An Open Letter to the CPSO

Regarding the 2015 Draft Document “Profession Obligations and Human Rights”

Introduction

The College of Physicians and Surgeons of Ontario has been meticulous to address the quality and fiduciary obligations of physicians practising in a pluralistic society. In 99.9% of medical practice, there are few discrepancies of perspective about what constitutes proper practice and how to make referrals when necessary. However, in 0.1% of medical practice there are controversial situations that involve moral and ethical considerations and these situations have been and will continue to be problematic for both physicians and the College since consensus is difficult to achieve. What follows is a proposal for the College to be innovative in promoting a model which would allow individuals to have access to their choice of service in controversial services and at the same time, safeguard the conscientious behaviour of physicians.


WITH A WISE MODEL, BOTH PATIENT
CHOICE AND RESPECT FOR A PHYSICIANS
CONSTRAINTS OF CONSCIENCE IN
CONTROVERSIAL ETHICAL AND MORAL
MATTERS IS POSSIBLE......read on:

Background Observations/Facts/Premises

1. We live in a pluralistic society.
2. There is a very wide spectrum of ethnicity, religious persuasion, worldview etc.
3. These same diversities are evident within all professions including the healthcare sector.
4. Both the Canadian Bill of Rights and Charter of Rights endorse the respect for diversity.
5. Ethical persuasions will depend on the foundational premises which undergird a particular point of view.
6. A uniformity of perspectives on many ethical and moral matters will never be achieved since there will never be consensus on the premises. For example a theistic conviction will never mesh with an atheistic one.
7. These diversities, therefore, will always require innovative resolution in the provision of services within the healthcare sector if individual rights are to be preserved.
8. Without some form of societal compromise and civil honest dialogue, there will be an
inevitable effort to coerce some to “park their convictions outside of their workplace” and to
act contrary to their conscience.
9. There is a risk for individuals as well as groups to claim freedom for their own perspectives
whilst denying the freedom for others holding a contrary view. Ironically, global rules can be
mandated by but a few individuals.
10. What is “legal” as defined by law is not necessarily what is right or wrong by more absolute
standards. As an example, the murder and torture of a slave in the old South was legal but
hardly moral, ethical or right.
11. There have been massive paradigm shifts in the Oaths taken by graduating physicians. The
Hippocratic Oath, considered normative for a couple of thousand years, clearly forbade
abortion and euthanasia. That boundary has been moved substantially with graduates
swearing allegiance to the law which can relatively easily be changed (and has been
changed).

What we have before us is both a practical matter but also a political matter. The practicalities
are well understood by the CPSO, and there are safeguards for the provision of good healthcare
in all its aspects. But what also needs to be understood is the pressure by some to change and
homogenize society to their own agendas by political coercion.

To give an example, a complaint is lodged against a physician who refuses to prescribe the birth
control pill as a result of religious convictions. The physician has announced the office policy
clearly beforehand. There are innumerable other physicians within the community who are able
to accommodate the patient’s request but instead of accepting the one physician’s policy and
finding an accommodating physician, a complaint is lodged and it becomes a College and legal
battle. This has ceased being a practical matter of obtaining the requested birth control pill
since there is almost no difficulty in obtaining it from an alternate physician. Instead, it has
become a political lever to coerce the physician to change her view and, despite conscientious
objections, to prescribe.

ONE MUST DIFFERENTIATE THE PRACTICAL
CONSIDERATIONS FROM THE POLITICAL

Within the medical profession, there is represented a very wide spectrum of persuasion/
conscience pertaining to the ethical tensions within our society. For any given patient, there will
be no shortage of physicians that can be matched to their particular preferences. Thus, in
practice, there will always be the ability to match patient to physician.

THE SPECTRUM OF DIVERSITY WITHIN THE
MEDICAL PROFESSION ALWAYS PROVIDES
OPTIONS FOR THE INDIVIDUAL SEEKING
VARIOUS SERVICES THAT MAY BE
CONTROVERSIAL.
The key question is how the matching can be done without physicians having to put their consciences into deep freeze. The College has tightened the wording in the current draft on Professional Obligations and Human Rights in comparison to the document of 2008. There is a subtle implication that the rights of the patient will trump the rights of the physician on controversial issues. (Line 118 and 119). The term “care” in this sentence is not defined and given the context, obviously will apply to a minuscule slice of a physician’s practice. Nor is the term “impede” clarified. In real and practical terms, there will always be alternative routes for the patient. However, those with a political agenda to shape society may use these concepts to coerce physicians into complicity with convictions other than their own.

The College appropriately emphasizes that how something is communicated is as important as what is communicated. This indeed is important and a tone of care and understanding must be maintained.

However, the one very important sticking point for many physicians will be College’s directive to provide “an effective referral [which] means a referral made in good faith, to a non-objecting, available, and accessible physician or other health-care provider.” (Line 156 and 157) This statement constrains a physician more stringently than the statement of 2008 which stated that the physician “Advise patients or individuals who wish to become patients that they can see another physician with whom they can discuss their situation and in some circumstances, help the patient or individual make arrangements to do so.”

This shift in the proposed draft is putting the onus of responsibility on a physician who potentially feels herself to be an accomplice to an objectionable pathway, be it abortion or physician-assisted suicide etc. Is this necessary? Is there any way around this? Yes, there is. In a 2008 edition of “Dialogue” the notion of “balance” was discussed. There is a way to achieve respect for the diversity that prevails within our society and also respect the diversity of conviction amongst physicians.

The standard paradigm of guidelines, rules, and management of quality issues in the provision of healthcare has been well established and there is broad consensus about this. However, when there are controversial matters (and there will always be controversies as long as there are different world views), the rules established by the College, of necessity, will have to recognize the diversity of opinion. Otherwise, there will be a forced uniformity which obliterates bona fide protestations of conscience.

THE APPROACH TO THE CONTROVERSIAL AREAS (WHICH ALWAYS WILL BE WITH US) REQUIRES WISE INNOVATION TO PRESERVE THE INTENT OF THE CHARTER OF RIGHTS TO RESPECT THE RIGHTS OF ALL CONCERNED: PATIENTS AND PHYSICIAN ALIKE.
PROPOSAL OF A WORKING MODEL

1. Physicians should post within their offices or websites the areas of clinical services that they provide and any disclaimers that address potentially controversial matters (already, I believe, a College policy).
2. Patients accommodated within the practice should sign that they have read and understand the parameters of that particular practice.
3. The Ontario Government, OMA, CPSO etc. can establish easily accessible websites which list and identify physicians, clinics, and organizations which would provide services that are controversial and are willing to accommodate individuals for these. Publicly instituted series of options can be made easily accessible and transparent.
4. Physicians who feel unable to make referrals, could simply direct the individuals to the website(s) which patients can easily access, and find accommodating physicians.

INNOVATIVE MODELS ARE EASILY CONSTRUCTED TO ENSURE ACCESS TO CONTROVERSIAL SERVICES WHILST SAFEGUARDING A PHYSICIAN’S INTEGRITY OF CONSCIENCE AND PRACTICE.

As a society, we have somehow pushed theological considerations aside notwithstanding the Nation’s “Canadian Bill of Rights” attestation that we are a nation “under God”. It is not the prevue of the College to address these issues but, an adverse judgment for honestly held scruples is fraught with mischief in the long run. It is worth keeping in mind that over half of our population holds to firm religious convictions that surely speak principles into the public space and that our very laws have been religiously premised.

IT CANNOT BE IGNORED THAT OVER HALF OF OUR POPULATION HOLDS TO FIRM RELIGIOUS CONVICTIONS.

ALGORITHM

Before implementing the draft, it would also be wise for the College to explore the algorithm of how it would handle a complaint that a given physician would not provide a service on the basis of religious or moral convictions. There already have been such cases but this will increasingly be an issue as the Supreme Court has struck down the laws circumscribing Physician Assisted Suicide and new laws are enacted. One can be quite confident that a large segment of the physician community in Canada will have nothing to do with intentionally killing patients. There could be hundreds of cases of complaint.
Once physician-assisted suicide becomes legal, there will large numbers of physicians who will have nothing to do with intentionally killing patients. Will they be brought to tribunals?

Will the College resist the politicization of healthcare and support the right to conscience of physicians who commit themselves to a high standard of care for their patients? Will the College recognize that there are models which enable patients to obtain the care that they wish whilst at the same time safeguard the integrity of conscience of physicians who subscribe to convictions that may be Christian, Jewish, Muslim, Hindu or otherwise? Or will the College strip physicians of their licenses if they refuse to bend to a purely humanistic politics? Will there be coercive measures to force compliance when alternative neutral models can be constructed?

The College also needs to be vigilant to discern complaints which are designed to target dissenting physicians for political ends as compared with bona fide complaints pertaining to quality or true accessibility issues. The publication of services via the media or websites or identifying the same on practice profiles would go a long way to resolve complaints and avoid the politically motivated agendas. The recently well publicized comment of one physician who expressed the opinion that physicians with scruples should get out of medicine (or not be allowed in), exemplifies the politics of intolerance that is hurtful and harmful to our society. It also contravenes the Human Rights Code.

Without the College making adequate accommodation for physicians who are constrained by conscience on controversial situations, the logical outcome would be the blocking of such individuals from being accepted into medical schools (contrary to the Human Rights Code) and practicing medicine. For that matter, there are politically motivated individuals and organizations who would shape society to their own agendas by preventing those with religious convictions from entering the legal profession, government, as well as medicine. Intimidating and expensive lawsuits are not uncommon. There is, of course, nothing new about such a strategy. Honest debate and dialogue are sometimes in short supply.

Before implementing the draft policy, it would be advisable for the College to study the algorithm of response when complaints are brought against physicians who feel constrained by the voice of conscience in controversial matters.
Summary:

1. We live in a pluralistic society which is safeguarded by the laws of the land.
2. There are models by which the diversity of conviction can be respected and at the same time services provided that are controversial.
3. This is a call for the CPSO to support and promote (or at least recognize) the models that avoid arbitrary penalties for those who seek to practice to high moral and ethical standards.
4. The current proposed rigidity with regard to making referrals in morally and ethically controversial situations plays into the political agenda rather than recognizing that in reality, there is no lack of physicians willing to provide service on the other side of the controversy.

I commend the efforts of the College to formulate policies that are fair and balanced but I also perceive that the College is bending to a political agenda that seeks to squash the soul of the medical profession. I trust that these reflections will provide a helpful perspective. A broad view of how we came to be and where we are going is essential!