August 3rd, 2014

To the College of Physicians and Surgeons of Ontario,

We thank the College for the opportunity to submit our opinion regarding the review of the policy ‘Physicians and the Ontario Human Rights Code’. While we do not believe this most recent review was necessary, it has been more open than its immediate antecedent, and we thank you for the change.

Defining the Question

Public discussion of the policy in question invariably focuses on the following question: Should a physician be compelled to facilitate a treatment or procedure that is legal, but that the physician believes to be unethical? Indeed, this was the point of greatest importance in the last review, and the College appears to indicate a similar place for it this time, by including it in a survey on its website. We will therefore make it the sole concern of our submission.

Our organization obviously has a strong interest in this question as it concerns abortion, but we point out that it actually concerns every legal medical act, from sex change surgery to psychotherapy for unwanted same-sex attraction. It also concerns any presently forbidden act as soon as it becomes legal later. Plausible possibilities include euthanasia, euthanasia of infants, and organ harvest without explicit consent. We think that most physicians have ethical objections to some legal acts, so we will attempt to answer the question as it applies to all physicians.

This discussion is not about the fate of a few isolated Catholics in Ottawa, whose livelihoods seem to some a small sacrifice. It is about the very meaning of medicine.

To summarize our view, we believe that the College’s present policy of respecting the conscientious decisions of physicians must stand. A policy of coercion would violate doctors’ most basic human rights. Worse, it would invert the very basis of medicine, by commanding physicians to disregard the good of their patients and consider instead their own standing in the profession. We recognize that the opposite is sometimes alleged in the media, and defend our view below.

Freedom of Action in General

Citizens of a liberal democracy enjoy freedom of action, both personally and professionally, except where the compelling need of their fellow citizens places justifiable limits on the same. We assume that the College will agree to this principle. In general, such a need must be more compelling when it seeks to command an action against the citizen’s will (as in the case at hand) than when it forbids an action the citizen wishes to perform. Examples from the non-medical world abound: a Jewish butcher need not sell pork, even if his is the only shop in town. Note that while his position is strengthened by religion, it does not depend on it. A butcher of no faith whatever could make the same decision for reasons of economy or personal taste, or for no reason at all. Many might be annoyed, but few would allege a duty to change his practice.

How does this change in the practice of medicine, if it does? A few public voices suggest that a patient seeking a legal treatment is in sufficient need to justify the abridgement of a physician’s freedom. We find this contrary to intuition. A popular example in recent weeks is the case of the patient disappointed in her search for
oral contraceptives. We think it obvious that the inconvenience of finding another doctor is not sufficient hardship to justify the first physician’s expulsion from medicine. Nonetheless, many arguments purport to prove the opposite. We address the chief three below.

Arguments Against Freedom of Action for Physicians. Replies to the Same.

First, it is frequently suggested that physicians waive their own interests, and therefore their right to make ethical judgments about treatment, when they undertake the care of others. Second, it seems that the physician who assists with some legal treatments and not others mocks the law by creating one of his own. Finally, it is suggested that mandating referrals for contentious treatments offers a reasonable middle ground, respecting the physician’s conscience while ensuring treatment for the patient. We address these below.

I) The objection that physicians give up their own rights and ethical judgment when they undertake the life of medicine is flawed for two reasons. It arises from a wrong application of a right principle, namely that a medical relationship exists primarily for the good of the patient. This principle does not in fact abrogate any of the physician’s rights. He may not wrong the patient either by commission or omission, but he had no such right in the first place. He must honour within reason any agreements he has made with the patient, but he will obviously not make such an agreement to a treatment that he believes is wrong. Any rights he had before, such as privacy, control of his schedule and expectation of reasonable payment, he retains.

More importantly, acting in accord with his ethical judgment is not a physician’s right, but his duty. He does so not in contradiction of the principle above (‘the good of the patient first’), but precisely to follow it. This is particularly obvious in the face of possible sanction from a regulatory body. What more selfless act could a physician perform than to risk her whole career rather than do what she thinks is bad for her patient?

II) The objection accusing conscientious physicians of writing their own law is based on a misunderstanding of law. Under this misunderstanding, the law’s silence on an act implies approval, and demands cooperation in the act by citizens subject to the law. This error is well illustrated by the editorial Let Conscience be Their Guide? Conscientious Refusals in Healthcare, in a recent edition of the journal ‘Bioethics’. The authors take it for granted that physicians have a duty to assist with all legal medical acts. They then cast conscientious refusals as an attempt to gain exemption from that duty. As we will show here, there is no such duty, so no such exemption is required.

Law has both a proscriptive aspect (thou shalt not) and a prescriptive (thou shalt). Our submission discusses only those acts which are legal, but which some refuse to perform. They therefore do not fall under the law in either of its aspects. Law does not proscribe all possible bad acts, but only those which are gravely harmful and which are likely to be contained by the power of the state. Most bad acts fail at least one of these tests. It is not illegal to pull your sister’s hair, speak rudely at work or trip an opponent, because none of these is a grave injustice. Marital infidelity is a grave injustice, but a law against it would be nearly unenforceable. All of these are acts that the law just doesn’t notice, along with innumerable other acts both bad and good. It is evident therefore that an act’s not being illegal does not make it good.

This has an important consequence for the matter at hand. A policy of assisting with all legal acts would apply not only to good or indifferent acts, but also to all the evil acts that the law does not consider. It necessarily implicates every single physician in every wrong action that is not specifically condemned by law. Consider just a few medical acts that are legal somewhere, but that some physicians think are wrong even with consent. Psychotherapy to alter sexual attraction, infibulation, sale of organs, euthanasia, euthanasia of infants, sex change surgery, CPR in patients near death… surely some of these are unethical! But if the list of non-illegal acts is coterminous with the list of acts a physician must provide, then physicians in jurisdictions where these acts are legal must participate or find themselves in dereliction of duty.

A further illustration is offered by changes in the law. For example, euthanasia is presently condemned by Canadian law as murder. This law may one day be struck down. With a mandatory referral policy, all physicians would be required to facilitate an act that would have landed them in prison the day before the law changed. Such mass reversals of ethical practice do not happen in liberal states, but only under the worst forms of despotism. They do not reflect right or wrong, but only the triumph of the powerful.

III) In spite of protestations to the contrary, referral does not relieve the referring doctor of responsibility for what follows. Intermediate causes are still causes. The falling climber is saved primarily by the mountain to
which he is secured, but the mountain would be no use without the intervening rope. The rope
is therefore a cause. In ethics, one who lends assistance to an action is an agent in the same,
even when someone else performs the action itself. The bank clerk who provides the thief
with the vault combination sleeps at home through the burglary, but is still guilty. In the
medical realm, one need only consider an action that one personally finds abhorrent to be
convinced that referral does not exculpate. Perhaps you, the reader, believe it is wrong to buy
and sell human organs. If you did nothing more than tell a dialysis patient where he could buy
a kidney for a few thousand dollars, could you sleep at night? Should you? A policy of
mandatory referral would seek to put every doctor in exactly this position sooner or later.

**Proscribing Conscientious Practice Undermines the Medical Profession**

The cornerstone of all true medical ethics is the assumption that a physician will
never act against the good of the patient. This principle is stated three times in the Hippocratic
Oath alone, and reiterated in the CMA Code of Ethics: “Recommend only those diagnostic
and therapeutic services that you consider to be beneficial to your patient or to others.” Both
the Criminal Code of Canada and the Code of Ethics accept that some actions are wrong even
with consent. It will happen from time to time that a patient requests just such a treatment. It
will also happen that a patient requests a perfectly legitimate treatment that the physician
mistakenly believes to be harmful. In either case, the physician acquiescing against his
judgment chooses to wrong his patient, and is unworthy to practice medicine.

Consider the practical implications of a well enforced policy of referral for all legal
treatments. Only two categories of physicians could survive. First, those who happen to agree
precisely with the present list of legally proscribed and permitted treatments. These would
exist largely by coincidence, and every change in the list would eliminate some of them. By
far the larger group would be those who do not allow any ethical consideration to influence
their decisions, but delegate their consciences to the legislative bodies in power. Some in this
group would not think about ethics at all, and some would be conscious of occasional
wrongdoing, but would prefer their own security to the good of their patients. Can anyone
pretend that creating such a gang, for they cannot be called a profession, would be in
anyone’s interest?

**Conclusion**

The systematic compulsion of physicians to do what they think is wrong would
reduce us not to technicians, as is often alleged, but to lifeless tools. Some patients hope for
just that, assuming that they would hold the tools themselves, and apply them as they wish.
But the tragedies of the last century teach us otherwise. In the end, mere tools are wielded
only by those with the strength and the will to take them.

We thank the College for their consideration of our submission, and wish you the
wisdom to make a just decision.

Respectfully,

/s/ Benjamin Turner MD
on behalf of Canadian Physicians for Life