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Position Paper #95

The Refusal to Provide Health Care in Canada

A Look at “Conscientious Objection” Policies in Canadian Health Care

Many people may be unaware that in Canada, doctors have the “right” to refuse to provide legal and necessary treatments for personal or religious reasons. Further, doctors usually don’t even have to refer patients to someone who can provide the objected-to service. This permitted abandonment of patients is not monitored and there are rarely any repercussions for doctors who may cause harm to patients as a result.

This paper explains why so-called “conscientious objection” in health care is unethical and unworkable and has nothing in common with true conscientious objection in the military.

Please see the Appendix: [Canadian Policies and Laws on “Conscientious Objection” in Health Care](#),¹ which describes, quotes, and critiques the policies of the Canadian Medical Association (CMA) and each College of Physicians and Surgeons across Canada as they relate to the refusal to treat and obligation to refer, in particular for abortion care, but also medical assistance in dying (MAiD).

“Conscientious Objection” in General

Doctors in Canada are allowed to refuse treatment for personal or religious reasons. They also have no obligation to refer appropriately except in Ontario, where an “effective referral” is required to a provider or agency that can do the service. Five provinces require referral to someone who can at least provide information (NB, PE, QC, SK, AB), but that is not an effective

¹ <http://www.arcc-cdac.ca/postionpapers/95-appendix-policies-conscientious-objection-healthcare.pdf>

referral. BC makes referral optional, while three provinces have no requirement to refer at all (NL, NS, MB). These three provinces rely on the policies and ethical codes of the Canadian Medical Association (CMA), which do not require a referral, at least not an effective one.

“Conscientious Objection” for Medical Assistance in Dying

Since 2015, every province has passed a policy or law related specifically to medical assistance in dying (MAiD). All allow treatment refusals under “conscientious objection” (“CO”) and require some form of referral – at least to information resources but in several cases direct referrals to providers or agencies who can provide MAiD (an effective referral).

In fact, treatment and referral policies around MAiD are generally superior and far more comprehensive than policies around abortion and reproductive health – which usually don’t even exist.

Conflict with Anti-discrimination Clauses

Policies that allow refusal to treat or refer under “CO” *conflict directly* with anti-discrimination clauses in the ethical codes of the CMA and most provincial Colleges of Physicians and Surgeons. These clauses generally prohibit refusal to treat for reasons of medical condition or illness, gender/sex, and other grounds (ethnicity, disability, etc).

Treatment refusals under “CO” in reproductive health care are discriminatory because such care is largely delivered to women (and transgender people), especially abortion care, and unwanted pregnancy is a condition for which the standard of care is induced abortion. Refusal to provide MAiD under “CO” is also arguably discriminatory based on grounds of the patient having a terminal and irremediable medical condition or illness, or on grounds of disability.

Lack of Enforcement

Physician refusals to provide treatment or make a required referral under “CO” are not monitored and rarely disciplined because there is no means to do so except through patient complaints to the provincial Colleges. Very few patients would bother to make a complaint for several reasons:

- Almost all women seeking abortions will prioritize their privacy and confidentiality, especially given the stigma of abortion.
- MAiD patients and their families would usually be too incapacitated or grief-stricken.
- Most people lack knowledge of referral policies by the Colleges.
- Even if people know they were wronged, they may not have the capacity or desire to pursue a complaint.
- Complainant names are shared with the ‘offending’ doctor, and patients may decide not to complain out of fear of alienating or losing their family doctor.

Given the complete lack of adequate enforcement mechanisms, Canadian policies on so-called “conscientious objection” are essentially worthless. It’s very unlikely a doctor would face any repercussions for not referring, or for referring inappropriately – such as to an anti-choice counselling agency run by untrained volunteers.

Unfortunately, there is no data on what refusers are doing or what they’re saying to patients, and we rarely hear about what happens to patients who have been refused care. But it’s safe to assume that most doctors who are socially conservative are not making any effective referrals, particularly for abortion care or MAiD, even if required by law or policy, because they feel this makes them “complicit.”²

In an apparent attempt to get around this problem, many Canadian policies put the referral at arm’s length – i.e., refusers must refer to someone else who could then refer the patient to an actual provider. However, such policies could lead to a potentially endless chain of referrals to non-providers, since no-one is required to make an effective referral. But more importantly, it would likely satisfy few refusers, since their perceived “complicity” does not change by referring to someone else who will then make the effective referral. In fact, many refusers follow a “conscience absolutism” doctrine, under which “the professional is not obligated directly or indirectly to participate in [a service] provision or facilitate patient access to it.”³ That means no information and no referral that might in any way lead the patient to the requested service.

What’s Wrong with “Conscientious Objection”?

A growing number of health care professionals, researchers, and bioethicists⁴ have concluded that “conscientious objection” is inappropriate and harmful in health care.⁵ It represents an abuse of medical ethics and professional obligations to patients, and should instead be called “refusal to treat” or “dishonourable disobedience”.⁶ The practice should be recognized as an authority figure’s discriminatory imposition of their personal beliefs on vulnerable others – *not* as stemming from a right of conscience.

The harms of refusal to treat under “CO” have been extensively documented.⁷ The denial of legal and necessary care is a violation of patients’ right to health care and moral autonomy. The extent of harm caused is on a continuum and is often much worse than a short delay – around the world, women needing abortions have been left to suffer serious injury or even die.⁸ Even if the harm seems minimal – i.e., the refuser refers appropriately and the patient receives services promptly, denial of care is still inherently harmful – it demeans patients by

² <https://www.sciencedirect.com/science/article/pii/S2213560X14000034>

³ <https://ndpr.nd.edu/news/conscientious-objection-in-health-care-an-ethical-analysis/>

⁴ <https://www.sciencedirect.com/science/article/pii/S0301211517303573#bib0010> (see references 2,3,4,5)

⁵ <https://www.sciencedirect.com/science/article/pii/S0301211517303573>

⁶ <https://www.sciencedirect.com/science/article/pii/S2213560X14000034>

⁷ <https://www.sciencedirect.com/science/article/pii/S0301211517303573>

⁸ <http://www.conscientious-objection.info/category/victims-of-co/>

undermining their dignity and autonomy and sends a negative message that stigmatizes them and the health care they need.

The term “conscientious objection” is a misnomer as it has nothing in common with conscientious objection in the military (see Figure 1). For example, soldiers are conscripted, are relatively powerless, and must accept consequences for exercising their CO; while doctors choose their profession, enjoy a position of power and authority, and rarely face consequences for refusing to treat under “CO”.

Figure 1: Military Conscientious Objection vs. Refusal to Treat under “CO” in Health Care

Soldiers...	Healthcare Professionals...
<ul style="list-style-type: none"> • Are drafted into compulsory service 	<ul style="list-style-type: none"> • Apply for their position voluntarily • Compete for training and jobs
<ul style="list-style-type: none"> • Are powerless • Must obey orders from superiors 	<ul style="list-style-type: none"> • Are in position of authority and trust • Treat patients who depend on them
<ul style="list-style-type: none"> • Conquer and kill for their country 	<ul style="list-style-type: none"> • Save patients’ lives and improve health
<ul style="list-style-type: none"> • When claiming right of CO: <ul style="list-style-type: none"> • Must justify their stance • Usually must undergo rigorous review process • Are punished, or must complete alternate service 	<ul style="list-style-type: none"> • When claiming “right” of CO: <ul style="list-style-type: none"> • Rarely have to justify it • Are often protected by law/policy • Rarely face discipline • Retain their positions • May benefit by escaping stigma, and boosting career, reputation, salary

(by Dr. Christian Fiala and Joyce Arthur, 2017)

Doctors have a special responsibility to serve the public, and they enjoy a privileged position and a monopoly on health care. Patients are dependent on doctors and generally cannot obtain safe or effective care outside the medical system. When doctors claim the “right” to deny treatment, they are deliberately refusing to do part of their chosen profession for personal reasons, thereby abandoning their fiduciary duty to patients and abusing their trust.

How Can We Stop the Refusal to Treat?

Doctors with personal objections to some types of care should exercise their freedom of conscience by not entering fields where their objection will be a problem. If they choose to do so anyway, they are disrespecting their own conscience and therefore should forfeit any “right” to deny care to patients.

Measures should be taken to screen out refusers at the medical school stage if they wish to enter family practice or Obstetrics/Gynecology, as both fields frequently require the prevention and treatment of unwanted pregnancy. The same goes for MAiD – anyone may find themselves in need of this service someday, and very sick people on their deathbeds should not have to struggle to find a willing doctor or suffer the trauma of being transferred to another hospital because of refusals by institutions or individual doctors.⁹

The goal should be to reduce the number of existing refusers as much as possible – emulating the examples of Sweden, Finland, and Iceland, where the refusal to provide abortion is disallowed.¹⁰ This can be done by moving refusers towards abortion provision (or MAiD) through values clarification workshops and similar education, or helping them transfer to other disciplines where their refusal won’t be a problem. If those measures fail, disincentives could be imposed, such as lower priority for hiring and lower pay, prohibitions on practicing alone, mandatory registration and scrutiny, liability for refusals, and other disciplinary measures.

Another possible option is to set up a centralized referral agency that people can contact to get a direct referral to a provider in their region. Alberta and Ontario have done this for MAiD. This circumvents the problem of refusers, but has other drawbacks:

- Provincial governments and Colleges must ensure sufficient providers in every region.
- It’s only feasible if enough providers can be found.
- It represents a workaround that doesn’t exist for other treatments.
- It gives cover to refusers, as if their refusal is acceptable when it’s not.
- It insulates refusers from patients they should be treating.
- It requires patients to forgo their regular family doctor or specialist and receive treatment from a stranger who doesn’t know their history.
- The patient’s regular doctor might not be aware that the treatment took place and will no longer have a complete medical record of their patient.
- It can reinforce secrecy and stigma.

⁹ <https://www.theglobeandmail.com/news/national/patients-botched-transfer-renews-calls-for-assisted-dying-in-all-publicly-funded-health-care-facilities/article37536563/>

¹⁰ <http://www.conscientious-objection.info/wp-content/uploads/2016/10/Yes-we-can-Successful-examples-of-disallowing-conscientious-objection-in-reproductive-health-care.pdf>

Conclusion

Doctors in Canada are able to refuse the provision of legal and necessary health care under the guise of so-called “conscientious objection.” Although most provinces require some form of referral, there is no monitoring or adequate enforcement, giving doctors near-carte blanche to deny referrals as well. There is an unwarranted assumption by regulatory authorities that refusers will respect the rules. Meanwhile, what actually happens to patients who are denied services or a referral is unknown as it has not been studied.

“Conscientious objection” as used in health care is a propaganda term that has nothing in common with true conscientious objection in the military. The refusal to treat under “CO” is a violation of patient rights and medical ethics. It is inherently harmful to patients, who bear the burden of care denial while refusers suffer no consequences for their actions and even have their refusals protected by policy and law. But the very idea of a doctor refusing to provide health care is antithetical to the purpose of medicine – to care for others. It should not be recognized as a right, and measures should be taken to phase it out over time.