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Institutional freedom of conscience in relation to euthanasia and assisted suicide

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EXECUTIVE SUMMARY

Scope

The subject of this paper is an institution's refusal to provide or facilitate euthanasia/assisted suicide (EAS) for reasons of conscience: the exercise of *preservative* freedom of conscience. This typically reflects desire to preserve institutional moral integrity by refusing to be complicit in, cooperate in or otherwise support or encourage the killing of patients and a desire to prevent harm to others. Institutional religious integrity is not addressed.

Institutional freedom of conscience

The concept of institutional freedom of conscience or religion has been examined and challenged repeatedly since at least the early 1970's. Claims that facilities like hospitals and hospices cannot rely on constitutional guarantees of freedom of conscience *because* they are not individuals are untenable because they are contradicted by legal history and widespread practice. At best, they provide superficial camouflage for efforts to compel unwilling institutions to provide morally contested services favoured by the claimants, or anti-religious discrimination, or both. Regardless of structure, “institution” in the sense relevant here is an entity that always manifests a collective enterprise by individuals, so the term “entity/collective” is used to keep this in mind.

Critical presumption

This paper presumes that entities/collectives are entitled to rely upon constitutional guarantees of freedom of conscience, notwithstanding differences between individuals and collectives in the exercise of that freedom. Individuals and entities/collectives are equally concerned to avoid complicity in perceived wrongdoing. This obviously includes taking part directly in what they deem to be a wrongful act, but also causally contributing to by collaboration or contingent cooperation. However, factors relevant to moral decision-making by entities/collectives are not necessarily identical to those affecting the exercise of freedom of conscience by individuals, nor do they play out in the same way.

Addressing the problem of cooperation

Cooperation in evil, a complex moral problem, is complicated by modern pluralism. Reasonable people working from the same moral principles can arrive at different conclusions about the permissibility of contingent cooperation. This can lead to tension and adverse or even hostile reactions

capable of jeopardizing institutional existence. On the one hand, this might be considered a reason serious enough to excuse some form of contingent cooperation. On the other, to excuse cooperation because of duress might encourage state and professional authorities to suppress freedom of conscience by imposing severe penalties for conscientious objection.

A further problem is that a decision to cooperate could be misunderstood as affirmation of the moral acceptability of a procedure. Entities/collectives may be especially concerned about this given the public impact and significance of their decisions. The risk of normalizing perceived wrongdoing by cooperation may tip the balance against it. Similarly, refusal to cooperate may reflect reasonable concern that excusable cooperation would force an institution onto a slippery slope leading to collaboration.

Providing information and assistance

Individual practitioners and institutions frequently face requests for two forms of contingent cooperation: the provision of information necessary to enable informed medical decision making about EAS, and provision of assistance for patients — especially those severely debilitated and socially isolated — to navigate the health care and social services systems. In the Project's experience, individual practitioners are able to respond to these requests by taking care not to do so in a way that implies support for EAS, while refusing to connect patients directly with EAS practitioners or EAS services. Objecting entities/collectives can take the same approach by requiring all patient enquiries about EAS be directed to staff members trained to provide patients with information and assistance without compromising institutional moral integrity.

Institutional challenges

However, institutions face problems that are more challenging than those facing individuals because patients eligible for or seeking EAS are frequently receiving other extended care or treatment in a facility and may have legal rights attached to their occupancy status. Objecting entities/collectives can continue to provide unrelated treatment and care only if patients remain in their facilities, so they are forced to confront a number of issues: a patient's legal occupancy status, patient transfers, the privacy of practitioner-patient consultations in a facility, adverse effects of EAS procedures on staff and other patients, and the actual ability of the entity/collective to satisfactorily distance itself from EAS.

Entities/collectives that want to avoid moral entanglement in EAS are likely to forbid participation or support by facility staff. If not precluded from doing so by a patient's residential or quasi-residential status, they must also consider a range of options for transfers of patients, bearing in mind the risks options pose to the moral integrity of the institution. If legally unable to enforce a no-EAS condition of occupancy, objecting entities/collectives may prevent or restrict EAS-related activities and expressions of support for EAS in facility staff and common areas.

The provision of any EAS service in a facility may require an institution to grant privileges for that purpose, which would probably be unacceptable to an objecting entity/collective. However if transfer of patients seeking EAS is legally impossible, it may be the only way to impose enforceable restrictions intended to protect other patients, staff and institutional moral integrity, and it may be the only alternative to closing the institution.

Legal protection

The need for legal protection of preservative freedom of conscience for institutions has become more evident because of continuing efforts by partisans and governments to compel them to kill or cooperate in killing their patients. Notwithstanding the focus here on euthanasia and assisted suicide, legal protection should apply to all procedures or services an entity/collective is unwilling to provide for reasons of conscience; morally contested procedures should not be specifically identified.

Legislation must be broad enough to encompass providing or participating directly in a morally contested service, as well as collaboration and morally significant contingent cooperation. Since the classification of morally contested procedures as "health" services, "care" or "medical" treatment is often disputed, legislation should use broad, neutral terms less open to polemical misuse: "service", "treatment", and "procedure", for example.

While the law should reflect the fact that the exercise of freedom of conscience is intrinsic to medical practice, what is needed is protection for preservative freedom of conscience (refusing to do what one believes to be wrong); this is foundationally important. To minimize uncertainties and facilitate navigation of ethically contentious situations, the law should define an institution's obligations when it refuses to provide morally contested services. The Project's model of a general protection of conscience law illustrates how this can be done.

Adjudicating conflicts

The exercise of preservative freedom of conscience should be reasonable. Reasonableness should be presumed when "what is objected to is something over which there is a history of dispute between recognised bodies of thought or over which reasonable people have disagreed or could disagree."

That certain kinds of conduct would implicate an institution in perceived wrongdoing must be established by rational analysis of evidence. Courts should apply a rational and coherent theory of cooperation that articulates principles needed to identify collaboration and contingent cooperation. In so doing, they must adopt an institution's sincere moral evaluation of the gravity of the wrongness of a contested act. Were a court to apply a substantially different moral evaluation of a contested act, it would irreparably prejudice the proceeding and may even eviscerate constitutional guarantees of freedom of conscience. Courts must ensure that an entity/collective's decision reflects a rational and coherent theory of cooperation, but they must allow entities/collectives leeway in their evaluation of relevant factors. Courts should not substitute their own judgements for institutional decisions that fall within a range of rationally justifiable alternatives.

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I. INTRODUCTION

Scope of paper

I.1 On grounds of freedom of conscience or religion an institution may refuse to allow a procedure in its facility because it considers it to be immoral. Alternatively, it may refuse to allow procedures it deems to be fundamentally incompatible with and destructive of its institutional purpose or philosophy, even if it does not have a moral objection, citing freedom of thought, belief, opinion, expression and association. Finally, some refusals may be based on all of these grounds.

I.2 Morally contested procedures (like abortion or body reconfiguration) usually require at least functional support from an institution (such as the use of surgical theatres, pharmaceuticals, medical supplies and staff) and normally involve requests from people seeking specific, short-term procedures. In these situations, conflicts with institutional policies can usually be avoided by providing advance notice of services not provided and by directing people elsewhere.

I.3 In contrast, patients eligible for or seeking euthanasia or assisted suicide are frequently receiving extended care or treatment in a facility for other reasons, and may have legal rights attached to their occupancy status. Further, it is possible for non-institutional practitioners to provide euthanasia or assisted suicide to patients in a facility without requiring facility resources or the assistance or direct participation of facility staff. These factors complicate reconciliation and accommodation of institutional-patient differences.

I.4 In this paper the subject is exclusively an institution's refusal to provide or facilitate euthanasia/assisted suicide (EAS) for reasons of conscience: the exercise of *preservative* freedom of conscience.[1],[2] This may reflect unwillingness to be complicit in, cooperate in or otherwise support or encourage the killing of patients and a desire to prevent harm to others — understood from the perspective of an objecting entity/collective. This includes the harm of leading others to believe that EAS is morally acceptable or encouraging others to seek it. References to "institutional moral integrity" are specific to these issues, distinct from institutional *religious* integrity, which would include concerns about denominational identity. The distinction should not be taken to diminish the importance of religious integrity as an aspect of freedom of religion.

Institutional freedom of conscience

I.5 The concept of institutional freedom of conscience or religion has been examined and challenged repeatedly since at least the early 1970's, when, following the decision of the US Supreme Court in Roe v Wade, attempts were made in the United States to compel denominational hospitals

[1] Introduced in Sean Murphy & Stephen Genuis, "Freedom of Conscience in Healthcare: Distinctions and Limits" (2013) 10(3) J Bioethical Inquiry 347 [Murphy & Genuis], online: <https://link.springer.com/article/10.1007%2Fs11673-013-9451-x>.

[2] Discussed and applied in Sean Murphy et al, "The Declaration of Geneva: Conscience, Dignity and Good Medical Practice" (2020) 66(4) World Med J 41 [Murphy et al], online: <https://www.wma.net/wp-content/uploads/2020/12/wmj_4_2020_WEB.pdf>.

to provide abortions.[3]

I.6 Hospitals were the first institutions of interest in the controversy, but the focus gradually enlarged to encompass corporations and unincorporated collectives that exist in a variety of forms. It is reasonable to extend this to include incorporated and unincorporated businesses and collectives of various kinds. Regardless of structure, "institution" in the sense relevant here is an entity that always manifests a collective enterprise by individuals. The collective action of individuals is easily obscured by terms like "corporation" and "entity," the term "entity/collective" is used to keep this in mind.

I.7 Many of those examining or challenging the corporate exercise of conscience or religion by hospitals have not questioned the premise that a hospital can have a corporate conscience, as it were. Instead, they have argued for negotiated accommodation[4] or the legal suppression or restriction of corporate religious or moral beliefs in order to force hospitals to provide or at least morally contested procedures.[5,6,7] Some, also apparently accepting the premise that an institution can exercise corporate moral judgement, have suggested that religious denominations should be prohibited from operating hospitals.[8]

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3 Betty Berger, "Constitutional Law: Private Hospital May Refuse to Perform Abortion. Doe v. Bellin Memorial Hospital, 479 F.2d 756 (7th Cir. 1973)", Note, (1974) 18:3 Saint Louis University LJ 440.

4 Anna Maria Cugliari, Tracy E Miller, "Moral and Religious Objections by Hospitals to Withholding and Withdrawing Life-Sustaining Treatment" (1994) 19(2) J Community Health 87-100, online: <https://www.proquest.com/openview/0e5044819cb3a285c8ea4ca62da314e9/1?pq-origsite=gscholar&cbl=1820843>.

5 Eugene L Berl, "Hill-Burton Hospitals After Roe and Doe: Can Federally Funded Hospitals Refuse to Perform Abortions?" (1974) 4(1) NYU Rev L & Soc Change 83-97, online: <https://socialchangenyu.com/wp-content/uploads/2017/12/Eugene-L.-Berl_RLSC_4.1.pdf>

6 Brietta R Clark, "When Free Exercise Exemptions Undermine Religious Liberty and the Liberty of Conscience: A Case Study of the Catholic Hospital Conflict" (2003) 82(3) Or L Rev:625-694.

7 Cameron Flynn, Robin Fretwell Wilson, "Institutional Conscience and Access to Services: Can We Have Both?" (2013) 15(3) AMA J Ethics Virtual Mentor 226-235, online: <https://journalofethics.ama-assn.org/sites/journalofethics.ama-assn.org/files/2018-05/pfor1-1303.pdf>.

8 Louise Gagnon, "Morgentaler's call for secular-only hospitals earns tepid response" (2003) 168(3) CMAJ 332, online: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC140491/pdf/20030204s00036p331.pdf>.

I.8 Others, however, claim that only individual human persons can have a conscience: that institutions cannot have consciences, and so cannot seek protection under constitutional guarantees of freedom of conscience and religion.[9,10,11] A number of commentators have responded with arguments to the contrary, sometimes asserting that constitutional guarantees of freedom of conscience protect institutions, even if institutions cannot be said to have or exercise conscience in same way that individuals do.[12,13,14,15]

Legal history and practice

I.9 Law has imbued collectives with characteristics normally associated with individual persons since ancient times. Roman law granted cities corporate status; guilds, monasteries and universities were incorporated in the middle ages.[16] These legal developments recognized the natural inclination and need for persons to work collectively to achieve important personal and social goods.

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[9] Spencer L Durland, "The case against institutional conscience" (2011) 86(4) Notre Dame L Rev 1655-1687, online: <https://scholarship.law.nd.edu/cgi/viewcontent.cgi?article=1086&context=ndlr>.

[10] George J Annas, "At Law: Transferring the Ethical Hot Potato" (1987) 17(1) Hastings Center Report 20-21, online: <https://www.jstor.org/stable/3562436?origin=crossref>.

[11] Bernard M Dickens, "Conscientious objection and professionalism" (2009) 4(2) Expert Reviews in Obstetrics & Gynecology 97–100, online: <https://www.tandfonline.com/doi/full/10.1586/17474108.4.2.97>.

[12] Mark R Wicclair, "Conscientious refusals by hospitals and emergency contraception" (2011) 20(1) Cambridge Q Healthcare Ethics 130-138, online: <https://www.cambridge.org/core/journals/cambridge-quarterly-of-healthcare-ethics/article/abs/conscientious-refusals-by-hospitals-and-emergency-contraception/4F35EE78998653E1C4EEE3E69877BBD8>.

[13] Christopher Kaczor, "Conscientious objection and health care: A reply to Bernard Dickens" (2012) 18(1) Christian Bioethics 59-71, online: <https://academic.oup.com/cb/article-abstract/18/1/59/402604?login=false>.

[14] Helen M Alvare, ed, *The Conscience of the Institution*, (South Bend, Indiana: St. Augustine's Press, 2014).

[15] Christopher Tollefsen, "Institutional Conscience, Corporate Persons, and Hobby Lobby" in Jeffrrey B Hammond & Helen M. Alvaré, eds, *Christianity and the Laws of Conscience* (Cambridge: University Press, 2021) 395–413.

[16] Philip J Stern, "The Corporation in History" in Grietje Baars & Andre Spicer, eds, *The Corporation (A Critical, Multi-Disciplinary Handbook)* (Cambridge: University Press, 2017).

I.10 Legal recognition that entities/collectives providing health care are moral agents entitled to exercise freedom of conscience is fully consistent with this tradition, even though the moral agency of an entity and individual person differ in some respects. Further, it makes no sense to hold that a person is entitled to exercise freedom of conscience individually, but loses that freedom the moment he joins with someone else in a collective enterprise, especially one meant to put into practice beliefs informing the exercise of that freedom.

I.11 Taking a practical example from Australia, the Legislative Assembly of Queensland, the Australian Medical Association (AMA), Rottweiler Club of Queensland and the West Woombye Rural Fire Brigade are all entities/collectives operating in the state of Queensland. The Legislative Assembly and West Woombye Rural Fire Brigade are unincorporated entities; the AMA and the Rottweiler Club are incorporated. All have codes of ethics or conduct requiring their members to adhere to ethical principles,[17,18,19,20] just as denominational and other private entities have ethical directives governing employees and health care facilities they operate in Queensland.

I.12 While particulars vary among jurisdictions, what we find in Queensland is also found elsewhere. For example, codes of ethics or conduct bind members of the Canadian and American medical associations[21,22] and Rottweiler Clubs (incorporated entities)[23,24] and the Canadian and

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[17] The Legislative Assembly of Queensland, *Code of Ethical Standards together with The Guide to the Code of Ethical Standards and Rules Relating to the Conduct of Members,* Brisbane: LAQ, 2018, online:
<https://documents.parliament.qld.gov.au/assembly/procedures/codeofethicalstandards.pdf>.

[18] The Australian Medical Association, *AMA Code of Ethics 2004*, Barton: AMA, 2016, online: <https://www.ama.com.au/sites/default/files/2021-02/AMA_Code_of_Ethics_2004._Editorially_Revised_2006._Revised_2016_0.pdf>

[19] The Rottweiler Club of Queensland, RCQ Code of Ethics, Beenleigh: RCQ, 2013, online: <http://rcqld.net/code-of-ethics/>.

[20] The West Woombye Rural Fire Brigade, *Code of Conduct: A guide for all people working for or on behalf of the Department of Emergency Services*, in D7.16 RFB Training Manual 2007, Brisbane: Dept. of Emergency Services, 2007, online:
<http://westwoombyeruralfirebrigade.net/Docs/D7.16%20DES%20Code%20of%20Conduct.pdf>.

[21] The Canadian Medical Association, Code of Ethics and Professionalism, online: <https://policybase.cma.ca/viewer?file=%2Fmedia%2FPolicyPDF%2FPD19-03.pdf>.

[22] The American Medical Association, AMA Code of Medical Ethics, Chicago: AMA, 2022, online: <https://www.ama-assn.org/delivering-care/ethics/code-medical-ethics-overview>.

[23] The Rottweiler Club of Canada, *The Rottweiler Club of Canada Incorporated Code of Ethics*, Edmonton: RCC, 2021, online:

American senates (unincorporated entities).[25,26]

Critical presumption

I.13 Since there is no dispute that entities/collectives like the West Woombye Rural Fire Brigade, the Canadian Medical Association, the American Senate and Rottweiler clubs can ingrain foundational ethical or moral beliefs into codes of ethics that govern their members and operations, denominational or private entities/collectives operating health care and related facilities ought to be able to do so. Further, the concept of organizational ethics developed since the 1990's[27] demonstrates that it is reasonable to consider entities to be ethical actors.[28,29]

I.14 For all of these reasons, this paper presumes that entities/collectives are entitled to rely upon constitutional guarantees of freedom of conscience, notwithstanding differences between individuals and collectives in the exercise of that freedom. This is a legal point (and can be a political or public policy position). It does not follow from this that factors relevant to moral decision-making by

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<https://rottclub.ca/wp-content/uploads/2021/08/RCC_COE_2021.pdf >.

[24] The American Rottweiler Club, *American Rottweiler Club Mandatory Practices*, Ft. Wright, KY: ARC, 2019 online: <https://www.amrottclub.org/mandatory-practices-eff-2019-10-15/>.

[25] The Senate of Canada, *Ethics and Conflict of Interest Code for Senators*, Ottawa: SOC, 2021, online: <https://seo-cse.sencanada.ca/media/0s0did20/ethics-and-conflict-of-interest-code-for-senators-code-r%C3%A9gissant-l-%C3%A9thique-et-les-conflits-d-int%C3%A9r%C3%AAts-des-s%C3%A9nateurs-august-3-2021.pdf>.

[26] The United States Senate Select Committee on Ethics, *Senate Ethics Manual*, Washington, DC: USGPO, 2003, online: <https://www.ethics.senate.gov/public/index.cfm/senate-ethics-manual>.

[27] Robert T Hall, "Organizational Ethics in Healthcare" online: (2022) Encyclopedia.com, online: <https://www.encyclopedia.com/science/encyclopedias-almanacs-transcripts-and-maps/organizational-ethics-healthcare>.

[28] Fiona Mcdonald, Christy Simpson, Fran O'Brien, "Including Organizational Ethics in Policy Review Processes in Healthcare Institutions: A View from Canada" (2008) 20(2) Healthcare Ethics Committee Forum 137, online: <https://www.researchgate.net/publication/51408254_Including_Organizational_Ethics_in_Policy_Review_Processes_in_Healthcare_Institutions_A_View_from_Canada>.

[29] Paul R Rao, "Ethical Considerations for Healthcare Organizations" (2020) 41(3) Seminars in Speech and Language 266, online: <https://www.thieme-connect.com/products/ejournals/abstract/10.1055/s-0040-1710323>.

entities/collectives are identical to those affecting the exercise of freedom of conscience by individuals, or play out in the same way. The concept of individual freedom of conscience is applied analogically to collectives, so some differences are to be expected.

II. INDIVIDUALS & ENTITIES/COLLECTIVES: COMMON CONCERNS

Collaboration and cooperation

II.1 Individuals and entities/collectives are equally concerned to avoid complicity in perceived wrongdoing. This obviously includes taking part directly in what they deem to be a wrongful act, but also causally contributing to it in morally significant ways. Morally significant active forms of contribution that engage freedom of conscience are typically understood to include ordering the act, recommending or encouraging it, and other forms of collaboration or facilitation, such as helping a patient connect with someone who will provide a morally contested service.

II.2 Some authors appear to assert that there is an unqualified duty to prevent evil, insisting, for example, that a practitioner who believes that abortion is evil "should do everything she can to stop her patient having an abortion."[30] From this it would seem to follow that morally culpable contributions to wrongdoing include failing to denounce, reveal or actively obstruct it.

II.3 Others, however, do not adopt this rigorist approach. One may acknowledge a general obligation to speak out against and prevent wrongdoing, yet hold that the obligation is not absolute; that it may be qualified and even nullified by various factors. Much depends upon what is meant by "doing everything one *can*" to prevent evil. Among other things, what *can* be done is circumscribed by the rule of law.[31]

II.4 For example, individual practitioners may be prohibited from obstructing patient access to

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[30] Julian Savulescu, Udo Schuklenk, "Doctors Have no Right to Refuse Medical Assistance in Dying, Abortion or Contraception" (2016) Bioethics 9702(June) 1 at 7, online: <http://doi.wiley.com/10.1111/bioe.12288>.

[31] "MORE: This country's planted thick with laws from coast to coast — man's laws, not God's — and if you cut them down — and you're just the man to do it — d'you really think you could stand upright in the winds that would blow then? (*Quietly*) Yes, I'd give the Devil benefit of law, for my own safety's sake." Robert Bolt, *A Man for All Seasons: A Play of Sir Thomas More*, (Scarborough, Ont: Bellhaven House, 1968) at 39, reflecting More's affirmation that he would give judgement in favour of the devil rather than his own father if the devil had the better case. William Roper, "The Life of Sir Thomas More" in J Rawson Lumby, ed, *More's Utopia* (Cambridge: University Press, 1897) at xxv.

legal services[32] and trying to change patients moral views,[33] and patients often have a legal right to control and direct the dissemination of information in their medical records.[34] Such general regulations and laws can be justified for a number of reasons in relation to the whole of medical practice, not just in relation to morally contested services. Individuals and entities/collectives may consider them unavoidable limitations that can constrain them from discouraging or preventing wrongdoing, but do not make them complicit in it.

II.5 Beyond collaborative conduct readily associated with complicity, individuals and entities/collectives are also concerned about "more subtle questions concerning types of cooperation that are not of themselves morally wrong but might be so depending on the circumstances"[35] [here identified as "contingent cooperation"]. This is a more complex problem because "by cooperating in a bad act a person does a *further* bad act; and we should all minimise the number of bad acts we perform,"[36] yet, embedded and interconnected as we are in a morally pluralist matrix, it is impossible to completely avoid cooperation with evil except by not acting at all, an option not deemed realistic by moral philosophers.[37,38]

Prudential judgement and reason-giving

II.6 It is widely recognized that "cooperation in evil lies among the most complex of moral

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32 The College of Physicians and Surgeon of New Brunswick, *Code of Ethics*, Rothesay, NB: CPSNB, 2022 at para 12, online: <https://cpsnb.org/en/medical-act-regulations-and-guidelines/code-of-ethics>.

33 The General Medical Council, *Pesonal beliefs and medical practice*, London: GMC, 2013 at para 30-31, online: <https://www.gmc-uk.org/-/media/documents/personal-beliefs-and-medical-practice-20200217_pdf-58833376.pdf>

34 Canadian Medical Protective Association, "Did you know? Patients can restrict access to their health information" (November, 2017; Revised September, 2021), CMPA (website), online: <https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2017/did-you-know-patients-can-restrict-access-to-their-health-information>.

35 David Oderberg, *Opting Out: Conscience and cooperation in a pluralistic society*, (London, UK: Institute of Economic Affairs, 2018) [Oderberg] at 46.

36 *Ibid* at 52.

37 *Ibid*.

38 Joseph Parkinson, *Material Cooperation and Catholic Institutions* (PhD thesis) University of Notre Dame Australia, 2001) [unpublished] [Parkinson] at 193 online: <https://researchonline.nd.edu.au/cgi/viewcontent.cgi?article=1019&context=theses>.

problems" and is complicated further by modern pluralism.[39] This becomes particularly evident in decisions by individual practitioners and entities/collectives about the moral acceptability of contingent cooperation. These require prudential judgement, typically turning upon whether or not sufficiently serious reasons exist to excuse cooperation, including an assessment of the probability and nature of harms arising from cooperation and non-cooperation.

II.7 Reasonable people working from the same moral principles can arrive at different conclusions about the permissibility of contingent cooperation. This can lead to tensions among otherwise like-minded colleagues, cynicism from the public and accusations of hypocrisy and bad faith from unfriendly critics. In addition, people unfamiliar with the kind of moral reasoning required are likely to dismiss it as legalistic hairsplitting, especially if they see nothing wrong with a morally contested procedure to begin with.

II.8 Objecting individuals or entities/collectives might consider the likelihood of adverse reactions capable of jeopardizing individual professional standing or institutional existence a reason serious enough to excuse some form of contingent cooperation. On the other hand, they may worry that such an excuse would encourage state and professional authorities to suppress freedom of conscience by imposing severe penalties for conscientious objection.[40]

II.9 A further problem is that a decision to cooperate based upon morally relevant facts in a particular case (such as threatened closure of an institution) could be understood by others to affirm the moral acceptability of a procedure (rather than the permissibility of cooperation in defined circumstances). For some objecting individuals or entities/collectives, the likelihood of normalizing perceived wrongdoing by cooperation may tip the balance against it. Similarly, they might refuse otherwise excusable cooperation if they believed that cooperation would force them onto a slippery slope leading to collaboration.

III. INDIVIDUALS & ENTITIES/COLLECTIVES: COMMON ISSUES

Providing information

III.1 Providing information is a form of contingent cooperation; it may or may not be morally acceptable. For example, the General Medical Council in the United Kingdom suspended the license of a physician for six months because he had provided information about live donor organ transplantation and had thus encouraged the trade in human organs, even though he had not actually participated in the trade.[41]

III.2 In the Project's experience, however, individual objecting practitioners are willing to provide information necessary to enable informed medical decision making about EAS and facilitate patient

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39 *Ibid* at 226.

40 Oderberg, *supra* note 35 at 57.

41 "Organ trade GP suspended", *BBC News* (15 October, 2002), online: <http://news.bbc.co.uk/2/hi/health/2329447.stm>.

contact with other health care service providers or agencies, but are careful not to do so in a way that might imply their support for it. For example, they may provide contact information for health care providers or services generally, but may refuse to direct patients specifically to an EAS practitioner or EAS delivery service. By this means these practitioners avoid any positive action causally connected to killing their patients, leaving patients free to pursue their legal options.

III.3 Objecting entities/collectives can take the same approach, though they have to rely on employees to implement it. Since the circumstances, personalities and interests of patients vary considerably, it is not possible to script sensitive practitioner-patient discussion about morally contested options. Moreover, not all employees can handle such discussions satisfactorily. Hence, entities/collectives may require that all patient enquiries about EAS be directed to staff members trained to provide patients with information without compromising institutional moral integrity.

Patient medical condition and social connections

III.4 Patients who are so debilitated, socially isolated or circumstantially handicapped that they are unable to contact health care personnel or obtain medical treatment are clearly at risk and in need of assistance in all circumstances, not just in relation to accessing a morally contested service.

III.5 In the Project's experience, individual objecting practitioners who encounter such patients are usually unwilling to connect them directly to EAS practitioners or an EAS delivery service because that would directly facilitate the procedures and imply their support for it. However, they are willing to connect patients with a responsible and reliable agency or person who can help them navigate the health care system, even if the assistant might help a patient obtain euthanasia or assisted suicide. This accommodates patient wishes and allows individual practitioners to continue to provide other treatment and care without compromising their moral integrity.

III.6 This can be done by an objecting entity/collective through designated personnel (as per III.3) if a socially isolated patient in an advanced state of physical decline needs active assistance to negotiate the EAS process and EAS is not available in the facility providing care. Patient advocates who have a general mandate to assist patients (rather than an EAS-specific mandate) may be available in some jurisdictions.

IV. INDIVIDUALS & ENTITIES/COLLECTIVES: DISTINCTIONS

Individual vs. institutional authority

IV.1 People form or join entities/collectives because it is understood that entities/collectives have more socio-political influence than individuals. This is relevant to institutional freedom of conscience because people are inclined to assign far more weight to the ethical views of an institution like the Australian Medical Association than to those of an individual practitioner. Considering the specific case of Catholic hospitals in a 2001 thesis about institutional cooperation, Joseph Parkinson observed that "institutions would not normally be expected to be open to the same subjective influences as individual moral agents."

> It may be asking too much of an individual person to possess a suficient knowledge of ethics, law, business, and economics as well as sufficient poise and prudence to guide

> every assessment of complex cases of cooperation. But a major corporate institution such as a Catholic hospital could reasonably be expected to have access to precisely such expertise and virtue, and to make considerable use of them in assessing its institutional commitments.[42]

IV.2 A related consideration is that the methods and effects of decision-making by individuals and institutions differ. Individual practitioners are solely responsible for making moral decisions about cooperation and ensuring that they are consistent over time, even though they are likely to consult others in the process. This largely involves ongoing internal reflection and commitment, occurring out of the public eye. Their decisions are usually known to and affect only those directly involved. Entities/collectives arrive at and express ethical positions differently (typically by means of group discussion and policy-making) and rely upon employees to instantiate those positions in day-to-day operations. Hence, policies must be written, open and clearly articulated to ensure that they are consistently applied by different employees over time. Institutional decisions about cooperation thus have a public character and wider impact, so that they can be expected to have more widespread consequences than decisions by an individual practitioner.

IV.3 In a concluding comment on this point, Parkinson argues that "the institution's corporate structure, its decision-making processes, its access to greater resources, and the ecclesial significance of its actions all seem to place it in a class apart from the individual moral agent."[43] Substituting "public" for "ecclesial," the comment is equally apt in reference to non-denominational entities/collectives. Since the public impact and significance of decisions by an entity/collective about cooperation can be expected to be greater than decisions by individual practitioners, it is reasonable for entities/collectives to be especially sensitive to the possibility that cooperation may be perceived to suggest the acceptability of a procedure.

Facility design

IV.4 Medical offices and clinics are usually designed to allow private individual consultations, separate from patients consulting other physicians in the same practice or waiting to be seen. Patients remain only as long as necessary; their interactions with other patients are limited. As a result, consultations with individual practitioners about morally contested procedures affect only the practitioners and patients directly involved.

IV.5 The privacy of practitioner-patient consultations in institutional settings is highly variable. A residential occupant may have a private apartment or a small private room and bathroom (much like a private hospital room). Institutional occupants (residents or not) may share a room with one or more others, separated from them only by curtains. Moreover, institutional and residential

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[42] Parkinson, supra note 38 at 245.

[43] *Ibid.*

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occupants are more likely to discuss their respective illnesses and plans with others[44] because they usually share common areas and services over extended periods. These factors and other elements of facility design are relevant to concerns about adverse effects of EAS on other patients.

Practitioner privileges

IV.6 The personal integrity of individual objecting practitioners is not compromised by colleagues who provide services they are unwilling to offer, even if they are practising in the same clinical setting. However, entities/collectives may reasonably believe that institutional moral integrity will be compromised if they allow services they consider immoral to be provided in their facilities by non-institutional staff. Hence, unlike individuals, entities/collectives must be concerned about what non-objecting practitioners do in their facilities.

Episodic vs. continuous treatment

IV.7 The episodic nature of practitioner-patient encounters in clinical practice enables individual objecting practitioners to clearly separate themselves from euthanasia and assisted suicide. They can continue to provide medical treatment and care to patients seeking EAS from other practitioners without being involved in any step in the process. They are not responsible for providing patients with living accommodation. They need not be concerned about where the EAS process will occur, nor about the effects of the process or the procedures on their other patients or employees. In contrast, objecting entities/collectives can continue to provide unrelated treatment and care only if patients remain in their facilities, so they are forced to confront all of these issues.

V. ENTITIES/COLLECTIVES: SPECIFIC ISSUES

Occupancy status

V.1 Unlike individual practitioners, objecting entities/collectives can continue to provide unrelated treatment and care only if patients remain in their facilities. Moreover, sometimes a facility may be a patient's residence — a nursing home, for example. In any case, a patient who remains in a facility occupies (and possibly shares) living space that he does not own, and legal rights and freedoms associated with occupancy vary. Thus, a patient's legal occupancy status can impose constraints on entities/collectives not experienced by individual practitioners.

Residential occupancy

V.2 Residential occupants (tenants) rent or lease apartments, condominiums, houses or other residential premises from individuals or entities/collectives. Conditions of occupancy, typically written and sometimes statutory, are intended to protect the rights, freedoms and interests of occupants, the property interest of the owner and the rights, freedoms and interests of others who are living in the same building or complex. The rights and freedoms of occupants relevant to the provision of EAS are freedom of movement and association and security against invasions of

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[44] YouTube, "Allow Me to Die: Euthanasia in Belgium" (15 September, 2015) at 00h:40m:00s to 00h:43m:30s [All Me to Die], online: <https://youtu.be/hCRpuTRA7-g>.

privacy, including interference with communication.

V.3 With respect to lawful activity involving the relevant rights and freedoms, residential occupants are free to have visitors come and go as they choose, to communicate privately with visitors, and to do as they wish inside the premises they occupy, even if the premises, like an apartment, is part of a larger facility. It is obvious that this would permit occupants to arrange for and obtain EAS in their own premises without the cooperation of owners of the facility.

V.4 Absent explicit agreement by occupants, owners and managers of a residential facility have no authority to manage or interfere in their occupants' affairs. Hence, they are not legally or morally responsible for an occupant's wrongdoing, and an entity/collective cannot be complicit in euthanasia or assisted suicide of a residential occupant simply because the procedures are provided in a residential premises in a facility it owns.

Institutional occupancy

V.5 For present purposes, institutional occupants occupy living space provided by an entity/collective in conjunction with an enterprise or programme it offers; payment may or may not be required. Examples are religious communities, university residences, homeless shelters, residential drug and alcohol rehabilitation centres and hospitals, hospices and nursing homes. An institutional occupant may sometimes have quasi-residential status, enjoying a subset of full residential rights and freedoms.

V.6 Conditions of institutional occupancy are likely to include restrictions the entity/collective considers necessary to protect its property interests, integrity and the success of its enterprise, as well as restrictions necessary to protect others. The extent of restrictions will depend upon the nature of the entity/collective and its enterprise. For example, a drug rehabilitation centre may limit personal privacy, restrict visitors, set curfews and impose other restrictions one would not expect to find in a university residence.

V.7 Institutional occupants who freely seek to participate in or benefit from an institutional enterprise normally accept restrictions, understanding that they must leave if they become unwilling to abide by conditions of occupancy. An entity/collective might insist upon compliance with a no-EAS policy as a condition of institutional occupancy, so that patients admitted to a facility understand that they must move elsewhere if they subsequently decide that they want the service. This is analogous to the situation of someone hired as a nurse in an abortion facility, but who later decides that abortion is wrong. A guarantee of freedom of conscience does not entitle her to retain her position while refusing to participate in the procedure. That would subvert the operation of the facility and be unfair to the facility owner. The law should protect people from injustice, not from consequences of decisions they later find personally disadvantageous.

V.8 However, this model of institutional occupancy may not accurately represent the actual situation of patients in facilities providing medical treatment, care and living assistance. For example, patients needing institutional palliative or nursing care may not be free to choose among facilities. Further, some jurisdictions may grant them quasi-residential occupancy status that prevent entities/collectives from setting and enforcing a no-EAS condition of occupancy.

V.9 Even if unable to set a no-EAS condition of occupancy, objecting entities/collectives may

want to prevent or restrict EAS-related activities and expressions of support for EAS in order to protect other patients,[45] staff[46] and institutional moral integrity. For example: a nursing home that is unable to prevent EAS in a resident's room may refuse to take custody of EAS drugs, refuse to allow celebrations associated with anticipated EAS elsewhere in the facility, prohibit employees from participating in or supporting the procedure, and limit the provision of EAS to times when other residents are likely to be absent or sleeping.

Transfers: permanent, temporary or none

V.10 As previously noted, objecting practitioners can continue to provide care unrelated to euthanasia and assisted suicide without having to consider a transfer of care, but this issue cannot be avoided when a patient continues to receive unrelated care in a facility owned by an objecting collective/entity. Legal requirements for EAS typically involve consultations and assessments that must be completed before EAS can be provided. These steps, as well as the provision of EAS, must occur somewhere. Hence, objecting entities/collectives are likely to consider transferring patients seeking EAS to avoid moral entanglement in the procedure, unless transfer is precluded by residential or quasi-residential status.

Permanent transfer

V.11 Patients interested in pursuing EAS could be advised by objecting entities/collectives that they can request to be permanently transferred to another facility. This would make clear that the entities/collectives oppose the procedures and refuse to collaborate in them, though they are willing to cooperate in patient-initiated transfers of care. It would also relieve the entity/collective of the need for further cooperation, as well as concerns for other patients and staff and for institutional moral integrity.

V.12 However, a permanent transfer would deprive an entity/collective of the opportunity to address and remedy factors leading a patient to ask for the procedure. As a result, some entities/collectives may prefer that patients seeking EAS not be permanently transferred, in the hope that they will ultimately opt for palliative care rather than euthanasia or assisted suicide.

Temporary transfer

V.13 If patients are not permanently transferred when they request EAS, objecting entities/collectives face two choices. They would have to allow at least some parts of the EAS process in their facilities, or transfer a patient out and back at each stage to try to avoid involvement in the process. Each temporary transfer to accommodate EAS would require some degree of cooperative activity by the entity/collective's employees: arguably greater staff involvement than

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[45] *Ibid*.

[46] "Nurse diagnosed with PTSD after interaction with patient seeking euthanasia: Tribunal rules 'her own convictions' caused her injury. Denies claim for compensation" (10 October, 2017), *Protection of Conscience Project* (website), online: <https://www.consciencelaws.org/law/commentary/legal089-001.aspx>.

would occur were non-facility personnel to independently carry out at least preliminary steps in the facility.

V.14 Objecting entities/collectives could draw a line between preliminary assessments that may not ultimately lead to EAS and consultations that effectuate a patient's choice for the procedure, allowing non-institutional staff to provide the former in their facilities but requiring a permanent transfer for the latter. This would minimize facility staff involvement and indicate their ultimate opposition to EAS.

V.15 In either case, the risk of adverse effects on other patients would remain, and allowing some EAS consultations to occur in a facility may be thought to suggest the acceptability of EAS and thus compromise institutional moral integrity.

No transfer

V.16 An objecting entity/collective could also take the position that it will not cooperate or collaborate in EAS: that it will forbid facility staff participation and the use of facility resources, but will not interfere with or prevent non-facility personnel providing consultations for EAS and even EAS in its facility.[47] In this case, the entity/collective would presumably be satisfied that the arrangement would not put other patients or staff at risk, would not likely lead others to believe that EAS is morally acceptable, and would not require authorization of EAS in granting privileges to non-facility staff.

Practitioner privileges

V.17 An entity/collective may restrict the kinds of procedures and services it provides and what its employees or independent health care personnel offer through its facilities. Indeed, this may be required by law, which is likely to differ among jurisdictions. Objecting entities/collectives may refuse to explicitly authorize the provision of EAS services in granting privileges to non-facility EAS practitioners because that would affirm the acceptability of the procedures. They may also refuse to describe EAS as "end of life care" or "palliative care".

V.18 Where explicit authorization of EAS is required by law in a grant of privileges, the only options open for objecting entities/collectives would seem to be permanent transfer or temporary transfer for every stage of the EAS process.

V.19 However, it may be legally impossible to transfer even temporarily a residential or quasi-residential patient seeking EAS who is unwilling to be transferred. In this situation, objecting entities/collectives face a dilemma.

i) They could refuse to grant explicit privileges, but EAS practitioners and patients may surreptitiously circumvent the restriction, which may have other adverse

[47] Jamie O'Brien, "WA Church speaks out: we will not facilitate euthanasia", The Catholic Weekly (2 July, 2021) online: <https://www.catholicweekly.com.au/wa-church-speaks-out-we-will-not-facilitate-euthanasia/>.

affects.[48]

ii) They could grant *other* privileges to non-facility EAS practitioners, and then tolerate their provision of EAS as long as they abide by restrictions. However, this would require an entity/collective absolutely opposed to EAS to make a policy explaining how it can be provided in its facility. This approach seems hopelessly convoluted.

iii) They could grant EAS privileges, making clear their opposition to EAS and setting out restrictions on provision of the service to protect other patients and staff. This would at least ensure the enforceability of the restrictions.

V.20 Note that diagnosing, assessing and documenting illnesses and disorders, disease progression, competence, etc. are not necessarily associated with EAS, even though such criteria are likely to be required for it. Hence, enforceable prohibitions would probably have to be limited to specific EAS-related activities, such as the completion of a written EAS request or other EAS forms. Since an entity/collective cannot intrude upon practitioner-patient communications, it may be impractical or impossible to prevent EAS assessments, and violation of a prohibition is likely to be enforceable only in retrospect.

VI. ENTITIES/COLLECTIVES: SUMMARY

VI.1 Like individual practitioners, entities/collectives want to avoid complicity in EAS that arises from collaboration, but also want to avoid contingent collaboration whenever possible. Circumstances of practice confront entities/collectives with many possibilities for contingent cooperation, so the problem of contingent cooperation is more challenging for entities/collectives than individuals.

VI.2 Patients eligible for or seeking euthanasia or assisted suicide are frequently receiving extended care or treatment in a facility for other reasons, and may have legal rights attached to their occupancy status. Much depends on the law in a jurisdiction and whether the patients are residential, quasi-residential or institutional occupants.

VI.3 If not precluded from doing so by a patient's residential or quasi-residential status, objecting entities/collectives must decide whether to permanently transfer patients seeking EAS to avoid moral entanglement in the procedure, transfer them temporarily at each stage in the EAS process, or allow some or all of the EAS process to occur in their facilities, while forbidding participation or support by facility staff. In considering the alternatives they would have to evaluate the risk that the moral integrity of the institution would be undermined. If legally unable to enforce a no-EAS condition of occupancy, objecting entities/collectives may prevent or restrict EAS-related activities and expressions of support for EAS in facility staff and common areas in order to protect other patients and staff and institutional moral integrity.

VI.4 The provision of any EAS service in a facility may require an institution to grant privileges

[48] Kelly Grant, "Vancouver doctor cleared of wrongdoing in probe into assisted death at Orthodox Jewish nursing home", *The Globe and Mail* (7 August, 2019).

for that purpose, which would probably be unacceptable to an objecting entity/collective. However, if transfer of patients seeking EAS is legally impossible, it may be the only way to impose enforceable restrictions intended to protect other patients, staff and institutional moral integrity, and it may be the only alternative to closing the institution.

VII. LEGAL PROTECTION OF INSTITUTIONAL FREEDOM OF CONSCIENCE

The need for protection

VII.1 Legal history and practice demonstrates that characteristics strictly proper to individuals, including rights, freedoms and liabilities, have been attributed by analogy to entities/collectives. Further, codes of ethics or conduct have been promulgated by incorporated and unincorporated entities/collectives for decades without eliciting protests that, not being individuals, they cannot adhere to and enforce moral or ethical beliefs in their operations [I.9 – I.12].

VII.2 Thus, claims that facilities like hospitals and hospices cannot rely on constitutional guarantees of freedom of conscience *because* they are not individuals are untenable. At best, they provide superficial camouflage for efforts to compel unwilling entities/collectives to provide morally contested services favoured by the claimants, or anti-religious discrimination, or both. The controversy about institutional freedom of conscience is not new, but the need to protect in preservative freedom of conscience in law has become more evident in light of continuing efforts by partisans and governments to compel unwilling entities/collectives to kill or cooperate in killing their patients.[49],[50]

Legislation

A broad and principled approach

VII.3 The preceding discussion focused on euthanasia and assisted suicide because the problem of contingent cooperation is more complex in the case of patients receiving treatment or care in an institution. However, legal protection should apply to all procedures or services an entity/collective is unwilling to provide for reasons of conscience. For several reasons, morally contested procedures should not be specifically identified in legislation.

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[49] Jocelyn Downie, “When freedom of conscience and freedom of religion meet medical assistance in dying (MAID)” (Harold G. Fox Distinguished Lecture Series delivered at Lakehead University, 3 February 2022), [unpublished] 00h:28m:27s to 00h:41m:07s online: <https://www.youtube.com/watch?v=r62EDzykBCw>.

[50] Delta Hospice Society, News Release, “BC Hospice challenges closure over government’s proeuthanasia policy: Government refuses compromise” (26 February, 2020) online: <https://news.consciencelaws.org/?p=10042>.

VII.4 A significant shortcoming of procedure-specific legislation is that it is inflexible. A law that prevents coercion with respect to abortion does not apply to artificial reproduction, eugenic practices or human experimentation. Responding to ethical controversies spawned by the rapid advance of medical technology is especially challenging. It is not practical to develop a protection of conscience law applicable to a single procedure, and repeat the process every time a new controversy arises.

VII.5 Moreover, when laws are developed in the midst of controversies about specific procedures or problems they may be shaped by features unique to the circumstances and prove problematic when considered in other contexts. A special problem arises in the case of morally contested procedures, when what ought to be judicious reflection on freedom of conscience becomes entangled in partisan debates about the acceptability of the procedures themselves. Opposing sides may well come to see such laws merely as strategic weapons to be turned to ideological advantage.

VII.6 Conscience laws developed in relation to specific procedures tend to foster and entrench morally partisan viewpoints, whether that of a dominant majority or a powerful minority. This leads to discrimination, either by allowing conscientious objection to some procedures, but not others, or by imposing arbitrary and discriminatory limits on the exercise of freedom of conscience: by, for example, supporting refusal to refer for euthanasia, but compelling referral for artificial reproduction.

VII.7 It is thus preferable to take a broad and principled approach that keeps the focus on the nature and importance of freedom of conscience, avoiding entanglement in controversies about the acceptability of specific morally contested procedures.

Collaboration and contingent cooperation

VII.8 Protective legislation must be broad enough to encompass not only providing or participating directly in the provision of a morally contested service, but collaboration and morally significant cooperation. For example, the WMA identifies a range of conduct that practitioners should avoid in relation to procedures deemed unethical, including referral,[51] countenancing, condoning, facilitating

[51] World Medical Association, "WMA Declaration on Euthanasia and Physician-Assisted Suicide" (13 November, 2019), *WMA* (website), online: <https://www.wma.net/policies-post/declaration-on-euthanasia-and-physician-assisted-suicide/>.

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or aiding,[52,53] providing skills, premises, supplies, substances or knowledge, including individual health information,[54] planning, instruction or training, preparation of reports,[55,56] incitement[57] and retrospectively affirming or supporting unethical practices.[58]

Terminology

VII.9 The classification of a morally contested procedure as health care or medical treatment is itself often disputed. For example, euthanasia by lethal injection is accurately described as a service, procedure or treatment. To call it a *health* service, *medical* procedure or *care* gives normative force to disputed "metaphysical, philosophical and moral premises that can be rationally contested but

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52 World Medical Association, "WMA Declaration of Hamburg Concerning Support for Medical Doctors Refusing to Participate in or to condone, the use of Torture and other Cruel, Inhuman or Degrading Treatment" (13 July 2020), *WMA* (website), at para 1, online: <https://www.wma.net/policies-post/wma-declaration-of-hamburg-concerning-support-for-medical-doctors-refusing-to-participate-in-or-to-condone-the-use-of-torture-or-other-forms-of-cruel-inhuman-or-degrading-treatment/>.

53 World Medical Association, "WMA Declaration of Tokyo: Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment" (25 May, 2020), *WMA* (website), at para 1, 5, 9, online: <https://www.wma.net/policies-post/wma-declaration-of-tokyo-guidelines-for-physicians-concerning-torture-and-other-cruel-inhuman-or-degrading-treatment-or-punishment-in-relation-to-detention-and-imprisonment/>.

54 *Ibid* at para 2, 5.

55 World Medical Association, "WMA Resolution on the Prohibition of Physician Participation in Capital Punishment" (6 October, 2018), *WMA* (website), online: <https://www.wma.net/policies-post/wma-resolution-on-prohibition-of-physician-participation-in-capital-punishment/>.

56 World Medical Association, "WMA Resolution on Prohibition of Forced Anal Examination to Substantiate Same-Sex Sexual Activity" (17 October, 2017), *WMA* (website), at para 6, online: <https://www.wma.net/policies-post/wma-resolution-on-prohibition-of-forced-anal-examinations-to-substantiate-same-sex-sexual-activity/>.

57 *Ibid* at para 2.

58 World Medical Association, "WMA Statement on Organ and Tissue Donation" (21 August, 2020), *WMA* (website), at para 34–36, online: <https://www.wma.net/policies-post/wma-statement-on-organ-and-tissue-donation/>.

cannot be empirically validated," among them "the dogmatic claim that a human being can be better off dead."

> In a free and democratic society, it ought to be unacceptable to force physicians to profess this article of faith, or to demonstrate practical adherence to it by killing or facilitating the killing of a patient.[59]

VII.10 Unreflective use of terms like "care", "health" and "medical" expresses and invites uncritical acceptance of such underlying premises and beliefs, thus prejudicing discussion, legal reasoning and policy from the outset; polemical use of the terms certainly does. By using broad terms like "service", "treatment", "procedure" and "recommendation" the law would retain the capacity to address typical and uncontroversial elements of medical practice in a manner less open to polemical misuse in relation to contested services or procedures. It would also make it easier to defend against incidental or deliberate ethical, legal or regulatory subversion of medical ethics.

Role of conscience in medicine

VII.11 Legislation should at least implicitly acknowledge that the exercise of freedom of conscience is intrinsic to medical practice. The centrality of conscience to medical practice was a prominent concern of the organizers of the World Medical Association (WMA) and WMA assemblies that first approved the *Declaration of Geneva* and *International Code of Medical Ethics*.[60,61] In reviewing the origins of these documents, the Project Administrator and co-authors affirmed and applied the insight of the WMA founders:

> [T]he practice of medicine is an inescapably moral enterprise. Physicians first consider the good of patients, always seeking to do them some kind of good and protect them from evils. Hence, moral or ethical views are intrinsic to the practice of medicine, and every decision concerning treatment is a moral decision, whether or not physicians consciously advert to it. To demand that physicians must not act upon moral beliefs is to demand the impossible, since one cannot practise medicine without reference to moral beliefs. (References

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59 Sean Murphy et al, "The WMA and the Foundations of Medical Practice: Declaration of Geneva (1948), International Code of Medical Ethics (1949)" (August, 2020) 66:3 World Med J 2 [*WMJ Foundations*], at p 5–6, online: <https://www.wma.net/wp-content/uploads/2020/08/wmj_3_2020_WEB.pdf#page=4> .

60 Sean Murphy *et al*, "The Declaration of Geneva: Conscience, Dignity and Good Medical Practice" (December, 2020) 66:4 World Med J 43, [*WMJ Conscience*] at 41, online: <https://www.wma.net/wp-content/uploads/2020/12/wmj_4_2020_WEB.pdf#page=43> .

61 *WMJ Foundations*, *supra* note 59 at 3.

omitted)[62]

Focus on preservative freedom of conscience

VII.12 The distinction between doing what one believes to be right (*perfective* freedom of conscience) and refusing to do what one believes to be wrong (*preservative* freedom of conscience) is important. Refusing to do what is believed to be wrong is foundational to personal integrity and necessary for the exercise of perfective freedom of conscience. It is also a minimal requirement for social stability that is reflected generally in law.[63,64]

VII.13 Further, the exercise of perfective freedom of conscience is generally taken for granted and governed by an extensive body of professional standards, regulations, legislation and jurisprudence, such as obligations related to technical competence, obtaining services, informed consent, etc. In contrast, the exercise of preservative freedom of conscience has been under increasing attack for decades and legislation protecting it is limited. Thus, without denying the importance of perfective freedom of conscience, what is needed is legislated protection for preservative freedom of conscience.

Focus on institutional obligations

VII.14 Since the exercise of freedom of conscience is intrinsic to medical practice, (VII.11) legislation should not purport to define situations in which it can be exercised. Instead, it should define the obligations of institutions when refusing to provide a morally contested service. This will provide a roadmap that should minimize uncertainties for patients and help all parties respectfully navigate ethically contentious situations. The Project's model of a general protection of conscience law (which applies both to individuals and institutions) illustrates how this can be done.[65]

Adjudicating conflicts

Presumption

VII.15 That the morality of some procedures or services is contested is a consequence of pluralism, but pluralism need not imply that "anything goes". The exercise of preservative freedom of conscience should be reasonable. For present purposes, reasonableness should be presumed when "what is objected to is something over which there is a history of dispute between recognised bodies

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[62] *WMJ Conscience*, *supra* note 60 at 42.

[63] Murphy & Genuis, *supra* note 1.

[64] Murphy et al, *supra* note 2.

[65] Protection of Conscience Project, "An Act to Ensure Protection of Conscience in Health Care (Model of a general protection of conscience law)"(29 Nov 2019), *PCP* (website), online: <https://www.consciencelaws.org/law/model/model-statute002.aspx>.

of thought or over which reasonable people have disagreed or could disagree."[66]

Cooperation a matter of fact

VII.16 That certain kinds of conduct would implicate an institution in perceived wrongdoing must be treated as a matter of fact, to be established by rational analysis of evidence. A sincere belief that X constitutes illicit cooperation is insufficient in itself to support such a finding.[67] Professor David Oderberg explains:

> An objector's mere claim that they are illicitly involved, or compromised, by assisting however remotely with some primary act to which they object cannot be taken at face value. This can no more be a matter of mere sincerity than a litigant's belief that they were treated by some other party negligently, unjustly or unreasonably. These are matters for courts to determine, and involvement by cooperation is in the same category.[68]

VII.17 It is important to note that, in relatively recent significant constitutional cases, the Supreme Court of the United States and the Ontario Court of Appeal failed to take this approach.[69],[70] Instead — incorrectly, in the Project's view — they conflated rather than distinguished the issues of religious belief and complicity.[71,72,73]

VII.18 A different approach is required. The distinction between religious belief and complicity can

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[66] Oderberg, supra note 35 at 91.

[67] *Ibid* at 71.

[68] *Ibid* at 126.

[69] *Burwell v. Hobby Lobby Stores, Inc*., 573 U.S. 682 (2014), 134 S. Ct. 2751 (2014) [*Hobby Lobby*], online: <https://www.supremecourt.gov/opinions/13pdf/13-354_olp1.pdf>.

[70] *The Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario*, 2018 ONSC 579 (CanLII) [*CMDS v CPSO 2018*], online: <https://www.canlii.org/en/on/onscdc/doc/2018/2018onsc579/2018onsc579.html>.

[71] *Hobby Lobby*, *supra* note 69 at 36.

[72] The Supreme Court of the United States cited but appears to have misunderstood Professor Oderberg's analysis, and failed to apply it. See *Hobby Lobby*, *supr*a note 69 at 36, n. 34; Oderberg, *supra* note 35 at 69–73.

[73] *CMDS v. CPSO 2018*, *supra* note 70 at para 93, 108, 205.

and should be maintained by applying a rational theory of cooperation.[74] At a minimum, a theory of cooperation must coherently articulate principles that can be applied to identify collaboration and contingent cooperation (II.1-9, IV.1-3). This would develop existing practice, not depart from it. Courts routinely apply similar principles in determining that a person is a party to an offence or is civilly liable for misconduct by someone else. These decisions involve rational analysis of the evidence of knowledge, intention and conduct; they do not hinge on religious beliefs about participation or liability.

Adopting the institutional perspective

VII.19 Two important caveats are required here. The most obvious is that, at a minimum, for the purpose of applying a theory of cooperation to the evidence, an adjudicator must adopt an institution's sincere moral evaluation of the gravity of the wrongness of a contested act. Irreparable prejudice would be introduced were an adjudicator to apply a moral evaluation of a contested act substantially different from that of the institution because that would at least lead to a substantially different conclusion about the permissibility of contingent cooperation. For example: if one holds that procedure X is morally equivalent to telling a white lie, a much broader range of cooperation would be permitted than if it were morally equivalent to homicide.

VII.20 Further, adjudicators who apply a substantially different moral evaluation of a contested act may even eviscerate constitutional guarantees of freedom of conscience. For example, in *CMDS v CPSO 2018* the Ontario Court of Appeal uncritically adopted the position of the state: that euthanasia and assisted suicide are beneficial forms of medical treatment. The Court then applied the state's beneficent view of euthanasia to the issue of compulsory referral for the procedure, effectively equating referral for homicide and assisted suicide with referral for kidney dialysis.[75]

VII.21 As a result, the Court failed to recognize its duty to adjudicate a constitutional challenge based on freedom of religion and conscience in relation to state-mandated participation in killing people.[76] Instead, it implicitly adjudicated the case as one in which the central issue was ensuring equitable access to health care. The Court demonstrated the total eclipse of freedom of conscience and religion in ruling that practitioners with religious objections to providing a service themselves (killing their patients included) were obliged to propose a scheme to ensure that someone else would provide the service (killing their patients included).[77]

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[74] Oderberg, *supra* note 35 at 40-68.

[75] *CMDS v. CPSO 2018*, *supra* note 70 at para 85, 130, 144, 146, 155, 159, 168–169, 194, 201, 210.

[76] To be clear, the case was argued and decided on the issue of freedom of religion, not freedom of conscience. *CMDS v. CPSO 2018*, *supra* note 70 at para 116.

[77] *Ibid* at para 170-171.

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Deference

VII.22 The second caveat is that, while an adjudicator must, on the basis of the evidence, determine whether an act would amount to contingent cooperation, she must not substitute her own judgement for that of an institution with respect its moral permissibility. So, for example, entities/collectives may arrive at different conclusions about transferring patients seeking EAS. An adjudicator may personally disagree with an institutional conclusion, perhaps preferring institution A's conclusion to institution B's. However, she must not become entangled in the moral dispute at the heart of the conflict or in prudential institutional moral judgements by imposing her own moral reasoning about the permissibility of cooperation on an entity/collective.

VII.23 This should not be understood to exempt institutional decisions from judicial review, but to require adjudicators to demonstrate the kind deference to moral judgements of entities/collectives about contingent cooperation that Canadian courts are expected to demonstrate in relation to the policy judgements of the state. Moral decision-making about the permissibility of contingent cooperation is a complex process; adjudicators must accord entities/collectives leeway in their evaluation of factors relevant to their decision. If an institutional decision falls within a range of rationally justifiable alternatives, an adjudicator must not override it simply because she can conceive of an alternative she thinks superior. On the other hand, if an entity/collective cannot offer an explanation of its decision that is consistent with a rational and coherent theory of cooperation, the decision may not be upheld.[78]

VIII. LEGAL PROTECTION: SUMMARY

Need

VIII.1 The need to protect in preservative freedom of conscience in law has become more evident in light of continuing efforts by partisans and governments to compel unwilling entities/collectives to kill or cooperate in killing their patients.

Scope

VIII.2 Legal protection should apply to all procedures or services an entity/collective is unwilling to provide for reasons of conscience; morally contested procedures should not be specifically identified in legislation. Instead, a broad and principled approach should be adopted, keeping the focus on the nature and importance of freedom of conscience, and avoiding entanglement in controversies about the acceptability of specific morally contested procedures. Legislation must be broad enough to encompass providing or participating directly in a morally contested service, as well as collaboration and morally significant cooperation.

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[78] *Cf RJR-MacDonald Inc v Canada (Attorney General),* 1995 CanLII 64 (SCC), [1995] 3 SCR 199 at para 160, online: <https://www.canlii.org/en/ca/scc/doc/1995/1995canlii64/1995canlii64.html>.

Terminology

VIII.3 The classification of a morally contested procedure as health care or medical treatment is itself often disputed, so legislation should use accurate by neutral terms like “service”, “treatment”, and “procedure”. Broad terminology is flexible and less open to polemical misuse.

Focus

VIII.4 Without denying the importance of perfective freedom of conscience (doing what one believes to be right), what is needed is protection for preservative freedom of conscience (refusing to do what one believes to be wrong). Legislation should reflect the fact that the exercise of freedom of conscience is intrinsic to medical practice and the foundational importance of preservative freedom of conscience.

Structure

VIII.5 Legislation should assume that the exercise of institutional freedom of conscience is intrinsic to institutional operations. To minimize uncertainties and facilitate navigation of ethically contentious situations, it should define institutional obligations when refusing to provide, facilitate or cooperate in morally contested services. The Project’s model of a general protection of conscience law illustrates how this can be done.

Reasonableness

VIII.6 The exercise of preservative freedom of conscience should be presumed to be reasonable. when “what is objected to is something over which there is a history of dispute between recognised bodies of thought or over which reasonable people have disagreed or could disagree.”

Collaboration and contingent cooperation

VIII.7 That certain kinds of conduct would implicate an institution in perceived wrongdoing must be treated as a matter of fact, to be established by rational analysis of evidence. Consistent with the approach taken in determining that a person is a party to an offence or is civilly liable for misconduct by someone else, courts should apply a rational and coherent theory of cooperation that articulates principles needed to identify collaboration and contingent cooperation.

VIII.8 In applying a theory of cooperation, an adjudicator must adopt an institution’s sincere moral evaluation of the gravity of the wrongness of a contested act. Were a court to apply a substantially different moral evaluation of a contested act, it would irreparably prejudice the proceeding may even eviscerate constitutional guarantees of freedom of conscience. While entitled to ensure that an entity/collective’s decision reflects a rational and coherent theory of cooperation, courts must accord entities/collectives leeway in their evaluation of relevant factors. Courts should not substitute their own judgements for institutional decisions that fall within a range of rationally justifiable alternatives.