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RE: Professional Obligations and Human Rights – Draft Policy

Dear Members of the Policy Review Committee,

This submission is informed by academic, clinical and community perspectives shared by two program areas at Sherbourne Health Centre. Rainbow Health Ontario (RHO) is a knowledge transfer and exchange program funded by the MOHLTC to improve access to services and promote the health of lesbian, gay, bisexual and trans (LGBT) communities in Ontario. RHO provides clinical training and resources to health professionals and carries out research, resource development and policy consultations in the area of LGBTQ health. The LGBTQ Parenting Network (LGBTQ PN) has a mandate to support LGBTQ parenting through training, research, resource creation, and direct services to the LGBTQ community. We are both programs of Sherbourne Health Centre which is a major centre for comprehensive primary care for LGBTQ people.

Our submission provides feedback on the Draft Policy with an explicit focus on the barriers faced by our diverse LGBTQ communities in accessing equitable care and in obtaining specific needed medical services. We commend the College for its assertion that discrimination is an inappropriate reason to deny services, but we are also concerned that prejudicial attitudes toward LGBT people are part of the theology of some religions and without a more fine-grained analysis of their implications, the degree to which religious and moral beliefs can be used as a justification to limit certain elements of care is unclear. Additionally, a stated lack of clinical competence can be used as an excuse to deny care when a provider is uncomfortable with or biased towards certain groups of patients. This is particularly frequent in the case of trans people.

Undoubtedly, these issues require additional remedies such as changes to the educational curriculum, research, additional guidance documents and partnerships with LGBT
organizations. Nonetheless, we ask the College to ensure that this Policy on Professional Obligations and Human Rights include explicit mention of LBGT people and sufficient examples of contentious issues that physicians are prompted reflect on the ways that religious, moral and clinical competence issues may be used to deny equitable and dignified care to LBGT patients. We note that the Draft Policy does make reference to the needs of other vulnerable groups such as people with disabilities or elderly people and provides examples of situations in which the physician must make sincere efforts to accommodate the needs of these patients.

Thank you for consideration of this submission. We are pleased to answer any questions you may have or to offer further consultation in this area.
Executive Summary:

Despite recent legislative changes and increased human rights, lesbian, gay, bisexual and trans* (LGBT) people still suffer significant societal discrimination. A significant body of literature shows that LGBT people experience a range of health disparities that are related to minority stress, reluctance to engage with the health system, and barriers located within the health system itself. It is not surprising that some healthcare providers share prejudicial attitudes or feel uncomfortable with LGBT people. The North American medical education system provides an average of only five hours of instruction on the needs and issues of LGBT people (Obedin-Maliver, 2011) with the result that medical students have little opportunity to examine learned prejudices or to gain the knowledge and skills to provide this population with competent and welcoming care.

Recommendations:

- We recommend the policy name LGBTQ people as a marginalized group because they frequently experience discrimination within health care settings.
- We commend the initiative to update the policy to incorporate the addition of gender expression and gender identity. We recommend adding examples of a physician’s duty to accommodate patients’ gender identity and expression.
- We recommend adding precise definitions and examples to illustrate “duty to accommodate” and “undue hardship” as these concepts are central to protecting human rights.
- We recommend explaining the steps physician must undertake to determine whether a request for health services presents an instance of competing human rights.
- We recommend that physicians be guided on how to weigh their right to act on their moral or religious beliefs against the right of their patients to access health services, as outlined by the Ontario Human Rights Commission.
- We recommend providing more guidance on limiting services on the basis of clinical competency to distinguish between justified concerns and those based on bias or misunderstandings of the healthcare needs of LGBTQ people. This should include encouragement to add new skills and knowledge.
- We recommend establishing common expectations for physicians who decide to refer to another clinician in all circumstances, whether the decision to deny care was based on clinical competence or the physician’s moral or religious beliefs.
LGBTQ People are a Vulnerable and Marginalized Population

Academic studies and community surveys alike document significant inequities in the health and well-being of sexual and gender minority communities in North America (GLMA 2000, Institute of Medicine 2011, Tjepkema, 2008; Bauer 2012). In Canada’s 2003 and 2005 Community Health Surveys, Statistics Canada data showed that among individuals aged 18–59, 21.8% of homosexuals and bisexuals reported that they had an unmet health care need - nearly twice the proportion of heterosexuals (12.7%). In addition, homosexual and bisexual people were more likely than heterosexuals to find life stressful (Tjepkema, 2008). The Trans Pulse study which provided population level data for trans people in Ontario showed that unmet health needs and stress related concerns were far higher among trans people than among cisgender people. (Scanlon, 2010; Bauer, 2012 and 2014; Rotondi, 2013).

Duty to Accommodate

We recommend adding the following examples of physicians’ duty to accommodate, which would benefit LGBTQ patients as well as others:

- Intake forms and signage should recognize that people may live in a variety of family configurations and relationships. For example, forms that only offer fields for a child’s “mother” and “father” exclude families with two mothers or two fathers or more than two parents. Signs posted to “mothers” in a NICU or prenatal care clinic also reflect a presumption of who is in a family, and who gives birth.

- A “preferred name” and “preferred pronoun” field should be added to charts and the patient’s preferred name and pronoun should be used in conversation. Using a patient’s appropriate name builds rapport which is fundamental to the patient-physician relationship, and protects the patient’s privacy where their name and biological sex may not match their gender expression

Undue Hardship

We recommend explaining the concept of “undue hardship” as it might relate to serving LGBT people to clearly show the boundaries of a physician’s duty to accommodate.

Clinical Competence

We recommend the policy encourage physicians to build their clinical competence and equip themselves to provide care to LGBTQ people.

There are many journals and guidebooks on LGBT clinical care and many organizations that can offer excellent cultural competence training. Rainbow Health Ontario offers both cultural and clinical training to physicians and other health care providers. The College itself may wish to place greater emphasis on the acquisition of relevant knowledge and skills as requirements for a license to practice medicine.

Physicians who have this training are increasingly comfortable dealing with both routine issues and more specialized ones such as advising on fertility options, or providing hormone therapy
for trans patients. This latter skill is in keeping with the World Professional Association for
Transgender Health Standards of Care (WPATH 2014) which strongly recommends that
initiation and continuation of hormone therapy be considered part of primary health care without
the need for referral to a specialist in most circumstances.

Unfortunately, trans people are commonly denied even routine health care services or treated
with disrespect. Findings from Ontario’s Trans PULSE study showed the following:

“One in ten trans people who had accessed an emergency room presenting in
their felt gender had been refused care or had care terminated prematurely,
because they were trans. One-quarter reported being belittled or ridiculed by an
emergency care provider for being trans. Among those with a family physician,
approximately 40% had experienced discriminatory behaviour from a family
doctor at least once. These experiences included refusal of care or refusal to
examine specific body parts, being ridiculed, and the use of demeaning
language.”

(Bauer et al. 2015, manuscript in preparation)

Experiences of discrimination and transphobia are very detrimental to the mental health of trans
patients. Continued denial of health care to someone who is ready to start a medical transition
can lead to higher rates of suicidality (TransPULSE 2010).

Some types of denial of service might be in patients’ best interest. For example, a surgeon who
is not competent in providing sex reassignment surgery, would likely be well-advised to make an
appropriate referral to a surgeon who does provide that care.

Other denials of health services may not be in patients’ best interest, and may constitute a
violation of a patient’s human rights, when the care sought is within the scope of the physician’s
practice. An example of this is the denial of routine gynecological, fertility and obstetrical
services to trans men. We are aware of numerous examples of physicians who have stated that
providing care to a trans patient is outside of their area of clinical expertise, while providing that
same care to non-trans or cisgender women.

As a result of widespread lack of knowledge of transgender health, many trans people
experience challenges in finding appropriate specialists to consult, even on health matters that
are not specific to trans people. In some cases, a lack of clinical knowledge may be a bona fide
justification for referring a patient to another provider, but in many cases, lack of clinical
knowledge is presented as a justification to deny care, a decision which was based on a lack of
familiarity and experience interacting with trans people, or a discomfort with trans people or their
bodies.

When a Physician Must Refer to another Health Care Provider

In the draft policy, physicians who decide to limit health services for moral or religious reasons
are cautioned that a decision to limit health services may violate a patient’s rights and are
provided with guidance on how to communicate their decision and what their obligations are in helping the patient find another provider.

Where the issue is genuinely one of clinical competency, physicians should be similarly guided on how to explain their decision and how to make an appropriate and timely referral. All too often, appropriate referrals are not made, which violates patients’ human rights and compromises their access to care.

We recommend harmonizing the guidance given around both moral and religious beliefs and competence by creating a strong section on how to communicate a competency based decision to the patient, and how to make an appropriate referral,

**Ensuring Access to Care**

We recommend that all physician or surgeon be required to maintain an effective referral plan for services they are unwilling or unable to provide. Further, we recommend that any physician or surgeon who is unwilling to offer care to some or all LGBTQ people be required to maintain an effective referral plan. Finally, we recommend that any physician or surgeon who is frequently asked to provide care that other similarly qualified practitioners are providing, but which they believe to be outside of their clinical competence, be encouraged to seek out ways to enhance their competence, such as further training.

**Competing Rights**

Competing human rights are of particular interest to LGBTQ people, since as the Ontario Human Rights Commission reports: “The human rights grounds most often cited in competing human rights claims include gender, creed, sexual orientation and disability, although other grounds and legal rights have also been invoked.” (OHRC 2012). Since many religions are reported to regard homosexual behaviour as sinful or immoral, it is imperative that the CPSO address this issue directly.

We suggest that the college provide stronger guidance to physicians surrounding their obligations to reconcile their religious and moral beliefs with their clinical practice. This guidance should be informed by the OHRC’s position on competing rights, which sets a very high standard for determining when two sets of human rights are in competition.

Additionally, we recommend adding examples situations in which a physician might have the right to limit care based on moral or religious beliefs. For example, how is a physician expected to approach such issues as insemination for a lesbian couple, or counselling regarding safe sexual practices with two gay men?

Providing care to LGBTQ people should only infrequently constitute a significant violation of a physician’s rights to religion and moral beliefs and it would be helpful to know when this might legitimately be the case. Without any guidelines, moral or religious beliefs might be used to justify prejudice or discomfort, rather than a legitimate reason to deny care.
We suggest referring to the Ontario Human Rights Commission's “Policy on competing human rights” within the policy as a tool for physicians to use while they actively consider their own rights and their patients’ rights in order to decide their obligations to their patients.

We thank the College for granting this opportunity to comment on the new Policy on Professional Obligations and Human Rights and we look forward to the final document.
References


Tjepkema, M. Health care use among gay, lesbian and bisexual Canadians. Statistics Canada, Health Reports, 19:1, March 2008