Response to: "The College of Physicians and Surgeons of Ontario on MAiD referrals"

We are writing to respond to Dr. Steven Bodley's letter, "The College of Physicians and Surgeons of Ontario on MAiD referrals,"[1] which was in response to the *CMAJ* editorial by Dr. Kelsall.[2] Since beginning our medical training, we have encountered a variety of viewpoints about medical assistance in dying (MAiD). Although some physicians strongly advocate for increased access to MAiD, many others are not comfortable with the thought of being implicated in, much less performing, this procedure. In our classes, we have been encouraged to make space for the multiple perspectives that exist in our diverse society. We are saddened to see that this inclusivity does not extend to practising physicians, specifically with respect to the protection of their consciences. The College of Physicians and Surgeons of Ontario's effective referral policy for MAiD does not go far enough in protecting the religious freedom of physicians.

According to the college's policy (no. 4–16) on MAiD, an effective referral is required to be made in "good faith to a non-objecting, available, and accessible physician, nurse practitioner or agency." Although Dr. Bodley insists that "an effective referral is not synonymous with a direct referral," this does not change the fact that, regardless of the health care practitioner or agency to whom a physician is sending a referral, he or she is still making a referral. It is unfortunate that the college does not acknowledge that the provision of an "indirect" referral still renders the referring physician complicit. Most other jurisdictions in the world that have legislation on physician-assisted suicide do recognize this and do not demand an effective referral of objecting physicians. The Divisional Court of Ontario acknowledged that the policy breaches the religious freedom of physicians.

Even more unfortunate is that medical students training in Ontario must now seriously consider taking their skills and talents to another province or jurisdiction in which they can practise their vocation in such a way to uphold their integrity.

Clinical encounters with suicidal patients during our psychiatry rotations have helped us to appreciate the sense of intolerable suffering with which some individuals live. We are disturbed by the notion that we may one day have to grapple with deciding which suicidal patients should be provided with suicide prevention and which should be assisted with suicide. This is particularly concerning because the legislation is currently being considered to expand access to mature minors and to patients solely with mental health concerns. However, we are rapidly learning that these experiences and concerns can lead to very inconvenient perspectives. It has been suggested by some that those of us who hold these views should steer clear from choosing specialties that require interaction with older adults who may seek this service. Alternatively, we could have been prevented from entering the medical field altogether.

We hope that going forward, those in positions of power may be reminded that the existence of multiple viewpoints in medicine is not a liability but simply a reflection of the diverse community of physicians in Canada — this is something to be protected, not eliminated.

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2. Kelsall D. Physicians are not solely responsible for ensuring access to medical assistance in dying. *CMAJ* 2018;190:E181.

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