MITCHELL | HAMLINE
School of Law

March 21, 2021

(via humanrights@cpso.on.ca)

College of Physicians and Surgeons of Ontario
80 College Street
Toronto, Ontario M5G 2E2

Dear CPSO:

Re: Consultation on Professional Obligations and Human Rights Policy

I am a law professor currently serving as the Fulbright Canada Research Chair in Health Law, Policy and Ethics at University of Ottawa. I appreciate the opportunity to participate in the preliminary consultations regarding the *Professional Obligations and Human Rights Policy*. Furthermore, I would be delighted to continue engagement with the CPSO as it revises the policy. Such work is precisely the mission of my Fulbright award.

I submitted comments through the CPSO survey tool on this consultation. The additional comments below focus on specific language. These comments are not designed to change the scope or meaning of the policy. Rather, they are designed to improve its clarity and effectiveness.

1. **Sections 6 to 9.** The policy is structured to imply that there are two reasons that physicians may refuse: (a) for reasons of clinical competence and (b) for reasons of conscience or religion. The policy misses an important *third* category. Here, the physician may *not* refuse for either competence or conscience, yet conscience still affects the physician's judgment. For example, a physician morally uncomfortable with MAID may determine that the patient lacks capacity because they more rigorously test capacity when it comes to MAID. This bias may not even be conscious. But it is real, and the policy should do more to warn against it. I recognize that Section 2(b) warns against this in prohibiting discrimination when "providing existing patient with health care or services." Later sections warn about providing full and complete information. But the policy could be more explicit in warning against allowing conscience to affect or corrupt medical judgment. Outright refusals are not the only way in which conscience and religion can affect patients.

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2. **Section 8.** This language says: "physicians must provide a referral." But since you already defined a specific term, "effective referral," it seems appropriate to use that term here.

3. **Section 8.** You suggest that refusing a prospective patient can be "abandonment." But abandonment applies only *after* formation of a treatment relationship. It does not apply when the physician refuses to form a relationship in the first place with "those seeking to become patients." Physicians do not normally owe duties to non-patients. I understand that CPSO is *adding* the duty to refer when refusing to accept a patient. That is fine. But the explanation or rationale for imposing that duty should not be abandonment.

4. **Section 17.** The emergency exception is stated categorically: "must provide care in an emergency." What if the objecting physician can find a timely substitute? The *Advice* document suggests that so long as the patient "will not experience an adverse clinical outcome," the original physician has made an "effective referral."

5. **Endnote 2.** The definition of "available and accessible" seems incomplete given the objectives. The referral location may be geographically convenient and "accepting patients." But how soon can the patient be seen for the relevant service? The *Advice* document also focuses on only the timing of the "referral" and "connection" but not on timing of the actual health service.

Sincerely,

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