I. Background (1970-2011)

I.1 Revision of the CMA *Code of Ethics* (1970)

I.1.1 The Canadian Medical Association was one of the groups that supported the legalization of abortion. However, when the law was passed in 1969, its *Code of Ethics* still described abortion as "a violation both of the moral law and of the criminal code of Canada, except when there is justification for its performance." According to the *Code*, abortion was justified only when "continuance of pregnancy would imperil the life of the mother."[1]

I.1.2 In 1970 the General Council of the CMA, the governing body of the association, approved the first major revision of its *Code of Ethics* in 50 years. It did not mention abortion because, said the chairman of the ethics committee, "we consider it to be like any other surgical procedure."[2]

I.1.3 However, the new *Code* did include the following statement, obviously made necessary by the legalization of abortion:

> **Personal morality**
> 15. An ethical physician will, when his personal morality prevents him from recommending some form of therapy which might benefit the patient, acquaint the patient with these factors.[3]

I.1.4 A few months later the CMA Board of Directors decided that it would be ethical for a physician to refer a patient to another physician for consideration of an abortion, but not to an "abortion counselling agency."[4]

I.2 CMA, abortion and freedom of conscience (1971)

I.2.1 The following year, in a 78/74 vote following a 90 minute debate, the CMA General Council declared that abortion could be justified on "non-medical social grounds." The next day the Council approved nine further resolutions concerning abortion, including two of particular significance:

> 4. That faced with a request for an abortion, a physician whose moral or religious beliefs prevent him from recommending and/or performing this procedure should so inform the patient so that she may consult another physician.
>
> 7. That physicians or other health personnel should not be required to participate in the termination of a pregnancy; and that a patient should not be forced to have a pregnancy terminated.[5]

I.3 CMA and abortion controversy

I.3.1 By 1974 it had become clear that most abortions were being performed for "non-medical - social, psycho-social or socioeconomic - reasons."[6] Dramatic yearly increases in abortion rates continued for a decade.[7,8,9,10] The broadened grounds for abortion and continuing increases in the abortion rate increased the likelihood of conscientious objection to the procedure and of conflict between patients and physicians. It also brought raging controversy. In 1974 the CMA Director of Communications disclosed that the Association was being inundated with letters about abortion from physicians and the public.[6] One physician noted that members of the Association had "strongly opposing opinions" about the morality of abortion, and warned that "it will be impossible to find a compromise" that would satisfy all of them.[11]

I.3.2 Delegates at the 1976 Alberta Medical Association annual general meeting saw a need to reaffirm its policy that "no pressure be applied against physicians or hospitals that do not conduct abortions,"[12] which suggests that such pressures were being felt.

I.3.3 Certainly, there is evidence of this in the professional literature of the period from the United States, the United Kingdom and Italy. The Protection of Conscience Project has identified over 60 articles or letters in professional journals published between 1970 and 1979 that indicate that collisions were occurring between those demanding the provision of abortion and those refusing to provide them.[13,14]

I.4 CMA introduces mandatory referral into the *Code of Ethics* (1977)

I.4.1 Meeting in Quebec in June, 1977, the CMA General Council received a report from the Association's Ethics Committee titled "Moral dilemmas in Medical Students and Psychiatric Residents." The report offered the following quotation:

> There is increasing interest in psychiatry and medicine as indicated by the recent proliferation of books and articles in the area. One reason for this may be that at no other point in medical history has the physician been faced with so many moral issues as at the present time. Euthanasia, definition of death, patients' rights, abortion, human experimentation, behaviour control, allocation of scarce resources, genetic engineering are just a few of the major issues currently under close scrutiny. . .[15]

I.4.2 With respect to the professional literature then available on the subject, the quotation continued:

> Most articles have been impressionistic, anecdotal and highly opinionized. The problem with the literature in this area is that it explores and describes ethics and virtues as situational specific attributes and as conformity to a societal standard instead of looking for basic principles such as justice, dignity and the sanctity of life. Further, the previous research has utilized too non-standard and unsystematic

approaches to warrant any definitive statements.[15]

I.4.3 Council reaffirmed the CMA position that all references to therapeutic abortion should be removed from the *Criminal Code*. Dr. L.H. Leriche (registrar of the College of Physicians and Surgeons of Alberta[16]) insisted that anything that could be done to reduce the hypocrisy associated with abortion would be commendable. Referring to the operation of therapeutic abortion committees, he said:

> "These committees meet and declare a perfectly healthy, sane 17 year old girl mad," he declared. "So mad that she must have an emergency operation the following Tuesday morning to destroy a fetus. That is hypocracy." [sic][17]

I.4.4 Acting on a recommendation from the Ethics Committee, the Council also revised the provision in the *Code of Ethics* that had introduced the requirement that physicians notify patients of "personal" moral beliefs that might prevent them from recommending a procedure. It had been editorially modified in 1975.[18]

I.4.5 The revision was not reported in the contemporaneous *Canadian Medical Association Journal* (CMAJ) account of the meeting,[17] which described it as "uncontroversial meeting by the standards of some CMA annual gatherings," with only "mild discussion" of contentious topics.[17] In contrast, a CMAJ news report published the year following indicated that the debate had been long and emotional.[19]

I.4.6 According to a later statement by the CMA Director of Communications, abortion was the "principle [sic] area of concern" when the Council debated the proposal.[20] Consistent with this, Dr. Leriche, whose comment about therapeutic abortion committees is noted above, was one of the key participants in the discussion.

I.4.7 The Council was presented with the following proposal:

1975 Code of Ethics	***Proposed Change***
Personal morality 15. An ethical physician will, when his personal morality prevents him from recommending some form of therapy which might benefit the patient, will so acquaint the patient.	**An Ethical Physician:** 16. when his personal morality prevents him from recommending some form of therapy which might benefit his patient <u>will so advise his patient and will advise the patient of his right to seek other opinions.</u>

I.4.8 After some discussion and a proposal to replace "benefit" with "affect," Dr. L.H. Leriche and Dr. H.W.V. Letts moved that the section should require the physician to "advise the patient of other sources of assistance."[21]

I.4.9 Dr. Leriche argued that "compassion is the basis of ethics," of professionalism and of

medical practice, and that the profession has a responsibility to patients "who should not be abandoned in any regard." Hence, a physician who disagrees with "a particular form of therapy" must not "abandon" the patient. He added that the ethics committee was "perhaps one of the most important. . . at this time because there are changing principles and philosophies and the profession should adjust itself accordingly."[21]

I.4.10 The revision that was finally adopted stated:

> 16. An ethical physician, when his personal ethic prevents him from recommending some form of therapy will so acquaint his patient and will advise the patient of other sources of assistance.[19,21]

I.5 Controversy about mandatory referral (1977-1978)

I.5.1 It soon became obvious that the revision had made things worse. In January, 1978, blaming "incorrect mass media news stories" for "spreading confusion," the CMA's Director of Communications, D.A. Geekie, had to issue a clarification. He assured physicians that the revision did not mean that they were obliged to refer a patient to a colleague who would certainly provide the contested service. That interpretation, he said, "would be contrary to the intent of the Ethics Committee that proposed the change."

> Prior to the June 1977 meeting of General Council, a physician with a conflict of interest (professional vs personal interest position) because of his personal morality, was required to inform the patient, and nothing more. The Ethics Committee recognized that, on occasion, this could result in a patient being (*de facto*) abandoned - a result that was not in keeping with the tenets of the profession. The intent of the change was to place responsibility on the physician, not only to inform the patient of the conflict of interest created by his moral position, but also to help the patient find other sources of assistance.[19]

I.5.2 Mr. Geekie explained that objecting physicians could refer patients "to a clergyman for religious counselling, to all three or to other sources of assistance," but that the revision did not "suggest or state" that the patient must be referred "to a colleague who is in favour of abortion on demand."

> Indeed, CMA policy clearly opposes such an approach. The Association has encouraged physicians to bring unbiased professional judgement to bear on each individual case. He should avoid the simplistic role of dispenser of a service desired or thought to be desired, by the patient.[19]

I.5.3 The attempt at clarification did not help. The revised policy continued to be highly divisive, one physician noting that it was generating "confusion and dismay" within the Association.[22]

I.5.4 The Director of Communication's disclaimer notwithstanding, much of the concern arose because even physicians who appear to have been willing to provide or refer for abortions feared that their objecting colleagues would be pressured to become morally complicit in what they considered to be murder.[22] One objecting physician insisted that "[n]o patient has the right to anything other than what a physician can in his conscience do," and protested that it was "intolerable that the CMA is telling me I may not follow my conscience in this most serious matter."[23]

I.5.5 The CMA's general secretary defended the policy, paraphrasing the arguments advanced by Dr. L.H. Leriche's when he proposed it (I.4.9). He returned to the theme of abandonment:

> In suggesting changes in the *Code of Ethics* the CMA's committee on ethics attempted to underline the right of the patient to have other opinions, and the responsibility of the physician to indicate that she has that right. General Council, in its wisdom, strengthened the recommendation, and indicated that, in its view, the physician has a broader responsibility not to abandon the patient or impede her from obtaining help from other sources of assistance.[24]

I.5.6 The accusation of "abandonment" was strenuously rejected as at least an exaggeration[25] and as an injustice,[23] and the illusion of moral neutrality ridiculed:

> . . .we are told to bring "unbiased professional judgement to bear on each individual case." How can there be an unbiased position in this situation? The only stance that could approach an unbiased position is to have no moral conviction and assume "the simplistic role of dispenser of a service", a position we are told to avoid. . . . [25]

I.5.7 These arguments were supported by the Newfoundland Medical Association, which passed a resolution to that effect "because many physicians might have moral and religious objections to passing their patients on as well as to recommending abortions themselves." The Ontario Medical Association also expressed reservations about the provision.[20] Even Doctors for Reform of the Abortion Law protested the new provision and clarification, though their concern was that it might cause delays in providing the service.[26]

I.6 CMA removes mandatory referral from *Code of Ethics* (1978)

I.6.1 The problem was brought to the meeting of the General Council in June, 1978. Alberta College Registrar Dr. LeRiche defended the amendment he had secured to the *Code* by attacking objecting physicians who refused to facilitate abortion by referral:

> "It's like a father who throws his fifteen-year-old daughter out of the house when she's pregnant, because he's a strict and bigoted moralist and pregnancy outside marriage is outside his religion."

> LeRiche wanted to see acceptance of "the very splendid article 16 which we debated splendidly last year, and then we can lay this matter to rest."[20]

I.6.2 However, by a vote of 81 to 68[20] the Council restored the original wording of the provision under section 16 of the *Code of Ethics:*

> 16. An ethical physician, when his personal morality prevents him from recommending some form of therapy which might benefit his patient will so acquaint the patient;[27]

I.7 CMA referral/conscience policy post-Morgentaler (1988)

I.7.1 In 1988, after the Supreme Court of Canada struck down all legal restrictions on abortion, the CMA revisited its policies on the procedure. Key points in the policy for the post-Morgentaler era:

- Objecting physicians should not be required to participate;
- The policy on referral was unchanged -

  - Objecting physicians were obliged to disclose their views to patients so that they might consult other physicians (see I.2.1);

  - there was no requirement that they facilitate the procedure by referral.[28]

I.7.2 The policy included special reference to the need to protect objecting physicians:

> No discrimination should be directed against doctors who do not perform or assist at induced abortions. Respect for the right of personal decision in this area must be stressed, particularly for doctors training in obstetrics and gynecology, and anesthesia.[28]

I.7.3 The wording of the *Code* remained unchanged until 1990, when a reference to "religious conscience" was added and the section re-numbered.[29] A 1996 revision dropped reference to religion, required acknowledgement of the "influence" of personal morality and distinguished between a patient's needs and wants.[30] The 2004 edition of the *Code* (now in force) introduced "values language" and again re-numbered the provision, but the policy remained intact.[31]

I.8 CMA Director of Ethics reaffirms referral policy (2000-2002)

I.8.1 In 2000, the Project Administrator wrote to the Canadian Medical Association concerning its policy on referral for abortion. In a subsequent telephone conversation, Dr. John R. Williams, then CMA Director of Ethics, confirmed that the Association did not require objecting physicians to refer for abortion. He explained that the CMA had once had a policy that required referral, but had dropped it because there was "no ethical consensus to support it." This was clearly a brief reference to the short-lived 1977 revision of the

Code of Ethics and ensuing controversy. (I.5 to I.6)

I.8.2 Two years later, speaking of physicians who decline to provide or to refer for contraceptives for religious reasons, Dr. Williams said, "[They're] under no obligation to do something that they feel is wrong."[32]

I.9 Canadian Psychiatric Association affirms referral policy (2003)

I.9.1 A 2003 annotation of the CMA *Code of Ethics* for the Canadian Psychiatric Association offered the following comment (referring to the 1990 wording of the Code):

> Section 16 is the latest version of the CMA's statement on personal morality. The difficulties which arose with the previous statement are attributable to the failure to recognize that a physician's moral beliefs are paramount. A code of ethics can never require someone to carry out what he believes to be an immoral act.[33]

I.10 CMA reaffirms referral policy (2006)

I.10.1 In a guest 2006 editorial in the *CMAJ,* law professors Sanda Rodgers of the University of Ottawa and Jocelyn Downie of Dalhousie University complained that "[s]ome physicians refuse to provide abortion services and refuse to provide women with information or referrals needed to find help elsewhere."[34]

I.10.2 The authors insisted that refusal to refer for abortion constituted malpractice and could lead to "lawsuits and disciplinary proceedings," though none of the cases that had been proposed by some of the authors' like-minded colleagues supported such a claim.[35]

I.10.3 The editorial triggered a flood of letters from protesting physicians and other concerned correspondents,[36,37,38,39] but the authors did not retreat from their position, insisting that a "duty to refer" could be derived from the CMA *Code of Ethics* and *Policy on Induced Abortion* - a tendentious argument at best, dependent upon their peculiar interpretation of the documents.[40]

I.10.4 Dr. Jeff Blackmer, then CMA Executive Director of Ethics, reaffirmed Association policy that referral was not required.

> However, you should not interfere in any way with this patient's right to obtain the abortion. At the patient's request, you should also indicate alternative sources where she might obtain a referral. This is in keeping with the obligation spelled out in the CMA policy: "There should be no delay in the provision of abortion services."[41]

I.10.5 This was generally understood to mean that objecting physicians should provide or direct patients to general information that would help them to contact other physicians, such as a directory of local clinics. It would then be up to the patient to locate someone willing to

provide an abortion, consistent with the 1971 AGC resolution (I.2.1).

I.10.6 The CMAJ declared the subject closed. The negative response to the editorial from the medical profession convinced Professor Downie that policy reform by the CMA was unlikely, so she turned her attention to provincial regulatory authorities to persuade them to use the law to force a change in the CMA *Code of Ethics*.[42]

I.11 CMA Executive Director of Ethics suggests mandatory referral is the norm (2007)

I.11.1 Three months after defending the CMA position on referral against Downie and Rodgers, Dr. Jeff Blackmer, identifying himself as the CMA's Executive Director of Ethics, published a white paper for the World Medical Association (WMA) that included discussion of conscientious objection.[43] A disclaimer stated that the paper "does not necessarily reflect the opinion" of the WMA and was not WMA policy. Although the paper appeared to represent Dr. Blackmer's personal views, there was no disclaimer with respect to the CMA.

I.11.2 After a general discussion of conscientious objection, Dr. Blackmer turned his attention to referral. He claimed, "While there is some debate about this issue, the majority of the current literature, if not current policy and legislation, appears to support the obligation to refer." (p. 17) He cited only four sources from 2000 to 2006 to support this claim. (p. 32) The Project bibliography lists 154 papers from this period that deal directly or indirectly with the issue, so the assertion that four of 154 papers constitutes a "majority of current literature" seems exaggerated.[44]

I.11.3 The sources might have been proposed simply as examples of a current trend, but this is unsatisfactory. Trends current among medical professionals in the first half of the twentieth century favoured "the science of the improvement of the human race by better breeding"[45] and widespread acceptance of eugenics as "the cutting edge of science."[46] This resulted in laws like the *Alberta Sterilization Act*, which Emily Murphy praised as a compassionate way to deal with "the human wreckage . . . dumped from foreign lands" in Canada .[47] The subsequent history of the Alberta Eugenics Board and other eugenics enthusiasts demonstrates that trends are unreliable indicators of sound ethical development.[48]

I.11.4 Dr. Blackmer next identified six aspects of conscientious objection warranting particular attention, singling out the issue of referral by objecting physicians as "fertile ground for policy development and professional guidance." (p. 17) He also asserted that objecting physicians "do not have a right to obstruct" and must not "actively *or passively*" obstruct patients from obtaining services from another clinician (emphasis added, p. 18). He did not define "passive" obstruction, which could be taken to mean simple non-cooperation.

I.11.5 Finally, he suggested that national medical associations not develop procedure-specific

policies on conscientious objection, but "a separate policy that can be used in multiple circumstances."(p. 18)

I.12 CMA reaffirms referral policy after CPSO controversy (2008)

I.12.1 The next major development came in 2008, when the Ontario Human Rights Commission (OHRC) attempted attempted to suppress freedom of conscience in the medical profession in Ontario through the College of Physicians and Surgeons of Ontario (CPSO).

I.12.2 In its first submission, the OHRC implied that physicians who refuse to provide or refer for services based on moral or religious convictions are acting in "total disregard" of patients. Citing *Trinity Western University v. British Columbia College of Teachers*, the Commission claimed that the Supreme Court of Canada had ruled that "providers of public services are expected to essentially 'check their personal views at the door' when providing a their services."

> Allowing refusal of healthcare based on personally held religious beliefs would deny the equality rights of those requiring this essential service. A physician's denial of services or refusal to provide a woman with information relating to contraception or abortion, for example, would be discriminatory based on sex, as only women can become pregnant.[49]

I.12.3 A controversy erupted when news of the plan became public.[50] The adverse response seems only to have reinforced the OHRC's determination to suppress freedom of conscience among physicians. In its second submission it again cited the Trinity Western decision and the mantra, "the freedom to hold beliefs is broader than the freedom to act on them." It suggested that physicians should be told, "It is the Commission's position that doctors, as providers of services that are not religious in nature, must essentially 'check their personal views at the door' in providing medical care."[51]

I.12.4 The 25,000 member Ontario Medical Association asked that the document be withdrawn, stating, "We believe that it should never be professional misconduct for an Ontarian physician to act in accordance with his or her religious or moral beliefs."[52,53]

I.12.5 The hostile response forced the College to delete the most objectionable language in the draft policy, though it prevented public or professional comment on the revised draft by keeping it secret until the day it was presented to the College Council for approval.[54]

I.12.6 A few days after approval of *Physicians and the Ontario Human Rights Code*, Dr. Bonnie Cham, Chair of the CMA Ethics Committee, noted that the CMA had considered freedom of conscience in health care, "including the impact of offering and not offering abortion services." She reaffirmed the organization's support for "the identifiable minority" of physicians who do not agree with abortion, and observed that there is still "a minority who would not refer" for abortion.[55]

I.13 From abortion to euthanasia (2011)

I.13.1 Professor Jocelyn Downie, whose 2006 CMAJ guest editorial demanding compulsory referral for abortion generated a strong negative reaction, is also a leading proponent of euthanasia. In 2011 she was one of six members of the "expert panel" of the Royal Society of Canada that recommended legalization of assisted suicide and euthanasia.[56] Only two of the panel members were physicians;[57] four of the six, including one of the physicians, had previously advocated euthanasia and assisted suicide.[58,59,60,61]

I.13.2 Professor Downie and her expert colleagues explained that *because* it is agreed that objecting health care professionals can be forced to refer for "reproductive health services,"[62] they should be forced to refer for euthanasia. Hence, the panel recommended that if "religious or moral conscience" prevents health care professionals from providing euthanasia or assisted suicide, "they are duty bound to refer their patients to a health care professional who will."[63]

I.13.3 Given the repudiation of her views by the CMA, Professor Downie must have known that, outside of Quebec, there was *no* agreement that objecting health care professionals should be compelled to refer for abortions. This inconvenient fact was left out of the expert report. Instead, compulsory referral for euthanasia and assisted suicide was presented an entirely reasonable and uncontested "procedural solution" to the "problem" caused by people who refuse to do what they believe to be wrong.

Notes

1. Canadian Medical Association *Code of Ethics* (1965) Transcribed from the original by A. Keith W. Brownell MD, FRCPC and Elizabeth "Libby" Brownell RN, BA (April 2001) (http://www.royalcollege.ca/portal/page/portal/rc/common/documents/bioethics/primers/medical_ethics/CMACodeofEthics1965.pdf) Accessed 2015-06-17

2. *The Physician and the Liberal Society: Understanding in Winnipeg*. Association News, CMAJ July 18, 1970, Vol. 103, p. 195

3. Canadian Medical Association *Code of Ethics* (1970) Transcribed from the original by A. Keith W. Brownell MD, FRCPC and Elizabeth "Libby" Brownell RN, BA (April 2001) (http://www.royalcollege.ca/portal/page/portal/rc/common/documents/bioethics/primers/medical_ethics/CMACodeofEthics1970.pdf) Accessed 2015-06-17

4. Board of Directors Meeting: "Therapeutic Abortion Study Major Association Project: Finance Committee Reports Mild Optimism for Year." *CMAJ* Volume 103(11) 1218, November 21, 1970. (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1930622/pdf/canmedaj01607-0085.pdf) Accessed 2015-06-17

5. "Canadian Medical Association 104th Annual Meeting, Halifax, Nova Scotia." *CMAJ* Volume 104(12) 1132-1134, June 19, 1971 (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1931049/pdf/canmedaj01621-0080.pdf) Accessed 2015-06-17

6. Geekie D.A. "Abortion: a review of CMA policy and positions." *CMAJ* September 7, 1974, Vol. 111, 474-477 (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1947796/pdf/canmedaj01589-0082.pdf) Accessed 2015-06-17

7. The number of abortions increased from 11,152 in 1970 to almost 39,000 in 1971, an increase from a rate of 3.0 to 8.3 per 100 live births. "Therapeutic abortion: government figures show big increase in '71." *CMAJ,* May 20, 1972, Vol. 106, 1131 (http://pubmedcentralcanada.ca/pmcc/articles/PMC1940714/?page=1) Accessed 2015-06-17

8. By 1975 the rate was 13.8/100. [J.B.S. "1975 abortion report more informative than its predecessors." *CMAJ*, October 22, 1977, Vol. 117, 933 (http://pubmedcentralcanada.ca/pmcc/articles/PMC1880128/?page=1) Accessed 2015-06-17

9. CMA President Bette Stephenson stated that the CMA was concerned about the abortion rate and "most disturbed . . . that even more abortions are being performed . . .than are indicated in the alarming figures released by Statistics Canada." Stephenson B. "Abortion: an open letter." CMAJ, 22 February, 1975, Vol. 112, 492 (http://pubmedcentralcanada.ca/pmcc/articles/PMC1956171/?page=1)] Accessed 2015-06-17.

10. In 1976 there were about 54,500 abortions (14.9/100 live births). [E.M.R., "1976 advance report on abortion compares statistics with 1975." *CMAJ*, January 7, 1978 Vol. 118, 76 (http://pubmedcentralcanada.ca/pmcc/articles/PMC1880452/?page=1)] Accessed 2015-06-17.

11. Gibbard B. "Therapeutic abortion." (letter) *CMAJ*, January 7, 1975, Vol. 112, 25-27 (http://pubmedcentralcanada.ca/pmcc/articles/PMC1956037/?page=1) Accessed 2015-06-17

12. Geekie D.A., "Alberta medical association annual meeting quiet - by western standards." *CMAJ,* November 6, 1976 Vol. 115, 908-910 (http://pubmedcentralcanada.ca/pmcc/articles/PMC1879110/) Accessed 2015-06-17

13. Protection of Conscience Project Bibliography: Periodicals & Papers (1970-1974) (http://www.consciencelaws.org/bibliography/periodicals-1970-74.aspx)

14. Protection of Conscience Project Bibliography: Periodicals & Papers (1975-1979) (http://www.consciencelaws.org/bibliography/periodicals-1975-79.aspx)

15. Canadian Medical Association, "Proceedings of the 110th Annual Meeting including the Transactions of the General Council, Quebec City, Quebec, June 20, 21, 22, 1977," p. 87.

16. Identified as registrar in newspaper report in 1976 and in directory in 1983. "Drinking doctors urged to seek proper help." *Brandon Sun*, 24 September, 1976; *Internet Archive*, "Social Resources Inventory: Edmonton Region" (September, 1983)." (https://archive.org/stream/socresinvedm1983/socresinvedm1983_djvu.txt) Accessed 2015-06-16

17. "Quebec City is a lively place, CMA annual meeting delegates discover." *CMAJ*, July 9, 1977, Vol. 117, p. 76.

18. Canadian Medical Association *Code of Ethics* (1975) Transcribed from the original by A. Keith W. Brownell MD, FRCPC and Elizabeth "Libby" Brownell RN, BA (April 2001) (http://www.royalcollege.ca/portal/page/portal/rc/common/documents/bioethics/primers/medical_ethics/CMACodeofEthics1975.pdf) Accessed 2015-06-17

19. Describing the 1978 Council meeting that saw provision revert to its former wording, the CMAJ stated: "The major part of the debate concerned the wording of the paragraph of the *Code of Ethics* that deals with personal morality.unlike last year, the discussion was brief and free of emotion." "Ethics problem reappears." *CMAJ*, July 8, 1978, Vol. 119, 61-62

20. Geekie D.A. "Abortion referral and MD emigration: areas of concern and study for CMA." *CMAJ*, January 21, 1978, Vol. 118, 175, 206 (http://europepmc.org/backend/ptpmcrender.fcgi?accid=PMC1880354&blobtype=pdf) Accessed 2015-06-17

21. Canadian Medical Association,"Proceedings of the 110th Annual Meeting including the Transactions of the General Council, Quebec City, Quebec, June 20, 21, 22, 1977," p. 86.

22. Forster J.M. "Code of Ethics: abortion referral (letter)." *CMAJ*, April 22, 1978, Vol. 118, 888 (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1818235/?page=1) Accessed 2015-06-17

23. Shea J.B. "Code of Ethics: abortion referral (letter)." *CMAJ*, April 22, 1978, Vol. 118, 890 (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1818248/?page=1) Accessed 2015-06-17

24. Wilson R.G. "Code of Ethics: abortion referral (letter)." CMAJ, April 22, 1978, Vol. 118, 896

25. Firth S.T. "Code of Ethics: abortion referral (letter)." *CMAJ*, April 22, 1978, Vol. 118, 895 (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1818224/?page=1) Accessed 2015-06-17

26. Cameron P, Cohen M, Rapson L, Watters WW. "Code of Ethics: abortion referral (letter)." *CMAJ*, April 22, 1978, Vol. 118, 890, 895

(http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1818248/?page=1) Accessed 2015-06-17

27. Canadian Medical Association *Code of Ethics* (1978). Transcribed from the original by A. Keith W. Brownell MD, FRCPC and Elizabeth "Libby" Brownell RN, BA (April 2001) (http://www.royalcollege.ca/portal/page/portal/rc/common/documents/bioethics/primers/medical_ethics/CMACodeofEthics1978.pdf) Accessed 2015-06-17

28. Canadian Medical Association, Policy: *Induced abortion*. Approved by the CMA Board of Directors, December 15, 1988. (https://www.cma.ca/Assets/assets-library/document/en/advocacy/CMA_induced_abortion_PD88-06-e.pdf#search=induced%20abortion) Accessed 2015-06-17

29. "16. An ethical physician when his personal morality or religious conscience prevents him from recommending some form of therapy which might benefit his patient will so acquaint the patient." Canadian Medical Association *Code of Ethics* (1990) Transcribed from the original by A. Keith W. Brownell MD, FRCPC and Elizabeth "Libby" Brownell RN, BA (April 2001) (http://www.royalcollege.ca/portal/page/portal/rc/common/documents/bioethics/primers/medical_ethics/CMACodeofEthics1990.pdf) Accessed 2015-06-17

30. "8. Inform your patient when your personal morality would influence the recommendation or practice of any medical procedure that the patient needs or wants." Canadian Medical Association *Code of Ethics* (1996) (http://www.royalcollege.ca/portal/page/portal/rc/common/documents/bioethics/primers/medical_ethics/CMACodeofEthics1996.pdf) (Transcribed 10 March, 2001) Accessed 2015-06-17

31. "12. Inform your patient when your personal values would influence the recommendation or practice of any medical procedure that the patient needs or wants." Canadian Medical Association *Code of Ethics* (2004) (http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf) Accessed 2015-06-17

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