July 22, 3015

Members of Council, College of Physicians and Surgeons of Saskatchewan
101 - 2174 Airport Drive
Saskatoon, Saskatchewan S7L 6M6

Dear Council Members,

Thank you for requesting feedback on the College of Physicians and Surgeons of Saskatchewan (CPSS) draft Conscientious Objection policy (the Policy). As you may be aware, the Christian Medical and Dental Society (CMDS) of Canada, the Canadian Federation of Catholic Physicians' Societies (CFCPS), and Canadian Physicians for Life (CPL) are deeply invested in safeguarding the rights of all Canadians. We greatly appreciate the time and effort the Council has put into drafting this policy, and we are grateful for the improvements that have been introduced in the draft that was approved in principle by Council in June 2015.

We would like to offer input regarding two primary concerns: the language used in sections 5.2 and 5.3 and the requirements outlined in section 5.4. These sections as written will still force physicians to act contrary to their moral convictions. We believe that these concerns can be resolved with minor changes to the draft policy and we hope that, through continued collaboration, the Policy will serve its stated purpose of providing "clear guidance to physicians and the public." During the March 2015 meeting of Council, the Associate Registrar expressed frustration that those of us with objections to the original draft Policy had proposed no alternatives. Thus, we have taken the liberty of tracking our suggestions on the enclosed copy of the Policy.

Although we appreciate that the Council has moved away from using the word "referral," we are concerned that the language used in its place is unclear and could be misconstrued in the future to mean a referral. As a remedy, section 5.2 should begin with: "Physicians must ensure their patients receive the full and balanced health information…" Further, in the second paragraph of this section, it should read: "The obligation to inform patients may be met by providing the patient with information to allow the patient to arrange timely access to the full and balanced health information…" This rephrasing clarifies the obligations of both physician and patient, ensures the patient has access to the required information, and allows the physician the freedom to find creative solutions in the exercise of her conscience.

In Section 5.3, physicians are directed to "make an arrangement that will allow the patient to obtain access to the health service." Although the Policy attempts to clarify the phrase, "make an arrangement," we think it remains at risk of misinterpretation. As a remedy, this section could be rewritten using wording that appears on the flow chart on the back of the draft policy that was handed out to members of the public at the June council meeting, and clearly outlines the responsibilities of both the physician and the patient. It would require the physician to "provide the patient with

information to allow the patient to arrange timely and effective access to medical services." We further suggest that this flow chart be posted on the web site and be incorporated into the formal policy document, as it provides helpful clarity. In addition, the wording of Sections 5.2 and 5.3 could be interpreted as disqualifying a physician from having any discussions with their patients about an issue when the physician has conscientious concerns about the procedure. We understand that this is not the intent of Council (again, the flow chart is helpful here), and have suggested explicit clarification on the point.

The physician's obligation to provide care to prevent imminent harm is indisputable. Although section 5.4.a makes this principle explicit, the language in the rest of section 5.4 goes much further. First, section 5.4.b speaks about "jeopardizing the patient's health or wellbeing." This phrase is very broad and could be interpreted to include psychological and/or social wellbeing as well as physical health. For example, if a woman argues that being told by a physician, "I do not participate in abortion," damages her self-esteem, this section could compel a doctor to participate in a procedure to which she is morally opposed. In fact, this is exactly the position Canadian academic Carolyn McLeod took in her paper, "Harm or Mere Inconvenience: Denying Women Emergency Contraception" (2010, *Hypatia* 25(1), 11-30), and we are confident that she is not the only one who would make this argument.

Second, section 5.4 includes a paragraph that addresses treatment that "must be provided within a limited time to be effective." It is unclear what treatments section 5.4.b and the concluding paragraph that follows are designed to address that are not already addressed in section 5.4.a (preventing imminent harm). The language in these sections is ambiguous and does not clarify the physician's obligations. As a remedy, these sections could readily be removed from the Policy, leaving section 5.4.a intact to ensure patients receive care to prevent imminent harm.

If treatment that "must be provided within a limited time to be effective" would include emergency contraception and/or medical abortion, then that paragraph would be very problematic for many of our members. Furthermore, although the Policy states at the outset that it is not intended to address physician assisted suicide or euthanasia, we believe there is a strong likelihood that this Policy will serve as a template for addressing these practices once they are legal, making this part of section 5.4 especially problematic. For example, if a patient requests euthanasia because he is experiencing intolerable pain, would a doctor be compelled to end the patient's life if no other doctor can be found in a time frame that the patient finds acceptable? Who would define *timeliness* and *efficacy* in a situation in which the patient has decided she wants to be dead before tomorrow? This concern was dismissed at the June meeting of the Council on the basis of the time constraints that would presumably be required by safeguards that would presumably be in place should this situation arise in the future. This casual dismissal presumes too much to be reassuring. While it will likely take a number of days for someone to be assessed for suitability for assisted death, thereafter (i.e., once approved) the patient could decide to end their life at a time of their own choosing, which could then place a conscientiously objecting physician in an untenable situation, should a consenting physician be unavailable. This is expressly

opposed to the decision of the Supreme Court that legalized assisted death, which clearly indicated that no physician could be forced to participate in physician assisted death. (*Carter* para.132)

In addition to the comments made here, CMDS, CFCPS, and CPL have also prepared a submission that reviews the legal considerations pertaining to the conscience rights of physicians. We have included a copy of this submission with this email and hope that it will clarify our legally grounded objections to certain portions of the policy.

We are grateful that the Council has been willing to address such a challenging topic, and we hope that our comments will assist in your efforts to create a policy that will best serve the people of Saskatchewan.

Sincerely,

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ENCL. 2015-6-19 CPSS Conscientious Objection Policy - CMDS, CFCPS, CPL Suggested Changes
Submissions of CMDS, CFCPS and CPL

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