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Institute of Comparative Law
Faculty of Graduate Studies and Research
McGill University

# WHEN PROFESSIONAL RIGHTS CONFLICT WITH HUMAN RIGHTS:

## LEGAL AND ETHICAL ISSUES.

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirement for the degree of

MASTERS OF LAW

by Mona Sidarous

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Mona Sidarous

**WHEN PROFESSIONAL RIGHTS CONFLICT WITH HUMAN RIGHTS: LEGAL AND ETHICAL ISSUES**

Institute of Comparative Law
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Masters of Law, Specialty in Bioethics

## THESIS ABSTRACT

My aim is to demonstrate that professionals perceive they have a right to refuse to provide their services and are currently acting accordingly. This thesis explores whether a professional right to refuse services exists; if so, the limits of this right; and whether a professional 'right' to refuse services ought to exist and in what circumstances. This requires analysis of whether refusals to provide professional services might be considered unethical conduct according to existing codes of ethics and moral theories, unprofessional conduct within the norms of professional regulatory and disciplinary bodies, or illegal conduct according to Canadian law, in particular, human rights law. The issues are examined primarily with reference to physicians who treat patients and some comparisons are made with physician clinical researchers and lawyers. The shift from a duty-based system of professional service to a rights-based system of professional privileges has led to conflicting goals of professional self-regulation, and some possible resolutions to this conflict are explored.

Mona Sidarous
**Les problèmes légaux et éthiques lorsque les droits des professionnels entrent en conflit avec les droits des personnes.**
Institute of Comparative Law
McGill University
Masters of Law

## RESUMÉ DES THèSIS

Mon objectif est de démontrer que les professionnels perçoivent qu'ils ont le droit de refuser leurs services et qu'ils agissent en conséquence à l'heure actuelle. Cette thèse explore la possibilité que le droit d'un professionnel de refuser ses services puisse exister; si oui, quelles sont les limites de ce droit; et, est-ce-que le 'droit' d'un professionnel de refuser ses services devrait exister et dans quelle(s) circonstance(s). Ceci exige que l'on analyse si le refus de donner un service professionnel peut être considéré un comportement non-éthique selon les codes d'étiques existants et les théories morales, un comportement non-professionnel à l'intérieur des normes des organismes qui règlementent et disciplenent les professionnels, ou un comportement illegal selon les lois du canada, en particulier, la charte des droits des personnes. Ces questions sont examinées en référence première avec les médecins qui soigvent les patients et certaines comparaisons sont faites avec les médecins avec les médecins en recherche clinique et les avocats. Le passage d'un système basé sur le devrai à un système basé sur les droits des privilèges des professionnels a amené des objectifs conflictuels à l'intérieur de l'auto-règlementation professionnelle, et nous explorons certains solutions à ces conflits.

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CONTENTS

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# INTRODUCTION

> "It would not be correct to say that every moral obligation involves a legal duty; but every legal duty is founded on a moral obligation."[1]

The line between law and morality is often difficult to discern. Society demands and enforces the requirement that ordinary citizens act lawfully while there is no such enforceable requirement that they also act ethically[2]. However, the situation changes somewhat when the ordinary citizen is also a professional. Professionals have been highly respected, well-remunerated members of society who enjoy self-government and self-regulation[3] of their

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[1] R. v. Instan, [1893] 1 Q.B. 450 at 453.

[2] Some writers use the terms 'moral' and 'ethical' interchangeably, while others believe they should be distinguished, although there is no consensus in the literature on the way such a distinction should be drawn. In this paper, however, the term 'ethical' will be utilized and the terms are distinguished in the following manner: the term 'moral' will refer to norms and values that reflect rightness and what ought to be; the term 'ethical' will refer to the concepts of rightness or equity in the context of an action or practice.

[3] In this paper, self-government of a profession refers to the power of the profession to control the internal organization, the finances, the operation and membership of the profession. Self-regulation refers to the power of the profession to define its own educational standards and its own

profession, a state-delegated power to regulate qualifications, registration of licensing, and disciplinary measures. Since professionals have been endowed with many privileges and hold positions of trust in the provision of their services, they are required to act not only lawfully but also ethically[4].

In order to retain the power to self-govern, professionals must demonstrate to society that they are worthy of such a privilege and that the profession itself is in the best position to establish the boundaries of what constitutes ethical conduct. Traditionally this has been accomplished by codes of ethics being enacted by the professions themselves. We, as a society, should continually examine these boundaries and engage in debate with the professions where a divergence exists between our notions of ethical conduct and theirs. Given that professions have exclusive authority to demarcate what constitutes ethical conduct, it is easy to see how conflicts between public and professional objectives will

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standards of ethical conduct.

[4] While there is an emerging convention that discussions of ethics and law take place with reference to the ethical considerations first followed by the legal considerations, in this paper the legal considerations will be raised first and then the ethical considerations will be addressed. This order has been selected for this paper since consideration of professional freedom requires discussion first of the laws which have delegated self-governing and self-regulatory powers to the professions, and then a discussion of the professions' regulation of their members primarily through codes of ethics.

arise.

One issue which embodies just such a conflict arises when the right of professionals to refuse to provide services denies particular individuals or particular groups access to professional services they require, and leads to discriminatory practices. It is this issue which will be analyzed in this thesis as it involves a complex legal and ethical debate about the autonomy of professionals and the future of autonomy for professionals. When considering the provision of professional services, we must also be cognizant that some duties may rest with individual professionals, others with the profession itself or at the institutional level, and still others may rest at the governmental level. In this thesis, however, only an in-depth analysis of the duties and rights of individual professionals with respect to the provision of services will be undertaken.

In an attempt to be precise and avoid generalities, the issue will be discussed primarily in relation to the duties of physicians to treat patients and the rights of physicians to refuse to treat patients. In order to seek insights on this main theme, some comparisons will be made to the duties and rights of physicians who engage in clinical research to refuse to include patients in clinical trials, and the duties and rights of lawyers to refuse to provide advice and representation to persons. Any similarities or differences which exist between the legal or ethical obligations of these three professional groups will be highlighted and possible explanations for these findings will be offered.

The issue of whether a professional has a right to refuse to provide his or her services will then be explored by addressing the following questions in chapters two, three and four respectively;

1. Do individual professionals have a legal or an ethical duty to provide services and if so, under what circumstances? Correlatively, do they have a right to refuse to provide services and if so, under what circumstances (having regard to the current regulation of professionals through law and codes of ethical conduct)? Analysis of these issues will offer insight into what is presently deemed to be unprofessional conduct with respect to the provision of professional services.

2. What are the practical effects of a professional's refusal to provide services and the restrictions therein, on the individual seeking the services, on the professional, and on society at large? Analysis of this issue will offer insight into what might be unethical conduct.

3. Could refusals by professionals to provide services,

or restrictions on the right to provide services, be the subject of legal challenges on the basis of a violation of human rights? Analysis of this issue will offer insight into what might be illegal conduct.

It should be noted that while chapters two, three and four are designed to examine primarily issues of unprofessional conduct, unethical conduct and illegal conduct respectively, the nature of the inquiries undertaken herein will inextricably link these issues and they will undoubtedly be raised in all of the chapters.

The way we choose to resolve the conflicts between professionals' rights to refuse to provide services and the human rights not to be discriminated against in the provision of services, will have substantial implications on many crucial policy considerations. Policy considerations will include: whether a right to professional services can be established; if there is such a right to services who has the ultimate duty to provide these; will this right be a legal right (as opposed to a moral right) and if so, what legal doctrines can defend this right; and finally, whether self-regulation of professions is still viable in today's society or whether it should be replaced by third-party regulation.

Before undertaking an in-depth analysis of the issue in relation to the three chosen professions and in order to use such an analysis to formulate future approaches, it is important to trace briefly the history of professional organizations and assumption of their self-governing powers, the rationale for state-delegated power of self-regulation and how self-government fits into the structure of the Canadian legal system.

# CHAPTER ONE - THE EMERGENCE OF PROFESSIONS AND THEIR PLACE TODAY

When discussing issues that involve professionals, it is first necessary to define what constitutes a profession. By identifying the defining characteristics of a profession, it will be shown how these characteristics have led to the grant of self-governing and self-regulating powers to professional groups. An analysis of these powers which professionals presently enjoy can then be undertaken, since it will be shown in the following chapter that the boundaries of professional duties to provide services and their rights to refuse to provide services have largely been defined by the professions themselves.

## *1. WHAT IS A PROFESSION?*

There is little definitive authority or agreement on a single definition of a profession, but many characteristics have repeatedly been identified in the body of literature on this point. Consider the following passages, written by lawyers and predominantly referring to but not limited to the legal profession, which demonstrate the characteristics that have been attributed in the past to professions.

In 1867, A.V. Dicey took the position that a profession is distinguishable from a trade or business in the following way:

> [I]n the case of a profession its members sacrifice a certain amount of individual liberty in order to ensure certain professional objects. In a trade or business the conduct of each individual is avowedly regulated simply by the general rules of honesty and regard to his own interest.[1]

Other writers such as Roscoe Pound identify three essential elements of a profession, namely organization, learning (that is, the pursuit of a learned art), and a spirit of public service. He goes on to say that financial incentives, while of primary purpose in trade and business are merely incidental in a profession.[2]

Still other academics include autonomy as a defining characteristic of professions. Consider the following view of Eliot Friedson:

> When a number of people perform the same activity and develop common methods, which are passed on to new recruits and come to be conventional, we may say that workers have been organized into an occupational group, or an occupation. In the most general classification, a profession is an occupation.
> However, a profession is usually taken to

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[1] FR, II (New Series), p.689 in W.J. Reader, <u>Professional Men: The Rise of the Professional Classes in Nineteenth-Century England</u> (New York: Basic Books Inc., 1966) at 159.

[2] <u>The Lawyer From Antiquity to Modern Times</u> (1953) in G.C. Hazard, Jr. and D.L. Rhode, eds., <u>The Legal Profession: Responsibility and Regulation</u> (New York: The Foundation Press Inc., 1985) at 89.

> be a special kind of occupation... [T]he most strategic distinction lies in legitimate, organized autonomy - that a profession is distinct from other occupations in that it has been given the right to control its work...Unlike other occupations, professions are _deliberately_ granted autonomy... And while no occupation can prevent employers, customers, clients, and other workers from evaluating its work, only the profession has the recognized right to declare such "outside" evaluation illegitimate and intolerable.[3]

This characteristic of the autonomy of a profession is by far the most contentious. While it has been formally established in many present-day statutes which deem certain professions to be self-governing, the state extended such powers as a privilege. This position is in sharp contrast to those individuals (largely members of various professional groups) who believe that self-government is an essential feature of being a professional, indeed so essential that it approaches a right to self-govern. It is submitted that while self-government obviously serves the best interests of professionals, it may also serve the interests of the public but it is not always so.

It is imperative that we achieve some consensus on how a profession is defined as more and more occupations are seeking and being granted this status. We have moved from the

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[3] _Profession of Medicine_ (1973) in J. Areen _et.al._, _Law, Science and Medicine_ (New York: The Foundation Press, Inc., 1984) at 259.

cautious attitude of the British Parliament in the early 1800's which granted primarily to doctors and lawyers charters and privileges of professional functions restricted by law to their own members[4], to the more liberal attitude of modern-day governments in granting professional status, such as the Province of Quebec which has recognized forty professional occupations as of 1989[5]. When we designate professional status today are we simply recognizing, as Dicey and Pound have, the members' sacrifice of individual liberty and a spirit of public service, or are we also deliberately granting a right of self-government as Friedson suggests? It is doubtful whether professionals and members of the public would respond alike to this question, but it is hoped that policy makers hold a consistent view and are able to communicate this clearly to both the professions and the public alike.

It will now be demonstrated how the organization, education and nature of public service of professionals has led to the professional autonomy which is enjoyed today.

## 2. *THE HISTORY OF PROFESSIONALIZATION*

### *(A) Organization*

One way to trace the transformation of an

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[4] Reader, **supra**, note 1 at 164.

[5] *Professional Code*, R.S.Q., c. c-26, Schedule I.

organization into a professional body is to follow the development of its professional associations from a purely unofficial body into a formal body corporate. One of the earliest transformations in professional organizations took place in England with the establishment of the Royal College of Physicians, chartered by King Henry VIII in 1518 following the enactment of the Barbers and Surgeons Guild in 1512, which gave rights to train and examine applicants and required high moral and inter-professional obligations[6]. While the medical profession in England began to organize formally during this period, it consisted largely of loose associations of doctors with little power until they evolved by the nineteenth century into professional organizations with stature, organizational structure and power. In Britain in 1832, the Provincial Medical and Surgical Association was founded (the name being changed to the British Medical Association in 1856)[7].

A similar evolution took place in professional associations in America. In eighteenth century America, professional practice other than the clergy was a part-time vocation and all the professions (including the clergy) were

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[6] See M.A. Somerville, "Experimentation on the Person: A Comparative Survey of Legal and Extra-Legal Controls", Vol. I (Doctor of Civil Law Thesis, McGill University, 1978) [unpublished] at p.174 who, in endnote 19, gives references of works which document the history of this institution.

[7] N. Parry and J. Parry, The Rise of the Medical Profession (London: Croom Helm Ltd., 1976) at 125-129.

prevented from forming a united hierarchy due to geographic isolation and sporadic economic development.[8] For example, lawyers in urban communities enjoyed greater power and prestige than their counterparts in more remote frontier areas[9], preventing unity among the members of the bar. During this period, professional organizations in the medical and legal communities existed only in the more populous places, and even then were at most loose associations formed largely for social and library purposes.[10] By the nineteenth century, however, these loose associations had evolved into formal professional organizations with the formation of the American Medical Association in 1847[11] and the formation of the American Bar Association in 1878[12].

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[8] M. Larson, The Rise of Professionalism: A Sociological Analysis (1977) in G.C. Hazard, Jr. and D.L. Rhode, The Legal Profession: Responsibility and Regulation (New York: The Foundation Press Inc., 1985) at 20.

[9] Ibid.

[10] For a discussion of the early medical organizations, see D.H. Calhoun, Professional Lives in America (Cambridge: Harvard University Press, 1965) at ch.2; for a discussion of the early legal organizations, see J.W. Hurst, The Growth of American Law (1950) in G.C. Hazard, Jr. and D.L. Rhode, eds., The Legal Profession: Responsibility and Regulation (New York: The Foundation Press Inc., 1985) at 73-76.

[11] "Principles of Medical Ethics and Current Opinions of the Council on Ethical and Judicial Affairs-1989" in R.A. Gorlin, ed., Codes of Professional Responsibility, 2nd ed. (Washington: BNA Books, 1990) 190.

[12] J.W. Hurst, The Growth of American Law (1950) in G.C. Hazard, Jr. and D.L. Rhode, eds., The Legal Profession: Responsibility and Regulation (New York: The Foundation Press, Inc., 1985) at 75.

In Canada, the formation of professional associations also evolved under similar circumstances, although slightly later than in the United States. The Canadian Medical Association was founded in Quebec City in 1867, the same year as Confederation[13]. The Canadian Bar Association first met in 1915 and passed its first code of ethics in 1920, and subsequently became incorporated in 1921[14].

Many factors contributed to the organization of professions and the rise of professional autonomy in Western society and of primary importance were developments in the economy, educational institutions and social conditions. Professions began to evolve into organized bodies for their governance with the onset of the industrial revolution. It has been proposed that this gave rise to: (1) expanding free markets for which they could supply their 'commodities'; (2) a need for the producers of these commodities to be produced, which meant that the professionals must be adequately trained and socialized to trade on the professional market; and (3) a standardization of professional services being marketed through education and

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[13] Canadian Medical Association: What it is and What it Does (Ottawa: Canadian Medical Association, 1993) at 2.

[14] Act of Incorporation (11-12 George V. Chap. 79) By-Law and Regulations of the Canadian Bar Association, Originally passed by Council 1957, am. 1992 (Ottawa).

continued regulation of the professions.[15]

Some writers argue that the origins of professional organization can best be analyzed by employing economic theories. Magali Larson proposes that the professional market differs somewhat from traditional markets in that the power does not lie with the consumers but with the producers. Larson states:

> The atypical "community of profession" did not extend its nomic functions beyond the boundaries of its own market position: the solidarity of the professional producers was seldom, if ever, mobilized to advocate or help the organization of their own consumers. Thus, on the consumer side, the ideal professional market closely approximates the atomistic liberal model, while on the producers' side, with all due qualifications, it presents an analogy with the rise of corporate capitalism against the consequences of anarchic competition. ...[A]lthough the professional community, based on solidarity and on a shared set of cognitive and normative rules, may be seen as part of the reaction against the market, its aims were formulated within a market orientation...[16]

Other writers, such as Emile Durkheim, wrote from a sociological perspective which stressed the importance of the division of labour in the organization of professions. Durkheim saw the increased division of labour as potentially dangerous to the social order and saw professions as moral communities which produced ethics and rules, a "desirable

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[15] Larson, **supra**, note 8 at 22-23.

[16] Ibid. at 25-26.

alternative to the excesses of laissez-faire individualism" in capitalist industrial societies.[17]

Furthermore, no discussion of market influences with respect to the establishment of professional organizations would be complete without briefly mentioning the role that internal competition played. When North American communities were more geographically separate, it was common for one professional to enjoy a monopoly over a single community. However, as greater numbers of individuals began to hold themselves out as professionals and smaller settlements were transformed into more densely populated regions, competition between professionals became a reality. In order to reduce competition, they sought to strengthen associations among themselves[18] and moved to restrict membership to the associations and thus the professions. In this way, marketplace competition of professional services played a major role in the transformation from voluntary professional associations to mandatory membership in professional organizations.[19]

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[17] N. Parry and J. Parry, The Rise of the Medical Profession (London: Croom Helm Ltd., 1976) at 22.

[18] D.H. Calhoun, Professional Lives in America (Cambridge: Harvard University Press, 1965) at 54.

[19] For a more in-depth analysis of the role of competition in the self-regulation of professionals, consider the opposing view-points presented in the following two articles: S. Ostry, "Competition Policy and the Self-Regulating Professions" in P. Slayton and M.J. Trebilcock, eds., The Professions and Public Policy (Toronto: University of Toronto Press, 1978) at 17; J. Younger, "Competition Policy and the Self-Regulating

Thus, the formal organization of professional associations led to the assumption of power to permit or deny membership, this control being essential for self-government of a profession.

### *(B) Learning*

Market forces, however, did not operate in isolation to create an environment inducive to the creation of professional organizations and professional autonomy. Specialized learning was also a means of maintaining the exclusivity of a profession and restricting membership to the profession. From the time of the Enlightenment, rationality was gaining ground in Western civilization. As Friedson points out, "the medieval universities of Europe spawned the three original professions of medicine, law and the clergy"[20]. The establishment of formal educational institutions and in particular universities, combined with the growing emphasis on scientific knowledge and rational principles, did much to advance the process of professionalization. This increased emphasis on learning eventually began to affect the nature of professional associations (for example, expanding medical knowledge meant that meetings of physicians assumed a

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Professions" in P. Slayton and M.J. Trebilcock, eds., The Professions and Public Policy (Toronto: University of Toronto Press, 1978) at 30.

[20] "The Theory of Professions: State of the Art" in R. Dingwall and P. Lewis, eds., The Sociology of the Professions (London: The Macmillan Press Ltd., 1983) 19 at 23.

decidedly more medical agenda[21] and no longer served primarily as a social club).

It should also be noted that with the growth of medical societies and associations during the early nineteenth century there was a parallel growth in the market for medical literature and reporting, with 107 new journals being introduced from 1801-1840.[22] These journals provided a vehicle for the communication of scientific advances, professional meetings, ideas and politics concerning the profession.[23] The availability of transportation and postal services at this time also facilitated communication between professional communities previously isolated by geography, and made possible exchanges between foreign jurisdictions through journal publications and individuals educated in universities abroad.

The increasing emphasis on, and exchange of, knowledge eventually gave professionals a claim to control an area requiring superior expertise. The professions began defining educational criteria through training in standardized studies, qualifying examinations and the issuance of diplomas.

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[21] Calhoun, **supra**, note 18 at 27.

[22] P.W.J. Bartrip, Mirror of Medicine: A History of the British Medical Journal, (Oxford: Clarendon Press, 1990) at 8.

[23] Ibid. at 9.

Thus, professional education became formalized and used as a means of specializing the area and further restricting membership to the professions.

## *C. The Self-Sacrifice Principle*

Historically, the nature of professional service was seen to be distinct from other services as it embodied ideologies of public service and self-sacrifice. These ideals are perhaps most clearly rooted in the medical profession. One has only to recall the tenets of the Hippocratic Oath, which physicians took from the time of the fifth century B.C.[24] stating, "I will apply...measures for the benefit of the sick according to my ability and judgment: I will keep them from harm and injustice", and also, "Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice..."[25].

While the Hippocratic Oath was modified slightly over the ages (Christianized in the tenth or eleventh century

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[24] American Medical Association, "Principles of Medical Ethics and Current Opinions of the Council on Ethical and Judicial Affairs - 1989", **supra**, note 11 at 189.

[25] Edelstein, Ancient Medicine at 6, in Areen et. al. eds., Law, Science and Medicine (New York: The Foundation Press, 1984) at 274.

A.D. to eliminate reference to pagan gods[26]), it remained in Western civilization an important ethical document which was a testament to the commitment of physicians to benefit exclusively the patient. The next most significant contribution to medical ethics was the Code of Medical Ethics written by the English physician and philosopher, Thomas Percival, in 1803[27], which maintained the self-sacrifice principle at the core of the Hippocratic tradition. The principles enunciated in these codes of ethics formed the basis of modern day codes of medical ethics adopted by medical associations today.

Other professions, such as the legal profession, may not have defined their commitment to public service as famously as the medical profession, yet lawyers were identified as the champion of public rights and the earliest legal codes of ethics reinforced such commitments.

It is interesting to note that in the recent past, virtually all of the professional codes of ethics have begun to reflect a diminishing emphasis on the self-sacrifice of professionals and the primacy of the patient or client. The ethical documents have now increased emphasis on the

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[26] "Principles of Medical Ethics and Current Opinions on Ethical and Judicial Affairs - 1989", **supra**, note 11 at 190.

[27] Ibid.

obligations the professional owes to others, in addition to the rights of professionals. Consider the following comment about the recent revisions in the codes of medical ethics:

> Only in these very recent versions...did the Hippocratic commitment to benefit exclusively the patient...begin to give way to other ethical commitments - those that take into account the interests of the rest of society; those that take into account physicians' rights and duties as well as benefits and harms;...[28]

### *(D) The Rise of Self-Government and Self-Regulation*

As professions evolved into powerful organizations, they maintained control over their memberships and over the knowledge that is unique to the provision of their services. They also adopted codes of ethics affirming their commitment to public service, which historically was defined as selfless and absolute. The movement towards professional self-regulation began in North America around the turn of the century[29] in an attempt by professions to avoid government regulation. It was permitted by the public and governments in recognition of the specialized nature of professional practices and the trust which professional members enjoyed by society in light of their public service and ethical

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[28] R.M. Veatch, "A Theory of Medical Ethics" (1981) **in** Areen et. al. eds., Law, Science and Medicine (New York: The Foundation Press, 1984) at 275.

[29] Larson, **supra**, note 8 at 24.

commitments to the public. The privileges of self-government and self-regulation of professions have become entrenched in the notion of professionalism and are now defining characteristics of professions. Indeed, these privileges have now assumed the status of a 'right' in the minds of most professionals.

Presently, the state has delegated to the professions the power to self-regulate through legislation. For instance, in Quebec the *Professional Code*[30] and the *Medical Act*[31] provide the medical profession with self-regulating and self-governing powers. In Ontario the medical profession was one of five professions delegated these powers under the *Health Disciplines Act*[32]. The *Health Disciplines Act* was repealed under the *Regulated Health Professions Act*[33], proclaimed in force on January 1, 1994, but the medical profession will continue its powers of self-government and self-regulation under the new legislation. Similar legislation is in place which delegates these powers to the legal profession such as the *Law Society Act*[34] of Ontario and

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[30] R.S.Q. c. C-26.

[31] R.S.Q., c.M-9.

[32] R.S.O. 1980 c.196, as am. 1983 c.59; 1986 c.28 and 1986 c.34.

[33] S.O. 1991 c.18.

[34] R.S.O. 1990, c.L-8.

*An Act Respecting the Barreau du Quebec*[35].

Self-regulation of professions is intended to ensure the protection of the public. It is premised on the principle that members of a profession are uniquely qualified to establish standards of professional conduct because "the members of the profession are best qualified to determine the appropriate standards of competence."[36] The rationale for allowing self-government of a profession includes:

> 1. that the profession itself has the clearest knowledge of how to regulate internal standards;
> 2. that the profession has the best understanding of the need for changes and can implement changes more efficiently than can government;
> 3. that the profession will bear the costs of regulating the quality of service; and
> 4. that the profession can form a relationship of trust with the public if the government has shown confidence in its role.[37]

However careful reflection must be given to whether the protection of the public is best achieved in this way. Since professionals and society may hold differing views about whether self-regulation and self-government are rights or privileges, it is necessary to reach a consensus on what goals

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[35] R.S.Q. c. B-1.

[36] P. Jacobs, "Practice Before Health Disciplines Tribunals" in F.R. Moskoff, ed. Administrative Tribunals: A Practice Handbook for Legal Counsel (Toronto:Canada Law Book Inc., 1989) 145 at 147.

[37] B. Williams, "Abuse of Power by Professional Self-Governing Bodies", [1979] L.S.U.C. Lectures, 345 at 346.

are being advanced.

## 3. *GENERAL PRINCIPLES IN CANADIAN ADMINISTRATIVE LAW*

With this state-legislated authority to self-govern and self-regulate, it is important to understand how these powers fit into the larger structure of the Canadian legal structure. Recognized professions are now empowered to set up internal structures comprised of committees, boards and tribunals to regulate among other things the education, licensing and discipline of their members. While administrative activity in the regulation of professions is largely independent, such activity is still subject to the administrative law of the particular jurisdiction.

Administrative law may be defined as "the body of general principles which govern the exercise of powers and duties of public authorities"[38]. In Canada, administrative law is based largely on the English model in that two fundamental principles have been adopted: the first is the primacy of common law is applicable to government agents[39], and the second is the jurisdiction of the superior courts to review decisions reached by tribunals.

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[38] H.W.R. Wade, Administrative Law, 5th ed. (New York: Oxford University Press, 1982) at 5.

[39] R. Dussault and L. Borgeat, Administrative Law: A Treatise, vol. 1, 2nd ed., (Toronto: Carswell, 1985) at 18.

By contrast, the administrative law of France, le droit administratif, is a distinct division of law. There are two fundamental principles of le droit administratif: the first is that different rules of law apply to le droit administratif, and secondly disputes where the state/government is a party are not subject to review by ordinary courts but by a hierarchy of administrative courts that have exclusive jurisdiction to apply le droit administratif.[40]

An important distinction exists between the way judicial review of administrative tribunals is carried out in Canada (and England) and in France. In the Canadian system, courts will not intervene if they find a tribunal has made an incorrect decision provided it acted within its jurisdiction. Judicial review is limited to cases:

> 1. where the tribunal acted outside its jurisdiction or lost jurisdiction through abuse of discretion;
> 2. where the tribunal has failed to comply with the principles of natural justice or the duty to be fair;
> 3. where there is an apprehension that the tribunal was biased; or
> 4. in some cases, where the tribunal made an error of law.[41]

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[40] A. Lamer, "Administrative Tribunals - Future Prospects and Possibilities" (1992), 5 C.J.A.L.P. 107 at 112.

[41] Ibid. at 113-114.

Thus, in the Canadian system, tribunals are quite powerful since they often make decisions that are not reviewable in substance by the courts. In France, the higher administrative courts look at the substance of the decisions of the tribunals and assess the correctness of these decisions. "The emphasis is on procedure in English [and Canadian] law, it is on substance in French law."[42]

In Quebec, the principles of administrative law are virtually identical to those in the other nine provinces, following the English model. However, it is important to note that Quebec derives its procedural standards from the *Code of Civil Procedure* and these legislative norms which Quebec administrative law draws upon are largely outside the common law, distinguishing it somewhat from the other nine common law provinces.

Having reached an understanding of what a profession is and the role for self-government and self-regulation of professions today, we may now turn to a closer examination of how self-regulating professions define the existence of duties to provide services and in what circumstances, and the existence of rights to refuse to provide services and in what circumstances.

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[42] R. David, English Law and French Law (London: Stevens and Sons, 1980) at 83.

# CHAPTER TWO: THE PROFESSIONAL'S RIGHT TO REFUSE TO PROVIDE SERVICES.

Do individual professionals have a legal or an ethical duty to provide services and if so, in what circumstances? Correlatively, do they have a right to refuse to provide services and if so, under what circumstances? Analysis of these issues will offer insight into what is presently deemed to be unprofessional conduct with respect to the provision of professional services.

## *1. INTRODUCTION*

To date, there has been extensive analysis of professional obligations and the limits thereof, in the context of existing professional-client relationships. The issues of the existence of professional autonomy prior to such a relationship fully crystallizing, and any restrictions thereupon which may exist regarding the appropriateness of professionals to decline their services, have not been the subject of extensive debate. In order to engage in discussions of the appropriate limits of professional freedom, it is important to establish what duties professionals have to provide their services or what rights they currently have to refuse to provide services to patients or clients.

In considering the issue of whether there exists a professional duty to provide services or a right to refuse to provide services, two preliminary points need to be considered. First, we must consider when the professional relationship begins in order to understand when professionals could begin to owe duties to their patients or clients. Secondly, we need to consider whether refusals to provide professional services could be thought of as a right, and if so, what this would mean.

## A. *When a Professional Relationship Begins*

It is important to deal with the notion that a professional relationship does not crystallize, and therefore the professional owes no duties to the patient or client, until the professional and the patient or client agree to establish a relationship. This is not accurate. At least one court has already confirmed that a physician's obligations to a patient can begin prior to a formal agreement between the physician and patient.[1] Furthermore, it should be noted that a professional does owe some obligations to the client immediately whether or not there is agreement to establish a relationship, such as the duty to hold in confidence the information disclosed by the individual seeking services. Therefore, it is submitted that a professional relationship

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[1] St. Germain v. R., [1976] R.S.Q. 185 (Que. C.A.).

crystallizes immediately upon contact between the professional and the client seeking services, some professional obligations such as confidentiality begin immediately whether or not the relationship continues and other professional obligations will not begin until the professional relationship continues.

## *B. The Meaning of a Right to Refuse Professional Services*

It is also important to clarify our expression of and articulation of rights in order to understand if a professional may have a right to refuse to provide legitimate services. While there is a large body of jurisprudential theory relating to the notion of rights, an in-depth analysis of this will not be undertaken in this paper. It is, however, important to identify and distinguish the concept of rights used in this paper in order to give meaning to the discussion of professional rights which will follow.

Some of the most famous analysis of legal relations between individuals, the judicial system and governments, was undertaken by Professor Wesley Hohfeld early in this century[2]. It is with reference to this analysis that the following identification of professional rights and duties is based.

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[2] Hohfeld, "Some Fundamental Legal Conceptions as Applied in Judicial Reasoning", (1913) 23 *Yale Law Journal*, 16; (1917) 26 *Yale Law Journal*, 710.

Professor Hohfeld addressed the problem that the terms "duties" and "rights" are commonly used by lawyers to express multiple meanings and confusion often results. In his works, he identified eight concepts which express legal relationships. He did not propose the clarification of these concepts through formal definitions, rather, by grouping them into pairs of "correlatives" and "opposites". He chose this analysis for the following reason:

> Since all legal relations, however numerous and complex, can be reduced to the relations of one man with another - of one individual with another - every such relation has two ends, each of these requiring and being actually given a name of its own. Any legal relation, therefore, is described from the two standpoints of the two individuals.[3]

Hohfeld then arranged the correlatives of his conceptions and terms in the following scheme:

**(1) A right correlates with a duty.** A right is an affirmative claim against another. The correlative 'duty' is the obligation of the second person for the benefit of the first person.

**(2) A privilege correlates with a no-right.** A privilege is one's freedom from the right or claim of another, that is, there is an absence of duty on the part of the first person who has the privilege. The correlative 'no-right' means that

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[3] W.W. Cook, ed., <u>Fundamental Legal Conceptions as Applied in Judicial Reasoning, by Wesley Newcomb Hohfeld</u> (Connecticut: Greenwood Press, Publishers, 1978) at ix.

there is an absence of a right on the part of the second person. (For example, sometimes witnesses are privileged when testifying - there is an absence of duty to testify - as in the case of the privilege against self-incrimination.)

**(3) A power correlates with a liability.** A power is one's ability to produce changes in legal relations. The correlative 'liability' is the situation that occurs when a second person's legal relations are altered by the power of the first person.

**(4) An immunity correlates with a disability.** An immunity is one's exemption from legal power, that is, legal relations vested in one person cannot be changed by another. The correlative 'disability' refers to the lack of power of the second person to alter the first person's legal relations.

Hohfeld's analysis may be employed in the context of discerning the legal relations between a professional and his or her client. With respect to the issue of a professional refusing to provide legitimate services, it is submitted that this may accurately be seen as a 'right' as described by Hohfeld. Consider the following analogy. In the medical context, the law has clearly recognized patients' rights and physicians' duties. For example, patients have the right to refuse treatment and according to Hohfeld's analysis, this concept correlates with a duty. Physicians (and other health care practitioners) have a correlative duty not to persist with treatment because they are respecting the autonomy of those patients. Very similarly, it can be argued that physicians' rights and patients' duties may also exist. For example, physicians may have a right to refuse to provide their services and this concept correlates with a duty. Patients would then have a correlative duty not to persist with requesting services from that physician because they are respecting the autonomy of that physician. While physicians may have a **right to refuse** to treat patients, it cannot be argued that they have a **right to choose** patients since this would imply that there is a correlative duty to be patients when chosen, and such a proposition is clearly inconceivable. Thus, while a rights-duty analysis may be applied to physicians' refusals to treat patients, only a privilege-no duty analysis may be applied to physicians' choice of patients. The same reasoning should hold true for other professional-client relationships.

This notion of rights may be further subdivided into positive content rights and negative content rights. A positive content right is a **right to** something while a negative content right is a **right against** something[4]. In the

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[4] For an excellent discussion of the distinction between positive and negative content rights in the human rights context, see, M.A. Somerville, "Human Rights and Medicine: The Relief of Suffering" **in** I. Cotler and F.P. Eliadis, eds., International Human Rights Law (Montreal: The Canadian Human Rights Foundation, 1992) at 505; and M.A. Somerville, "The Right to Health: A Human Rights Perspective", text of a

context of this subdivision of rights, a positive content right to professional autonomy in choice of patients would give the professional a right to choose her patients or clients, while a negative content right to professional autonomy in choice of patients would give the professional the right to refuse some patients or clients. Hence, it can be argued that professionals may have a negative content right to refuse to provide services to their patients or clients in some circumstances.

It should be emphasized that just because it is possible for such a professional right to exist does not necessarily mean that it ought to exist in our society or that it does exist in our society. In light of the recent 'patients' rights movement' and the general preoccupation with rights in today's society, it is not surprising that professionals are increasingly demanding recognition of 'professional rights'. This phenomenon, however, must be approached with extreme caution. Recognition of such rights may add to the inherent power imbalance in professional-client relationships and may lead to injustice. It will also inevitably change the essence of professional service from advancing public needs to advancing the professional's wishes.

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speech, now printed in J. Mann and C. Dupuy, eds., <u>SIDA, sante, droits de l'homme / AIDS, Health and Human Rights</u> (Veyrier-du-Lac (Annecy), France: Fondation Marcel Merieux, Institut des Sciences du Vivant, 1993) pp. 75-90.

Recognition of professional rights requires careful consideration and extensive debate, much more than has been engaged in thus far.

The remainder of this chapter will examine how far our society has progressed in this debate and whether a right to refuse professional services does exist today. An analysis of what rights or obligations professionals currently have to refuse or provide services to prospective patients or clients, will be undertaken with reference to current statutes, common law and ethical guidelines governing professionals. A comparison will be made between the professional rights and duties of physicians, clinical researchers and lawyers and any similarities or differences which appear will be highlighted.

## 2. *DO PHYSICIANS HAVE A DUTY TO PROVIDE TREATMENT?*

### A. *The Legal Duties of a Physician*

In Canada, self-governing and self-regulating provincial medical bodies have been delegated these powers by provincial statutes. In Ontario, the College of Physicians and Surgeons of Ontario is the self-governing and self-regulating body which has been given these powers pursuant to section 46(2) of the *Health Disciplines Act*[5] and will continue to exercise these powers once this legislation is replaced by the *Regulated Health Professions Act*[6]. In Quebec, the Corporation professionnelle des medecins du Quebec is the body which has been given self-governing and self-regulating powers pursuant to sections 12 and 23 of the *Professional Code*[7] and pursuant to the *Medical Act*[8].

Currently, these medical bodies have full responsibility for the regulation of the profession. Their powers include regulation of educational standards of their members, grants of membership to the associations, licensing criteria, and disciplinary matters. These self-governing and self-regulating bodies are required by their enabling statutes to protect and represent the public's interests, whereas the professional associations (such as the Ontario Medical Association and the Quebec Medical Association) are supposed to protect and represent the interests of their members.

These enabling statutes do not themselves delineate the legal and ethical parameters of physicians' practices, nor

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[5] **Supra**, Chapter 1, note 32.

[6] **Supra**, Chapter 1, note 33.

[7] **Supra**, Chapter 1, note 30.

[8] **Supra**, Chapter 1, note 31.

do they delineate what duties physicians owe to patients, their profession or society at large. In some instances, physicians' duties are prescribed by law occasionally through the work of legislatures[9] but more commonly through courts which develop common law doctrines[10]. For the most part, however, the state has delegated the responsibility for defining these duties to the self-governing and self-regulating medical profession through the appropriate bodies it establishes.

In examining the specific issue of whether there is a statutory duty for physicians to provide treatment to patients who seek access to at least a minimum standard of health care, it is important to consider if there is a statutory right to health care. In Canada, there is no statutory right to health care although there may be two openings provided by provincial legislation. First, the

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[9] For example, physicians in Ontario are under a duty to comply with the reimbursement regime of the Ontario Health Insurance Plan ("OHIP") and are prohibited from charging or accepting payment for a greater amount than the amount payable under OHIP: *Health Care Accessibility Act*, R.S.O. 1990, c. H-3, s.2.

[10] For example, the doctrine of informed consent as it applies to medical malpractice cases has developed through recent judicial decisions. See Hopp v. Lepp, [1980] 2 S.C.R. 192, [1980] 4 W.W.R. 645 (S.C.C.); Reibl v. Hughes, [1980] 2 S.C.R. 880, 114 D.L.R. (3d) 1, 14 C.C.L.T. 1, 33 N.R. 361; McLean v. Weir and Goff, [1980] 4 W.W.R. 330 (B.C.C.A.), 18 B.C.L.R. 325. For a discussion of these cases and their impact on the development of the doctrine of informed consent, see M.A. Somerville, "Structuring the Issues in Informed Consent" (1980-81), 26 McGill L. J. 740.

*Health Disciplines Act* of Ontario states in section 3(1) that it is the duty of the Minister to "ensure that the rights of individuals to the services by health disciplines of their choice are maintained". (It should be noted that the reference to "health disciplines" in that section is ambiguous as it could refer to either health professions or health professionals. It is likely however, that the legislators were referring to the profession rather than the individual professional otherwise they would have probably used more specific language.) The legislation falls short, however, of articulating what rights individuals may have to these services.

Secondly, Quebec is somewhat of an exception[11] by virtue of section 2 of the *Quebec Charter of Human Rights and Freedoms*[12] and section 5 of the *Health and Social Services Act*[13]. The former establishes a general right to have assistance if one's life is in peril and the latter establishes a legal right to "adequate" medical care which gives rise to a corresponding duty on the part of institutions to provide such care. Therefore, while there is some statutory authority establishing a (limited) duty to provide

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[11] M.A. Somerville, "Human Rights and Medicine: The Relief of Suffering", **supra**, note 4 at 508.

[12] R.S.Q. c. C-12.

[13] R.S.Q. c. S-5.1.

medical treatment at an institutional level, there is no statutory authority establishing any duty to provide medical treatment at an individual physician level[14].

Similarly, the common law does not impose upon a physician a duty to undertake the care of a patient, however once a doctor-patient relationship is formed the physician does owe his or her patient the duty to exercise reasonable care, skill and judgment until the severance of the relationship[15].

Therefore, when considering how much professional freedom a physician has in deciding whether or not to undertake the treatment of a patient, the law seems to permit substantial professional freedom for physicians.

## *B. The Ethical Duties of a Physician*

The privilege of regulating its members is a trust undertaken by the medical profession. One of the most important means of exercising their regulatory power has been

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[14] It may be argued, however, that if a physician is an employee of an institution with a limited duty to provide medical care, the physician could have a delegated duty to provide care.

[15] E.I. Picard, Legal Liability of Doctors and Hospitals in Canada, 2nd ed. (Toronto: Carswell Legal Publications, 1984) at 3 and 153.

through the formulation of guidelines which delineate minimal standards of ethical conduct required of physicians. The governing bodies have provided some guidance on the issue of a physician's obligation to treat patients in their published codes of ethics which depict what constitutes ethical behaviour for physicians.

## The CMA Code of Ethics

The Canadian Medical Association ("the CMA") has put forth its position regarding the minimal standards of ethical conduct for physicians in its published Code of Ethics[16]. With the exception of Quebec (discussed later), the CMA Code of Ethics has been adopted by the governing bodies in all the provinces as the official statement of ethical conduct applicable to their physicians.

With respect to the issue of a physician's choice of patients, the following sections of the CMA Code of Ethics are most relevant:

> **An ethical physician**
> ...
> **11.** will recognize the responsibility of a physician to render medical service to any person regardless of colour, religion or political belief;
>
> **12.** shall, except in an emergency, have the right to refuse to accept a patient;

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[16] 1990 edition.

> ...
>
> 16. will inform the patient when personal morality or religious conscience prevent the recommendation of some form of therapy.

In analyzing the CMA's position with respect to a physician's choice of patients, the following issues should be highlighted:

1. An ethical physician has the right to refuse to treat a patient, subject to specific exceptions.
2. An ethical physician's right to refuse to treat a patient is limited to non-emergency situations. Thus, in emergency situations, a patient's 'right' to treatment appears to supersede a physician's right to refuse treatment. Note, however, that "emergency" is not defined in the CMA Code of Ethics.
3. An ethical physician may not discriminate against a patient on the basis of colour, religion or political belief. Discrimination on the basis of other grounds (for example sex, sexual orientation, nature of the patient's illness and age) is not prohibited in this Code of Ethics although it may be prohibited by the law.
4. An ethical physician may refuse to provide therapy or even recommend therapy to a patient on the grounds of personal morality or religious conscience. It remains unclear whether a physician's personal morality or religious conscience gives the physician an unlimited right to refuse to treat a patient

or if this, too, is limited to non-emergency and non-discriminatory practices.[17]

## The Quebec Code of Ethics of Physicians

Pursuant to the *Professional Code* in Quebec, each professional corporation is required to adopt a code of ethics by way of regulation in accordance with section 87 of the *Professional Code*. Thus, the Code of Ethics of Physicians[18] has been adopted by the Corporation professionnelle des medecins du Quebec and has legal status in Quebec.

With respect to the issue of a physician's choice of patient, the Quebec Code of Ethics states the following:

> **2.03.05.** A physician may not refuse to treat a patient because of the patient's morals, political convictions or language; he may, however, if he deems it to be in the medical interest of the patient, send the latter to a physician conversant with the patient's language.
>
> **2.03.06.** The physician must, where his moral or religious convictions prevent him from prescribing or dispensing a treatment that may be appropriate, acquaint his patient with these factors; he must also advise him of the possible consequences of not receiving such treatment.
>
> ...
>
> **2.03.47.** If a physician has reason to believe that a patient manifests a condition leading

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[17] I would submit that the latter interpretation should be adopted. This point will be argued in greater detail **Infra**, Chapter 3, Section 3.

[18] R.S.Q. c. M-9, r.4.

> to grave consequences in default of immediate medical attention, he should give him aid and supply the best possible care.

In analyzing the Quebec Code of Ethics with reference to a physician's freedom to choose patients, the following issues should be highlighted:

1. Physicians are not explicitly granted a general right to refuse patients. Such a right, however, is implicit.

2. A physician should provide treatment to a patient (as distinguished from "his patient" referred to elsewhere in the regulation) in specific circumstances set out; namely when a patient is believed to have a condition leading to "grave circumstances in default of immediate attention". The term "grave circumstances" is also undefined in this regulation. It is important to note the choice of words used in this provision; it is stated that a physician "should", rather than a physician "must" (which appears frequently elsewhere in the Code of Ethics) provide treatment in these dire circumstances. This provision is similar to the 'emergency exception' in the CMA Code of Ethics but it does not go as far as the latter in restricting a physician's right to refuse services in emergency situations.

3. A physician may not discriminate against a patient on the basis of the patient's morals, political convictions or language. Again, discrimination on the basis of other grounds is not prohibited in the Code of Ethics for Physicians

although it may be prohibited by law.

4. A physician may refuse to treat a patient on the basis of the personal morality or religious convictions of the physician. Again, the Quebec Code of Ethics leaves unclear whether a physician's personal morality or religious convictions gives the physician an unlimited right to refuse to treat a patient or if this, too, is limited to non-emergency and non-discriminatory practices (as defined within this regulation).

It should be noted that recently the Bureau of the Corporation professionnelle des medecins du Quebec proposed an amendment by way of draft regulation[19] to the 'discrimination' clause of the Quebec Code of Ethics of Physicians, that is, section 2.03.05. It was proposed that the existing section 2.03.05 would be replaced by the following section:

> "**2.03.05** A physician may not refuse to treat a patient solely for reasons related to the nature of the illness presented by the patient, or because of the patient's morals, political convictions or language; he may, however, if he deems it to be in the medical interest of the patient, send the latter to another physician."

This amendment would prohibit physicians from refusing to treat HIV-positive patients. No further expansion of the grounds of prohibited discrimination was considered, so it seems that physicians who refuse to treat patients on the

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[19] Gazette Officielle du Quebec, Vol. 124, No. 20 (May 13, 1992) at 2602.

basis of race, sex, sexual orientation, etc., would still be deemed to be acting ethically. This amendment to the Quebec Code of Ethics of Physicians is, however, still in the draft stage.

The AMA Code of Ethics

The American Medical Association ("the AMA") has also stated its position on the professional freedom of physicians to choose patients[20]. In the preamble to the Principles of Medical Ethics, the AMA defines the essentials of honourable behaviour for a physician and it includes the following:

> VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

The issue of freedom of choice of physicians and patients is also specifically addressed by the AMA in section 9.06 of the Principles of Medical Ethics, which essentially provides: (1) every patient has the right to free choice of physicians; (2) as a practical matter, emergencies may preclude a patient's free choice of physicians; and (3) the concept of free choice assures a patient can choose a physician and likewise a physician may decline to accept an individual as a patient.

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[20] "Principles of Medical Ethics and Current Opinions of the Council on Ethical and Judicial Affairs - 1989", **supra**, Chapter 1 note 11.

The AMA's position is similar to the CMA's position in that a physician's right to free choice of patients is recognized, but is also restricted by emergency situations (and "emergency" again is undefined). The AMA also leaves open the question of whether an emergency situation will always restrict a physician's right to decline to treat a patient or if the personal morality or religious conscience of a physician will exempt him or her from the 'emergency exception'.

The AMA, however, goes much further in prohibiting discrimination in the provision of medical services than does the CMA or the Corporation professionnelle des medecins du Quebec. While the AMA recognizes a general right of physicians to choose their patients and therefore a right to refuse to treat patients, it limits the exercise of this right on some grounds. The AMA limits this right in emergency situations and further for discriminatory reasons set out in section 9.11 of the Principles of Medical Ethics. In that section it is stated that "physicians who offer their services to the public may not decline to accept patients because of race, color, religion, national origin or any other basis that would constitute illegal discrimination." The prohibited grounds of refusal to provide medical services recognized by the AMA are much broader than those recognized by any codes of ethics for physicians in Canada.

## Conclusions on a Physician's Ethical Duty to Treat

The above analysis of the current codes of ethics guiding Canadian and American physicians reveals some significant similarities and differences. All three codes of ethics accept that an ethical physician has a right to refuse to provide treatment to a patient. The Quebec Code of Ethics of Physicians seems to go the furthest in protecting a physician's freedom of choice of patient, stating that in an emergency situation, the physician "should" treat a patient. In contrast, the CMA statement and the AMA statement both clearly prohibit the physician from exercising his or her right to refuse to treat in emergency situations. Finally, all three codes of ethics recognize that it is unethical for physicians to decline to treat a patient on the prohibited grounds of discrimination specified within each code. While the CMA Code of Ethics and the Quebec Code of Ethics of Physicians prohibit a physician's refusal to treat on very narrow grounds, the AMA Principles of Medical Ethics goes much further in prohibiting a physician's refusal to treat on any basis that would constitute illegal discrimination. None of the codes of ethics address the issue of whether the physician's personal morality or religious convictions will override the emergency exception and the non-discrimination exception to the physician's general right to refuse treatment to a patient.

Therefore, when considering how much professional freedom a physician has in deciding whether or not to undertake the treatment of a patient, the ethical guidelines establish a general right to refuse to treat patients which is restricted only by the very narrow exceptions of situations and non-discrimination (as defined in the code of ethics adopted in the given jurisdiction).

## 3. *DO PHYSICIAN CLINICAL RESEARCHERS HAVE A DUTY TO INCLUDE SUBJECTS IN CLINICAL TRIALS?*

### A. *Terminology and Definitions*

In order to examine the issue of whether clinical researchers have a duty to include patients in clinical trials, it is important to define the scope of inquiry and to define the terminology which will be used in this thesis. For the purposes of this thesis, it will be necessary to consider definitions of medical research, clinical research, and non-therapeutic research. (It should be noted that within the biomedical community, there is still debate about the definitions of biomedical research and distinctions between types of research which should be adopted when discussing issues involving biomedical research.)

(1) Medical Research - The Medical Research Council of

Canada has defined "research" as "the generation of data about persons, through intervention or otherwise, that goes beyond that necessary for the individual person's immediate well-being."[21] Thus, "medical research" will refer to the generation of medical data about persons, through intervention or otherwise, that goes beyond that necessary for the individual persons's immediate well-being. The general category of medical research may be subdivided into "clinical research" where the goal is to attain knowledge with reference to care of patients directly involved in the research, and "non-therapeutic research" where the goal is to attain knowledge with reference to care of patients but not necessarily those directly involved in the research.

(2) <u>Clinical Research</u> - This refers to medical research combined with professional care[22], that is, the subject of the research is also a patient in need of treatment. It may also be described as "therapeutic research" which has been defined as "research in which it can be foreseen that the substance of the inquiry... will likely provide direct benefit to (at least

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[21] Medical Research Council of Canada, "Guidelines on Research Involving Human Subjects - 1987" (Ottawa: Supply and Services Canada, 1987) **at 7.**

[22] World Medical Association, "Declaration of Helsinki" (1964); Revised (1975); Revised again (1983): **Reprinted in** "Medical Ethics Declarations" (1984) 31:4 *World Medical Journal*.

some of) the research subjects"[23]. The point is, however, that it is hoped that it might provide benefit to the subjects. That is, while the goal of clinical or therapeutic research is still the pursuit of knowledge, there is the intention and the possibility that the intervention will provide direct benefits for some patients. It is simply not known (if it were the research would not be necessary) who among the patients will benefit and who will not. For example, testing a new drug in a given patient population where it is likely to provide direct benefit to (at least some of) the patients would be considered therapeutic or clinical research.

(3) Non-therapeutic Research - 'Non-therapeutic research' has been defined as "research in which it can be foreseen that the substance of the inquiry... will likely provide no direct benefit to (any of) the research subjects"[24]. The goal of non-therapeutic research is the pursuit of knowledge but it does not intend direct benefit to patients who are the subjects of the research. This non-therapeutic research may be performed on a patient population but without any likelihood that the intervention will benefit the subjects. For example, testing a new machine to detect a body function

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[23] National Council on Bioethics in Human Research, Consent Panel Task Force, "Report on Research Involving Children" (May, 1992) at p.vii.

[24] Ibid.

(pulse rate) in a given patient population is not likely to provide direct benefit to (any of) the patients and would be classified as non-therapeutic or pure research.

For the purposes of this thesis, the issue of access to clinical trials will be considered only in the context of research conducted by physicians which is likely to provide direct benefit to (at least some of) the research subjects who are also patients, that is clinical research. Conflicts between individuals who wish to participate in trials and researchers who wish to control their trials by excluding certain individuals, primarily arise when there is the potential for therapeutic benefits. Therefore, consideration will not be given to the obligations of clinical researchers engaged in non-therapeutic research. It should, however, be acknowledged that clinical research may be conducted in a wide variety of disciplines including nursing, rehabilitative medicine and psychology, to name a few.

## *B. The Legal Duties of a Physician Clinical Researcher*

It is somewhat difficult to discern which laws govern the practices of clinical researchers generally in Canada. It is more difficult to discern which laws govern clinical researchers who are physicians than it is, for example, in the case of physicians treating patients. This is because the professional practices of clinical researchers (irrespective of whether the researcher belongs to a profession) have not been distinctly recognized by Parliament, nor have clinical researchers been legislatively recognized as a self-governing or self-regulating profession[25]. There is no Canadian statute which creates a corporate body of clinical researchers and delegates to this body specific powers and duties, as there is for instance, for medicine in general and law.

The absence of a comprehensive legislative scheme to regulate research on human subjects should not, however, lead to the conclusion that clinical researchers in general and physician clinical researchers in particular, are not subject to any statutory regulation in Canada. While the Law Reform Commission of Canada has recommended that a general federal statute be enacted to regulate experimentation[26], presently there are general provisions in both federal and provincial legislation that may apply to the practices of physician clinical researchers. They may also apply to the practices of physicians who treat patients and other health care professionals.

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[25] For example, the *Professional Code* of Quebec does not recognize clinical researchers as one of the forty self-governing and self-regulating professions it applies to.

[26] See Working Paper 61, Biomedical Experimentation Involving Human Subjects (Ottawa: Law Reform Commission of Canada, 1989).

Undoubtedly, some provisions of the *Criminal Code*[27] which set out offences against the person such as homicide, assault and aggravated assault could be relevant, as would be the provisions which relate to criminal negligence. The following sections of the *Criminal Code* are also relevant because they recognize legal duties and a standard of care required in the exercise of these duties:

> **Duty of persons undertaking acts dangerous to life.**
>
> 216. Every one who undertakes to administer surgical or medical treatment to another person or to do any other lawful acts that may endanger the life of another person is, except in cases of necessity, under a legal duty to have and to use reasonable knowledge, skill and care in so doing.
>
> **Duty of persons undertaking acts.**
>
> 217. Every one who undertakes to do an act is under a legal duty to do it if an omission to do the act is or may be dangerous to life.

There are also provincial statutes which create legal duties which may apply to clinical researchers. Most provinces have a statutory definition of the practice of medicine which is sufficiently broad to include clinical research. For instance, in Ontario the practice of medicine has been defined in section 3 of the *Medicine Act, 1991*[28]:

> 3. The practice of medicine is the assessment of the physical or mental condition of an individual and the diagnosis, treatment

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[27] R.S.C. 1985, c. c-46 (as amended).

[28] S.O. 1991, c.30.

> and prevention of any disease, disorder or dysfunction.

Similarly, in Quebec, the *Medical Act* may be interpreted as applying to therapeutic clinical researchers by virtue of section 31 which states:

> **31.** Every act having as its object to diagnose or treat any deficiency in the health of a human being, constitutes the practice of medicine.
>
> The practice of medicine shall compromise, in particular, medical consultation, prescribing of medication or treatment, radiotherapy, attendance at confinements, establishing and controlling diagnosis and treatment of illnesses or diseases.

These statutory definitions of medicine would embrace therapeutic clinical research conducted by physicians as part of the practice of medicine. This is particularly important in that clinical researchers engaged in such practices will be assigned at least the legal duties owed by other physicians practicing medicine[29].

Quebec is somewhat unique from other provinces in that, apart from the existence of general provisions in provincial medical acts which will apply to clinical researchers, there is also specific legislative control over clinical research by virtue of Article 20 of the *Civil Code of Lower Canada* which provides the following:

> **20.** A person of full age may consent in

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[29] See Legal Duties Owed by Physicians, Chapter 2, Section 2(A), **supra**.

> writing to disposal inter vivos of a part of his body or submit to an experiment provided the risk assumed is not disproportionate to the benefit anticipated.
>
> A minor capable of discernment may do likewise with the authorization of a judge of the Superior Court and with the consent of the person having parental authority, provided that no serious risk to his health results therefrom.
>
> The alienation must be gratuitous unless its object is a part of the body susceptible of regeneration.
>
> The consent must be in writing; it may be revoked in the same way.

This provision was the law in Quebec but was replaced when the new *Civil Code of Quebec* became law on January 1, 1994. The following provisions of the new *Civil Code of Quebec* now govern clinical research in Quebec:

> **20.** A person of full age who is capable of giving his consent may submit to an experiment provided that the risk incurred is not disproportionate to the benefit that can reasonably be anticipated.
>
> **21.** A minor or person of full age who is incapable of giving his consent may be submitted to an experiment only in the absence of serious risk to his health and of objection on his part, provided that he understands the nature and consequences of the act; the consent of the person having parental authority or of the mandatary, tutor or curator is required.
>
> An experiment may be carried out on one person alone only if a benefit to the health of that person may be expected, and the authorization of the court is required.
>
> An experiment on a group of minor persons or incapable persons of full age shall be

carried out within the framework of a research project approved by the Minister of Health and Social Services, upon the advice of an ethics committee of the hospital designated by the Minister or of an ethics committee created by him for that purpose; in addition, such an experiment may be carried out only if a benefit to the health of persons of the same age group and having the same illness or handicap as the persons submitted to the experiment may be expected.

Care considered by the ethics committee of the hospital concerned to be innovative care required by the state of health of the person submitted to it is not an experiment.

**22.** A part of the body, whether an organ, tissue or other substance, removed from a person as part of the care he receives may, with his consent or that of the person qualified to give consent for him, be used for purposes of research.

**23.** When the court is called upon to rule on an application for authorization with respect to care, the alienation of a part of the body, or an experiment, it obtains the opinions of experts, of the person having parental authority, of the mandatary, of the tutor or the curator and of the tutorship council; it may also obtain the opinion of any person who shows a special interest in the person concerned by the application.

The court is also bound to obtain the opinion of the person concerned unless that is impossible, and to respect his refusal unless the care is required by his state of health.

**24.** Consent to care not required by a person's state of health, to the alienation of a part of a person's body, or to an experiment shall be given in writing.

It may be withdrawn at any time, even verbally.

**25.** The alienation by a person of a part or product of his body shall be gratuitous; it may not be repeated if it involves a risk to his health.

> An experiment may not give rise to any financial reward other than the payment of an indemnity as compensation for the loss and inconvenience suffered.

In Canada, there is no statutory right to participate in a clinical trial although there could be rights to not be wrongfully excluded from clinical trials on the basis of human rights legislation (discussed in detail in Chapter Four, **infra**). However, given that the definition of medicine may be extended to include therapeutic research, there may be some scope to argue that a limited duty to provide access to clinical trials may exist at the institutional level, although no such duty applies to individual providers[30]. This should be compared to the American situation, where recent legislative initiatives taken by the National Institute of Health ("the NIH")[31] require the Director of the NIH to ensure that women and minorities are included as subjects in clinical trials. The NIH is expected to publish guidelines addressing what responsibilities will be assigned to the Director. Therefore, in the American context, there exists a clear statutory duty to include certain vulnerable patients in clinical trials. This duty, however, still exists only at the governmental level and not directly on the individual provider.

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[30] _Ibid_.

[31] _The NIH Revitalization Act of 1993_, Public Law 103-43 (signed into law on June 10, 1993).

Thus, while there is some statutory control over clinical researchers in Canada, there are no statutory provisions which directly establish a specific duty on clinical researchers to include specific patients in their clinical trials.

In addition to the statutory duties to which clinical researchers are subject, the common law also imposes duties on clinical researchers. This has been predominantly with respect to the obligation to obtain informed consent from subjects involved in research. The informed consent doctrine in the context of medical research might be thought of as a mechanism for self-exclusion of patients or subjects from participation in research trials. The law has focused thus far on protecting patients or subjects from wrongful inclusion in clinical trials or research studies but has not yet developed to consider protecting patients or subjects from wrongful exclusion from clinical trials or research studies.

The recognition of the legal obligation to obtain informed consent in the research setting began with, <u>Halushka</u> v. <u>University of Saskatchewan</u>[32], the first Canadian case to recognize a clinical researcher's common law duty of care. In particular, the case established that clinical researchers owe

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[32] (1965), 53 D.L.R. (2d) 436, 52 W.W.R. 608 (Sask.C.A.).

a duty of full disclosure to their subjects. In that case, the research subject was a student who was paid $50 to participate in the test of a new anaesthetic but was not informed of any risks associated with the new drug nor was he informed that a catheter would be advanced to and through his heart. The subject signed a consent form releasing the doctors of any liability, however, when he suffered a cardiac arrest during the test and brought an action against the doctors, the court held that the consent was invalid. In awarding damages to the plaintiff, Mr. Justice Hall stated the following:

> In my opinion the duty imposed upon those engaged in medical research...is at least as great as, if not greater than, the duty owed by the ordinary physician or surgeon to his patient. There can be no exceptions to the ordinary requirements of disclosure in the case of research as there may well be in ordinary medical practice. The researcher does not have to balance the probable effect of lack of treatment against the risk involved in the treatment itself. The example of risks being properly hidden from a patient when it is important that he should not worry can have no application in the field of research. **The subject of medical experimentation is entitled to a full and frank disclosure of all the facts, probabilities and opinions** which a reasonable man might be expected to consider before giving his consent.[33] (Emphasis added)

The common law has also begun to describe what standard of care is required of clinical researchers. In <u>Halushka</u>, the Court applied the objective reasonable person

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[33] <u>Ibid</u>. 53 D.L.R. (2d) at 443-4.

test in determining what ought to be the appropriate scope of disclosure by a researcher engaged in non-therapeutic research. The Alberta Court of Appeal found this standard toc onerous for therapeutic, innovative therapy in Zimmer v. Ringrose[34], while reinforcing the appropriateness of the Halushka test in the purely experimental context:

> In the case of a truly "experimental" procedure, like the one conducted in Halushka... no therapeutic benefit is intended to accrue to the participant. By contrast...the silver nitrate method was experimental only in the sense that it represented an innovation in sterilization techniques which were relatively untried... [T]he application of the standard of disclosure stated in the Halushka case would be inappropriate in this instance.[35]

Most recently, the courts have defined the standard of disclosure of clinical researchers in Weiss v. Solomon[36]. In that case, doctors at a Montreal hospital were performing non-therapeutic research on ophthalmic drops when a subject died during the course of the experiment, apparently from an adverse reaction to a dye used in the experiment. The Court found that the researcher had not fulfilled his duty to disclose and stated that in research, the duty to inform is the most exacting and includes informing of "all known risks including those which are rare or remote, especially if they

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[34] (1978), 16 C.C.L.T. 51 (Alta. C.A.).

[35] Ibid. at 59-60.

[36] (1989), 48 C.C.L.T. 280 (Que. S.C.).

may entail grave consequences"[37]. The Court further held that the duty of disclosure must extend to all aspects of the experimental undertaking, including all procedures incidental to the actual experiment.

Thus, the common law and civil law in Canada have expressly recognized some legal duties owed by clinical researchers to subjects enroled in trials, and have begun to define the standard of care of these duties but have thus far only considered duties owed by clinical researchers to subjects enroled in clinical trials. There is, however, presently no common law or civil law recognition of duties owed by clinical researchers to individuals who wish to have access to clinical trials. Hence, the law has not yet recognized a legal duty on clinical researchers to provide access to clinical trials to individuals who seek potential benefits from such participation.

Therefore, when considering how much professional freedom a clinical researcher has in deciding whether or not to allow specific individuals access to his or her clinical trial, the law seems to allow total professional freedom for clinical researchers.

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[37] (Trans.) Ibid. at 303.

## *C. The Ethical Duties of a Physician Clinical Researcher*

Clinical researchers (when acting as such) are primarily regulated by guidelines and codes of ethics rather than by legislation and regulations[38]. The Medical Research Council of Canada ("the MRC"), which is an agent of the federal government[39], has affirmed its preference for regulation of clinical research through guidelines based on the following rationale:

> Guidelines can accommodate more easily than law the shifting social evaluations that affect research, and can influence responses in subtle ways rather than with the rigidity often found in legislation. Further, guidelines can exert an influence beyond their strict limits, while legislation tends to mark the limits of its influence.[40]

While there is obvious value in this position, it is suggested that both legislation and guidelines would be useful in prescribing the standards of appropriate research practices and enforcing such standards.

Currently, there are both national and international guidelines in place which specifically regulate the practices

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[38] Medical Research Council of Canada, "Guidelines on Research Involving Human Subjects", **supra**, note 21 at 10-11.

[39] Medical Research Council Act, R.S.C. 1985, c. M-4, s.13(1).

[40] "Guidelines on Research Involving Human Subjects", **supra**, note 21 at 11.

of clinical researchers. While compliance with these guidelines is prima facie voluntary, the consequences of non-compliance may range from withdrawal of research funds to criminal and civil sanctions if the actions of the researcher violate general legal norms.

Canadian Guidelines on Clinical Research

In the Canadian context, there have been attempts to define the boundaries of what constitutes ethical behaviour for clinical researchers. The first official document addressing this issue was "Ethics"[41], published by the Canada Council in 1977. This report provided ethical guidelines for universities seeking grants for research subjects from the Canada Council, and it emphasized the principles of informed consent, confidentiality of information obtained and provided to the researcher, and risk assessment.

The next two documents regulating clinical research in Canada were produced by the MRC. In 1978, "Ethics in Human Experimentation"[42] was published, summarizing the legal and ethical issues related to experimentation and concluding that specific ethical issues should be supervised by the

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[41] The Canada Council, "Ethics", Report of the Consultative Group on Ethics (Ottawa: Supply and Services Canada, 1977).

[42] Medical Research Council of Canada, "Ethics in Human Experimentation", Report 6 (Ottawa: Minister of Supply and Services Canada, 1978).

institution conducting the research after general guidelines were met. This report was followed in 1987 by "Guidelines on Research Involving Human Subjects"[43] which affirmed the MRC's position that regulation of clinical researchers should continue to be in the form of self-regulation by codes of ethics rather than by legislative action.

Most recently, in 1989 the Law Reform Commission of Canada published "Biomedical Experimentation Involving Human Subjects"[44], recommending that research involving human subjects be subject to statutory regulation. The Commission stated:

> Where the integrity of the person can legally be endangered, it seems important that limits and rules be clearly defined. It is up to the law to protect basic values, and it cannot and must not leave this role to ethics. Moreover, and contrary to what one might think, there are many researchers nowadays who would like to have a clear idea of what may legally be done and what should be prohibited.[45]

In essence, therefore, the existing Canadian guidelines delineating ethical conduct for clinical researchers seem to address the duties a clinical researcher owes to his or her subject to ensure the protection of the subject and respect for the autonomy of the subject. A right

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[43] **Supra**, note 21.

[44] **Supra**, note 26.

[45] Ibid. at 58.

to autonomy might also be the basis of access to a clinical trial.[46] Presently, these guidelines are completely silent as to the existence of a clinical researcher's right to refuse to admit patients into his or her clinical trial or a patient's right to have access to a clinical trial. Canadian guidelines addressing the issue of selection of subjects are needed. (Note that the MRC recently decided to revise its present guidelines and is being asked to consider the above issue.)

## International Guidelines on Clinical Research

In the international sphere, there are several guidelines in existence which seek to regulate clinical research. The first international instrument which sought to regulate clinical research was the Nuremberg Code[47] in 1947. This was the first international recognition (at least implicitly) that experimentation on human subjects was legitimate and legal as long as certain criteria were met.[48]

Perhaps the most comprehensive international instrument governing clinical research is the Helsinki

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[46] This point is elaborated upon later in this text. See **infra**, Chapter 3, Section 2.

[47] **Reprinted in** Trials of War Criminals before the Nuremberg Military Tribunals under Control Council Law No.10, vol. 12 (Washington: U.S. Government Printing Office, 1949) at 81-82.

[48] Working Paper 61, Biomedical Experimentation Involving Human Subjects, **supra**, note 26 at 8.

Declaration[49] adopted by the World Medical Association first in 1964, then revised in Tokyo in 1975 and again in Venice in 1983. For the first time, this document recognized a distinction between therapeutic and non-therapeutic clinical research, although the 1975 revision indicates that there should be no differences in regulating either of these activities as the health of the subject is always the paramount consideration.

Another important international document is the International Guidelines for Biomedical Research Involving Human Subjects[50] (also known as the Declaration of Manila), adopted in 1981 by the World Health Organization and the Council for International Organizations of Medical Sciences. This document provides guidelines for the application of the principles articulated in the Helsinki Declaration (in particular for developing countries) as well as providing guidelines for obtaining informed consent from research subjects.

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[49] World Medical Association, "Declaration of Helsinki" (1964); Revised (1975); Revised again (1983): **Reprinted in** "Medical Ethics Declarations" (1984) 31:4 *World Medical Journal*.

[50] World Health Organization and the Council for International Organizations of Medical Sciences, **Reprinted in** Z. Bankowski and N. Howard-Jones (eds.) Human Experimentation and Medical Ethics, XVth CIOMS Round Table Conference (Geneva: CIOMS, 1982) at 409-423.

While the above instruments are the most comprehensive international guidelines on clinical research, attention should also be drawn to specific clauses which appear in other international documents which do not primarily deal with clinical research. For instance, Article 7 of the "International Covenant on Civil and Political Rights"[51] which was adopted by the General Assembly of the United Nations in 1966 and ratified by Canada, states the following:

> 7. No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.

A similar position can also be found in Article 3 of the "European Convention on Human Rights"[52].

All of these international guidelines are noteworthy in that they recognize clinical research as a legitimate practice **only** if certain conditions are met, and they "promote the humanitarian notion that the interests of society cannot justify every act and that unrestricted human experimentation cannot be allowed solely on the basis of general social

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[51] (1976) 999 U.N.T.S., **in** Working Paper 61, Biomedical Experimentation Involving Human Subjects, **supra**, note 26 at 10.

[52] *JOCE*, 9 May 1975, at 13-22 **in** Working Paper 61, Biomedical Experimentation Involving Human Subjects, **supra**, note 26 at 10.

utility"[53]. While there are problems with enforcement of international guidelines as breach of these do not attract traditional legal sanctions, they are nonetheless important as they may establish part of a researcher's standard of care, as has been affirmed by recent judicial decisions[54].

Despite the existence of comprehensive international guidelines delineating ethical conduct for clinical researchers, these guidelines seem to focus on the relationship between a clinical researcher and his or her subject, and strive to ensure the protection of the subject and the respect for the autonomy of the subject. The international guidelines on human research are also silent with respect to delineating if a clinical researcher has a right to refuse patients access to the clinical trial.

### Ethical Guidelines for Physicians Applicable

In addition to the specific ethical guidelines

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[53] Working Paper 61, Biomedical Experimentation Involving Human Subjects, **supra**, note 26 at 10.

[54] The Quebec Supreme Court, for example, confirmed that international instruments make up part of the researcher's standard of care for disclosure in Weiss v. Solomon, **supra**, note 36 at 304:

C'est la declaration d'Helsinki qui imposait cette obligation au Dr. Kaback:

> In research on man, the interest of science and society should never take precedence over considerations related to the well-being of the subject.

regulating the practices of clinical researchers, the codes of ethics for physicians are also applicable to physicians who engage in clinical research. The codes of ethics for physicians apply to all physicians whether or not they are directly engaged in the clinical practice of medicine. For example, the CMA Code of Ethics recognizes physicians who undertake clinical research, most specifically in section 17:

> **An ethical physician**
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> 17. will ensure that, before initiating clinical research involving humans, such research is appraised scientifically and ethically and approved by a responsible committee and is sufficiently planned and supervised that the individuals are unlikely to suffer any harm. The physician will ascertain that previous research and the purpose of the experiment justify this additional method of investigation. Before proceeding, the physician will obtain the consent of all involved persons or their agents, and will proceed only after explaining the purpose of the clinical investigation and any possible health hazard that can be reasonably foreseen.

Since the codes of ethics for physicians will apply to physicians who are also clinical researchers, presumably the general right of a physician to refuse patients[55] will also be extended to clinical researchers, as will the exceptions to this general right on the basis of emergency and non-discrimination. Query whether a patient with a life-threatening illness for which there is no cure may demand

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[55] See <u>Ethical Guidelines for Physicians</u> discussion in Chapter 2, Section 2(B), **supra**.

access to a therapeutic clinical trial on the basis that she is in an emergency. (Recall that there is no definition of "emergency" in the codes.)

Thus, when considering how much professional freedom a physician clinical researcher has in deciding whether or not to allow specific patients access to a clinical trial, the specific ethical guidelines for clinical research seem to permit total professional freedom for clinical researchers with respect to exclusion of subjects. The general ethical guidelines for physicians will also apply to physician clinical researchers, establishing a general right to refuse patients access to clinical trials with very narrow exceptions of emergency situations and non-discrimination (as defined in the code of ethics adopted in the given jurisdiction).

## *4. DO LAWYERS HAVE A DUTY TO PROVIDE SERVICES?*

### *A. The Legal Duties of a Lawyer*

In Canada, the legal profession is a self-governing and self-regulating profession whereby provincial law societies have been delegated these powers through provincial statutes. In Ontario, the Law Society of Upper Canada is the self-governing and self-regulating body which has been delegated these powers pursuant to the *Law Society Act*[56]. In Quebec, the Corporation professionnelle des avocats du Quebec is the body which has been delegated self-governing and self-regulating powers pursuant to sections 12 and 23 of the *Professional Code* and pursuant to *An Act Respecting the Barreau du Quebec*[57].

Currently, these law societies have been delegated full responsibility for the regulation of the legal profession. Their powers include regulation of legal educational standards of their members, admission of members and prescribing their rights and privileges, licensing criteria, conduct and disciplinary matters, and authorizing and publishing a code of professional conduct and ethics for lawyers. These self-governing and self-regulating bodies are required by their enabling statutes to protect and represent the public's interests, whereas the professional associations (such as the Canadian Bar Association of Ontario and the Canadian Bar Association, Quebec Branch) are supposed to protect and represent the interests of their members.

It should be noted that the statutes which govern the legal profession do not themselves delineate the legal and ethical parameters of lawyers' practices, nor do they define

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[56] **Supra**, Chapter 1, note 34.

[57] **Supra**, Chapter 1, note 35.

the legal or ethical obligations of lawyers to their clients, their profession or society at large. In some instances, a lawyer's duties are prescribed by law, occasionally through the work of the legislatures[58], but more commonly through the common law doctrines developed by the courts[59]. For the most part, however, the state has delegated the responsibility for delineating these duties to the self-governing and self-regulating legal bodies.

With respect to the issue of whether there exists a statutory duty for lawyers to provide legal services, again it should be considered whether there exists a statutory right to the service. In Canada, it is clear that there is no general right to legal services recognized in any statute.

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[58] For example, in Ontario a solicitor of record is under a duty to act and remain the solicitor of record for his or her client until either the client gives notice of change of solicitor or the solicitor is removed from the record after giving notice and serving such notice on his or her client and every other party: *Rule 15.04, Rules of Civil Procedure,* O. Reg. 560/84 (as amended); pursuant to the *Courts of Justice Act, 1984*, S.O. 1984 c.11, s.65.

[59] For example, the courts have expanded the doctrine of foreseeability in tort law to apply in cases of damages of pure economic loss, not only for clients with whom professionals are in a contractual relationship with, but also to non-clients whom the professional had reason to believe would rely upon that advice: Hedley Byrne v. Heller & Partners Ltd., [1964] A.C. 465, [1963] 2 All E.R. 575 (H.L.); where bankers giving references as to credit-worthiness of their customers, were sued on the grounds of reliance by third parties on innocent but negligent misrepresentation. The doctrine has been further expanded to include persons whom the professional may not even know: Anns v. Merton London Borough Council, [1978] A.C. 728, [1977] 2 All E.R. 492 (H.L.).

There is, however, constitutional authority establishing a very limited right to have legal representation.

Section 10 (b) of the *Canadian Charter of Rights and Freedoms*[60] ("the *Charter*") provides:

> **10.** Everyone has the right on arrest or detention...
> (b) to retain and instruct counsel without delay and to be informed of that right;...

In the first instance, this right is limited to circumstances where there is arrest or detention, and it is further limited to the right to "retain and instruct" a lawyer; it does not in fact establish a right to have a lawyer provided. In fact, the right to have a lawyer provided is only available to those who are arrested or detained **and** meet the financial eligibility criteria established by the provincial Legal Aid plans which are created by provincial statutes and regulated by the provincial law societies. This gives rise to a corresponding duty on the profession (since it is the provincial law societies which regulate and primarily fund the legal aid plans) to provide counsel in these circumstances. Thus, while there exists some statutory authority providing a very limited duty to provide legal services on the part of the profession, there is no statutory

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[60] Constitution Act, 1982, Part I; **Reprinted in** R.S.C. 1985, Appendix II, No. 44.

authority establishing any duty to provide legal services on the part of the individual.

Similarly, the common law has not imposed upon a lawyer a duty to undertake to provide services to a client. The common law does, however, impose fiduciary duties on lawyers once a solicitor-client relationship is established and it may impose fiduciary duties on lawyers even after the termination of the relationship and sometimes between lawyers and third parties[61].

It is submitted that since the common law has already recognized that lawyers may owe fiduciary obligations to third parties who the lawyer had reason to believe would rely on her actions and advice, these obligations should be imposed on lawyers dealing with prospective clients. Thus, it is suggested that where a lawyer is capable of providing the service requested but she refuses, and she can reasonably foresee the results of her refusal to serve the client will lead to substantial harm[62], the lawyer should be found to be

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[61] For a thorough discussion of fiduciary obligations of lawyers, see S.M. Grant and L.R. Rothstein, <u>Lawyers' Professional Liability</u> (Toronto: Butterworths Canada Ltd., 1989) at chapter 3.

[62] It is acknowledged that it will be problematic to define 'substantial harm'. It is, however, proposed that generally, economic loss should not constitute 'substantial harm'. Rather, the 'substantial harm' principle should apply to matters such as those which seriously threaten the client's liberty or personal security interests, or which threaten the

in breach of her fiduciary obligations and may be liable for damages.

Therefore, when considering how much professional freedom a lawyer has in deciding whether or not to undertake to provide services to a prospective client, the law seems to permit total professional freedom for lawyers and recognizes only a very limited duty on the profession to provide counsel where the accused has been arrested or detained and cannot afford to retain counsel.

## *B. The Ethical Duties of a Lawyer*

The legal profession has been entrusted with the privilege of regulating its members. In this regard, the professional legal bodies have formulated guidelines and codes of ethics which delineate the minimal standards of ethical conduct required of lawyers. These published ethical guidelines and codes of ethics provide some guidance to the issue of a lawyer's duty to provide services with respect to delineating what constitutes ethical behaviour for lawyers.

### The CBA Code of Professional Conduct

The Canadian Bar Association ("the CBA") has stated

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physical or mental well-being of the client or her immediate family.

its position on what constitutes minimal ethical conduct for lawyers in its published Code of Professional Conduct[63]. In considering a lawyer's relationship with a prospective client, the CBA's position is found in Rule XIV, Commentary 6:

> The lawyer has a general right to decline employment (except when assigned as counsel by a court) but it is a right the lawyer should be slow to exercise if the probable result would be to make it very difficult for a person to obtain legal advice or representation. Generally speaking, the lawyer should not exercise the right merely because the person seeking legal services or that person's cause is unpopular ... or because of the lawyer's private opinion about the guilt of the accused... [T]he lawyer who declines employment should assist the person to obtain the services of another lawyer ...

The CBA recognizes a lawyer's unlimited right to refuse to provide services but it does advise caution in some circumstances. There is no recognition of an exception to the lawyer's right to refuse on the basis of emergency circumstances of the client nor is there an exception on the basis of **any** grounds of discrimination. This right is not extended to court-appointed lawyers.

## The LSUC Professional Conduct Handbook

In Ontario, the Law Society of Upper Canada ("the LSUC") has issued its ethical guidelines for lawyers in the

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[63] 1988 edition.

Professional Conduct Handbook[64]. Its stance on the ethical obligations of lawyers in providing services is virtually identical to that issued by the CBA, stating in Rule 12, Commentary 5 that "[t]he lawyer has a general right to decline a particular employment (except when assigned as counsel by a court), but it is a right to be exercised prudently..." The remainder of the LSUC commentary is exactly identical to that stated in the CBA commentary.

It is, however, exciting to note that the LSUC has recently considered a reinstatement of Rule 12, Commentary 5, proposing a Rule of Professional Conduct on non-discrimination[65]. The proposed rule is as follows:

> **Rule 28**
> Discrimination by the lawyer on the grounds of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, record of offences, marital status, family status, or disability with respect to professional employment of other lawyers, articled students or any other person, or in professional dealings with other members of the profession or any other person is professional misconduct.
>
> **Commentary 1**
> ... Discrimination in employment or in the provision of services not only constitutes professional misconduct, it violates the Ontario *Human Rights Code*.
> ...

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[64] 1987 edition.

[65] Draft of June 25, 1993; Annexed to the Benchers Bulletin Vol.1, No.9 (June 1993).

> **Commentary 5**
> The Rule applies to the conduct of any member in any aspect of the provision of professional service, whether the action or omission at issue is that of the member, the member's partner or any employee or agent subject to the member's direction or control.

While it is suspected that this proposed rule was intended primarily to protect members of the legal profession from discrimination by other members of the legal profession (since the commentaries deal mainly with discrimination in the workplace), it will nonetheless provide protection for prospective clients. If passed, this rule would prohibit a lawyer from discriminating in her refusal to provide services on the grounds set out in the Ontario human rights legislation and would recognize such a refusal to be professional misconduct. A discussion of whether human rights legislation or the *Charter* would apply to the provision of professional services (irrespective of whether professional regulatory bodies recognize it in their codes of ethics) will be discussed in more detail in Chapter Four, **infra.** It is submitted that it should but professionals do not seem to have acknowledged this, as can be demonstrated by the present opposition expressed by the legal profession in Ontario to adopting the proposed rule referred to above and the lack of recognition of prohibitions to discriminatory practices in the legal codes of ethics.

## The Quebec Code of Ethics of Advocates

As was stated above, each professional corporation is required to adopt a code of ethics by way of regulation in accordance with section 87 of the *Professional Code*. Thus, the Corporation professionnelle des avocats du Quebec has adopted the Code of Ethics of Advocates[66], which has legal status in Quebec.

With respect to the issue of whether a lawyer has a duty to provide services to a prospective client, the Code of Ethics of Advocates is quite clear as it addresses this issue in a single section:

> **3.05.01** The advocate may accept or refuse a mandate.

Thus, the Quebec Code of Ethics of Advocates recognizes an absolutely unlimited right of lawyers to refuse to provide their services. This right is not restricted to lawyers who are engaged in private practice, nor is it restricted to non-discriminatory practices of lawyers. The Quebec Code of Ethics of Advocates does not even caution lawyers about how they should exercise their right to refuse to provide services.

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[66] R.S.Q. c. B-1, r.1.

## The ABA Model Code of Professional Responsibility and Code of Judicial Conduct

The American Bar Association ("the ABA") has expressed a similar position to that of the CBA and LSUC regarding the issue of whether a lawyer is under a duty to provide legal services to a prospective client. The ABA states in Canon 2, Ethical Consideration ("EC") 2-26[67]:

> **EC 2-26** A lawyer is under no obligation to act as advisor or advocate for every person who may wish to become his client; but in furtherance of the objective of the bar to make legal services fully available, a lawyer should not lightly decline proffered employment...

As with the CBA and the LSUC ethical guidelines, the ABA guidelines do not expressly restrict a lawyer's right to refuse to provide services for discriminatory reasons.

The ABA position regarding the freedom of lawyers to choose clients does, however, differ from the CBA and the LSUC positions in one very significant way. The CBA and the LSUC have both stated that lawyers who act as counsel appointed by the courts do not have the freedom to choose clients as do lawyers who engage in private practice, and these codes are silent as to whether court-appointed counsel are ever free to deny representation to a client whose cause they find repugnant. This differs dramatically from the ABA position in

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[67] American Bar Association, <u>Model Code of Professional Responsibility</u>.

Rule 6.2 of the Rules of Professional Conduct[68]:

> **RULE 6.2**
> A lawyer shall not seek to avoid appointment by a tribunal to represent a person except for good cause, such as: ...
> (c) the client or the cause is so repugnant to the lawyer as to be likely to impair the client-lawyer relationship or the lawyer's ability to represent the client.

Thus, while the Canadian Bar Association's position is clear (as is the LSUC's) that court-appointed lawyers will not have the freedom to choose clients as lawyers in private practice do, the American Bar Association guidelines do provide a court-appointed lawyer with the right to refuse to represent a client where there is "good cause". The ABA does not define "good cause" but does give an example of this to be when the client or the client's cause is "so repugnant" to the lawyer that it affects her ability to represent the client.

## Conclusions on a Lawyer's Ethical Duty to Provide Services

The above analysis of the current rules of professional responsibility guiding Canadian and American lawyers reveals some significant similarities and differences. All four of the above guidelines provide that a lawyer's

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[68] American Bar Association Model Rules of Professional Conduct, 1989 edition, in R.A. Gorlin, ed., Codes of Professional Responsibility, 2nd ed. (Washington: BNA Books, 1990) at 377.

refusal to provide advice or representation to a prospective client can be ethical conduct. Again, the Quebec Code of Ethics of Advocates seems to go the furthest in protecting a lawyer's right to refuse to provide services to a prospective client, providing absolutely no caution or restriction to the exercise of this right in the code itself. In contrast, the CBA, the LSUC and the ABA at least require that lawyers engaged in private practice be cautious in exercising this right. The CBA and the LSUC do not extend this right to court-appointed lawyers but they leave open the question of whether reasons of personal morality or religious convictions may override the duty of court-appointed lawyers to provide representation. The ABA has stated that in some circumstances where there is "good cause", even a court-appointed lawyer will have the right to refuse to represent a client. Finally, none of the ethical guidelines and codes of ethics examined above recognize that it is unethical for a lawyer to decline a relationship with a client for discriminatory reasons.

The omission of references in the codes of ethics to anti-discrimination in the provision of services might be explained on the basis that these obligations and parameters are adequately recognized in law and thus do not need to be repeated in the codes. Such a position is unconvincing given the large number of other legal obligations of professionals which are also ethical obligations and are referred to in the codes of ethics. It is submitted that the codes of ethics should include (or refer to) all the obligations and rights a professional may exercise in the context of his or her professional practice.

Therefore, when considering how much professional freedom a lawyer has in deciding whether or not to undertake a relationship with a client, the ethical guidelines and codes of ethics (which is subordinate legislation in Quebec) recognize a lawyer's right to refuse to provide services which is restricted only in the case of court-appointed lawyers in Canada and in the case of court-appointed lawyers without "good cause" in the United States. The ethical guidelines for lawyers do not expressly restrict a lawyer's right to refuse to provide services to non-discriminatory practices, although such a proposal is currently being considered in Ontario.

## 5. *COMPARISON BETWEEN MEDICAL AND LEGAL PROFESSIONS*

There are important similarities and differences between the rights and duties of medical and legal professionals with respect to the provision of services:

1. There is no statutory authority establishing a duty on physicians, clinical researchers or lawyers to undertake a relationship with a prospective patient or client;

2. There is some common law authority establishing a duty on a physician to provide treatment to a prospective patient but this is currently limited to emergency situations; this duty may apply to clinical researchers if the clinical trial can be established as a treatment and there is an emergency situation; there is no common law authority establishing a duty on lawyers to provide services.

3. Subject to some exceptions, there is no ethical duty on physicians, clinical researchers or lawyers to provide services (as recognized by the existing guidelines and codes of ethics); in fact, there is recognition in these guidelines and codes of ethics of the rights of these professionals to refuse to provide their services.

4. The only exceptions acknowledged by the profession to the right of physicians who practice medicine to refuse patients, are in emergency situations (which are not defined) and for discriminatory reasons based on the colour, religion or political beliefs of the patient. There are no exceptions to the right of clinical researchers to refuse access to clinical trials. The only exception to the right of lawyers to refuse their services to clients is in the case of court-appointed lawyers, while the right of privately practicing lawyers to refuse clients are absolutely unrestricted.

## *6. CONCLUDING REMARKS*

The above comparisons require some reflection. First, it seems obvious that these self-regulating bodies in Canada have failed adequately to protect the public against discrimination in the provision of professional services. The issue of whether professionals who practice in a discriminatory fashion would be in contravention of human rights legislation will be the subject of discussion in Chapter Four of this text. However, at this point it is remarkable to note the recognition of only a few prohibited grounds for refusals of medical services in the codes of ethics for physicians, and the absence of any such prohibited grounds for refusals of legal services in the codes of ethics for lawyers. This state of affairs is most embarrassing. Surely it is time for these outdated codes of ethics to be reconsidered in light of our present societal values and goals. If non-professionals are not permitted to discriminate in the provision of services on the grounds stipulated in human rights legislation, it seems bizarre that professionals who are entrusted by society to be ethical and hold themselves to higher standards of conduct, do not themselves recognize at least the basic principles of respect for persons which are recognized in human rights legislation.

Secondly, the codes of ethics specifically for clinical researchers are silent on the issue of whether there is an 'emergency exception' to the right of clinical researchers to deny patients access to clinical trials. While it is suggested that the codes of ethics for physicians, which recognizes an 'emergency exception' to the right to refuse to treat patients, will also apply to physicians who conduct clinical research, it seems peculiar that the specific codes of ethics for clinical researchers are totally silent on the issue. It seems possible that a patient who suffers from a terminal illness for which there is no satisfactory treatment, may be considered in emergency and should have access to a clinical trial.

Thirdly, the existence of an 'emergency exception' to a physician's right to refuse treatment potentially applies to all physicians in Canada and the United States. In contrast, in the legal community it affects only court-appointed members of the profession. This distinction seems to suggest that legal services are not as important to the public as medical services since there is no recognized 'emergency' where legal services are crucial. A moral distinction between a lawyer's duty and a doctor's duty to serve the public seems difficult to draw. If a person (who does not meet the financial eligibility criteria for legal aid) is denied legal representation by a privately practicing lawyer in criminal matters, constitutional matters, or family matters, it is easy to imagine how that person's well-being may be compromised. It is difficult to imagine how a lawyer (practicing privately) who deprives an individual of necessary legal services in an urgent situation is acting ethically, since a refusal to provide services in such circumstances seems to offend the principle of non-maleficence which is basic to the notion of ethics. The absence of an 'emergency exception' in the provision of legal services by privately practicing lawyers, whether intentional because of the lack of importance of legal services or because of self-protection on the part of the profession, should be reconsidered and rectified.

Furthermore, it merits speculation whether the 'emergency exception' will override a physician's right to refuse to provide an acceptable treatment on the basis that such treatment conflicts with the physician's moral or religious convictions. This issue remains unresolved by the current codes of ethics for physicians which acknowledge both an 'emergency exception' to the refusal to treat and a physician's right to refuse to provide services for moral or religious reasons. (For example, such a conflict may arise where a patient requests an abortion but the physician refuses on the basis of religious convictions and referrals are impossible because the geographic area is underserviced.)

This gap in the codes of ethics for physicians must be addressed by the medical profession. It will be considered in greater detail in the following chapter.

There is no similar gap in the codes of ethics for lawyers in Canada simply because there is no recognition that lawyers (other than court-appointed lawyers) are under an obligation to provide services in emergencies. As a result, lawyers do not have to rely on moral or religious grounds to justify their refusal to provide services in this context. If the 'emergency exception' were recognized for privately practicing lawyers, then the personal convictions of lawyers would likely surface as exceptions to the obligation to provide services (as is already recognized by the ABA) and the potential conflict would also have to be addressed.

Finally, while there is some recognition by the regulatory bodies of the professions that the issue of discrimination in the provision of professional services needs to be addressed, the actions taken have either not gone far enough or have been spurred by self-interest of the professions. Both the Corporation professionnelle des medecins du Quebec and the Law Society of Upper Canada in Ontario are responding to this issue. The former has proposed draft regulation to include the nature of the patient's illness as an inappropriate ground upon which to refuse treatment (to address the issue of discriminating against HIV-positive patients), while the latter has proposed an amendment to the Rules of Professional Conduct to include discrimination on any of the prohibited grounds specified in the provincial human rights legislation as professional misconduct. While both of these proposals should be fully supported, they also warrant close scrutiny. Quebec's proposal simply does not go far enough to eliminate discrimination in the medical profession on other grounds, although the very existence of the proposal indicates the medical profession is aware of the problems of discrimination in the provision of services. Ontario's proposal does address the issue adequately but it is unlikely that the current proposal will be embraced by the legal profession[69]. Furthermore, considering the commentaries to the proposed rule focus primarily on employment issues within the legal profession (addressing billable hour targets and benefits) and the recent attention to gender discrimination in the legal profession[70], this proposal seems to have little to do with the protection of the public interest and everything to do with the self-interests of the profession itself.

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[69] Members of the Law Society of Upper Canada have been notified of the proposed amendment and have been invited to comment on it.

[70] For example, a Task Force was recently chaired by Madam Justice Bertha Wilson to address gender discrimination in the legal profession: Task Force on Gender Equality, "Touchstones for Change: Equality, Diversity and Accountability" (Ottawa: Canadian Bar Foundation, August, 1993).

It is hoped that the professional regulatory bodies will continue to deal with the issue of discrimination in the provision of services but that future actions will provide adequate protection against discrimination and will be truly motivated by the public interest, as their mandates require.

# CHAPTER THREE: THE EFFECTS AND IMPLICATIONS OF A PROFESSIONAL'S REFUSAL TO PROVIDE SERVICES

What are the effects and implications of a professional's refusal to provide services and the restrictions therein, on the individual seeking the services, on the professional and on society at large? Analysis of this issue will offer insight into what might be unethical conduct.

## *1. INTRODUCTION*

As was shown in the previous analysis, a professional has no legal duty to provide services to prospective patients or clients. It was also concluded that a professional does not have an ethical duty (as recognized in the respective codes of ethics) to provide services to prospective patients or clients except in limited circumstances, which vary between the professions. It was further suggested in the previous chapter that professionals may actually have a right to refuse to provide services to prospective patients or clients. This means that patients or clients who seek services do not have a right to the services of an individual professional, although they may have a limited right to services from an institution or from the profession.

We must now address the issue of whether the exercise of a professional right to refuse to provide services to individuals, in light of the existing restrictions outlined above, is problematic, and if so, if it is unacceptably so. Rather than engage in a theoretical discussion of how this right might be exercised in the abstract, reference will be made to actual experiences which have occurred in the Canadian medical context. The issues that present at both the individual level (from the perspectives of patients and physicians) will be canvassed. Some common reasons that physicians have refused to provide their services will be discussed generally and also with reference to four moral theories, in order to consider whether such practices might constitute unethical conduct.

## 2. *SERVICES REFUSED - THE PATIENT'S PERSPECTIVE*

Canadian patients may be refused access to medical services by physicians for a number of different reasons. In the present discussion, consideration of this issue will not be undertaken in the following circumstances: where a treatment is not medically indicated, including where a patient requests this; where the treatment is beyond the skills and expertise of the physician; where the physician's workload is fully committed; where the patient is uninsured or unable to pay; or where the treatment requires a resource which is unavailable. Rather, the issue will be discussed in the following scenario : a patient requests a medically indicated treatment from a capable physician who refuses to provide the treatment for non-medical reasons. In such a scenario, what are the consequences to the patient of the physician's refusal to treat? Quite simply, it seems that a patient finding herself in this predicament must either herself locate another physician who will provide the treatment or she must forego the treatment. Consider the following illustrations of the problem.

### (i) Case #1: Refusal to Treat on the basis of Sexual Orientation:

In 1993, a patient complained to the College of Physicians and Surgeons of British Columbia that she had been refused artificial insemination ("AI") from a physician on the basis that she was lesbian[1], alleging that the physician had engaged in unethical conduct. The patient also filed a human rights complaint in her province which is pending.

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[1] This complaint was brought by (the patient) Dr. Tracy Potter of Coquitlam, B.C. This case has not been reported officially but has been widely reported in the media. I am most grateful to Ms. Sandra Benson (who was designated by the patient as her spokesperson and agent) for discussing the details of this case with me on October 17, 1993 and granting me permission to discuss this case in the context of this thesis.

The physician cited a personal reason for declining to provide services to this patient. He stated that he was previously involved as a witness in a lawsuit between two lesbian women for maintenance of the children conceived through his provision of AI to one of them. His name was not protected from publication, and as a result, he is now uncomfortable about providing AI services to lesbians for fear of any further legal involvement. While this physician is not the only physician who provides AI in British Columbia, he does have the only frozen sperm bank in the province.

The Practice Performance & Conduct Committee (the complaints committee) of the College of Physicians and Surgeons of British Columbia has advised the patient that the physician in question did not offend the CMA Code of Ethics (which has been adopted by the B.C. College as their official Code of Ethics) although the complaint is currently before the Council of the College. According to the Practice Performance & Conduct Committee, the physician has a right to refuse to provide services in non-emergency circumstances and they did not find the physician had engaged in unethical conduct. Presumably, they noted that the CMA Code of Ethics does not preclude sexual orientation as a prohibited grounds to refuse to treat a patient.

It may be that the medical profession's position with respect to the provision of AI treatment is distinguishable from provision of other services. If the standard practice in the profession is to provide AI treatment only when there is evidence of medical infertility, this may be a reason for refusal to provide AI services to lesbian patients if they are not medically infertile. In this way, it may be important to distinguish refusal to provide AI services on the basis of sexual orientation from the refusal to provide other medical treatments to patients on the basis of sexual orientation. If such a distinction is to be made however, there should be clear indications from the medical profession about when it is appropriate to provide AI services to patients. Given that AI services are presently made available to patients who are not medically infertile, the medical profession should be providing this treatment to patients in a non-discriminatory manner.

The issue of physicians refusing to provide AI services on the basis of a patient's sexual orientation begs consideration of two important points. The first is that as a result of the CMA Code of Ethics (adopted as the official guidelines on ethical conduct of physicians in all provinces other than Quebec) and the Quebec Code of Ethics of Physicians, there is no prohibition on physicians refusing to treat patients on the basis of sexual orientation. Hence it is possible that physicians across Canada may deny services to patients on the basis of their sexual orientation and are not subject to any disciplinary action by their regulatory bodies. Taken to its extreme, if all Canadian physicians refused treatment to patients on the basis of their sexual orientation then no gays or lesbians in Canada would receive medical treatment except in emergency circumstances. Can the medical regulatory bodies possibly sanction such an omission in the codes of ethics and reconcile this with their legislatively-stated purpose of protecting the public interest? Furthermore, can denial of treatment based on the sexual orientation of the patient ever be reconciled with the concepts of universality of health care in Canada, with ethics in medicine, or with justice in society?

Secondly, it appears that physicians who refuse to treat patients do not have to provide justifications on the basis of their personal morality or religious conscience. This physician felt that his discomfort about the risk of being involved with the legal system as a witness was a valid reason to refuse to provide a patient with treatment. Apparently the complaints committee of the College of Physicians and Surgeons of British Columbia concurred with him. May we conclude that **any** reason that a physician provides for refusing to treat particular patients, no matter how arbitrary or ill-founded, will be an acceptable basis upon which to refuse patients who are not emergency cases?

In this scenario, the consequences to the patient are severe. She is forced to find on her own another physician to provide treatment. While there are other physicians in British Columbia who are capable of providing AI services, the only sperm bank in the province is the one managed by the physician who refused to treat her. Her only alternative would be to find a sperm bank in the United States (and pay for access). Otherwise, the patient will be denied access to AI services in her province.

### (ii) Case #2: Refusal to Treat based on Gender

> Worried about a sexual abuse complaint, a family doctor refuses to do a pelvic exam and sends his female patient to a hospital instead.
>
> Another doctor doesn't give a breast exam to a patient complaining of back pain - a potential sign of breast cancer - because he fears it will be misinterpreted.
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> Those are just two of many incidents around the province in what Dr. Wendy Graham, chair of the Ontario Medical Association's women's health committee, calls "a growing backlash".[2]

The Ontario Medical Association has also reported:

> "We have lots of reports now of physicians who have said they're no longer going to do pelvic, breast or rectal examinations. We believe it will have adverse effects, particularly on women's health which has been targeted by the legislation," said Dr. Gray *(Chair of the OMA's regulated health*

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[2] The Toronto Star, July 4, 1993, p. A1.

*professions act committee).*[3]

There is growing concern that Ontario women are being refused some treatments by physicians as a result of a backlash among health care professionals to *An Act to Amend the Regulated Health Professions Act, 1991*[4] ("*RHPA Amendment Act, 1993*"), commonly referred to as *Bill 100* before it was proclaimed in force. This legislation was proclaimed in force by the Parliament of Ontario December 31, 1993, and proposes significant changes to the *Regulated Health Professions Act, 1991*[5] to include sexual abuse of patients by health care practitioners as an act of professional misconduct and includes several procedural and other changes. The *RHPA Amendment Act, 1993* has received a very hostile reception from Ontario physicians, as has the entire process of considering sexual abuse within the medical profession which ultimately led to this legislation. The background leading up to this legislation is important to consider and will be briefly outlined below.

From the outset, addressing the issue of sexual abuse within the medical profession has been a contentious

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[3] Family Practice Newsletter, Vol. 6, No. 1 (Jan. 3, 1994) at p. 2.

[4] S.O. 1993, c.37.

[5] **Supra**, Chapter 1, note 33.

undertaking. In January, 1991, the College of Physicians and Surgeons of Ontario ("the CPSO") commissioned an independent Task Force[6] to examine the issue of sexual abuse of patients by its members. Over a period of seven months, the Task Force held a public inquiry to investigate the problem, in the form of public and private hearings and a confidential telephone line, and ultimately issued its conclusions and recommendations in the Fall of that year. While the public was no doubt served by an investigation into the problem of sexual abuse by physicians, the CPSO was apparently not acting with the best interests of the public in mind when it commissioned the Task Force. Consider the following comments by Dr. Joseph Homer, Chairman of the Legal and Internal Change Subcommittee of the CPSO which formed the Task Force:

> The real issue for the future centres around the future of self-regulation of the medical profession in Ontario. The response of the profession to the Task Force and the recommendations of Council should assure that future. The public...should be reassured by that response.[7]

Earlier, the Ontario Medical Association echoed a similar sentiment:

> Without public confidence, professional self-regulation cannot survive. Had the College

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[6] College of Physicians and Surgeons of Ontario, <u>Task Force on Sexual Abuse of Patients: The Final Report</u> (Toronto: Nov. 25, 1991) at 10.

[7] "Report on the Task Force on the Sexual Abuse of Patients - Recommendations Reviewed by Council", Sept. 14, 1992, at 1.

> not responded, it is likely that the Task Force, or a similar effort, would have been formed by someone else, most likely the government. *It is unlikely that the concerns of the medical profession would have been considered, in an even cursory manner, had the Task Force been struck by government.*[8] (Emphasis added.)

While there is no doubt that benefits have been reaped by investigating the issue, it is clear that the CPSO's initiative in establishing the Task Force on Sexual Abuse was to avoid relinquishing this power to government and to ensure that the concerns of the medical community were protected. The CPSO did not accept many of the recommendations made by the Task Force, modified some and accepted a few. The CPSO made final recommendations to the Government of Ontario. When the Government of Ontario proceeded with legislative action in the form of *Bill 100* which was not entirely reflective of the CPSO's recommendations, Ontario's medical community began lobbying for changes. Warnings have been issued about the negative consequences to the profession[9] and to patients about enacting such legislation.

Today, some Ontario physicians are refusing to take medical histories and perform pelvic or breast examinations on

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[8] P. Rhodes, "On Leadership and Professional Self-Regulation", *Ontario Medical Review*, Dec. 1991, at 1.

[9] T. Tremayne-Lloyd, "The Changing Face of Physician/Patient Relationships", *Treating the Female Patient*, Vol. 7, No. 2, May 1993.

patients, preferring instead to refer patients to same-sex physicians. The medical profession describes this practice as "deferred examinations" rather than denial of service, and justifies this practice on the basis of "gender discomfort".[10] However, since eighty per cent of Ontario physicians are men, deferring examinations to female physicians often results in these examinations not being performed.[11]

According to physicians, the fear of wrongful claims of sexual abuse are creating a problem of gender discomfort between physicians and patients resulting in some patients being denied requisite treatment, and the only solution is to change the *RHPA Amendment Act, 1993*.[12] But should we not expect our physicians to attempt to understand when certain acts are inappropriate according to patients, rather than avoiding the issue by referrals to same-sex physicians? Is it reasonable or necessary for physicians to practice defensive medicine in order to avoid false allegations of sexual abuse

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[10] I would like to thank Dr. Wendy Graham, Chair of the Ontario Medical Association's Women's Health Committee, for discussing this problem with me by telephone on October 27, 1993.

[11] Ibid.

[12] Ibid. During our discussion, Dr. Graham suggested that the problem of gender discomfort will only be corrected if the definition of sexual abuse (section 3 of the *RHPA Amendment Act, 1993*) is changed to reflect the perpetrator's perception only rather than the patient's, and if the mandatory reporting requirement of suspected sexual abuse by colleagues (section 18 of the *RHPA Amendment Act, 1993*) is removed.

by patients when complaints of sexual impropriety against doctors are very few and the number of convictions are even fewer[13]? Is it reasonable or necessary for doctors to refuse these services to patients when doctors may take preventative actions to avoid misunderstandings, such as asking a nurse to remain present during an examination? This denial of service to women unfairly compromises the health of women in Ontario. While the fear of litigation around the *RHPA Amendment Act, 1993* is undoubtedly a reality, it is submitted that given the political history of the Bill, denial of service to (predominantly) female patients is essentially a political statement by the doctors of Ontario. It is an expression of the medical community's displeasure with a threat to their self-regulation.

As a result, female patients who are denied breast, pelvic and rectal examinations from male physicians who are experiencing gender discomfort, are forced to seek treatment from other physicians, likely female physicians. At best, this practice will cause delays in treatment which may

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[13] According to the CPSO, in 1991 7.6% of the complaints against physicians alleged sexual impropriety (124 of 1,642) and 0.67% of the total complaints resulted in convictions of sexual impropriety (11 of 1,642). In 1992, the number of complaints against physicians alleging sexual impropriety rose slightly to 7.7% (144 of 1,862) but the number of convictions for sexual impropriety decreased to 0.27% (5 of 1,862): The College of Physicians and Surgeons of Ontario, News Release "Quick Facts", (September, 1993). I am grateful to Ms. Lambert-Theriault (Complaints Officer) of the CPSO for providing me with this publication.

compromise the health of the patient. At worst, this practice may result in these services not being provided to patients at all.

### (iii) Case #3: Exclusion from Clinical Trials based on Gender

> Women of reproductive age have often been excluded as participants in clinical trials because of possible risks to a fetus. This has not been just a matter of special concern or paternalism. In addition, it has been a matter of avoiding unnecessary risks of legal liability. Older women have been excluded because they often have multiple health problems that may create risks for them and confuse the results of the trial. And finally, the more kinds of participants enroled in a trial, the more difficult the analysis and interpretation. Given these problems, as well as the indeterminate contribution of sexism, it is not surprising that most clinical trials have been heavily, if not exclusively, weighted toward men.[14]

When devising policies for clinical research, attention has often been devoted to ensuring that those who participate as subjects of research are doing so voluntarily and are fully informed of the risks of such participation. Recently, however, attention has also been drawn to those who are excluded from participating in clinical trials and the results of such denial. Those who have considered the latter

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[14] Angell, M.: Caring for Women's Health - What is the Problem? *N Engl J Med* 1993; 329: 271-272.

issue have identified specific populations[15] who are routinely excluded and have begun to question the rationale for such exclusionary practices.

Women represent a portion of the population frequently excluded from clinical trials. Some writers have recognized the under-representation of women with HIV infection or AIDS in therapeutic HIV/AIDS drug trials to date[16]. Others have studied the exclusion of the elderly and women from clinical trials of drug therapies used to treat acute myocardial infarction[17], and concluded that "such exclusions limit the ability to generalize study findings to the patient population that experiences the most morbidity and mortality from acute myocardial infarction"[18]. Still other studies have addressed the issue of excluding women of childbearing age in drug studies[19]. In short, some have

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[15] For example, women, the elderly and minorities have most frequently identified in the literature as excluded from clinical trials.

[16] Levine, C.: Women and HIV/AIDS Research: The Barriers to Equity. IRB 1991; (Jan/April): 18-22.

[17] Gurwitz, J.H., Col, N.F., Avorn J.: Exclusion of the Elderly and Women From Clinical Trials in Acute Myocardial Infarction. JAMA 1992; 268(11): 1417-1422.

[18] Ibid. at 1417.

[19] Halbreich, U., Carson, S.W.: Drug Studies in Women of Childbearing Age: Ethical and Methodological Considerations. J Clin Psychopharmacol 1989; 9(5): 328-333.

concluded that there has been an overrepresentation of white men as research subjects in the past[20]. The problems inherent in this practice and the justifications for gender exclusion will now be considered.

There are three main reasons why exclusion of specific populations of patients from participation in clinical trials is problematic. First, patients who are denied access to therapeutic clinical trials are denied access to potential therapeutic benefits of the drugs or therapies which are being tested. This is a somewhat novel position which reflects a significant shift in perceptions of clinical research. Previously clinical trials were viewed as primarily a risk to the subject and beneficial to the researcher and to society at large, whereas recently there has been a shift towards viewing clinical trials as also beneficial to the subject.

Secondly, there is concern that exclusionary practices may result in harm to specific populations when new drugs or therapies are approved for medical practice and prescribed by physicians when the effects on specific populations are still unknown. It is also conceivable that specific populations will be harmed by doctors who withhold

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[20] Dresser, R.: Wanted - Single, White Male for Medical Research. Hastings Center Report 1992; 22(1): 24-29.

potentially useful drugs or therapies from them because of the unknown effects on these specific populations.

Finally, the practice of denying specific populations access to clinical trials may threaten the principles of autonomy and respect for persons which are so fundamental to our conception of medical ethics specifically and to our society generally. We have moved from accepting benevolent paternalism on the part of researchers making decisions for their subjects, to the rise of the concept of autonomy of the individual which maintains that there is an inalienable right to self-determination and a right to be free from outside interference. A subject's right to be fully informed of the risks and benefits of participation in a clinical trial (the "cardinal principle" of research on human subjects[21]) reflects these principles. A patient who is excluded from enroling in clinical trials is prevented from exercising her right to self-determination, prevented from determining for herself whether or not to enrol in the trial and whether or not to assume the risks. Is this not a denial of the autonomy of the person and a grant of power to the researcher which continues the paternalism that has historically been so predominant?

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[21] Medical Research Council of Canada, "Guidelines on Research Involving Human Subjects", **supra**, Chapter 2 note 21, at 21.

As was mentioned above[22], many reasons have been offered by clinical researchers to justify the exclusion of specific populations from participation in clinical trials. Women are often excluded on the basis that they have the potential to be or actually are pregnant. For example, the FDA issued guidelines that stated for Phase I studies, in general women of childbearing potential should be excluded and for Phase II studies women may be included, provided segment II and the female part of segment I of the FDA Animal Reproduction Guidelines have been completed[23]. Many reasons have been put forth to justify such practices.

First, it has been suggested that this cautious approach is often a result of the fear of litigation which may ensue should women be exposed to treatments in the course of clinical trials that will lead to adverse consequences in future pregnancies.[24] It is more than coincidental that the FDA guidelines and similar positions were advanced shortly after the Thalidomide experiences of the 1970's and the litigation that followed. It should be noted, however, that the Thalidomide experiences were a result of drugs given to women during the course of medical practice and not in the

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[22] Angell, **supra**, note 14.

[23] Food and Drug Administration: General Considerations for the Clinical Evaluation of Drugs. Washington, D.C.: U.S. Government Printing Office, 1977.

[24] Levine, **supra**, note 16 at 19.

course of clinical trials.

If women and future offspring will be adversely affected by certain therapies, it would seem logical to discover this at the clinical trial stage rather than after the therapy is approved as part of medical practice. Fewer individuals would be exposed to harm in a trial compared to the number of individuals who may be harmed if the drug or therapy is distributed to the public. Furthermore, from a strictly economical perspective, litigation that may arise from damages incurred during a clinical trial would certainly be minimal given the smaller number of potential plaintiffs, compared to the large number of potential plaintiffs should the drug or therapy be publicly available. Finally, it should be noted that risk of liability for damage to subjects is always a concern in research involving human subjects and is not limited to female subjects.

Secondly, the fear of unknown effects of substances on future progeny is often a concern to researchers. Women of childbearing potential are often excluded from trials because of concern about the possibility of significant reproductive risks caused by exposure to substances. The concern about possible reproductive consequences when women are exposed to substances should be contrasted to the lack of concern about possible reproductive consequences when men are exposed to substances. Levine points out that some writers have now acknowledged a "new concept", namely that drug and chemical exposure in men can affect their progeny.[25] If concern for future progeny is significant enough to exclude women of reproductive potential from participating in clinical trials, should this not be extended to men of reproductive potential? The validity of such justification for exclusion of women needs to be questioned in light of this omission.

Finally, the risk of teratogenicity should a female subject be or become pregnant is another common justification for the exclusion of women from clinical trials. Concerns for the condition of women who are or could become pregnant while enroled as research subjects and concerns for their potential children, are obviously factors which must be considered by researchers. It does not follow, however, that a categorical exclusion of all women on this basis is reasonable.

Many protocols do not pose any known or foreseeable risks to future children. For example, most HIV/AIDS protocols do not pose any foreseeable risks to future children and yet only a small number of these research subjects are women.[26] If a protocol does not pose any known or foreseeable risks to future children, it is difficult to see how exclusion

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[25] _Ibid_.

[26] _Ibid_.

of all women of childbearing potential could be justifiable.

The more difficult considerations arise when foreseeable risks to future children are either unknown or known to be present to some degree. Where there is potential benefit to the woman by enroling in a clinical trial but also potential or unknown risks of harm to potential offspring, the issue is less obvious. Some may employ a risk-benefit analysis to assess the legitimacy of excluding women, that is, where the potential benefit to the woman is great and the potential risk to offspring is small then exclusion of women is unjustifiable. If the potential benefit to the woman is great and the potential risk to offspring is unknown, some believe a cautious approach of excluding all women from clinical trials is best. It is submitted that the latter approach is difficult to justify. To have a categorical exclusion of women from clinical trials based on their childbearing potential ignores the fact that many women are either not sexually active or are reliable in their contraceptive practices. To take away from women the decision of whether or not to enrol in a clinical trial when they are not actually pregnant is to infringe their right to autonomy, unjustifiably.

Thus, specific populations have been denied access to clinical trials. As a result of such exclusionary practices, individuals are denied potential benefits from clinical trials. These populations are also put at a higher risk when drugs or therapies are later approved for distribution and made available without having been tested on those populations. Presently, those who are the subject of these exclusionary practices will have no other access to the potential benefits offered in clinical trials.

## *3. RESTRICTING REFUSAL - THE PHYSICIAN'S PERSPECTIVE*

Canadian physicians have refused their services to patients for a number of different reasons. Again, the present discussion will focus on the following scenario : a patient requests a medically indicated treatment from a capable physician who refuses to provide the treatment for non-medical reasons. In this scenario, what reasons may a physician have for refusing to treat a patient and are all reasons acceptable? What consequences will flow if the physician is compelled to offer his or her services and is not permitted to refuse the patient? These issues will be considered with reference to the above scenarios of refusal of services to patients. The reasons for physicians' refusal to provide medical services will also be considered with reference to four moral theories in order to consider whether such practices may constitute unethical conduct.

## *A. Discrimination*

Occasionally, physicians may cite reasons for refusing to treat patients which may in fact, be based on ignorance and prejudice. In the first scenario, a lesbian patient was refused AI services from a physician. He stated that he was unwilling to provide these services to lesbian patients (while he continues to provide these services to heterosexual women) because he did not want to be involved as a witness later in child custody matters. This implies that lesbian couples are more likely to break up and fight for custody of children than are heterosexual couples.

If this was indeed the motivation for the physician's refusal, it is founded largely on ignorance. Ignorance in turn breeds prejudice. If this was not the physician's true motivation, we may conclude that denial of services to lesbian patients but provision of the same services to heterosexual patients is based on prejudice against lesbians and is discriminatory.

Physicians may feel that they should have autonomy in their practice of medicine. They may argue that restricting their choices of patients to avoid discrimination would infringe their right to liberty. Yet we do not endorse discrimination by non-professionals in society, so why should professionals who are expected to act ethically be entitled to a greater degree of autonomy which permits discriminatory practices? Even if we accept that physicians have the right to refuse to treat, such a right cannot be absolute. This may indeed be an infringement of a physician's right to liberty, however an ethical physician should not be permitted to discriminate in his or her practice.

## *B. Fear of Litigation*

As was illustrated above, the fear of litigation is a common reason that physicians may decline to provide services to patients. In the first scenario where a lesbian patient was refused AI services by a physician, he was not concerned that he might be the subject of litigation but rather the fear of *being involved with* litigation, as a witness, was the reason he cited for his refusal. In the second scenario, the reaction to the *RHPA Amendment Act, 1993* has led Ontario physicians to refuse to perform intimate examinations on patients. The growing practice of defensive medicine in Ontario has been attributed by the medical profession to physicians' fear of being the subject of sexual impropriety charges. Similarly in the third scenario, it was suggested that clinical researchers are excluding women of childbearing potential from clinical trials because of the fear of being the subject of litigation should there be unfortunate consequences for potential offspring.

The fear of litigation has never been recognized as a legitimate limitation of a physician's ethical or legal obligations to his or her patient. The question is whether it should be so recognized. That physicians fear litigation is quite understandable. Lawsuits can be very expensive, professionally damaging and emotionally draining. Yet at core it seems offensive that physicians, who are advantaged members of society by virtue of their educational and financial position, ought to be protecting themselves at the expense of those more vulnerable in society, namely their patients who seek help when they require medical attention.

Some may take the position that physicians are acting appropriately when they avoid what they perceive to be high-risk situations which may lead to litigation. This position may support the notion that physicians have the right to protect themselves from lawsuits and thus it follows that physicians have the right to choose patients whom they feel safe with.

While this position engenders sympathy for the plight of physicians, it should not be embraced. We ought not absolve physicians of their obligations[27] for reasons of mere

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[27] Recall the proposition set out early in Chapter 2 that a physician's obligation to the patient begins even before there has been a formal agreement to enter a relationship.

inconvenience. The problem of fear of litigation could be better handled by taking steps to avoid needless litigation. We should educate both the public and the lawyers whom they consult about the proper use of judicial channels and the cost of abusing the system. We should educate physicians how to better communicate with patients and respect them as persons, in order to avoid misunderstandings and feelings of alienation. We should encourage conflict resolution in forums other than the courts, such as mediation of medical-ethical-legal issues by trained professionals. Finally, if the matter is still referred to the courts, we should ensure that sufficient protection is available to accused persons and then be confident that justice will be done.

### *C. Moral or Religious Objections*

Physicians may refuse to treat patients because the proposed treatment conflicts with their own moral or religious beliefs. This situation is the most difficult to respond to. Consider how the situation in the first scenario might be complicated if the physician had refused to provide the lesbian patient with AI because his religion teaches him that homosexuality is a sin and providing the requested treatment would be sinful or that providing AI treatment to any woman is a sin (for example, a position which the Catholic church holds).

As was outlined in Chapter Two, medical codes of ethics recognize that a physician may refuse to treat a patient on the basis of moral or religious objections of the physician. The codes leave open the question whether physicians have the right to refuse to treat on moral or religious grounds even in emergency circumstances. At first blush, the proposition that physicians have the right to moral and religious freedom seems unquestionable. It is because this freedom is so important to physicians and society at large, and because decisions to refuse treatment to patients can have such a profound effect on their lives, that the issue requires careful consideration.

Some may argue that conflict between a physician's right to moral and religious freedom and a patient's right to basic medical care is best resolved by referring the patient to other physicians who are willing to provide the treatment. While this may avoid the problem where referrals are possible, the problem remains unresolved if referrals are not possible either because of geographic disparity (the patient is in an understaffed area of the country and there are no other physicians available to perform the service) or because of time constraints (the situation is an emergency and delayed treatment would compromise the patient's health).

Since the codes of ethics provide little insight into whether discriminatory objections, or fear of litigation may be limitations to the actions of an ethical physician in his or her practice of medicine, or how to resolve the moral dilemma when a physician's moral or religious convictions conflict with his or her duty to treat a patient, a consideration of four different moral arguments which have discussed professional responsibility to provide services will be undertaken. Through analysis of these arguments, it will be shown that none of the theories supports the notion that refusal to treat based on discriminatory reasons or fear of litigation is ethical, and only one argument strongly supports the conclusion that in circumstances where referrals are not possible, a physician has a moral obligation to provide services which are legitimately performed by other members of the profession despite considerations of litigation and religious or moral convictions of the physician.

### *(i) The Self-Sacrifice Principle*

The issue may be considered in light of the argument advanced by Abigail Zuger[28], whose vision of the practice of medicine entails a degree of self-sacrifice. Zuger has written about "physician-oriented" ethical issues of how difficult decisions made by physicians impact on their lives (as opposed to the lives of their patients). In considering

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[28] Zuger, A.: Professional Responsibilities in the AIDS Generation. Hastings Center Report 1987; 17(3): 16-20.

whether a physician is ethically obliged to care for an AIDS patient, she looks to a theory of medical professionalism which holds physicians to higher standards of integrity and altruistic character. There is a societal expectation that physicians make sacrifices for their patients, which for Zuger translates into a physician's duty to treat a patient under difficult circumstances.

While a "spectrum of self-sacrifice" exists in the medical profession, this theory holds that the principle of altruism is inherent in the profession itself and is the grounding for physicians to be held to higher duties to treat patients under difficult circumstances. Indeed, this altruistic vision of physicians is supported by the first principle of ethical behaviour in the CMA Code of Ethics, "Consider first the well-being of the patient."

I support this vision of the practice of medicine which holds physicians to higher standards of integrity and altruism. This theory would easily find that discriminatory reasons and considerations of litigation would not be consistent with notions of altruism, and thus would be unacceptable reasons for physicians to refuse to treat patients. This principle cannot, however, be extended far enough to apply to the moral dilemma posed above. First, acceptance of a view of physicians as altruistic in treating patients under difficult circumstances will not necessarily imply acceptance of this principle applied to physicians faced with moral or religious conflicts. Situations that present physicians with hardship, unpleasantness and even fear are distinguishable from situations which require physicians to sacrifice their religious convictions or personal morality. In the first instance, physicians are asked to endure situations which they are exposed to ordinarily only to a greater degree, and to extend their threshold of tolerance for the sake of their patients. In the second instance, physicians are asked to violate their convictions of what an ethical practice of medicine entails and are asked to further a cause which they oppose. If we ask this from our physicians, it should not be simply because we expect more from them.

### *(ii) The Contractual Model*

Discussions of professional responsibilities often take place by adopting contractual models. Keeping promises is a well-accepted ethical principle. By viewing professional services in contractual terms, one may look to the contract to argue that promises made obligate the professional to provide these services.

Within a contractual model, the provision of medical treatment is the essence of a contract made between the patients and the physician as the provider of medical services. The AMA appears to have adopted this contractual view in its statement on the physician-patient relationship and respect for law and human rights:

> **9.12** The creation of the physician-patient relationship is contractual in nature. Generally, both the physician and the patient are free to enter into or decline the relationship. A physician may decline to undertake the care of a patient whose medical condition is not within the physician's current competence. However, physicians who offer their services to the public may not decline to accept patients because of race, religion, national origin, or any other basis that would constitute illegal discrimination...[29]

It is possible to look to contractual principles to argue that, in entering the medical profession the physician has entered into a contract with the public to provide his or her services. If at the time of entering the contract the physician did not take exception to the type of services which (s)he would provide (apart from specialists), this later variation of the contract cannot be unilaterally imposed. Thus, the physician has undertaken to provide all available services within his or her expertise and the patient has a right to rely on these implied promises. An ethical physician must respect the promises (s)he made.

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[29] "Principles of Medical Ethics and Current Opinions of the Council on Ethical and Judicial Affairs", **supra**, Chapter 1 note 11, at 221.

While there are several problems with relying on this theory to justify limiting a physician's freedom to choose patients, two main objections will be discussed here. First, it is not clear who the patient has contracted with. Some will argue it is with the individual physician, but it is equally plausible that others will argue that the contract is really with the profession or perhaps the government[30]. If one cannot determine with certainty who the contracting parties are, then one cannot say with certainty who has the ultimate duty to provide treatment to the patient. Secondly, contractual obligations do not extend to unconscionable acts. Even if there is a contract with the physician, if a proposed treatment is considered unconscionable the existence of a contract will not ensure its performance. Therefore, applying a contractual model fails to resolve the moral dilemma even if it could apply to considerations of discriminatory choice of patients or refusal to provide services based on the fear of litigation.

### *(iii)* *The Equality Principle*

Another argument which has been advanced embraces a

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[30] On this point, the universality of the Canadian health care system as set out by legislation, implicates the government as a party to the contract for providing medical services. This will not necessarily be true for the government's role in the provision of legal services since there is no universal program in place, or for medical services provided in other countries where universality is not supported by government.

theory of value for the minimal well-being of all citizens.[31] Equal opportunity to have access to services which achieve this end, such as basic education, legal and health services, is promoted in this theory. Maldistribution of basic services must be overcome in this theory. Assuming the goal of equal access to professional services is pursued by the society, the potential for professionals to refuse to serve patients or clients may impede success.

Michael Bayles is a proponent of this view that the central importance of these basic services gives rise to rights to these services. In considering the circumstances under which a professional will have a solid ethical reason for refusing a patient or client, different positions are offered but one is especially relevant to the moral dilemma considered above.

His moral integrity argument is as follows.[32] If a professional is ethically opposed to providing services in a given circumstance but another professional is not so opposed, it is better for the unopposed person to perform them since this would not violate his or her own moral integrity whereas the former would be violated. (Note that if a professional's

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[31] M.D. Bayles, Professional Ethics, 2nd ed. (Belmont: Wadsworth Publishing Co., 1989) at 59.

[32] Ibid.

refusal to provide services is based on discriminatory reasons or fear of litigation rather than ethical objections, her moral integrity will not be compromised if she performs the service. Therefore, these considerations are not relevant to the moral integrity theory and would not be justifiable reasons for the refusal of professional services.) When no other professional is available (he gives an example of a physician in Alaska who is asked to perform an abortion), "then making services equally available sometimes justifies providing the service"[33].

Thus, this theory provides room for professional freedom to exist but when it threatens the equal availability of services, the professional's moral integrity may not be paramount. This theory has elements of a harm-benefit analysis. If a professional is unopposed to providing a service which is available, no harm will be done in that person performing the act. If the only professional available to provide the service is ethically opposed, the harm of violating his or her moral integrity will have some personal negative effects but this may be justified by avoiding the greater harm of violating the principle of equality of access to necessary services.

This moral argument is quite persuasive.

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[33] Ibid.

Personally, I can accept the first proposition quite easily, that the minimal well-being of all citizens is of fundamental importance and so equality of access to services also is highly valued. However the second proposition, that violation of individual rights (the professional's right to integrity) may be justified in the name of the greater social good, is more difficult to accept.

In Canada, we live in a social climate where individual rights are highly protected, and we also live in the '*Charter* era' where infringement of individual rights by government will only be permitted if it can be demonstrably justified in a free and democratic society. (For example, the value of freedom of speech is so great that people are permitted to publish hate literature.) Thus, accepting that individual rights of professionals will be sacrificed to achieve a greater social good which Bayles' argument defines as equality of access to services, may not be easily accepted by all. If this argument defined the greater social end beyond positive rights to equal availability of services and included negative rights, such as the right to non-discrimination, this position would be more easily accepted.

### *(iv) The Non-Discrimination Argument*

If there is a duty of a professional to provide services to patients or clients in the face of a moral or religious conflict when no other professional is available, the basis for such a duty is best justified by adopting the rationale of Benjamin Freedman[34]. In considering the duty to treat the infectious, Freedman employed a 'thought experiment' to envision a world without such a duty. If this approach is applied to the present ethical dilemma, the following is anticipated.

It has been decided that a professional does not have an obligation to provide services when they are opposed to doing so for moral or religious reasons. So a Catholic physician is justified in denying his patient an abortion even though she has no other possibility of obtaining this medical service. It does not matter that people living in the same country and the same province but in a more populated area access this medical service easily. Maldistribution of medical services would be ingrained in this system.

Other patients' access to health care would also be denied. Respecting one physician's moral or religious convictions would necessitate respecting all physicians' morals and religions. Jehovah's Witnesses believe receiving blood transfusions is a sin. Their religion sees everyone who

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[34] B. Freedman, "Health Care Workers' Occupational Exposure to HIV: Obligations and Entitlements" in C. Overall and W.P. Zion, eds. Perspectives on Aids - Ethical and Social Issues (Toronto: Oxford University Press, 1991).

partakes in the prohibited activity as sinners and not just those who belong to their religion.[35] Thus, medical professionals who are observant Jehovah's Witnesses will not give patients, regardless of their denominations, blood transfusions nor will they be peripherally involved with such a treatment (for example, a nurse could not assist in an operation where a blood transfusion was being given to a patient). Imagine a world where this was completely accepted, even in emergency situations. In emergency circumstances, patients who do not have access to other non-Jehovah's Witness professionals would be denied blood transfusions which have been recognized as standard medical treatment by the medical community for years.

The problem, of course, is that it would be very difficult if not impossible to determine what would constitute a legitimate moral or religious conflict which would pre-empt a patient's right to medical treatment during emergencies. What if there was a New Religion whose followers believed that all black people were Satan's Workers and evil. Because of their beliefs, those followers in the medical profession refuse to treat all black people under any circumstances. In a world where physicians were without duties to provide

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[35] "How Can Blood Save Your Life?" (Pennsylvania: Watch Tower Bible and Tract Society, 1990); "Blood Transfusion - Why Not for Jehovah's Witnesses?" (Governing Body of Jehovah's Witnesses).

patients with available services during emergencies in the face of moral or religious conflicts, this too would be legitimate. It would be virtually impossible to decide that only certain conflicts would be accepted, those of the mainstream, while others would be rejected. (The same would, of course, be true if physicians routinely refused to treat patients for discriminatory reasons without a religious or moral objection or if physicians were without duties to provide treatment for other reasons, such as the fear of litigation).

A world like this would breed much anxiety and chaos in recipients of health care. They would have no way of knowing what the religious or moral convictions are of those health care professionals who happen to be available during emergencies. Several serious consequences would flow from these concerns.

1. Assuming they are conscious, patients will be very careful to interview the physician and medical team as to their religious or moral views before treatment begins. If the patient is undergoing an emergency, this process may waste valuable time and put the patient at more risk.

2. Individuals will become fearful of people of different religions and beliefs since they will be ignorant of different convictions and may believe their well-being is threatened by

these differences. Ignorance breeds fear. Racism and discrimination will thrive in this environment. It will spread to other institutions in society.

3. Our multicultural society will begin to segregate. Non-Catholics will not want to live in a Catholic community for fear of receiving 'Catholic treatment' during an emergency. Non-Jehovah's Witnesses will avoid areas populated by Jehovah's Witnesses. Even those who are of the same religious persuasion will fractionate into smaller groups of those who are very orthodox in their beliefs and those who are non-observant. There will be no harmony of differences, only different groups of homogenous people.

4. Medicine in smaller communities will be more mistrusted since the choice of physician will influence the type of services provided and the choice will be very limited in rural communities.

5. Paternalism in the medical profession will gain renewed strength as physicians' rights will be paramount to patients' rights and patients will have less power to choose treatments that suit their lifestyles best.

6. To avoid these problems, the medical schools may prefer candidates who have very few strongly held moral or religious convictions. Amoral doctors will be preferred to those with morals in order to avoid possible conflicts with patients. Those who initially conceal their convictions in order to gain entrance to the medical profession will be rewarded for their

deception. Later they can be free to express their convictions and the conflicts will continue.

It is important to understand the philosophical underpinnings of this moral argument. It seems to bear closest resemblance to the type of moral philosophy embraced by Kant. At first blush, it may seem that a rule utilitarian[36] approach (which judges the rightness of a rule by its consequences) is the most obvious theory that this argument employs. However, rule utilitarianism may not be sufficiently flexible to be the basis of the fourth argument. Rule utilitarianism can endorse a rule that states doctors must provide treatment within their competency to their patients. If 'Providing treatment' is a rule, then a physician who declines to treat a patient because doing so would violate his or her conscience, when another physician is available who agrees to provide the treatment because (s)he sees it as unoffensive, would not be doing the right thing. This is not part of the argument posed above.

Kant's deontological approach[37] is more similar to that used in the above argument. Kant recognizes there is intrinsic human worth when he states that people must be

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[36] R. Munson, Intervention and Reflection: Basic Issues in Medical Ethics, 4th ed. (Belmont: Wadsworth Publishing Co., 1992) at 7.

[37] Ibid. at 11-12.

treated as ends and not only means, and therefore standards that make the basic worth of one individual unequal to another violate Kant's theory. For Kant, the consequences of an action are morally irrelevant but actions that promote discrimination will not be found to be morally right. It is upon this principle that the argument posed above also rests.

One important point must be highlighted when considering the application of Kant's principles to the moral dilemma posed above. Kant's notion that we have duties to rational persons and his distinction between perfect and imperfect duties must be fully appreciated in the context of resolving a physician's conflict when asked to provide treatment which violates his or her conscience. The duty not to harm a rational person is a perfect duty so we may say that providing necessary treatment in an emergency is something a physician must always do to be moral. An obligation to observe the tenets of one's religion may not fall within Kant's duties to rational beings. This would mean that where there is a conflict, one's perfect duty to a rational person would be higher than one's duty to a supernatural entity.

Therefore, it is submitted that the non-discrimination argument supports the position that when no referral is possible in an emergency situation, a professional has a moral obligation to provide services which are legitimately provided by other members of the profession. This would be the case whether the refusal was because of discriminatory reasons, a fear of litigation, or because of religious or moral conflict. Obligating professionals to provide services for causes they are in personal conflict with is not lightly recommended. I am not oblivious to the gravity of this suggestion. Nonetheless, this position may be defended by application of a Kantian-type moral argument which seeks to prevent discrimination by recognizing duties owed equally to all rational beings. This moral argument should be extended to other professionals such as lawyers, whose services may be as essential for the well-being of individuals as are medical services. This should be reflected in the very high ethical duties that professionals owe to society.

## *4. CONCLUDING REMARKS*

Having considered the effects and implications of a professional's refusal to provide services, several conclusions may be drawn. First, it was established that physicians are refusing to provide legitimate services to patients for non-medical reasons. This is not an abstract discussion. It was also shown that these refusals have resulted in some patients being denied access to legitimate services: a lesbian denied AI services, Ontario women denied intimate examinations, women denied access to clinical trials.

These practices are problematic because they are destroying the essence of the professional-client relationship, the trust in the professional.

As a society, we must consider carefully the value of liberty and the limits thereof. Professional autonomy and patient-client autonomy cannot always coexist harmoniously. When a balance cannot be achieved, which should be paramount? Some will say that professional autonomy should be supreme because when professionals are forced to provide services they oppose, they will become embittered, will not perform well, and their patients or clients will suffer in the end. Others will say that patient-client autonomy should always be paramount as long as they are requesting legitimate services, because to deny some people and not others would create inequity, and to raise professional rights above patient-client rights would tarnish the image of professionals as trustworthy and committed to public service.

Both of these positions have some merit but such absolute statements may not be entirely appropriate. Society should consider whether all refusals to provide professional services ought to be weighted equally. It is submitted that refusals to provide services based on matters of inconvenience and risk of litigation incurred by the physician ought never to take precedence over patients' access to appropriate medical services, and should be deemed to be unprofessional conduct by the professional regulatory and disciplinary bodies and unethical conduct by society at large. Refusals to provide legitimate services which the physician is morally or ethically opposed to is by far the more difficult determination. I would suggest, however, that to limit patients' access to services in this scenario would be paramount to endorsing discrimination by physicians and encouraging discrimination in society more generally. Professional autonomy should have limits and should not extend to choice of patients. The discrimination which will follow may either be direct, as in the case of refusing patients, or as Margaret Somerville has pointed out, "indirect or hidden discrimination may occur if the 'wrong kind of sick people' can be avoided"[38]. The following chapter will consider whether there may be legal consequences to a professional's refusal to provide services.

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[38] "The Right to Health: A Human Rights Perspective", **supra**, Chapter 2 note 4, at p.11 of the text of the speech.

# CHAPTER FOUR: POTENTIAL LIABILITY OF A PROFESSIONAL'S REFUSAL TO PROVIDE SERVICES

Could refusals by professionals to provide services, or restrictions on the right to refuse to provide services, be the subject of legal challenges on the basis of a violation of human rights? Analysis of this issue will offer insight into what might be illegal conduct.

## *1. INTRODUCTION*

Thus far, we have seen that professional regulatory bodies have recognized a general right belonging to their members to refuse to provide their services, with very few exceptions. There would, then, be very few occasions where these bodies would find that a member had engaged in unprofessional conduct for refusing to provide legitimate services to prospective patients or clients. As a result, there is a perception among professionals that they have a 'right' to refuse the provision of their services, and as was illustrated earlier, they are exercising this right today. In the previous chapter, the more common motivations for professionals to refuse to provide their services were examined. The analysis which followed attempted to determine whether such behaviour was unethical, as opposed to unprofessional, according to various moral theories. It was argued that such behaviour is indeed unethical. In this chapter, we will consider whether such practices might also be illegal.

A full discussion of the possible legal consequences of professionals exercising a right to refuse services would necessitate a paper in itself. One would need to explore all the possible private law remedies based on negligence, issues of vicarious liability, breaches of statutory duties, etc., as well as potential criminal sanctions, constitutional challenges and human rights violations. In this chapter, the legality of a professional's refusal to provide services will only be considered in the context of human rights challenges based on the *Canadian Charter of Rights and Freedoms* ("the *Charter*"), in particular sections 15 and 7, and human rights legislation in place in Canada. For the purposes of this discussion, the relevant issues will largely fall under the jurisdiction of provincial human rights legislation and the laws of Ontario and Quebec will be considered.

## 2. A CHARTER CHALLENGE

Could patients who have been denied medical treatment from physicians for discriminatory reasons or who have been excluded from clinical trials for discriminatory reasons, or physicians who are obliged to provide their services, challenge such action on the basis that they are constitutionally invalid under the *Charter*? It is submitted that while some individuals' *Charter* rights may be infringed by these practices, it will be difficult for them to find remedy through the *Charter* since it will be difficult to establish that the *Charter* will apply to the physician defendants or other potential parties who may be defendants to such an action.

In determining whether a patient who has been refused medical treatment or access to a clinical trial for discriminatory reasons or a professional who is obliged to provide his or her services may bring a successful *Charter* challenge, three issues must be addressed: first, whether the *Charter* will apply to the potential defendants in the circumstances; secondly, do the exclusionary practices infringe a constitutionally protected right of the plaintiff; and finally, if these practices do infringe a constitutional right, is this infringement demonstrably justified in a free and democratic society.

## *A. Application of the Charter*

If the discriminatory provision of medical services or exclusionary access to clinical trials become the subject of a constitutional challenge, the potential defendants may include the individual professionals, the hospitals or universities which employs these professionals and authorizes their practices, and the governing bodies which issue guidelines and regulate professional conduct. In analyzing the applicability of the *Charter* to these potential defendants, attention should be drawn to s. 32(1) of the *Charter* which states the following:

> 32. (1) This Charter applies
> (a) to the Parliament and government of Canada in respect of all matters within the authority of Parliament including all matters relating to the Yukon and Northwest Territories; and
> (b) to the legislature and government of each province in respect of all matters within the authority of the legislature of each province.

The Supreme Court of Canada has clearly stated that the *Charter* will not be applicable to disputes between private parties.[1] The *Charter* will only apply if one party to the litigation is 'government' or if one party is challenging 'government action'.[2] Thus, for the *Charter* to apply to any or all of these parties, the party must be shown to be 'government' or must be carrying out 'government action' when it enacts its policies.

The issue of whether an entity is part of government

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[1] R.W.D.S.U., Local 580 v. Dolphin Delivery Ltd., [1986] 2 S.C.R. 573.

[2] Ibid.

came before the Supreme Court of Canada in McKinney v. University of Guelph[3], where it was argued that the mandatory retirement policy set by a university infringed s.15 of the *Charter*. The majority decision, delivered by LaForest, found that the university did not form part of the government apparatus and thus, did not fall within the ambit of the *Charter*. The majority found the university was not part of government because the institution was autonomous in managing its own affairs, because academic freedom (especially relating to appointments, tenure decisions and dismissal of academic staff) was inconsistent with government control, and that to be part of government requires more than simply to be a creature of statute and perform a public service. The majority did not elaborate on what would be required to find an entity to be part of government for the purposes of *Charter* challenges. The minority in this case did provide more specific guidelines for deciding whether an entity is part of government. The test as described by Wilson J. is as follows:

> 1. Does the legislative, executive or administrative branch of government exercise general control over the entity in question?
>
> 2. Does the entity perform a traditional government function or a function which in more modern times is recognized as the responsibility of the state?
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> 3. Is the entity one that acts pursuant to statutory authority specifically granted to it to enable it to further an objective that government seeks to promote in the broader

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[3] [1990] 3 S.C.R. 229, 76 D.L.R. (4th) 545.

public interest?[4]

An affirmative answer to any of these questions, while not determinative, is a strong indication that the party is a part of 'government' and is bound by the *Charter*.

## The Medical Research Council ("MRC")

The MRC is the agency responsible for the regulation of medical research in Canada. If individuals or groups of individuals believed their *Charter* rights had been violated because of exclusion from a clinical trial, the MRC may be named as a defendant in a legal action. As was previously mentioned,[5] the MRC is an agent of the federal Crown and it may be the party most easily identified as 'government' or performing 'government action'.

Since the MRC is a Crown agent, it must comply with the *Charter*.[6] It seems to easily fall within Madam Justice Wilson's third test for deciding if an entity is 'government', that is, the MRC acts with statutory authority specifically granted to it to further a public interest. Its enabling

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[4] Ibid. 76 D.L.R. (4th) at 592.

[5] **Supra**, Chapter 2 note 39.

[6] R. Tassé, "Application of the Canadian Charter of Rights and Freedoms (Sections 30-33 and 52)" **in** G.A. Beaudoin and E. Ratushny, eds. The Canadian Charter of Rights and Freedoms, 2nd ed. (Toronto: Carswell, 1989) 65 at 80.

statute does not simply ask the MRC to carry out specific functions and enforce specific guidelines, rather the MRC is granted very wide discretionary powers and functions.[7] For example, it provides funds for research and presumably exercises its discretion in the distribution of these funds to promote the broader public interest. It is open to a court to consider the purpose and effects of the enabling legislation or subordinate legislation created by the MRC in determining whether it is inconsistent with a right or freedom guaranteed under the *Charter*. This approach is well established as a result of the majority judgments delivered by Chief Justice Dickson (as he then was) in R. v. Big M Drug Mart Ltd.[8] ("Big M Drug Mart"), R. v. Edwards Books and Art Ltd.[9] ("R. v. Edwards Books") and his judgment in R. v. Morgentaler[10] ("Morgentaler"). In Big M Drug Mart, he wrote:

> In my view, both purpose and effect are relevant in determining constitutionality;

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[7] It is interesting to compare the very broad discretionary powers granted to the MRC with, for example, the more specific and restrictive powers and duties of the Canadian Radio-television and Telecommunications Commission ("the CRTC") established under the *Canadian Radio-television and Telecommunications Commission Act*, R.S.C. 1985, c. C-22. For example, s.14(1) of its enabling legislation requires the CRTC to regulate and supervise all aspects of the Canadian broadcasting system with a view to implementing the broadcasting policy (which is very detailed and specific) enunciated in s.3 of the *Broadcasting Act*, R.S.C. 1985, c. B-9.

[8] [1987] 1 S.C.R. 110.

[9] [1986] 2 S.C.R. 713.

[10] [1988] 1 S.C.R. 30, 44 D.L.R. (4th) 385.

> either an unconstitutional purpose or an unconstitutional effect can invalidate legislation. All legislation is animated by an object the legislature intends to achieve. This object is realized through the impact produced by the operation and application of the legislation. Purpose and effect respectively, in the sense of the legislation's object and its ultimate impact, are clearly linked, if not indivisible. Intended and actual effects have often been looked to for guidance in assessing the legislation's object and thus, its validity.
>
> Moreover, consideration of the object of legislation is vital if rights are to be fully protected. The assessment by the courts of the legislative purpose focuses scrutiny upon the aims and objectives of the legislature and ensures they are consonant with the guarantees enshrined in the *Charter*. The declaration that certain objects lie outside the legislature's power checks governmental action at the first stage of unconstitutional conduct. Further, it will provide more ready and more vigorous protection of constitutional rights by obviating the individual litigant's need to prove effects violative of *Charter* rights. It will also allow courts to dispose of cases where the object is clearly improper, without inquiring into the legislation's actual impact.[11]

Dickson C.J.C.'s judgment in <u>Morgentaler</u> was an example of an analysis of the "effect" of a law resulting in a finding that the law was inconsistent with a *Charter* right. He added to his comments in <u>Big M Drug Mart</u> regarding the relevance of both purpose and effect in determining constitutionality, and stated:

> Even if the purpose of legislation is unobjectionable, the administrative procedures

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[11] **Supra**, note 8 at 331-332.

> **created by law** to bring that purpose into operation may produce unconstitutional effects, and the legislation should then be struck down.[12]

Applying the reasoning of these cases to the present discussion of the MRC, it may be argued that if the purpose and effect of either the enabling legislation (with respect to the effects of the discretion granted to the MRC) or subordinate legislation (with respect to regulations that may be passed to regulate clinical research trials and medical research generally) is to infringe a constitutionally protected right or freedom, the legislation could be held to be invalid. Thus, the MRC may be liable as an independent government body or a body delegated by statute to carry out government action if it is found that it violated the *Charter* by permitting discrimination of vulnerable populations in gaining access to clinical trials.

Since the courts have not yet been asked to consider what responsibility the MRC has in protecting the constitutional rights of individuals enroled in or refused access to clinical trials or medical research generally, it is difficult to predict the outcome of such a challenge should it be made. Yet with the recognition that the MRC is a Crown agent and is bound by the *Charter*, and that it is responsible

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[12] **Supra**, note 10, 1 S.C.R. 30 at 62.

for protecting the public interest, it remains possible that the MRC may be a defendant in a constitutional challenge by individuals refused access to clinical trials.

It is interesting to also consider the issue of whether the MRC may be liable as a result of the effects of underinclusive legislation (for example, the omission or failure to provide adequate guidelines), which permits discrimination of vulnerable populations in gaining access to clinical trials. In one case[13], the Supreme Court of Canada found no liability on the part of a Crown agent for not enacting regulations governing warnings with respect to gas furnaces and, giving no reasons, stated it was not for the Court to say that regulations should have been enacted. It should, however, be noted that in Kwong the claim was based on negligence on the basis of failure to warn of risks and did not invoke a constitutional challenge. Some recent obiter comments made by Wilson J. (concurred in by L'Heureux-Dube J.) in Lavigne v. Ontario Public Service Employees Union[14], suggest that this might make a difference:

> On the other hand, it must be recognized that if this Court were to hold without qualification that the *Charter* does not apply to permissive legislation, the door would surely be open to widespread abuse at the hands of government. This Court has already acknowledged that technical avoidance of the

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[13] Kwong v. R. in Right of Alberta, [1979] 2 S.C.R. 1010.

[14] [1991] 2 S.C.R. 211.

> application of the *Charter* is to be discouraged. Thus for instance, in McKinney the Court remained unconvinced that the word "law" in s.15 should be read restrictively so as to exclude contracts. Foreseeing the misuse to which such a finding could be put, LaForest J. commented at p.277: "It would be easy for the legislatures and governments to evade the restrictions of the *Charter* by simply voting money for the promotion of certain schemes." By analogy, it is easy to envision that government may avoid its duty to respect the guarantees embodied in the *Charter* through the vehicle of permissive legislation. This, of course, is a result which this Court should seek to avoid. What qualifications therefore need to be added to the general principle that permissive statutory provisions standing alone are insufficient to call the *Charter* into play?
>
> As a general observation, I would think that in each case all the circumstances would have to be carefully examined to determine whether government had significantly encouraged or supported the act which is called into question. Depending upon the context, the enactment of a permissive provision may indeed support a finding of governmental approval or encouragement of a particular activity sufficient to invoke the protective guarantees of the *Charter*.[15]

While these comments seem to indicate some willingness by the Supreme Court of Canada to consider underinclusive legislation in the context of *Charter* challenges, some writers have recognized that courts, including the Supreme Court of Canada have been reluctant to decide these issues thus far.[16] It is submitted that a 'purpose and effects' analysis of legislation

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[15] Ibid. at 247-248.

[16] D. Pothier, "Charter Challenges to Underinclusive Legislation: The Complexities of Sins of Omission" (1993), 19 Queens L.J. 261.

could be extended to underinclusive legislation and bring it within the ambit of *Charter* protection. At present, however, the lack of Canadian legal precedents on this point seem to indicate that the likelihood of a successful constitutional challenge on the basis of the MRC's omission to invoke adequate guidelines is uncertain and seems unlikely.

## The Hospital or University:

Whether the *Charter* will bind the actions of hospitals or universities is determined by the nature and extent of governmental control exercised over the institution, and whether it is sufficient to conclude that the institution is part of government.[17] The Supreme Court of Canada considered the applicability of the *Charter* to universities in McKinney, referred to above, and to hospitals in Vancouver General Hospital v. Stoffman[18]. The Supreme Court of Canada held that although these institutions are established by statute and perform important public service, they are essentially autonomous bodies and make day-to-day decisions without being subject to government authority. Therefore, these institutions did not fall within the ambit of the *Charter* in these cases.

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[17] Tassé, **supra**, note 6 at 85.

[18] (1990), 118 N.R. 254 (S.C.C.).

It was stated in Stoffman that while the incorporating statute provided for government approval of broad policy decisions, the policies in question (dealing with mandatory retirement of doctors) were not subject to governmental approval. Thus, the likelihood of a court reaching the conclusion that a hospital would fall within the ambit of the *Charter* and be subject to constitutional challenge for access to medical treatment or therapeutic clinical trials is admittedly small in light of the Supreme Court of Canada's pronouncements in the above-mentioned cases.

## Professional Regulatory Bodies

Since the *Charter* only applies to bodies or agencies which have been shown to be controlled by government to the extent that they themselves are part of government, it is uncertain whether professional bodies responsible for regulating the professions will be bound by the *Charter*. The regulatory bodies, such as the College of Physicians and Surgeons of Ontario or the Corporation professionelle des medecins du Quebec, are not Crown agents. They are considered independent of provincial governmental control for the purposes of creating internal policies such as hiring staff or granting service contracts.[19] They must, however, comply with the *Charter* when they exercise their regulatory powers. Such

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[19] Tassé, **Supra**, note 6 at 87.

a conclusion has already been established in the case of the legal profession as a result of the ruling in Re Klein and Law Society of Upper Canada:

> In promulgating rules relating to legal advertising or relations between the press and the bar, the Law Society is performing a regulatory function on behalf of the "Legislature and government" of Ontario within the meaning of s.32 of the *Charter*... In my view, the fact that the Rules and commentaries in the code of professional conduct have not been adopted as regulations under the *Law Society Act* does not prevent them from falling within the ambit of the *Charter*... In enforcing the prohibitions against fee advertising and commenting to the press through the discipline process, the Law Society effectively makes these prohibitions part of the law of Ontario and subject to the constitutional restraint of the *Charter*.[20]

Therefore, since professional regulatory bodies are delegated subordinate legislative power they should be bound by the *Charter* in the exercise of this power. It should follow, then, that they could be defendants in a constitutional challenge brought by members of the public who allege the subordinate legislation issued by these bodies with respect to the provision of services offends the rights and freedoms guaranteed in the *Charter*. It may also be possible for regulatory bodies to be defendants in a constitutional action brought by members of the professions who allege their

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[20] (1985), 13 C.R.R. 120 (Ont. Div. Ct.) at 153-154.

constitutional rights and freedoms have been infringed[21] by the subordinate legislation issued by the professional body and subsequent disciplinary actions that the disciplinary bodies may pursue. If constitutional challenges against professional regulatory bodies are contemplated, they will likely rely on the Supreme Court of Canada's pronouncements in Big M Drug Mart, R. v. Edwards Books and Morgentaler, referred to above, to argue that the purpose and effect of the specific legislation should be the basis of constitutional invalidity. If, on the other hand, the complained of action is a result of underinclusive legislative initiatives of the regulatory bodies, rather than a result of the subordinate legislation itself, it is uncertain whether a *Charter* challenge would succeed, although it seems unlikely at present for the same reasons as discussed previously in relation to the MRC.

## The Physician Practicing Medicine Generally or Conducting Clinical Research:

Despite the fact that physicians who treat patients are, and physicians who conduct therapeutic clinical research may be, engaged in the provision of government services (that

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[21] For example, a professional may claim that his or her freedom of religion has been infringed if (s)he is required by the subordinate legislation issued by the regulatory bodies, to provide services which are contrary to his or her religious beliefs.

is, medical services), the courts have not yet considered individual providers of medical services to be 'government' bodies or carrying out 'governmental actions'. Thus, it is highly unlikely that the *Charter* will apply to individual physicians who practice medicine generally or conduct clinical research.

Therefore, determining the applicability of the *Charter* to possible defendants in a constitutional challenge concerning the individual provision of professional services may be difficult to assess. It will certainly depend on whether the courts will find that the particular defendant is 'government' or undertaking 'government action' and how such an assessment is made. It is simply uncertain whether any of the four parties discussed above could be subject to a *Charter* challenge. It is submitted, however, that a court may possibly find the MRC, as a Crown agent, and the professional regulatory bodies, as exercising subordinate legislative powers, bound by the *Charter* and thus may be named defendants in a constitutional challenge. The likelihood of a court making this finding will depend largely on the specific facts and issues of the case before it and the powers exercised by the potential defendants. It is further submitted that a court would not find hospitals, universities or individual professionals bound by the *Charter* and therefore they would not be defendants in a constitutional challenge to the provision of professional services.

## B. *Infringement of a Charter Right?*

If a court does find one or more of the potential defendants are bound by the *Charter*, could infringement of a right or freedom guaranteed by the *Charter* be found? It is anticipated that if such a challenge were made it would likely be on the basis of an infringement of s.15(1) or s.7 of the *Charter*.

### (i) Infringement of Equality Rights - s.15(1)

> **15. (1)** Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

The Supreme Court of Canada recently considered the manner in which a right to equality under s.15 of the *Charter* should be analyzed. In Andrews v. Law Society of British Columbia[22], McIntyre J. suggested the following analysis should be undertaken when considering whether s.15 of the *Charter* was infringed: (1) determine if there is an infringement of one of the equality rights in s.15, that is, whether the statute or policy in question makes distinctions between groups or classes of persons based on personal

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[22] [1989] 1 S.C.R. 143.

characteristics[23]; (2) if inequality is found, determine if it is discriminatory; and (3) if discrimination is determined, it must then be examined in light of s.1 to determine if it is demonstrably justifiable in a free and democratic society.

McIntyre's analysis should be applied to the consideration of the practices of some physicians who refuse to provide treatment to specific populations, or exclude specific populations from participation in clinical trials. Where refusal to provide medical services to patients or include patients in clinical trials is based on gender, childbearing potential[24], sexual orientation, race, etc., these are clearly practices which infringe one (or more) of the rights protected under s.15 as the distinctions are made on the basis of personal characteristics. Thus, the first branch of this analysis is satisfied.

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[23] It should be noted that the prohibited bases of discrimination which appear in s.15 of the *Charter* may not be exhaustive but rather, include analogous grounds. This is important when one considers that discrimination may occur on grounds other than those specifically listed, for example, the health status of a person may be an analogous ground to 'physical disability'. While a full discussion of this issue is beyond the scope of this thesis, it should be noted that in Andrews, Ibid., McIntyre J.'s first branch of s.15 analysis speaks of determining the infringement of "one of the equality rights" protected in s.15, rather than one right. This seems to suggest that there are many rights to equality and supports the argument that the bases in s.15 are merely exemplary rather than exhaustive.

[24] Note that the Supreme Court of Canada has held that discrimination on the basis of pregnancy constitutes discrimination on the basis of sex; Brooks v. Canada Safeway Ltd., [1989] 1 S.C.R. 1219, 59 D.L.R. (4th) 321.

Since not all inequalities fall within the scope of s.15(1), the next branch in the application of McIntyre's analysis is to determine whether the infringement is also discriminatory. The following definition of "discriminatory" was offered by McIntyre in Andrews:

> [D]iscrimination may be described as a distinction, whether intentional or not but based on grounds relating to personal characteristics of the individual or group, which has the effect of imposing burdens, obligations, or disadvantages on such individual or group not imposed upon others, or which withholds or limits access to opportunities, benefits and advantages available to other members of society.[25]

This definition of "discriminatory" was also adopted in the recent Supreme Court of Canada decision, Rodriguez v. British Columbia (Attorney General)[26] by Lamer C.J. in dissent, and he added the following:

> Even in imposing generally applicable provisions, the government must take into account differences which in fact exist between individuals and so far as possible ensure that the provisions adopted will not have a greater impact on certain classes of persons due to irrelevant personal characteristics than on the public as a whole. In other words, to promote the objective of the more equal society, s.15(1) acts as a bar to the executive enacting provisions without taking into account their possible impact on already disadvantaged classes of persons.[27]

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[25] **Supra**, note 22 at 174.

[26] [1993] 3 S.C.R. 519.

[27] Ibid. at 549.

Access to medical treatment or to therapeutic clinical trials may be considered a 'benefit' or 'advantage' by many. Yet this may be disputed on the basis that such treatment only provides a <u>potential</u> benefit or advantage rather than a definite benefit or advantage, especially when one considers the case of therapeutic clinical trials. One may argue that in light of the broad definition of "discriminatory" adopted by the Supreme Court of Canada, even denial of a potential benefit or advantage may be found to be discriminatory. (Query whether the courts will draw a distinction between a significant potential for benefit - perhaps in the case of denial of a standard therapy - and an unknown or minimal potential - perhaps in the case of a clinical trial - and how such an evaluation will be made.) However, even if access to general medical treatment or a clinical trial is not found to be a 'benefit' or 'advantage', it will likely be recognized as an 'opportunity' available to other members of society and the practices in question will be found to infringe the rights protected by s.15(1) of the *Charter*. Therefore, if the *Charter* is found to apply to potential defendants, patients who have been refused medical services or access to a clinical trial on a prohibited ground of discrimination under s.15(1) of the *Charter* could challenge these actions as unconstitutional.

## (ii) Infringement of Right to Security of the Person - s.7

> 7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

The *Charter* guarantees the right to security of the person under s.7. To understand what is protected by this right, we may look to judicial interpretations of this section. This right was considered in R. v. Morgentaler[28], and Beetz J. commented:

> "Security of the person" must include a right of access to medical treatment for a condition representing a danger to life or health without fear of criminal sanction.[29]

In Morgentaler, referred to above, Wilson J. agreed with Dickson C.J.C. and Beetz J. on the point that the right to security of the person under s.7 of the *Charter* "protects both the physical and psychological integrity of the individual".[30] The right to security of the person was also discussed by McLachlin J., in dissent, in Rodriguez:

> Security of the person has an element of personal autonomy, protecting the dignity and privacy of individuals with respect to decisions concerning their own body. It is part of the persona and dignity of the human being that he or she have the autonomy to

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[28] **Supra**, note 10.

[29] Ibid. in 44 D.L.R. (4th) 385 at 428.

[30] Ibid. in 44 D.L.R. (4th) 385 at 492.

decide what is best for his or her body.[31]

Before one proceeds with considering how these definitions of a right to security of the person might be applied in the context of physicians who refuse to provide services, it is important to note that these cases (and hence the definitions of this right) were considered in the context of a constitutional challenge to criminal legislation. It is clear that the right to security of the person can be infringed by the "fear of criminal sanction" as Beetz J. wrote above, but it is unclear whether *Charter* protection of the right to security of the person extends beyond the criminal domain. It should be noted that each of the majority judgments in <u>Morgentaler</u> specifically stated that *Charter* protection of the right to security of the person could be considered in the criminal context but they each stated that they would not consider what other contexts might attract *Charter* protection of this right. They did not say that it was limited to the criminal context. Furthermore, the judgment of Dickson C.J.C. in <u>Morgentaler</u> is particularly important since he focused on the procedural effects of this legislation on the right to security of the person rather than the substantive purpose of the legislation. Since the purpose of this criminal legislation was not of primary importance in his decision, this might represent less commitment to limiting

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[31] **Supra**, note 26 at 618.

*Charter* protection of the right to security of the person only to criminal legislation being challenged.

That infringement of the right to security of the person has been considered primarily in relation to criminal legislation and legislative action up to this point is important to recognize, but it has not been decided that it can **only** be argued with respect to *Charter* challenges to criminal law. It remains uncertain, therefore, whether the courts may consider non-criminal legislation capable of infringing this *Charter* right. Since the question remains open for now, consideration will be given to how this right to security of the person might be construed in the context of physicians who refuse to treat patients and physicians who exclude patients from clinical trials.

Failure to provide treatment to patients or denying patients access to therapeutic clinical trials may constitute denial of "medical treatment for a condition representing a danger to life or health" as described by Beetz J., or could constitute a denial of "the autonomy to decide what is best for his or her body" as described by McLachlin J. Failure to provide access to treatment or access to clinical trials, especially in the case of serious or life-threatening conditions, could thus offend the right to security of the person guaranteed in s.7. It may be actionable under the

*Charter* if a court finds that a body has the duty to provide access to treatment and failed to do so. If the professional regulatory bodies through their subordinate legislative powers or the MRC as an agent of the Crown is found by the courts to have a duty to provide access to medical services or clinical trials, there may be a finding that s.7 of the *Charter* was infringed.

It may also be considered whether the s.7 guarantee of security of the person would be infringed if there is denial of access to medical treatment or a clinical trial because the patient cannot afford to pay for treatment and the government refuses to do so, creating financial hardship for the plaintiff. Recall, for example, the lesbian patient who was refused AI services from a physician in British Columbia who owned the only public sperm bank in the province and claimed that other physicians in the province who provided this service would have to order the sperm from the United States and incur costs to the patient. It is also conceivable that patients would demand access to a clinical trial where there is no cost for medication, whereas the costs for medication outside a clinical trial may be very high. However, the courts will not extend s.7 rights to protect economic benefits. In <u>Brown</u> v. <u>British Columbia (Minister of Health</u>[32], the Court held that the practice of the B.C.

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[32] (1990), 66 D.L.R. (4th) 444 (B.C.S.C.).

government to not fund the costs of AZT during clinical trials was not an infringement of s.15 since the Court found no discrimination, and was not an infringement of s.7 since the Court found only economic deprivation to the plaintiffs which is not within the scope of s.7.

On the issue of economic interests, McLachlin J.A. (as she then was) clearly stated in Whitbread v. Walley[33] that s.7 does not extend to economic interests, and s.7 should not be interpreted as establishing a right to "any benefit which may enhance life, liberty or security of the person"[34]. She states, however, in the same case that there is a critical difference between legislation or government action which directly tells a woman what she can and cannot do with her body (referring to Morgentaler) and legislation which affects monetary recovery.

## Principles of Fundamental Justice

Every person has the right to life, liberty or security of the person guaranteed in s.7, but s.7 also provides that these rights are not to be infringed except in accordance with the 'principles of fundamental justice'. This

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[33] (1988), 51 D.L.R. (4th) 509 (B.C.C.A.), 26 B.C.L.R. (2d) 203, [1988] 5 W.W.R. 313.

[34] Ibid. at 521-2.

phrase has been the subject of much judicial commentary but today is interpreted broadly by courts to include not only procedural fairness but also substantive content. This became clear as a result of the decision in Reference re Section 94(2) of the Motor Vehicle Act (B.C.)[35] of the British Columbia Court of Appeal which held:

> With these considerations in mind the meaning to be given to the phrase "principles of fundamental justice" is that it is not restricted to matters of procedure but extends to substantive law and that the courts are therefore called upon, in construing the provisions of s.7 of the Charter, to have regard to the content of the legislation.[36]

On appeal to the Supreme Court of Canada[37], the Court unanimously held that section 94(2) of the legislation in question did violate s.7 of the *Charter* and in the course of delivering their judgment, held that "fundamental justice" did not have an exclusively procedural content but included also substantive content and indeed was a broader concept than natural justice. In the words of Madam Justice Wilson in Reference re Section 94(2), "it is hard to see why one's life and liberty should be protected against procedural injustice and not against substantive injustice."[38]

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[35] (1983), 147 D.L.R. (3d) 539, affirmed by the Supreme Court of Canada, **infra** note 37.

[36] Ibid. at 763.

[37] Reference re Section 94(2) of the Motor Vehicle Act (B.C.), [1985] 2 S.C.R. 486.

[38] Ibid. at 531.

As a result, s.7 constitutional challenges that do not involve procedural or evidentiary matters may be reviewed by the court on the actual substance of the law or subordinate legislation in question, its merits and its effects[39], thereby usurping the role normally reserved for the legislators. This is particularly meaningful in the context of possible s.7 challenges of refusals to provide legitimate professional services. If a s.7 challenge is made, it will not likely bring into question the procedural content of the particular subordinate legislation or government action. Rather, it may provide the court an opportunity to consider the substantive content of the government action which results in the denial of professional services. Thus, it is submitted that if a court finds an individual has been deprived of a right guaranteed by s.7 because of the denial of professional services or access to a clinical trial, it may find that such deprivation will not be found to be in accordance with the 'principles of fundamental justice' as presently interpreted by the courts. Such a holding will depend on the specific facts of the case and the reasons for the refusal of services (for example, if there are limited resources and it has been decided that they should be allocated to the most seriously ill first, this might lead to a denial of treatment to some patients but the reasons for denial of treatment are likely to

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[39] P. Garant, "Fundamental Rights and Fundamental Justice (Section 7)" in G.A. Beaudoin and E. Ratushny, eds. The Canadian Charter of Rights and Freedoms, **supra**, note 6 at 382.

be found to be fundamentally just). There may, however be a finding that the denial of treatment or access to services infringed the rights protected in s.7.

Therefore, while it is possible that denial of medical treatment to patients or denied access to clinical trials may be challenged on the basis that there is an infringement of s.7 of the *Charter*, it may be difficult for a court to find that s.7 had been violated. The denied service must be of such gravity that it clearly violates either the right to 'life' or more likely, the right to 'security of the person'. If the courts do find that s.7 has been infringed, this finding will likely be made on the basis that the right to security of the person (if such treatment is life-threatening) and the autonomy interest embodied in the right to security of the person has been infringed. If the courts do make such a finding in these circumstances and look at the procedural, but more importantly for this discussion, the substantive content of the government action alleged to have caused the infringement, they must also find that this infringement is not in accordance with the 'principles of fundamental justice' in order to find s.7 has been violated.

While a plaintiff may challenge the constitutionality of being refused medical services or access to a clinical trial on the basis of an infringement of his or her right to security of the person, it is submitted that such a claim will be more difficult to establish than a claim made on the basis of wrongful discrimination on a prohibited ground as set out in s.15(1) of the *Charter*.

## C. Is Infringement of the *Charter* Demonstrably Justified?

> 1. The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

A law or policy which infringes a right or freedom guaranteed under the *Charter* will be deemed unconstitutional unless it is saved by s.1 of the *Charter*. If a plaintiff in a constitutional action demonstrates that a right or freedom guaranteed by the *Charter* has been denied to him or her by government action, and in the case of a right guaranteed in s.7 that the denial was not in accordance with the principles of fundamental justice, then the onus is on the government to establish that the denial is reasonable and such as can be demonstrably justified in a free and democratic society.

In deciding if the infringement in question is demonstrably justified, the Supreme Court of Canada established a two-branch test in R. v. Oakes[40] ("Oakes") for analyzing s.1 of the *Charter*, namely that the legislative or policy objective is considered, and the means chosen to achieve that objective are considered. For the first branch of the test to be satisfied, the objective should be considered in the following manner:

> [The objective] must be "of sufficient importance to warrant overriding a constitutionally protected right or freedom" ... The standard must be high in order to ensure that objectives which are trivial or discordant with the principles integral to a free and democratic society do not gain s.1 protection. It is necessary, at a minimum, that an objective relate to concerns which are pressing and substantial in a free and democratic society before it can be characterized as sufficiently important.[41]

For the latter branch of the test to be satisfied, the means chosen to attain the objective must be reasonable and demonstrably justified in a free and democratic society. This involves a 'proportionality test' to be applied, and the following must be shown: (1) that the means chosen to achieve the objective are rationally connected to the objective they are to serve, and are fair and not arbitrary; (2) that the means impair as minimally as is reasonably possible the right or freedom in question; and (3) that the infringement of the right is sufficiently proportional to the importance of the

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[40] [1986] 1 S.C.R. 103.

[41] Ibid. at 138-139.

objective sought to be achieved.

The judgment of C.J.C. Dickson in Oakes and the test he outlined in that case were very strongly stated and gave the impression that all components of the test had to be answered in the affirmative in order for the challenged law or action to be saved under s.1. This may be cause for concern since if this test is applied as outlined by Dickson C.J.C., a challenged law which infringes a constitutionally protected right or freedom will almost never be saved. As a result, the judiciary could be usurping the powers normally reserved for Parliament. The cases post-Oakes have commented on this issue and have attempted to restrain the Oakes test and the interpretation adopted by Dickson C.J.C. in that case.

In R. v. Edwards Books and Art Ltd.[42], Dickson C.J.C. seems to have relaxed the Oakes test somewhat:

> The Court stated [in Oakes] that the nature of the proportionality test would vary depending on the circumstances. Both in articulating the standard of proof and in describing the criteria comprising the proportionality requirement the Court has been careful to avoid rigid and inflexible standards.[43]

Mr. Justice LaForest's judgment in the same case also attempted to restrain the interpretation of the Oakes test.

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[42] **Supra**, note 9.

[43] Ibid. at 769.

> [H]aving accepted the importance of the legislative objective, one must in the present context recognize that if the legislative goal is to be achieved, it will inevitably be achieved to the detriment of some. Moreover, attempts to protect the rights of one group will also inevitably impose burdens on the rights of other groups. There is no perfect scenario in which the rights of all can be equally protected.
>
> In seeking to achieve a goal that is demonstrably justified in a free and democratic society, therefore, a legislature must be given reasonable room to manoeuvre to meet these conflicting pressures. Of course what is reasonable room will vary with the context... That being so, it seems to me that the choice of having or not having an exemption for those who observe a day other than Sunday must remain, in essence, a legislative choice... They are choices a court is not in a position to make.[44]

Mr. Justice McIntyre's judgment in Reference re Public Service Employee Relations Act (Alta.)[45] also makes the point that judicial deference to Parliament should not be lost in a s.1 analysis:

> The section 1 inquiry involves **the reconsideration by a court of the balance struck by the Legislature in the development of labour policy.** The Court is called upon to determine, as a matter of constitutional law, which government services are essential and whether the alternative of arbitration is adequate compensation for the loss of a right to strike... This is a legislative function into which the courts should not intrude. It has been said that the courts, because of the

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[44] Ibid. at 795-796.

[45] [1987] 1 S.C.R. 313.

> *Charter*, will have to enter the legislative sphere. Where rights are specifically guaranteed in the *Charter*, this may on occasion be true. But where no specific right is found in the *Charter* and the only support for its constitutional guarantee is an implication, the courts should refrain from intrusion into the field of legislation. That is the function of the freely-elected Legislatures and Parliament.[46] (Emphasis added)

As a result of the judicial interpretations of a s.1 analysis, it may be concluded that while the Oakes test will be referred to by courts when they assess whether or not the challenged law or government action can be reasonably and demonstrably justified in a free and democratic society, the test will not be applied rigidly. While it does give judges the power "to enter the legislative sphere", the cases after Oakes seem to indicate that judicial deference to the Legislatures and to Parliament ought to be exercised.

In considering a s.1 analysis in the context of physicians' refusals to provide medical treatment and examinations to patients, the legislative or policy objective may be the preservation of physicians' autonomy. If this is so, the resulting infringement of individual rights to non-discrimination under s.15 of the *Charter* or to security of the person under s.7 must be considered rationally connected to the government's objective, minimal and proportional. It is

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[46] Ibid. at 419-420.

submitted that despite the recent judicial deference to Legislatures and Parliament, a court would not reach this conclusion. The legislators and courts in Canada have clearly stated that discrimination must be taken seriously and should not be permitted. Furthermore, the courts have increasingly recognized the inherent power imbalance in professional-client relationships. In light of these trends, it does not seem likely that a court would find that government action which infringes the constitutional rights of patients in order to further the right to autonomy of physicians would be considered demonstrably justifiable in our present society, and therefore saved by s.1 of the *Charter*. If the government action had the more specific objective of protecting professionals' right to religious freedom as guaranteed in s. 2(a) of the *Charter* (by permitting them to refuse to provide services based only on religious objections), then the courts may be more willing to find that the resulting infringement of individual constitutional rights is justifiable under s.1. This, of course, would only be important if the physician's refusal to provide services was based on a religious objection. Presently, however, the government action is not sufficiently narrow to claim that this is the legislative or policy objective.

In the case of refusing women of childbearing potential (as an example of a specific population often excluded) access to clinical trials, the policy objectives may range from protection of researchers' and manufacturers' liability if the trials lead to adverse consequences in future pregnancies to reduction of the risks of teratogenicity of potential offspring.[47] It is submitted that these objectives will be insufficient to find the infringement of s.15(1) and/or s.7 of the *Charter* "reasonable" and "demonstrably justified". Often the means chosen to achieve the objective has no rational connection, as is the case with the fear of liability objective since the risk of liability will be much greater if drugs with adverse effects on specific populations are later marketed and prescribed to them without ever having been tested in these populations. Furthermore, by instituting a categorical exclusion of all women of childbearing potential whether or not they are pregnant in order to avoid the risk of teratogenicity, it cannot be said that the means chosen to achieve the objective impair individual constitutional rights as minimally as possible.

Therefore, if a patient who is refused medical services by a physician can show that the *Charter* binds one or some of the responsible parties who are named as defendants, and can prove that as a result of the government's action the refusal resulted in the infringement of a constitutional right

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[47] See **supra**, Chapter 3, Section 2(iii), for a detailed discussion of the justifications for excluding women of childbearing potential from clinical trials.

or freedom, it is unlikely that this infringement would be "demonstrably justified". Since it would not be saved by s.1 of the *Charter*, these practices would be constitutionally invalid and the court would have the power to declare the offending subordinate legislation invalid or prohibit the offending policy from continuing.

## 3. *A CHALLENGE UNDER HUMAN RIGHTS LEGISLATION*

Could specific patients or groups of patients who have been refused medical treatment from physicians or refused access to clinical trials for discriminatory reasons challenge such practices under human rights legislation? It is submitted that such a complaint is indeed possible and in fact, is much more likely to succeed than an action brought under the *Charter*.

In Canada, there exists both federal and provincial human rights legislation which set out very similar prohibited grounds of discrimination and discriminatory practices. A complaint alleged against an individual or organization regulated by federal authority will be brought under the

*Canadian Human Rights Act*[48] ("the *CHRA*"), while those alleged against an individual or organization acting under provincial authority is subject to provincial human rights legislation.

Since health services are provincially regulated, it is submitted that any complaints alleging discrimination against physicians in the provision of services would be heard pursuant to provincial human rights codes.[49] In Ontario, such a complaint would be brought under the *Human Rights Code, 1981*[50] ("the *OHRC*"). The relevant provisions of the *OHRC* are as follows:

> **PART I**
>
> **1.** Every person has a right to equal treatment with respect to services, goods, and facilities, without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, family status or handicap.
>
> ...
>
> **PART II**
>
> **10 (2).** The right to equal treatment without discrimination because of sex includes the right to equal treatment without discrimination because a woman is or may become pregnant.
>
> ...

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[48] R.S.C. 1985, c.H-6.

[49] It is important to note, however, that if a complaint were brought against a federal body such as the MRC, it would be brought under the *CHRA*.

[50] R.S.O. 1990, c. H-19.

> 11(1). A right of a person under Part I is infringed where a requirement, qualification or factor exists that is not discrimination on a prohibited ground but that results in the exclusion, restriction or preference of a group of persons who are identified by a prohibited ground of discrimination and of whom the person is a member, except where,
>
> (a) the requirement, qualification or factor is reasonable and *bona fide* in the circumstances;...

In Quebec, such a complaint would be brought under the *Charter of Human Rights and Freedoms*[51] ("the *Quebec Charter*"). The relevant provisions of the *Quebec Charter* are as follows:

> **1.** Every human being has a right to life, and to personal security, inviolability and freedom.
>
> He also possesses juridical personality.
>
> **2.** Every human being whose life is in peril has a right to assistance.
>
> Every person must come to the aid of anyone whose life is in peril, either personally or calling for aid, by giving him the necessary and immediate physical assistance, unless it involves danger to himself or a third person, or he has another valid reason.
>
> ...
>
> **9.1** In exercising his fundamental freedoms and rights, a person shall maintain a proper regard for democratic values, public order and the general well-being of the citizens of Quebec.
>
> In this respect, the scope of the freedoms and rights, and limits to their exercise, may be fixed by law.
>
> **10.** Every person has a right to full and

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[51] R.S.Q. c. C-12.

> equal recognition and exercise of his human rights and freedoms, without distinction, exclusion or preference based on race, colour, sex, pregnancy, sexual orientation, civil status, age except as provided by law, religion, political convictions, language, ethnic or national origin, social condition, a handicap or the use of any means to palliate a handicap.
>
> Discrimination exists where such a distinction, exclusion or preference has the effect of nullifying or impairing such right.
>
> ...
>
> **12.** No one may, through discrimination, refuse to make a juridical act concerning goods or services ordinarily offered to the public.
>
> ...
>
> **15.** No one may, through discrimination, inhibit the access of another to public transportation or a public place, such as a commercial establishment, hotel, restaurant, theatre, cinema, park, camping ground or trailer park, or his obtaining the goods and services available there.

If one recalls the discussion in the previous chapter of recent medical practices that are and have resulted in patients being refused treatment simply because they are women or because they are lesbians, and patients being refused access to clinical trials because they are women and of childbearing potential, it is easy to see how these practices may be challenged as discriminatory practices under provincial human rights legislation.

However, whether physicians who engage in these medical practices could be found to be in violation of the provincial human rights legislation will depend on the resolution of the following two issues:

(1) whether there is a right to equal treatment with respect to the provision of medical services or access to clinical trials under the provincial legislation (that is, whether medical services are "goods", "services" or "facilities); and,

(2) if so, whether this right is infringed if medical services are refused on a prohibited ground of discrimination and such discriminatory practices are reasonable or *bona fide* in the circumstances or justified by law.

These issues will now be examined with reference to the human rights legislation in place in Ontario and Quebec.

### A. *Equal Treatment with Respect to Medical Services*

At this time, the issue of whether patients have a right to equal treatment from physicians or institutions or a right to equal access to clinical trials without discrimination based on their personal characteristics (for example, sex, sexual orientation, or nature of the patient's illness) has not been decided by a human rights tribunal or a court. In discussing this issue, one should recall the proposition set out previously in Chapter Two that physicians who conduct therapeutic clinical research are engaging in the practice of medicine.[52] The issue becomes simply whether patients have a right to non-discriminatory treatment with respect to access to medical services.

The *OHRC* provides in section 1 that every person has the right to equal treatment without discrimination on the grounds listed, with respect to "services, goods and facilities". The *Quebec Charter* provides in section 10 that every person has a right to equal recognition and exercise of his human rights and freedoms on the grounds listed, and prohibits discrimination in the provision of "goods or services ordinarily offered to the public" in section 12 and access to "a public place" in section 15. It must then be determined whether the right to equal treatment with respect to "goods", "services" or "facilities" or "public place" without discrimination may be interpreted as including the provision of medical services or access to a clinical trial.

### (i) "Goods"

Could medical services be considered "goods" under the *OHRC* or "goods ... ordinarily offered to the public" under the *Quebec Charter*? The term "goods" is commonly defined in legal dictionaries as anything that is the subject of trade or commerce and is most often used to refer to property such as

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[52] See The Legal Duties of a Clinical Researcher, **supra**, Chapter Two, Section 3 (P).

merchandise, raw materials or supplies.[53] This definition also appears in some statutes such as the *Criminal Code*[54] which defines "goods" in s. 379 as "anything that is the subject of trade or commerce". Since medical services are not associated with trade or commerce, it is submitted that in light of these definitions medical services would not qualify as "goods" under the *OHRC* or the *Quebec Charter*.

### (ii) "Services"

Could medical services be considered "services" under the *OHRC* or "services ordinarily offered to the public" under the *Quebec Charter*? The *OHRC* provides a brief definition of "services" in s.10(1):

> "services" does not include a levy, fee, tax or periodic payment imposed by law.

This legislation falls short, however, of defining what "services" are. Similarly, the *Quebec Charter* does not provide a definition of "services". This issue has, however, been considered on occasion by boards of inquiry and tribunals hearing human rights complaints in addition to higher courts entertaining applications for judicial review.

In a recent case before a board of inquiry in Ontario, a complaint alleging discrimination in the provision

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[53] H.C. Black, Black's Law Dictionary, 5th ed. (Minnesota: West Publishing Company, 1979).

[54] **Supra**, Chapter 2, note 27.

of services on the basis of handicap was made by an AIDS patient against a dentist.[55] In that case, it was alleged that the patient arranged an appointment with the dentist and once he arrived and disclosed that he had AIDS, the dentist acted in such a way "calculated to discourage Mr. Jerome from becoming a patient"[56]. The respondent argued that he simply postponed the appointment until the end of the day for good and sufficient reasons, while the Commission argued that the respondent's deferral constituted discrimination without adequate justification. Even though the Board concluded that on the facts there was no actionable discrimination in the provision of services based on handicap in this case[57]t it did accept the argument that AIDS is a handicap. Furthermore, the respondent-dentist conceded in this case that dental services are services within the meaning of the *OHRC* and the Board of Inquiry accepted this point. Since "medical services" have been defined as including dental services[58], this case is helpful in establishing that medical services are "services" within the meaning of the *OHRC*.

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[55] *Mr. Jerome* v. *Dr. Paul DeMarco*, 1 [1992] O.H.R.C. Decision, 438.

[56] *Ibid*. at 439.

[57] The Board did find that the patient was discriminated against because of his AIDS status but accepted that on the facts, the respondent had a full and complete defence for his differential treatment of the patient in the circumstances.

[58] D. Dukelow *et. al.*, *The Dictionary of Canadian Law* (Barrie: Thomson Professional Publishing Canada, 1991).

Under the *Quebec Charter* "services ordinarily offered to the public" should still include medical services as "services" despite the fact that not all members of the public require medical services. In <u>Canada (Attorney General)</u> v. <u>Rosin</u>[59], Mr. Justice Linden considered the meaning of "services...customarily available to the general public" in section 5 of the *Canadian Human Rights Act*[60] ("the *CHRA*") and stated:

> It is difficult to contemplate any government or branch of government contending that a service offered was a private one, not available or open to the public. Indeed, it may well be said that everything government does is done for the public, is available to the public, and is open to the public. Moreover, to allow a government to evade the operation of the [*CHRA*] merely by setting up eligibility requirements and then arguing that the program is not open to the public is unacceptable: a program is still offered to the public, even though all members of the public cannot avail themselves of it.[61]

The Saskatchewan Court of Appeal has also stated that all services offered by a government are services offered to the public.[62] Since medical services are funded by and administered through provincial governments, these cases suggest that medical services would still be considered

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[59] [1991] F.C. 391.

[60] **Supra**, note 48.

[61] **Supra**, note 59 at 398.

[62] <u>Re Saskatchewan Human Rights Commission and Government of Saskatchewan Department of Social Services</u> (1989), 52 D.L.R. (4th) 253, 9 C.H.R.R. D/5181.

"services ordinarily offered to the public" under human rights legislation such as that in place in Quebec despite the fact that not all members of the public would avail themselves of these services.

Another decision that should be noted when considering the issue of whether medical services are "services" under human rights legislation is the recent case of Chiang v. Natural Sciences and Engineering Research Council[63]. In that case, the Canadian Human Rights Tribunal considered whether the Natural Sciences and Engineering Research Council ("NSERC") is providing a service to the public when it awards research grants, within the meaning of s.5 of the *CHRA* which states:

> It is a discriminatory practice in the provision of goods, services, facilities or accommodation customarily available to the general public
>
> (a) to deny, or to deny access to, any such goods, service, facility or accommodation to any individual, or
>
> (b) to differentiate adversely in relation to any individual, on a prohibited ground of discrimination.

The Tribunal found that NSERC is providing a service to the public within the meaning of the *CHRC* when it awards research grants, stating that NSERC is a public body governed by legislation and the members of NSERC are hired at public

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[63] (1992), 17 C.H.R.R. D/63 (Can. Trib.).

expense to distribute public funds. Despite the fact that NSERC distributes funds to a particular group (namely natural scientists), the Tribunal still concluded that it is providing a service to the public and therefore prohibited from engaging in discriminatory practices under the *CHRA*.

It is submitted that there is no valid difference between a body which awards research grants to natural scientists and a body that awards research grants to physicians who conduct clinical research. This case may then be considered good authority upon which to propose that the MRC (or any other public body that distributes public funds for clinical research) is also providing a service to the public and would similarly be prohibited from engaging in discriminatory practices as set out in the *CHRA* or provincial human rights legislation. If the MRC is providing a public service and issues guidelines which effectively permit discrimination in access to clinical trials, it may be engaging in discriminatory practices under the *CHRA*. Similarly, if an institutional review board is deemed to be a public body (depending on whether it is authorized by regulation and whether its members are hired at public expense) and it is found to carry out a public service when it approves clinical trials which exclude patients on a prohibited ground of discrimination as set out in provincial human rights legislation, it may be engaging in discriminatory practices.

Finally, when considering the interpretation of "services" in the *OHRC* and "services ordinarily offered to the public" in the *Quebec Charter*, it is important to note that judicial decisions have confirmed that human rights legislation in Canada is to be construed broadly[64]. Thus it is submitted that since human rights legislation is to be construed broadly, and given that it has already been applied to the provision of dental services, government services, and public bodies awarding research grants, medical services will be found to be "services" within the relevant provision of provincial and federal human rights legislation and therefore subject to the prohibitions set out in the legislation.

### (iii) "Facilities"

Could institutions or clinics which provide medical services be considered "facilities" under s.1 of the *OHRC* or "a public place" under s.15 of the *Quebec Charter*? Neither term is defined in either legislation although s.15 of the *Quebec Charter* gives some examples of "a public place":

> **15.** No one may, through discrimination, inhibit the access of another to public transportation or a public place, such as a commercial establishment, hotel, restaurant,

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[64] See for example, Attorney General of Canada v. Cumming (Bailey), [1980] 2 F.C. 122, 1 C.H.R.R. D/91 (T.D.); Peel Board of Education v. Ontario Human Rights Commission (1990), 12 C.H.R.R. D/7 (Ont. S. C.).

> theatre, cinema, park, camping ground or trailer park, or his obtaining the goods and services available there.

The issue of whether institutions or places that provide medical services are facilities or public places within the meaning of human rights legislation, has not often been considered. However, one case brought under the *CHRA* did consider the issue of whether a hospital was a facility customarily available to the public. In Yvonne Peters v. University Hospital, Saskatoon[65], a federal board of inquiry considered a complaint[66] by a blind woman who was denied access as a visitor in a hospital because she was accompanied by her guide dog. She alleged denial of her right of access to a facility customarily available to the general public on the basis of disability. During the course of this decision, the board concluded that the hospital was a facility to which the public was customarily admitted, despite the fact that some restrictions on access may exist. It held that while the hospital has a right to impose certain restrictions on visitors, in this case the restrictions did not justify treating disabled persons differently. As a result, the board

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[65] 2 [1981] C.H.R.R. D/77.

[66] In this case, the complaint was brought under the *CHRA* rather than the provincial legislation because at that time, the Lieutenant Governor in Council of Saskatchewan had assigned authority to administer *The Blind Persons Rights' Act, 1978*, R.S.S. 1978, c. B-3.1, to the Canadian Human Rights Commission.

held that the hospital had discriminated against the complainant.

In light of this decision, it is clear that hospitals are considered public facilities in the context of human rights legislation. It may be argued then, that other institutions (for example, medical clinics) which provide medical services to the public may also be considered facilities or public places under provincial human rights legislation and therefore subject to the prohibitions set out in the relevant legislation.

## *B. Justification of the Infringed Right*

It has been shown above that medical services would be considered "services" within provincial human rights legislation and institutions which provide medical services to the public would be considered "facilities" or "public places" within this legislation. Both the *OHRC* and the *Quebec Charter* provide that every person shall have the right to full and equal access to services and facilities without discrimination on the grounds set out in the legislation. As was discussed in the previous chapter, there have been instances where medical treatment has been refused to patients on the basis of their sexual orientation, on the basis of gender, and on the basis of the possibility of pregnancy. These are all prohibited grounds of discrimination under s.1 and s.10(2) of the *OHRC* and under s.10 of the *Quebec Charter*.

These practices clearly infringe the rights protected under provincial human rights legislation but whether they are deemed to be discriminatory practices prohibited by the legislation depends on whether they are justifiable infringements. Section 11 (1) of the *OHRC* states that a right protected under Part I is infringed except where it is "reasonable or *bona fide* in the circumstances" and s. 9.1 of the *Quebec Charter* states that the limits to individual rights and freedoms "may be fixed by law."

The justifications for physicians' refusal to provide medical treatment or access to clinical trials include most commonly the fear of liability, the desire to protect and preserve professional autonomy, the protection of future offspring of the female patient, and less commonly the avoidance of risks to the health of physicians (as in the refusal to treat HIV-infected patients), and the advancement of the religious or moral convictions of individual physicians. To date, none of these justifications have been "fixed by law". What is left to determine, then, is whether they are reasonable or *bona fide* in the circumstances.

Since these issues have not yet come before the tribunals or courts in the context of alleged human rights violations, it is somewhat difficult to predict whether these objectives will justify the infringement of a right or freedom protected by provincial human rights legislation. The infringement of a human right to equal access to services and facilities, especially when these are of a medical nature and could have life-threatening or serious consequences if denied, should not be easily justifiable.[67] Discrimination in the provision of these services should not be considered "reasonable or *bona fide*" because of reasons of inconvenience or (often minimal) risks to professionals who are generally in positions of power and are able to take adequate precautions to minimize these risks. Nor should gender or sex discrimination in the provision of these services be justifiable on the basis that they potentially pose risks to potential offspring, because both sexes are exposed to unknown substances during clinical trials. If the risk to potential offspring is of such concern then both men and women of childbearing age should be denied access to clinical trials. It is submitted that only the advancement of religious or moral convictions of individual physicians may be deemed a "reasonable or *bona fide*" justification for the infringement of a human right. It may be held that the protection of religious or moral convictions, even if they result in

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[67] Note also that section 2 of the *Canada Health Act*, R.S.C. 1985, c. C-6, requires each province to provide access to "necessary" medical services.

occasional discriminatory practices, is of sufficient importance that it justifies the infringement of a patient's right to equal access to medical services especially if the required services could be easily attained elsewhere. This, however, would have to be carefully considered by the tribunals and would likely be influenced by the individual facts of each case.

Therefore, individuals have the right to equal access to medical services under provincial human rights legislation and the right not to be discriminated against in the provision thereof in accordance with the grounds listed in the relevant legislation. The discriminatory practices described throughout this paper would not likely withstand a challenge under the *OHRC* or the *Quebec Charter* and would thus be illegal. The applicants in such an action would be entitled to the remedies provided by the legislation including some monetary damages as well as having made available the opportunity or privilege denied.

## *4. CONCLUDING REMARKS*

Despite the fact that the professional regulatory bodies recognize a right of physicians and lawyers to refuse to provide their services generally and only restrict this right in very limited circumstances, if professionals refuse their services in such a way as to violate human rights these actions may be deemed to constitute illegal conduct and legal consequences will follow. It was shown above that the refusal to provide medical services may be unconstitutional and in violation of provincial human rights legislation in Canada. It was concluded that an action alleging that the government has engaged in unconstitutional activity by refusing to provide medical services which resulted in the infringement of individual rights or freedoms guaranteed by the *Charter* will be difficult to advance primarily because of the difficulty of proving that the responsible parties are carrying out government action. Despite this hindrance, it is possible that some parties, namely the MRC and professional regulatory bodies, may be found by the courts to be carrying out government action. As a result, if their subordinate legislation or policies are found to violate a *Charter* right, most likely the equality rights under s.15(1) or the right to security of the person under s.7, then it may be difficult for these defendants to argue that these infringements are reasonable and demonstrably justified in a free and democratic society. The courts may find that the legislation or policy permitting refusals to provide medical services are unconstitutional.

It is submitted that the more likely and certain legal challenge to refusals to provide professional services will come under provincial human rights legislation. This legislation guarantees every person the right to equal access to services and facilities or public places without discrimination, which is defined broadly in the legislation. Human rights legislation does not apply only to government or government action and hence an application under this legislation will be unrestricted in challenging discriminatory practices as long as the denied activity falls within the definition of "services" or access to "facilities" or "public places" in the legislation. It was argued above that medical services should be considered "services" within the meaning of the provincial human rights legislation and that denial of access to institutions which provide medical services to the public would be denial of access to "facilities" or "public places". It can be concluded then, that discriminatory practices in the provision of services or access to facilities or public places will contravene the rights articulated in human rights legislation the infringement can be justified as reasonable and *bona fide* in the circumstances, or is fixed by law. It was further submitted that the most common justifications for refusal to provide medical services would not be justifiable under human rights legislation in Canada and only a refusal based on a religious or moral objection might be considered sufficient to prevent a finding that human rights legislation was violated. Therefore, many of the current practices of professionals of refusing their services may possibly be unconstitutional and would likely be illegal if challenged under the human rights legislation in place in Canada.

# CHAPTER FIVE - CONCLUDING COMMENTS: DEBATING THE FUTURE OF PROFESSIONAL SELF-REGULATION

This thesis has examined the issues of whether professionals have a right to refuse to provide services, the limitations of this right, the effects of the exercise of this right, and the legal implications of exercising this right in a discriminatory manner.

From the analysis undertaken in this thesis, we may conclude that the professional regulatory bodies currently recognize that professionals do have a right to refuse to provide services and have recognized few restrictions to the exercise of this right. It may be concluded that professionals are permitted by their self-regulatory bodies to engage in some discriminatory practices in exercising their right to refuse to provide services and this would be deemed to be professional conduct except in very few circumstances. With reference primarily to the medical profession, this paper has demonstrated that discrimination is occurring in the provision of professional services. After examining the most common reasons that professionals refuse to provide their services, the issue of refusal to provide professional services was analyzed with reference to four different moral theories which considered professional obligations to provide services and the ethical justifications for these. It was argued that refusal to provide medical services might be considered unethical, even if the refusal was based on a religious or moral objection of the individual physician. While the legality of this conduct has not yet been challenged to date, it was established that discrimination in the provision of professional services would not likely withstand a legal challenge, at least on the basis of Canadian human rights law. Future legal challenges may be the impetus for the regulatory bodies to amend their codes of ethics to recognize this conduct as unethical. This may be a rare occasion where law precedes ethics.

In light of the analysis undertaken in this paper, it is concluded that the perceived right of professionals (as reinforced by the professional regulatory bodies) to refuse patients or clients has led to discrimination in the provision of services. We must now consider the broader issue of whether the interests of the public can be adequately protected through self-regulation of the professions. The resolution of this issue will be largely dependent on the choices which professionals make in defining their professional goals for the future. Essentially, they must choose whether they will aspire to promote the public interest, their own interests, or some combination of these interests. Three possible models will be suggested to demonstrate how the choices that professionals will make are likely to decide the future regulation of the professions.

## Model One: Public Interest Paramount; Self-Sacrificing

In the first model, professionals decide that public interest should take precedence over professional self-interest. They choose to limit their self-interest in recognition that their primary purpose is to serve the public. Professionals choose to forfeit their interest when these conflict with the public interest. Self-regulatory bodies act only to protect the public and self-regulation is preserved. The regulatory practices are designed to protect the public interest and do not attempt to balance this with the interest of professionals. For example, amendments to codes of ethics to prohibit discriminatory practices by professionals in the provision of services would be directed to protecting vulnerable persons in society and would not balance this with the interests of professionals. Therefore, in this model, professional autonomy would be limited by the professions themselves because they are acting altruistically to advance the public interest.

### Model Two: Professional Interests Paramount; Self-Serving

In the second model, professionals decide that their self-interest should take precedence over the public interest. They do not recognize their primary purpose as serving the public but to practice their profession in order to maximize their benefits and minimize their risks. Professionals choose to forfeit the public interest when these conflict with their self-interest. Self-regulatory bodies essentially act to protect the members of the profession. The regulatory practices are designed to protect the interest of professionals but may attempt to balance this with the public interest if to do so would be self-serving. For example, amendments to codes of ethics to include non-discriminatory practices by professionals in the provision of services would be initiated by the perceived threat of a third party undertaking this action. (If a third party undertook such action, there would not be adequate protection of professional interest in the resulting policy or action.) Public interest is only protected if to do so preserves the self-regulatory power of professionals which in turn protects professional interest. The result will often be inadequate protection of the public since minimal action is taken by the regulatory bodies in order tc maximize the freedom of the profession. Therefore, in this model, public interest is restricted by the professional interest because professionals are not acting to advance the public interest.

In this model, the notion of professionalism must necessarily be redefined. The characteristics of self-sacrifice, public service and high ethical standards no longer define professionals; rather they are professionals simply by virtue of their specialized knowledge and training. When professionals are defined as individuals who act to promote the interest of others, they are both legally and ethically required to do so. This is what separates professionals from non-professionals. In this model, however, professionals have chosen to advance their own best interest and not the best interest of others. Society should no longer require them to act ethically since they will be akin to non-professionals, promoting their own interest.

Self-regulation may be lost in this model if protection of the public interest is the rationalization for its existence. Self-regulation may, however, be continued if it is extended on the basis that self-regulation is necessary simply because professionals have special knowledge of their disciplines and not because they are in the best position to protect the public.

## Model Three: Balance of Interests; Third Party Involvement

In the third model, professionals decide that the public interest and their self-interest are both important and may be equally so. They attempt to balance their self-interest with the public interest in a fair and just way. While they recognize that their primary duty is to serve society, they also believe that they have the right to be self-interested. The regulatory bodies act primarily to protect the public interest but may attempt to balance this with the interest of professionals where appropriate. For example, amendments to codes of ethics to prohibit discriminatory practices by professionals in the provision of services would be directed to protecting vulnerable persons in society but will attempt to protect the interest of the members only to promote fairness, not in an attempt to preserve power.

In this model, the public interest is advanced but is balanced with professional interest. The original notion of professionalism is preserved because they are still acting primarily to serve the public and would still be subject to high ethical standards, while professional rights are also acknowledged. It is submitted that the best way to achieve the joint goals of this third model is to add an independent third party to the professional regulatory process than to expect professionals alone, who are interested parties in the process, to achieve a just balance between public service and self-interest simultaneously.

Parliament delegated self-regulatory powers to the professions as a privilege on the premise that they had special knowledge which would enable them to make decisions in the profession, and that they would protect the public interest. If it were shown that the professions were not adequately protecting the public interest, Parliament could then redelegate these regulatory powers to a new regulatory body or committee composed of members of the profession and independent third parties. The minority of members on the committee should be composed of members of the profession while the majority of members would be third parties who by virtue of their independence could protect the public interest better, and also have some expertise. Two possible choices for this third party will be presented: the more obvious choice is government; the less obvious choice is ethicists. The latter should be preferred for a number of reasons.

First, government officials often do not have special knowledge about the professions or the ethical standards to which the professionals should be held. The ethicist may or may not be a member of the profession to be regulated (depending on what other profession the ethicist belongs to), but she will have expertise in the area of ethics, ethical principles and ethical theories which will be common to all professions. It is this training which primarily gives the ethicist valuable expertise in the realm of regulating professionals. In addition, the ethicist who is not a member of the profession to be regulated still has some special knowledge of the issues particular to that profession by virtue of her study of the ethical problems facing that profession. For instance, there are many bioethicists who are philosophers, lawyers and theologians and who have made valuable contributions to the field of bioethics, not because of any special knowledge of science or medicine, but by virtue of their study of these problems from an ethical perspective. If these ethicists have sufficient special knowledge to resolve ethical dilemmas within the professions, surely we may assume that they could also engage in the regulation of that profession.

Secondly, because political parties change power every few years, delegating the regulation of professions to government may result in inconsistencies. Ethicists are not susceptible to such fluctuations and as a result they are likely to regulate professions in a more consistent, and therefore, more efficient manner.

Thirdly, the independence of the third party is of fundamental importance. Governments are elected bodies which are still susceptible to political pressure from powerful, well-organized professional associations. This is clearly demonstrated by the successful lobbying efforts of Ontario doctors through the Ontario Medical Association, surrounding *An Act to Amend the Regulated Health Professions Act, 1991*[1]. This legislation is a drastic reduction of the proposals of the independent Task Force on Sexual Abuse by Physicians[2], and the lobbying around *An Act to Amend the Regulated Health Professions Act, 1991* still continues. Ethicists, on the other hand, are not elected individuals so they would be less susceptible to pressures from the professional associations and thus their independence would be more guaranteed. Furthermore, while an ethicist may also be a member of the profession which she is regulating (for example an ethicist who is also a physician participates in the regulation of the medical profession), it is likely that she would still be impartial in regulating the profession since she would be acting in her capacity as an ethicist rather than as a physician, to make decisions and policies. In fact, it may be advantageous to have an ethicist who is also a member of the profession being regulated simply because she will have more familiarity with the discipline, yet she will still be independent from her role as that professional for the

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[1] **Supra**, Chapter 3, note 4.

[2] **Supra**, Chapter 3, note 6.

purposes of regulation.

Finally, there is a growing disillusionment with politicians in our present society and this must also be considered when both the public and the profession will be asked to rely on the third party for appropriate regulation of the profession. Ethicists, on the other hand, are well-respected by the professions and are frequently consulted in the health care field for their assistance in the resolution of difficult dilemmas which professionals face.

While ethicists seem to be a wise choice for independent third parties which participate in professional regulation, there are two issues which must be addressed before this suggestion is fully recommended. First, it is unclear who is an ethicist. The emergence of professional ethicists is still a very recent phenomenon which has occurred mainly in the field of bioethics. Universities are just beginning to develop programs and award degrees for studies in bioethics and training programs for bioethicists. Presently, there is debate within the ethics community over the issue of whether ethics should be recognized as a distinct profession and what the appropriate accreditation of ethicists should be. It is important to reach a consensus on who may hold him or herself out to be an ethicist and what type of training is required. In light of Model Three, this is necessary both for the selection of ethicists to participate in professional regulation, and to set some minimum standard of practice and knowledge which ethicists will be held to. Already some individuals will clearly qualify as ethicists before the field of ethics is formalized, by virtue of their academic training in ethics and their contribution to the field to date, and will be clear choices as participants in professional regulation. There are others, however, who may not or should not qualify as ethicists. Since professional regulation is too important to be performed by 'ethicists' who do not have adequate training in ethics, it is hoped that there will be some consensus soon on who is an ethicist.

The other concern about choosing ethicists to participate in professional regulation is whether they are capable of regulating all professions. To date, most ethicists have practiced in the health care field and are bioethicists. Is there adequate training, then, for ethicists to regulate non-medical professions? It is submitted that there is. Ethical principles and ethical theories are not profession-specific so they may be applied to a variety of contexts to facilitate decision-making and policy-making. There will, however, be less literature and fewer case studies addressing ethics in non-medical professions since many of the leading ethicists and ethical theories have addressed medical ethics. Thus, it is submitted that ethicists will be able to regulate both medical and non-medical professions.

Therefore, in the third model, involving an independent third party in professional regulation can achieve a satisfactory balance between the public interest and professional interest. Ethicists may be the most appropriate third party to undertake professional regulation by virtue of their independence and their special training.

## Personal Recommendation for Future Regulation of Professions

In this thesis I have concluded that by permitting discriminatory practices in the provision of professional services such as those referred to earlier, the professional self-regulatory bodies have failed to fulfil their purpose of protecting the public interest. They chose instead to advance the interests of professionals by retaining professional autonomy in the choice of clients. When self-regulatory professional bodies protect the interests of their members to the extent that they violate the public's basic human rights, which are codified and are part of the fabric of our society, this is an indication that the problems with the current regulation of professions are now critical. It is time for serious reflection on the future of the regulation of professions.

As a professional, I am concerned about whether protection of the public interest is best achieved by the current mechanism of professional regulation. I am also concerned that professionals today are frustrated by societal expectations that they feel are unattainable. It is time for professionals to re-examine their professional goals in order to determine whether these goals are best attained through self-regulation. Professional self-analysis may begin with reference to the three models suggested above, which depict different professional goals and describe the mechanisms for the future regulation of professions to attain these goals.

In a perfect world, Model One would be viable, altruistic professionals would abound, conflicts between public and professional interests would be rare, and self-regulation could be guaranteed. In a dismal world, Model Two would prevail, professionalism would be redefined, professionals would only be self-serving, conflicts between public and professional interests would abound, and self-regulation may be jeopardized.

Our world is neither perfect nor dismal so Models One and Two do not reflect an accurate account of professional cultures today, although it is likely that some professionals will find their goals reflected in these models. Our world is complex, being both noble and pragmatic. The current professional culture is best reflected by the third model which recognizes the duality of interests of professionals and concludes that professional regulation, perhaps by members of the profession and ethicists, should replace or modify current self-regulation of professions.

There is a myth that professionals simply act in the public interest. It is necessary to dispel this myth in order to find realistic solutions to the critical problems that exist. It is necessary for professionals to acknowledge, to themselves and to society, that they have dual interests.

Professionals may be very different types of individuals but there are some strikingly common threads that bind all professionals together. In the first instance, professionals have common pursuits. I believe that professionals ultimately seek to better the lives of individuals. I believe they are driven by a desire to decrease suffering in the world, to strengthen the weak, to assist individuals to lead more peaceful lives, but most of all, to inspire hope for the future.

To hold this belief, I must also believe that professionals have certain values in common. They must honour life and the quality of life. They must have respect for persons, respect for the dignity of persons, respect for the autonomy of persons, and respect for the differences of persons. They must value ethics and integrity. They must also condemn the imposition of suffering, exploitation and injustice.

This optimism must, however, be tempered with reality, for professionals share something else in common. They are, after all, just people. They, too, are touched by political climates, economic realities, and personal concerns. They all have fears, biases and limited experiences. No matter how lofty their aspirations, they are confined in practice by the limits of their life experiences and the boundaries of their individual characters.

While it is heartening to realize that professionals may profoundly affect the lives of individuals, they may do so because they have been empowered to do so. The reality is that power may easily be misused or even abused. It would be naive to think that the personal interests and ideologies of individual professionals will easily be sacrificed for the benefit of those whom they serve. Undoubtedly, such a sacrifice will be difficult, and will require enormous effort and integrity. It may, however, be impossible to expect such a sacrifice of anyone. Professionals cannot and should not deny the human frailty to which they are susceptible.

If protection of the public interest is a real goal of professionals, and human frailty a realistic consideration, should professionals not abdicate their position as self-interested decision-makers in order to achieve the optimum fairness to the public? Professionals are loathe to lose self-regulation because they believe to do so would end the notion of professionalism itself. I do not share this sentiment. To question the role of self-regulation is not the same as questioning the notion of professionalism itself. I believe to be a professional is to be trusted, because the public interest is served, because the clients' interests are respected, and because the professional acts ethically and with integrity. If professionals are no longer trusted because they are seen to be self-interested, only then is the notion of professionalism threatened. If self-regulation leads to the disintegration of trust in a professional-client relationship because it perpetuates and condones self-interest, is it not more harmful to professionalism in the end? Without professionals being entrusted by the public, can they really decrease suffering, achieve peace and promote justice? Can they ever inspire hope for the future?

I believe the conflict between professional rights to refuse to provide services and human rights not to be discriminated against in the provision of services is a result of the conflict within professional goals themselves.

Professionals wish to serve the public by providing services but they also wish to be free to refuse their services for personal reasons. The conflict arises not from the competing interests between the professions and society at large, rather it is a result of the competing interests **within** the professions. This realization is crucial since only if the conflict is properly articulated can a resolution be considered. Professionals need to address the duality of their professional goals in their philosophy, in their codes of ethics, and in their conduct. This self-analysis should necessarily lead professionals to suggest and debate alternatives to self-regulation. I have presented Model Three as a springboard for such a debate about whether ethicists should be delegated responsibility or partial responsibility for the regulation of professions.

While professionals may feel threatened by such a proposal, it should be emphasized that this is not a condemnation of professionals. It is simply an acknowledgment that human frailty prevents an interested party from achieving fairness and objectivity to the same degree as an impartial party. The need for such an acknowledgment by professionals seems to be supported by the conclusions of this thesis. This acknowledgment has already been made frequently in our society. It is present at the core of our society by the adoption of democratic political institutions rather than dictatorships, a recognition that power should not be retained by a party unconditionally and unchallenged. It is further recognized in our judicial institutions which safeguard against partiality and influence by demanding that disputes between interested parties be resolved only by independent, impartial third parties, to prevent the administration of justice being brought into disrepute. It is both surprising and disappointing that this acknowledgment has not also been recognized in our professional regulatory institutions.

The ultimate indicator of the degree to which professionals aspire to promote the public interest will be their willingness to engage in debate over the merits of third party regulation. If this debate unfolds and a search for an appropriate third party does commence, ethicists should at least be considered and perhaps even tried. The future of self-regulation, professionalism, and the well-being of the public, depend on how this debate will unfold.

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