Regulation of Belief-Based Care Denial in Canada

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Introduction

Belief-based care denial in health care is "the refusal by a health care professional to provide a legal medical service or treatment, for which they would normally be responsible, based on their objection to the treatment for personal or religious reasons."[1] This is often referred to as "conscientious objection," a term that has been called a misnomer in healthcare because of major dissimilarities with conscientious objection in the military.[2] This paper will use the term "belief-based care denial".

Reproductive health care, medical assistance in dying, and gender-affirming care are the main fields in medicine where belief-based care denial is accepted as an argument to limit a patient's access to a medical treatment they are legally entitled to access.[3] The vast majority of countries allow the exercise of belief-based care denial in healthcare, often with no limitations or very few,[4] including Canada. In most provinces and territories in Canada, physicians who object to the treatment being sought by a patient are not even required to refer them to another physician who will provide that care.

This paper will provide a summary of the current state of belief-based denial of care in Canada, with particular focus on how it relates to medical assistance in dying and reproductive healthcare, specifically abortion. First, we will examine federal statutes regulating "conscientious objection," followed by similar provincial statutes, as well as those Bills whose passage failed. Second, we will turn to regulation by federal agencies and the provincial Colleges of Physicians and Surgeons and the differences between provinces. Then we will look to Canadian case law. Finally, we will look at international regulation of belief-based care denial.

Federal Statutes

Belief-based care denial is not regulated in a standard way across Canada. It is governed through policies of the provincial Colleges of Physicians and Surgeons, and federal medical assistance in dying (MAiD) legislation, as well as Quebec's provincial MAiD legislation. It most often is addressed in relation to abortion and MAiD. In order to understand the exercise of

[1] Christian Fiala & Joyce H Arthur, "There is no defence for 'Conscientious objection' in reproductive health care." (2017) 216 | European Journal of Obstetrics & Gynecology and Reproductive Biology | 254.
[2] Christian Fiala & Joyce H Arthur, "The CO Debate: 'Conscientious Objection' is still dishonourable disobedience" (2014) | British Pregnancy Advisory Service Reproductive Review.
[3] Christian Fiala & Joyce H Arthur, ""Dishonourable disobedience" – Why refusal to treat in reproductive healthcare is not conscientious objection." (2014) 1 | Woman – Psychosomatic Gynaecology and Obstetrics | 12.
[4] Red de Acceso al Aborto Seguro de Argentina, "Global Map of Regulatory Standards regarding Conscientious Objection to Abortion."

belief-based care denial, it is important to understand how abortion and MAiD are regulated in Canada.

Abortion and belief-based care denial

In 1969, Parliament passed a number of amendments to the *Criminal Code*.[5] These amendments specified the rules surrounding when an abortion could be legally performed. The original section of the *Criminal Code* that made it an offence to obtain an abortion remained, however, and the amendments included subsections outlining the exceptions to the existing law. This amendment allowed for individuals to obtain an abortion if a three-physician therapeutic abortion committee, who could not perform abortions themselves, agreed that the pregnancy was a danger to the health or life of the abortion seeker.

In 1983, Dr. Henry Morgentaler and two other doctors were charged with conspiring with each other with intent to procure abortions, contrary to ss 423(1) and 251(1) of the *Criminal Code*.[6] This was appealed to the Supreme Court of Canada on grounds that the *Criminal Code* provisions were unconstitutional because they violated abortion seekers' rights to security of person under Section 7 of the *Canadian Charter of Rights and Freedoms*. In 1988, the Supreme Court sided with the appellants, ruling 5 to 2 that the law violated Section 7, and could not be saved under Section 1 of the *Charter*. The majority agreed that abortion laws as they currently stood infringed upon abortion seekers' right to security of person and that they were being deprived of that right in a manner not in accordance with the principles of fundamental justice.

Following this decision, the Mulroney government announced that it would draft a new law to limit abortion.[7] Numerous proposals were made, but none were adopted and the government's motion was defeated.[8] In November of 1989, Bill C-43 was introduced in the House of Commons by the then Minister of Justice. It would have made it a criminal offence to provide an abortion unless it was done by, or under the direction of, a physician who believed that the abortion seeker's health would be harmed if an abortion was not provided.[9] This bill was narrowly defeated by a tie vote in the Senate in January 1991.

The defeat of Bill C-43 left Canada with no legislation governing abortion, and that remains the case today. Provinces, however, have restricted and regulated access to abortion in various

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[5] *Criminal Code of Canada*, RSC 1985 c C-46.

[6] *R v Morgentaler,* [1988] 1 SCR 30.

[7] Pro-Choice Action Network, "Abortion History - Chronology of Events" (2007).

[8] Canada, *Abortion: Constitutional and Legal Developments* (Ottawa: Library of Parliament Research Branch, 1989).

[9] Ibid.

non-criminal ways.[10] There have been continued attempts at the federal level to pass private member bills related to abortion, but all have failed thus far.[11] This included several bills related to protecting healthcare workers who want to deny care based on their conscience.

The first attempt to pass belief-based care denial laws federally in Canada came in 1991. Liberal MP Don Boudria brought forward private member Bill C-220. This proposed Bill essentially criminalized abortion provision as a job requirement. It would have made it an indictable offence to directly or indirectly require a health care provider to "perform or participate directly or indirectly in an abortion procedure." This was one of three bills MP Boudria brought forward that year that attempted to restrict or criminalize abortion provision. All three failed to pass.

In 1997, Liberal Senator Stanley Haidasz presented for first reading "*An Act to amend the Criminal Code to prohibit coercion in medical procedures that offend a person's religion or belief that human life is inviolable*."[12] This Bill would have criminalized "coercion" by employers, educators, and professional associations, making it an offence punishable on summary conviction. It would have been an offence for an employer to refuse to employ or promote, or to dismiss a health care practitioner who refused to provide legal health care services that "offend a tenant of the practitioner's religion, or the belief of the practitioner that human life is inviolable." Additionally, it would have criminalized educators and schools who refuse to admit or grant accreditation in a field based on the practitioner's refusal to provide legal health care services, as well as professional associations who refuse to admit, refuse to advance, or exclude individuals from the association based on their refusal. The Bill failed to pass and was reintroduced by Liberal Senator Raymond Perrault in 1999 to the same result.[13]

In 1998, a nearly identical bill, Bill C-461, was brought forward by Reform MP Maurice Vellacot under the name "*An Act to amend the Criminal Code to prohibit coercion in medical procedures that offend a person's religion or belief that human life is inviolable*."[14] The following year he attempted to introduce the same bill as Bill C-207.[15] It died on the order paper following an

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[10] Pro Choice Action Network, supra.

[11] Abortion Rights Coalition of Canada, "Anti-Choice Private Member Bills and Motions Introduced in Canada Since 1987" (2023).

[12] Bill S-7, *An Act to amend the Criminal Code to prohibit coercion in medical procedures that offend a person's religion or belief that human life is inviolable*, 1st Sess, 36th Parl, 1997.

[13] Bill S-11, *An Act to amend the Criminal Code to prohibit coercion in medical procedures that offend a person's religion or belief that human life is inviolable*, 2nd Sess, 36th Parl, 1999.

[14] Bill C-461, *An Act to amend the Criminal Code to prohibit coercion in medical procedures that offend a person's religion or belief that human life is inviolable*, 1st Sess, 36th Sess, 1998.

[15] Bill C-207, *An Act to amend the Criminal Code to prohibit coercion in medical procedures that offend a person's religion or belief that human life is inviolable*, 2nd Sess, 36th Parl, 1999.

election call. He brought it forward again as Bill C-422 in December 1999 following the election.[16] In 2001, he again introduced the same bill as Bill C-246; it did not reach a second reading.[17] In 2008, he made his final attempt with Bill C-537, a slightly edited version of his previous bills, with the same result as Bill C-246.

After 2008, no attempts have been made to pass this type of "freedom of conscience" legislation in relation to abortion, but two similar attempts have been made in relation to medical assistance in dying. Regardless of which medical procedures these legislative attempts explicitly target, they still have impacts on **all** medical treatments and practices.

Medical Assistance in Dying and Belief-Based Care Denial

In 2015, the Supreme Court of Canada ruled in *Carter v Canada* that the criminalization of medical assistance in dying (MAiD) was unconstitutional as it unjustifiably infringed on Section 7 rights to life, liberty, and security of the person under the *Charter*[18]. This ruling declared that Section 241(b) and s. 14 of the *Criminal Code* were invalid to the extent that they prohibit MAiD for competent adults who meet specific criteria. The Supreme Court of Canada gave the government of Canada until June 6, 2016, to create a new law[19]. In April 2016, the federal government tabled Bill C-14 which contained amendments to the *Criminal Code* that would permit MAiD in accordance with specific eligibility criteria and safeguards[20]. In 2019, the Superior Court of Quebec ruled in *Truchon c Procureur général du Canada* that the government's eligibility criteria were unconstitutional. The court said that the criteria restricted access to MAiD to those who were nearing the end of their life, declaring both the "reasonable foreseeability of natural death" criteria in the *Criminal Code* and the "end-of-life" criteria in Quebec's provincial MAiD law to be unconstitutional[21]. While this ruling is only binding in Quebec, the Government of Canada accepted the ruling and committed to amending MAiD laws[22], leading to the introduction of Bill C-7 in March 2021, permitting MAiD for individuals whose death is not reasonably foreseeable[23].

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[16] Abortion Rights Coalition of Canada, supra.

[17] Bill C-246, *An Act to amend the Criminal Code to prohibit coercion in medical procedures that offend a person's religion or belief that human life is inviolable*, 1st Sess, 37th Parl, 2001.

[18] Carter v Canada (Attorney General), 2015 SCC 5

[19] Canada, Health Canada, "Medical Assistance in Dying" (Ottawa: Health Canada, 2023)

[20] Canada, Health Canada, "First Annual Report on Medical Assistance in Dying in Canada" (Ottawa: Health Canada, 2020)

[21] *Truchon c. Procureur général du Canada*, 2019 QCCS 3792

[22] Canada, Department of Justice, "What We Hear Report: A Public Consultation of Medical Assistance in Dying (Ottawa: Department of Justice, 2020).

[23] Bill C-7, *An Act to amend the Criminal Code (medical assistance in dying)*, 2nd Sess, 43rd Parl, 2021.

In response to the initial legalization of MAiD, conservative politicians again began introducing "freedom of conscience" private member bills, similar to those introduced in reference to abortion care. In 2018, Conservative MP David Anderson introduced private member's Bill C-418, the "*Protection of Freedom of Conscience Act*." The text of the Bill reads as follows:

> This enactment amends the Criminal Code to make it an offence to intimidate a medical practitioner, nurse practitioner, pharmacist or any other health care professional for the purpose of compelling them to take part, directly or indirectly, in the provision of medical assistance in dying.
>
> It also makes it an offence to dismiss from employment or to refuse to employ a medical practitioner, nurse practitioner, pharmacist or any other health care professional for the reason only that they refuse to take part, directly or indirectly, in the provision of medical assistance in dying.[24]

This legislation died on the order paper with the end of the parliamentary session. In 2021, Conservative MP Kelly Block introduced private member's Bill C-268, the "*Protection of the Freedom of Conscience Act (MAiD)*.[25]" The bill was worded identically to David Anderson's previous Bill C-418. Similarly, this bill died with the end of the parliamentary session in 2021. Based on this trend, it is unlikely this issue has been put to bed and similar bills may be introduced in future sittings of the legislature.

The introduction of such legislation is largely supported by conservative and religious groups in Canada, as well as by conservative medical groups such as Physicians for Life, the Physicians' Alliance against Euthanasia,[26] and the Coalition for HealthCARE and Conscience[27]. These groups express several concerns with MAiD legislation, particularly about being "forced" to take part in MAiD or facing reprimand for not taking part in MAiD. But the *Criminal Code* amendments that legalize MAiD very clearly state that "[f]or greater certainty, nothing in this section compels an individual to provide or assist in providing medical assistance in dying."[28] Additionally, in *Carter v Canada*, the Supreme Court of Canada's decision specifically noted at paragraph 132 "[i]n our view, nothing in the declaration of invalidity which we propose to issue would compel

[24] Bill C-418, *An Act to amend the Criminal Code (medical assistance in dying)*, 1st Sess, 42nd Parl, 2018.

[25] Bill C-268, *An Act to amend the Criminal Code (intimidation of health care professionals)*, 2nd Sess, 43rd Parl, 2021 (Protection of Freedom of Conscience Act).

[26] Alex Schadenberg, "Press Release: A growing number of Canadian physicians are being bullied to participate in MAiD" (9 March 2020), online (blog): Euthanasia Prevention Coalition.

[27] Catholic Register Editorial Board, "Editorial, A conscience solution" (13 May 2021), Online: The Catholic Register.

[28] *Criminal Code of Canada*, supra.

physicians to provide assistance in dying." [29] Both the law as well as the SCC ruling that guided the creation of the law on MAiD make clear that unwilling physicians are not required to provide MAiD under federal statute or case law.

Provincial Statutes

Manitoba Bill 34

Following the 2015 Supreme Court's decision in *Carter* and the above legislative changes from the federal government legalizing MAiD, the Coalition for Healthcare and Conscience began lobbying for Bill 34 in Manitoba.[30] Bill 34, *The Medical Assistance in Dying (Protection for Health Professionals and Others),* passed in 2017 and became law. This bill protects belief-based care deniers from disciplinary action, should they refuse to provide or otherwise aid in providing MAiD services. The Coalition for Healthcare and Conscience is an umbrella organization of religious groups seeking protection for physicians who refuse to provide legal medical services, at the expense of patient care.

According to Cory Ruf from Dying With Dignity Canada, "this provision could suggest that physicians have absolutely no obligation to ensure that patients in their care have access to compassionate treatment that they seek and to which they have a right."[31] The bill offers employment protection for care deniers, but does not extend those same protections to those who feel a duty to provide care but work in a facility where the contested service is not offered, such as Catholic hospitals. Even the College of Physicians and Surgeons of Manitoba asked for amendments to be made to this bill to ensure that vulnerable patients still have access to MAiD, to no avail.[32]

As noted above, the Supreme Court explicitly stated in *Carter* that health care workers who do not wish to participate in MAiD for reasons of conscience cannot be forced to participate.[33] Additionally, the *Criminal Code* provision clearly states that "nothing in this section compels an individual to provide or assist in providing medical assistance in dying."[34] Despite this, Manitoba's Bill 34, *The Medical Assistance in Dying (Protection for Health Professionals and Others) Act* was passed unanimously in the provincial legislature in 2017.

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[29] *Carter v Canada*, supra.

30 CBC Radio, "Critics call bill aimed to protect health workers unwilling to offer assisted death 'one-sided'" (3 November 2017). Online: CBC Radio.

31 Holly Caruk, "Doctors, advocacy groups address proposed law protecting those who object to assisted dying" (7 November 2017), Online: CBC News.

32 Ibid.

33 Carter v Canada, supra.

34 Criminal Code of Canada, supra.

This bill provides that medical professionals "may refuse to provide medical assistance in dying on the basis of his or her personal convictions" and may additionally "refuse to aid in the provision of medical assistance in dying."[35] Professional regulatory bodies are also restricted from requiring members to provide or aid in the provision of MAiD, and must dismiss patient complaints that relate solely to care refusals. Further, no professional may face disciplinary action for their refusal, and an employer cannot take action against an employee for that refusal if based on the refuser's personal convictions.

These provisions mean that belief-based care deniers are not only not required to provide MAiD, but are also given expansive leeway to not even provide a referral to a patient seeking MAiD under section 2(2) of the act. While patients in Manitoba have as much of a legal right to MAiD as patients anywhere else in Canada, Bill 34 has left them in the most vulnerable position when seeking care, as physicians are under no obligation to even provide them with accurate information about the care they are seeking, and patients cannot seek any redress from regulatory bodies. In a conservative province such as Manitoba where many doctors may decide to deny care, Bill 34 risks having a major negative impact on patients seeking MAiD care.

Alberta Bill 207

In 2019, Alberta MLA Dan Williams (Peace River) introduced private member's Bill 207, titled *Conscience Rights (Health Care Providers) Protection Act*. This Bill, similar to Bill 34 in Manitoba, provided that health care providers would be permitted to refuse care if they determined "that their conscience beliefs would be infringed" by providing that service.[36] This additionally included a provision that regulatory bodies could not impose a requirement for a health care provider to "make statements" that would infringe the beliefs of care deniers, meaning they would not have been required to provide information or referrals to patients, or even treat them respectfully. This Bill would have also meant regulatory bodies would have had to dismiss all complaints related to denial of care, and that those who refused to provide care would have been protected from liability for their actions. This means they would have been immune from any legal action, thus leaving no recourse whatsoever to patients who might be harmed by care denials.

[35] Bill 34, *The Medical Assistance in Dying (Protection for Health Professionals and Others) Act*, 2nd Sess, 41st Leg, Manitoba, 2017.

[36] Bill 207, *Conscience Rights (Health Care Providers) Protection Act*, 1st Sess, 30th Leg, Alberta, 2019.

Bill 207 was voted down at committee the same year[37] after drawing criticism from politicians across party lines. The Bill was publicly criticized by physicians, as well as advocates for MAiD, reproductive rights, and LGBTQ+ rights, for hindering Albertans' ability to access safe and legal health services to which they have a right.[38] According to Friends of Medicare, Bill 207 would have "eliminat[ed] the patient's right to effective referral and privilege[ed] religious health professionals above all others by providing them with immunity from any harms that their denial of service will cause patients."[39] Nonetheless, the College of Physicians and Surgeons of Alberta did not oppose the bill and offered minor amendments.[40] While this Bill was not successful in this iteration, it is likely not the end, and it would not be surprising to see a similar or even identical bill be brought forward again in Alberta, another province, or federally, given the strength and persistence of religious and conservative lobby groups.

Federal Policies – Canadian Medical Association

The CMA *Code of Ethics and Professionalism*[41] does not require an effective referral by physicians who refuse to provide care. The Code states that physicians are to "act according to [their] conscience" but must "meet [their] duty of non-abandonment to the patient by always acknowledging and responding to the patient's medical concerns and requests whatever your moral commitments may be."

In its policy on *Medical Assistance in Dying*,[42] the CMA names "respect for freedom of conscience" as one of the "foundational considerations" that underpin the policy. It states that the CMA "believes that physicians must be able to follow their conscience" and "supports physicians who, for reasons of moral commitments to patients and for any other reasons of conscience, will not participate in decisional guidance about, eligibility assessments for, or provision of medical assistance in dying." They further say that "the right of patients to seek medical assistance in dying does not compel individual physicians to provide it," And that physicians who "choose not to provide or otherwise participate in assistance in dying are not required to provide it, to otherwise participate in it, or to refer the patient."

[37] Phil Heidenreich, "Alberta's controversial 'conscience rights' Bill 207 voted down in committee hearing" (22 November 2019), Online: Global News.

[38] Friends of Medicare, "Bill 207 is a political attack on Albertan's access to legal health care services" (7 November 2019), Online: Friends of Medicare.

[39] Friends of Medicare, "Bill 207 puts personal beliefs of health care providers ahead of professional obligations to patients" (16 November 2019), Online: Friends of Medicare.

[40] Lisa Johnson, "Consultation, possible changes after pushback against conscience rights bill" (18 November 2019), Online: Edmonton Journal.

[41] Canadian Medical Association, "CMA Code of Ethics and Professionalism" (8 December 2018).

[42] Canadian Medical Association, "Medical Assistance in Dying" (27 May 2017).

Provincial Policies and Regulations

All provincial Colleges of Physicians and Surgeons adopt outright or adapt the Canadian Medical Association's *Code of Ethics and Professionalism*. In every province, physicians are allowed to refuse to provide treatment based on their conscientious objections, and aside from Ontario and Nova Scotia, physicians are not required to provide an "effective referral", meaning a referral to a provider or agency that can provide the service the patient is requesting. Alberta, New Brunswick, Prince Edward Island, Quebec, Saskatchewan and Yukon require a referral to a physician or resource who can provide information, which is not an effective referral. British Columbia, Manitoba, Newfoundland and Labrador, Northwest Territories, and Nunavut do not require a referral at all.

Alberta

The College of Physicians and Surgeons of Alberta adopts the CMA *Code of Ethics and Professionalism*, but also has an additional *Conscientious Objection*[43] standard and a *Medical Assistance in Dying*[44] standard. Under these two standards, an effective referral to the MAiD coordination agency is required. Notably, there is no effective referral requirement for services other than MAiD, such as abortion. The *Conscientious Objection* standard requires a referral to a physician or resource that will "provide accurate information about all medical options." In particular, the standard provides:

1. A regulated member must communicate promptly and respectfully about any treatments or procedures the regulated member declines to provide based on his/her Charter freedom of conscience and religion.
2. A regulated member must not withhold information about the existence of a procedure or treatment because providing that procedure or giving advice about it conflicts with his/her Charter freedom of conscience and religion.
3. A regulated member must not promote his/her own moral or religious beliefs when interacting with patients.
4. When Charter freedom of conscience and religion prevent a regulated member from providing or offering access to information about a legally available medical or surgical treatment or service, the regulated member must ensure that the patient who seeks such advice or medical care is offered timely access to:
   a) a regulated member who is willing to provide the medical treatment, service or information; or

[43] College of Physicians and Surgeons of Alberta, "Standards of Practice: Conscientious Objection" (1 June 2016).
[44] College of Physicians and Surgeons of Alberta, "Standards of Practice: Medical Assistance in Dying (MAID)" (1 June 2016).

b) a resource that will provide accurate information about all available medical options.

This is not an effective referral requirement, as information by itself is not care. However, the *Medical Assistance in Dying* standard states that refusing physicians "must ensure that reasonable access to the Alberta Health Services medical assistance in dying care coordination service is provided to the patient without delay." This is essentially an effective referral, as all cases of MAiD in the province must go through a MAiD coordination agency that will connect patients to physicians who provide MAiD.

British Columbia

The College of Physicians and Surgeons of British Columbia does not require effective referrals from refusing physicians. The CPSBC has guidance for belief-based care denial within their practice standard on *Access to Medical Care Without Discrimination*[45]. The "conscientious objection to providing care" section reads as follows:

1. Registrants are not obliged to provide treatments or procedures to patients which are medically unnecessary or deemed inappropriate based on scientific evidence and their own clinical expertise.
2. While registrants may make a personal choice not to provide a treatment or procedure based on their values and beliefs, the College expects them to provide patients with enough information and assistance to allow them to make informed choices for themselves. This includes advising patients that other physicians or surgeons may be available to see them or suggesting that the patient visit an alternate health-care provider. Where needed, registrants must offer assistance and must not abandon the patient.
3. Registrants in these situations should not discuss in detail their personal beliefs if not directly relevant and should not pressure patients to disclose or justify their own beliefs.
4. In all cases, registrants must practise within the confines of the legal system, and provide compassionate, non-judgmental care according to the CMA Code of Ethics and Professionalism.

This section indicates that doctors can make a "personal choice" to refuse care and they are merely "expected," not required, to provide information. Again, this not health care. Nothing in this section indicates a requirement for effective referral – that is, a referral to a provider or agency that can provide the service the patient is requesting.

[45] College of Physicians and Surgeons of British Columbia, "Practice Standard: Access to Medical Care Without Discrimination" (7 March 2023).

BC's *Medical Assistance in Dying*[46] practice standard requires an "effective transfer of care" but when describing what that looks like, it is clear that the requirement does not amount to an effective referral:

> Registrants who object to MAiD on the basis of their values and beliefs are required to provide an effective transfer of care for their patients by advising patients that other practitioners may be available to see them, suggesting the patient visit an alternate physician or service, and if authorized by the patient, transferring the medical records as required. Where needed, registrants must offer assistance to the patient and must not abandon the patient.

This indicates that, under this policy, an "effective transfer of care" may only require advising a patient that other practitioners may be available to see them or suggesting a patient visit another physician, but without being obligated to provide an actual referral or other real assistance.

Manitoba

The College of Physicians and Surgeons of Manitoba adopts the CMA *Code of Ethics*, meaning refusers are not required to provide an effective referral.[47] Manitoba's *Medical Assistance in Dying (MAiD) Standard of Practice*[48] does not require a refuser to provide a referral at all:

> 1.2. On the grounds of the conscience-based objection, a physician who receives a request for MAiD may refuse to:
>
> 1.2.1. provide it; or
>
> 1.2.2. personally offer specific information about it; or
>
> 1.2.3. refer the patient to another physician who will provide it
>
> 1.3. A physician who refuses to refer a patient to another physician or to personally offer specific information about MAiD on the grounds of a conscience-based objection must:
>
> 1.3.1. clearly and promptly inform the patient that the physician chooses not to provide MAiD on the grounds of a conscience-based objection; and

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[46] College of Physicians and Surgeons of British Columbia, "Practice Standard: Medical Assistance in Dying" (10 May 2022).

[47] College of Physicians and Surgeons of Manitoba, "Code of Ethics" (June 2019).

[48] College of Physicians and Surgeons of Manitoba, "Standard of Practice: Medical Assistance in Dying (MAiD)" (9 June, 2021).

> 1.3.2. provide the patient with timely access to a resource that will provide accurate information about MAiD, including how a patient can make a request for MAiD or to be assessed for eligibility for MAiD.

This policy is the result of *The Medical Assistance in Dying (Protection for Health Care Professionals and Others) Act,* Bill 34, which, as outlined above, passed in 2017. This law has allowed Manitoba to create the most restrictive and non-patient-centred policy related to belief-based care denial anywhere in Canada.

New Brunswick

The College of Physicians and Surgeons of New Brunswick adopts a slightly modified version of the CMA code. Their *Code of Ethics* indicates that physicians must inform patients of personal values that would influence their recommendations and must provide a referral to another practitioner but only if denial or delay of treatment might cause harm:

> 12. Inform your patient when your personal values would influence the recommendation or practice of any medical procedure that the patient needs or wants. If the denial or delay of treatment has the potential to cause harm, the physician is obligated to expedite access to another physician if possible. In any case, the physician cannot obstruct such access.[49]

The College's policy on *Moral Factors and Medical Care* provides more clarification on a physician's obligations:

1. A physician must communicate clearly and promptly about any treatments or procedures the physician chooses not to provide because of his or her moral or religious beliefs.
2. A physician must not withhold information about the existence of a procedure or treatment because providing that procedure or giving advice about it conflicts with their moral or religious beliefs.
3. A physician must not promote their own moral or religious beliefs when interacting with patients.
4. When moral or religious beliefs prevent a physician from providing or offering access to information about a legally available medical or surgical treatment or service, that physician must ensure that the patient who seeks such advice or medical care is offered

[49] College of Physicians and Surgeons of New Brunswick, "Code of Ethics" (November 2021).

> **timely access to another physician or resource** that will provide accurate information about all available medical options. [Their emphasis]

The wording of this policy does not equate to an effective referral. Physicians must provide timely referral to another physician or resource who will provide information, but again information is not healthcare. It could even potentially include misinformation about abortion that is "accurate" from the perspective of an anti-abortion doctor.

A bulletin from the College in 2015 indicates that they have created a preliminary MAID guideline, but eight years later it is still not publicly available.[50] A CBC article from 2015 indicates that a portion of the guideline states that a physician unwilling to provide MAiD must refer the patient to another doctor.[51] It is not clear if that referral must be to a physician who is willing and able to provide MaiD.

Newfoundland and Labrador

The College of Physicians and Surgeons of Newfoundland and Labrador adopts the CMA *Code of Ethics and Professionalism*, meaning refusing physicians are not required to provide a referral. Their *Standards of Practice for Medical Assistance in Dying*[52] "recommends" that refusers provide patients with a referral to an accessible and available physician willing to provide MaiD:

Section 6.3:

> The College **recommends** that a physician who declines to participate in medical assistance in dying offer the patient timely access to another medical professional (or appropriate information resource, clinic or facility, care provider, health authority, or organization) who is:
>
> a. available to assist the patient;
> b. accessible to the patient; and
> c. willing to provide medical assistance in dying to a patient who meets the eligibility criteria [Emphasis added.].

Northwest Territories

The Northwest Territories Health and Social Services Authority oversees physicians in the territory and there is no physician's college in the territory. The Authority adopts the CMA *Code*

[50] College of Physicians and Surgeons of New Brunswick, "Bulletin December 2015" (December 2015).
[51] Julianne Hazlewood, "College of Physicians releases assisted suicide guidelines" (15 December 2015), Online: CBC News.
[52] Abortion Rights Coalition of Canada, "Canadian Policies and Laws on "Conscientious Objection" in Health Care" (November 2022).

of Ethics and Professionalism, meaning refusing physicians are not required to provide a referral. The Authority has no other publicly available policies or standards of care.

Nova Scotia

In 2022, the College of Physicians and Surgeons of Nova Scotia established a policy entitled the *Obligations for Services for Patients*.[53] The policy states that "physicians have the right to limit the health services they provide for legitimate reasons of conscience, religion, or scope of practice." However, this policy also creates a requirement for effective referral by physicians refusing to provide care. It states that:

> Physicians must:
>
> a. when choosing to limit the health services they provide for reasons of conscience or religion, do so in a manner that respects patient dignity, ensures access to care, and protects patient safety;
> b. communicate their objection directly and with sensitivity to existing patients, or those seeking to become patients, and inform them that the objection is due to personal and not clinical reasons;
> c. in communicating their objections, not express personal moral judgments about the beliefs, lifestyle, identity, or characteristics of existing patients, or those seeking to become patients. This includes not refusing or delaying treatment because the physician believes the patient's own actions have contributed to their condition;
> d. not promote their own religious beliefs when interacting with patients, or those seeking to become patients, nor attempt to convert them;
> e. provide information about all clinical options that may be available or appropriate to meet patients' clinical needs or concerns;
> f. not withhold information about the existence of any procedure or treatment because it conflicts with their conscience or religious beliefs;
> g. **provide the patient with an effective referral**; [Emphasis added]
> h. not impede access to care for existing patients, or those seeking to become patients;
> i. **proactively maintain an effective referral plan** for the frequently requested services they are unwilling to provide; and [Emphasis added]
> j. provide care in an emergency, where it is necessary to prevent imminent harm, even where that care conflicts with their conscience or religious beliefs.

The College's *Professional Standard Regarding Medical Assistance in Dying*[54] also explicitly requires physicians unwilling to provide MAiD to "complete an effective transfer of care for any patient requesting medical assistance in dying."

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[53] College of Physicians and Surgeons of Nova Scotia, "Professional Standards Regarding Obligations for Services for Patients" (27 May 2022).

[54] College of Physicians and Surgeons of Nova Scotia, "Professional Standard Regarding Medical Assistance in Dying" (14 December 2018).

Nunavut

NU Physicians adopts the CMA *Code of Ethics and Professionalism*, meaning refusing physicians are not required to provide a referral. They have no other publicly available policies or standards of care.

Ontario

While the College, in their *Professional Obligations and Human Rights* document, "recognizes that physicians have the right to limit the health services they provide for reasons of conscience or religion," that freedom must be balanced against the right of patients to access care.[55] In cases where a conflict arises between a physician's objections and a patient's interest, the interest of the patient prevails.[56] This policy requires refusing physicians to provide an effective referral in a timely manner to a physician or agency who can provide the service. An effective referral under this policy involves "taking positive action to ensure the patient is connected to a non-objecting, available, and accessible physician, other health-care professional, or agency."

In addition to requiring effective referral, the policy requires physicians to proactively maintain an effective referral plan for services they are unwilling to provide and requires physicians to provide care in an emergency where the service is necessary to prevent imminent harm, even if that care conflicts with their conscience or religious beliefs.

The College's *Medical Assistance in Dying* policy also explicitly requires an effective referral.[57]

Prince Edward Island

The College's *Policy on Conscientious Objection to Provision of Services* requires a referral, but only to someone who can provide "accurate information," not to someone who can provide the service that the patient seeks.[58] The "moral and religious beliefs affecting medical care" section of the policy states:

1. A physician must communicate clearly and promptly about any treatments or procedures the physician chooses not to provide because of his or her moral or religious beliefs.

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[55] College of Physicians and Surgeons of Ontario, "Professional Obligations and Human Rights" (March 2015).

[56] Ibid.

[57] College of Physicians and Surgeons of Ontario, "Medical Assistance in Dying" (April 2021).

[58] College of Physicians and Surgeons of Prince Edward Island, "Policy on Conscientious Objection to Provision of Service (4 November 2019).

2. A physician must not withhold information about the existence of a procedure or treatment because providing that procedure or giving advice about it conflicts with their moral or religious beliefs.

3. A physician must not promote their own moral or religious beliefs when interacting with patients.

4. When moral or religious beliefs prevent a physician from providing or offering access to information about a legally available medical or surgical treatment or service, that physician should ensure that the patient who seeks such advice or medical care is offered timely access to another physician or resource that will provide accurate information about all available medical options.

> While physicians may make a personal choice not to provide a treatment or procedure based on their values and beliefs, the College expects them to provide patients with enough information and assistance to allow them to make informed choices for themselves. This includes advising patients that other physicians may be available to see them, or suggesting that the patient visit an alternate health-care provider. Where needed, physicians must offer assistance and must not abandon the patient.

It is noteworthy that the failure to advise a patient that the physician's personal beliefs prevent them from providing treatment, is considered professional misconduct under the College regulations,[59] While the failure to provide a patient with health care due to the physician's personal beliefs is *not* considered professional misconduct.

The College's *Policy on Medical Assistance in Dying*[60] does not require an effective referral. In fact, refusing doctors need only inform their patients of their objections by posting a notice at their office. If a request is received by that physician for MAiD, the physician must not act as a barrier, but is not even required to provide information to their patients – the policy allows for the provision of information to be delegated to another person or agency.

Quebec

The Collège des médicins du Québec implies a requirement for effective referral within its *Code of Ethics of Physicians*, though it is not explicitly stated in the policy:

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[59] College of Physicians and Surgeons of Prince Edward Island, "Regulations" (1 May 2014).

[60] College of Physicians and Surgeons of Prince Edward Island, "Policy on Medical Assistance in Dying" (4 November 2019).

> 24. The physician should inform the patient of personal beliefs that may prevent the physician from recommending or providing professional services that may be appropriate, and advise the patient of the possible consequences of not receiving such professional services. The physician must then offer to assist the patient in finding another physician.[61]

The wording of this policy is not explicit enough to amount to a requirement for an effective referral.

Quebec's medical aid in dying policy is not publicly available.[62] Quebec has codified MAiD in law with the *Act Respecting End-of-Life-Care*.[63] Section 31 of this act requires that any physician who refuses a request for MAiD must notify a superior within their institution. That superior must, as soon as possible, find another non-objecting physician. Section 50 explicitly states that:

> 50. A physician may refuse to administer medical aid in dying because of personal convictions, and a health professional may refuse to take part in administering it for the same reason. In such a case, the physician or health professional must nevertheless ensure that continuity of care is provided to the patient, in accordance with their code of ethics and the patient's wishes.

Under this legislation, patients will receive a referral if their physician refuses, but that referral does not have to come directly from the physician themselves, instead allowing for a delay in treatment by not requiring a direct effective referral by the refusing physician themselves.

Saskatchewan

The College of Physicians and Surgeons of Saskatchewan does not require an effective referral by refusing physicians. The College's *Conscientious Objection* policy[64] allows physicians to refuse to provide a service but requires that they "make an arrangement" for the patient to obtain the information required to make an informed choice and "that will allow the patient to obtain access to the health service if the patient chooses." The policy states that "Those obligations will generally be met by arranging for the patient to meet with another physician or other health care provider who is available and accessible and who can either provide the

[61] Quebec, Code de déontologie des Médecins, chaiptre M-9 r 17 (1 October 2022).
[62] Collège des Médecins de Québec, "Medical aid in dying: Practice guide and pharmacological guidelines" (29 November 2019).
[63] Quebec, Act respecting end-of-life-care (1 January 2023).
[64] Abortion Rights Coalition of Canada, "Canadian Policies and Laws on "Conscientious Objection" in Health Care" (November 2022).

health service or refer that patient to another physician or health care provider who can provide the health service."

This allows a refusing physician to refer a patient to another physician for information who will then have to refer them to another physician for care, leading to delays in receiving care; this does not amount to an effective referral.

The College's *Unplanned Pregnancy* guideline[65] takes a stronger stance. It indicates that physicians who refuse to provide abortion should follow the *Conscientious Objection* policy, but goes further to say:

In accepting responsibility for medically evaluating and counseling a patient in circumstances in which termination of the pregnancy might be contemplated, the responsible physician:

> 5) Will fully apprise the patient of the options she may pursue and provide her with accurate information relating to community agencies and services that may be of assistance to her in pursuing each option.
>
> > c) With reference to the option of termination of the pregnancy, the physician should apprise the patient of the availability of abortion services in the province, or elsewhere, in accordance with any current law or regulation governing such services and should ensure that the patient has the information needed to access such services or make the necessary referral. The patient should be provided the information regarding the nature of termination options, to the best of the physician's ability.

However, this still does not amount to an effective referral, as it does not involve a direct referral to a provider willing and able to provide the service.

The College's *Medical Assistance in Dying* policy[66] requires a physician to "arrange timely access to another physician or resources" or offer the patient "information and advice about all the medical options available." This also does not amount to an effective referral, as it does not involve a direct referral to a provider willing and able to provide the service.

[65] College of Physicians and Surgeons of Saskatchewan, "Guideline: Unplanned Pregnancy" (January 2017).
[66] College of Physicians and Surgeons of Saskatchewan, "Policy: Medical Assistance in Dying" (November, 2018).

Yukon

The Yukon Medical Council adopts the CMA *Code of Ethics and Professionalism*, but also has two additional relevant standards of practice: the *Moral or Religious Beliefs Affecting Medical Care* standard[67] as well as a standard of practice for *Medical Assistance in Dying (MAID)*[68].

The *Moral or Religious Beliefs Affecting Medical Care* standard requires refusing physicians to ensure that patients are offered timely access to another physician or resources that will provide accurate information about all available medical options:

1. A physician must communicate clearly and promptly about any treatments or procedures the physician chooses not to provide because of his or her moral or religious beliefs.
2. A physician must not withhold information about the existence of a procedure or treatment because providing that procedure or giving advice about it conflicts with their moral or religious beliefs.
3. A physician must not promote their own moral or religious beliefs when interacting with patients.
4. When moral or religious beliefs prevent a physician from providing or offering access to information about a legally available medical or surgical treatment or service, that physician must ensure that the patient who seeks such advice or medical care is offered timely access to another physician or resource that will provide accurate information about all available medical options.

This policy is written in such a way that it does not necessarily require a referral to a physician who will provide MAiD, but rather a "physician or resources that will provide accurate **information** about all available medical options." [Emphasis added]

The *Medical Assistance in Dying (MAID)* standard is similar:

> There is nothing in the Criminal Code that compels a physician to prescribe or administer MAID. Physicians who have a conscientious objection to medical assistance in dying are not obligated to proceed further through the process map and evaluate a patient's inquiry for medical assistance in dying. Objecting physicians must provide the patient with timely access to another non-objecting physician or resource with accurate information about all available medical options.

[67] Yukon Medical Council, "Moral or Religious Beliefs Affecting Medical Care."
[68] Yukon Medical Council, "Standard of Practice: Medical Assistance in Dying (MAID)."

Again, the policy requires the referral to be to a "physician or resource with accurate information about all available medical options." This is not a requirement for effective referral.

Canadian Case Law

Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario

The Ontario College of Physicians and Surgeons adopted an effective referral policy in 2015, requiring that physicians who object to providing certain medical procedures or pharmaceuticals on a religious or moral basis must provide an effective referral to patients whom they refused to treat.[69] An effective referral in this case was defined as a "referral made in good faith to a non- objecting, available, and accessible physician, other health-care professional, or agency." In response to the adoption of this policy, the Christian Medical and Dental Society challenged the constitutionality of requiring effective referrals. They were unsuccessful in their original case at the Ontario Superior Court and appealed to the Ontario Court of Appeal.

The Christian Medical and Dental Society ("CMDS"), alongside the Canadian Federation of Catholic Physicians' Societies, Canadian Physicians for Life, and five individual physicians, alleged that the policy violated physicians' rights under the *Charter*. They contended that these violations were on two grounds. First, they argued that the policy was a violation of their individual right to freedom of conscience and religion under s. 2(a) by requiring them "to be complicit in procedures that offend their religious beliefs." Second, they argued that the requirements discriminated against them based on their religious beliefs, contrary to s. 15(1).

The Court found that while the policy did interfere with the applicants' freedom of religion, in a manner that was neither trivial nor unsubstantial, that infringement was justified under s. 1 of the Charter. This section guarantees the rights and freedoms set out in the Charter, but states that those rights and freedoms can be "subject to reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society."

The Court held that the College's policy's effective referral requirement is a limit prescribed by law. The policy allows physicians the right to limit the health care services they choose to provide due to reasons of conscience, while requiring physicians to uphold their fiduciary duty to their patients, which obligates them to always act in the best interest of their patients. The

[69] *The Christian Medical and Dental Society of Canada et al v College of Physicians and Surgeons of Ontario*, 2019 ONCA 393.

Court determined that this policy represented a compromise, striking "a reasonable balance between patients' interests and physicians' Charter-protected religious freedom."

The Court also held that the effective referral policy did not violate s. 15(1) of the Charter, because the policy's requirements do "not have the effect of reinforcing, perpetuating or exacerbating a disadvantage experienced by, or promoting prejudice against, religious physicians; nor do they restrict access to a fundamental social institution or impede full membership in Canadian society." The Court was clear that the policy did not amount to discrimination, but rather represented an "attempt to balance equitable access to health care with physicians' religious beliefs."

In conclusion, the Court dismissed the appeal, ruling the effective referral policy was not discriminatory towards objecting physicians, and that while the policy interfered with an individual objecting physician's freedom of religion, that infringement was justified. This judgement was not appealed to the Supreme Court of Canada so is currently only a binding ruling in Ontario.

Other Case Law

There have not been any other lawsuits related to College policies at this time. Part of this may be related to the lack of monitoring and enforcement of these policies, which will be discussed in more detail below. There are some labour and employment cases related to conscientious objection, but none were found that were relevant to belief-based denial of care.

Barriers to Recourse

Unfortunately, the average patient faces many barriers to recourse when faced with belief-based denial of care. There is a lack of information about the options a patient who experiences denial of medical services has available to them. In order to seek recourse against a refusing physician, a patient must have a significant amount of social capital, education, and resources.

As part of this research, the Abortion Rights Coalition of Canada attempted to obtain information on the number of complaints filed with the College of Physicians and Surgeons of Ontario (CPSO) about belief-based denial of care and the outcome of those complaints. We chose this College as they have the longest standing effective referral policy. The College declined our request, indicating that they do not provide data for research purposes and the data was outside of the scope of the standard data that they do provide. This makes it impossible to know the scope of complaints the College receives or the degree of harms caused by belief-based care denials.

Also concerning is the lack of a specific penalty for breaching the requirement for an effective referral.[70] In fact, in order to weaken the case of the applicants, the CPSO argued in Ontario Divisional Court that "the Policies are not binding or coercive documents" as they lack a penalty for non-compliance.[71] But without monitoring and enforcement, an effective referral policy is not sufficient despite looking strong on paper.

International Standards

It is notable that no international agreement or standard recognizes a broad right to deny healthcare based on personal beliefs. Instead, all express concerns about the impact of the practice and call for regulation and restriction of its use to ensure that patients have access to healthcare.

United Nations

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) is an international Bill of Rights adopted by the United Nations General Assembly. While it does not mention conscientious objection specifically, it does state that "It is discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women."[72] CEDAW further states that "if health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers."[73]

The International Covenant of Civil and Political Rights (ICCPR), adopted by the United Nations in 1966, is a treaty outlining many rights, including the right to life. The UN Human Rights Committee General Comment No. 36 focuses on Article 6 of the ICCPR (Right to Life).[74] This Article indicates that while States may adopt measures designed to regulate abortion, those measures cannot violate the rights of the pregnant person. Additionally, the Article provides that States should work to remove existing barriers to effective access to safe and legal abortion, "including barriers caused as a result of the exercise of conscientious objection by individual medical professionals."[75]

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

[71] Ibid at para 109.

[72] *General Recommendation No. 24: Article 12 of the Convention (Women and Health)*, UN Committee on the Elimination of Discrimination Against Women (1999)

[73] Ibid

[74] *General Comment No 36 (2019) International Covenant on Civil and Political Rights,* Human Rights Committee (3 September 2019).

[75] Ibid.

The International Covenant of Economic, Social and Cultural Rights (ICESCR) is another multilateral treaty adopted by the United Nations. The covenant itself says nothing about conscientious objection but does include the Right to Health (Article 12).[76] This right has been further interpreted as the Right to Sexual and Reproductive Health by the Committee on Economic, Social and Cultural Rights.[77] The committee, in their General Comment Number 22 on the Right to sexual and reproductive health, clearly states that "unavailability of goods and services due to ideologically based policies or practices, such as the refusal to provide services based on conscience, must not be a barrier to accessing services."[78] It is additionally indicated in that comment that where belief-based care denial is permitted, it must be appropriately regulated to "ensure that it does not inhibit anyone's access to sexual and reproductive health care, including by requiring referrals to an accessible provider capable and willing to provide the services being sought, and the performance of services in urgent or emergency situations."[79] The comment further indicates that states must also "prohibit and prevent private actors from imposing practical or procedural barriers to health services" including things like the dissemination of misinformation, fees, and third-party authorization requirements.[80]

In addition, a number of other conventions and committees comment on conscientious objection and the right to sexual and reproductive health services. For example, the Special Rapporteur on the Right to Health explicitly stated that conscientious objection creates barriers to access and that if a State allows the practice, referrals and alternative services must be available in cases where a medical professional refuses to provide the care requested by the patient.[81]

World Health Organization

The World Health Organization (WHO) has stated that the "refusal of abortion on the basis of conscience has been shown to impose significant burdens on [abortion seekers]."[82] The WHO, in their Law and Policy Recommendation 22: Conscientious Objection, was clear that "as a matter of human rights law, States that allow conscientious objection must organize their health system and abortion provision in a way that ensures that conscientious objection does not result in the refusal of legally available abortion care."

[76] *International Covenant on Economic, Social and Cultural Rights,* GA Res 2200A (XXI) (16 December 1966).
[77] *General Comment No 22 (2016) on the Right to sexual and reproductive health*, Committee on Economic, Social and Cultural Rights (2016).
[78] Ibid.
[79] Ibid.
[80] Ibid.
[81] *Right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, Special Rapporteur of the Human Rights Council, United Nations.
[82] *Law and Policy Recommendation 22: Conscientious Objection*, World Health Organization.

The WHO, in Recommendation 22, also makes clear that States must "regulate the exercise of conscientious objection in a way that reflects best international clinic practice, protects abortion seekers, and ensures that provider refusal does not undermine or hinder access to quality abortion care." In their technical policy statement on abortion, the WHO recommends that "health services be organized in such a way as to ensure that an effective exercise of the freedom of conscience of health professionals in the professional context does not prevent patients from obtaining access to services to which they are entitled under the applicable legislation."[83]

International Medical Advisory Panel

The International Medical Advisory Panel (IMAP) is a panel of leading experts in the field of sexual and reproductive health who provide medical and technical advice to the International Planned Parenthood Federation.[84] IMAP has affirmed a patient's right to an effective referral. In their Statement on Conscientious Objection, the Panel has stated that "a provider who asserts conscientious objection has an obligation to immediately refer the patient to another health care worker who can provide the requested medical service."[85] The Panel does not deny the right for physicians to refuse to provide that requested service, but say that "it is not an absolute right in that it may not be an obstacle for access to health services for others."

The International Federation of Gynecology and Obstetrics

The International Federation of Gynecology and Obstetrics (FIGO) statement on conscientious objection states that "whenever the exercise of conscientious objection results in delays, increased burdens for women and girls, or no access at all, it should no longer be accepted as conscientious objection but defined as an unjustified denial of health services."[86] FIGO is clear that if a physician refuses to provide care, they must provide effective referrals. Providers' primary duty is to treat their patients, and any objection must be secondary to that primary duty and "therefore, essential services cannot be denied."

FIGO recommends that conscientious objection should be regulated in a manner that prevents healthcare institutions from attempting to invoke conscientious objection. According to FIGO's statement on conscientious objection, healthcare institutions must not be allowed to "invoke

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[83] *Safe Abortion: Technical and Policy Guidance for Health Systems*, World Health Organization.

[84] International Planned Parenthood Federation, "International Medical Advisory Panel" (15 June 2016).

[85] International Planned Parenthood Federation "IMAP Statement on conscientious objection." (24 January 2017).

[86] International Federation of Gynecology and Obstetrics, "Conscientious Objection: a barrier to care" (19 October 2021).

conscientious objection to systemically object to the provision of abortion care."[87] So, while a physician can attempt to invoke "conscientious objection" in order to refuse to provide abortion care, an institution, such as a faith-based hospital, cannot refuse abortion broadly on the basis of "conscientious objection."

Conclusion

Even today, physicians in most provinces in Canada are not required to so much as provide an effective referral to patients who they refuse to provide care to, on the basis of their personal beliefs. In the two provinces where the Colleges of Physicians and Surgeons require an effective referral, there remains a lack of monitoring and enforcement and patients still face barriers to recourse against those physicians who refuse to follow College policies. For the purposes of this paper, ARCC was unable to locate any cases of physicians facing professional consequences for refusal to provide care despite a "requirement" for effective referral from their governing College.[88]

Belief-based denial of care comes up most often in relation to MAiD and reproductive healthcare, such as abortion and contraceptive access. Unlike abortion, MAiD is now regulated under the federal *Criminal Code* by a law passed in 2016, while abortion has remained decriminalized since 1988. The legislation for MAiD likely led medical groups and advisory groups to develop detailed guidelines around it,[89] since similar detailed guidelines were never developed for abortion care. However, those who advocate for "conscientious objection" are unsatisfied with the MAiD law and guidelines because they disagree with the requirement to provide a referral, as shown by the lawsuit against CPSO, Bill 34 enacted in Manitoba 2017, and the recent Alberta and federal private member bills that sought to guarantee the ability to deny MAiD care and referrals while protecting doctors from any consequences of their refusals.

The opposition to MAiD care and abortion care is such that we can expect further attempts to protect care deniers, beyond the protections that any law or guideline currently gives them. While the Ontario Court of Appeal agreed that an effective referral requirement was a way to "balance" patients' right to access healthcare and doctors' right to conscience, this compromise largely benefits physicians since, as a practical matter, it appears they bear no penalty or burden for disregarding it, while the burden falls largely on patients.

[87] Ibid.

[88] This does not necessarily mean that these cases do not exist, but none were found during research for this paper.

[89] Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying, "Final Report" (30 November 2015).

Canada still has a long way to go in protecting patients' rights and ensuring that patients have the right to access the care they are legally entitled to. This will require every College to enact effective referral policies at the very least. Further, those policies need to be monitored and compliance must be effectively enforced. Without effective enforcement, a requirement for an effective referral is meaningless. The rights of patients to receive the care they require must take priority over the rights of refusing physicians.

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