

Response of the Christian Medical and Dental Association to the College of Physicians and Surgeons of Ontario consultation on the Professional Obligations and Human Rights Policy (POHR Policy) and the MAID Policy

May 14, 2021

We would like to thank the College for the opportunity to comment on these policies. The recent legislation expanding the eligibility criteria for MAID to include patients with disabilities, serious chronic illness, and eventually mental illness has dramatically expanded the number of patients who will qualify for MAID. This will also substantially increase the numbers of physicians who, because of their commitment to the incalculable and intrinsic value of each patient, are unable to make an effective referral to a willing provider. In order to ensure that physicians who cannot participate in MAiD for ethical reasons will still be able to care for their patients, we are hoping that the College will consider clarifications to the existing policy and advice to the profession.

We would like to offer the following recommendations for some clarifications that we believe would reasonably resolve our concerns. While these recommendations are focused on MAID policy, they also apply to other controversial procedures that may be the subject of the POHR policy.

1. Please consider avoiding the term “effective referral”. The College definition of this term in the policy is nuanced, but we are concerned about it not being well understood. We have heard anecdotes of hospital administrators, medical educators and physicians themselves who still think that the policy requiring an effective referral entails that physicians be required to make a formal referral. Because they may be unwilling to make a formal referral, many physicians may face potentially serious consequences that can affect their training or career, even if they are open to less formal mechanisms of ensuring effective access. Using a different term would provide an opportunity to clarify with the multiple stakeholders what is meant. We would respectfully request that the College take action with key stakeholders (hospitals, medical schools, other health care institutions, other health care professionals and physicians themselves) to make them aware of the actual requirements implicit in the term “effective referral”.
2. The precise wording of the policy itself defines effective referral in the context of an end goal, that of ensuring that the patient has access to a procedure even when their physician can't support it. It is better, in our opinion, to allow the physicians to use their professional judgement on how to achieve the goal of patient access rather than micromanaging their response. It is difficult, if not impossible, to set rules on the types of mechanisms that should be employed in so many diverse settings. The goal of the policy is to ensure that physicians do not obstruct or interfere with patient access when they respectfully disagree with the patient on whether a procedure is appropriate. We absolutely do not condone taking any steps to block access to procedures which are legally available in Canada.

The College policy currently requires an effective referral which is defined as “taking positive action to ensure the patient is connected² to a non-objecting, available, and accessible³ physician, other health-care professional, or agency.”

There will be factors that affect access that are beyond the control of the individual physician. These factors include having sufficient physicians who are prepared to provide the procedure, for example. Having said this, the onus for creating established access routes like Telehealth/Care Coordination Service for controversial procedures should not rest with the individual physician. This, we argue, is a responsibility that falls to health system stakeholders—the Ministry of Health, healthcare administrators and other professions.

We would prefer language such as “the physician must ensure that there are no barriers within their control to the patient accessing the procedure through pathways provided by the Ministry of Health.” Physicians should be permitted to use multiple strategies to make sure the patient can access the procedure, bearing in mind the clinical context, the patient’s needs, the location of the clinical encounter, available options, and their own ethical concerns. To this end, we specifically ask that the College includes two more examples in the list of examples provided in the Advice to the Profession. Specifically, we ask that “provision of information on how to access the procedure” and “transfer of Most Responsible Physician (MRP) status in a facility” be added to the list. We understand the College’s reluctance to allow for a complete transfer of care for conscience concerns. No patient should be abandoned. However, where a willing physician is available to assume care and the patient is in agreement, as in a patient who is in a group practice or in a facility, a complete transfer of care should be permitted as an accommodation for the physician who is unable to participate in MAID.

3. We recommend that there be no further elaboration on the provision of information to the patient than what is currently in the policy. MAID proponents are suggesting that, when patients potentially meet eligibility criteria, patients should be told that they may qualify for MAID even before the patient asks. Given that such a proactive suggestion could easily be perceived as a devaluation of the patient as a person, we believe that any such requirement would seriously undermine the physician-patient relationship. Advising a patient that they should consider MAID upon being diagnosed with a disability or a mental health issue may undermine trust in the profession’s commitment to the intrinsic value of every patient.

The original judge in the Carter case in the BC Supreme Court held that there was no consensus in the medical care system on the ethics of medically assisted death. While the case and the subsequent Supreme Court ruling held that MAID was constitutional, it did not hold that every member of the health care system had to embrace it as being

good for patients. ¹ Forcing physicians to practice as if MAID is always good and appropriate medical care despite very real and widespread concerns about the quality and lack of alternatives, medical ethics, the public trust, and inappropriate influences on vulnerable patients disregards the fundamental patient advocacy responsibilities of physicians.

4. On its face the policy seems to indicate that the physician must make an effective referral immediately upon the patient making a reference to MAiD. We are concerned that this could lead to many premature assessments for patients who primarily need reassurance of their value and who need a gentle dose of ‘hope’ and ‘tincture of time’ (the value of which every experienced physician can attest). How will a psychiatrist care for a patient with suicidal ideation if every time they mention their suicidal thoughts they end up being referred for an assessment? Physicians who oppose MAID do so out of a concern for the health and well-being of the patient and should be trusted to explore the reasons for the wish and alternative therapies. We recommend that the College revise the policy so that the physician will only be required to address access when the patient has expressed a firm resolve to explore MAID.
5. Undue influence – The policy is clear that conscientious objectors must not make statements to the patient expressing criticisms or judgments about their personal treatment decisions. We wholeheartedly endorse this respectful stance. Yet we would also ask that this same policy apply to physicians’ comments to their patients when their patients do not accept MAID or other controversial procedures because of religious or ethical reasons. All patients have a right to have their choices respected to the extent legally permitted. Physicians should be cautioned against judging patients either because they would prefer certain procedures or because they would prefer to avoid certain procedures. Sadly, we find that it is a common experience among religious or cultural minorities to feel disrespected by their physician even though their choices are grounded in their sincerely held values.

In conclusion, both the CPSO and CMDA are heavily invested these policies. This investment is entirely appropriate because they deal with issues of profound importance to both patients and physicians. We appreciate the careful attention of the CPSO to these issues and your willingness to hear from us. We assure you of our willingness to continue to dialogue with you on these matters. We hope that we will achieve an acceptable solution that will ensure effective access to procedures to which many physicians object while avoiding moral distress for the physicians subject to your authority who sincerely wish to treat their patients in accordance with the dignity and respect that they so richly deserve.

¹ “thoughtful and well-motivated people can and have come to different conclusions about whether physician assisted death can be ethically justifiable” (*Carter, BCSC, para. 323*);