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Submission to the College of Physicians and Surgeons of Ontario

Re: *Physicians and the Ontario Human Rights Code*

11 September, 2008

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Abstract

The principle that conscientious objectors ought to be forced to refer for or otherwise facilitate a morally controversial procedure would apply to *all* controversial procedures, such as sex-selective abortion, infant male circumcision, assisted suicide and euthanasia or even the amputation of healthy body parts.

To demand that physicians provide or assist in the provision of procedures or services that they believe to be wrong treats them as things or tools to be used by others. This is unacceptable because it denies their "essential humanity."

In principle, it is not unreasonable for physicians to refuse to refer patients for procedures to which they object for reasons of conscience. The referral/facilitation required in the draft is the same kind of action that is defined as "participation" in the AMA policies on capital punishment and torture.Professional associations will refuse all forms of direct and indirect participation even in legal acts that they deem to be immoral. This is precisely the position taken by conscientious objectors.

Physicians who decline to do something they believe to be wrong are not discriminating against individuals on grounds prohibited by the *Ontario Human Rights Code*. Their concern is to avoid direct or indirect complicity in wrongdoing, not with the personal characteristics, status or inclinations of a patient.

In adjudicating complaints that involve conflicts centred on the exercise of freedom or conscience by physicians, the College should confine its review to issues clearly within its competence, leaving human rights issues to be addressed by more appropriate authorities.

The four principles to which the draft statement refers do not support the view that physicians are obliged to "set aside their personal beliefs" and do what they believe to be wrong, nor do the principles contribute to the resolution of potential conflicts in such cases.

Physicians should not be accused of preaching simply because they comply with ethical guidelines that require them to disclose moral or religious views that may influence their practice, or explain their position while providing information necessary to respect the principle of informed consent.

The Project recommends that College Council take the position that the suppression of fundamental freedoms among physicians in the province must proceed without the assistance of the College of Physicians and Surgeons.

I. Introduction

Policies of the Ontario Human Rights Commission

I.1. The submissions of the Ontario Human Rights Commission to the College, dated 14 February, 2008[1] and 15 August, 2008,[2] indicate that the principal threat to freedom of conscience and religion for physicians in the province of Ontario emanates from the Commission rather than from the College of Physicians and Surgeons. The OHRC submissions raise more issues than the College's draft policy.

I.2. Further: the Commission has extensive authority to review statutes and regulations and direct individuals and organizations in the interpretation and application of the *Human Rights Code*. This is backed by the threat of prosecution before the Human Rights Tribunal, which is guided by Commission policies in its adjudication of cases.[3]

I.3. As reflected in its August submission, the Commission claims the power to direct the College as to the precise wording of its ethical guidelines. Its apparent intention is to use the College as an instrument through which it will dictate the terms upon which religious and non-religious believers will be permitted to practise medicine in Ontario. What other claims it may make to direct the development of medical ethics remain to be seen.

Intentions of the College of Physicians and Surgeons

I.4. Unfortunately, some will suspect that *Physicians and the Ontario Human Rights Code* reflects College thinking previously frustrated by resistance from physicians, now resurrected with the help of the OHRC.[4] Alternatively, the draft policy may be seen as a first effort by the College to accommodate itself to a new role as surrogate for the Commission. A more charitable assessment would see *Physicians and the Ontario Human Rights Code* as a good-faith attempt at harm reduction: better that the "inevitable" suppression of freedom of conscience among physicians be managed quietly by knowledgeable and sympathetic colleagues than by the OHRC. There are precedents for this approach.[5]

Scope of this submission

I.5. Nonetheless, the present submission takes *Physicians and the Ontario Human Rights Code* at face value, and is largely confined to the policy as formulated by the College rather than the policy the OHRC wishes to impose. It is not possible here to adequately address the issues raised in the OHRC submissions, particularly since the Commission, in its fixation on the provision of services, does not appear to appreciate the distinction between surgery and automotive repair.

I.6. The scope of the present submission is further restricted to those parts of the policy dealing with moral or religious beliefs and professional misconduct.

I.7. Since the publication of "Physicians and the Ontario Human Rights Code," the President of the College has affirmed that, despite the statements made in the draft policy, "the College does not expect physicians to provide medical services that are against their moral or religious beliefs."[6] An e-mail to physicians repeated this assurance and drew specific attention to concerns raised among respondents to a purported obligation to assist patients in

obtaining morally controversial services.[7] Accordingly, the focus of this submission will be the issue of referral.

II. Preliminaries

II.1 Before dealing with substantive questions it is necessary to draw attention to a number of points that are highly relevant to the discussion, but which are usually overlooked.

Belief: **religious and otherwise**

II.2 It has become an article of faith with many, especially many holding public positions, that faith has no place in public and professional life. This is evident in the dogmatic assertion by the OHRC of its belief that physicians "must essentially 'check their personal views at the door' in providing medical care."[8]

II.3 The OHRC claim calls to mind comments made by Dr. James Robert Brown in 2002. A professor of science and religion of the University of Toronto, Dr. Brown offered a simple solution for health care workers who don't want to be involved with things like abortion or contraception. These "scum" - that was his word - should "resign from medicine and find another job." His reasoning was very simple.

> Religious beliefs are highly emotional - as is any belief that is affecting your behaviour in society. You have no right letting your private beliefs affect your public behaviour.[9]

II.4 Now, when Dr. Brown declared that no one should be allowed to let private belief affect public behaviour, he was doing precisely that. He was acting publicly upon *his* private belief that conscientious objectors in health care should not be allowed to act publicly upon *their*s. Dr. Brown did not explain why this should be so, but others have made the attempt.

II.5 Religious beliefs, so the argument goes, are unreliable and divisive because they are unscientific, essentially 'private' and 'personal' in nature. It is said that they must be banished from public affairs in a secular society in the interests of social harmony, progress and, now, human 'rights.' Proponents of this view point to religious wars and persecutions throughout history to justify their claims. However, considered within a broader social and historical context that includes the oppressive and frequently bloody pursuit of secular objectives in the French Revolution, Stalinist Russia and Nazi Germany, the argument is unpersuasive. And it becomes even less persuasive in the case of individuals.

II.6 For example: after ten years of bloody wars, the ancient Indian emperor Asoka became a Buddhist, and decided that he should rule his people like a father, with "morality and social compassion." Among other things, he provided them with free hospitals and veterinary clinics, and built new roads and rest houses for travellers.[10] In other words, Asoka let his private beliefs affect his public behaviour. Like Mother Teresa of Calcutta - who also let her private beliefs influence her public behaviour - Asoka is still revered in India, nicknamed "the saint."

II.7 Moving from ancient times into the last century, one recalls that fewer than half the

Canadians who landed at Dieppe in 1942 made it back. The Royal Hamilton Light Infantry landed with 582 men; 365 were killed or taken prisoner.[11] John Foote was honorary chaplain to the regiment. For eight hours, repeatedly exposing himself to "an inferno of fire," he assisted the Regimental Medical Officer, going out to the wounded, carrying them to shelter, and, later, carrying them on his back to evacuation landing craft. Ultimately, he chose to stay on the beach and be taken prisoner with those left behind.[12]

II.8 Asoka, Mother Teresa and John Foote were religious believers, but it is false to assert that only religious believers are motivated by belief. In 1915, at Ypres, Canadian physician Francis Scrimger ordered the evacuation of his dressing station, but remained behind to stabilize a wounded officer. As shells dropped around him, demolished the building and set it on fire, he shielded his patient with his own body as he worked, and then carried the larger man to safety through an artillery barrage.[13] Foote, a Presbyterian minister, and Scrimger, "an atheist by outward appearances,"[14] both acted in accordance with their personal beliefs; both were awarded the Victoria Cross.

II.9 If one accepts the logic of Professor Brown, Scrimger deserved the award but Foote did not, because Foote had no business letting his *religious* beliefs influence his public behaviour. On the other hand, the stated policy of the Ontario Human Rights Commission would deny both recognition, on the broader grounds that both failed to 'check their personal views at the door' when the bullets started to fly.

II.10 The stories of Foote and Scrimger may remind physician members of the College Council of countless colleagues in the profession who, through the centuries, have died of contagious and incurable diseases contracted because they refused to abandon their patients. Not a few of this number were motivated by personal beliefs, religious or otherwise, but the profession has never taken towards them the attitude now demanded of it by the Ontario Human Rights Commission.

II.11 All public behaviour - how one treats other people, how one treats animals, how one treats the environment - is determined by what one believes. All beliefs influence public behaviour. Some of these beliefs are religious, some not, but all are beliefs. That human dignity exists - or that it does not - or that human life is worthy of unconditional reverence - or merely conditional respect - and notions of beneficence, justice and equality are not the product of scientific enquiry, but rest upon faith: upon beliefs about human nature, the meaning and purpose of life, the existence of good and evil.

II.12 Disputes about morality - about the morality of contraception, assisted suicide, stem cell research or artificial reproduction - are always, at the core, disputes between people of different beliefs, whether or not those beliefs are religious. "Everyone 'believes'," writes social critic Iain Benson. "The question is, what do we believe in and for what reasons?"

> Once we realize that everyone necessarily operates out of some kind of faith assumptions we stop excluding analysis of faith from public life. We cannot simply banish "religious" faiths from our common conversations about how we ought to order our lives together while

> leaving unexamined all those "implicit faiths" in such areas as public education, medicine, law or politics.[15]

Establishment consensus and the ethics of the profession

II.13 It might be argued that Professor Brown's declaration expressed, not just a private conviction, but a broad public consensus, a consensus of serious establishment thinkers (like members of the OHRC), or, perhaps, a consensus reflecting "the ethics of the profession."[16]

II.14 However, this kind of 'consensus' is typically achieved by taking into account only opinions consistent with ethical, moral or religious presuppositions that are congenial to a dominant elite. The resulting 'consensus' is, in reality, simply the majority opinion of like-minded individuals, not a genuine ethical synthesis reflecting common ground with those who think differently.[17] Unfortunately, this usually becomes clear only when documents like *Physicians and the Ontario Human Rights Code* become public knowledge, and those excluded from the table make themselves heard.

II.15 More to the point, to identify beliefs as 'private' or 'personal' does not help to resolve a question about the exercise of freedom of conscience. The beliefs of many conscientious objectors, while certainly personal in one sense, are actually shared with tens of thousands, or even hundreds of thousands or hundreds of millions of people, living and dead, who form part of great religious, philosophical and moral traditions. If their beliefs are 'private,' those of Professor Brown, the College Council and the OHRC are not less so. Disputes about what counts as 'private' or 'public' thus end in a stalemate.

II.16 The question does not turn on privacy, but truth. If the College Council possess a moral vision that is superior to that of objecting physicians, it is clear that Council's superior moral views ought to prevail. But, in that case, Council members should be able and willing to explain first, why they are better judges of morality than objecting physicians, and, second, why their moral judgement should be forced upon unwilling colleagues. Avoiding the issue by hiding behind noble sounding phrases like "the ethics of the profession" will not do.

Limits to expression

II.17 It is argued that there are limits to the exercise of freedom of conscience and religion. This is hardly a new proposition. Oliver Cromwell said as much 400 years ago.

> As for the People [of Ireland], what thoughts they have in matters of Religion in their own breasts I cannot reach; but shall think it my duty, if they walk honestly and peaceably, Not to cause them in the least to suffer for the same. And shall endeavour to walk patiently and in love towards them to see if at any time it shall please God to give them another or a better mind. And all men under the power of England, within this Dominion, are hereby required and enjoined strictly and religiously to do the same.[18]

But to act *publicly* upon religious belief was, for Cromwell, another matter.

> . . . I shall not, where I have the power, and the Lord is pleased to bless

> me, suffer the exercise of the Mass . . . nor . . . suffer you that are Papists, where I can find you seducing the People, or by any overt act violating the Laws established; but if you come into my hands, I shall cause to be inflicted the punishments appointed by the Laws.[19]

II.18 Cromwell, the Supreme Court of Canada and the Ontario Human Rights Commission all agree that "the freedom to hold beliefs is broader than the freedom to act on them."[20] So, for that matter, do those who support freedom of conscience in health care. The principle is not in dispute. What is in dispute is where the line between belief and expression is to be drawn, and what is to be done with those who cross it. The Irish did not share Cromwell's views about where the line should be drawn, nor is it clear that there is anything approaching a consensus in Canada on this point. So it is instructive to remember Oliver Cromwell and the Irish when social and political elites begin to sound like the Lord Protector.

The needs of the patient: anthropology counts

II.19 What is conducive to human well-being is determined by the nature of the human person. There can be no agreement upon what is good for the patient without first agreeing upon that. One's understanding of the nature of the human person determines not only how one defines the needs of the patient, but how one approaches every moral or ethical problem in medicine.

II.20 Reasoning from different beliefs about what man is and what is good for him leads to different definitions of "need," different understandings of "harm," different concepts of right and wrong, and, ultimately, to different ethical conclusions.[21]

II.21 Consider two different statements: (a) man is a creature whose purpose for existence depends upon his ability to think, choose and communicate; b) man is a creature for whom intellect, choice and communication are attributes of existence, but do not establish his purpose for existence. Statements (a) and (b) express non-religious belief, not empirically verified fact. Such beliefs - usually implicit rather than explicit - direct the course of subsequent discussion.

II.22 Bioethicists working from (a) would have little objection to the substitution of persistently unconscious human subjects for animals in experimental research.[22] Those who accept (b) would be more inclined to object.[23] Finally, bioethicists who do not believe in 'purpose' beyond filling an ecological niche would dismiss the whole discussion as wrong-headed.

II.23 What must be emphasized is that when people cannot achieve a consensus about the morality of a procedure, it is frequently because they are operating from different beliefs about the nature of the human person. Disagreement is seldom about facts - the province of science - but about what to believe in light of them - the province of philosophy and religion.

II.24 These considerations also apply when one attempts to rationally limit freedoms or balance conflicting rights claims.

Social contract

II.25 One frequently encounters references to a "social contract" between the medical profession and society, especially in discussions about the meaning of "professionalism."[24] The Royal College of Physicians has suggested that, in relation to medical practice, it is more accurate to speak of a "moral contract" between society and the profession.[25] Others have argued that the concept of a social "covenant" provides a better framework for ethical reflection.[26]

II.26 It is important to recognize that, whether the term of choice be contract or covenant, or the contract be social or moral, all such notions are convenient fictions. *The Oxford Companion to Philosophy* makes the point:

> Contract, social: The imaginary device through which equally imaginary individuals, living in solitude (or, perhaps, nuclear families) , without government, without a stable division of labour or dependable exchange relations, without parties, leagues, congregations, assemblies or associations of any sort, come together to form a society, accepting obligations of some minimal kind to one another, and immediately or very soon thereafter binding themselves to a political sovereign who can enforce those obligations.[27]

II.27 Theories of 'contract' and 'convenant' are tools that can be usefully employed to explore different aspects of human relationships, but they become dangerous when they are thought to offer adequate explanations of those relationships, or when one moves from speculative discussion and analysis to the enforcement of purported obligations. It is also necessary to recall that claims about the precise content of a contract become especially intense when the parties involved disagree.

Social contract and socialized medicine

II.28 Socialized medicine has been and continues to be a great benefit to many people, but little attention has been paid to the dynamic of expectation that arises when the state assumes primary responsibility for the delivery of health care. Health care providers come to be seen as state employees, and citizens begin to believe that they are entitled to demand from health care providers the services they have paid for through taxes.

II.29 In this case it is argued that there is an actual rather than theoretical social contract for the provision of health care, and that the state and the medical profession are parties to it. Nonetheless, given the nature and complexity of health care, much of the precise content of such a contract must remain undefined, so that conflicts like the one now faced by the College will arise. The problem becomes especially acute when legal but morally controversial procedures are the focus of the conflict.

II.30 Citizens are likely to expect the state to enforce what they consider to be the terms of the contract against reluctant employees and other health care providers through institutions like the College of Physicians and the OHRC. However, even if one posits the existence of a

contract, such an expectation ignores two key points.

II.31 First: the terms of the contract on this issue have never been defined or settled. It is a matter of fact that, in assisting in the birth of medicare, the medical profession did not agree that its members would, from that point, deliver every service demanded by the public, regardless of their conscientious convictions. The state, a party to the contract, can ask that it be re-negotiated, but cannot unilaterally demand that the profession "read in" non-existent provisions.

II.32 Second: even if physicians have become *de facto* employees of the state since the introduction of public health care, it does not follow that they cannot exercise freedom of conscience and religion. On the contrary: as employees of a "service industry," they are entitled to the same accommodation of freedom of conscience and religion available to employees of other service industries.

II.33 The standard - set out by the OHRC itself - is that they must be accommodated to the point of undue hardship.[28] Given the enormous resources available to their employer - the state - it is difficult to imagine under what circumstances it might experience "undue hardship" in the delivery of health care. Not incidentally, physicians are also entitled to demand that their employer - the state - not permit their workplace environments to be poisoned against them by state institutions, like the OHRC.

Fiduciary duty

II.34 Moving from imaginary devices to actual law, some writers assert that the fiduciary duties of physicians requires them to subordinate their conscientious convictions to those of their patients. Professors R.J. Cook and B.M. Dickens have made this claim,[29] citing the Supreme Court of Canada case, *McInerney v. MacDonald*.[30]

II.35 However, *McInerney* had absolutely nothing to do with conflicts of conscience. It concerned the duty of a physician to release a patient's medical records to her upon request, and the nature of fiduciary relationships was not discussed at length. Moreover, the Court ruled that fiduciary relationships and obligations are "shaped by the demands of the situation"; they are not governed by a "fixed set of rules and principles." Mr. Justice La Forest, writing for the court, stated, "A physician-patient relationship may properly be described as'fiduciary' for some purposes, but not for others."[31] In other words, that the physician patient relationship is fiduciary for the purpose of disclosing patient records does not imply that it is fiduciary for the purpose of suppressing the conscientious convictions of the physician.

II.36 Finally, the court in *McInerney* accepted the characterization of the physician-patient relationship as "the same . . . as that which exists in equity between a parent and his child, a man and his wife, an attorney and his client, a confessor and his penitent, and a guardian and his ward."[32] Pursuing the analogy, no one has ever suggested that the fiduciary obligations of parents, husbands, attorneys, confessors, and guardians require them to sacrifice their own integrity to the "desires" of others. *McInerney* does not even remotely imply that physicians have such a duty.[33]

Legality

II.37 It is also said that health care workers cannot refuse to provide any legal procedure, as if the legality of the procedure were sufficient to impose a duty to provide it upon either the profession as a whole or individual physicians. It can be shown that this is not yet the case, though the OHRC appears to be taking this position.

II.38 **Sex selective abortion:** There is no law against sex-selective abortion in Canada, nor against determining the sex of an infant before birth. Nonetheless, the Deputy Registrar of the College of Physicians and Surgeons of British Columbia was horrified in August, 2005, when he learned that a pre-natal gender testing kit was being marketed on the internet. Dr. T. Peter Seland, described gender selection as "immoral." He explained that College policy was not to disclose the sex of a baby until after 24 weeks gestation in order to reduce the risk of gender selection, and that physicians violating the policy were liable to be disciplined by the College.[34] This clearly indicates that the legality of a procedure is not reason enough to compel a health care worker to provide it.

II.39 **Amputation:** In 1999, Dr. Robert Smith of Scotland performed single leg amputations on two patients who desired the amputation of healthy limbs. The surgery was performed with the permission of the Medical Director and Chief Executive of the hospital, in a National Health Service operating theatre with NHS personnel, after consultation with the General Medical Council and professional bodies.[35] The procedures were legal and even deemed ethical by regulatory authorities, but, to date, no one has argued that this is sufficient reason to oblige surgeons to amputate healthy limbs upon request, and to compel physicians to refer for such surgery.

II.40 **Execution**: Capital punishment is legal in a number of jurisdictions. 35 of the 38 American states that use lethal injection as a means of execution permit the participation of physicians, and 17 of them require it. "Thirteen jurors, citizens of the state, have made a decision," explained one physician who assists with executions. "And if I live in that state and that's the law, then I would see it as being an obligation to be available."[36] The law is the law, after all. However, despite the legality of the procedure, and in defiance of the laws that actually require the attendance of physicians, the Code of Ethics of the American Medical Association forbids the participation of physicians in executions,[37] and those who ignore the ban risk losing their licenses to practise.[38] In the face of pending decision of the American Supreme Court, a guest editorial commented on the obvious conflict between the expectations of the law and the attitude of physicians:

> In their fuller examination of *Baze v. Rees*, the justices should not presume that the medical profession will be available to assist in the taking of human lives . . .The future of capital punishment in the United States will be up to the justices, but the involvement of physicians in executions will be up to the medical profession.[39]

III. The problem of complicity

Meaning of *Physicians and the Ontario Human Rights Code*

III.1 At first glance, the College draft policy *Physicians and the Ontario Human Rights Code* and subsequent clarification by the President are contradictory and confusing. On the one hand, the draft policy states that "there may be times when it may be necessary for physicians to set aside their personal beliefs," and implies that those who fail to do so face prosecution for professional misconduct or human rights offences.[40] On the other, the President has publicly stated that "the College does not expect physicians to provide medical services that are against their moral or religious beliefs."[41]

III.2 The apparent contradiction is resolved by attending more closely to the President's statement. College officials do not expect physicians *to provide* services that they believe to be wrong (i.e., perform or assist in an abortion, for example), but this does not preclude a demand that they facilitate the provision of such services (by arranging for abortion). And this is exactly what the draft policy proposes:

> Tell patients about their right to see another physician . . . If patients or potential patients cannot readily make their own arrangements to see another doctor or health care provider, *physicians must ensure arrangements are made, without delay, for another doctor to take over their care*.[42] (emphasis added)

Similarly, the draft policy strongly implies that physicians are obliged to help individuals arrange for artificial reproduction.[43] In principle, there is no reason why such a rule would not extend to any other morally controversial procedure.

III.3 It thus appears that College officials are working from what might be called the 'Absolutionist Premise:' that someone who merely arranges for an act is absolved of moral responsibility because only someone who actually does an act is morally responsible for it. In the words of the American College of Obstetricians and Gynecologists, "the logic of conscience, as a form of self-reflection on and judgement about whether one's own acts are obligatory or prohibited, means that it would be odd or absurd to say, "I would have a guilty conscience if she did X."[44]

III.4 Alternatively, College officials may admit that some moral responsibility is incurred by referral or by otherwise facilitating a procedure, but that the degree of responsibility is sufficiently diminished in such cases that it is of no real significance. Call this the 'Dismissive Premise.'

III.5 On either account, the position of College officials raises the issues discussed in paragraphs II.12 to II.15. Whether they assert that referral or facilitation do not incur moral responsibility, or that the degree of moral responsibility incurred is so minimal as to be inconsequential, they are making a moral judgement and demanding that others adhere to it.

Complicity in torture

III.6 **The Absolutionist Premise** is illustrated by the opinion of *Newsweek* columnist Jonathan

Alter. In the weeks following the terrorist attacks on the United States in September, 2001, Alter argued that it was time to think about torturing terrorist suspects who might have information about plans for such horrendous crimes. He acknowledged that physical torture was "contrary to American values," but argued that torture is appropriate in some circumstances, and proposed a novel 'compromise:' that the United States turn terrorist suspects who won't talk over to "less squeamish allies,"[45] a practice known as "extraordinary rendition." The allies would then do what Americans would not, without compromising American values.

III.7 Less than a year later, Canadian citizen Maher Arar, returning home from Zurich through New York, was detained, interrogated and "rendered" to Syria by U.S. authorities.[46] In Syria he was imprisoned for almost a year, "interrogated, tortured and held in degrading and inhumane conditions."[47]

III.8 A subsequent "comprehensive and thorough" investigation "did not turn up any evidence that he had committed any criminal offence" and disclosed "no evidence" that he was a threat to Canadian security."[48] College Council will recall that a commission of inquiry was appointed to investigate "the actions of Canadian officials" in the case.[49]

III.9 What was of concern to Mr. Arar, the public and the government was whether or not Canadian officials had caused or contributed to what happened to Mr. Arar, even though his deportation to Syria was effected by the United States, and Syrian officials imprisoned and tortured him. The key issue was whether or not Canada was complicit in torture.

III.10 Concern about Canadian complicity surfaces repeatedly in the report of the commission of inquiry: in briefing notes to the Commissioner of the RCMP,[50] in the testimony of the Canadian Ambassador to Syria,[51] in references to the possibility of RCMP complicity in his deportation,[52] about the perception of complicity if CSIS agents met Mr. Arar in Syria,[53] in the suggestion that evidence of complicity could show "a pattern of misconduct,"[54] and in the conclusions and recommendations of the report itself.[55]

III.11 The issue of complicity arose again in 2007 when a report in Toronto's *Globe and Mail* alleged that prisoners taken in Afghanistan by Canadian troops and turned over to Afghan authorities were being mistreated and tortured.[56] "Canada is hardly in a position to claim it did not know what was going on," said the *Globe*. "At best, it tried not to know; at worst, it knew and said nothing."[57] On this view, one can be complicit in wrongdoing not only by acting, but by failing to act, and even by silence. The *Globe* editorial brings to mind the words of Martin Luther King and Mahatma Ghandi.[58]

III.12 Thus far the complicity of government officials. But *The Lancet*, among others, has asked, "How complicit are doctors in the abuse of detainees?"[59] and other journal articles have explored the answer with some anxiety.[60]

III.13 The Arar Inquiry, the concerns raised by the *Globe and Mail* story about Afghan detainees and the alarm raised about physician complicity in torture make sense only on the presumption that one can be morally responsible for acts actually committed by another

person. The Absolutionist Premise does not provide a plausible starting point for moral reasoning.

Complicity in capital punishment

III.14 **The Dismissive Premise** is more promising. Granted that one can be morally responsible for acts actually committed by another, there may be differences of opinion about what kind of action or omission incurs such responsibility. These differences need not be thoroughly canvassed in this paper. It is sufficient to ask if the kind of action required by the draft policy could have that effect. That is: if a physician refers or otherwise helps a patient to obtain what be believes to be an immoral procedure, is he a culpable participant in the provision of the procedure?

III.15 The issue of culpable participation in a morally controversial procedure has been considered by the American Medical Association in its policy on capital punishment.[61] It forbids physician participation in executions, and defines participation as

> (1) an action which would directly cause the death of the condemned;
>
> (2) an action which would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned;
>
> (3) an action which could automatically cause an execution to be carried out on a condemned prisoner.

III.16 Among the actions identified by the AMA as "participation" in executions are the prescription or administration of tranquillizers or other drugs as part of the procedure, directly or indirectly monitoring vital signs, rendering technical advice or consulting with the executioners, and even (except at the request of the condemned, or in a non-professional capacity) attending or observing an execution.

III.17 The attention paid to what others might consider insignificant detail is exemplified in the provision that permits physicians to certify death, providing that death has been pronounced by someone else, and by restrictions on the donation of organs by the deceased.

III.18 The AMA also prohibits physician participation in torture. Participation is defined to include, but is not limited to, "providing or withholding any services, substances, or knowledge to facilitate the practice of torture."[62] The Canadian Medical Association, while not faced with the problem of capital punishment, has voiced its opposition to physician involvement in the punishment or torture of prisoners. The CMA states that physicians "should refuse to allow their professional or research skills to be used in any way" for such purposes.[63]

Complicity and referral

III.19 While referral is not mentioned in the AMA policy on capital punishment, nor in the Canadian or American policies on torture, one cannot imagine that either the AMA or CMA would agree that physicians who refuse to participate in torture or executions should be made to "ensure arrangements are made, without delay" to find a substitute. In fact, it is likely that

both the CMA and AMA would censure a physician who did so voluntarily, on the grounds that such conduct would make him complicit in a gravely immoral act.

III.20 In any case, it is reasonable to hold that the kind of action required by *Physicians and the Ontario Human Rights Code* is the same kind of action that is defined as "participation" in the AMA policies on capital punishment and torture. The model provided by the AMA policy indicates that, in principle, at least, it is not unreasonable for physicians to refuse to refer patients for procedures to which they object for reasons of conscience, on the grounds that referral would make them complicit in a wrongful act.

III.21 The point here, of course, is not that capital punishment or torture are morally equivalent to artificial reproduction, contraception or other controversial medical procedures. The point is that, when professional associations are convinced that an act is seriously wrong - even if it is legal - one finds them willing to refuse all forms of direct and indirect participation in order to avoid moral complicity in the act. This is precisely the position taken by conscientious objectors in health care.

Complicity and dirty hands

III.22 Having considered the problem of complicity, it is now worth asking why the subject of complicity in wrongful acts is not only of grave concern to ethical physicians, medical journals, and professional associations, but why it can so thoroughly arouse the public, the media, and politicians: why commissions of inquiry will so meticulously investigate the possibility of complicity, producing hundreds upon hundreds of pages of detailed analysis of the evidence taken, at no little cost to the public purse.

III.23 A jaded few will respond that reports of scandal will always sell newspapers, that scandal always energizes the self-righteous (both the religious and the politically-correct varieties) and that scandal is one of the traditional weapons used against opponents by politicians of all stripes. There is some truth to this, but, going deeper into it, why is complicity in wrongdoing scandalous?

III.24 The answer must be that there is something about complicity in wrongdoing that triggers an almost instinctive reaction in people, something about it that touches some peculiar, deep and almost universal sense of abhorrence. One says "almost" instinctive and "almost" universal because, of course, there have always been exceptions: Eichmanns, Pol Pots, Rwandan machete men, for example. And the degree of sensitivity varies from person to person, from subject to subject, and from one culture to another. Nonetheless, complicity in wrongdoing can be a source of scandal, a political weapon and the subject for public inquiries only because it has some real and profound significance.

III.25 The nature of that significance is suggested by a number of expressions: "poisoned" fruit doctrine, "tainted"evidence, money that has to be "laundered," and "dirty" hands. A senior Iraqi surgeon, commenting on the complicity of physicians in torture under Saddam Hussein, said that "the state wanted them to have 'dirty hands'."[64] In contrast, some writers refer approvingly to a "dirty hands principle":

> Philosopher Sidney Axinn tells us the Dirty Hands principle "holds that in order to govern an institution one must sometimes do things that are immoral." He goes on to say that advocates would claim that "we do not want leaders who are so concerned with their own personal morality that they will not do `what is necessary' to ... win the battle.... We have an inept leader if we have a person who is so morally fastidious that he or she will not break the law when that is the only way to success" (Axinn, 1989: 138).[65]

But whichever view one takes of "dirty hands," all of these expressions convey an uncomfortable sense that something is felt to be soiled by complicity in wrongdoing. What is that something? And what is the nature of that cloying grime?

III.26 The answer suggested by the Project is that the "something" is not a "thing" at all, but the human person, and that the sense of uncleanness or taint associated with complicity in wrongdoing is the natural response of the human person to something fundamentally opposed to his nature and dignity.

IV. The human person

The integrity of the human person

IV.1 The physician, a unique some*one* who identifies himself as "I" and "me,"[66] has only *one* identity, served by a single conscience that governs his conduct in private and professional life. This moral unity of the human person is identified as integrity, a virtue highly prized by Martin Luther King, who described it at as essential for "a complete life."[67]

> [W]e must remember that it's possible to affirm the existence of God with your lips and deny his existence with your life. . . . We say with our mouths that we believe in him, but we live with our lives like he never existed . . . That's a dangerous type of atheism.[68]

IV.2 Against this, some writers have invoked the venerable concept of self-sacrifice. "Professionalism," Professor R. Alta Charo suggests rhetorically, ought to include "the rather old-fashioned notion of putting others before oneself."[69]

IV.3 But self-sacrifice, in the tradition of King, Gandhi and Lewis, while it might mean going to jail or even the loss of one's life, has never been understood to include the sacrifice of one's integrity. To abandon one's moral or ethical convictions in order to serve others is prostitution, not professionalism. "He who surrenders himself without reservation," warned C.S. Lewis, "to the temporal claims of a nation, or a party, or a class" - one could here add 'profession' - "is rendering to Caesar that which, of all things, emphatically belongs to God: himself."[70]

IV.4 The integrity or wholeness of the human person was also a key element in the thought of French philosopher Jacques Maritain. He emphasized that the human person is a "whole, an open and generous whole" that to be a human person "involves totality."[71]

> The notion of personality thus involves that of totality and independence; no matter how poor and crushed a person may be, as such he is a whole, and as a person subsists in an independent manner. To say that a man is a person is to say that in the depth of his being he is more a whole than a part and more independent than servile.[72]

IV.5 This concept is not foreign to the practice of modern medicine. Canadian ethicist Margaret Somerville, for example, asserts that one cannot overemphasize the importance of the notion of 'patient-as-person' and acknowledges a "totality of the person" that goes beyond the purely physical.[73]

The dignity and inviolability of the human person

IV.6 "Man," wrote Maritain, "is an individual who holds himself in hand by his intelligence and his will."

> He exists not merely physically; there is in him a richer and nobler existence; he has spiritual superexistence through knowledge and through love.[74]

IV.7 Applying this principle, Maritain asserted that, even as a member of society or the state, a man "has secrets that escape the group and a vocation which the group does not encompass."[75] His whole person is engaged in society through his social and political activities and his work, but "not by reason of his entire self and all that is in him."[76]

> For in the person there are some things - and they are the most important and sacred ones - which transcend political society and draw man in his entirety above political society - the very same whole man who, by reason of another category of things, is a part of political society.[77]

IV.8 Even as part of society, Maritain insisted, "the human person is something more than a part;"[78] he remains a whole, and must be treated as a whole.[79] A part exists only to comprise or sustain a whole; it is a means to that end. But the human person is an end in himself, not a means to an end.[80] Thus, according to Maritain, the nature of the human person is such that it "would have no man exploited by another man, as a tool to serve the latter's own particular good."[81]

IV.9 British philosopher Cyril Joad applied this to the philosophy of democratic government:

> To the right of the individual to be treated as an end, which entails his right to the full development and expression of his personality, all other rights and claims must, the democrat holds, be subordinated. I do not know how this principle is to be defended any more than I can frame a defence for the principles of democracy and liberty.[82]

In company with Maritain, Professor Joad insisted that it is an essential tenet of democratic government that the state is made for man, but man is not made for the state.[83]

IV.10 To reduce human persons to the status of tools or things to be used for ends chosen by others is reprehensible: "very wicked," wrote C.S. Lewis.[84] Likewise, Martin Luther King condemned segregation as "morally wrong and awful" precisely because it relegated persons "to the status of things."[85]

IV.11 Similarly, Polish philosopher Karol Wojtyla (later Pope John Paul II):

> . . . we must never treat a person as a means to an end. This principle has a universal validity. Nobody can use a person as a means towards an end, no human being, nor yet God the Creator.[86]

IV.12 Maritain, Joad, Lewis, King and Wojtyla reaffirmed in the twentieth century what Immanuel Kant had written in the eighteenth: "Act so that you treat humanity, whether in your own person or in that of another, always as an end and never as a means only."[87]

Human dignity and freedom of conscience

IV.13 Perhaps ironically, this was the approach taken when Madame Justice Bertha Wilson of the Supreme Court of Canada addressed the issue of freedom of conscience in the landmark 1988 case *R v. Morgentaler*. Madame Justice Wilson argued that "an emphasis on individual conscience and individual judgment . . . lies at the heart of our democratic political tradition."[88] Wilson held that it was indisputable that the decision to have an abortion "is essentially a moral decision, a matter of conscience."

> The question is: whose conscience? Is the conscience of the woman to be paramount or the conscience of the state? I believe. . . that in a free and democratic society it must be the conscience of the individual. Indeed, s. 2(*a*) makes it clear that this freedom belongs to "everyone", i.e., to each of us individually.[89]

IV.14 "Everyone" includes every physician. But, at this point in the judgement, Wilson was not discussing whether or not the conscience of a woman should prevail over that of an objecting physician, but how the conscientious judgement of an individual should stand against that of the state. Her answer was that, in a free and democratic society, "the state will respect choices made by individuals and, to the greatest extent possible, will avoid subordinating these choices to any one conception of the good life."[90]

IV.15 Quoting the above passage from Professor Joad's book, Wilson approved the principle than a human person must never be treated as a means to an end - especially an end chosen by someone else, or by the state. Wilson rejected the idea that, in questions of morality, the state should endorse and enforce "one conscientiously-held view at the expense of another," for that is "to deny freedom of conscience to some, to treat them as means to an end, to deprive them . . .of their 'essential humanity'."[91]

IV.16 In the tradition of Kant, C.S. Lewis, Martin Luther King, Cyril Joad and Karol Wojtyla, and following Madame Justice Wilson, for the OHRC or the College of Physicians and Surgeons to demand that physicians provide or assist in the provision of procedures or services that they believe to be wrong is to treat them as means to an end and deprive them of their

"essential humanity."

IV.17 The OHRC proposes physicians, as a matter of principle and even as a matter of law, can be compelled to do what they believe to be wrong, and that they can be punished if they do not. It is the position of the Project that this is a blasphemy against the human spirit. Applying to the Commission's demands the words of Alexander Solzhenitsyn, "To this putrefaction of soul, this spiritual enslavement, human beings who wish to be human cannot consent."[92]

V. *Physicians and the Ontario Human Rights Code*

Policy

V.1 According to *Physicians and the Ontario Human Rights Code*, "physicians should be aware that the College is obliged to consider the [*Human Rights*] *Code* when determining whether physician conduct is consistent with the expectations of the profession. Compliance with the *Code* is one factor the College will consider when evaluating physician conduct."

V.2 The College acknowledges that it "does not have the expertise or the authority to make complex, new determinations of human rights law," which suggests that it believes that it has the expertise and authority to apply existing human rights law. Even if one accepts this opinion, prudence suggests that compliance with the *Code* should not be a significant factor in the College's assessment of a case except in the clearest of cases.

V.3 Complaints involving physicians who have declined to do something for reasons of conscience or religion are not the clearest of cases. The profound and complex issues involved and the far-reaching consequences of decisions in such cases afford the College good reason to confine its review to issues clearly within its competence, and leave human rights issues to be dealt with directly by those who profess to have the requisite expertise and authority.

Providing medical services without discrimination

V.4 Physicians who decline to do something they believe to be wrong are not discriminating against individuals on grounds prohibited by the *Ontario Human Rights Code*. Their concern is to avoid direct or indirect complicity in wrongdoing, not with the personal characteristics, status or inclinations of a patient.

Moral or religious beliefs

V.5 In its discussion of physician-patient conflicts arising from the religious convictions of the physician, *Physicians and the Ontario Human Rights Code* makes no clear distinction between the *needs* of a patient and the *desires* of a patient, referring at one point to needs,[93] and at another to "a patients's need or desire."[94] This must be clarified, because the difference between "need" and "desire" is significant. Similar clarification is necessary with respect to the meaning of "require,"[95] since it can be interpreted to mean either a *bona fide* need for treatment, or a demand by the patient that may or may not reflect such a need.

V.6 The draft policy acknowledges that "[p]ersonal beliefs and values and cultural and religious practices are central to the lives of physicians and patients." However, given what follows, it is clear that this is merely a *pro forma* observation that contributes nothing of substance to

the document.

V.7 *Physicians and the Ontario Human Rights Code* states that physicians whose moral or religious beliefs affect their practise of medicine should "proceed cautiously." Added to this is a warning that physicians who "restrict medical services offered" on the basis of their conscientious convictions may be prosecuted for professional misconduct or violations of the *Human Rights Code*, and that, should that occur, they will have "no defence." This must be read in conjunction with the principal policy statement concerning moral or religious beliefs:

> . . . as a physician's responsibility is to place the needs of the patient first, there will be times when it may be necessary for physicians to set aside their personal beliefs in order to ensure that patients or potential patients are provided with the medical treatment and services they require.

V.8 Taken together, these statements indicate that the exercise of fundamental freedoms of conscience and religion by physicians is barely tolerable, even indefensible, and that physicians will sometimes be expected to do what they believe to be wrong.

V.9 It is unclear whether this is meant as a friendly warning or a veiled threat. In either case, a free people grateful for hard-won liberties bequeathed to them by the likes of John Foote and Francis Scrimger will find it profoundly offensive and demeaning.

V.10 For reasons explained in Part IV, it is unreasonable to suggest that a physician ought to sacrifice his personal integrity by conforming to a request or demand that he do something he believes to be wrong. The suggestion is based upon an erroneous understanding of the concept of sacrifice.

No hierarchy of rights

V.11 According to *Physicians and the Ontario Human Rights Code*, "there is no hierarchy of rights in the Charter; freedom of religion and conscience, and equality rights are of equal importance."[96]

V.12 In the relevant passage in the judgement cited to support the statement, the court addressed arguments from religious groups that to grant persons of the same sex the legal right to 'marry' would threaten their religious freedoms. The intervening Interfaith Coalition had expressed concern that "religions whose beliefs preclude the recognition of same-sex marriage could find themselves required to participate in such marriages, or be discriminated against because of their beliefs." The court, however, did not think the concern was valid, because "there is no hierarchical list of rights in the Charter, and freedom of religion and conscience must live together with s. 15 equality rights."

> One cannot trump the other. . . the equality rights of same-sex couples do not displace the rights of religious groups to refuse to solemnize same-sex marriages which do not accord with their religious beliefs.

> Similarly, the rights of religious groups to freely practise their religion cannot oust the rights of same-sex couples seeking equality, by insisting on maintaining the barriers in the way of that equality.[97]

V.13 In the event of a collision between freedom of conscience and religion and equality rights, it is not clear how the issue can be adjudicated if Canadian courts insist that there is "no hierarchy of rights," except by applying the personal, social, moral, philosophical or political views of the adjudicator. In any case, the reference to the non-hierarchical arrangement of *Charter* rights does not support the view that physicians are obliged to "set aside their personal beliefs" when faced by demands that they provide services or procedures to which they object for reasons of conscience. If the passage has any relevance to the exercise of freedom of conscience by physicians, it is that it cannot be trumped by the kind of appeal to equality rights that is being made by the OHRC.

Interference with others

V.14 According to *Physicians and the Ontario Human Rights Code*, the "[f]reedom to exercise genuine religious belief does not include the right to interfere with the rights of others."[98]

V.15. The single sentence in the case to which this statement refers appears a part of the judgement that discusses the failure of the BC College of Teachers to balance religious freedom against other freedoms.

> Students attending [Trinity Western University] are free to adopt personal rules of conduct based on their religious beliefs provided they do not interfere with the rights of others. Their freedom of religion is not accommodated if the consequence of its exercise is the denial of the right of full participation in society.[99]

V.16 In essence, the court was, in this part of the judgement, reiterating the view that one *Charter* right cannot trump another, and that restriction on the exercise of religious freedom of teachers can only be justified by evidence that the restriction is required to prevent some kind of "detrimental impact on the school system."

V.17 The College draft statement contains two significant words: "genuine" and "interfere." The former does not appear in the judgement cited, and it is not clear what purpose it serves in the College document. The substantive meaning of the statement turns entirely upon what constitutes "interference."

V.18 The significance of the draft statement in the present context is whether or not refusing to participate in what one holds to be a wrongful act can constitute "interference" with another's "rights," and (considering the case cited) how this could have a "detrimental impact"on the delivery of health care.

V.19 Even if one believes that such a refusal does constitute interference and does have some kind of detrimental impact, one moves no further towards a satisfactory resolution of the conflict.

The demand by a patient that a physician do what he believes to be wrong can *also* be characterized as "interference" with another's rights, and it can *also* be said to have a "detrimental impact" on the delivery of health care, since it can hardly be maintained that medical ethics will be vastly improved if the only physicians permitted to practice are those willing to do what they believe to be wrong.

V.20 Like the reference to the non-hierarchical arrangement of rights in the *Charter*, the second statement in the College draft document does not support the view that physicians are obliged to "set aside their personal beliefs" when faced by demands that they provide services or procedures to which they object for reasons of conscience.

Freedom is limited

V.21 According to *Physicians and the Ontario Human Rights Code*, "the right to freedom of religion is not unlimited, it is subject to such limitations as are necessary to protect public safety, order, health, morals or the fundamental rights or freedoms of others."[100]

V.22 One of the cases cited to support the statement concerns a teacher who, when not working, was locally notorious for his virulently anti-semitic public statements and writings that were reasonably perceived to have poisoned the school environment against Jewish students.[101] It is not clear what relevance this case has to that of a physician who refuses to participate in what he considers to be a wrongful act, unless the College believes a physician who refuses to do what he believes to be wrong is a threat to public safety, order, health, morals or the fundamental rights or freedoms of others.

V.23 The leading case cited is the origin of the wording used in the draft statement. A Calgary drug store was charged under the *Lord's Day Act* for operating on Sunday. The Supreme Court of Canada struck down the *Act* because its "acknowledged purpose" was "the compulsion of religious observance" and employed "a form of coercion inimical to the spirit of the *Charter*," thus offending its guarantee of freedom of religion and conscience.[102]

V.24 The first point to note is that what the College document puts forward as a case that supports *limitation* of religious freedom was actually about the *importance* of religious freedom and the need to protect religious minorities in a country "from the threat of 'the tyranny of the majority.'" The principle has application in the case of a physician threatened by the College or the OHRC for refusing to do what he believes to be wrong, but not in the way suggested by the draft document.

V.25 The part of the judgement from which the College draft policy was drawn deserves to be quoted at somewhat greater length:

> A free society is one which aims at equality with respect to the enjoyment of fundamental freedoms, and I say this without any reliance upon s. 15 of the *Charter*. Freedom must surely be founded in respect for the inherent dignity and the inviolable rights of the human person. . . .

> . . . .One of the major purposes of the *Charter* is to protect, within reason, from compulsion or restraint. . . . Freedom in a broad sense embraces both the absence of coercion and constraint, and the right to manifest beliefs and practices. Freedom means that, subject to such limitations as are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others, no one is to be forced to act in a way contrary to his beliefs or his conscience.

V.26 In this passage, Mr. Justice Dickson was emphasizing the importance of religious freedom, not the importance of restricting or suppressing it. Again, the College draft policy does not contribute to the resolution of potential conflicts between a physician and a patient who demands that he do something he believes to be wrong.

Balancing and "core" beliefs

V.27 According to *Physicians and the Ontario Human Rights Code*, "courts will consider how directly the act in question interferes with a core religious belief;" and, further, "Courts will seek to determine whether the act interferes with the religious belief in a 'manner that is more than trivial or insubstantial. The more indirect the impact on a religious belief, the more likely courts are to find that the freedom of religion should be limited."[103]

V.28 Neither of the cases cited to support the draft statement refers to or distinguishes between direct and indirect impacts on religious belief. Neither of the cases cited uses the term "core" religious belief. In fact, the principal value of the leading case cited is found in the Supreme Court's affirmation that neither the state nor its courts are qualified to "to interpret and determine the content of a subjective understanding of a religious requirement." It is open to the court only "to inquire into the sincerity of a claimant's belief, where sincerity is in fact at issue."[104] The College statement thus implies a more restrictive approach to religious belief than was taken in either of the decisions.

V.29 The leading case cited resulted in a split 5-4 decision. Five judges found that infringement had occurred and that it was not trivial or insubstantial; three ruled there was no infringement, except with respect to one of the appellants, which they found to be legitimate; one held that an infringement had occurred but was justifiable in view of the rights of others. The differing views of the judges and a ruling by the bare majority suggests the unpredictable nature of "rights-balancing" exercises that depend, ultimately, on an adjudicator's subjective views about the relative importance of religious belief and other social concerns.

V.30 In the absence of any ordering principle, the introduction of the terms "trivial" and "insubstantial" does not shed any additional light on the problem of balancing conflicting rights and freedoms. Once more, the draft College statement does not support the view that physicians are obliged to "set aside their personal beliefs" when faced by demands that they do something they believe to be wrong.

Professional misconduct

Providing information

V.31 The draft policy states that physicians must provide information and advice to patients about all available procedures, even if they conflict with their moral or religious beliefs. The expectation presumes either that the mere giving of information or advice has no moral significance, or, if it does, that it is inconsequential. This is not necessarily the case.

V.32 This is demonstrated by the policies of the AMA on physician participation in execution and torture. The AMA prohibits physicians from rendering technical advice or consulting with executioners or "providing . . .knowledge to facilitate the practice of torture." (See III.15-III.18) It is also demonstrated by the policy of the College of Physicians and Surgeons of British Columbia, which forbids disclosure to the parents of the sex of a child *in utero*. (See II.37) Finally, in 2002, 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 to undercover reporters and had thus encouraged the trade in human organs,[105] even though he had not actually participated in the trade.

V.33 The difficulty here is to balance the desire of a physician to avoid complicity in a wrongful act with the importance of informed decision-making by the patient, which requires that the patient have all of the information relevant for the purpose of choosing a course of treatment. It is necessary to respect both the freedom of conscience of the physician and the freedom and right of the patient to make a fully informed choice.

V.34 One satisfactory compromise would see the physician explain all legal options, including those he finds morally objectionable, and disclose the fact and reasons for his objections. In this way, the patient obtains the information he requires to make a fully informed choice, but the physician has not compromised his own integrity by appearing to recommend a procedure that he considers morally objectionable. In such circumstances it is important for the physician to convey his position in a manner that does not provoke justifiable concern about "preaching" or attempting to "convert" the patient to his opinion. On the other hand, it is equally important to avoid gratuitous accusations of "preaching" or attempting to "convert" the patient simply because the physician has made his own views clear.

Treating with respect

V.35 The requirement that a physician not express personal judgements about the lifestyle of a patient appears to preclude even discussion about smoking, the need for a change of diet or an increase in exercise. Health and lifestyle are usually related. The wording of the policy should be revised to reflect this.

V.36 The College should make clear that physician will not be considered to be promoting his own religious beliefs or seeking to convert patients simply because he has complied with ethical guidelines that require him to disclose views that may influence his recommendations for treatment, or because he has disclosed his views in circumstances described in V.34.

V.37 Similarly, a complaint should not lie against a physician for expressing a judgement about the

patient by reason only that he has complied with ethical guidelines that require him to disclose views that may influence his recommendations for treatment, or that he has disclosed his views in circumstances described in V.34.

Referral/facilitation

V.38 In support of its position, *Physicians and the Ontario Human Rights Code* cites *Personal Beliefs and Medical Practice*, a policy document produced by Britain's General Medical Council.[106] Paragraph 21 of that document asserts that an objecting physician must provide a patient with contact information for a colleague who will provide the controversial procedure. It also directs the reader to the relevant passage in an earlier publication, *Good Medical Practice (2006),* which advises physicians that if they have declined to provide a procedure and advised a patient of his right to see another doctor, they must "ensure that arrangements are made for another suitably qualified colleague to take over" if it is not practical for the patient to do so.[107]

V.39 *Physicians and the Ontario Human Rights Code* did not explain why it chose to refer to a British policy document rather than Canadian publications like the CMA approved *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care.*[108]

V.40 In any case, the GMC documents do not appear to have taken into account evidence taken in 2004 and 2005 by the British House of Lords Select Committee on Assisted Dying for the Terminally Ill and the conclusions of the Committee. The bill, in its original form, included a requirement that objecting physicians refer patients for euthanasia. Numerous submissions protested this provision because it made objecting physicians a moral party to the procedure,[109] and the Joint Committee on Human Rights concluded that the demand was probably a violation of the European Convention on Human Rights.[110] The bill's sponsor, Lord Joffe, promised to delete the provision in his next draft of the bill.[111]

V.41 For the reasons set out in Part III and Part IV, the requirement that an objecting physician facilitate what he believes to be a wrongful act by referring a patient or otherwise arranging for the provision of the treatment is unacceptable.

VI. Looking to the future

VI.1 The principle that conscientious objectors ought to be forced to refer for or otherwise facilitate a morally controversial procedure would, logically, apply to *all* controversial procedures. If for no other reason than prudent self-interest, physicians and other health care workers who are inclined to support mandatory referral should think carefully about the broader ramifications of such a policy, especially if their own views would make them unwilling to facilitate sex-selective abortion, infant male circumcision, assisted suicide and euthanasia or even the amputation of healthy body parts.

VI.2 There is no reason to distinguish between the amputation of healthy legs and the amputation of healthy genitals. If a man can compel a surgeon to alter his body to conform to his self-

image or understanding of himself as a female, there is no principled reason why someone who sees himself as a one-legged or one-armed person should not be able to demand that a healthy leg or arm be amputated to conform to his self-image, and at public expense. According to the OHRC, to refuse to refer for sex-change surgery or to perform the surgery would, in the former case, invite prosecution for wrongful discrimination on grounds of sexual 'orientation.' Continuing to apply its logic, to refuse to perform or refer for amputation would be wrongful discrimination on grounds of disability (BIID).

VI.3 That one might be forced to refer for or otherwise facilitate assisted suicide and euthanasia is not a possibility that is commonly considered, since the procedures are illegal in most jurisdictions. But laws can be changed, as they have been in the Netherlands, Belgium and Oregon, and such changes in law bring with them changes in expectations. Since late 2003, general practitioners in Belgium unwilling to perform euthanasia have faced demands that they help patients find physicians willing to provide the service. It is argued that mandatory referral for euthanasia is required by respect for patient autonomy, the paradigm of "shared decision making" and the fact that euthanasia is a legal "treatment option."[112]

VII. Recommendation to the College

VII.1 The Ontario Human Rights Commission appears to be of the opinion that it has the authority and competence to restrict and suppress the exercise of fundamental freedoms of conscience and religion in the province Ontario. It demonstrates an alarming enthusiasm for this project.

VII.2 On the other hand, the expertise of the College of Physicians and Surgeons lies in the practice of medicine. It is doubtful that the College can contribute to an improvement in the practice of medicine or enhance the enjoyment of fundamental rights and freedoms in Ontario by accepting a new and troublesome role as a surrogate for the OHRC.

VII.3 The submissions of the OHRC to the College also bring the Council face to face with the issue of complicity. Members of the College Council must ask to what extent they wish to be complicit in the actions of the OHRC.

VII.4 Whether for reasons of conscience or reasons of competence, or both, it is open to the College Council to take the position that the suppression of fundamental freedoms among Ontario physicians may be the task of the OHRC, but that the OHRC must proceed without the assistance of the College of Physicians and Surgeons. The Project recommends this as a just and prudent response that will not compromise the mandate or responsibilities of the College.

Related documents

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(http://www.consciencelaws.org\Examining-Conscience-Ethical\Ethical10.html)

Budziszewski, J. *Handling Issues of Conscience*
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(http://www.consciencelaws.org/Project/Examining-Conscience-Ethical/Ethical60.html)

Notes

1. *Submission of the Ontario Human Rights Commission to the College of Physicians and Surgeons of Ontario regarding the draft policies relating to establishing and ending physician-patient relationships*. 14 February, 2008. (http://www.ohrc.on.ca/en/resources/submissions/surgeons) Accessed 2008-08-31

2. *Submission of the Ontario Human Rights Commission to the College of Physicians and Surgeons of Ontario Regarding the draft policy, "Physicians and the Ontario Human Rights Code."* 15 August, 2008. (http://www.ohrc.on.ca/en/resources/submissions/physur) Accessed 3008-08-31

3. Murphy, Sean, *The New Inquisitors*. Protection of Conscience Project (31 August, 2008) (http://www.consciencelaws.org/Examining-Conscience-Legal/Legal36.html)

4. Thinking like that illustrated in a controversial guest editorial in the July, 2006 edition of the *Canadian Medical Association Journal*. Rodgers, Sanda and Downie, Jocelyn, "Abortion: ensuring access." CMAJ July 4, 2006; 175 (1) (http://www.cmaj.ca/cgi/content/full/175/1/9) Accessed 2008-09-02

5. Explaining his decision to participate in an execution by lethal injection, inevitable in view of the law, an American nurse asked an interviewer, "Are you, as a doctor, going to let [an untrained layman] stab the inmate for half an hour because of his inexperience? . . . I wasn't. . . If this is to be done correctly, if it is to be done at all, then I am the person to do it." Gawande, Atul, *When Law and Ethics Collide - Why Physicians Participate in Executions*. N Engl J Med 354;12, March 23, 2006, p. 1227. (http://content.nejm.org/cgi/content/full/354/12/1221?query=TOC) Accessed 2008-09-11) Similarly, a psychiatrist explained his participation in the Nazi euthanasia programme in terms of harm reduction: "taking part in the selections . . . in order to prevent worse things from happening." Lifton, Robert Jay, *The Nazi Doctors: Medical Killing and the Psychology of Genocide*. Basic Books, 1986, p. 112

6. Zuliani, Preson, "Doctors do not have to violate beliefs." *Ottawa Citizen*, 23 August, 2008 Responding to Warren, David, "Refusing to do harm." *Ottawa Citizen*, 20 August 2008. (http://www.canada.com/ottawacitizen/news/letters/story.html?id=16631e26-c448-4694-8168-ec45d3bbdd63) Accessed 2008-09-01

7. "We do not expect physicians to provide services that are contrary to their moral or religious beliefs." The e-mail acknowledged that a requirement that physicians may be required to help patients arrange for morally objectionable procedures had "raised concerns from respondents." " E-mail from the College of Physicians and Surgeons of Ontario, 20 August 2008

8. *Submission of the Ontario Human Rights Commission to the College of Physicians and Surgeons of Ontario Regarding the draft policy, "Physicians and the Ontario Human Rights Code."* 15 August, 2008. (http://www.ohrc.on.ca/en/resources/submissions/physur) Accessed 3008-08-31

9. "Dr. James Robert Brown, a professor of science and religion at the University of Toronto, said he agrees with prosecuting a doctor with that sort of conflict. "Suppose someone (doctor) said, 'I'm uncomfortable with (treating) a minority,' I'd say, 'So long scum'," said Brown."

"Brown believes performing abortions and offering other forms of contraception are necessary and if Dawson won't perform them, then, Brown added, 'Fine - just resign from medicine and find another job."

"Religious beliefs are highly emotional - as is any belief that is effecting your behaviour in society. You have no right letting your private beliefs effect your public behaviour." Canning, Cheryl, "Doctor's faith under scrutiny:Barrie physician won't offer the pill, could lose his licence." *The Barrie Examiner*, February 21, 2002
[http://www.consciencelaws.org/Repression-Conscience/Conscience-Repression-17.html]

10. Asoka ascended his father's throne in 269 BC. Time-Life Books, *TimeFrame 400 BC - AD 200: Empires Ascendant*, p. 107-109

11. More than 900 out of 5,000 Canadian soldiers were killed; nearly 2000 were captured. An example of the carnage: of the Royal Regiment of Canada, half were killed, just 65 of 554 made it back to England, and only 22 of them were unwounded. Readers Digest, *The Canadians at War 1939/45*. Vol. 1, p. 181, 192.

12. "Upon landing on the beach under heavy fire he attached himself to the Regimental Aid Post . . . During the subsequent period of approximately eight hours, while the action continued, this officer not only assisted the Regimental Medical Officer in ministering to the wounded . . . but time and again left this shelter to inject morphine, give first-aid and carry wounded personnel from the open beach . . . . On these occasions, with utter disregard for his personal safety, Honorary Captain Foote exposed himself to an inferno of fire and saved many lives by his gallant efforts . . . Honorary Captain Foote continued tirelessly and courageously to carry wounded men from the exposed beach to the cover of the landing craft. He also removed wounded from inside the landing craft when ammunition had been set on fire by enemy shells. When landing craft appeared he carried wounded from the Regimental Aid Post to the landing craft through heavy fire. On several occasions this officer had the opportunity to embark but returned to the beach as his chief concern was the care and evacuation of the wounded. He refused a final opportunity to leave the shore, choosing to suffer the fate of the men he had ministered to for over three years." Citation, as reported in *The London Gazette*, 14 February, 1946. Reproduced on the website of the Royal Hamilton Light Infantry: *Hon LCol John Weir Foote, VC, CD* (http://www.rhli.ca/veterans/foote_story.html) Accessed 2008-09-05

13. "Realizing the dangerous situation, Scrimger organized the evacuation of the wounded to the rear, but one of his patients, Captain H. F. McDonald, had a serious head wound. Any movement before he was stabilized would likely kill him. Scrimger chose to stay behind. The shells fell around them and then began to land on the farm. The slight, 5-foot-7-inch doctor, who weighed

only 148 pounds, shielded McDonald's prone body while he worked over him. During the bombardment, the building was demolished and set on fire, but both Scrimger and McDonald survived the whirling shrapnel and exploding ammunition. Blinded by the smoke and heat of the fire, Scrimger pulled the larger, unconscious infantry officer onto his back and staggered out of the building. German infantry were advancing on the farm and the only escape was to cross the moat to the rear. Lurching to safety with McDonald on his back, Scrimger passed through the barrage, moving from shell hole to shell hole for cover. Hiding in a nearby ditch throughout the rest of the day, they avoided the enemy infantry. Captain McDonald later testified that each time the shells exploded around them, "Captain Scrimger curled himself round my wounded head and shoulder to protect me from the heavy shell fire, at obvious peril to his life. He stayed with me all that time and by good luck was not hit."
Canadian War Museum, *Backgrounder:"Francis Scrimger, V.C.* (http://www.warmuseum.ca/cwm/media/bg_scrimger_e.html) Accessed 2008-09-11

14. Kingsmill, Suzanne, *Francis Scrimger: Beyond the Call of Duty.* Hannah Institute for the History of Medicine, Dundurn Press Ltd., 1991, p. 25. See also *"The greatest devotion to duty": Dr. Francis Scrimger and his Victoria Cross.* McCulloch, I. CMAJ. 1994 February 1; 150(3): 414–416. (http://www.pubmedcentral.nih.gov/pagerender.fcgi?artid=1486153&pageindex=1) Accessed 2008-09-04)

15. Benson, Iain T., "There are No Secular 'Unbelievers.'" *Centrepoints 7*, Vol. 4, No. 1, Spring 2000, P. 3.
http://www.consciencelaws.org/Examining-Conscience-Issues/Ethical/Articles/Ethical10.html

16. For example: "The moral position of an individual pharmacist, if it differs from the ethics of the profession, cannot take precedence over that of the profession as a whole." College of Pharmacists of British Columbia Bulletin, *Ethics in Practice: Moral Conflicts in Pharmacy Practice*. March/April 2000, Vol. 25, No. 2, P. 5. For further information about the bulletin and related issues, see Project Report 2001-01, *College of Pharmacists of British Columbia: Conduct of the Ethics Advisory Committee,* 26 March, 2001.
(http://www.consciencelaws.org/Conscience-Project-Reports/Report-2001-01.html)

17. One critic outlines the extent of the penetration of bioethics principlism, as defined in the American Belmont Report: "Many colleges and universities already require a course in bioethics in order to graduate, and most medical and nursing schools have incorporated it in their curricula. Bioethics is even being taught now in the high schools. And what is being taught as bioethics are the Belmont principles, or renditions of one or more of these principles as defined in Belmont terms. Nods may be given to 'alternative' propositions here and there, but in the end it is the language of principlism which sets the standards." Irving, Dianne N., *What is "Bioethics"? (Quid est "Bioethics"?)*. Tenth Annual Conference: Life and Learning X (in press)University Faculty For Life, Georgetown University,Washington, D.C.
(http://www.lifeissues.net/writers/irv/irv_36whatisbioethics07.html) Accessed 2008-09-11

18. Cromwell, Oliver, "Declaration of the Lord Lieutenant of Ireland." (January, 1649) Carlyle, Thomas, *Oliver Cromwell's Letters and Speeches, with elucidations*. Boston: Estes and Lauriat, 1886, Vol. I, Part 5, p. 18.

19. Cromwell, Oliver, "Declaration of the Lord Lieutenant of Ireland." (January, 1649) Carlyle, Thomas, *Oliver Cromwell's Letters and Speeches, with elucidations*. Boston: Estes and Lauriat, 1886, Vol. I, Part 5, p. 18.

20. *Trinity Western University v. College of Teachers*, [2001] 1 S.C.R. 772, 2001 SCC 31 (http://scc.lexum.umontreal.ca/en/2001/2001scc31/2001scc31.html)

21. A practical observation is that ethical advice "falls squarely into the most contested domain of social and public policy. Rawlsians and feminists; casuists and communitarians: all have their divergent visions of what individuals should find life worth living for, or be willing to live with. And these visions will not always coincide with the wishes of the patient, much less the consensus of society." Shalit, Ruth, "When we Were Philosopher Kings." *The New Republic,* April 28, 1997.
http://www.consciencelaws.org\Examining-Conscience-Issues\Ethical\Articles\Ethical09.html

Smith, Wesley J., "Is Bioethics Ethical?" *The Weekly Standard*, 28 May, 2000.
http://www.consciencelaws.org\Examining-Conscience-Issues\Ethical\Articles\Ethical11.html

22. Richard G. Frey, "The ethics of the search for benefits: Animal experimentation in medicine," in Raanan Gillon (ed.), *Principles of Health Care Ethics* (New York: John Wiley & Sons, 1994), pp. 1067-1075; cited in Irving, Dianne N., "Scientific and Philosophical Expertise: An Evaluation of the Arguments on 'Personhood'". *Linacre Quarterly* February 1993, 60:1:18-46 [Updated and extensively revised, September 20, 1996]
http://www.consciencelaws.org\Examining-Conscience-Issues\Background\GenScience\BackGenScience06.html

23. Bleich, Dr. J. David, "Euthanasia", in *Judaism and Healing: Halakhic Perspectives* (1st Ed.), Ktav Publishing House, 1981, p. 139. Essay reprinted in *A Matter of Choice: Responsibility to Live, Right to Die - Five Discussion Papers from the Jewish Perspective on Euthanasia.* 13 April, 1994, Lubavitch Centre, Vancouver, B.C. (Ethics and Torah forum series)

24. "Medical professionalism includes both the relationship between a physician and a patient and a social contract between physicians and society." *CMA Policy: medical professionalism.* http://www.cma.ca/index.cfm/ci_id/3300/la_id/1.htm (Update 2005) P. 1 (Accessed 2008-09-06)

"Professionalism is also the moral understanding among medical practitioners that gives reality to the social contract between medicine and society. This contract in return grants the medical profession a monopoly over the use of its knowledge base, the right to considerable autonomy in practice and the privilege of self-regulation." *Canadian Stakeholders Coalition on Medical Professionalism*, quoted in *CMA: Medical Professionalism*

http://www.cma.ca/index.cfm/ci_id/3300/la_id/1.htm (Accessed 2008-09-06)

"Professionalism is the basis of medicine's contract with society." "Medical Professionalism in the New Millennium: A Physician Charter." *Annals of Internal Medicine,* 5 February 2002 | Volume 136 Issue 3 | Pages 243-246 http://www.annals.org/cgi/content/full/136/3/243 (Accessed 2008-09-06)

"In Canada and the United States the social basis of the extraordinary grant of occupational authority and independence to professionalized occupations such as medicine and law has been a social contract between the profession and the public. Professionalism is the moral understanding among professionals that gives concrete reality to this social contract." Sullivan, William M., *Medicine under threat: professionalism and professional identity*. CMAJ, March 7, 2000; 162 (5) http://www.cmaj.ca/cgi/reprint/162/5/673 (Accessed 2008-09-06) Similarly, Cruess, Sylvia R. and Cruess, Richard L., *Professionalism: a contract between medicine and society.* CMAJ 7 March 2000; 162 (5) (http://www.cmaj.ca/cgi/reprint/162/5/668) Accessed 2008-09-06

25. "We also exchanged, or rather subsumed, ***social contract*** and ***morality*** into a single term, ***moral contract***. It seemed to us that the idea of a moral dimension to medicine was important. It indicated something right and good in relation to the behaviours and actions of a doctor. The ultimate expression of those behaviours and actions is perhaps best summed up in the idea of a contract between the public and the profession – a moral contract. A social contract, while a correct description of the mutual agreement that exists between the public and profession, seemed too neutral a term. We wanted to emphasise an ethical edge to that mutual agreement."*Doctors in Society: Medical Professionalism in a Changing World*. Royal College of Physicians Report of a Working Party (December, 2005), para. 2.15 (http://www.rcplondon.ac.uk/pubs/books/docinsoc/docinsoc.pdf) Accessed 2008-09-06

26. Latimer, Elizabeth J., *Accidental patient. A doctor takes a different view*. Can Fam Physician. 2002 August; 48: 1295–1296. (http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=2214087&blobtype=pdf) Accessed 2008-09-06. James T.C, *The Patient-Physician Relationship: Covenant or Contract?* Mayo Clin Proc. 1996;71:917-918 (http://www.mayoclinicproceedings.com/inside.asp?AID=3655&UID=) Accessed 2008-09-07

27. Honderich, Ted (Ed.) *The Oxford Companion to Philosophy* (2nd Ed.) Oxford: Oxford University Press, 2005. p. 174

28. Ontario Human Rights Commission, *The Duty to Accommodate.* (http://www.ohrc.on.ca/en/resources/Policies/PolicyDisAccom2?page=PolicyDisAccom2-THE.html#Heading165) Accessed 2008-09-07

29. Cook RJ, Dickens BM, "In Response". J.Obstet Gyanecol Can, February, 2004; 26(2)112.

30. *McInerney v. MacDonald* (1992), 93 Dominion Law Reports (4th) 415 (Supreme Court of Canada)

31. Recalling an earlier case (*Canson Enterprises Ltd. v. Boughton & Co.* [1991] 3 S.C.R. 534),

32. Quoting LeBel, J. in *Henderson v. Johnston*, [1956] O.R. 789 at p. 799.

33. For an analysis of subsequent arguments made by Cook and Dickens on this point, see Murphy, Sean, *Postscript for the Journal of Obstetrics and Gynaecology Canada: Morgentaler vs. Professors Cook and Dickens*. (http://www.consciencelaws.org\Examining-Conscience-Legal\Legal30.html)

34. Lee, Jenny, "Official slams 'sex selection' blood test: Gender of fetus can be seen five weeks into pregnancy." *Vancouver Sun*, 13 August, 2005. (http://www.canada.com/vancouver/vancouversun/news/story.html?id=1735ec8d-56cc-4510-89e8-c62c480e97b6) Accessed 2005-10-10

35. Ramsay, Sarah, "Controversy over UK surgeon who amputated healthy limbs." *The Lancet*, Volume 355, Number 9202, 05 February 2000. Dr. Smith waived his fee and the patients paid for the surgery. (http://www.thelancet.com) Accessed 2001-10-04

36. Gawande, Atul, *When law and ethics collide - Why physicians participate in executions*. N Engl J Med 354;12 23 March, 2006, 1221-1229 (http://content.nejm.org/cgi/content/full/354/12/1221?query=TOC) Accessed 2008-09-08

37. American Medical Association Policy E-2.06: Capital Punishment (June, 1998) (http://www0.ama-assn.org/apps/pf_new/pf_online?f_n=resultLink&doc=policyfiles/HnE/E-2.06.HTM&s_t=execution&catg=AMA/HnE&catg=AMA/BnGnC&catg=AMA/DIR&&nth=1&&st_p=0&nth=6&) Accessed 2008-09-06

38. Gawande, Atul, *When law and ethics collide - Why physicians participate in executions*. N Engl J Med 354;12 23 March, 2006, 1221-1229 (http://content.nejm.org/cgi/content/full/354/12/1221?query=TOC) Accessed 2008-09-08

39. Curfman, Gregory D., Morrissey, Stephen, and Drazen, Jeffrey M., *Physicians and Execution*. N Engl J Med 358;4 (http://content.nejm.org/cgi/content/full/NEJMe0800032) Accessed 2008-09-08

40. *Physicians and the Ontario Human Rights Code*, p. 4 (http://www.cpso.on.ca/Policies/consultation/HumanRightsDRAFT_08.pdf) Accessed 2008-09-11

41. Zuliani, Preson, "Doctors do not have to violate beliefs." *Ottawa Citizen*, 23 August, 2008 Responding to Warren, David, "Refusing to do harm." *Ottawa Citizen*, 20 August 2008.

(http://www.canada.com/ottawacitizen/news/letters/story.html?id=16631e26-c448-4694-8168-ec45d3bbdd63) Accessed 2008-09-01. Further: "We do not expect physicians to provide services that are contrary to their moral or religious beliefs." E-mail from the College of Physicians and Surgeons of Ontario, 20 August 2008

42. *Physicians and the Ontario Human Rights Code*, p. 6-7 (http://www.cpso.on.ca/Policies/consultation/HumanRightsDRAFT_08.pdf) Accessed 2008-09-11

43. *Physicians and the Ontario Human Rights Code*, p. 5, note 5. (http://www.cpso.on.ca/Policies/consultation/HumanRightsDRAFT_08.pdf) Accessed 2008-09-11

44. American College of Obstetricians and Gynecologists, *The limits of conscientious refusal in reproductive medicine.* ACOG Committee Opinion No. 385. Obstet Gynecol 2007; 110: 1203-8 (http://www.acog.org/from_home/publications/ethics/co385.pdf) Accessed 2008-09-11

45. Alter, Jonathon, "Time to Think About Torture." *Newsweek*, 5 November, 2001, p. 45.

46. *Maher's Story*. (http://www.maherarar.ca/mahers%20story.php) Accessed 2008-09-08

47. Commission of Inquiry into the Actions of Canadian Officials in Relation to Maher Arar, *Report of the Events Relating to Maher Arar: Analysis and Recommendations*. (hereinafter, "*Arar Inquiry: Analysis and Recommendations*") p. 9 (http://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/maher_arar/07-09-13/www.ararcommission.ca/eng/AR_English.pdf) Accessed 2008-09-08

48. *Arar Inquiry: Analysis and Recommendations,* p. 35-36 (http://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/maher_arar/07-09-13/www.ararcommission.ca/eng/AR_English.pdf) Accessed 2008-09-08

49. *Deputy Prime Minister Issues Terms of Reference for the Public Inquiry into the Maher Arar Affair.* (http://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/maher_arar/07-09-13/www.ararcommission.ca/eng/Terms_of_Reference.pdf) Accessed 2008-09-08

50. Re: briefing note for RCMP Commissioner Zaccardelli: "Assistant Commissioner Proulx states [in the note] that the RCMP can be considered complicit in Mr. El Maati's detention in Syria. However, Mr. Proulx testified that it was the media and public who would consider the RCMP's actions to be complicit. He did not personally believe that the RCMP was complicit, nor was he referring to complicity in the criminal sense." Commission of Inquiry into the Actions of Canadian Officials in Relation to Maher Arar, *Report of the Events Relating to Maher Arar: Factual Background,* Vol. 1, (hereinafter "*Arar Inquiry: Vol. I*") p. 64 (http://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/maher_arar/07-09-13/www.ararcom

mission.ca/eng/Vol_I_English.pdf) Accessed 2008-09-08.

51. "The Ambassador did not consider that seeking the fruits of the Syrian interrogation made Canada complicit in obtaining information that might have been the product of torture. He reasoned that he did not ask the Syrians to continue interrogating Mr. Arar so that Canada could obtain information. Furthermore, the Ambassador did not have any evidence that Mr. Arar was being tortured or held incommunicado. *Arar Inquiry: Vol. I*, p. 271 (http://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/maher_arar/07-09-13/www.ararcommission.ca/eng/Vol_I_English.pdf) Accessed 2008-09-08.

52. "Superintendent Killam was aware that Secretary Powell had given Minister Graham the clear impression that the RCMP was complicit in Mr. Arar's deportation. However, Superintendent Killam testified that, even without making further inquiries in response to the media reports, he was able to exclude the possibility that the allegation of complicity might be true, because the allegation was inconsistent with the RCMP position."*Arar Inquiry: Vol. I*, p. 299 (http://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/maher_arar/07-09-13/www.ararcommission.ca/eng/Vol_I_English.pdf) Accessed 2008-09-08.

53. "Mr. Solomon prepared a draft memorandum for the Minister . . .which dealt with the upcoming CSIS trip to Syria and stated . . . "there are concerns as to whether a visit to Arar by Canadian intelligence officials may make Canada appear complicit in his detention and possible poor treatment by Syrian authorities." *Arar Inquiry: Vol. I*, p. 309 (http://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/maher_arar/07-09-13/www.ararcommission.ca/eng/Vol_I_English.pdf) Accessed 2008-09-08.

"Mr. Livermore testified that the original statement about the reliability of the confession and the possible complicity by Canada if CSIS was to meet with Mr. Arar was "very much on the speculative side" and "it was anticipating something that we later ironed out with CSIS, namely that they would not seek access to Mr. Arar."
Arar Inquiry: Vol. I, p. 310
(http://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/maher_arar/07-09-13/www.ararcommission.ca/eng/Vol_I_English.pdf) Accessed 2008-09-08

54. ". . . the intervenors suggest that the circumstances under which these individuals ended up in Syrian detention raise troubling questions about whether Canadian officials were complicit in their detention. The evidence of what happened to them could possibly show a pattern of misconduct by Canadian officials." 770 Commission of Inquiry into the Actions of Canadian Officials in Relation to Maher Arar, *Report of the Events Relating to Maher Arar: Factual Background,* Vol. II, p. 770
(http://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/maher_arar/07-09-13/www.ararcommission.ca/eng/Vol_II_English.pdf) Accessed 2008-09-08

55. "Canadian officials did not participate or acquiesce in the American decisions to detain Mr. Arar and remove him to Syria. I have thoroughly reviewed all of the evidence relating to events both before and during Mr. Arar's detention in New York, and there is no evidence that any Canadian authorities — the RCMP, CSIS or others — were complicit in those decisions." *Arar Inquiry: Analysis and Recommendations,* p. 29 (http://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/maher_arar/07-09-13/www.ararcommission.ca/eng/AR_English.pdf) Accessed 2008-09-08

"Although decisions to interact must be made on a case-by-case basis, they should be made in a way that is politically accountable, and interactions should be strictly controlled to guard against Canadian complicity in human rights abuses or a perception that Canada condones such abuses." *Arar Inquiry: Analysis and Recommendations*, p. 35 (http://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/maher_arar/07-09-13/www.ararcommission.ca/eng/AR_English.pdf) Accessed 2008-09-08

"If it is determined that there is a credible risk that the Canadian interactions would render Canada complicit in torture or create the perception that Canada condones the use of torture, then a decision should be made that no interaction is to take place." *Arar Inquiry: Analysis and Recommendations*, p. 199 (http://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/maher_arar/07-09-13/www.ararcommission.ca/eng/AR_English.pdf) Accessed 2008-09-08

"Even if one were to accept that Canadian officials were somehow complicit in those arrests, that would not change my conclusion, based on the evidence at the Inquiry, that Canadian officials did not participate or acquiesce in the American decision to send Mr. Arar to Syria from the United States." *Arar Inquiry: Analysis and Recommendations,* p. 271 (http://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/maher_arar/07-09-13/www.ararcommission.ca/eng/AR_English.pdf) Accessed 2008-09-08

"Information should never be provided to a foreign country where there is a credible risk that it will cause or contribute to the use of torture. Policies should include specific directions aimed at eliminating any possible Canadian complicity in torture, avoiding the risk of other human rights abuses and ensuring accountability." *Arar Inquiry: Analysis and Recommendations*, p. 345 (http://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/maher_arar/07-09-13/www.ararcommission.ca/eng/AR_English.pdf) Accessed 2008-09-08

"Clearly, the prohibition against torture in the Convention against Torture is absolute. Canada should not inflict torture, nor should it be complicit in the infliction of torture by others." *Arar Inquiry: Analysis and Recommendations,* p. 346 (http://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/maher_arar/07-09-13/www.ararcommission.ca/eng/AR_English.pdf) Accessed 2008-09-08

56. Smith, Graeme, "From Canadian custody into cruel hands." *Globe and Mail*, 23 April, 2007 (http://www.theglobeandmail.com/servlet/story/RTGAM.20070423.wdetainee23/BNStory/Afghanistan/) Accessed 2008-09-07

57. Editorial, "The truth Canada did not wish to see." *Globe and Mail*, 2 April, 2007. (http://www.globeauto.com/servlet/story/RTGAM.20070423.weafghan23/BNStory/specialComment/) Accessed 2008-09-08

58. "We will have to repent in this generation, not merely for the hateful words and actions of the bad people, but for the appalling silence of the good people."King, Martin Luther, *Letter from Birmingham Jail*, 16 April, 1963. (http://www.nobelprizes.com/nobel/peace/MLK-jail.html) Accessed 2005-08-02
"Non-cooperation with evil is as much a duty as is cooperation with good."Gandhi, Mahatma, *Statement before Mr. C. N. Broomfield, I. C. S., District and Sessions Judge*. Ahmedabad, 18 March, 1922. (http://www.mahatma.com/php/showNews.php?newsid=3&linkid=12) Accessed 2005-08-02

59. Editorial, "How complicit are doctors in the abuse of detainees?" *The Lancet*, Vol 364, August 21, 2004, p. 725-729

60. Miles, Steven H., "Abu Ghraib: its legacy for military medicine." *The Lancet*, Vol 364, August 21, 2004, p. 725-729; Lifton, Robert Jay, *Doctors and Torture.* N Engl J Med 351;5

61. American Medical Association Policy E-2.06: Capital Punishment http://www0.ama-assn.org/apps/pf_new/pf_online?f_n=resultLink&doc=policyfiles/HnE/E-2.06.HTM&s_t=execution&catg=AMA/HnE&catg=AMA/BnGnC&catg=AMA/DIR&&nth=1&&st_p=0&nth=6& (Accessed 2008-09-08)

62. American Medical Association Policy E.2.067: Torture. (http://www0.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/E-2.067.HTM&&s_t=&st_p=&nth=1&prev_pol=policyfiles/HnE/E-1.02.HTM&nxt_pol=policyfiles/HnE/E-2.01.HTM&) Accessed 2008-09-08

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