OMA Ontario Medical Association

Ontario Medical Association Submission

CPSO Preliminary Policy Consultation – Professional Obligations and Human Rights Policy

May 2021

The Ontario Medical Association (OMA) welcomes the opportunity to provide comments to the CPSO regarding its current Professional Obligations and Human Rights policy. Below is the OMA's preliminary feedback on the existing policy. We look forward to providing additional feedback when the revised policy is available for consideration.

We have conducted a review of the draft policy and consulted with members. Members were asked to: (1) identify areas of the policy where additional clarification is needed, (2) identify ideas that are missing from the policy and (3) identify which actions might be considered appropriate when providing an effective referral (based on the CPSO's interest in this area). The feedback received is summarized below.

Areas Where Additional Clarity/Additional Information is Requested:

Definitions:
Additional clarity is requested regarding the term "Effective Referral". Confusion exists between this term and the generally used clinical term "referral". While a footnote in the policy explains what each term means, the use of a different phrase or expression that does not contain the word "referral" would be preferable to avoid further misunderstanding. As well, the section regarding Clinical Competence mentions the term "referrals" while the section for Conscientious Objection mentions "effective referrals". Clarity is requested to explain the difference between these two terms.

In addition, clarity is sought on the expected timing and acknowledgement of an effective referral. For example, the Transitions in Care policy indicates that, "Consultant physicians must acknowledge referrals in a timely manner, urgently if necessary, but no later than 14 days from the date of receipt." Members asked if the same time frame applies to effective referrals. The Transitions in Care policy also notes that, "Following an assessment of the patient… consultant physicians must prepare a consultation report that includes the information necessary for the health-care provider(s) involved in the patient's care to understand the patient's health status and needs." Members asked if MAID assessors and providers would be asked to provide a consultation report back to the referring physician.

While the policy contains a section about Clinical Competence, it is suggested that a definition of clinical competence be added to the Definitions section to explain the term up front.

The grounds for discrimination under the Human Rights Code (race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status, and disability) are noted in a footnote in the policy. It would be helpful to have a Grounds for Discrimination definition added to this section, so the grounds are apparent right at the beginning of the policy.

Human Rights, Discrimination, and Access to Care
Survey participants were asked if any additional grounds of discrimination should be added to the policy, in addition to the grounds already outlined in the Human Rights Code. It is suggested that lifestyle habits, such as smoking, drug use, and alcohol consumption, as well as other grounds of discrimination, including weight, geography, refugee status, and socioeconomic status be considered as possible additions to the policy.

Conscience or Religious Beliefs
Under this section, the policy states, "Where they choose to limit the health services they provide for reasons of conscience or religion, physicians must do so in a manner that respects patient dignity,

ensures access to care, and protects patient safety." It is suggested that more detail and examples to explain this point further be added to the Advice to the Profession document.

Respecting Patient Dignity

At point 11, the policy states, "In the course of communicating their objection, physicians must not express personal moral judgments about the beliefs, lifestyle, identity, or characteristics of existing patients, or those seeking to become patients. This includes not refusing or delaying treatment because the physician believes the patient's own actions have contributed to their condition." This last sentence seems to be very specific. Perhaps it would be more appropriate to move this to the Advice Document as an example to demonstrate this idea.

Ensuring Access to Care

Participants suggest that the policy clearly state that the transfer of medical records from the referring physician to the physician accepting the referral is part of the duty of care and should be completed in a timely manner.

At point 16, the policy states, "Physicians must proactively maintain an effective referral plan for the frequently requested services they are unwilling to provide." It would be helpful for the Advice Document to explain what is meant by an effective referral plan, what it would contain, and for a template to be provided.

At point 17, the policy states, "Physicians must provide care in an emergency, where it is necessary to prevent imminent harm, even where that care conflicts with their conscience or religious beliefs." It would be helpful to clarify what is meant by the term "imminent harm".

In the Medical Record Keeping section of the Medical Assistance in Dying policy, it states, "Physicians who decline to provide MAID must document that an effective referral was made, the date it was made, and the physician, practitioner, and/or agency to which the referral was made." Participants suggest that this documentation requirement be added to the Professional Obligations and Human Rights policy as well, so that effective referrals are noted under this policy for reasons other than MAID.

Appropriate Actions for an Effective Referral

Through its consultation process, the CPSO expressed an interest in identifying which actions might be considered appropriate when providing an effective referral. Responses to our member survey are as follows:

- 30% of participants indicated that the physician or designate could tell the patient they cannot help them, and the patient can look for a non-objecting physician or non-objecting healthcare professional who is willing to provide the service.
- 44% indicated the physician or designate could provide the patient with the contact information for a non-objecting physician or non-objecting healthcare professional and leave it to the patient to get in touch.
- 51% indicated the physician or designate could contact a non-objecting physician or non-objecting healthcare professional and arrange for the patient to be seen or transferred.
- 67% indicated the physician or designate could connect the patient with an agency charged with facilitating referrals for the healthcare service and arranges for the patient to be seen at that agency.

- 66% indicated a practice group in a hospital, clinic or family practice model could identify patient queries or needs through a triage system, matching the patient directly with a non-objecting physician in the practice group.
- 57% indicated a practice group in a hospital, clinic or family practice model could identify a point person who will provide the healthcare to the patient or will take positive action to connect the patient to a non-objecting physician or non-objecting healthcare professional or agency. The objecting physician or their designate connects the patient with that point person.
- 1% indicated none of the above.

Additional Comments

Comments were made that physicians may have other reasons for restricting their practices other than personal or religious convictions or "clinical competence". For example, some physicians simply do not have the capacity to take on additional patients while others have a practice that focuses on a particular demographic or medical condition.

As well, some participants indicated that additional resources are needed for physicians to make appropriate referrals, such as a central directory of specialists by region. Some rural or underserviced communities have few specialists or physicians able to take on more complex referrals, making it difficult for patients to receive timely access to care.

The OMA appreciates the opportunity to provide feedback regarding the CPSO's Professional Obligations and Human Rights policy. Please contact us if you have questions or require additional feedback while revising the policy.