March 5, 2015

Council of the College of Physicians and Surgeons of Saskatchewan
321- 21st St E
Saskatoon, SK   S7K 0C1
via email to communications@cps.sk.ca

Dear Colleagues and Public Representatives of the Council,

Thank you for the opportunity to provide input into the draft document of the College of Physicians and Surgeons of Saskatchewan (CPSS) entitled Policy – Conscientious Refusal ("the Draft"). I acknowledge the importance and difficulty of the work this represents. I would like to be able to support it, but I cannot. There is much that I will leave for others to address. I will speak to three areas of concern:

1. **A Transformative Change to the Status Quo**

This Draft has been presented as a relatively minor modification to the status quo, a clarification with some broadening of scope. The Draft does far more than that, for at least three reasons:

**From guideline to policy.** The status quo is articulated in the document entitled Guideline: Unplanned Pregnancy (“the Guideline”) from 2011. A policy carries more weight than a guideline and is thus more likely to result in disciplinary action if violated.

**The requirement to participate through referral and, possibly, direct action.** The current Guideline does contain a referral requirement. It does not, however, require a referral for termination per se. It states that “any physician who is unable to be involved in the further care and management of any patient when termination of the pregnancy might be contemplated should inform the patient and make an expeditious referral to another available physician.” It goes on to say

5) c) With reference to the option of termination of the pregnancy, the physician should apprise the patient of the availability of abortion services in the province, or elsewhere, in accordance with any current law or regulation governing such services, and should ensure that the patient has the information needed to access such services or make the necessary referral. The patient should be provided the information regarding the nature of termination options, to the best of the physician’s ability.

The use of the word *or* rather than *and* in the phrase “should ensure that the patient has the information needed to access such services *or* [emphasis added] make the necessary referral" was not incidental. It was an intentional choice by council members when the Guideline was revised in 2011, specifically to accommodate those colleagues for whom referral is morally
equivalent to direct action. Because the Draft would explicitly require direct referral for any morally contested intervention and even, in some circumstances, require direct provision of a morally contested intervention, its implementation would be a seismic and transformative shift away from the status quo.

Paradoxically, the very Draft that purports to protect patients from abandonment by their doctors would actually require doctors to intentionally place patients in harm’s way to protect the doctors’ self-interest in avoiding disciplinary action by their regulatory authority. That would be abandonment and dereliction of the duty to always act in the best interests of the patient.

The broadening of the scope from unplanned pregnancy to all of medical and surgical practice. The all-encompassing scope of the Draft has the potential to profoundly impact every physician and surgeon in Saskatchewan, regardless of discipline. The requirements in Section 5 are coercion cloaked in the language of compromise, and are particularly pernicious in the wake of the recent Carter decision.


About authorship, bias, and conflicts of interest. Training in critical appraisal teaches us to consider several questions concerning the author(s) of any document under review.

What are the author’s credentials [and] institutional affiliation … past writings, or experience? Is the book or article written on a topic in the author’s area of expertise? … Is the author associated with a reputable institution or organization? What are the basic values or goals of the organization or institution?

Editors, authors, and peer reviewers should disclose interests that might appear to affect their ability to present or review work objectively. These might include relevant financial interests … or personal, political, or religious interests.

The International Committee of Medical Journal Editors’ definition of conflicts of interest is as follows:

A conflict of interest exists when professional judgment concerning a primary interest … may be influenced by a secondary interest. Perceptions of conflict of interest are as important as actual conflicts of interest.

Disclosure is understood to be the most effective way of addressing unavoidable biases. “All authors must include a ‘competing interests’ statement fully disclosing any conflict or potential appearance of conflict, if any.” The absence of such disclosure with respect to the origins of the CPSS Draft is deeply disquieting.
Origins/authorship of the Draft. In reading the Draft, those of us familiar with the work of Dr. Jocelyn Downie could not fail to see the very high degree of concordance between the Draft and the model policy (“the Model”) that Dr. Downie and her colleagues in the Conscience Research Group (CRG) published in 2013.10 It has been asserted that the CPSS Draft was not simply taken from the Model, but it is apparent that the Draft and the Model have a common lineage. How did that come to pass? What is the CRG? Who are its members? What are their interests?

According to their website, the CRG is a group of faculty in Law and Philosophy:

We specialize in health care ethics and health law, and are investigating the permissibility of conscientious refusals by health care professionals to provide health care services such as abortions. Our particular concern is with refusals to provide reproductive health care services… The research involves five projects, each with their own distinct research questions, which we aim to answer in part from a feminist perspective.11

Dr. Downie also has a keen interest in assisted death, and co-authored a paper in 2008 presenting a model statute to allow assisted suicide, which includes the following:

There are many individuals whose lives are no longer worth living to them who have not been diagnosed with a terminal illness. They may be suffering greatly and permanently, but are not imminently dying. There is no principled basis for excluding them from assisted suicide…

The statute does not require that individuals who are given assistance with suicide are of the age of majority. Mature minors (i.e., individuals under the age of majority who are competent) are not excluded under this Act.12

How did this group of lawyers and philosophers, with their very particular agenda, come to offer their services as policy developers to the regulatory authorities in Canadian medicine? How is it that the CPSS Draft so closely resembles their Model? Their paper provides the following explanation:

Carolyn McLeod brought together a team of academics from philosophy and law to reflect on the moral and legal dimensions of conscientious refusals in healthcare. The meetings of this team provided rich soil within which to germinate the seed for a model policy. In this paper, we recount the stages that were involved in developing this policy and then present the policy itself in the hopes of encouraging its adoption by Colleges of Physicians and Surgeons across the country. …

Motivated and informed by this policy review and also by our team’s philosophical work on conscientious objections, the next stage of the project involved drafting a model conscientious objection policy for uptake by Canadian
physician regulatory bodies. We decided to proceed by way of regulatory bodies rather than the CMA for two main reasons: 1) the Colleges of Physicians and Surgeons, not the CMA, are the regulators of physicians, which means their policies have more force than CMA policies; and 2) in view of the reaction of the CMA to the editorial described earlier, we thought CMA policy reform was unlikely…

I submit that the evident interests, agendas and biases of these authors are important contextual information for anyone seeking to critically assess the Draft, and should have been disclosed.

**People of faith notable by their absence.** It has been asserted that the Draft is a compromise between extreme positions, what might be called the middle ground. However, there is no information provided to suggest that either the CRG or the CPSS Council sought input from both sides of the issue. Downie, McLeod and Shaw report that

The [Modal] policy included the adoption of useful elements of existing policies along with insights from the philosophers on the research team. Feedback on the draft policy was also solicited from a number of relevant experts: academics who do research primarily in health law, biomedical ethics, medicine or other health professions; physician regulatory body members; and local community organizations dealing with women’s health, sexual health, and the health of more marginalized populations (e.g. rural populations, street youth, First Nations).

The CRG authors make no mention of feedback being solicited from religious organizations such as the Catholic Health Alliance of Canada, the Muslim Medical Association, the Christian Medical and Dental Society of Canada, or the Canadian Federation of Catholic Physicians’ Societies. Similarly, there is no information available to suggest that the CPSS Council sought such input in the development of the Draft.

It is difficult to accurately locate the middle ground when everyone involved is looking for it from the same side of the field.

3. **The Impact on the Practice of Medicine in Saskatchewan**

**The distinction between preference and principle.** Preference is “a greater liking for one alternative over another or others.” Principle is “a fundamental truth or proposition that serves as the foundation for a system of belief or behaviour or for a chain of reasoning.” Preferences can be readily set aside when circumstances warrant. Principles are only meaningful if they are adhered to even when circumstances make it difficult to do so, and it is unacceptable to expect physicians to set aside their deeply held principles, particularly when doing so would force them to commit actions that they consider to be harmful. This then raises the issue of compromise.
The moral maturity required to compromise without being compromised. Compromise entails "evidence of tolerance, prudence and a commitment to fairness..." whereas being compromised entails... “erosion of personal moral integrity and lack of moral courage.” 20 Edmund Pellegrino writes,

Physicians who lay claim to moral integrity are obliged to comprehend their own beliefs sufficiently well to know when they can compromise and when not... Moral maturity is a part of moral integrity and requires knowing which acts destroy moral integrity and which do not.21

The impact of ethical distress and moral residue. Moral residue is “that which each of us carries with us from those times in our lives when in the face of ethical distress we have seriously compromised ourselves or allowed ourselves to be compromised.” 22 Webster and Baylis describe the consequences of moral residue for health care professionals and their patients, including loss of trust in the patient-caregiver relationship, desensitization, burnout, disengagement, and an increased likelihood of moral compromise in the future.23 None of this can be healthy for our patients, our profession, ourselves.

In the few short weeks since the release of the Draft, I’ve heard older colleagues talking about ensuring that their retirement plans are in order. Younger colleagues have explored reactivation of their licenses in other provinces, and some have applied to write the USMLE (the American licensing examination) to open additional options to the south. Students, both in-province and from elsewhere in Canada, as they were preparing for this week’s CaRMS match, contacted me to discuss whether they should reconsider their rank order lists to try to steer clear of Saskatchewan. Residents are questioning whether their plans to practice in rural settings are in jeopardy, since location and distance may make timely referral difficult, and put them in a position of having to directly provide morally contested services. Rural practitioners are wondering whether they’ll need to relocate.

Those who think the medical profession would be better off without having to effectively accommodate conscientious refusals of their colleagues may see the potential departure of these doctors as (to quote the software engineers) a feature rather than a bug. However, if it truly is the goal of the CPSS Council to work toward a medical profession that intentionally excludes particular faith groups, it is incumbent upon you to make that intention explicit to the “moral owners” 24 of the CPSS, the very patients whom we seek to serve.

I respectfully ask you to rescind your approval of this Draft, and start again.

Sincerely,

Sheila Rutledge Harding, MD, MA, FRCPC
Haematologist
CC. Hon. Dustin Duncan, Minister of Health  
Hon. Greg Ottenbreit, Minister Responsible for Rural and Remote Health  
Hon. Don Morgan, MLA, Saskatoon Southeast


3 Ibid, p. 2.

4 Full disclosure: I was a member of Council in 2011 and participated in the revision of the Guideline.

5 I have come to recognize that some of my colleagues who do not share my moral concerns about various contested treatments/procedures think that the referral option is a win-win for me; that it is a mechanism through which I am able to procure something I quietly consider to be beneficial for my patient while protecting me from repercussions within my faith community. These colleagues do not understand that I consider the contested activity to be harmful to patients, to families, to providers, to communities, and to the larger society. I don’t expect every colleague to share or even to understand this perspective, but I do expect it to be tolerated and accommodated within the profession.

6 Critically Analyzing Information Sources: Critical Appraisal and Analysis. Cornell University Library. Downloaded 2015-03-04 from http://guides.library.cornell.edu/criticallyanalyzing


8 Ibid

9 Ibid


15 Downie J, McLeod C & Shaw, J. Ibid. (p. 29).

16 Full disclosure: I am a long-term member of the Christian Medical and Dental Society of Canada (CMDS) and a co-signatory to the joint submission from CMDS and the Canadian Federation of Catholic Physicians’ Societies.

17 “He who knows only his own side of the case knows little of that. His reasons may be good, and no one may have been able to refute them. But if he is equally unable to refute the reasons on the opposite side, if he does not so much as know what they are, he has no ground for preferring either opinion… Nor is it enough that he should hear the opinions of adversaries from his own teachers, presented as they state them, and accompanied by what they offer as refutations. He must be able to hear them from persons who actually believe them…he must know them in their most plausible and persuasive form.” (John Stuart Mill)

18 Oxford Dictionary

19 Ibid


23 Ibid