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Dear members of the subcommittee for the CPSO draft policy entitled ‘Professional Obligations and Human Rights’:

Thank you for the invitation to submit feedback. I would like to address your three questions:

Does the draft policy provide useful guidance?  
Firstly, I would like to applaud the efforts of the college to delve into the difficult matter of balancing rights. As the Canadian population, both physician and patient, continues to diversify it becomes more important to provide guidance on how to navigate through differences of any nature that may affect patient care. Certainly, this policy advocates for patients to be provided with care without discrimination and makes the CPSO position on discrimination explicitly clear. Secondly the policy outlines with useful examples, ways which physicians can better accommodate patients that face barriers accessing care.

Are there any issues not included in the draft policy that should be addressed? If so, what are they?  
The following terminology requires greater clarification: ‘moral’, ‘promotion’ (of religious beliefs), ‘timely’ (in reference to referral), ‘imminent harm, suffering or deterioration’.

Are there other ways in which the draft policy should be improved? A key aspect to address is how to reach an appropriate mechanism that respects all involved and ensures ‘that the person receiving care is not at risk of harm or abandonment’

There are a few points within the policy that require revision to ensure the draft policy achieves its goals.

1. Issue of referral (lines 156-161)  
If a legally permissible and publicly-funded health service is deemed morally unacceptable by a physician, referral OR provision of a service both require formal cooperation with a perceived morally unacceptable act. As such, a requirement to provide a referral for a conscientious-objecting physician would be equivalent, although perhaps less grave, than the direct provision of the service.
2. Application of the Charter (lines 113-136)
It is clear from the policy discussion on the Charter that this draft policy would not see the right of the physician to maintain moral integrity to be more important than the desire of the patient to obtain a health service, but surely when one considers this in a clinical context the hierarchy would become clear? I do not see how the funding structure of a procedure by definition makes it a right. Similarly, I am sure we can agree that while there is an overlap between morality and legality, they are not the same. This paragraph would suggest that the moral integrity of a physician should be compromised the moment a law changes or the funding structure for a procedure changes. This is absurd.

An example: multifocal intraocular lenses (IOLs) are a recent innovation in the refractive surgery market. While there are a few ophthalmologists and several pharmaceutical companies touting their benefits, at the moment the majority of ophthalmologists do not implant these lenses because of perceived lack of benefit compared to standards IOLs. The studies are contradictory, so every physician who implants or does not implant them is making a clinical decision based on conscience. If the government decides to publically fund multifocal lenses tomorrow and a patient desired a multifocal lens, this policy would mandate that physicians morally unwilling to perform the procedure refer to colleagues they believe are not acting in the patient’s best interests (by implanting a multifocal lens) or, in a situation where another physician is not available (imminent harm, suffering and/or deterioration is very subjective), perform the surgery.

In my understanding of the current draft proposal, a patient may be able to lodge a complaint against a physician who respectfully presents all the options of intraocular lenses, explains that he or she cannot implant multifocal lenses, uses a variety of studies to mask his or her moral objection and politely refuses to refer the patient for multifocal lens implantation because he or she believes it is not in the patient’s best interest, while still planning to provide ongoing care. In summary, a physician could be reprimanded for not providing a referral for a multifocal IOL.

Does the patient have a right to obtain a multifocal lens because he or she wants it? Is a desire equivalent to a right?

Multifocal IOLs are a trivial example but if this policy intends to target all physicians who act according to their morality, it applies even here. This draft policy seems to be to be too broad in application, and the application of the Charter seems too dogmatic for the nuances of evidence-based-yet-art medicine.

3. Unfortunate discriminatory tone (lines 123-127; 146-148)
If this policy is not truly directed to physicians who make decisions according to their conscience (aka: gut, instinct, moral reasoning, appraisal of the literature), but instead directed at only religious physicians, then it is discriminatory. The undertone of condescension and disgust towards religion as evidenced by the statement that ‘physicians must not promote their own religious beliefs when interacting with patients, nor attempt to convert them’ is unfortunate and undermines the first three pages that espouse the principles of respect and condemn discrimination.
In conclusion, precisely because physicians feel they are acting in their patients’ best interest, which is truly paramount, physician will and should act with their moral integrity intact. In my opinion, the great majority of physician-patient interactions will be guided by the first 3.5 pages of the draft policy. These interactions foster a relationship of entrustment between physician and patient which can allow for the respect of both the physician’s right to practice medicine in accordance with his or her conscience and the patient’s right to the best care. Any physician acting within the first 3.5 pages will ensure that the patient is neither harmed, nor abandoned.

May I suggest that in the case of morally contentious health care services that patients claim as rights by nature of their desire to obtain them, the College encourage establishing public health clinics to truly ensure access to care, rather than asking physicians to compromise their professional and personal integrity?