



Position Paper #95

The Refusal to Provide Health Care in Canada

A Look at Policies around “Belief-based Care Denial” in Canadian Health Care

Many people may be unaware that in Canada, doctors have the “right” to refuse to provide legal and necessary treatments based on their personal or religious beliefs. Further, doctors usually don’t even have to refer patients to someone who can provide the objected-to service.¹ This permitted abandonment of patients is not monitored and rarely are there any repercussions for doctors who may cause harm to patients as a result.

This paper explains why so-called “conscientious objection” in healthcare is unethical and unworkable. Because the practice is not “conscientious” and has nothing in common with true conscientious objection in the military, we will use the term “belief-based care denial” to describe it.

Please see the Appendix: *Canadian Policies and Laws on “Conscientious Objection” in Health Care*,² 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 belief-based care denials and the obligation to refer, in particular for abortion care, but also medical assistance in dying (MAiD).

Belief-based Care Denial in General

Doctors in Canada are allowed to deny care based on their personal or religious beliefs. They also have no obligation to refer appropriately except in Ontario and Nova Scotia, where an “effective referral” is required to a provider or agency that can do the service. Five provinces

¹ <https://thesexmed.com/putting-patients-first-balancing-the-conscience-rights-of-physicians-with-unimpeded-access-to-abortion/>

² <https://www.arcc-cdac.ca/wp-content/uploads/2020/06/95-appendix-policies-conscientious-objection-healthcare.pdf>

require referral to someone who can at least provide information (NB, PE, QC, SK, AB), but that is not an effective referral. BC makes referral optional, while two provinces have no requirement to refer at all (NL, MB). These two provinces rely on the policies and ethical codes of the Canadian Medical Association (CMA), which do not require a referral.

Belief-based Care Denial 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 belief-based care denials and require some form of referral – at least to information resources, but in at least three provinces (NS, ON, AB), direct referrals are required to providers or agencies who can provide MAiD.

Treatment and referral policies around MAiD are generally superior and more comprehensive than policies around abortion and reproductive health – which usually don't even exist.

Conflict with Anti-discrimination Clauses

Policies that allow belief-based care denials 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 care denials for reasons of medical condition or illness, gender/sex, and other grounds (ethnicity, disability, etc.).

Belief-based care denials in reproductive health care are discriminatory because such care is largely delivered to women and 2S/LGBTQQIPAA people, especially abortion care. Unwanted pregnancy is a medical condition, for which induced abortion is the standard of care that physicians should be obligated to offer. Refusal to provide MAiD due to personal beliefs is also discriminatory based on grounds of the patient having a terminal and irremediable medical condition or illness, or on grounds of age or disability.

Further, all College and CMA policies stress the need to prioritize patient interests. For example, the Nova Scotia College's policy says: "The rights of patients are paramount, and their interests must prevail." But that vital ethic directly contradicts belief-based care denial, the very essence of which is the prioritization of doctors' interests over that of patients.

Lack of Enforcement

Physicians who deny treatment or refuse to make a required referral due to their personal beliefs 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 people 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.

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- 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 belief-based care denial 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 denied 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.”³

In an apparent attempt to get around this problem, many Canadian policies put the referral at arm’s length – i.e., care deniers 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. More importantly, it would likely satisfy few care deniers, since their perceived “complicity” does not change by referring to someone else who will then make the effective referral. In fact, many care deniers 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.”⁴ That means no information and no referral that might in any way lead the patient to the requested service.

What’s Wrong with Belief-based Care Denial?

A growing number of health care professionals, researchers, and bioethicists^{5,6} have concluded that belief-based care denial is inappropriate and harmful in health care.⁷ A 2017 international conference on the topic concluded that it should not be allowed.⁸ Further, belief-based care denial has never been designated as a right by any international human rights body.⁹ While global human rights agreements recognize the right to conscience as a basic individual right, this does not equate to a right to deny healthcare based on “conscience”. Human rights bodies including the United Nations and the World Health Organization have concluded that belief-based care denial too often serves to restrict healthcare and burden patients, and that its exercise should be significantly limited.⁹

³ <https://www.sciencedirect.com/science/article/pii/S2213560X14000034>

⁴ <https://ndpr.nd.edu/news/conscientious-objection-in-health-care-an-ethical-analysis/>

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

⁶ <http://www.conscientious-objection.info/category/publications-by-others/>

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

⁸ <https://iwhc.org/resources/unconscionable-when-providers-deny-abortion-care/>

⁹ <https://www.conscientious-objection.info/wp-content/uploads/2020/12/Intl-groups-agreements-CO.pdf>

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Belief-based care denials represent an abuse of medical ethics and professional obligations to patients and have also been called “dishonourable disobedience”.¹⁰ 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 belief-based care denial have been extensively documented.¹¹ Refusing to provide 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, people needing abortions have been left to suffer serious injury or even die.¹² Even if the harm seems minimal – i.e., the care denier refers appropriately and the patient receives services promptly, a refusal of care is still inherently harmful – it demeans patients by undermining their dignity and autonomy and sends a negative message that stigmatizes them and the healthcare they need.

Belief-based care denials are invariably accompanied by one or more of the following harmful or abusive behaviours in addition – which indicates that such refusals are inherently wrong because they invite abuses that conflict with medical codes of ethics:

- Refusing to refer
- Failing to provide necessary information
- Lying to patients; providing misinformation
- Judging or criticizing them
- Violating their privacy
- Not listening to them; dismissing their concerns
- Delaying them; making them wait for treatment or tests
- Not attending to them in hospital
- Not providing pain relief
- Failing to follow standard medical protocols
- Waiting till patient is near death before acting

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 care based on their beliefs, 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.

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 and must accept consequences for exercising their conscience; while doctors choose their profession and rarely face repercussions for belief-based care denials.

¹⁰ <https://www.sciencedirect.com/science/article/pii/S2213560X14000034>

¹¹ <https://www.sciencedirect.com/science/article/pii/S0301211517303573>

¹² <http://www.conscientious-objection.info/category/victims-of-co/>

Figure 1: Military Conscientious Objection vs. Belief-based Care Denials

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 conscientious objection: <ul style="list-style-type: none"> • Must justify their stance • <u>Usually</u> must undergo rigorous review process • Are punished, or must complete alternate service 	<ul style="list-style-type: none"> • When exercising belief-based care denial: <ul style="list-style-type: none"> • Rarely <u>have to</u> 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, 2022)

How Can We Stop Belief-based Care Denial?

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 those opposed to abortion and contraception 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. Regarding 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 care denials by institutions or individual doctors.¹³ Since any doctor could potentially get a request for MAiD, all medical students should be made aware of referral obligations if they lack the expertise (or moral fortitude) to do it themselves.

The goal should be to reduce the number of existing care deniers as much as possible – emulating the examples of Sweden, Finland, Bulgaria, and Ethiopia, where belief-based care denial is not allowed.^{14, 15} This can be done by moving care deniers towards abortion provision

¹³ <https://www.theglobeandmail.com/news/national/patients-botched-transfer-renews-calls-for-assisted-dying-in-all-publicly-funded-health-care-facilities/article37536563/>

¹⁴ <https://www.conscientious-objection.info/wp-content/uploads/2022/11/countries-that-disallow-conscientious-objection.pdf>

¹⁵ <http://www.conscientious-objection.info/wp-content/uploads/2016/10/Yes-we-can-Successful-examples-of-disallowing-conscientious-objection-in-reproductive-health-care.pdf>

(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. (Note: Solutions to the problem do not involve "forcing" doctors to do abortions or MAiD.)

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 care deniers, 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.

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 care deniers will respect the rules. Meanwhile, what actually happens to patients who are refused 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. Belief-based care denials are a violation of patient rights and medical ethics. They are 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.