CHRISTIAN LEGAL FELLOWSHIP | ALLIANCE DES CHRÉTIENS EN DROIT

285 King Street, Suite 202, London, ON N6B 3M6 | 519.601.4099

Submissions of Christian Legal Fellowship re: Public consultation on proposed revision to the International Code of Medical Ethics (ICoME) concerning conscientious objection and effective referrals

Christian Legal Fellowship (CLF) appreciates the opportunity to comment on the World Medical Association (WMA)'s proposed revisions to the International Code of Medical Ethics (ICoME) concerning conscientious objections and effective referrals.

By way of background, CLF is a national association of over 700 lawyers, law students, and jurists, representing more than 40 Christian denominations. We are also a non-governmental organization in Special Consultative Status with the Economic and Social Council of the United Nations with a well-established history of engaging matters of national and international public policy and law. Our members contribute to peer-reviewed, scholarly legal journals (both in Canada and internationally) on matters of human rights and moral, legal, and political philosophy, and professional ethics. Over the past 40 years, we have developed institutional expertise and insight concerning the importance of freedom of conscience, particularly within regulated professions.

Debate in Canada around how best to navigate physicians' conscientious objections is ongoing. However, many Canadians physicians' interests in maintaining robust conscience protections have been heightened by Parliament's recent expansion of eligibility for physician assisted suicide (PAS) to include persons whose natural death is not reasonably foreseeable.[1] CLF has addressed multiple Canadian decision-makers on these issues, including physicians' regulators, courts, legislatures, and Parliament. In every case, we advocate for the integrity of physicians' consciences in caring for their patients.

CLF shares the WMA's currently stated position on professional ethical integrity, namely, that "a physician shall **always** exercise his/her **independent professional judgment** and maintain the highest standards of professional conduct"; and "a physician shall be dedicated to providing competent medical service in **full professional and moral independence**, with compassion and respect for human dignity."[2] The updated version of the proposed Code elaborates on this further: "The physician ***must*** **practise with conscience, honesty, and integrity**, while **always exercising independent professional judgment** and maintaining the highest standards of professional conduct."[3] Indeed, it is because CLF shares these commitments to protecting conscience and a

[1] In the absence of further legislative change, Canadians whose sole underlying condition is mental illness will also become eligible for PAS in 2023, and further discussions are currently underway concerning the eligibility of minors. See Bill C-7, *An act to amend the Criminal Code (medical assistance in dying)*, 2nd Sess., 43rd Parl., 2021 (assented to 17 March 2021), S.C. 2021, c. 2.

[2] See "WMA International Code of Medical Ethics" (Adopted by the 3rd WMA General Assembly, October 1949), online: <https://www.wma.net/policies-post/wma-international-code-of-medical-ethics/> (emphasis added).

[3] See "Revised Draft for Public Consultation: WMA International Code of Medical Ethics April 2021", online: <https://www.wma.net/wp-content/uploads/2021/04/ICoME-Apr2021_public-consultation-210427.docx> (emphasis added).

physician's integral moral independence that we write to **urge you to not adopt Article 27 of the April 2021 Revised Draft ICoME**.[4]

The WMA's positions on physicians' conscientious objections through instruments such as the ICoME exert considerable worldwide influence over policy debates in this area. CLF is deeply concerned that adopting Article 27, particularly in the context of Canada's controversial expansion of PAS, encourages disregard for not only objecting physicians' fundamental human rights, but also those of marginalized patient groups – particularly Canadians with disabilities who seek care from physicians who agree that assisted suicide is never an appropriate medical solution for disability-related suffering.

1) Article 27 proposes a conception of conscientious objection that fails to accommodate physicians whose consciences preclude them from aiding the death of patients.

Ensuring respect for the independent operation of physicians' consciences is the primary means of preserving space for equality and diversity. And yet, for many physicians, the obligation set forth in the proposed Article 27 would provide no meaningful accommodation at all. Particularly in the context of PAS, mandatory effective referral policies fail to adequately recognize two crucial facts:

First, PAS is categorically distinct from any other act an individual may perform as a healthcare professional; it is the *only* act wherein a physician intentionally terminates, or aids in terminating, his or her patient's life.[5] In the Canadian context, PAS is only permitted through detailed *Criminal Code* provisions that expressly exempt the procedure from constituting what – in all other contexts – would be a criminal offense.[6] PAS is, for legal purposes, the act of inflicting death upon another person with their consent.[7] For many physicians, this is not "medicine" at all.[8] Even the trial court that invalidated Canada's blanket prohibition on PAS stated that "thoughtful and well-motivated people can and have come to different conclusions about whether physician-assisted death can be ethically justifiable", and for some physicians, it is "ethically inconceivable" to ever participate in "intentionally ending the life of a patient".[9] Similar statements could be made concerning other controversial but lawful procedures. The fact that PAS is now legal in several jurisdictions – even for patients who are not dying – does not change the legitimacy of these ethical objections.

Second, for many physicians, taking positive action to place a patient into the hands of another for the express purpose of aiding that patient in terminating his or her own life (i.e. an effective referral) is morally equivalent to *performing* PAS. Indeed, the World Medical Association's currently stated

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[4] The proposed Article 27 reads as follows: "Physicians have an ethical obligation to minimize disruption to patient care. Conscientious objection must only be considered if the individual patient is not discriminated against or disadvantaged, the patient's health is not endangered, and undelayed continuity of care is ensured ***through effective and timely referral to another qualified physician***" (emphasis in original). *Ibid.*

[5] Abortion may also fall into this category when not intended to save the mother's life, but to terminate the life of the unborn child.

[6] Canada's *Criminal Code* carves out a special regime for "medical assistance is dying" as an exemption to the offences of culpable homicide (s. 222), aiding a person to die by suicide (s. 241(1)(b)), and administering a noxious thing (s. 245(1)).

[7] *Criminal Code*, s. 227(4).

[8] The World Medical Association's position is that it is "firmly opposed to euthanasia and physician-assisted suicide". See "WMA Declaration on Euthanasian and Physician-Assisted Suicide" (Adopted by the 70th WMA General Assembly, October 2019), online: <https://www.wma.net/policies-post/declaration-on-euthanasia-and-physician-assisted-suicide/>.

[9] *Carter v. Canada (Attorney General)*, 2012 BCSC 886 at paras 310, 343.

position on PAS rightly recognizes the validity of precisely this type of objection.[10] The ethical significance of such referrals is also recognized by the Canadian Medical Association,[11] and several Canadian provincial regulators. An analogous mode of moral culpability is also enshrined in Canadian law through party offenses, whereby one who *aids* in a criminal act shares legal responsibility with the primary perpetrator of the offense.[12]

Supporters of mandatory effective referrals often fail to recognize that the physician who facilitates, directly or indirectly, the death of his or her patient bears the moral and emotional responsibility of doing so long after the patient is gone. This is a serious matter, and it can have demonstrable and profoundly negative impacts on objecting physicians' psychological well-being.[13] Whatever one's views on the desirability of decriminalizing PAS, the reality of this burden should elicit high degrees of empathy and respect for professionals whose consciences prevent their complicity in this controversial, and only recently (in Canada) *permissible*, practice.

Accommodating physicians by ensuring they are never coerced into aiding PAS is justifiable by the extraordinary nature of the action being requested – namely, the termination of a human life. Moreover, such accommodation contributes significantly to the preservation and enhancement of diversity within the medical profession by keeping the door open to all competent candidates, regardless of their religion or creed.

We have focused on PAS for its clear exemplification of the burden that effective referrals can place on conscientious objectors, but similar reasoning would apply to other procedures to which physicians might object to on the basis of conscience. Article 27 would encourage regulators in Canada and elsewhere to exclude conscientious and qualified physicians from any area of medicine in which requests for PAS or other ethically objectionable procedures are likely to arise.

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[10] The World Medical Association's current position is that no physician should be obliged to provide a referral for assisted suicide or euthanasia: "WMA Declaration on Euthanasian and Physician-Assisted Suicide" (Adopted by the 70th WMA General Assembly, October 2019), online: <https://www.wma.net/policies-post/declaration-on-euthanasia-and-physician-assisted-suicide/>.

[11] The Canadian Medical Association's position is that "physicians must be able to follow their conscience without discrimination when deciding whether or not to provide or participate in assistance in dying", including whether to refer a patient to someone who will provide PAS. See CMA Policy, "Medical Assistance in Dying" (2017), online: <https://policybase.cma.ca/documents/policypdf/PD17-03.pdf>.

[12] Section 21 of the *Criminal Code* states: "21. (1) Every one is a party to an offence who (a) actually commits it; (b) does or omits to do anything for the purpose of aiding any person to commit it; or (c) abets any person in committing it. (2) Where two or more persons form an intention in common to carry out an unlawful purpose and to assist each other therein and any one of them, in carrying out the common purpose, commits an offence, each of them who knew or ought to have known that the commission of the offence would be a probable consequence of carrying out the common purpose is a party to that offence."

[13] See, e.g., Michael Quinlan, "When the State Requires Doctors to Act Against their Conscience: The Religious Freedom Implications of the Referral and the Direction Obligations of Health Practitioners in Victoria and New South Wales", (2017) 2016:4 B.Y.U. L. Rev. 1237, at 1271: "Health practitioners who consistently act against their conscience can also become desensitized to it. They are at greater risk of developing indifference to patients and 'doubling' or 'compartmentalization,' leading to a weakened ability to make the types of ethical decisions critical for health practitioners."

2) Access to services does not require objecting physicians to provide mandatory effective referrals.

It is important to bear in mind that the number of medical procedures which are likely to elicit physicians' conscientious objections are relatively few in number. Access to such procedures may be less convenient or instantaneous in some cases than some might desire. However, it is not at all clear that accessing them is any more difficult than accessing the many other specialized, elective procedures currently offered in Canada and elsewhere. Nor is it clear that conscientious accommodation would materially cause or contribute to any systemic delays. At least one Canadian court recently confirmed this to be true in the Canadian experience, finding in 2018 that "there is no study or direct evidence that demonstrates that access to health care is, or was, a problem that was caused by physicians objecting on religious or conscientious grounds to the provision of referrals for their patients".[14]

However, even if conscientious objection does result in delayed access to a procedure in some cases, one must bear in mind the extraordinary nature of many of the procedures that elicit such objections. Delay in accessing services is, in many cases, an unavoidable reality of the finite human and financial resources available to public systems such as Canada's. Exempting conscientious objectors from referring for PAS and abortion in particular, is ethically justifiable on the basis of the unique and lasting burden that taking a human life can impose on the responsible actors. The administrator of PAS, *not* the patient, ultimately bears this burden. It is inequitable to impose that burden on a professional against his or her will.

That many jurisdictions around the world, including the majority of those which permit PAS, maintain robust conscience protections demonstrates that equitable access does not require mandatory effective referrals for PAS and other ethically objectionable procedures. We strongly urge the WMA to forgo the proposed endorsement of mandatory effective referrals in Article 27, at least for the extraordinary act of intentionally ending human lives.

3) Discouraging the conscientious practice of medicine diminishes the quality of healthcare for both physicians and patients

CLF is especially concerned that the WMA's adoption of Article 27 will encourage the alienation of physicians from all or part of the medical profession in Canada and elsewhere, based on their conscientious objection to performing ethically questionable procedures—including, for example, PAS to address suffering that is non-life threatening and could be addressed by other means.[15] This result impoverishes the healthcare system by incentivizing competent and conscientious practitioners to move elsewhere, to the detriment of both the medical profession and the public.

Medical professionals are expected to practice conscientiously, and there is a cost to overriding their ability to doing so. CLF is among those who believe the public is best served by ensuring physicians are not forced to violate their ethical framework such that they burnout from moral distress, become

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[14] *The Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario*, 2018 ONSC 579 at para 147.

[15] For example, Canada's new PAS regime does not require patients to exhaust or even try other "reasonable and available" medical means to relieve their suffering – only that they give "serious consideration" to them. See Bill C-7, *supra* note 1 (now *Criminal Code* section 241.2(3.1)(h)).

desensitized to their consciences, or are forced to leave medical practice altogether, further exacerbating doctor shortages and health care delays.[16]

The WMA should also be mindful of the risk of creating a monoculture within various healthcare systems under its influence on the issue of PAS and other controversial procedures. Many patients cherish the opportunity to entrust their healthcare needs to professionals who share their ethical framework on fundamental life issues. Many would be distraught to know that only those physicians and nurses who do not conscientiously object to PAS are permitted to work in palliative and other areas of care. Mandating effective referrals risks eliminating the legitimate diversity of professional ethical views on this subject, thereby reducing the representativeness of the medical profession in these areas relative to the communities it is entrusted to serve.

This lack of representation will be most acutely felt by marginalized communities. In the context of PAS, this is particularly true of patients with disabilities, who already face enormous challenges as a result of systemic ableism. A number of Canadians with disabilities testified before Parliament recently, sharing traumatizing experiences of having to insist on basic healthcare interventions in the face of ableist stereotypes and presumptions.[17] In one case, a patient had to confront a physician's ableist presumptions about her quality of life and repeatedly insist that she wanted oxygen to help her breathe. While breathing supports would be standard procedure in a similar situation for a person without a disability, this patient identified that "[a]ll the doctors seemed to see was a disabled woman alone, sick, tired, and probably tired of living."[18]

In light of these challenges, many have an increased sense of trepidation and fear under Canada's expansion of PAS for disability-related suffering. One can reasonably infer this is also true in other countries where such practices are permitted. As one woman explained to our Parliament's Standing Committee on Justice and Human Rights: "Knowing that those caring for you consider death to be a possible (or even favorable) treatment option, **rips away any feelings of security and trust** that may have been left."[19] These fears will only be exacerbated through the encouragement of regulatory policies that muzzle conscientious objectors, forcing them to facilitate PAS or other controversial procedures through effective referrals, and perhaps even precluding them from practicing in certain areas of medicine.

Physicians who conscientiously object to providing controversial services like PAS are uniquely equipped to support individuals with disabilities who otherwise feel targeted and unsafe in a healthcare system that has failed to adequately support them. Knowing that their healthcare provider rejects ableist presumptions – and shares their ethical conviction that PAS is never an appropriate medical solution for a non-life threatening disability – will be profoundly reassuring for many. By continuing to support the accommodation of conscientious objectors, the WMA will be strengthening the medical profession's representativeness, in Canada and elsewhere, thereby fostering greater inclusivity and accessibility to healthcare, and especially for marginalized populations.

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[16] See note 13, *supra*.

[17] See, for instance, Roger Foley, "Evience: Tuesday, November 10, 2020", Standing Committee on Justice and Human Rights, Number 006, 43rd Parl, 2nd Sess at 1111-1116.

[18] Taylor Hyatt, "Evidence: Tuesday, November 10, 2020", Standing Committee on Justice and Human Rights, Number 006, 43rd Parl, 2nd Sess at 1226 and 1228.

[19] Elizabeth Mack, Brief, Standing Committee on Justice and Human Rights (27 November 2020), online: <https://www.ourcommons.ca/Content/Committee/432/JUST/Brief/BR10949827/br-external/MackElizabeth-e.pdf> (emphasis added).

4) Medical conscience is informed by clinical – not just personal – considerations

CLF is concerned that the proposed Article 27 reflects a conception of conscientious objection that divorces the physician's independent judgment from the best interests and care of patients. Conceptualizing professional conscience as purely "personal" and never "clinical" is not only a false dichotomy, but also a dangerous one, because it extricates ethical considerations from clinical practice. As CLF argued before the Canadian courts in the *CMDS v CPSO* litigation, this is an impossible divide:

> [A]s the [Ontario] Court of Appeal has recognized, "ethical considerations form an essential part of medical decision-making". Any exercise of professional judgment is inherently and necessarily holistic; it integrates clinical experience, education, and — critically — a morally-informed ethical framework. All ethical decisions are informed by one's moral philosophy. Such beliefs will likely develop over time, being challenged or confirmed by factors such as clinical experience, but they remain relevant, rational and required elements of professional decision-making. **Attempts to bifurcate the "moral" from the "clinical" undermine the very idea of professional judgment, which necessarily integrates both elements. Such integration is foundational to a professional's integrity, which is a fundamental quality and essential element in all professional relationships**.[20]

CLF urges the WMA to re-examine its approach, and to reject the bifurcation of independent physicians' consciences from patients' interests and quality of care. Ultimately, the broader public interest is best served by respecting an appropriate degree of ethical diversity within the medical profession, such that physicians are free to apply their expertise and judgment, including their ethical judgment, as to the patients' best interests. Insisting on effective referrals, especially for controversial procedures such as PAS and abortion will diminish the expertise, representativeness, and overall quality of care in many jurisdictions.

Closing thoughts

The WMA has a commendable history of advocating for the ethical practice of medicine around the globe, including through its commitment to the utmost respect for human dignity and life. CLF implores the WMA to continue this legacy by forgoing the bifurcation of the physician's conscientious practice from the patient's best interests and quality of care. Respect for and accommodation of independent physician conscience is crucial to the continuation of medical practice as a fundamentally humanitarian endeavour, and not simply a technician's trade. The WMA is uniquely positioned to influence this continuation in the face of an increasingly consumeristic and transactional view of medical practice. **We urge the WMA to do so by restating its support for the accommodation of conscience, particularly in those cases where human life hangs in the balance.**

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[20] Factum of the Interveners The Evangelical Fellowship of Canada, The Assembly of Catholic Bishops of Ontario, and The Christian Legal Fellowship in *CMDS v CPSO* (Court of Appeal file no. C65397) at para 15 (references omitted, emphasis added) quoting *Flora v Ontario Health Insurance Plan*, 2008 ONCA 537 at para 75.