CPSO – Human Rights in the Provision of Health Services

Consultation closes on 28 November

Documents can be found here: http://policyconsult.cpso.on.ca/?page_id=14240
Answers below relate to line numbering in the 'Advice to the Profession' document

Following the usual questions about personal data, the online survey questions continue with:

From the following list, please indicate if it is reasonable and important to expect physicians to take reasonable steps to incorporate these concepts in their practices.

Please select all that apply:

Cultural Humility

(Reasonable/Important/Both/None)

Cultural Safety

(Reasonable/Important/Both/None)

Anti-racism

(Reasonable/Important/Both/None)

Anti-oppression

(Reasonable/Important/Both/None)

Elaborate (optional)

The draft policy has new draft expectations for physicians in circumstances where patients request to receive care from a physician with a particular social identity (e.g., race, ethnicity, culture, sexual orientation and/or gender identity, spiritual/secular/religious beliefs, etc.).

Please indicate the extent to which you agree or disagree that the following draft expectations are reasonable in response to patient requests to receive care from a physician with a particular social identity:

Complete the 'grid' (not reproduced here).

Under **optional elaboration:**

I would think it reasonable to accommodate a request from a patient to be seen and examined by a doctor who is the same sex as that patient. A polite request should not be refused on the grounds that it is necessarily sexist.

In the same way, I think it would be understandable for a female/male patient to request not to be seen by a transwoman/transman. A patient might well feel uncomfortable in such a situation. Their

request should not be interpreted as transphobic and discriminatory, but simply accepted for what it is - a wish to be seen, examined and treated by someone of the same biological sex as themselves. Wherever possible, such requests should be accepted as reasonable and accommodated.

Lines 82-85

We welcome the draft policy permission to talk with patients about their spiritual, secular and religious beliefs when relevant to patient decision-making, or where it may enable the physician to suggest supports and resources that may assist the patient. We assume that, with the agreement of the patient, this would include freedom to offer prayer. Studies have repeatedly shown that patients value the support they find through prayer (eg, Koenig HG. Research on Religion, Spirituality, and Mental Health: A Review. The Canadian Journal of Psychiatry. 2009;54(5):283-291. doi:10.1177/070674370905400502), and we suggest that this be added as an explicit example in the text.

Lines 135-136

We have a question about the scope of the term 'hardship.' The concept of 'moral harm' or 'moral injury,' suffered by healthcare professionals who are forced to act against their consciences, is well recognised. Acting against one's conscience has been shown to lead to burnout, fatigue and emotional exhaustion (see, for example, Magelssen M. 'When should conscientious objection be accepted?' Journal of Medical Ethics, 2012;38:18-21; Koenig HG, Al Zaben F. Moral Injury: An Increasingly Recognized and Widespread Syndrome. J Relig Health. 2021 Oct;60(5):2989-3011. doi: 10.1007/s10943-021-01328-0. Epub 2021 Jul 10. PMID: 34245433; PMCID: PMC8270769.)

In the draft policy we note that the doctor is not required to accommodate a patient's needs where to do so would result in 'undue hardship' for the physician. In these situations, effective referral to another physician is not mandated. Our contention is that injury to the moral integrity of a physician, by being required to act against their conscience, should be considered at least as great a hardship as any other hardship and given the same priority.

Lines 189-194

The draft Advice makes clear that physicians do not have to accommodate a patient's discriminatory request. It recognises that physicians do suffer harm (e.g., emotional exhaustion, fear, self-doubt, and increased cynicism, leading to physician burnout and a negative impact on patient care) after encounters with patients who are discriminatory towards them. These are the very same harms and impact that physicians who are required to act against their conscience experience (see, for example, Koenig's paper, referenced above, under lines 82-85). Yet, the harm resulting from the internal moral conflict in a physician forced to act against their conscience is not recognised. In effect, the Advice states that physicians do not have to accommodate discrimination unless that discrimination relates to their sincerely held ethical or religious beliefs, in which case they must accommodate it and suffer the harm. We strongly contend that this is as unfair as it is inconsistent. In our view it is also unlawful in that it discriminates on the basis of religion that is prohibited under s.15 (Equality rights) of the Canadian Charter of Rights and Freedoms.

The draft Advice maintains the existing "effective referral" examples and a new, less onerous example has been added: providing the patient with contact information for a non-objecting, available, and accessible physician, other health-care professional, or agency in appropriate circumstances (e.g., where the patient does not need assistance).

Please indicate if the example is clear, reasonable, and strikes the right balance (select all that apply):

Complete the grid, not reproduced here.

The draft policy maintains the existing “effective referral” requirement and new safeguards have been added for physicians to take reasonable steps to confirm that a patient was connected and to take further action to provide an effective referral if they learn the patient was not connected, given that a new, less onerous example has been added to the draft Advice.

The following draft list sets out CPSO’s expectations of physicians when providing an effective referral.

Please indicate which draft expectations are clear, reasonable, and strike the right balance (select all that apply):

Complete the grid, not reproduced here.

Optional elaboration

We appreciate the attempt to balance the conscience rights of the doctor with the rights of the patient to access the legal treatment they seek but contend that the draft Advice fails to do this justly.

The Advice offers the physician, who has a conscientious objection to a certain treatment or procedure, various options all of which amount to 'effective referral.' The Advice fails to recognise that, morally speaking, there is no difference for the objecting physician between effective referral and direct referral. His or her moral integrity is equally compromised whether the referral is direct or indirect. He or she suffers an internal moral conflict that is equally harmful in either case.

We commend the balance expressed by the UK General Medical Council in 'Personal Beliefs and Medical Practice' where physicians who conscientiously object to providing a particular service are required to tell a patient that they do not provide that particular treatment or procedure and to ensure that the patient has enough information to arrange to see another doctor who does not hold the same objection. 'Effective referral' is not required as long as the patient has access to that information and can reasonably be expected to access the treatment they seek.

We would also respectfully draw to your attention the updated and recently published World Medical Association Code of Medical Ethics that takes much the same stance as the GMC: 'The physician must immediately and respectfully inform the patient of this objection and of the patient’s right to consult another qualified physician and provide sufficient information to enable the patient to initiate such a consultation in a timely manner.' (https://www.wma.net/policies-post/wma-international-code-of-medical-ethics/)

HUMAN RIGHTS IN THE PROVISION OF HEALTH SERVICES

Do you have any comments or suggestions on the clarity, comprehensiveness, and/or reasonableness of the draft policy? For example, how can we improve the draft policy's clarity? How can we make the draft policy more comprehensive? What expectations, if any, did you find unreasonable?

We find the requirement for effective referral (s.9b, lines 99-108) to be unreasonable. In our opinion it does not strike a just balance between the right of the patient to access the treatment they seek and the right of the doctor to practice according to their conscientiously held beliefs.

As it stands, the draft policy fails to take sufficient account of the moral harm or injury suffered by the objecting physician. The concept of moral harm in healthcare settings is now well established - see, for example, Koenig HG, Al Zaben F. Moral Injury: An Increasingly Recognized and Widespread Syndrome. J Relig Health. 2021 Oct;60(5):2989-3011. doi: 10.1007/s10943-021-01328-0. Epub 2021 Jul 10. PMID: 34245433; PMCID: PMC8270769.

Long-term effects have been shown to include emotional fatigue and exhaustion, burnout and depression (Magelssen M. 'When should conscientious objection be accepted?' Journal of Medical Ethics, 2012;38:18-21).

Human Rights legislation protects as fundamental the right to freedom of conscience and beliefs, religious or otherwise.

A physician fiduciary responsibility is to act in the best interests of his or her patient. If a physician believes that a particular treatment requested by a patient is not in that patient's best interest, then he/she is morally obliged not to supply that treatment. Any Code that forces the physician to act against his/her convictions is morally flawed. Even if a colleague might feel differently, the physician must not be forced by the Code to refer for treatment that he/she believes not to be in the patient's best interest.

In support of this, we cite a recent High Court case in the UK ([2022] EWHC 2440 (Admin)) in which Judge HHJ Sephton KC argued that 'I do not accept that a medical professional who has reached the conclusion that a treatment is adverse to the patient's needs is required to find another medical professional who will administer that treatment. My view is, I believe, consistent with Burke and Re J (A minor) and is also consistent with the professional guidance offered to doctors by the General Medical Council....If the President was urging that a professional is obliged to find another who will administer treatment which the professional believes is adverse to the patient's needs, then I must, with the greatest of respect, disagree.'

As stated above, we commend the stance adopted in the UK General Medical Council's Good Medical Practice, that does not mandate effective referral.