



Centre for Cultural Renewal  
Centre pour un Renouveau Culturel



**“Physicians, Patients, Human Rights, and Referrals: A Principled Approach to Respecting the Rights of Physicians and Patients in Ontario”**

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

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**Introduction:**

The issue of whether it is “discriminatory” for a physician to refuse to refer a patient for a procedure that the physician does not wish to perform or be associated with is once again on the front burner. We are aware that there has been wide-spread concern about whether (and to what extent) the conscience and beliefs of physicians are being taken into consideration by the College of Physicians and Surgeons of Ontario (COPSO). The Ontario Medical Association (to name but one group) has expressed concerns with the way in which COPSO is responding to the Ontario Human Rights Commission (OHRC) letter of earlier this year in its Draft <sup>1</sup>. Because there have been concerns and because the issue is one of wide-spread importance to all citizens in Ontario (and other provinces) it is a good thing that the time both for making submissions and for their consideration has been extended by COPSO and I thank you in advance for this opportunity to do so.

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<sup>1</sup> See Draft; Physicians and the Ontario *Human Rights Code*, undated, [http://www.cpsso.on.ca/Policies/consultation/HumanRightsDRAFT\\_08.pdf](http://www.cpsso.on.ca/Policies/consultation/HumanRightsDRAFT_08.pdf)[http://www.cpsso.on.ca/Policies/consultation/HumanRightsDRAFT\\_08.pdf](http://www.cpsso.on.ca/Policies/consultation/HumanRightsDRAFT_08.pdf)> last accessed September 11, 2008. For the OMA concerns see: Charles Wells “OMA fears intrusion into MD’s Beliefs”, *National Post*, Saturday, August 23, 2008 at <http://www.nationalpost.com/news/canada/story.html?id=743272> (last accessed September 10, 2008).

### ***The Issue:***

Barbara Hall, the Chief Commissioner of the Ontario Human Rights Commission, has written a letter to the *National Post* (September 7, 2008 “Doctors Must not Discriminate” <http://www.nationalpost.com/story.html?id=774376>) outlining her view that there is a requirement to refer. She is not a medical physician; neither is she a philosopher or capable, apparently, of the kind of thinking that is necessary in this area, as her letter shows:

Like other professionals, doctors are entitled to make decisions about the services they offer based on their clinical competence. And, doctors, like patients, are also entitled to accommodation of their religious beliefs as much as possible. In some situations, like a medical clinic, it might be appropriate to refer a patient on to another professional who will help them. *But patients should not have to shop around for medical treatment they were denied for non-clinical discriminatory reasons.* (emphasis added).

For “non-clinical discriminatory reasons”, read: the exercise of conscience or religion. In fact, there are many technically “non-clinical” reasons in medicine why people cannot always get what they want. For example, an older person may well not get the transplant over a younger patient who is more likely to benefit - - a discrimination or distinction based upon “age” yet one that we justify. There are many such examples.

The accommodation of differing beliefs is just one more area in which there may be something that comes between what a patient wants and can reasonably expect. But the point here is that Chief Commissioner Hall thinks it is acceptable, as a general principle, to discriminate against those who have one set of conscientiously held or religious beliefs on behalf of others who have a different set of beliefs. In addition she asserts that such conscientious or religiously based reasons for action are discriminatory. Human Rights, it seems, now entails monitoring conflicting beliefs in society, turning them into one half of a human rights issue, and then, by eradicating the possibility of dissent (for that is what a physician’s ability to refuse to refer amounts to) forcing some citizens to effectively implicate themselves in the beliefs of other citizens. Under the Canadian Constitution all rights must be consistent with the concept of a “free and democratic society” so one must wonder how Chief Commissioner Hall’s conception of the truncation of these freedoms can survive scrutiny.

On this interpretation of the Chief Commissioner and as represented in the Draft there is the real spectre of no meaningful public freedom of conscience or religious belief for doctors. Such a radical truncation is intolerable in a free and democratic society. The right of citizens to express their consciences and beliefs is not something that must be “parked in the waiting room.” If society wishes to have conscientious physicians, it cannot at large dictate how those consciences are free to operate about matters that raise deeply personal beliefs. To remove the capacity to refuse to refer, in the manner suggested by Chief Commissioner Hall, Dr. Zuliani in his letter and in the Draft is a gross interference with the proper scope of a physician’s rights. This direction of non-referral is the drift of recent communications and direction from the OHRC to the COPSO and the College’s Draft Response and the reason why the Centre for Cultural Renewal felt it necessary to make this submission.

Here is how your College responded, through its current President, to an article by Lorne Gunter and an editorial in the *National Post* last August:

All services that doctors provide -- including decisions to accept or refuse individuals as patients, decisions about providing treatment or granting referrals to existing patients and

decisions to end a doctor-patient relationship--are subject to the obligations of the Human Rights Code.

Contrary to your editorial, the college does not expect physicians to provide medical services that are against their moral or religious beliefs. If physicians feel they cannot provide a service for these reasons, the draft policy does expect physicians to communicate clearly, treat patients with respect and *provide information about accessing care*.

(see: "Doctors' Hands Not Being Forced" *National Post*, August 22, 2008 by Dr. Preston Zuliani, president, College of Physicians and Surgeons of Ontario, Toronto.  
<http://www.nationalpost.com/related/topics/story.html?id=740721>)

### ***Analysis and Submission:***

It would appear that, for "provide information about accessing care" Dr. Zuliani, on behalf of COPSO means, like Chief Commissioner Hall, "refer." If that was not what was meant and something like a neutral phone referral information service was what was anticipated, then the College should say so more clearly. To agree with the blunt approach of Chief Commissioner Hall, as the Draft appears to, is not sustainable or advisable.

With respect the policy of other bodies, such as the Canadian Medical Association and certain provincial medical associations, which clearly state that there is no duty to refer, are superior in so far as they strike a better balance between the needs of patients and the beliefs and consciences of physicians. (I cite the relevant policy from the CMA showing this later on in this Submission).

If the College is genuinely concerned about the provision of information regarding care there are other less intrusive and destructive ways of accomplishing this goal. For example, the College could extend what it already has in place; namely to create a "physician's referral service" that would direct inquiries from the public to physicians and surgeons who work in the relevant areas. This number could be provided in a handy form (flyers, posters etc.) for physicians to have available in ways that are *not issue specific* for the physician thereby creating the moral problem which exists with referral.

This number and listing (akin to that established by some Bar Associations for lawyers) could assist patients in finding information about how to "access information about health care." This way the individual physician who has an objection to this kind of referral in specific circumstances would not find him or herself in a difficult situation and the concerns about access to medical care (the purported reason for the concerns in relation to "ending the physician-client relationship") would be addressed.<sup>2</sup> Availability of alternative sources for information about physicians and their areas of practice would then be coming from a central source and not from a physician who finds him or herself in a position of conflict in relation to the specific issue.

The central point here may be framed as a question. If I am a physician with a conscientious or religious objection to something that a person wishes me to do, must I help the person find

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<sup>2</sup> The approach taken in the existing College "Sample Notification Letter" strikes a good balance here. That language is as follows: *For assistance in locating another physician, you may wish to contact the College of Physicians and Surgeons of Ontario (416-967-2626 or toll free 1-800-268-7096 ext. 626) or visit the College website at [www.cpsso.on.ca](http://www.cpsso.on.ca) and access the Doctor Search service.* (see: <http://www.cpsso.on.ca/policies/ending.htm>> last accessed Sept 11, 2008)

someone who will do that thing? The Draft seems to assume the answer to this is “yes” but there is no principled reason why that answer is the right one and strong arguments that it is wrong. A better way of balancing the “conflict” can be reached and that is what we should strive for.

There is something deeply political about the approach being taken by the Draft and by Chief Commissioner Hall in her public pronouncements. While the suggestion is that the requirement of referral is driven by concerns about non-discrimination this does not stand up to scrutiny when it is realized that there are other means available (as set out above) to protect both interests as much as possible. One cannot escape the sense, in reading the Draft, that religion or conscience objections are a “suspect category” that COPSO (following similar suspicions at the OHRC) wishes to have minimized as much as possible in order to obtain other health care outcomes - - such as easier and wider access to controversial practices.

One of the central policies of non-discrimination and a free and open society is a proper recognition of *modus vivendi* - - how to organize around divergent beliefs, not create spurious rank-orderings to make one persons beliefs (in this case the concerned physician’s) effectively disappear. The issue in this area is how to provide maximum respect for differences related to beliefs that it is legal to hold.

Issues such as abortion, contraception, euthanasia, whether a man should be in the physician’s office when a pap smear is done, reproductive technology, capital punishment etc.-- are all belief conflicts and are deeply involved in what we believe or do not believe, and physicians can be implicated in them all unless the right to dissent is recognized and protected. That you think something is just fine and unobjectionable while I think it is monstrous does not mean that your “all’s right with the world” or “I have a right to demand what I want” view can force me to make what you want happen. That is what underlies this current debate.

The Draft currently under consideration subordinates the rights of a physician to those of a patient under the idea that “putting the patient first” requires obviating personal beliefs or conscience. There is no sound basis for such an understanding. Nothing in the patient/physician relationship requires such a wholesale subordination of the physician’s beliefs. Here is the troublesome passage from the Draft.

#### ii) Moral or Religious Beliefs

If physicians have moral or religious beliefs which affect or may affect the provision of medical services, the College advises physicians to proceed cautiously.

*Personal beliefs and values and cultural and religious practices are central to the lives of physicians and their patients. However, as a physician’s responsibility is to place the needs of the patient first, there will be times when it may be necessary for physicians to set aside their personal beliefs in order to ensure that patients or potential patients are provided with the medical treatment and services they require.*

Physicians should be aware that decisions to restrict medical services offered, to accept individuals as patients or to end physician-patient relationships that are based on moral or religious belief may contravene the Code, and/or constitute

professional misconduct.<sup>3</sup>

It is important not to lose sight of a basic principle here. Canada endorses accommodation for conscience and religion (the co-joined right “conscience and religion” is what the *Charter of Rights and Freedoms* refers to at Section 2 (a)). This is a right all citizens have regardless of their occupations. Perhaps the Draft could say something positive about conscience and religion being important rather than casting a “chill” across the whole area.

No amount of demanding, pushing, complaining, cajoling, gossip, innuendo, begging or punishment can take away the right every Canadian has to act according to their consciences and religion. Whether a person can always be accommodated in such an exercise of conscience or belief is another matter - - the employer (if it is an employment situation) must accommodate up to the level of “undue hardship.” A physician must show that he/she acted responsibly in making it clear in a courteous way to the patient what the limits are of his/her medical practice.

### ***Citizens Owe Each Other a Measure of Respect as Well***

The patient, like every other citizen, has duties as well as rights. Part of the duty of one citizen is not to force another citizen (in this case a physician) to abandon his/her beliefs or act in breach of them. That is what Commissioner Hall, the letter from Dr. Zuliani and the Draft all fail to consider. Ethics and accommodation constitute a two-way street. They are not, in how the conflicts are set up, a one-way superhighway marked “what patient wants patient gets” - - medicine does not and should not work that way. Yet that seems to be the assumption underlying the current Draft.

Where the principles are properly applied, physicians do not lose their right to dissent, to disapproval and to non-involvement just because of the doctor-patient relationship. To allow that would be to give a “trump right” to patients. Yet no such “trump” exists. Patients have the right to good medical care, but *they do not have* the right to demand that any given physician perform services to which that person may have an ethical or religious objection. There is no duty to “put one’s religious or conscientious views to one side” in the manner suggested by the Draft.

In fact, it would be equally accurate to put the matter this way: “if you don’t like the scope of your physician’s practice go somewhere else.” All the physician has a duty to do is be clear with the patient that he or she will not do certain things - - things the doctor has every right as a free and autonomous citizen to refuse to do.

Physicians can be required not to discriminate against patients on the basis of race, gender, sexual orientation, religion or what have you. They can also be required not to proselytize or to act in inappropriate ways with patients. Equally, they cannot be required to place themselves in the chain of causation of procedures or practices they are opposed to for reasons of conscience under some supposed “second-order” ranking of their own beliefs.<sup>4</sup>

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<sup>3</sup> <[http://www.cpso.on.ca/Policies/consultation/HumanRightsDRAFT\\_08.pdf](http://www.cpso.on.ca/Policies/consultation/HumanRightsDRAFT_08.pdf)> last accessed September 11, 2008  
Emphasis added.

<sup>4</sup> One of the ironies of the existing Draft is that it purports to recognize the *Dagenais* principle that rights under the Charter are not “rank-ordered” yet in the way the entire Draft is oriented, the physician’s beliefs count as nothing against the demands of the patient. This cannot be correct and the existence of a blatant rank-ordering while purporting not to is a significant example of what would amount to institutional duplicity should this carry into practice.

Maybe something else underlies this tightening up of the instruments of the administrative State? Might there be a growing concern that many physicians don't want to do certain things that other citizens want? Could this be part of how "politics" in the widest sense works out in societies? I think so, and would assert further that that is why some people fear the freedom of free physicians. But it should not be the role of COPSO to act against the diverse interests of the Members of the College no matter how strident some of the voices within it are for their own beliefs to be advanced. Dissent and debate are how society (and its associations) *should* work.

The fine line that is being completely erased by those like Chief Commissioner Hall who wish to make physicians into the pull-strings of patients is that the patient can only require that physicians act on their best clinical and personal basis honestly and openly. It should be perfectly acceptable for a doctor to say

"I do not do X,Y & Z in my medical practice, if you wish X.Y and Z you must find a physician who does this. I can also not refer you for this to another physician, you are free to find such a person on your own."

If I believe euthanasia is immoral because, according to my beliefs and analysis the intentional taking of a human life is wrong, then it is pretty clear that *if* I am required, as Chief Commissioner Hall says I am (and Dr. Zuliani and the Draft suggests), to ensure that it happens anyway by writing down the address of the doctor whom I know does it and giving this to the patient, I am directly involved in doing it. The death of the patient, if it follows from my referral, happens, *in part, because of my referral*. As I am in the chain of causation I am implicated, I am supporting it by my actions and my ability to refuse is nullified. This is why the "right of non-referral" is such an important right.

Hiding the moral conflict behind the terms "referral" "discrimination" or "providing information" or avoiding the fact that there can be deep moral disputes behind such things as "providing information on accessing health care" the way COPSO in its Draft and Chief Commissioner Hall in her letter suggests, is just a way of saying "your conscientious scruples are irrelevant - - make the sought for outcomes happen in all cases whether you are opposed or not."

On the other hand, it can be seen that if I have no involvement in something I am not in any way implicated in what happens nor am I interfering in a person getting what they seek; it is the only neutral position. Required referral, on the other hand, is not neutral.

The Canadian Medical Association has been around this issue before: they do not require referrals. On what possible basis other than brute power of an over-weening administrative force could Chief Commission Hall and the OHRC think they know better than the doctors themselves? Answer: they have the power, or think they do. They also appear to have some allies in COPSO. This attitude, however, is not the friend of diversity and amounts to an egregious discrimination against a genuine pluralism of beliefs as well as an attack on the independence of professional bodies such as COPSO.

The CMA policy on abortion states as follows:

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.

(CMA, Policy on Induced Abortion, December 1988,  
<http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD88-06.pdf>)

Note, in this policy, how the physician's responsibility ends, as it should, with simply informing the patient of the doctor's "moral or religious" objection and it is up to the patient to consult another physician, not the doctor to refer her to one. It is this approach that the Draft over-rides.

***Conclusion: A Right of non-referral is mandated by sound Ethics and Law***

A recent article in the Student BMJ captures the correct approach on the question of the accommodation of conscience and belief in a medical context:

Conscientious objection in medicine is rarely an easy way out. It may add to paper work, complicate relationships with colleagues, and leave the doctor feeling vulnerable and isolated. However, history shows that rapid changes of law is reason enough to uphold the doctor's right to raise conscientious objection. We may never all agree on what is the right thing to do in difficult clinical and moral situations. But we need more doctors, not fewer, who are willing to defend what they think is right.<sup>5</sup>

Based on the foregoing analysis, it is submitted that your College should as a matter of sound ethics and law endorse a policy that respects the rights of conscience and religion guaranteed to every Canadian (including physicians and surgeons) under our *Constitution* including the right of non-referral. Such a failure to respect rights is not the best basis for a profession to operate- - particularly at a time when there is a shortage of physicians, many of whom have a choice of where they might want to settle and practice and for many of whom the practical aspects of conscientious beliefs accommodation (or its absence) may be an important consideration.

If we want conscientious physicians we must respect the exercise of conscience, not attempt to drive it into irrelevance as is being suggested by the OHRC and the Draft under consideration.

Respectfully Submitted,

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<sup>5</sup> Charles Williams "Conscientious Objection" *Student BMJ* 2008;16:235 /18, available at: <http://student.bmj.com/issues/08/07/life/264.php> (last accessed September 12, 2008).

