Summer 2013

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

Jocelyn Downie

Carolyn McLeod
The University of Western Ontario, cmcleod2@uwo.ca

Jacquelyn Shaw

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

By Jocelyn Downie, Carolyn McLeod, and Jacquelyn Shaw

Introduction

In 2008, one of us (JD) together with the former Dean of Law at the University of Ottawa (Sanda Rodgers), wrote a guest editorial for the *Canadian Medical Association Journal* on the topic of access to abortion in Canada. In the editorial, we argued, among other things, that "health care professionals who withhold a diagnosis, fail to provide appropriate referrals, delay access, misdirect women or provide punitive treatment are committing malpractice and risk lawsuits and disciplinary proceedings."[1] In response to a series of letters to the editor written about our editorial, we wrote that, under the CMA *Code of Ethics* (Update 2004)[2] and the CMA *Induced Abortion* policy (1988), "all physicians are under an obligation to refer"—that is, to make referrals for abortion—and "[the policy] does not allow a right of conscientious objection in

[1] S. Rodgers and J. Downie, 'Abortion: ensuring access' (2006) 175(1) *CMAJ* at 9.

[2] CMA *Code of Ethics* (Update 2004), online at: http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf.

relation to referrals."[3] The Executive Director of the CMA Office of Ethics (Jeff Blackmer) then weighed in, asserting that we were mistaken with respect to physicians' duty to refer.[4]

Several months later, the Co-Chairs of the Parliamentary Pro-Life Caucus wrote to our law deans and "ask[ed] that you take the necessary steps to ensure that your Faculty members -- who have tremendous power to influence the minds of our future lawyers and doctors -- not allow their own personal biases to impair their ability to accurately represent the law."[5] The extreme reaction to the suggestion that physicians have a duty to refer when patients request abortion services planted the seed for the development of a model policy on conscientious objections for Colleges of Physicians and Surgeons.

Inspired in part by the above sequence of events, Carolyn McLeod brought together a team of academics from philosophy and law to reflect on the moral and legal dimensions of conscientious refusals in healthcare.[6] The meetings of this team provided rich soil within which to germinate the seed for a model policy. In this paper, we recount the stages that were involved in developing this policy and then present the policy itself in the hopes of encouraging its adoption by Colleges of Physicians and Surgeons across the country.

---

[3] S. Rodgers and J. Downie, letter, 'Access to abortion' (2007) 176(4) *CMAJ* 494.

[4] J. Blackmer, 'Clarification of the CMA's Position Concerning Induced Abortion' 176(9): (2007) *CMAJ* at 1310.

[5] As quoted in J. Downie, 'On being a Legal Academic in a Politically Charged Environment,' in *20th Anniversary of Regina v. Morgentaler: Of What Difference? Reflections on the Judgment and Abortion in Canada Today* (National Abortion Federation & the Faculty of Law, University of Toronto, 2008) at 65.

[6] See See http://conscience.carolynmcleod.com/meet-the-team/.

The Process

We first critically evaluated and contributed to the philosophical and bioethical literature on conscience and conscientious refusals. Among the issues we examined were the moral nature and value of conscience, the moral demands on professionals, the potential benefit and harm of conscientious objections by health care professionals, and ethically plausible responses by professional bodies to these objections. Papers written for this part of the process are listed online on the website for our research team.[7]

We then embarked on a thorough review and analysis of existing policies of professional regulatory bodies for four different healthcare professions—medicine, nursing, pharmacy and dentistry—at national as well as provincial/territorial levels. The policy review results are available online,[8] and the full analysis of the policies is published elsewhere.[9] In sum, our policy review

> … uncovered confusion about, and differences among, the conscience-related policies of the various professions and jurisdictions. Potential implications of the confusion and variability include: regional disparities in patients' healthcare options and outcomes; increased care costs, some being borne by patients as they access alternative providers and others borne by Canada's health care system; interprofessional friction, particularly as interprofessional collaborative care alters traditional hierarchies and professional roles; and broadly, both patient and provider uncertainty regarding the services to be expected in a conflict. The policy environment with respect to conscientious objection across Canada is, to some extent, one of 'feast or famine': a confusing array of national and

[7] See http://conscience.carolynmcleod.com/publications/.

[8] See http://conscience.carolynmcleod.com/resources/.

[9] See J. Shaw and J. Downie, 'Welcome to the Wild, Wild North: Conscientious Objection Policies Governing Canada's Medical, Nursing, Pharmacy, and Dental Professions,' *Bioethics*, Special Issue: *Let Conscience be their Guide? Conscientious Refusals in Health Care* 28(1), 2014: 33-46.

> provincial policies applying in some regions, with significant policy gaps in others. Multiple, inconsistent, or conflicting policies appear likely to confuse practitioners and produce misunderstandings regarding obligations. A more consistent, comprehensive, and clear approach is needed to define the scope of permissible conscientious objection. Given the more restricted healthcare options and the potential to exacerbate existing northern health vulnerabilities, strong, clear policies controlling objection are needed, precisely where such policies are rare. These 'policy deserts' urgently warrant attention.[10]

Motivated and informed by this policy review and also by our team's philosophical work on conscientious objections, the next stage of the project involved drafting a model conscientious objection policy for uptake by Canadian physician regulatory bodies. We decided to proceed by way of regulatory bodies rather than the CMA for two main reasons: 1) the Colleges of Physicians and Surgeons, not the CMA, are the regulators of physicians, which means their policies have more force than CMA policies; and 2) in view of the reaction of the CMA to the editorial described earlier, we thought CMA policy reform was unlikely.

The policy was initially drafted for physicians with the intention that, if successful, it could be adapted for use by other healthcare professions. The policy included the adoption of useful elements of existing policies along with insights from the philosophers on the research team. Feedback on the draft policy was also solicited from a number of relevant experts: academics who do research primarily in health law, biomedical ethics, medicine or other health professions; physician regulatory body members; and local community organizations dealing women's health, sexual health, and the health of more marginalized populations (e.g., rural populations, street youth, First Nations, etc.). Based on the feedback we received, we modified our draft policy and present it here.

[10] J. Shaw and J. Downie, 'Welcome to the Wild, Wild North.'

A Model Policy on Conscientious Objection in Medicine

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

1. Purpose

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

2. Scope

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

3. Definitions

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

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

4. Principles

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

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

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

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

Physicians have an obligation not to abandon their patients.

Physicians' freedom of conscience should be respected.

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

5. Obligations

5.1 Taking on new patients

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

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

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

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

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

5.2 Providing information to patients

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

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

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

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

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

5.3 Providing referrals for health services

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

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

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

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

5.4 Treating patients

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

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

6. Complaints Process

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

7. Penalties

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

Conclusion

In Canada, there is currently great confusion and controversy about what the limits are, and should be, on physician conscientious objection. Our policy aims to improve this situation by making clear both to physicians when they can exercise their freedom of conscience, and to members of the public when they can expect physicians to accept them as patients and to provide them with information, referrals, and services once they become patients. Our hope is that, for the sake of protecting the public interest (as is their statutory authority and obligation), Colleges of Physicians and Surgeons across the country will adopt, implement, and strongly enforce our model policy.