Proposed Conscience Protection Procedures

The Canadian Medical Association (CMA) has developed a draft document called “Principles Based Approach to Assisted Dying in Canada”. This document has been presented to CMA members for consultation and will be voted on at CMA General Council in Halifax from August 23-26, 2015.

We represent CMA members in three organizations: Christian Medical and Dental Society (CMDS Canada), Canadian Federation of Catholic Physicians Societies (CFCPS) and Canadian Physicians for Life (CPL). Together we comprise several thousand Canadian physicians who are concerned about the legalization of assisted death (AD) and its effect on patient care. Our members have strong moral convictions that the scope of the practice of medicine does not include the intentional taking of a patient’s life. Under Canadian law, we cannot be forced to participate in AD – either by directly doing the act or by facilitating that act through referral. This proposal was drafted by a national committee of physicians and is endorsed by our member organizations. Thank you for taking the time to consider our views on this important topic.

Our members are very concerned about clause 5.2 in the current draft document that states:

> *5.2 Conscientious objection by a physician*
> *Physicians are not obligated to fulfill requests for medical aid in dying. There should be no discrimination against a physician for their refusal to participate in medical aid in dying. In order to reconcile physicians’ conscientious objection with patient access to care, a system should be developed whereby referral occurs by the physician to a third party that will provide assistance and information to the patient.*

We respectfully request that this clause be amended to the following:

> *5.2 Conscientious objection by a physician*
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> *Many physicians have moral convictions that will not allow them to participate in medical aid in dying. For this reason, physicians are not obligated to fulfill requests or refer for medical aid in dying. There should be no discrimination against a physician for her or his refusal to participate in medical aid in dying for moral or conscience reasons.*
>
> *The CMA recommends that each jurisdiction set up a process that provides direct patient access to an assessment for medical aid in dying while protecting physicians’ freedom of conscience. The following protocol is in response to this recommendation, while upholding the principle of "respect for physician values."*
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> *In response to a request from a patient for medical aid in dying the attending physician will:*
> *1. counsel the patient to determine whether there is an underlying cause for the request that could be otherwise resolved*
> *2. provide complete information to the patient about the medical options available to them. (If a patient chooses to be assessed for medical aid in dying, the physician will advise them that the patient or their representative can access that assessment directly using information provided to the general public by each jurisdiction).*
> *3. provide information from the patient’s file to the assessing physician chosen by the patient upon the patient’s request*
> *4. maintain the therapeutic relationship for care unrelated to medical aid in dying, unless the patient requests a transfer of care to another physician named by the patient. (In the*

case of a transfer of care, the patient's file and complete care will be turned over to the new physician.)

5. respect patients' right to autonomy, and the right not to be obstructed in their access to all legal alternatives at the end-of-life

We sincerely appreciate the CMA's support of conscience protection in this document, insofar as it attempts to protect the physicians' right not to participate directly in AD. It also seeks to protect physicians from discrimination because they will not participate. However, the clause falls short in that it does not protect physicians from the requirement to refer to a third party, which is a form of participation. Referral means recommending a particular course of medical treatment, or sending a patient to an expert to recommend a particular treatment. Referral of any kind is a form of participation, making our members accomplices to the controversial procedure. In criminal law, an accomplice is as guilty as the person who commits the crime.

Physicians will have conscience concerns for many different reasons. Many Christian physicians have a moral conviction that referral to a third party is cooperation in an act that is destructive for the patient. Experts in moral theology in both the Catholic and Evangelical churches confirm this conviction. Many physicians we represent will be unable to practice if the Colleges in each province adopt and enforce the proposed policy as written. We are not alone. This also affects many other physicians who, though they may not have a formal religious background, nevertheless do not want to participate on conscience grounds. We respectfully ask the CMA to revise this clause so that all physicians will be able will be able to care for their patients according to their conscience.

The remainder of this document provides detailed reasons why the CMA should revise this clause, as well as a detailed proposal as to how conscience could be protected even after the implementation of AD.

CONSCIENCE PROTECTION PROPOSAL

The following proposal is offered to demonstrate that it is possible to protect conscience rights of physicians without blocking access of patients to AD. There is no necessity to undermine conscience rights when allowing patients their autonomous decisions concerning end-of-life alternatives. The therapeutic relationship with an attending physician could continue for care that is unrelated to AD, unless the patient requests a transfer of care. In that case, complete care of the patient would be transferred.

Proposed process

1. Patient requests information or assistance to terminate his or her life from his or her physician.

2. Physician discloses his or her conscientious objection to participation in the termination of the life of this patient, including performing AD or referring the patient for AD.

3. Physician counsels the patient; listens to discern the goals of care of the patient and how these may be met; identifies and offers treatment for any physical, physiological or social issues impacting this request; and provides ongoing treatment, counseling and/or other referral(s) that may be appropriate. Physician provides information regarding the complete range of medical options for the patient.

4. The patient, or their representative, may access an assessment for AD directly. It is the

responsibility of Provincial and Territorial Departments of Health to create mechanisms that allow for access to AD that do not erode caregivers' conscience protections. This may be what is intended by the CMA proposal for a "third party" to provide access when a physician cannot facilitate AD because of conscience concerns. There is a similar model in Quebec. We simply propose that the CMA model allows for the possibility of patient initiation. This supports the overall philosophy of patient autonomy. If a patient chooses to pursue AD, the physician would advise that they or their representative could access the third party directly through mechanisms set up by the Department of Health (phone number, website, etc). Patients must have their cognitive capacity in order to consent to AD. Those who are unable to make a call because of physical challenges can have their representative assist them in accessing all legal alternatives.

5. Physician makes available the patients' chart and relevant information (i.e., diagnosis, pathology, treatment and relevant consults) to the new physician selected by the patient when requested and authorized by the patient.

6. Physician may maintain a therapeutic relationship with the patient for care unrelated to AD unless the patient requests a transfer of care to a specific physician selected by the patient. The physician with the conscientious objection must not be obligated to find a physician for the patient as this will be considered facilitating and actually participating in assisted death. In the event of a transfer of care the attending physician will transfer the patient's chart upon request of and with permission of the patient. The transfer of care results in the completion of the original physician-patient relationship.

7. A physician will respect the patient's autonomy, and the right not to be obstructed in their access to all legal alternatives at the end-of-life.

8. The death certificate and any documentation or reporting of AD is the responsibility of physician who performs AD.

THE REASONS

The following rationale is offered to support this proposal:

The importance of conscience protection for patient care

Physicians are professionals and must retain the ability to freely act in their patient's best interests. The best way to protect the public, the patient and the role of the physician is to safeguard physicians' conscience rights so they can practice with moral integrity and independence. If freedom of conscience is not respected for one procedure, it will soon be eliminated for all procedures.

With respect to AD as a particular example, we consider that it is never in the best interests of the patient. This is our moral conviction and it is well supported by our experience with patients. We have seen many patients who have asked to die at a low point in their lives only to find their circumstances improved later, resulting in a good life.

Physician-patient relationship

The physician-patient relationship must be based on openness, honesty and trust. Physicians can discuss options with patients, allowing the patient to make a fully informed, autonomous decision, even when the physician disagrees with the decision. We are not trying to impose our values on the patient – but we must maintain our right to step back from the process when our moral convictions will not allow us to facilitate something that we are convinced is not in the patient's long term interests. Many more physicians will likely benefit from conscience protection in the future, as opportunities for euthanasia will likely increase and new and controversial changes will

be proposed. In the Carter case, the Supreme Court has proposed the most liberal criteria for AD in the world. This will only become apparent as the decision is implemented.

Supreme Court of Canada

When the Supreme Court of Canada struck down the criminal prohibition against physician-assisted death (PAD) the court held that a physician's decision to participate in these procedures was a matter of conscience, protected by the *Canadian Charter of Rights and Freedoms.* Doctors cannot be forced to participate in assisted suicide or euthanasia against their will (para. 132). Participation includes referral to a third party.

No precedent for forced referral

No country or jurisdiction that has legislated euthanasia, except Quebec, has forced physicians to refer for euthanasia.

The Canadian Medical Association (CMA) Code of Ethics and other policies

These documents currently define physicians' professional responsibilities:

- **Code of Ethics:** Doctors must explain to their patients when their personal values might interfere with providing a service or referral. (s.12) We are also responsible to promote ethical access to health care resources in society in general. However, an individual physician is not obliged to provide for every patient request. Physicians may not participate in, nor support practices that violate basic human rights (s.9). We respectfully request that the CMA oppose any policy that forces doctors to violate their moral convictions or risk being disciplined as it amounts to discrimination on the basis of religion or creed. These doctors have a right to respect for their values. Lack of protection will result in the loss of excellent doctors and cause harm to patient care.

- The **CMA Policy on Abortion** does not require performance, or referral, and prohibits discrimination. The physician's duty is to continue to care for our patients' other needs. The policy on assisted suicide and euthanasia should have similar protections.

- **General Council** passed a motion in 2014 that "supports the right of all physicians, within the bounds of existing legislation, to follow their conscience when deciding whether to provide medical aid in dying." We believe that this motion includes all conscience rights including the freedom not to refer.

Direct patient access to service

Direct patient access would not morally implicate the conscientious objecting physician. The physician-patient relationship could be maintained. The provincial Departments of Health should be ultimately responsible for providing access to controversial services, not the individual doctor.

Public opinion

Recent Canada-wide public opinion polls indicate that the majority of respondents do not consider it appropriate to force a physician to refer for a procedure against their moral convictions, even though the patient might request the procedure. One direct access option is explicitly endorsed by a majority of respondents as a solution in such circumstances. This holds true when respondents are specifically asked about how a patient request for euthanasia should be handled. [i]

Physician conscience rights are at risk in Canada.

- **Quebec** became the first province in Canada to pass legislation to implement AD.

(Bill 52) If conscience will not allow a physician to euthanize a patient, the physician will be forced to refer to an official who will find a physician to perform the procedure. We are opposed to this requirement.

- The **College of Physicians and Surgeons of Ontario** (CPSO) recently passed a policy requiring referral, and in some circumstances, performance of procedures even when they go against the doctor's moral convictions. Our organizations have challenged this policy in court, as it is a breach of the *Charter*.

- The **College of Physicians and Surgeons of Saskatchewan** (CPSS) has asked for input on a new policy that requires the physician to "make arrangements" for a patient to get access to a controversial procedure, and even to perform such a procedure under certain circumstances. We have expressed our concerns directly to CPSS and have proposed amendments to this policy.

We have enjoyed the support of the CMA in the protection of conscience previously, but we are concerned that this support may be eroding with the changes proposed in this discussion document. The Hippocratic Oath supported our approach to medicine for 2400 years. It is unthinkable that physicians should now be disciplined by provincial colleges simply because they wish to follow the Oath.

Endorsed by:

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[i] In a May 2015 survey of 1,201 Canadians conducted by Abingdon Research (overall margin of error +/- 2.8%, 19 times out of 20), the majority of respondents did not support requiring doctors to refer for procedures that were against their moral convictions. The questions asked along with the results are reproduced below.

- Imagine a doctor disagrees with a patient about a treatment the patient wants, because of the doctor's moral convictions. The doctor cannot be forced to administer the treatment and the patient cannot be forced to follow the doctor's orders. What should be the outcome?

- The doctor should not be required to provide a referral to another doctor who will administer the treatment **(12%)**
- The doctor should tell the patient how to access the procedure, but not provide a formal referral **(44%)**
- The doctor should be required to provide a referral to another doctor who will administer the treatment **(44%)**

Note that 56% of respondents said that the physician should not have to refer, made up of those who would require information only (44%) and those who required no action at all. (12%) Furthermore, the majority of respondents supported direct access as a valid option when asked the following question:

- In some circumstances, patients can self-refer to a physician or service for a procedure. In a situation where a physician's moral or religious convictions do not allow them to refer for a procedure that is requested by a patient, and the patient can self-refer themselves for the service, what should happen?

- The physician must refer for the procedure **(31%)**
- The physician should have to make the patient aware that they can refer themselves for the procedure, but make no referral **(54%)**
- The physician should not have to make the formal referral **(16%)**

- When asked specifically about physicians whose religious beliefs would forbid them from referring to another physician who would provide euthanasia, 58% of respondents felt that those physicians should not have to perform euthanasia or refer for it. In contrast, 28% of respondents would require a referral, while 14% would require a physician to perform euthanasia, at least under some circumstances. The margin of error is higher on this question: +/- 5%, 19 times out of 20.