascertain wherever possible and recognize your patient's wishes about the initiation, continuation or cessation of life-sustaining treatment.	Deleted.
68	**28.** Respect the intentions of an incompetent patient as they were expressed (e.g., through a valid advance directive or proxy designation) before the patient became incompetent.	**C11**. Respect the values and intentions of a decisionally incompetent patient as expressed through advance care planning discussions or via a substitute decision-maker.
69	**29.** When the intentions of an incompetent patient are unknown and when no formal mechanism for making treatment decisions is in place, render such treatment as you believe to be in accordance with the patient's values or, if these are unknown, the patient's best interests.	
70	**30.** Be considerate of the patient's family and significant others and cooperate with them in the patient's interest.	Deleted
71	From 2004-26.	**C12.** Respect the patient's reasonable request for a second opinion.
72		**PHYSICIANS AND THE PRACTICE OF MEDICINE**
73	**Privacy and Confidentiality**	**Patient privacy and the duty of confidentiality**
74	**31.** Protect the personal health information of your patients.	**C13**. Fulfill your duty of confidentiality to the patient by keeping identifiable patient information confidential, collecting health information only to benefit the patient and sharing information only for that purpose and within the patient's circle of care, unless the informed consent of the patient has been obtained to do otherwise. See also C17.
75	**32.** Provide information reasonable in the circumstances to patients about the reasons for the collection, use and disclosure of their personal health information.	
76	**33.** Be aware of your patient's rights with respect to the collection, use, disclosure and access to their personal health information; ensure that such information is recorded accurately.	
77	**34.** Avoid public discussions or comments about patients that could reasonably be seen as revealing confidential or identifying information.	See C18.

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Ref.	2004 CMA Code of Ethics	2018 CMA Draft Code of Ethics
78	**35.** Disclose your patients' personal health information to third parties only with their consent, or as provided for by law, such as when the maintenance of confidentiality would result in a significant risk of substantial harm to others or, in the case of incompetent patients, to the patients themselves. In such cases take all reasonable steps to inform the patients that the usual requirements for confidentiality will be breached.	See C13.
79	**36.** When acting on behalf of a third party, take reasonable steps to ensure that the patient understands the nature and extent of your responsibility to the third party.	Deleted
80	**37.** Upon a patient's request, provide the patient or a third party with a copy of his or her medical record, unless there is a compelling reason to believe that information contained in the record will result in substantial harm to the patient or others.	**C14.** Consider both your duty to care and duty not to harm the patient when considering privacy requirements.
81		**C15.** Recognize and manage privacy requirements within clinical training environments, quality improvement initiatives and secondary uses of data for health system management.
82		**C16.** Appropriately manage privacy considerations that can arise from the use of new and emerging technologies in clinical contexts.
83		**C17.** Act as a data steward, controlling the extent to which information about the patient is protected, used or disclosed. As a data steward, you should use or disclose only the minimum amount of information necessary to fulfill the intended purpose.
84	See 2004-34.	**C18.** Avoid public discussions, including in public spaces or on social media, about patients that could reasonably be seen as revealing confidential or identifying information, or as being disrespectful to patients, their families or caregivers.

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Ref.	2004 CMA Code of Ethics	2018 CMA Draft Code of Ethics
85		**Managing and minimizing conflicts of interest**
86	Moved from 2004-11, 13.	**C19.** Recognize and disclose conflicts of interest that arise, or are perceived to arise, in the course of your professional duties and activities, and resolve them in the best interests of patients. Never exploit patients for personal advantage.
87		**C20.** Be transparent about relationships and transactions that may give rise to a conflict of interest, including in practice, education and research.
88	Moved from 2004-49.	**C21.** Enter into associations, contracts and agreements only if you can maintain your professional integrity and safeguard the best interests of the patient and communities.
89	Moved from 2004-50.	**C22.** Avoid using your role as a physician to promote services or products to patients for commercial gain.
90	**Research**	
91	38. Ensure that any research in which you participate is evaluated both scientifically and ethically and is approved by a research ethics board that meets current standards of practice.	**C23**. Ensure that any research in which you participate is evaluated both scientifically and ethically and is approved by a research ethics board that adheres to current standards of practice. Inform potential research participants about anything that may give rise to a conflict of interest, such as the source of funding and the nature of your participation including any compensation.
92	39. Inform the potential research subject, or proxy, about the purpose of the study, its source of funding, the nature and relative probability of harms and benefits, and the nature of your participation including any compensation.	
93	40. Before proceeding with the study, obtain the informed consent of the subject, or proxy, and advise prospective subjects that they have the right to decline or withdraw from the study at any time, without prejudice to their ongoing care.	Moved to C7.
94		**C24.** Recognize the potential for conflicts of interest between your role as a clinician and your organizational, administrative or leadership roles.

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Ref.	2004 CMA Code of Ethics	2018 CMA Draft Code of Ethics
94	**Responsibilities to Society**	**Physicians and society**
95	**41.** Recognize that community, society and the environment are important factors in the health of individual patients.	**C25.** Recognize that community, society and the environment are important factors that influence the health of the patient.
96	**42.** Recognize the profession's responsibility to society in matters relating to public health, health education, environmental protection, legislation affecting the health or well-being of the community and the need for testimony at judicial proceedings.	**C26**. Support the responsibility of the profession in matters relating to public and population health, health education, environmental protection, legislation affecting the health or well-being of the community and the need for testimony at judicial proceedings.
97	**43.** Recognize the responsibility of physicians to promote equitable access to health care resources.	**C27.** Promote shared stewardship of system resources and recognize the responsibility of the profession to promote equitable access to health care resources.
98	**44.** Use health care resources prudently.	
99		**C28**. Contribute to and collaborate with others in leading system change to improve health care delivery and address systemic health issues that impact public and population health.
100		**C29.** Recognize that medical tourism raises complex systemic and resource issues.
101		**C30.** Recognize that new and emerging technologies are changing the nature and role of medical practice and the social role of physicians.
102	**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.	**C31.** Provide opinions consistent with the accepted views of the profession when interpreting scientific knowledge to the public; indicate when presenting an opinion that is contrary to the accepted views of the profession.
103	See 2004-47	**C32.** Contribute to developing a more cohesive and integrated health system through inter-professional collaboration.

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Ref.	2004 CMA Code of Ethics	2018 CMA Draft Code of Ethics
104		**C33**. Recognize the importance of reconciliation between the medical profession and Aboriginal communities by working towards reconciling relationships and establishing and maintaining respectful and healthy relationships.
105	**Responsibilities to the Profession**	**PHYSICIANS AND COLLEAGUES**
106	**46.** Recognize that the self-regulation of the profession is a privilege and that each physician has a continuing responsibility to merit this privilege and to support its institutions.	Moved to 2018-Intro-8.
107	**47.** Be willing to teach and learn from medical students, residents, other colleagues and other health professionals.	See C32.
108	**48.** Avoid impugning the reputation of colleagues for personal motives; however, report to the appropriate authority any unprofessional conduct by colleagues.	See C40
109	**49.** Be willing to participate in peer review of other physicians and to undergo review by your peers.	Deleted.
110	Enter into associations, contracts and agreements only if you can maintain your professional integrity and safeguard the interests of your patients.	Moved to C21.
111	**50.** Avoid promoting, as a member of the medical profession, any service (except your own) or product for personal gain.	Moved to C22.
112	**51.** Do not keep secret from colleagues the diagnostic or therapeutic agents and procedures that you employ.	Deleted.
113	**52.** Collaborate with other physicians and health professionals in the care of patients and the functioning and improvement of health services.	Moved to C37.

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Ref.	2004 CMA Code of Ethics	2018 CMA Draft Code of Ethics
114	Treat your colleagues with dignity and as persons worthy of respect.	**C34.** Treat your colleagues, including physicians and medical learners, other health professionals, the health care team and staff, with dignity and as persons worthy of respect.
		C35. Cultivate respectful, open and transparent dialogue and relationships. Engage in respectful communications in all mediums.
		C36. Take responsibility for promoting civility and confronting incivility within and beyond the profession. Assume responsibility for your personal actions and behaviours that may contribute to negative workplace and training culture.
115	See 2004-52.	**C37.** Promote patient-, family- and caregiver-centred, team-based, collaborative models of care across and within specialties, and with other health professionals. Support multidisciplinary teams and practices to bolster collaboration, and a shared accountability for patient care.
116	See 2004-47.	**C38.** Value the exchange of knowledge and experience and be willing to teach and learn from medical and other colleagues.
117	See 2004-47.	**C39.** Promote and enable formal and informal mentorship and leadership opportunities across all levels of training, practice and health system delivery.
118	See 2004-48.	**C40**. Know and follow relevant reporting requirements and expectations placed on you by regulatory authorities.
119	**Responsibilities to Oneself**	**Physicians and self**
120	**53.** Seek help from colleagues and appropriately qualified professionals for personal problems that might adversely affect your service to patients, society or the profession.	**C41.** Seek help from colleagues and appropriately qualified professionals for personal problems that might adversely affect your health and your services to patients, society or the profession.

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Ref.	2004 CMA Code of Ethics	2018 CMA Draft Code of Ethics
121	**54.** Protect and enhance your own health and wellbeing by identifying those stress factors in your professional and personal lives that can be managed by developing and practising appropriate coping strategies.	**C42.** Be aware of what health and wellness services and other resources are available to you and colleagues in need. **C43**. Cultivate an environment of physical and psychological safety, conducive to challenging the status quo, as well as encouraging help-seeking behaviours. **C44.** Advocate for cultural and systemic change to remove individual- and system-level barriers to health and wellness. **C45.** Take steps to maximize meaningful co-existence of professional and personal life, recognizing that prioritizing opportunities for adequate rest, exercise, healthy eating and leisure will support professional and personal life. **C46.** Actively model healthy behaviours.