The fiduciary nature of the physician-patient relationship requires that physicians act in their patients’ best interests.”
Since ‘ought’ implies ‘can,’ this statement is, to speak precisely, certainly false. A fiduciary relationship may well entail an ethical obligation to aim to act in accordance with whatever elements of trust are invested in that particular relationship, which elements are derived from whatever responsibilities are rightly considered to be entailed by that relationship. However, a fiduciary relationship as such certainly does not entail a requirement of actually acting in the best interests of the beneficiary in the relationship. This is not a minor issue. To state the issue in the way the draft proposal does obscures the crucial and quite unavoidable element of the exercise of discretionary judgment on the part of the trustee (the physician) in determining what is in fact in their patient’s best interests. Such judgment, since it is fallible and will in some cases be irreducibly controversial, cannot serve as the basis for any kind of straightforward "requirement to act in a patient’s best interests." What is at stake in the fiduciary relationship between physicians and patients is precisely trust relative to making these kinds of unavoidably fallible judgments (which judgments may lead to actions which in fact turn out not to be in the patient’s best interests). Obviously one crucial point to retain in seeking to enunciate an intelligent and just policy regarding professional obligations is the fact that different individuals will have different judgments as to what constitutes “acting in the patient’s best interests,” and that these diverse judgments are from the nature of the case necessarily logically prior – and thus prior in the order of ethical analysis – to any obligations to act in accordance with any (putatively) objective standard of acting. From the start, the CPSO draft policy appears to systematically ignore this crucial point.

The key values of professionalism articulated in the College’s Practice Guide – compassion, service, altruism and trustworthiness – form the basis for the expectations set out in this policy.”

This claim seems to be pure bafflegab. It should be obvious to anyone who considers the matter that these “key values” are far too vague and subject to diverse interpretation to actually form any real, substantive basis for the various specific expectations set out in the draft policy.

Where physicians are unwilling to provide certain elements of care due to their moral or religious beliefs, physicians must communicate their objection directly and with sensitivity to existing patients, or those seeking to become patients, and inform them that the objection is due to personal and not clinical reasons.”
Implicit in this statement is the judgment of the CPSO that any "not clinical" reasons must be "personal" reasons. This is vague at best. It would seem to be clearly beyond the competence of the CPSO to make such an implicit determination about the general nature of reason-giving: that reasons must be either “clinical” or “personal.” If this is a merely stipulative use of the word “personal” – i.e., by stipulation any “non-clinical” reason will be called “personal” - then the CPSO should clarify what is meant by this distinction and attempt to offer some justification for choosing to express itself in terms of such an arbitrarily prejudicial dichotomy in this context. The governing council of the CPSO may well have some more-or-less collective
"personal" view about the general nature of the "non-clinical" reasons that physicians inevitably have, and in accordance with which they may be unwilling to provide "certain elements of care." But this "personal" view of the CPSO council – and to be clear, the view is clearly "non-clinical," it has nothing whatsoever to do with medical expertise, it is a highly controversial ethical and meta-ethical question - is not one which the CPSO has any right to impose on its members and their practise, or on their patients, who also have a stake in being able to rely upon the integrity and autonomy of their physicians, without this integrity and autonomy being compromised by seemingly groundless thought-policing from the physicians’ professional organization. Certainly if the CPSO does wish to arrogate to itself the right to dictate to its members certain ethical and meta-ethical positions in accordance with which its members must practise, it certainly has the obligation to communicate to its members and to the general public the reasons by which it holds itself to possess any such right, and why it holds itself justified in promoting, under threat of sanction, whichever particular ethical and meta-ethical suppositions it chooses to promote. The current draft policy does not provide, nor even attempt to provide, any such justification. In fact, it seems highly unlikely that the CPSO could justify claiming for itself such an aggressively ideological mandate, but if this is how the CPSO wants to behave, for the sake of consistency it must at least communicate the grounds for its judgment. Failure to do so is a failure of the CPSO to act in a way that upholds the dignity and autonomy of both physicians and patients, who prima facie should not be subjected to the seemingly whimsical behest of the decidedly "non-clinical" judgment of the CPSO in controversial ethical matters.

Lines 143-144: “In the course of communicating their objection, physicians must not express personal judgments about the beliefs, lifestyle, identity or characteristics of existing patients, or those seeking to become patients.”

Again, this claim is hopelessly vague and far too categorical. Besides the problem of failing to define what it is that constitutes a “personal judgment” as such, the scope of what might fall under the description of “expressing personal judgments about the beliefs, lifestyle, identity or characteristics of patients” is far too broad. To insist that physicians “must not” do this very broad and ill-defined thing is not only silly, in light of its vagueness, but would also seem to suggest that physicians’ responsibility to avoid saying anything that their patients might find disagreeable is more important than their responsibility to provide the care that, in the professional judgment of the particular physician, is in the best interests of the patient. Such a policy would seem to undermine the specific fiduciary relationship existing between doctors and patients, rather than safeguard it.

Lines 152-153: “Physicians must provide information about all clinical options that may be available or appropriate to meet patients’ clinical needs or concerns.”

This claim is again too categorical – “Physicians must…about all…” – in relation to the vague requirement it enjoins – “that may be…to meet patients’ clinical needs or concerns.” In reality, physicians must exercise judgment, first in assessing the “clinical needs or concerns” of patients, and then in providing information about the relevant, available clinical options of which they are
aware, and which they actually deem to be appropriate. A categorical insistence on informing patients of all options which just may be available or appropriate obscures this reality.

Lines 155-160: “Where physicians are unwilling to provide certain elements of care due to their moral or religious beliefs, an effective referral to another health care provider must be provided to the patient. An effective referral means a referral made in good faith, to a non-objecting, available, and accessible physician or other health-care provider. The referral must be made in a timely manner to reduce the risk of adverse clinical outcomes. Physicians must not impede access to care for existing patients, or those seeking to become patients.”

This statement is again vague and smacks of a needless ideological imposition upon the integrity, autonomy, dignity, and professional judgment of physicians, which imposition, again, will tend to impair the fiduciary relationships of physicians with patients. The draft does not appear to present any principles upon which this policy could be grounded or justified. The statement is plagued by the usual vagueness: What is meant by “certain elements of care”? Does this refer to “elements of care” in the general sense of effective options for addressing genuine medical issues, i.e., issues pertaining to the health of the patient? Or does “elements of care” refer to particular procedures that patients might request, regardless of the necessity of that procedure for addressing any genuine health issue? Unless the CPSO has a great deal more to offer in terms of relevant principled justification, the draft should be amended so that the latter, unreasonably aggressive construal of the fiduciary duty of physicians towards their patients is clearly excluded.

Lines 168-169: “Physicians must provide care that is urgent or otherwise necessary to prevent imminent harm, suffering, and/or deterioration, even where that care conflicts with their religious or moral beliefs.”

This statement is again too categorical. The point of balancing rights is that everyone’s rights matter. To say to someone, “I don’t care how wrong you think this is; you must do it,” might be justified in some very rare circumstances; but to effectively make this kind of demand in a blanket way, in relation to such vague conditions, is certainly an overreach and a grave imposition upon the conscience and professional judgment of physicians. In making this kind of statement the drafters of this policy seem to have forgotten the basic necessity of prudential judgment in the matter of balancing conflicting rights, as well as their own fiduciary duties towards their professional members, which must surely include a duty to respect the autonomy, dignity, trustworthiness, etc. of those members.