Consultation Submissions
May 14, 2021

Introduction

The College of Physicians and Surgeons of Ontario (CPSO) has invited feedback from stakeholders and the public in regard to three policies: Medical Assistance in Dying (MAID), Professional Obligations and Human Rights (POHR), and Planning For and Providing Quality End-of-Life Care (EOLC).

The Canadian Centre for Christian Charities (CCCC) appreciates the opportunity to participate in this important process. These policies touch on fundamental aspects of life, conscience, death, freedom, and human dignity – all of which have an impact that extends beyond the patient and physician.

With over 3,330 members, CCCC is the largest association of Christian charities in Canada and is itself a charity. CCCC serves all kinds of Christian ministries across Canada, including churches, overseas missions, relief and development charities, higher education institutions, foundations, fundraising organizations, health care institutions, hospice facilities and many more.

We have deep concern over the respect for and protection of conscientious practice, a concern that is heightened in light of Bill C-7, which extends MAID to people whose death is not reasonably foreseeable, removes safeguards (e.g. waiting periods, witnesses), and allows for MAID without contemporaneous consent. Furthermore, by March 2023 it will extend MAID to people whose sole underlying condition is mental illness.

After reviewing all of CPSO the policies, advice to the profession documents, and survey questions, we make three recommendations, as set out below.

Recommendations

1. Enhance conscience protection

Existing policies and guidance should be revised to protect conscience and eliminate referral obligations, as per the World Medical Association. Health care professionals should not be obliged to participate in procedures, whether directly, by referral or otherwise, that are contrary to their professional judgment, as informed by their ethical framework or that are contrary to the values or mission of their facility.
As the World Medical Association consistently re-affirms, “no physician should be forced to participate in euthanasia or assisted suicide, nor should any physician be obliged to make referral decisions to this end.”

Similarly, the Canadian Medical Association (CMA) has been consistent and clear in its view that, as it relates to MAID, “an environment must exist that insists practitioners abide by their moral commitments.” The CMA also affirms that “health care providers should not be expected or required to participate in procedures that are contrary to their professional judgment or personal moral values or that are contrary to the values or mission of their facility or agency.”

In a diverse society, patients ought to be entitled to receive care from health care professionals who practice “according to principles that reflect their own moral convictions, including those who value human life unconditionally.” A patient ought to be granted the dignity and autonomy of choosing care not only from physicians whose experience reflects their own, but within facilities, agencies, and institutions that similarly reflect their wishes, values and beliefs; settings that meet their spiritual needs in a manner that affirms them as a whole person. Patients belong to a diversity of cultures and it is insensitive to treat them as having a uniform, singular belief or view of the world.

We commend elements of the EOLC Policy and Advice to the Profession that direct physicians to:

- Respect the wishes, values, and beliefs of the patient;
- Provide care that manages physical, psychological, social and spiritual needs of patients;
- Conduct assessments that include non-medical factors such as satisfying spiritual needs as part of assessments;
- Treat patients with compassion and in a manner that affirms the whole person.

We urge the CPSO to reflect such respect in its own policies toward the values and beliefs of its members. A profession that reflects the diversity of the public it serves is more responsive to the needs of the public, enhances confidence in the profession, and is more competent.

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2. Remove the automatic referral requirement from the MAID Policy and align it with the EOLC Policy

The current MAID Policy and Process Map do not align with the EOLC Policy. The automatic referral requirement should be removed from the MAID Policy. Instead, like the EOLC Policy, the MAID Policy must explicitly incorporate the step of engaging patients in one or more discussions to understand the motivation for requests to die. Requests to die must not automate a referral, and certainly not before exploratory discussions and underlying concerns are identified and redressed.
The EOLC Policy and Advice to the Profession rightly guide physicians to “engage patients in a discussion and seek to understand their motivation,” and to “resolve any underlying issues that can be treated or otherwise addressed” if a patient asks to be euthanized.

In stark contrast, the MAID Policy demands that conscientious physicians immediately provide an “effective referral” for patients who ask to die. Such a policy strikes at the very heart of a conscientious physician who is then called upon to violate her moral integrity.

The MAID Policy creates a separate process for conscientious physicians that undermines the EOLC Policy and that skips absolutely essential steps for conscientious or non-conscientious physicians alike.

According to the MAID Process Map, after a patient makes an initial inquiry for MAID, physicians who have a conscientious objection “must provide the patient with an effective referral.” Yet, the EOLC Policy requires physicians to engage patients in a discussion to understand motivation and resolve any underlying issues. The EOLC Advice to the Profession also explains that conversations about end-of-life care “may need multiple opportunities to discuss in order to engage effectively.”

The MAID Policy and Process Map do not account for this step, and as it relates to conscientious physicians, the MAID Policy directly contradicts this step.

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3. Amend the POHR Policy so that it is internally consistent

Professional judgment is an inextricable combination of education, clinical competence and a morally informed ethical framework. The POHR policy must be revised to be internally consistent in its treatment of physicians regardless of the source that informs their ethical framework for professional judgment.

The POHR policy bifurcates clinical objections and competence from conscience. But it is impossible to separate a physician’s conscience from her clinical competence. What is clinical judgment devoid of ethical considerations?

Clinical judgment must, by definition, account for ethical considerations. This inextricable combination is an essential safeguard for patient care, for consistency, for understanding expectations, and for ensuring that a relationship of trust can be maintained. If a physician is always prepared – or indeed, obliged – to violate her conscience in her practice of medicine, how can she be trusted with the most intimate personal health concerns of her patients? The integrity of a physician to practice in accordance with moral insight and conviction extends throughout time to ancient history and Hippocrates. Hippocrates recognized that integrity is the
very backbone of ethical practice. Abandoning personal integrity in the face of patient demands is to abandon the very essence of why society esteems medicine as an honourable profession.

Similarly, organizations and institutions must be free to manage affairs – and engage medical professionals – in accordance with specific morally informed ethical, clinical frameworks.

For example, the Canadian Hospice Palliative Care Association explains that MAID is a practice separate and distinct from hospice palliative care; its joint statement with the Canadian Society of Palliative Care Specialists reiterates that “MAID is not part of hospice palliative care [...] nor is it one of the tools ‘in the palliative care basket’.” For palliative care physicians, the POHR Policy would attempt to distinguish between physicians who adhere to this statement on the basis of clinical competence and judgment devoid of ethical considerations and physicians who adhere to this statement on the basis of clinical competence informed by ethical considerations. The former have no “effective referral” obligations; the latter do.

The expectations of those who limit practice should be the same, and ethically-informed clinical decision makers must not be subject to “effective referral” obligations.

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**Conclusion**

This submission does not address every element of the policies that ought to be reconsidered; however, CCCC has highlighted some key areas of concern and urges the CPSO to carefully review its policies to enhance conscience protection, align the MAID Policy with the EOLC Policy so as to eliminate an automated referral trigger, and amend the POHR Policy so that it is internally consistent.