I appreciate the College’s willingness to open the debate on this Policy to Members and to the public. I hope the gesture is a sincere one, and that seriously expressed feedback might have a real chance to change or modify some core elements of the Policy that are of great concern to many of us. I note that public dialogue ran strongly against some of the coercive elements contained in earlier versions of this Policy, yet that does not seem to have deterred the College for moving forward in defiance of these concerns.

To me, the best part of the Policy is Line 81: “The duty to refrain from discrimination does not prevent physicians from limiting the health services they provide for legitimate reasons.” The questions would seem to revolve around what the College deems legitimate. It goes without saying that physicians must step away from providing services outside their area of clinical competence. The next sentence then tips the hat to objections based in “moral or religious beliefs”, and the text continues with a note to remind doctors to “do so in a manner that respects patient dignity and autonomy”. Again, this should go without saying.

The problem is, other elements of the Policy draft imply that the only way to respect a patient’s dignity is to give in to every demand, even if it violates a physician’s properly-formed conscience, and even if – as we shall see – it forbids any discussion of the advisability of a procedure on purely medical grounds. In other words, this Policy can be seen as simply a stately encoding of the old dictum, “The customer is always right.”

**The specifics**

I object to elements in the sections (ii) Moral and Religious Beliefs; [ i. ] Respecting Patient Dignity; and [ ii ] Ensuring Access to Care.

**Premise**

1. There is complicity in referral. The working group does not believe this, and that is the crux of the problem. There seems to be a notion that if physicians respecting
their conscience would simply refer a patient for abortion or doctor-assisted death, then there would be no problem. But consider this: in criminal law, whether you murder someone, or hire someone to do the killing, you can be found equally guilty. Just ask Peter Demeter or Helmuth Buxbaum.

**Practicality**

2. Professional standards and public safety can be ensured without compromising freedom of conscience.

3. The College already has an established protocol for a physician to restrict his or her practice. For example, a doctor returning to practice after successfully completing rehabilitation from narcotic abuse will often be restricted from prescribing narcotics. This fact must be posted clearly on a sign at his office entrance, allowing patients who need an ongoing supply of narcotic medication to self-select another medical practice.

4. Services are easily accessible without a classic MD-to-MD referral. In this day of Google, e-mail, texting and twitter (to say nothing of old-school methods of word-of-mouth and telephone), a patient could identify a compliant physician/clinic/supportive agency in a matter of seconds. Simply put, there is no credible service need for the morally harmful elements of this Policy.

**Ominous intent?**

5. As there is no practical reason to insist on every doctor becoming complicit in the commission of abortion and doctor-induced killing/euthanasia, is it not logical to suspect the reason is one of ideology? In other words, to bend the will of contrarian doctors to a unitary philosophy, to “ram it down their throats?”

*It is a feeble notion of pluralism that transforms ‘tolerance’ into ‘mandated approval or acceptance’*

--- Justice Gonthier, Supreme Court of Canada, in dissent in Chamberlain (2002).

**A violation**
6. The Canadian Medical Association (CMA) has repeatedly recognized the right to dissent and not to refer.

7. In *Codes of Ethics*, published by Toronto’s Hospital for Sick Children (1992): “An individual's conscience must always inform his or her actions even in the presence of a professional code, standards, or guidelines.”

8. Further, [the law] “does not impose liability on doctors, nurses or other health care workers refusing or omitting, on account of moral or religious beliefs, to perform such abortions.” – Crimes Against the Foetus, Law Reform Commission of Canada, 1989.

9. The proposed Policy results in discrimination on the basis of ethical orientation.

**Logical inconsistency**

10. Note that the reference to the *R v. Morgentaler* decision (ref 10, line 119) is inappropriate and not directly applicable, as the impeded access to ‘care’ (abortion) at that time was the mandatory referral through a hospital-based abortion committee. This is not at all like the present day, when abortion on demand is freely and widely available, and the perceived impediment to access (as allegedly addressed in this Policy) is simply that there are some physicians somewhere who do not wish to take part. The two situations could not be more different.

11. The College firmly opposes some procedures like female genital mutilation, admonishing physicians not to perform, endorse or refer for this hideous practice. I could not agree more. But what ethical authority imbues the College to direct members away from one procedure they find objectionable, yet direct them toward (with mandatory participation, no less) another act many Members also consider morally reprehensible?

12. The College asks for tolerance and respect for patients, yet displays intolerance and disrespect towards its Members. No one should be compelled to act against their own properly-formed conscience.
The practice of medicine

13. There are also professional, not moral, reasons to engage patients in a discussion about the ‘service’ they request. A vast and growing literature about the physical and mental complications of abortion should provide the basis for informing any decision to proceed. The College’s own research study revealed a fivefold increase in hospital admission rates for both physical and psychiatric reasons after abortion in Ontario. Does the College not stand by its own data as a subject for pre-procedure counselling? Similarly, a discussion about the development of the fetus at the stage of requested abortion would ensure that the pregnant patient might make a fully informed decision.

14. Finally, it must be said that many of us were shocked and embarrassed by the words of the College’s then-president in an interview published in the Catholic Register on December 17, 2014. He said, “It may well be that you would have to think about whether you can practice family medicine as it is defined in Canada and in most Western countries.” When asked what conscientious would-be family doctors should do in the face of such a Policy, he said, “Medicine is an amazingly wide profession with many, many areas to practice medicine.” Any reasonable person would conclude that he was warning readers that there would be no place in this province for new family doctors who are unwilling to violate their conscience and refer for abortion or doctor-assisted killing. As if to confirm the disturbing nature of these words, current College President vociferously denied a paraphrase of his words incorrectly contained in quotation marks by Dr. Margaret Somerville in an earlier Op-Ed piece in the Post. However, her paraphrase captured the essence of the former president’s words, and indeed his words follow logically from the text of the proposed Policy. While the current College President response was tactically opportunistic, it did not fool many people. She was pointing out a distinction without a difference. In my opinion, neither responses are honourable.

Conclusion

The proposed Policy is one that will sweep away a time-honoured and universally respected principle of conscientious objection. It is unnecessary as a measure to
facilitate care. It is coercive, abusive, and nakedly ideological. If implemented, it will be the focus of intense opposition and criticism. It is unlikely to withstand a legal challenge, in view of physician rights under the Chart, and will be an exhaustive and expensive drain on the College and its fee-paying Members. It is my hope that the College will see fit to drop the offending elements of this Policy, for the good of the profession and the public. There is a diversity of care practice in this province, and numerous practical and creative avenues for patients to access it without this Policy.