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# Submission to the Alberta College of Pharmacists
## Re: *Draft Code of Ethics*
**27 February, 2009**

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## Abstract

The *Draft Code of Ethics* does not address the situation of a pharmacist who, for reasons of conscience, refuses to fill a prescription for assisted suicide, euthanasia or post-coital interception. Further, it fails to define key terms, thus complicating its application in such a case.

The failure to define or limit key terms strongly suggests that pharmacists will be expected to enhance access to assisted suicide or euthanasia, even if they object to the procedures for reasons of conscience. At the least, a limitless obligation to "enhance access" provides limitless opportunities to prosecute objectors for professional misconduct.

This is particularly troubling because references to accommodation of freedom of conscience in the current *Code* have been removed from the *Draft Code*. It is not unreasonable to believe that deletion of reference to accommodation of freedom of conscience and the construction of the *Draft Code* are intended to force objecting pharmacists to enhance access to euthanasia, assisted suicide, post-coital interception, etc., and to compel them to assist the patient to obtain such services in a time frame acceptable to the patient.

To impose this requirement would effectively close the profession of pharmacy to anyone who finds such conduct morally unacceptable. It would present current members who would refuse to facilitate assisted suicide, euthanasia or post-coital interception with the choice of compromising their personal integrity or leaving the profession.

Arguments commonly advanced to support the notion that pharmacists should be forced to refer services to which they object for reasons of conscience are faulty or inadequate, in that they fail to fully address the issue of complicity in wrongdoing and the nature of the human person.

A long philosophical tradition, stretching from at least Immanuel Kant to *R. vs. Morgentaler* and beyond, insists that the nature of the human person is such that no one should be exploited by another by being reduced to the status of a tool or thing: that it is reprehensible to use a human person for ends chosen by others. Within this tradition, self-sacrifice 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: servitude, not service.

In the tradition of Kant, C.S. Lewis, Martin Luther King, Cyril Joad and Karol Wojtyla, and following Madame Justice Wilson in *R. vs. Morgentaler*, to demand that pharmacists 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."

A pharmacist's conscientious refusal to refer patients or assist them in obtaining euthanasia, assisted suicide, post-coital interception, etc. should not constitute professional misconduct. The College of Pharmacists of Alberta should not demand that a pharmacist actively facilitate a service or procedure he believes to be wrong. The *Draft Code of Ethics* should be revised to ensure that the document cannot be used for this purpose.

The College of Pharmacists of Alberta should include in its *Code of Ethics* a unambiguous policy of accommodating freedom of conscience through systemic cooperation that does not require active participation by an objecting pharmacist in conduct he believes to be wrong. The policy should not

apply to pharmacists who own, manage or are employed in pharmacies that clearly and publicly identify the scope of their practice to exclude certain services.

In any case, neither the ambiguous provisions of the *Draft Code* nor its silence on freedom of conscience can be construed to restrict the exercise of fundamental freedoms acknowledged and guaranteed by the *Canadian Charter of Rights and Freedoms*. While even fundamental rights and freedoms are not unlimited, the *Charter* requires that their limitation by state authorities (like the College of Pharmacists of Alberta) be "demonstrably justified" and be "prescribed by law." The *Draft Code* attempts nothing by way of demonstration, and it would strain credulity to argue that mere silence and ambiguity constitute a valid legal prescription for the suppression of freedom of conscience.

# I. Introduction

I.1. According to the Alberta College of Pharmacists, the *Draft Code of Ethics* is the product of "extensive review and deliberation of codes from other pharmacy organizations, health professions, and other industries around the world."[1] That being the case, it is remarkable that the *Draft* does not address the issue of freedom of conscience for pharmacists, since a review of readily available English language documents from pharmacy organizations demonstrates that this is of considerable interest within the profession. Moreover, recent and ongoing controversies in Canada and elsewhere indicate that freedom of conscience in health care is an issue of increasing importance.[2]

I.2. This submission addresses only those parts of the *Draft Code of Ethics* that could be applied to restrict or suppress the exercise of freedom of conscience of pharmacists in Alberta. The principal concerns arise in Part V and Part VIII of the *Code*.

# II. The context

II.1 Fifteen years ago the Canadian Pharmacists' Association (CPhA) told the Canadian Senate that objecting pharmacists, physicians and nurses should not have to"take part" or " participate" in euthanasia or assisted suicide. However, the Association added that their professional duty would oblige them to refer patients for the procedures if they were legal.[3] The Association saw no reason to revisit this claim in a review of the issue in 2000.[4]

II.2 In speaking for other professions the Association exceeded its mandate, but other Canadian pharmacy regulators appear to support its assertion concerning a purported ethical responsibility to ensure delivery of lethal drugs for euthanasia or assisted suicide. The National Association of Pharmacy Regulatory Authorities (NAPRA) claims that "objecting pharmacists have a responsibility to participate" in systems designed to deliver "pharmacy products and services" - like "prescribed drugs for emergency contraception and euthanasia."[5]

II.3 The NAPRA statement, including its explicit reference to euthanasia, has been adopted by the New Brunswick Pharmaceutical Society[6] and the Prince Edward Island Pharmacy Board.[7] The Ethics Committee of the College of Pharmacists of British Columbia has gone further, foreseeing the need for pharmacist involvement in "voluntary or involuntary suicide, cloning, genetic manipulation, or even execution."[8] Notably, alone among regulatory authorities, the College of Pharmacists of British Columbia not only demands that objecting pharmacists refer for drugs needed for such controversial procedures, but insists that they dispense them if others cannot be found to do so.[9]

II.4 Since it appears that the Canadian pharmacy establishment explicitly equates filling prescriptions for the post-coital interception with providing lethal drugs for legal euthanasia, the present discussion will follow their approach. The *Draft Code* will be considered within the context of a demand that an objecting pharmacist dispense or facilitate provision of drugs for assisted suicide, euthanasia or post-coital interception.

# III. Part V (*Draft Code*)

III.1 The *Draft Code* states:

> **V. Respect each patient's right to healthcare**
>
> 1. Having accepted professional responsibility for a patient, continue to provide services until they are no longer required or wanted, until another suitable pharmacist or other regulated health professional has assumed responsibility for the patient, or until the patient has been given reasonable notice that I intend to terminate the relationship.
>
> 2. Where a patient has an emergency, take appropriate action to provide care and reduce risks to the patient and the public, taking into account my competence and other options for assistance or care available.
>
> 3. When unable to provide service, assist the patient to obtain appropriate services from another authorized provider within a time frame fitting the patient's needs.
>
> 4. Recognize my limitations, and when indicated, refer the patient to other health professionals whose expertise can address the patient's need.

III.2 Part V does not address the situation of a pharmacist who, for reasons of conscience, refuses to fill a prescription for assisted suicide, euthanasia or post-coital interception. Further, the failure to define several key terms in Part V (*Draft Code*) complicates its application in such a case.

III.4 **"Health care"** The application of Part V (*Draft Code*) hinges upon the definition of "health care." Those who object to assisted suicide/euthanasia do not consider it to be a form of health care, and would argue that Part V (*Draft Code*) cannot be interpreted to require involvement with it. Others assert that it is simply a natural extension of palliative care, so that a failure to assist someone to obtain euthanasia or assisted suicide would constitute professional misconduct. Similar disputes may arise with respect to post-coital interception.

III.5 **"Patient's right."** Whatever "health care" might mean, the *Draft Code* presumes that a patient has a "right" to it. However, those who object to assisted suicide, euthanasia or post-coital interception would deny that patients could have a "right" to something that (in their view) is objectively wrong. Beyond that, objectors would deny that patients have a "right" to demand the assistance of those who believe that assisted suicide, euthanasia, post-coital interception, etc. are morally unacceptable.

III.6 **"Emergency; risk."** The *Draft Code* does not clarify what constitutes an "emergency"

or counts as a "risk," nor does it acknowledge that "risk" is a highly subjective term. Post-coital interceptives are described even in professional literature as "emergency" drugs. However, statistics produced by the drug's supporters can be cited to reach a different conclusion. According to one estimate, 12,000 prescriptions were thought to have prevented about 700 births.[10] Doing the math, one finds that only about 6% of these women might have been pregnant: other favourable estimates range from 6.2% to 8%. If up to 94% of patients do not actually need a drug, it is difficult to understand how a request for it can be characterized as an "emergency." But, if it is considered an emergency, surely a prescription for lethal drugs to end suffering would also be considered an emergency, since the suffering is immediate and real, and the need for the drug not merely speculative. On the other hand, while acknowledging that a patient's distress or suffering demands a compassionate and ethical response, objectors would not characterize assisted suicide, euthanasia, post-coital interception, etc. as compassionate or ethical.

III.7 **"Unable to provide service."** The *Draft Code* does not distinguish between the case of a pharmacist who is professionally incompetent to provide service and one who is "unable" to do so because it would compromise his personal integrity.

III.8 **"Assist the patient; refer the patient."** Whether an inability results from professional limitations or conscientious objection, the obligation imposed here presumes that offering assistance or providing a referral does not involve the pharmacist in unethical or immoral conduct.

## IV. Part VIII (*Draft Code*)

IV.1 The *Draft Code* states:

> **VIII. Serve as an essential health resource**
>
> 1. Enhance access to pharmacist services and care.
>
> 2. During public emergencies, be accessible and make resources available to care for patients and to mitigate further risk.
>
> 3. Serve patients who seek my care unless limited by my competence or the lack of information or resources necessary to do so.

IV.2 In this case, the failure to define or limit key terms strongly suggests that pharmacists will be expected to enhance access to assisted suicide or euthanasia, even if they object to the procedures for reasons of conscience. At the least, a limitless obligation to "enhance access" provides limitless opportunities to prosecute objectors for professional misconduct.

IV.3 Like Part V, Part VIII of the *Draft Code* does not address the exercise of freedom of conscience by a pharmacist.

## V. Purpose and effect of the *Draft Code*

V.1 The present *Code of Ethics* discusses the accommodation of conscientious objection, and the present *Code* does *not* demand referral or impose duties on an objector to assist a patient in obtaining euthanasia, assisted suicide, post-coital interception, etc. Hence, it is not unreasonable to believe that deletion of reference to accommodation of freedom of conscience and the construction of the *Draft Code* Parts V and VIII are intended to force objecting pharmacists to enhance access to euthanasia, assisted suicide, post-coital interception, etc. (Part VIII, *Draft Code*), and to compel them to assist the patient to obtain such services in a time frame acceptable to the patient (Part V *Draft Code*).

V.2 To impose this requirement would effectively close the profession of pharmacy to anyone who finds such conduct morally unacceptable. It would present current members who would refuse to facilitate assisted suicide, euthanasia or post-coital interception with the choice of compromising their personal integrity or leaving the profession.

V.3 However, neither the ambiguous provisions of the *Draft Code* nor its silence on freedom of conscience can be construed to restrict the exercise of fundamental freedoms acknowledged and guaranteed by the *Canadian Charter of Rights and Freedoms.* While even fundamental rights and freedoms are not unlimited, the *Charter* requires that their limitation by state authorities (like the College of Pharmacists of Alberta) be "demonstrably justified" and be "prescribed by law." The *Draft Code* attempts nothing by way of demonstration, and it would strain credulity to argue that mere silence and ambiguity constitute a valid legal prescription for the suppression of freedom of conscience.

## VI. The issues

VI.1 **Issue No. 1:** Should the College of Pharmacists of Alberta, through its revised *Code of Ethics* or ancillary guidelines, demand that a pharmacist actively facilitate a service or procedure he believes to be wrong, such as euthanasia, assisted suicide or post-coital interception? Put another way, should a pharmacist's conscientious refusal to refer patients or assist them in obtaining euthanasia, assisted suicide, post-coital interception, etc. constitute professional misconduct?

VI.2 **Issue No. 2:** Should the College of Pharmacists of Alberta include in its *Code of Ethics* provisions that honour and fully accommodate the exercise of freedom of conscience by pharmacists? If so, how can this be done?

## VII. Responding to the issues

VII.1 A number of claims are commonly made to support the view that pharmacists should be forced to provide or facilitate services even if they are contrary to their conscientious convictions. Responses to these claims are provided in Parts VIII to XVII.

VII.2 A pharmacist who refuses to facilitate what he believes to be wrong is motivated by a desire to avoid complicity in wrongdoing. Part XVIII addresses this problem and demonstrates that pharmacists who refuse to refer or otherwise actively facilitate assisted

suicide or post-coital interception are, in this respect, acting no differently than colleagues and professional medical organizations.

VII.3 Part XIX points out that beliefs about the nature of the human person lie at the root of any attempt to set limits to freedom of conscience. It is necessary to engage at this level in order to develop an adequate response to the issue. With this in mind, Part XX offers a description of the human person that is relevant to the present discussion.

## VIII. The new 'rights' language

VIII.1 The *Draft Code of Ethics* uses 'rights' language, but not the 'rights' language of the 1960's, when abortion law reform was proposed. When the National Association for the Repeal of Abortion Laws opened its doors in the United States in 1969, the claim that abortion was a 'right' was directed only at the repeal of laws against the procedure, so that women would be free to seek abortions and, as the *Globe and Mail* put it, so that physicians would be able "to perform their duties according to their conscience and their calling."[11] At that time, Canadians were repeatedly assured that "nobody would be forcing abortion procedures on anyone else."[12]

VIII.2 Current rights claims of the kind made in the *Draft Code of Ethics* must be distinguished from this early period. Contrary to early activist promises, current rights claims are meant to force health care workers and institutions to provide or at least facilitate abortion, contraception, artificial reproduction, euthanasia, assisted suicide, post-coital interception, etc., all of which remain morally controversial. A major 'mover and shaker' in this project is the Center for Reproductive Rights,[13] an American advocacy group described in internal documents as an organization "comprised largely of economically advantaged white women."[14] The Center's agenda includes, among other things, the legal enforcement of what it describes as inalienable sexual rights.[15]

VIII.3 The Center's ultimate goal is to establish what it calls "hard norms" - treaty-based international laws[16] - that recognize access to abortion as a fundamental human right.[17] It plans to develop a "culture of enforcement" that will compel governments to respect this 'right'[18] and enforce it against third parties - pharmacists and other health care workers.[19] Even as it works toward this end, it is cultivating "soft norms" in the form of statements by international, regional, and intergovernmental bodies.[20] The attempt by Canadian Professor Bernard Dickens to turn conscientious objection into a crime against humanity illustrates how this can be done (See Appendix "D").

VIII.4 Should the Center be successful it acknowledges that it will have effected "profound social change."[21] It will also have destroyed almost all hope of respect for freedom of conscience in health care. For if refusal to facilitate abortion or other morally controversial procedures were to become, in law, an offence like racial discrimination, conscientious objection would be prohibited, just as racial discrimination is now prohibited.[22]

VIII.5 Special attention should be paid to key features of the Center's strategy, notably its focus

on securing a following among social, political, academic and professional elites.[23] The medical profession is one of the "key sectors" that figures prominently in this strategy;[24] so, too, does the legal community.[25] The approach is summed up in the Center's question, "How can we influence the people who influence the legal landscape around reproductive rights?"[26]

**The courtship of the elites**

VIII.6 The courtship of the elites occurs in academic, professional and bureaucratic communities, largely out of the public eye, thus avoiding what one memo calls "nasty opposition."[27] This is especially important if professionals and academics may be more sympathetic to the CRR agenda than ordinary people.[28] An internal memo values the "stealth quality to the work," through which the Center achieves "incremental recognition of values without a huge amount of scrutiny from the opposition."[29]

VIII.7 Despite an admission that a 'right' to abortion cannot be found in existing international instruments, the Center and its allies argue that it is implicit in other internationally recognized rights, such as the right to life, liberty and security, and rights to privacy and freedom from discrimination.[30] They hope to secure "hard norms" by having binding treaties or protocols interpreted in this way,[31] in the expectation that other adjudicators will find such rulings persuasive.[32]

VIII.8 The Center's cultivation of "soft norms" is a very similar process, but takes place not only in adjudicative bodies but in international conferences that produce non-binding but persuasive opinions.[33] As "soft norms" quietly accumulate, it becomes easier for the Center to claim that they represent an emerging consensus that should be codified in binding "hard norms."[34] The development of "soft norms" is of great moment for freedom of conscience in health care because they will likely have the most immediate impact on conscientious objectors.

VIII.9 Professional associations, educational and regulatory authorities and influential individuals can support the CRR's work by developing "soft norms" closer to home - like the *Draft Code of Ethics*. Colleagues or academics will argue that, at a minimum, referral for euthanasia, assisted suicide, post-coital interception, etc. is an expected or even legally required standard of care. Ethicists and professional journals not infrequently express opinions hostile to freedom of conscience, as do individual health care practitioners.[35] Among Canadian pharmacy regulators, one even encounters unsubstantiated claims and dubious or false statements about the actions or ethical obligations of conscientious objectors.[36]

VIII.10 If such claims are repeated often enough by influential persons - like College councillors, law professors, or former deans of law faculties - even if the claims are false or exaggerated - they gradually assume the character of a new norm. Ideally, this new norm will be implemented by the disciplinary apparatus of self-governing professions as a standard of care in documents like the present *Draft Code of Ethics.*

VIII.11 If an objecting pharmacist is charged for misconduct, it is quite likely that members of the

professional tribunal hearing the case will have already been convinced of the new rights-based standard of care, or will have been prepared to accept the claims of experts called to testify to it. Should they ratify it by ruling against the objector, they will create a new "soft norm" that the CRR and its allies can use elsewhere in their continuing quest for international "hard norms." It might added that the establishment or confirmation of even a "soft" norm would be oppressive in the jurisdiction bound by the decision.

VIII.12 Parallel litigation can also be initiated in quasi-judicial forums, like human rights tribunals, which, in Canada, afford complainants the advantage of cost-free, aggressive inquisitions with extraordinary powers.

VIII.13 Those concerned about freedom of conscience and religion should take note of the polemics and tendentious reasoning involved in this project (see Appendix "D"). In particular, even if claims of 'rights' to abortion or contraception can be grounded in rights purportedly implicit in international instruments, it does not follow that they override the repeated explicit international recognition and support for freedom of conscience and religion.

## IX. Belief: religious and otherwise

**Claim**

IX.1 It has become an article of faith with many, especially many holding public positions, that faith has no place in public and professional life. A convenient example is found in the dogmatic assertion by the Ontario Human Rights Commission (OHRC) of its belief that physicians "must essentially 'check their personal views at the door' in providing medical care."[37] The same kind of claim has been made by some pharmacists.[38]

IX.2 The blatant 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 euthanasia, assisted suicide or post-coital interception . 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.[39]

**Response**

IX.3 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.

IX.4 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.

IX.5 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.[40] 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."

IX.6 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.[41] 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.[42]

IX.7 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.[43] Foote, a Presbyterian minister, and Scrimger, "an atheist by outward appearances,"[44] both acted in accordance with their personal beliefs; both were awarded the Victoria Cross.

IX.8 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.

IX.9 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.

IX.10 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.[45]

IX.11 The implicit faith to which Benson refers is exemplified in a statement by the Ethics Committee of the American College of Obstetrics and Gynecology (ACOG). "Although respect for conscience is a value," states the Committee, "it is only a prima facie value, which means it can and should be overridden in the interest of other moral obligations that outweigh it in a given circumstance."[46] The Committee's assertions about the relative importance of freedom of conscience and about what counts as overriding moral obligations are based on faith-assumptions shared by Committee members. It is implied that all reasonable people will accept those faith-assumptions, but, in fact, many reasonable people do not.

IX.12 The failure to acknowledge the faith-assumptions implicit in one's own position frequently leads to intolerance for opposing views, and it always makes sincere, respectful and progressive public discourse difficult. This is particularly true of discussion of freedom of conscience in health care.

## X. Establishment consensus and the ethics of the profession

**Claim**

X.1 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 or, perhaps, a consensus reflecting "the ethics of the profession."[47]

**Response**

X.2 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.[48]

X.3 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 and the College Council are not less so. Disputes about what counts as 'private' or 'public' thus end in a stalemate.

X.4 The question does not turn on privacy, but truth. If the College Council possess a moral vision that is superior to that of objecting pharmacists, 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 pharmacists, 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.

## XI. Social contract

**Claim**

XI.1 One frequently encounters references to a "social contract" between health care professions and society, especially in discussions about the meaning of "professionalism."[49] 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.[50] Others have argued that the concept of a social "covenant" provides a better framework for ethical reflection.[51] In any case, pharmacists fond of contract theory have applied it to the exercise of freedom of conscience by their colleagues.

> Pharmacy, like all professions, has been granted a monopoly right to provide services to the public. And professions have an obligation to provide recognized services to the public, because the public has no alternative. For this, professions receive prestige and financial reward.[52]
>
> Pharmacists have been authorized by our society to be the sole distributors of prescription medications to Canadian citizens. . . In exchange, society expects the pharmacist to give reasonable service in the provision of licensed medications to the general public. . . Should pharmacists stand in the way of a publicly approved treatment, the public will have no choice but to remove the responsibility for the provision of the treatment from pharmacists. Would pharmacists benefit by having the responsibility for handling Preven given to the school or public health nurse?[53]

**Response**

XI.2 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.[54]

XI.3 Theories of 'contract' and 'covenant' 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.

XI.4 Notions of monopoly and contract do not provide ethical principles adequate for the discussion of freedom of conscience in pharmacy. The exercise of fundamental freedoms should not be determined or limited by economic and professional self-interest.

## XII. Social contract and socialized medicine

**Claim**

XII.1 Socialized medicine in Canada 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. The President of the College of Physicians and Surgeons of Ontario offered the following comment during a recent controversy about freedom of conscience in medicine:

> In our society, we all pay taxes for this medical system to receive services . . . And if a citizen or taxpayer goes to access those services and they are blocked from receiving legitimate services by a physician, we don't feel that's acceptable.[55]

XII.2 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. Given the nature and complexity of health care, however, much of the content of the virtual contract must remain undefined, and conflicts will arise. The problem becomes especially acute when legal but morally controversial procedures are the focus of the conflict.

XII.3 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 Pharmacists and human rights commissions.

**Response**

XII.4 However, even if one posits the existence of a contract, such an expectation ignores three key points.

XII.5 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, health care professions did not agree that their 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.

XII.6 Second: when abortion was legalized in 1969, repeated assurances were given that health care workers would not be forced to participate in the procedure.[56] In fact, the government of the day rejected a protection of conscience amendment to the bill on the grounds that it was not necessary.[57] Subsequent coercion experienced by health care workers and present attempts to force objectors to become involved with the procedure suggest that the promises made when abortion was legalized were less than sincere. Continuing the analogy of contract for the purpose of the discussion, agreements obtained by fraud are not binding.

XII.7 Third: even if pharmacists 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.

XII.8 The standard is that they must be accommodated to the point of undue hardship.[58] 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, pharmacists are also entitled to demand that the state ensure that their workplace environments are not poisoned against them by state institutions - like human rights commissions.

## XIII. Fiduciary duty

**Claim**

XIII.1 Moving from imaginary devices to legal argument, some writers assert that the fiduciary duties of health care professionals requires them to subordinate their conscientious convictions to those of their patients. Professors R.J. Cook and B.M. Dickens have made this claim,[59] citing the Supreme Court of Canada case, *McInerney v. MacDonald*.[60]

**Response**

XIII.2 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."[61] In other words, that the relationship between a health care professional and patient 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 a pharmacist.

XIII.3 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."[62] 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 pharmacists have such a duty.

## XIV. "Negligence close to abandonment"

**Claim**

XIV.1 Professors Cook and Dickens claim that the Alberta case of *Zimmer vs. Ringrose* is authority for the proposition that failure to refer for abortion approximates patient abandonment:

> [T]he "failure to provide adequate follow-up care" . . . consisted in the defendant physician's *failure to refer* his patient to another physician who could facilitate *the abortion she wanted*. The Court found that this failure was negligence close to abandonment . . . a wilful failure or refusal to refer . . . may justify an award of aggravated or exemplary damages. (emphasis added)[63]

Dickens cites *Zimmer* to the same effect in Canadian Health Law and Policy (2nd Ed.).[64]

**Response**

XIV.2 Though they refer elsewhere to "historical background jurisprudence" to support their understanding of the case, Cook and Dickens cited none. Moreover, the rulings followed and referred to by the Court of Appeal in *Zimmer* were about informed consent, not freedom of conscience.[65]

XIV.3 The only relevant "historical background jurisprudence" appears to be the earlier decision of the trial court in *Zimmer*, and this does not assist Cook and Dickens. The failure to provide adequate follow-up care had two elements - not one, as the authors imply. The first was the physician's failure "to follow his patient's progress by conducting regular medical examinations during the summer of 1973," an omission the trial judge found to be "inconsistent with good clinical practice" that contributed to the fact that her pregnancy was not detected earlier.[66]

XIV.4 The second element was not the "failure to refer" alleged by the authors; the physician did *not* refuse or fail to refer the patient for abortion. In fact, she understood from him that she should have an abortion as soon as possible.[67] Nor was the issue a refusal to refer "for the abortion *she* wanted" (emphasis added). It was, rather, his decision to refer the woman for an abortion in Seattle rather than Edmonton. He testified that he advised her to get an abortion in Seattle to avoid the delay involved in Edmonton, where, he said, it was then necessary to obtain a psychiatric report to justify the procedure. He also believed that the suction procedure used in Seattle would be less traumatic for the patient than the saline method employed in Edmonton.[68]

XIV.5 The key fact noticed by the Court in ruling against the physician was that he "made no attempt to secure an abortion for the respondent in a hospital in Edmonton" (by, for example, referring her to a colleague) and thus failed "to display the degree of care and concern dictated by the situation."[69]

XIV.6 The trial judge had noted the same thing, and was sceptical of the physician's evidence:

> I cannot find that the [physician] made any effort to get medical and hospital care in Edmonton for the abortion and in this respect his attitude appears to have been casual. He failed to do everything he could for the welfare of his patient, and I cannot accept as true his statement to Mrs. Zimmer that she would have to be declared mentally unsound before she could be admitted to hospital in Edmonton for an abortion . . . At least. . . he should have consulted another gynaecologist in Edmonton before suggesting that she go to Seattle.[70]

XIV.7 In other words, having told the patient that she should get an abortion as soon as possible, he was expected to at least attempt to secure an abortion for the patient in Edmonton at the earliest opportunity. Rather than making such an attempt, he based his advice to go to Seattle on an untested assumption about the availability of the procedure. The patient took his advice and went to Seattle, but she was found to be too far along for suction. A saline abortion was performed, and "Mrs. Zimmer was left to abort in a hotel room, unattended by medical personnel." Thus,

> [T]he respondent underwent a more painful and emotionally distressing experience than was necessary in the circumstances. Her suffering would have been substantially reduced if the appellant had discharged his duty by arranging hospital care.[71]

XIV.8 Concluding the review of *Zimmer*, one can argue that a physician or pharmacist who urgently recommends a drug or procedure to a patient has a duty to do all that he reasonably can to help the patient obtain it, but *Zimmer* does not speak to a case in which a physician or pharmacist, for reasons of conscience, refuses to recommend a drug or procedure at all.

# XV. Legality

**Claim**

XV.1 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 pharmacists.

**Response**

XV.2 If this were a valid argument, it ought to apply to all other legal procedures. It can be shown that this is not the case.

XV.3 **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.[72] This clearly indicates that the legality of a procedure is not reason enough to compel a health care worker to provide it.

XV.4 **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.[73] 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.

XV.5 **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."[74] 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,[75] and those who ignore the ban risk losing their licenses to practise.[76] In the face of a 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.[77]

## XVI. Balance

**Claim**

XVI.1 Referral is often explained as "striking a balance" between the interests of the pharmacist and those of the patient.

**Response**

XVI.2 In cases of conscientious objection their interests cannot be balanced because they are not commensurable; they concern fundamentally different goods. A patient wants a particular product or service, but the pharmacist wishes to avoid complicity in wrongdoing and live and work according to his conscientious convictions. With sufficient imagination and political will one may find a way to accommodate the interests of both, but to compel the pharmacist to do what he believes to be wrong does not achieve 'balance' but effects his subordination.

## XVII. Limits to expression

**Claim**

XVII.1 It is argued that there are limits to the exercise of freedom of conscience and religion, and that it is 'appropriate' to limit a pharmacist's freedom by requiring referral.

XVII.2 It has been suggested that this approach is justified, at least in the case of physicians, by *Personal Beliefs and Medical Practice*, a policy document produced by Britain's General Medical Council.[78] 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.[79]

XVII.3 Similarly, the Royal Pharmaceutical Society of Great Britain, states that objecting pharmacists must refer patients "for the service they require."[80]

**Response**

XVII.4 The CMA approved *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care*[81] is to be preferred to GMC documents on this issue.

XVII.5 Neither the GMC nor RPhSGB documents 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,[82] and the Joint Committee on Human Rights concluded that the demand was probably a violation of the *European Convention on Human Rights*.[83] The bill's sponsor, Lord Joffe, promised to delete the provision in his next draft of the bill.[84]

XVII.6 Consistent with the findings of the Joint Committee on Human Rights, the General Medical Council ruled late last year that a general practitioner who refused demands to refer patients for abortion and prescribe post-coital interceptives was not acting improperly.[85] It is by no means certain that the RPhSGB policy on referral would withstand a legal challenge.

XVII.7 Return to the notion that there are limits to the exercise of freedom of conscience and religion; that, as the Supreme Court put it, "the freedom to hold beliefs is broader than the freedom to act on them."[86] 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.[87]

But to *act* 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.[88]

XVII.8 Cromwell, the Supreme Court of Canada and the Ontario Human Rights Commission all agree that the freedom to act on beliefs is less extensive than the freedom to hold them. 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.

XVII.9 The statement that mandatory referral can be justified as a kind of limit to freedom amounts to this: that a pharmacist is free to refuse to actually perform a procedure that he believes is wrong, but can be compelled to do what some other person believes is a lesser wrong, or what some other person thinks is not "really" a wrong at all. In short, the pharmacist is to be compelled to practise according to the conscientious convictions of someone else, to serve ends chosen by someone else even if he finds them abhorrent. This is a form of servitude, not service.

## XVIII. The problem of complicity

XVIII.1 Most people seem willing to grant that a health care worker who has serious moral objections to a procedure should not be compelled to perform it or assist directly with it. However, many people find it more difficult to understand why some health care workers object to even indirect forms of involvement: why some would refuse to refer patients for procedures they believed to be wrong.

XVIII.2 For example, the Canadian Pharmacists' Association (CPhA) agrees that objecting pharmacists should not have to "take part" or " participate" in euthanasia or assisted suicide, but claims that they (and physicians and nurses as well) are ethically obliged to "refer" for the services where they are legal.[89] In this respect the CPhA seems to follow the reasoning of the ACOG Committee on Ethics. The Committee claims that refusing to refer is illogical. "[T]he logic of conscience," it states, "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."[90]

XVIII.3 It thus appears that the Canadian Pharmacy Association and ACOG Committee 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.

XVIII.4 Alternatively, the CPhA and ACOG 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.'

XVIII.5 In passing, it should be noted that, on either account, the position of the CPhA raises the issues discussed in Parts IX and X. Whether it asserts that referral or facilitation do not incur moral responsibility, or that the degree of moral responsibility incurred is so minimal as to be inconsequential, it is making a moral judgement and demanding that others adhere to it.

### Complicity in torture

XVIII.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,"[91] a practice known as "extraordinary rendition." The allies would then do what Americans would not, without compromising American values.

XVIII.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.[92] In Syria he was imprisoned for almost a year, "interrogated, tortured and held in degrading and inhumane conditions."[93]

XVIII.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."[94] A commission of inquiry was appointed to investigate "the actions of Canadian officials" in the case.[95]

XVIII.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.

XVIII.10 Concern about Canadian complicity surfaces repeatedly in the report of the commission of inquiry: in briefing notes to the Commissioner of the RCMP,[96] in the testimony of the Canadian Ambassador to Syria,[97] in references to the possibility of RCMP complicity in his deportation,[98] about the perception of complicity if CSIS agents met Mr. Arar in Syria,[99] in the suggestion that evidence of complicity could show "a pattern of misconduct,"[100] and in the conclusions and recommendations of the report itself.[101]

XVIII.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.[102] "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."[103] 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 Gandhi.[104]

XVIII.12 Thus far, government officials. But the problem of complicity does not relate only to government officials. *The Lancet*, among others, has asked, "How complicit are doctors in the abuse of detainees?"[105] and other journal articles have explored the answer with some anxiety.[106]

XVIII.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, euthanasia and assisted suicide**

XVIII.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 involved in referral can have that effect. That is: if a pharmacist refers or otherwise helps a patient to obtain what he believes to be an immoral procedure, is he a culpable participant in the provision of it?

XVIII.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. It forbids physician "participation" in executions. [107] This is particularly relevant here because of the Canadian Pharmacy Association's position that referral for euthanasia or assisted suicide does not constitute participation in the procedures.

XVIII.16 The AMA 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.

XVIII.17 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.

XVIII.18 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.

XVIII.19 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."[108] 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.[109]

**Complicity and referral**

XVIII.20 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 have the duty to refer the state "in a timely manner" to other practitioners.[110] 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.

XVIII.21 It is reasonable to hold that the kind of action involved in referral 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 pharmacists 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.

XVIII.22 The point here, of course, is not that capital punishment or torture are morally equivalent to euthanasia, assisted suicide, post-coital interception, etc. 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.

**CMPA: referrals and complicity**

XVIII.23 In 2002 the College notified practitioners that it was the opinion of the Canadian Medical Protective Association (CMPA) that referral to non-regulated health care providers exposed physicians to civil liability "if medical problems arise during, or as a result of services provided by a non-regulated health care provider."

XVIII.24 The CMPA recommended that physicians "avoid all actions that could be construed as a patient referral to a non-regulated health care provider" - especially written referrals - and that physicians make clear to patients that it is their responsibility "to make all arrangements with the non-regulated health care provider." Further:

> If the patient requires something in writing. . . the note should clearly indicate . . . that the physician, though not objecting, is neither referring nor recommending the patient for the treatment.[111]

XVIII.25 The opinion of the CMPA was clearly based upon the premise that referral makes a physician complicit in what follows. The CMPA recommendations exactly parallel the position taken by pharmacists who refuse to refer patients for procedures or services the pharmacists believe to be wrong.

**Complicity and dirty hands**

XVIII.26 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, pharmacists, 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.

XVIII.27 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 motivated 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?

XVIII.28 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.*

XVIII.29 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'."[112] 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).[113]

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?

XVIII.30 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.

## XIX. The needs of the patient: anthropology counts

XIX.1 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 pharmacy or medicine.

XIX.2 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.[114]

XIX.3 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.

XIX.4 Bioethicists working from (a) would have little objection to the substitution of persistently unconscious human subjects for animals in experimental research.[115] Those who accept (b) would be more inclined to object.[116] Finally, bioethicists who do not believe in 'purpose' beyond filling an ecological niche would dismiss the whole discussion as wrong-headed.

XIX.5 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.

XIX.6 The same thing is true of disagreements about freedom of conscience for health care workers. Returning to the point made in XIX.1 to XIX.4, beliefs about the nature of the human person lie at the root of any attempt to set limits to this freedom. In fact, failure to engage at this level will probably frustrate more superficial efforts to resolve the conflict.

XIX.7 What follows is a plausible description of an aspect of the human person that is relevant to the present discussion. The threshold of plausibility ought to be sufficient, since the context for this discussion is a liberal democracy, in which there is an expectation that a plurality of more or less comprehensive world-views will be accommodated.

## XX. The human person

### The integrity of the human person

XX.1 The pharmacist, a unique some*one* who identifies himself as "I" and "me,"[117] 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."[118]

> [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.[119]

XX.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."[120]

XX.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."[121]

XX.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."[122]

> 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.[123]

XX.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.[124]

**The dignity and inviolability of the human person**

XX.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.[125]

XX.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."[126] 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."[127]

> 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.[128]

XX.8 Even as part of society, Maritain insisted, "the human person is something more than a part;"[129] he remains a whole, and must be treated as a whole.[130] 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.[131] 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."[132]

XX.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.[133]

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.[134]

XX.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.[135] Likewise, Martin Luther King condemned segregation as "morally wrong and awful" precisely because it relegated persons "to the status of things."[136]

XX.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.[137]

XX.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."[138]

**Human dignity and freedom of conscience**

XX.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."[139] 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.[140]

XX.14 "Everyone" includes every pharmacist. 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."[141]

XX.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'."[142]

## XXI. Summing up: mandatory referral or assistance

XXI.1 **Issue No. 1 reprise:** The primary issue raised by the *Draft Code of Ethics* is whether or not the College of Pharmacists of Alberta demand that a pharmacist actively facilitate a service or procedure he believes to be wrong, such as euthanasia, assisted suicide or post-coital interception. Put another way, should a pharmacist's conscientious refusal to refer to refer patients or assist them in obtaining euthanasia, assisted suicide, post-coital interception, etc. constitute professional misconduct?

XXI.2 Parts VIII to XVII demonstrate that arguments commonly advanced to support the notion that pharmacists should be forced to refer services to which they object for reasons of conscience are faulty or inadequate. Part XVIII and XIX suggest that any attempt to propose ethical guidelines for referral must fully address the issue of complicity in wrongdoing and the nature of the human person.

XXI.3 Part XX argues that a long philosophical tradition, stretching from at least Immanuel Kant to *R. vs. Morgentaler* and beyond, insists that the nature of the human person is such that no one should be exploited by another by being reduced to the status of a tool or thing: that it is reprehensible to use a human person for ends chosen by others. Within this tradition, self-sacrifice 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: once more, servitude, not service.

XXI.3 In the tradition of Kant, C.S. Lewis, Martin Luther King, Cyril Joad and Karol Wojtyla, and following Madame Justice Wilson in *R. vs. Morgentaler*, to demand that pharmacists 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."

XXI.4 **Issue No. 1: conclusion** A pharmacist's conscientious refusal to refer to refer patients or assist them in obtaining euthanasia, assisted suicide, post-coital interception, etc. should not constitute professional misconduct. The College of Pharmacists of Alberta should not demand that a pharmacist actively facilitate a service or procedure he believes to be wrong. The *Draft Code of Ethics* should be revised to ensure that the document cannot be used for this purpose.

## XXII. The need to explicitly address freedom of conscience

XXII.1 Of the 39 English language pharmacy associations or regulatory entities noted in Appendices "A" to "C," 29 have formally addressed the issue of freedom of conscience, either in codes of ethics or in practice guidelines, or both. In Canada, the subject has been considered by all of the English language pharmacy regulatory authorities, as well as NAPRA and the Canadian Pharmacists Association. This suggests that there is a need to include specific, unambiguous and ethically sound guidelines on the issue in the proposed *Code of Ethics*.

XXII.2 A second reason for including specific, unambiguous and ethically sound guidelines that protect freedom of conscience in the profession is provided by the continual efforts of powerful or influential individuals or groups to suppress freedom of conscience in health care. In the absence of such guidelines, they are likely to encourage harassment of objecting pharmacists, with a view to forcing them to participate in what they consider to be morally objectionable services, or forcing them out of the profession.

XXII.3 Ethically sound guidelines will balance respect for the personal integrity of the pharmacist and for his fundamental freedoms against the provision of pharmacy services to the patient, giving to each what is due in justice.

## XXIII. In search of consensus

XXIII.1 Not one of the 29 English language pharmacy associations or authorities noted in Appendices "A" to "C" that have addressed the issue of freedom of conscience prohibits conscientious objection. Only one - the College of Pharmacists of British Columbia - would require an objecting pharmacist to supply drugs for euthanasia, assisted suicide, post-coital interception, etc.. Only two (Arkansas and Georgia State Pharmacy Boards) impose no duties on an objector, perhaps reflecting state laws.

XXIII.2 Given the professional and regulatory responses summarized in Appendices "A", "B" and "C," it is impossible to argue that there is a genuine ethical consensus that objecting pharmacists should be forced to provide drugs for euthanasia, assisted suicide, or post-coital interception. Nor is it possible to argue that such a consensus exists on the issue of

referral. In this respect, it is noteworthy that regulators have sometimes see-sawed back and forth: Ontario is one case in point; the present *Draft Code of Ethics* for pharmacists in Alberta is another.

XXIII.3 Instead, the majority of responses surveyed repeatedly attempt to articulate what may be reasonably required of a conscientious objector, short of referral or some other kind of positive act. The range of responses is set out in Appendix "A." 20 of 29 entities with policies concerning freedom of conscience fall within one of two categories:

| | | |
|---|---|---|
| Systemic Cooperation | The objecting pharmacist is not required to directly assist in the delivery of a drug or service, but is to work cooperatively within a system that allows patients to access controversial drugs and services through other sources. | 13 |
| Personal Action or Systemic Cooperation | An objecting pharmacist may directly assist in the delivery of a drug or service by referral to a specific person or entity, or by some other act, OR work cooperatively within a system that allows patients to access controversial drugs and services through other sources. | 7 |

**Personal action or systemic cooperation**

XXIII.4 Referral requires a positive action by an objector to facilitate euthanasia, assisted suicide, post-coital interception, etc. So, too, does a policy like NAPRA's, which demands that an objector "pre-arrange access to an alternate source." Five Australian and two Canadian pharmacy authorities are described as requiring either personal action or systemic cooperation. A closer look at their responses is warranted.

XXIII.5 The 1998 *Code of Ethics* of the Pharmaceutical Society of Australia states that objecting pharmacists have a duty to ensure continuity of care, and, "when required, assist and refer clients to another pharmacist" for that purpose. Under what circumstances assistance and referral might be required is not considered.

XXIII.6 However, the issue of conscientious objection is discussed at length in a 2003 Society policy statement, *Ethical Issues in Declining to Supply*. At least four of Australia's state pharmacy boards adhere to standards set by the Pharmaceutical Society of Australia. It is reasonable to assume that they are also guided this statement. It does not insist upon referral or assistance, but advises that someone (unspecified) may have to "identify another reasonably available source for the required medicine or service" if conscientious objection results in "nonsupply of a product or service." It suggests that, "where a pharmacist's moral belief is likely to impact on the pharmacy services available to patients," pharmacists and their employers should agree upon strategies to accommodate objectors and patients, and steps should be taken by the owner or manager to inform patients of service limitations and alternative sources of pharmacy service. The statement makes clear that this kind of systemic cooperation would be consistent with the Society's *Code of Ethics*, although it cautions that there might be other legal ramifications for an

objector.

XXIII.7 The current position of two Canadian authorities, including the Alberta College of Pharmacists, is quite similar to that of the five Australian entities.

XXIII.8 The Alberta College of Pharmacists currently asserts that objecting pharmacists "must make reasonable efforts to ensure that clients are able to obtain these services from another authorized provider." More specifically, it states that objectors must "arrange the condition of their practice" to ensure continuity of care, and advises them to give timely notice of their views to their employers, presumably to enable their employers to accommodate both objectors and patients. Thus, the "reasonable efforts" envisioned could include making the kind of arrangements described in XXIII.6, and need not involve active facilitation of euthanasia, assisted suicide, post-coital interception, etc..

XXIII.9 The policy of the Saskatchewan College of Pharmacists on conscientious objection is less precise. It states that the objector's duty of care "might" require referral or pre-arrangement of "access to an alternate source," thus falling short of a demand for referral. It is reasonable to believe that the arrangements described in XXIII.6 would be acceptable in Saskatchewan.

**Systemic cooperation**

XXIII.10 The majority of responses indicate a preference for what is here described as "systemic cooperation." A glance at a few of the policies will suffice to explain what this means.

XXIII.11 The Manitoba Pharmaceutical Society requires objectors "to participate in a system designed to respect a patient's right to receive pharmacy products and services," without further specifying the nature of the participation. The same expectation is found in the ethical codes of pharmacy colleges in New Brunswick and Newfoundland, which add that the system "must be pre-arranged." They do not, however, identify the party responsible for the pre-arrangement. Consistent with these statements, pharmacy authorities in Nova Scotia and New Zealand require objectors to notify their managers, who are charged with the duty of arranging the practice to accommodate objecting pharmacists and patients. Similarly, the American Pharmacists Association "supports the ability of the pharmacist to step away, not in the way, and supports the establishment of an alternative system for delivery of patient care."

XXIII.12 The common element in these policies is that the responsibility to arrange access to assisted suicide, euthanasia or post-coital interception is not imposed on those who object to these services, but lies with those who do not. What is required of objecting pharmacists is that they notify their supervisors and colleagues of their views and cooperate with them as they accommodate their conscientious convictions and the desires of patients. They may not interfere with arrangements being made by others for assisted suicide, euthanasia , post-coital interception, etc., but they are not expected to help with them.

**The key distinction**

XXIII.13 The preceding discussion highlights the key distinction. Policies that demand that objectors make arrangements for alternative delivery or refer a patient require a positive act, while those that call for systemic cooperation do not. The result is same in both cases (the patient accesses euthanasia, assisted suicide, post-coital interceptives, etc.), but the former demand active participation by an objector in conduct he believes to be wrong.

XXIII.14 This explains why objectors often vehemently refuse demands that they refer or otherwise help a patient obtain controversial services, but may well be willing to work cooperatively within a system in which controversial services are provided by others.

## XXIV. The way forward

XXIV.1 The furor that resulted last year when it was suggested that Ontario physicians should be forced to refer for abortion and other controversial procedures demonstrates that a demand for referral is far more likely to generate significant and heated resistance from objectors than accommodation through a policy of systemic cooperation. Further, the fact that the majority of the pharmacy entities noted in Appendices “A” to “C” have already adopted this approach suggests that accommodation of pharmacists’ freedom of conscience and patients’ desire for service can be achieved in this way.

**Modifying the approach**

XXIV.2 Under a policy of systemic cooperation, the obligation to arrange access to euthanasia, assisted suicide, post-coital interception, etc. lies with pharmacy management, the pharmacy owner or others, not the objecting pharmacist. The obvious drawback to this is that it effectively bars objecting pharmacists from management positions and ownership of pharmacies. It is reasonable to ask if a policy of systemic cooperation can be modified to reduce this adverse effect.

XXIV.3 Such a modification is suggested by the opening of a pharmacy operating as an entity of Divine Mercy Care, a Catholic health care organization, in Chantilly, Virginia. DMC Pharmacy will not dispense, recommend or counsel for contraceptives and will adhere to other aspects of Catholic teaching. The pharmacy manager has expressed gratitude for the opportunity to work in an environment that respects his conscientious convictions. The pharmacy is intended to cater to "a special niche" of people who have similar views. Unlike some other states that have made ownership or management of pharmacies impossible for citizens who share such convictions, Virginia does not require pharmacies to carry or refer for contraceptives. NARAL Pro-Choice America recommends that the pharmacy be boycotted because it "doesn't respect [patient] choices."[143]

XXIV.4 The operation of the pharmacy, on the one hand, and the call for a boycott, on the other, demonstrates an appropriate balance in the exercise of freedom of conscience by parties with different views.

XXIV.5 Other suggestions might be proposed, but it is obvious that a policy of systemic cooperation can be modified so that it does not require any positive act on the part of pharmacists who own pharmacies, or who manage or are employed in pharmacies that

publicly identify the scope of their practice to exclude certain services.

## XXV. Summing up: accommodating pharmacists and patients

XXV.1 **Issue No. 2: reprise**. Should the College of Pharmacists of Alberta include in its *Code of Ethics* provisions that honour and fully accommodate the exercise of freedom of conscience by pharmacists? If so, how can this be done?

XXV.2 Part XXII explains why the *Code of Ethics* should include specific provisions to honour and fully accommodate the exercise of freedom of conscience by pharmacists. Parts XXIII and XXIV suggest, in general terms, the kind of policy that would accommodate objecting pharmacists and the desire of patients for pharmacy service.

XXV.3 **Issue No. 2: conclusion.** The College of Pharmacists of Alberta should include in its *Code of Ethics* a unambiguous policy of accommodating freedom of conscience through systemic cooperation that does not require active participation by an objecting pharmacist in conduct he believes to be wrong. The policy should not apply to pharmacists who own, manage or are employed in pharmacies that clearly and publicly identify the scope of their practice to exclude certain services.

## XXVI. Recapitulation

XXVI.1 The *Draft Code of Ethics* does not address the situation of a pharmacist who, for reasons of conscience, refuses to fill a prescription for assisted suicide, euthanasia or post-coital interception. Further, it fails to define key terms, thus complicating its application in such a case.

XXVI.2 The failure to define or limit key terms strongly suggests that pharmacists will be expected to enhance access to assisted suicide or euthanasia, even if they object to the procedures for reasons of conscience. At the least, a limitless obligation to "enhance access" provides limitless opportunities to prosecute objectors for professional misconduct.

XXVI.3 This is particularly troubling because references to accommodation of freedom of conscience in the current *Code* have been removed from the *Draft Code*. It is not unreasonable to believe that deletion of reference to accommodation of freedom of conscience and the construction of the *Draft Code* are intended to force objecting pharmacists to enhance access to euthanasia, assisted suicide, post-coital interception, etc. (Part VIII, *Draft Code*), and to compel them to assist the patient to obtain such services in a timeframe acceptable to the patient (Part V *Draft Code*).

XXVI.4 To impose this requirement would effectively close the profession of pharmacy to anyone who finds such conduct morally unacceptable. It would present current members who would refuse to facilitate assisted suicide, euthanasia or post-coital interception with the choice of compromising their personal integrity or leaving the profession.

XXVI.5 Arguments commonly advanced to support the notion that pharmacists should be forced

to refer services to which they object for reasons of conscience are faulty or inadequate, in that they fail to fully address the issue of complicity in wrongdoing and the nature of the human person.

XXVI.6 A long philosophical tradition, stretching from at least Immanuel Kant to *R. vs. Morgentaler* and beyond, insists that the nature of the human person is such that no one should be exploited by another by being reduced to the status of a tool or thing: that it is reprehensible to use a human person for ends chosen by others. Within this tradition, self-sacrifice 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: servitude, not service.

XXVI.7 In the tradition of Kant, C.S. Lewis, Martin Luther King, Cyril Joad and Karol Wojtyla, and following Madame Justice Wilson in *R. vs. Morgentaler*, to demand that pharmacists 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."

XXVI.8 A pharmacist's conscientious refusal to refer to refer patients or assist them in obtaining euthanasia, assisted suicide, post-coital interception, etc. should not constitute professional misconduct. The College of Pharmacists of Alberta should not demand that pharmacist actively facilitate a service or procedure they believe to be wrong. The *Draft Code of Ethics* should be revised to ensure that the document cannot be used for this purpose.

XXVI.9 The College of Pharmacists of Alberta should include in its *Code of Ethics* a unambiguous policy of accommodating freedom of conscience through systemic cooperation that does not require active participation by an objecting pharmacist in conduct he believes to be wrong. The policy should not apply to pharmacists who own, manage or are employed in pharmacies that clearly and publicly identify the scope of their practice to exclude certain services.

# Appendix "A"

**The Exercise of Freedom of Conscience in Pharmacy**
**Professional and Regulatory Responses**
**Table - February, 2009**

**Note:** For the purpose of this table, the most recent statement of an entity is taken to be its position on the issue.

| Legend | Meaning | Entities | No. |
|---|---|---|---|
| (NA) Not Addressed | The issue of conscientious objection is not addressed. | Soc. HospPh. Australia - PhBrd NSW - PhBrd ACT - PhS Ireland - Colorado BrdPh - Iowa PhA - Kansas PhAss - Michigan PhAss - PhSociety State of NY - S. Dakota PhA - | 10 |
| (P) Provide | Conscientious objection is prohibited. The objecting pharmacist is required to provide the controversial drug or service. | | 0 |
| (PPA) Provide/Personally Act | The objecting pharmacist is required to facilitate or arrange access to the controversial drug or service by referral to a specific person or entity, or by some other act, and to provide the controversial drug or service if this is not possible. | CPh. BC | 1 |
| (PA) Personal Action | The objecting pharmacist is required to facilitate or arrange access to the controversial drug or service by referral to a specific person or entity, or by some other act. | NAPh Reg. Authorities - Canadian PhA - Ont. CPh - PhS Kenya - RPhS Grt Brtn - California BrdPh | 6 |

| Legend | Meaning | Entities | No. |
|---|---|---|---|
| (SC)<br>Systemic Cooperation | The objecting pharmacist is not required to directly assist in the delivery of a drug or service, but is to work cooperatively within a system that allows patients to access controversial drugs and services through other sources. | NS CPh - Man CPhA - NB PhS - PEI PhBrd. - Nfld & Lab PhBrd - PhC New Zealand - American PhA - Colorado PhS - Neb. PhA - N. Carolina BrdPh- Oregon SBrdPh - Oregon SPhA - Penn S BrdPh | 13 |
| (PA/SC)<br>Personal Action or Systemic Cooperation | An objecting pharmacist may directly assist in the delivery of a drug or service by referral to a specific person or entity, or by some other act, OR work cooperatively within a system that allows patients to access controversial drugs and services through other sources. | PhS Australia - PhBrd NT - PhBrd Qlnd - PhBrd Tasmania - PhBrd Victoria - CPh Alberta - Sask CPh | 7 |
| (ND) No Duty | No duty is imposed upon an objecting pharmacist. | Ark SBrdPh - Georgia SBrdPh | 2 |
| | | | 39 |
| (EAS) | Includes consideration of pharmacist involvement in euthanasia or assisted suicide | NAPh Reg. Authorities - Canadian PhA - NB PhS - PEI PhBrd. - CPh. BC | 5 |
| (EX) Execution | Includes consideration of pharmacist involvement in execution | CPh. BC | 1 |
| * | Required by statute | | |

# Appendix "B"

**The Exercise of Freedom of Conscience in Pharmacy**
**Professional and Regulatory Responses**
**Summary - February, 2009**

## Australia

### Pharmaceutical Society of Australia

- Code of Professional Conduct 1998 . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . PA
- Ethical Issues in Declining to Supply . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . PA or SC

### Society of Hospital Pharmacists of Australia

- *Code of Ethics* . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . NA

### New South Wales

- Pharmacy Board of New South Wales
  - Pharmacy Practice Act . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . NA

### Australian Capital Territory

- Pharmacy Board of the ACT
  - Standards . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . NA

### Northern Territory

- Pharmacy Board of the Northern Territory
  - As per APhS and SHPhA Practice Standards . . . . . . . . . . . . . . . . . . PA or SC

### Queensland

- Pharmacy Board of Queensland
  - As per PhSA . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . PA or SC

### Tasmania

- Pharmacy Board of Tasmania
  - As per APhS and SHPhA via Pharmacy Code . . . . . . . . . . . . . . . . . PA or SC

**Victoria**

- Pharmacy Board of Victoria
  - As per APhS via Guidelines 2005 . . . . . . . . . . . . . . . . . . . . . . . . . . . PA or SC

## Canada

**National Association of Pharmacy Regulatory Authorities**

- Model Statement Regarding Pharmacists' Refusal
  to Provide Products or Services for Moral or Religious Reasons . . . . . . . . . . . . . . PA
- Model Standards of Practice for Canadian Pharmacists . . . . . . . . . . . . . . . . . . . . . NA
- Emergency Contraception . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . PA

**Canadian Pharmacists Association**

- Brief to Senate Committee 1994 . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . PA/EAS

**British Columbia**

- College of Pharmacists of British Columbia
  - Ethics Committee . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . PPA/EAS/EX
  - *Code of Ethics* . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . PPA

**Alberta**

- College of Pharmacists of Alberta
  - *Code of Ethics* 2008 . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . PA or SC
  - *Draft Code* 2009 . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . NA

**Saskatchewan**

- Saskatchewan College of Pharmacists
  - Statement Regarding Pharmacists' Refusal
    to Provide Products or Services for Moral or Religious Reasons . . . PA or SC

**Nova Scotia**

- Nova Scotia Pharmaceutical Society (Nova Scotia College of Pharmacists)
  - *Code of Ethics* 2002 . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . SC
  - *Code of Ethics* 2003 . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . SC
  - *Code of Ethics* 2007 . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . SC

**Manitoba**

- Manitoba Pharmaceutical Association
  - Emergency Contraception "Controversy" . . . . . . . . . . . . . . . . . . . . . . . . . . SC
  - Emergency Contraception (EC) Care . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . SC
  - Standards of Practice: Community . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . SC

**Ontario**

- Ontario College of Pharmacists
  - *Code of Ethics* 1996 . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . PA
  - Position Statement on
    "Refusal to Fill for Moral or Religious Reasons" . . . . . . . . . . . . . . . . PA or SC
  - *Code of Ethics*, Draft 3 . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . NA (?)
  - *Code of Ethics* . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . PA

**New Brunswick**

- New Brunswick Pharmaceutical Society
  - Model Statement Regarding Pharmacists' Refusal
    to Provide Products or Services for Moral or Religious Reasons PA or SC/EAS
  - *Code of Ethics* - Interpretation Document . . . . . . . . . . . . . . . . . . . . . . . . . SC

**Prince Edward Island**

- Prince Edward Island Pharmacy Board
  - Statement Regarding Pharmacists' Refusal
    to Provide Products or Services for Moral or Religious Reasons PA or SC/EAS

- *Code of Ethics* Guidelines for Interpretations . . . . . . . . . . . . . . . . . . . . . . . SC

**Newfoundland and Labrador**

- Newfoundland and Labrador Pharmacy Board
    - *Code of Ethics* . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . SC

## Ireland

**Pharmaceutical Society of Ireland**

- Code of Conduct for Pharmacists 2008 . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . NA

## Kenya

**Pharmaceutical Society of Kenya**

- The *Code of Ethics* and Standards
  for Pharmacy Practice in Kenya (2nd Ed) . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . PA

## New Zealand

**Pharmacy Council of New Zealand**

- *Code of Ethics* 2004 . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . SC

## United Kingdom

**Royal Pharmaceutical Society of Great Britain**

- *Code of Ethics* for Pharmacists and Pharmacist Technicians . . . . . . . . . . . . . . . . . PA

## United States

### American Pharmacists Association

- *Code of Ethics* . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . NA
- Pharmacist Conscience Clause . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . SC
- FAQ About Plan B OTC . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . SC
- Letter to the editor 2006-08-24 . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . SC

### Arkansas

- Arkansas State Board of Pharmacy . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . ND*

### California

- Business and Professions Code Sections . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . SC
- Board of Pharmacy Regulations . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . PA

### Colorado

- Colorado Board of Pharmacy Rules of Professional Conduct . . . . . . . . . . . . . . . . NA
- Colorado Pharmacists Society (APhA) . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . SC

### Georgia

- Georgia State Board of Pharmacy Rules . . . . . . . . . . . . . . . . . . . . . . . . . . . . . ND*

### Iowa

- Iowa Pharmacy Association *Code of Ethics* . . . . . . . . . . . . . . . . . . . . . . . . . . . . NA

### Kansas

- Kansas Pharmacists Association *Code of Ethics* . . . . . . . . . . . . . . . . . . . . . . . . . NA

### Michigan

- Michigan Pharmacists Association *Code of Ethics* . . . . . . . . . . . . . . . . . . . . . . . . NA

### Nebraska

- Nebraska Pharmacy Association Regulations . . . . . . . . . . . . . . . . . . . . . . . . . . . SC

**New York**

- Pharmacists Society of the State of New York *Code of Ethics* . . . . . . . . . . . . . . . . NA

**North Carolina**

- North Carolina Board of Pharmacy (APhA) . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . SC

**Oregon**

- Oregon State Board of Pharmacy
    - Considering Moral and Ethical Objections . . . . . . . . . . . . . . . . . . . . . . . . . SC

Oregon State Pharmacy Association

- Considering Moral and Ethical Objections . . . . . . . . . . . . . . . . . . . . . . . . . SC

**Pennsylvania**

- Pennsylvania State Board of Pharmacy
    - Statement of policy . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . SC

**South Dakota**

- South Dakota Pharmacists Association
    - *Code of Ethics* . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . NA

# Appendix "C"

**The Exercise of Freedom of Conscience in Pharmacy**
**Professional and Regulatory Responses**
**Details - February, 2009**

Only the URL of a document is provided when -

- the issue of conscientious objection is not addressed by an entity; or
- the issue of conscientious objection is not addressed, but a policy concerning it can be drawn from another source that is identified as an authority by the entity.

## AUSTRALIA

**Pharmaceutical Society of Australia**

**Code of Professional Conduct 1998** .................................... PA

(*Adapted from the Royal Pharmaceutical Society of Great Britain Code of Ethics*)

**Principle Nine**
A pharmacist shall ensure continuity of care for the patient in the event of labour disputes, pharmacy closure or conflict with personal moral beliefs.

**Obligations**
9.1 A pharmacist shall when required, assist and refer clients to another pharmacist in order to maintain service and care.

(http://www.psa.org.au/site.php?id=628) Accessed 2009-02-19

**Pharmaceutical Society of Australia**

**Ethical Issues in Declining to Supply**
October, 2003 ................................................ PA or SC

*This document represents the current, official position of the Pharmaceutical Society of Australia (PSA) relating to ethical issues that may arise when a pharmacist declines to supply a therapeutic product or pharmacy service*

**Background**
The Pharmaceutical Society of Australia (PSA) acknowledges that the profession carries a responsibility to provide a timely, accurate and high quality pharmacy service as needed by the Australian community.

Pharmacists approved to supply medicines under the Pharmaceutical Benefits Scheme (PBS) must maintain adequate stock (at their own expense) for the supply of

pharmaceutical benefits and may be called upon to provide the Health Insurance Commission with details of the stock held. In addition, they must publicly display a notice of their normal hours of business and are obliged to supply pharmaceutical benefits at other times if the prescription is marked "urgent" and initialled by the prescriber. [1]

There is no law that requires a pharmacist owner or employee to dispense any or all non-PBS prescription medicines. However, if a failure to supply is construed as discriminatory or as leading to foreseeable harm to the individual, then there is a risk of liability for the pharmacist (see below).

At common law, a trader may refuse to sell any product to any person. However, this right may be affected by other laws.

Pharmacy owners and their employees are subject to the Trade Practices Act 1974 which deals with issues such as anticompetitive conduct (Part IV), unconscionable conduct (Part IVA) and unfair practices (Part V Division 1).

**Intervention by pharmacists which may result in non-supply**
Codes of conduct have been issued by the PSA2 and by the Society of Hospital Pharmacists of Australia[3] to establish the principles and standards of behaviour expected by the profession of its members. A key principle espoused in these documents for guiding professional practice is that the health and well being of patients and the community should be the primary concern when providing professional services. The PSA code elaborates on this principle by establishing associated obligations. These include obligations to avoid supplying a medicinal product whose quality, safety or efficacy is in doubt; use professional judgement to prevent supply of excessive quantities of medicinal products or those likely to constitute an unacceptable hazard to patients; and ensure that all reasonable care is taken when dispensing medicines.

Though not widely appreciated by consumers or other health professionals, pharmacists are obligated to dispense medicines according to the prescription only to the extent that it is consistent with patient safety. In some jurisdictions this circumstance is recognised in legislation.[4] In limited situations, consideration of patient safety may lead to a pharmacist declining to dispense a prescribed medicine.[5]

The Society supports and encourages pharmacists to play an active role in monitoring and reviewing the medicines taken by patients. The resulting interventions, including those where the pharmacist acts to prevent supply in the interest of patient safety, are integral to achieving safe treatment and optimal therapeutic outcomes for patients.

They are a key element to achieving the quality use of medicines.

PSA recognises the right of pharmacists to decline to provide products or services to any individual. However, pharmacists are also reminded that as health service providers they are responsible for considering the health and well being of the individual concerned and the community above any commercial or other personal consideration.

**Declining supply on moral grounds**
PSA recognises and respects the right of individuals, including health professionals, to hold a moral belief on particular issues. It further recognises that at times these moral beliefs may impact on the roles undertaken by those health professionals.

While not legally binding, the codes of conduct may serve as a point of reference when the appropriateness of the professional conduct of a pharmacist is under consideration. This point is of particular relevance to a further two principles of the PSA Code of Conduct. Principle Two obligates pharmacists to uphold the reputation of the profession and adhere to legislative requirements while Principle Nine obligates pharmacists to ensure continuity of care, including in the event of a "conflict with personal moral beliefs".[2]

Care must be exercised where the objection to supply is essentially based on personal moral considerations. In the event that a moral belief of a pharmacist leads to the nonsupply of a product or service, PSA reminds pharmacists of the obligations established under the PSA code to accept responsibility for ensuring continuity of care — that is, timely access to the required medicine or service. This may involve the use of initiative to identify another reasonably available source for the required medicine or service, particularly in rural or remote areas or in other situations where access to alternate service providers may be limited.

In 2002, the South Australian Branch of PSA released a statement to pharmacists practising in that state.[6] The statement, which was based on legal advice received by the Branch, was that the pharmacist had a right to decline supply of prescription medicines where such supply would be contrary to a moral stance held by the dispensing pharmacist.

PSA recognises there are jurisdictional variations in the regulation of the pharmacy profession. Nevertheless, where a pharmacist's moral belief is likely to impact on the pharmacy services available to patients, pharmacists should consider the following.

- Employee pharmacists should reach agreement with their employer about

what limitations will apply to their dispensing and other pharmacy activities and have these formally recognised in their terms of employment.

- The owner/manager should have processes in place (eg. a sign or leaflet) to clarify to patients/consumers seeking pharmacy services, any limitations applicable to the services provided. The information provided should clearly inform the patient of appropriate alternative sources. The need for this process may be more compelling where the availability of alternate service providers is limited.

A pharmacist might choose a certain course of action based on moral beliefs which may result in the provision of a particular product or service being declined either generally or to particular persons. In such circumstances, the pharmacist should be aware of the following possibilities.

- An individual may claim discrimination (eg.based on medical, disability, cultural, religious or other legal grounds) or unconscionable conduct by the pharmacist.
- Where there is foreseeable risk of harm to the individual, the pharmacist could be held liable for any consequences that may arise from the decision to not supply.

Therefore pharmacists are strongly advised to obtain independent legal advice where their personal moral beliefs are likely to preclude the provision of a certain product or service in the course of their professional practice either generally or to particular persons.

**References**

1. Commonwealth Department of Health and Ageing. Schedule of Pharmaceutical Benefits. Canberra: CDHA; 2003 May.

2. Pharmaceutical Society of Australia. Code of Professional Conduct. In: Pharmacy Practice Handbook. Canberra: PSA; 2000.

3. The Society of Hospital Pharmacists of Australia. SHPA *Code of Ethics*. In: Johnstone JM and Viénet MD, eds. Practice Standards and Definitions. Melbourne: SHPA; 1996.

4. For example the Victorian Pharmacists Regulations 1992 (made under the Victorian Pharmacists Act 1974).

5. Pharmaceutical Society of Australia. Dispensing Practice Guidelines. In: Pharmacy Practice Handbook. Canberra: PSA; 2000.

6. Pharmaceutical Society of Australia. SA Branch Newsletter. Refusal to dispense. 2002; Jun.

(http://www.psa.org.au/site.php?id=837) Accessed 2009-02-20

**Society of Hospital Pharmacists of Australia**

***Code of Ethics*** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . NA
(http://www.shpa.org.au/pdf/practice_standards/code_of_ethics_ro.pdf) Accessed 2009-02-24

## New South Wales

**Pharmacy Board of New South Wales**
**Pharmacy Practice Act** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . NA
(http://www.austlii.edu.au/au/legis/nsw/consol_act/ppa2006165/) Accessed 2009-02-23

## Australian Capital Territory

**Pharmacy Board of the ACT**
**Standards 2008** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . NA
(http://www.legislation.act.gov.au/ni/2008-106/current/pdf/2008-106.pdf) Accessed 2009-02-23

## Northern Territory

**Pharmacy Board of the Northern Territory**
**As per APhS and SHPhA Practice Standards** . . . . . . . . . . . . . . . . . . . . . . PA or SC
(http://www.health.nt.gov.au/Health_Professions_Licensing_Authority_HPLA/Health_Registration_Boards/Pharmacy_Board/index.aspx) Accessed 2009-02-23

## Queensland

**Pharmacy Board of Queensland**
**As per PhSA** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . PA or SC
(http://www.pharmacyboard.qld.gov.au/publications.htm) Accessed 2009-02-23

## Tasmania

**Pharmacy Board of Tasmania**
**As per APhS and SHPhA via Pharmacy Code** . . . . . . . . . . . . . . . . . . . . . PA or SC
(http://www.regboardstas.com/pharmacy/Pharmacy-Code-2008.pdf) Accessed 2009-02-24

## Victoria

**Pharmacy Board of Victoria**
**As per APhS via Guidelines 2004/2005** . . . . . . . . . . . . . . . . . . . . . . . . . . . PA or SC
(http://www.pharmacybd.vic.gov.au/cmsdocs/guidelines2004.pdf) Accessed 2009-02-24

## CANADA

**National Association of Pharmacy Regulatory Authorities (NAPRA)**
**Model Statement Regarding Pharmacists' Refusal to Provide Products or Services for Moral or Religious Reasons** . . . . . . . . . . . PA

Approved by Council: November 1999

Developed by: Executive and Inter-Provincial Pharmacy Regulatory Committees

The use of prescribed drugs for emergency contraception and euthanasia is an arising issue that has prompted the pharmacy regulatory authorities to address the balance between the individual rights of pharmacists and professional responsibilities to their patients.

In response to the need for clear and consistent regulatory policy on this matter, NAPRA Council approved a model regulatory position statement on November 14, 1999. This model statement was developed following preliminary review by Council and Pharmacy Registrars in April of this year and external consultation with member Provincial and Territorial Regulatory Authorities, the Canadian Society of Hospital Pharmacists, the Canadian Pharmacists' Association and the Consumers' Association of Canada, throughout the summer months. NAPRA's member Provincial and Territorial Regulatory Authorities will now consider the model statement for adoption or adaptation and implementation.

"Pharmacists shall hold the health and safety of the public to be their first consideration in the practice of their profession. Pharmacists who object, as a matter of conscience, to providing a particular pharmacy product or service must be prepared to explain the basis of their objections. Objecting pharmacists have a responsibility to participate in a system designed to respect a patient's right to receive pharmacy products and services.

The following policy clauses reflect the need to meet a patient's requirements for pharmacy products and services while respecting a pharmacist's right of conscience:

> A pharmacist is permitted to object to the provision of a certain pharmacy product or service if it appears to conflict with the pharmacist's view of morality or religious beliefs and if the pharmacist believes that his or her conscience will be harmed by providing the product or service. Objections should be conveyed to the pharmacy manager, not to the patient.
>
> The individual pharmacist must pre-arrange access to an alternate source, to enable the patient to obtain the service or product that they need. Any alternate

means must minimize inconvenience or suffering to the patient or patient's agent."

(http://www.napra.ca/docs/0/95/157/165/179.asp) Accessed 2009-02-21

**National Association of Pharmacy Regulatory Authorities (NAPRA)**
Model Standards of Practice for Canadian Pharmacists . . . . . . . . . . . . . . . NA
(http://www.napra.ca/pdfs/practice/model_std_practice/MSPCP-Nov2005.pdf) Accessed 2009-02-20

**National Association of Pharmacy Regulatory Authorities (NAPRA)**
Emergency Contraception . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . PA

**Pharmacists' Professional Responsibility**
. . . Pharmacists who do not wish to provide EC treatment for personal reasons should maintain objectivity and remain professional in manner when dealing with patients. In this case, patients should be referred to an alternate source, as listed below. More information is found in the "Model Statement Regarding Pharmacists' Refusal to Provide Products or Services for Moral or Religious Reasons", approved by NAPRA Council in November 1999.

The Model Statement suggests that pharmacists not convey their personal objections to the patient. If the patient questions the pharmacist as to why he or she will not personally be providing the product or service, the pharmacist should answer in a manner that does not make the patient feel uncomfortable. Alternate sources for EC noted might include referral to one or more pre-arranged source options such as:

- another pharmacist in the same pharmacy
- another pharmacy in the vicinity
- the prescribing physician
- nearby hospital
- family planning clinic

(http://www.napra.ca/docs/0/95/157/165.asp) Accessed 2009-02-21

**Canadian Pharmacists Association**
**Brief to Senate Committee**
**Living and Dying with Dignity - Studying Euthanasia and Assisted Suicide**
**16 November, 1994** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . PA/EAS

. . . The physician, the pharmacist, the nurse should have a right to take part or not in assisting a person once he or she has reached a decision to put an end to his or her life. Should they elect not to participate, their duty to their patient requires that they refer them to health professionals who will assist them. . .

(http://www.pharmacists.ca/content/about_cpha/whats_happening/government_affairs/government_briefs_111694.cfm#pres) Accessed 2009-02-21

## British Columbia

### College of Pharmacists of British Columbia

**Ethics Advisory Committee**
**Ethics in Practice: Moral Conflicts in Pharmacy Practice**.
*Bulletin* March/April 2000 Vol. 25, No. 2 . . . . . . . . . . . . . . . . . PPA/EAS/EX

The *Code of Ethics* adopted by the College of Pharmacists of British Columbia acknowledges that some pharmacists have moral objections to providing certain recognized pharmacy services. . . These pharmacists must refer patients to colleagues who will provide such services, and in the end deliver these services themselves if it is impractical or impossible for patients to otherwise received them. . . .

Individual pharmacists may experience conscience problems when requested to provide services to which they have a moral objection. At present these services might include provision of contraceptives, syringes and needles for drug addicts, emergency contraceptives, high doses of narcotics to control intractable pain that might hasten death in the terminally ill, and medications for terminal sedation. In future these services might expand to include preparation of drugs to assist voluntary or involuntary suicide, cloning, genetic manipulation, or even execution. . . .

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. The public cannot be expected to consider it to be just bad luck if patients are refused recognized pharmacy services because their pharmacists have moral

objections to providing them. . .

(http://www.consciencelaws.org/Conscience-Archive/Reports/Report-2001-01a.html#APPENDIX "B")

**College of Pharmacists of British Columbia**
***Code of Ethics*** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . PPA

**Value 8** - A pharmacist ensures continuity of care in the event of job action, pharmacy closure or conflict with moral beliefs.

**Obligations**
1. A pharmacist has a duty through coordination and communication to ensure the provision of essential pharmacy care throughout the duration of any job action or pharmacy closure. Patients who require ongoing or emergency pharmacy care are entitled to have those needs satisfied.

2. A pharmacist is not ethically obliged to provide requested pharmacy care when compliance would involve a violation of his or her moral beliefs. When that request falls within recognized forms of pharmacy care, however, there is a professional obligation to refer the patient to a pharmacist who is willing to provide the service. The pharmacist shall provide the requested pharmacy care if there is no other pharmacist within a reasonable distance or available within a reasonable time willing to provide the service.

(http://www.bcpharmacists.org/legislation_standards/standards_of_practice/code_of_ethics_detailed).php Accessed 2009-02-20

## Alberta

**College of Pharmacists of Alberta**

***Code of Ethics* 2008** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . PA or SC

**Principle V:**
A pharmacist endeavours to ensure that the client's right to pharmaceutical service is met.

**Guidelines for interpretation:**
Pharmacists who are unable or are unwilling to provide appropriately prescribed pharmaceutical services (e.g. compounding of sterile products) to clients, must make reasonable efforts to ensure that clients are able to obtain these services from another authorized provider.

> Pharmacists who are unable or are unwilling to provide certain pharmaceutical services are obligated to arrange the condition of their practice so that the care of the client will not be jeopardized
>
> Pharmacists who are unable or are unwilling to provide a pharmaceutical service shall make it known to their potential employer or employee, whichever the case may be, before entering into a formal relationship. If their convictions change over the course of their career, pharmacists must make it known in their place of work.
>
> (https://pharmacists.ab.ca/nPharmacistResources/CodeofEthics.aspx) Accessed 2008-02-18

**College of Pharmacists of Alberta**

***Draft Code* 2009** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . NA
(https://pharmacists.ab.ca/Content_Files/Files/DraftCodeofEthics_dec2208.pdf )Accessed 2009-02-21

## Saskatchewan

**Saskatchewan College of Pharmacists**

**Statement Regarding Pharmacists' Refusal to Provide Products or Services for Moral or Religious Reasons** . . . . . . PA or SC

Pharmacists shall hold the health and safety of the public to be their first consideration in the practice of their profession. Pharmacists who object, as a matter of conscience, to providing a particular pharmacy product or service must be prepared to explain the basis of their objection. Objecting pharmacists cannot abandon their ethical duty of care to the patient, and respect of the patient’s right of autonomy to make informed decisions to receive pharmacy products and services based on objective and accurate information. The following policy clauses reflect the need to meet a patient's requirements for pharmacy products and services while respecting a pharmacist's right of conscience:

1. A pharmacist is permitted to object to the provision of a certain pharmacy product or service if it appears to conflict with the pharmacist's view of morality or religious beliefs, and if the pharmacist believes that his or her conscience will be harmed by providing the product or service. The reasons for the objection should be conveyed to the pharmacy manager, and to the patient. It would be improper and unethical conduct if the pharmacist used the opportunity to promote his/her moral or religious

convictions, or engage in any actions, which demean the patient.

2. Duty of care includes ensuring that the decisions of the pharmacist do no harm or promote the wellbeing of the patient. This might mean that the individual pharmacist refers the patient to, or pre-arranges access to an alternate source, to enable the patient to obtain the service or product that they need. Any alternate means must minimize inconvenience or suffering to the patient or patient's agent and must maintain patient confidentiality.

(http://www.napra.ca/pdfs/provinces/sk/skreference_manual/Pharmacists%20Refusal%20to%20Provide%20Products%20for%20Moral%20Reaons.pdf) Accessed 2009-02-21

## Nova Scotia

### Nova Scotia Pharmaceutical Society (Nova Scotia College of Pharmacists)

***Code of Ethics* 2002** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . SC
***Code of Ethics* 2003** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . SC
***Code of Ethics* 2007** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . SC

**Value V**
Pharmacists respect the rights of patients to receive pharmacy services and ensure these rights are met.

Pharmacists who are unable to provide prescribed medicines or services to their patients shall take reasonable steps to ensure these medicines/services are provided and the patients' care is not jeopardized.

Pharmacists who are unwilling to provide prescribed medicines or services to patients because of moral or religious reasons shall inform pharmacy management of their objections at the onset of employment. Pharmacy management shall provide reasonable accommodation of the pharmacist's right of conscience and develop an alternate means of providing the medicines or services. The alternate means shall be timely and convenient for the patient.

Pharmacists have a duty, through communication and co-ordination, to ensure the continuity of care of patients during pharmacy relocation/closure, job action, natural disasters or situations where continuity of care may be problematic.

2002: (http://www.napra.ca/docs/0/203/245/249/249/265.asp )Accessed 2009-02-21
2003: (http://www.napra.ca/docs/0/203/245/480.asp) Accessed 2009-02-24
2007: (http://www.nspharmacists.ca/ethics/index.html) Accessed 2009-02-18

# Manitoba

## Manitoba Pharmaceutical Association

**Notice to Pharmacy Managers**
**Emergency Contraception "Controversy"**
2 February, 2006 . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . SC

Over the past couple weeks, there have been many media reports regarding Emergency Contraception medication and the role of the pharmacist. . . .

While the MPhA has not received any reports of misconduct by pharmacists in the provision of Emergency Contraception care, the following information serves as an important reminder . . .

A pharmacist or pharmacy that refuses to sell emergency contraception as a matter of conscience needs to plan a process to enable patients to access the medication. . .

(http://napra.ca/pdfs/provinces/mb/NoticetoPharmacyManagersFeb206.pdf) Accessed 2009-02-21

## Manitoba Pharmaceutical Association

**MPhA Practice Guideline**
**Emergency Contraception (EC) Care (Post Coital Contraception)**
April, 2005, Updated 13 February, 2006 . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . SC

4) Pharmacists, who object to providing Emergency Contraception Care as a matter of conscience, must participate in a system that respects a patient's right to receive that care (MPhA SOP #1 & #5)*. Ensuring the patient's right to receive care could mean referral to a colleague, an emergency room, a clinic, or other health practitioner offering the care. If EC Care is not available in the pharmacy, a sign must be posted in the pharmacy advising patients that EC Care is not available and where the patient care can be obtained (e.g. a sign located in the pharmacy front window and/or at the dispensary). An obligation to provide care is not the same as refusal to supply a product for an individual patient based on professional judgement. When providing care with Schedule 2 or 3 medications, the pharmacist is accountable for that care. At times, a pharmacist may be requested to supply EC Care to a patient's agent. The pharmacist is undertaking a professional decision, and must still keep records including the reasons for the decision to supply care in the absence of the patient.

(http://napra.ca/pdfs/provinces/mb/ECPUpdatedGuideline2006-b.pdf) Accessed 2009-02-21

**Manitoba Pharmaceutical Association**

**Standards of Practice: Community**
**June, 2006** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . SC

**D. Pharmacist's Responsibilities in the Refusal to provide Products or Services for Moral or Religious Reasons**

1.9. Pharmacists shall hold the health and safety of the public to be their first consideration in the practice of their profession. Pharmacist who object, as a matter of conscience, to providing a particular pharmacy product or service must be prepared to explain the basis of their objections. Objecting pharmacists have a responsibility to participate in a system designed to respect a patient's right to receive pharmacy products and services.

1.10. The following policy reflects the need to meet a patient's requirement for pharmacy products and services while respecting a pharmacist's right of conscience:

1.10.1. A pharmacist is permitted to object to the provision of a certain pharmacy product or service if it appears to conflict with the pharmacist's view of morality or religious beliefs and if the pharmacist believes that his or her conscience will be harmed by providing the product or service. Objections should be conveyed to the pharmacy manager, not the patient.

(http://www.napra.ca/pdfs/provinces/mb/Standards-of-Practice-for-Community-Jun-19-2006.pdf) Accessed 2009-02-21

## Ontario

**Ontario College of Pharmacists**

***Code of Ethics* 1996** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . PA

**Principle Two**
The pharmacist actively promotes the well-being of every patient in a caring, compassionate manner. The patient's well-being is at the centre of the pharmacist's professional and business practices. This principle ensures that no patient shall be deprived of pharmaceutical services because of the personal convictions or religious beliefs of a pharmacist. Where such circumstances occur, the pharmacist refers the patient to another pharmacist who can meet the patient's needs. The pharmacist exercises his or her professional judgement to ensure that patients' needs are met in situations where emergency services or care may be required.

**Ontario College of Pharmacists**

**Position Statement on**
**"Refusal to Fill for Moral or Religious Reasons" (2001)** . . . . . . . . . . . . . PA or SC

Following is the position statement approved at the March 2001 Council meeting:

Pharmacists shall hold the health and safety of the public to be their first consideration in the practice of their profession. Pharmacists who object, as a matter of conscience, to providing a particular pharmacy product or service must be prepared to explain the basis of their objections.

Objecting pharmacists have a responsibility to participate in a system designed to respect a patient's right to receive pharmacy products and services.

The following clauses, reflect the need to meet a patient's requirements for pharmacy products and services while respecting a pharmacist's right of conscience:

> A pharmacist is permitted to decline providing certain pharmacy products or services if it appears to conflict with the pharmacist's view of morality or religious beliefs and if the pharmacist believes that his or her conscience will be harmed by providing the product or service. Objections should be conveyed to the pharmacy manager not the patient.
>
> The individual pharmacist must insure an alternate source, to enable the patient to obtain the service or product that they need. Any alternate means must minimize inconvenience or suffering to the patient or patient's agent.

(http://www.ocpinfo.com/client/ocp/OCPHome.nsf/d12550e436a1716585256ac90065aa1c/98948e68f8b1c6c485256af00050a94d?OpenDocument&PFV) Accessed 2009-02-18

**Ontario College of Pharmacists**

***Code of Ethics*, Draft 3**
**22 March, 2005** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . NA (?)

**Principle Four**
The pharmacist and pharmacy technician respects the autonomy, individuality and dignity of each patient and provide care with respect for human rights and without discrimination. No patient shall be deprived of pharmaceutical services because of the personal convictions or religious beliefs of a pharmacist or pharmacy technician

**Ontario College of Pharmacists**

***Code of Ethics* (December, 2006)** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . PA

**Principle Four**
Each member respects the autonomy, individuality and dignity of each patient and provides care with respect for human rights and without discrimination. No patient shall be deprived of access to pharmaceutical services because of the personal convictions or religious beliefs of a member. Where such circumstances occur, the member refers the patient to a pharmacist who can meet the patient's needs.

(http://www.ocpinfo.com/client/ocp/OCPHome.nsf/web/Code+of+Ethics) Accessed 2009-02-21

## New Brunswick
### New Brunswick Pharmaceutical Society

**Model Statement Regarding Pharmacists' Refusal to Provide Products or Services for Moral or Religious Reasons** . . . . . . . PA/EAS

Approved by Council: November 1999

Developed by: Executive and Inter-Provincial Pharmacy Regulatory Committees

The use of prescribed drugs for emergency contraception and euthanasia is an arising issue that has prompted the pharmacy regulatory authorities to address the balance between the individual rights of pharmacists and professional responsibilities to their patients.

In response to the need for clear and consistent regulatory policy on this matter, NAPRA Council approved a model regulatory position statement on November 14, 1999. This model statement was developed following preliminary review by Council and Pharmacy Registrars in April of this year and external consultation with member Provincial and Territorial Regulatory Authorities, the Canadian Society of Hospital Pharmacists, the Canadian Pharmacists' Association and the Consumers' Association of Canada, throughout the summer months. NAPRA's member Provincial and Territorial Regulatory Authorities will now consider the model statement for adoption or adaptation and implementation

"Pharmacists shall hold the health and safety of the public to be their first consideration in the practice of their profession. Pharmacists who object, as a matter of conscience, to providing a particular pharmacy product or service must be prepared

to explain the basis of their objections. Objecting pharmacists have a responsibility to participate in a system designed to respect a patient's right to receive pharmacy products and services.

The following policy clauses reflect the need to meet a patient's requirements for pharmacy products and services while respecting a pharmacist's right of conscience:

> 1. A pharmacist is permitted to object to the provision of a certain pharmacy product or service if it appears to conflict with the pharmacist's view of morality or religious beliefs and if the pharmacist believes that his or her conscience will be harmed by providing the product or service. Objections should be conveyed to the pharmacy manager, not to the patient.
>
> 2. The individual pharmacist must pre-arrange access to an alternate source, to enable the patient to obtain the service or product that they need. Any alternate means must minimize inconvenience or suffering to the patient or patient's agent."
>
> (http://www.nbpharmacists.ca/LinkClick.aspx?fileticket=wcx0ugUqRRE%3d&tabid=261&mid=695) Accessed 2009-02-21

**New Brunswick Pharmaceutical Society**

***Code of Ethics* - Interpretation Document**
**15 June, 2003** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . SC

**Statement V:**
A Pharmacist , Certified dispenser or Registered student shall respect the rights of patients to receive pharmacy products and services and ensure these rights are met.

**Guidelines for interpretation**
Pharmacists who object, as a matter of conscience, to providing a particular pharmacy product or service must be prepared to explain the basis of their objections to pharmacy management, not the patient.

Pharmacists who object, as a matter of conscience, to providing a particular pharmacy product or service have a responsibility to participate in a system designed to respect a patient’s right to receive pharmacy products and services. The system must be pre-arranged to enable the patient to obtain the product or service in a timely and convenient manner, minimizing suffering to the patient.

Pharmacists have a duty, through communication and coordination, to ensure continuity of care of patients during pharmacy relocation or closure, job action,

natural disasters or situations where continuity of care may be problematic.

(http://www.nbpharmacists.ca/LinkClick.aspx?fileticket=AXVpqXendDI%3d&tabid=261&mid=695) Accessed 2009-02-21

## Prince Edward Island

### Prince Edward Island Pharmacy Board

**Policy Statement**
**Statement Regarding Pharmacists' Refusal to Provide Products or Services for Moral or Religious Reasons**
June 2000 . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . PA or SC/EAS

The use of prescribed drugs for emergency contraception and euthanasia is an arising issue that has prompted the pharmacy regulatory authorities to address the balance between the individual rights of pharmacists and professional responsibilities to their patients.

In response to the need for a clear and consistent regulatory policy on this matter, NAPRA Council approved a model regulatory position statement on November 14, 1999. This model statement was developed following preliminary review by Council and Pharmacy Registrars in April 1999 and external consultation with member Provincial and Territorial Regulatory Authorities, the Canadian Society of Hospital Pharmacists, the Canadian Pharmacists Association and the Consumers' Association of Canada, throughout the summer months.

In June of 2000, the Prince Edward Island Pharmacy Board approved the Statement to provide direction and guidance on this issue to Island pharmacists.

"Pharmacists shall hold the health and safety of the public to be their first consideration in the practice of their profession. Pharmacists who object, as a matter of conscience, to providing a particular pharmacy product or service must be prepared to explain the basis of their objections. Objecting pharmacists have a responsibility to participate in a system designed to respect a patient's right to receive pharmacy products and services.

The following policy clauses reflect the need to meet a patient's requirements for pharmacy products and services while respecting a pharmacist's right of conscience:

1. A pharmacist is permitted to object to the provision of a certain pharmacy product or service if it appears to conflict with the pharmacist's view of morality or religious beliefs and if the pharmacist believes that his or her

conscience will be harmed by providing the product or service. Objections should be conveyed to the pharmacy manager, not to the patient.

2. The individual pharmacist must pre-arrange access to an alternate source, to enable the patient to obtain the service or product that they need. Any alternate means must minimize inconvenience or suffering to the patient or patient's agent".

(http://www.napra.ca/pdfs/provinces/pe/moral06200.pdf) Accessed 2009-02-21

**Prince Edward Island Pharmacy Board**

***Code of Ethics* Guidelines for Interpretations**
**2001 (October)** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . SC

**Statement V**:
Pharmacists respect the rights of patients to receive pharmacy products and services and ensure these rights are met.

**Guidelines for interpretation**
1. Pharmacists who object, as a matter of conscience, to providing a particular pharmacy product or service must be prepared to explain the basis of their objections to pharmacy management, not the patient.

2. Pharmacists who object, as a matter of conscience, to providing a particular pharmacy product or service have a responsibility to participate in a system designed to respect a patient's right to receive pharmacy products and services. The system must be pre-arranged to enable the patient to obtain the product or service in a timely and convenient manner, minimizing suffering to the patient.

3. Pharmacists have a duty, through communication and coordination, to ensure continuity of care of patients during pharmacy relocation or closure, job action, natural disasters or situations where continuity of care may be problematic.

(http://www.napra.ca/pdfs/provinces/pe/Code%20of%20Ethics0301.pdf) Accessed 2009-02-21

## Newfoundland and Labrador

**Newfoundland and Labrador Pharmacy Board**
***Code of Ethics***
2001 (4 February) . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . SC

**Statement V**:
Pharmacists respect the rights of patients to receive pharmacy products and services and ensure these rights are met.

**Guidelines for interpretation**
1. Pharmacists who object to providing a particular pharmacy product or service must be prepared to explain the basis of their objection to pharmacy management.

2. Pharmacists who are unable or unwilling to provide a particular pharmacy product or service have a responsibility to participate in a system designed to respect a patient's right to receive pharmacy products and services. The system must be pre-arranged to enable the patient to obtain the product or service in a timely and convenient manner, minimizing suffering to the patient.

3. Pharmacists have a duty, through communication and co-ordination, to ensure the continuity of care of patients during pharmacy relocation or closure, job action, natural disasters or situations where continuity of care may be problematic.

(http://www.nlpb.ca/Documents/Standards_Policies_Guidelines/NLPB-Code_of_Ethics.PDF) Accessed 2009-02-21

## IRELAND

**Pharmaceutical Society of Ireland**
Code of Conduct for Pharmacists 2008 . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . NA

(http://www.pharmaceuticalsociety.ie/Standards/upload/File/Code_of_Conduct/FINAL_CODE_CONDUCT_PHARMACISTS_CK_151208.pdf) Accessed 2009-02-21

## KENYA

**Pharmaceutical Society of Kenya**

**The *Code of Ethics* and Standards for Pharmacy Practice in Kenya (2nd Ed) 2004 (26 July)** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . PA

9. The pharmacist ensures continuity of care in the event of labour disputes, pharmacy closure and conflict with personal moral beliefs.

**9.1 Obligations**:
I. To refer a patient to another pharmacist.

ii. To ensure that when a pharmacy closes, the patients are informed of the pharmacy to which their records, if held, have been transferred.

**9.2 Standards**
The pharmacist:

I. Informs patients of the opening and closing hours of his/her pharmacy

ii. On duty should have his/her name displayed.

iii. Establishes a working relationship with a colleague on locum basis to ensure continuity of services subject to patients consent.

(http://www.pskonline.org/THE%20CODE%20OF%20ETHICS%20AND%20STANDARDS%20Second%20Edition[1].pdf) Accessed 2009-02-21

## NEW ZEALAND

**Pharmacy Council of New Zealand**

***Code of Ethics* 2004** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . SC

**Principle 7: Trustworthiness**
The pharmacist shall act in a manner that promotes public trust in the knowledge and ability of pharmacists and enhances the reputation of the profession

**Specific obligations**
**7.2 Conscientious objection ***
The pharmacist must, in advance, advise any employer, Charge Pharmacist, local general medical practitioners and patients of the pharmacy of any belief or conscientious objection which may influence or impact on their sphere of practice.

**Commentary to Principle 7**
**7.2 Conscientious objection**
s. 46 of The Contraception, Sterilisation and Abortion Act 1977 provides for a right of conscientious objection as follows: (1) Notwithstanding anything in any other enactment, or any rule of law, or the terms of any oath or of any contract (whether of employment or otherwise), noregistered medical practitioner, registered nurse, or other person shall be under any obligation

- To perform or assist in the performance of an abortion….
- …or supply or administer or assist in the supply or administering, of any contraceptive, or to offer to give any advice relating to contraception if he

objects to doing so on grounds of conscience.

The obligation in the Code does not in any way impinge on or seek to limit this right, but requires that where a pharmacist does object to supplying contraceptives, or object to giving advice relating to contraception on grounds of conscience, the pharmacist must advise any employer, Charge Pharmacist, local general medical practitioners and patients of the pharmacy of this objection.

(http://www.pharmacycouncil.org.nz/cms_show_download.php?id=39) Accessed 2009-02-21

## UNITED KINGDOM

**Royal Pharmaceutical Society of Great Britain**

***Code of Ethics* for Pharmacists and Pharmacist Technicians**
**1 August, 2007** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . PA

3.4 Ensure that if your religious or moral beliefs prevent you from providing a particular professional service, the relevant persons or authorities are informed of this and patients are referred to alternative providers for the service they require.

(http://www.rpsgb.org/pdfs/coeppt.pdf) Accessed 2009-02-20

## UNITED STATES

**American Pharmacists Association**

***Code of Ethics*** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . NA
(http://www.pharmacist.com/AM/Template.cfm?Section=Search1&template=/CM/HTMLDisplay.cfm&ContentID=2903) Accessed 2009-02-24

**American Pharmacists Association**

**Pharmacist Conscience Clause**
**March, 2008** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . SC

**APhA Position**

APhA recognizes the individual pharmacist's right to exercise conscientious refusal and supports the establishment of systems to ensure patient's access to legally prescribed therapy without compromising the pharmacist's right of conscientious refusal. When this policy is implemented correctly, and proactively, it is seamless to

the patient, and the patient is not aware that the pharmacist is stepping away from the situation. In sum, APhA supports the ability of the pharmacist to step away, not in the way, and supports the establishment of an alternative system for delivery of patient care.

APhA policy does not support lecturing a patient or taking any action to obstruct patient access to clinically appropriate, legally prescribed therapy. APhA policy does not interject the pharmacist between the patient and the physician.

(http://www.pharmacist.com/AM/Template.cfm?Section=Search1&CONTENTID=15688&TEMPLATE=/CM/ContentDisplay.cfm) Accessed 2009-02-20

**American Pharmacists Association**

**FAQ About Plan B OTC** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . SC

Q: Can I refuse sale of Plan B OTC?

A: APhA supports an individual pharmacist's ability to choose not to dispense a medication for personal, religious and moral reasons and also supports the establishment of systems to ensure patient's access to legally prescribed therapy. Pharmacists with objections to dispensing any medications, including Plan B OTC, should work with their management to develop any systems necessary to accommodate the patient's and pharmacist's needs..

(http://www.pharmacist.com/AM/TemplateRedirect.cfm?template=/CM/ContentDisplay.cfm&ContentID=17781) Accessed 2009-02-21

**American Pharmacists Association**
**Washington State Pharmacy Association**

**Letter to the editor 2006-08-24** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . SC

. . . it is important to note that the "conscience clause" which allows pharmacists to opt out of offering services that they find morally objectionable is not limited to emergency contraception. It is intended to protect all health professionals from being compelled to violate their beliefs, including dispensing medication for assisted suicide or executions. These are just some of the other activities that pharmacists may choose not to participate in. Well-constructed conscience clauses also support systems to assure patient access to legally prescribed clinically accurate therapy.

(http://www.pharmacist.com/AM/TemplateRedirect.cfm?template=/CM/ContentDisplay.cfm&ContentID=17776) Accessed 2009-02-21

# Arkansas
## Arkansas State Board of Pharmacy

**News - May, 2005**
**Conscience Clause** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . ND*

The Arkansas State Board of Pharmacy receives several calls each year regarding the conscience clause for pharmacists. While there is a law in Arkansas that addresses a pharmacist's right to refuse filling certain prescriptions, it is actually a public health law that has been in place since 1973.

**20-16-304. Public policy – Availability of Procedures, Supplies, and Information –Exceptions.**
It shall be the policy and authority of this state that . . .

(4) Nothing in this subchapter shall prohibit a physician, pharmacist, or any other authorized paramedical personnel from refusing to furnish any contraceptive procedures, supplies, or information; and

(5) No private institution or physician, nor any agent or employee of such institution or physician, nor any employee of a public institution acting under directions of a physician, shall be prohibited from refusing to provide contraceptive procedures, supplies, and information when the refusal is based upon religious or conscientious objection. No such institution, employee, agent, or physician shall be held liable for the refusal.

(http://www.arkansas.gov/asbp/pdf/newsletters/05/ar052005.pdf) Accessed 2009-02-21

# California
## California Board of Pharmacy

**(California Code of Regulations, Title 16**
**Section §1746. Emergency Contraception** . . . . . . . . . . . . . . . . . . . . . . . . . . . . PA.

(5) Referrals and Supplies: If emergency contraception services are not immediately available at the pharmacy or the pharmacist declines to furnish pursuant to conscience clause, the pharmacist will refer the patient to another emergency contraception provider. The pharmacist shall comply with all state mandatory reporting laws, including sexual abuse laws. . .

# Colorado
## Colorado Board of Pharmacy

**Rules of Professional Conduct** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . NA
(http://www.dora.state.co.us/pharmacy/Rules11-30-08.pdf) Accessed 2009-02-20

**Colorado Pharmacists Society**

**E-mail to Protection of Conscience Project from Exec. Dir.**
2009-02-10 15:18 (APhA) . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . SC
The *Code of Ethics* used by pharmacists in Colorado is the one developed by the American Pharmacists Association.

## Georgia

**Georgia State Board of Pharmacy**

**480-5-.03 Code of Professional Conduct** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . ND*

(n) Refusal to Fill Prescription. It shall not be considered unprofessional conduct for any pharmacist to refuse to fill any prescription based on his/her professional judgment or ethical or moral beliefs.

(http://sos.georgia.gov/acrobat/PLB/Rules/chapt480.pdf) Accessed 2009-02-21

## Iowa

**Iowa Pharmacy Association**

***Code of Ethics*** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . NA
(http://www.iarx.org/IowaPharmacy/Association/IPA.aspx) Accessed 2009-02-20

## Kansas

**Kansas Pharmacists Association**

*Code of Ethics* . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . NA
(http://www.kansaspharmacy.org/displaycommon.cfm?an=1&subarticlenbr=4)
Accessed 2009-02-20

## Michigan

**Michigan Pharmacists Association**

***Code of Ethics*** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . NA
(http://www.michiganpharmacists.org/mpa/join/ethicscode/) Accessed 2009-02-24

## Nebraska

**Nebraska Pharmacists Association**

**E-mail to Protection of Conscience Project from NPhA Finance & Marketing**

**Manager**
2009-02-23 12:30:41 . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . SC
Nebraska regulations refer to the APhA *Code of Ethics*.

## New York
### Pharmacists Society of the State of New York

***Code of Ethics*** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . NA
(http://www.pssny.org/web/2005/11/code_of_ethics.aspx) Accessed 2009-02-20

## North Carolina
### North Carolina Board of Pharmacy

**Frequently Asked Questions for Pharmacists on Conscience Clause** . . . . . . . SC

Q: Does North Carolina have a "Conscience Clause" for dispensing emergency contraceptives?

A: The Board has adopted a policy on pharmacists' refusal to dispense prescriptions in certain circumstances: . . .

Compassionate care and conscientious objection are not mutually exclusive.

A pharmacist has the right to avoid being complicit in behavior that is inconsistent with his or her morals or ethics. It is unacceptable, however, for pharmacists to impose their moral or ethical beliefs on the patients they serve. Pharmacists who object to providing a medication for a patient on this basis alone, therefore, should take proactive measures so as not to obstruct a patient's right to obtain such medication.

The Board notes that although pharmacists have a right to avoid moral or ethical conflict, they do not have a right to obstruct otherwise legitimate prescription dispensing or delivery solely on the basis of conscientious objection.

Board of Pharmacy staff interprets this policy to mean that if a pharmacist refuses to fill a prescription for emergency contraception then that pharmacist has an obligation to get the patient and the prescription to a pharmacist who will dispense that prescription in a timely manner.

(http://www.ncbop.org/faqs/Pharmacist/faq_ConscienceClause.htm) Accessed 2009-02-21

## Oregon
### Oregon State Board of Pharmacy

**Considering Moral and Ethical Objections**
Revised February 2007 . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . SC

. . . Just as other health care professionals and practitioners in Oregon have a choice, so do pharmacists have a choice whether or not to participate in activities they find morally or ethically objectionable. Oregon pharmacists cannot however, interfere with a patient's lawfully and appropriately prescribed drug therapy or request for drugs and devices approved by the U.S. Food and Drug Administration (FDA) for restricted distribution by pharmacies. . .

The Board of Pharmacy expects each Oregon Pharmacist-in-Charge (PIC) to adopt written policies and procedures that address the issues of pharmacists' moral, ethical and professional responsibilities. It is the Board's belief that pharmacy policies and procedures could allow a pharmacist to exercise his or her choice to not participate, and at the same time not interfere with the patient's right to receive appropriate and lawfully prescribed drug therapy or drugs and devices approved by the U.S. FDA for restricted distribution by pharmacies. These may include dispensing of the prescription or drug or device by another pharmacist on site or arranging for the prescription to be dispensed by a pharmacist at another site. The Board also expects Oregon pharmacists to discuss issues of moral, ethical and professional responsibilities with their Pharmacist-In-Charge and to understand and comply with the pharmacy's policies and procedures.

The Board expects that pharmacy policies and procedures will ensure patients in Oregon always receive appropriate and lawfully prescribed medications and information or drugs and devices approved by the U.S. FDA for restricted distribution by pharmacies in a timely and professional manner and that patients are not burdened by the pharmacist's individual beliefs. Interference with a patient's right to receive timely, professional prescription services and information or drugs and devices approved by the U.S. FDA for restricted distribution by pharmacies may be considered unprofessional conduct and could result in disciplinary action by the Board. (See attached "Clarification")

**Position Statement History**
Originally Adopted September 2005
Revised February 2007

**Clarification**
For Example, the Board would consider it unprofessional conduct for a pharmacist to lecture a patient about the pharmacist's moral or religious beliefs, to violate the patient's privacy or to destroy, confiscate or otherwise tamper with the patient's prescription.

The written policy should require an objecting pharmacist to inform the PIC in advance so that the PIC can reasonably accommodate that objection before a patient presents a prescription or makes a request for drugs and devices approved by the U.S. FDA for restricted distribution by pharmacies. The accommodation may not include permission to lecture the patient. The policy should also ensure that the patient's prescription or drug and device needs are met either by ordering the drug, if it is not in stock, pursuant to the usual pharmacy policies, by transferring or returning the prescription to the patient if the patient requests, or by referring the patient to another pharmacy nearby where the patient can get the prescription filled or receive drugs and devices approved by the U.S. FDA for restricted distribution by pharmacies. In the event of a referral, the pharmacist is responsible for identifying another pharmacy that has the medication in stock and will dispense the prescription or dispense drugs or devices approved by the U.S. FDA for restricted distribution by pharmacies.

(http://www.pharmacy.state.or.us/Pharmacy/Position_Statements.shtml#Considering_Moral_and_Ethical_Objections) Accessed 2009-02-20

**Oregon State Pharmacy Association**

**Follows OSBPh "Considering Moral and Ethical Objections"** . . . . . . . . . . . . . . SC
(http://www.oregonpharmacy.org/advocacy_center/objections.php) Accessed 2009-02-24

## Pennsylvania

### Pennsylvania State Board of Pharmacy

**Matters of Conscience - Statement of policy** . . . . . . . . . . . . . . . . . . . . . . . . . . . . SC

The State Board of Pharmacy (Board) by this notice adopts the following statement of policy regarding matters of conscience, to read as set forth in Annex A. The policy statement sets forth guidelines that should be considered when a pharmacist has a religious, moral or ethical objection to filling a prescription. These guidelines are intended to ensure that patients are not abandoned or neglected and that pharmacists are not forced to engage in activities that conflict with their religious, moral or ethical beliefs.

**Background and Purpose**
Questions have been raised regarding the professional obligations of licensed pharmacists with respect to providing services to which they may be religiously, morally or ethically opposed. The Board is publishing this policy statement to provide guidance to pharmacists and pharmacies on how to handle the situation when a

pharmacist has an issue with filling a prescription due to a religious, moral or ethical objection. This statement of policy is not intended to supersede relevant laws, rules or regulations. The Board also recognizes that professional judgment is often based upon a specific set of facts that requires a particular analysis and not every situation can be addressed with general guidance.

**Guidelines**
Pharmacists have a professional responsibility to ensure that their patients obtain properly ordered and therapeutically appropriate medications in a timely matter with appropriate counseling from a pharmacist. Pharmacists also have a responsibility to practice competently and to protect against abandoning or neglecting a patient in need of immediate care without making alternate arrangements. When a pharmacist recognizes that the pharmacist's religious, moral or ethical belief, will result in the refusal to fill a prescription that is otherwise available in a pharmacy, the pharmacist has a professional obligation to take steps to avoid the possibility of abandoning or neglecting a patient. When a pharmacist begins practice in a professional setting, the pharmacist should take steps that may include notification to the owner and pharmacist-manager if the pharmacist's beliefs will limit the drug products the pharmacist will dispense.

If a pharmacy employs a pharmacist who has identified circumstances that would preclude the filling of prescriptions for particular products, the owner and pharmacist-manager should devise reasonable accommodations that will respect the pharmacist's choice while assuring delivery of services to patients in need. This may include scheduling of pharmacists to allow a pharmacist who has a religious, moral or ethical objection to practice simultaneously with another pharmacist who will fill the requested prescription, entering into collaborative arrangements with pharmacies in close proximity, or other accommodations designed to protect the public.

In addition, a pharmacist who has a religious, moral or ethical objection to filling a particular prescription should avoid judgmental or confrontational activities with the patient and should not interfere with another pharmacist filling the prescription.

The policy statement set forth in Annex A is effective upon publication in the Pennsylvania Bulletin

(http://www.dos.state.pa.us/bpoa/lib/bpoa/20/phabd/SpecialNoticeMoC.pdf) Accessed 2009-02-24

## South Dakota

### South Dakota Pharmacists Association

***Code of Ethics*** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . NA
(http://www.sdpha.org/default.asp?navid=37) Accessed 2009-02-20

# Appendix "D"

## Conscientious Objection as a Crime Against Humanity

A.1 The ultimate goal of the U.S.-based Center for Reproductive Rights is to establish what it calls "hard norms" - treaty-based international laws[144] - that recognize access to abortion as a fundamental human right.[145] It plans to develop a "culture of enforcement" that will compel governments to respect this 'right'[146] and enforce it against third parties - pharmacists and other health care workers.[147] Even as it works toward this end, it is cultivating "soft norms" in the form of statements by international, regional, and intergovernmental bodies.[148]

A.2 Professor Bernard M. Dickens appears to follow this strategy in a standard text, *Canadian Health Law and Policy*. In his chapter on Informed Consent, addressing the topic of conscientious objection and disclosure of relevant information to a patient, he notes that Canada has ratified the 1998 *Treaty of Rome* constituting the International Criminal Court. Within the context of a discussion of the refusal of physicians or institutions to advise women about the availability of the morning after pill "in order to oblige continuation of any pregnancy that may occur," he continues:

> Articles 7 and 8 of the treaty characterize forced pregnancy following rape as a crime against humanity and as analogous to torture. Human rights commissions may share this view, reinforcing their concerns about non-disclosure constituting both discrimination against women and inhuman and degrading treatment. Accordingly, the right to object to perform or immediately participate in medical procedures on grounds of conscience carries no parallel right to refuse to inform those eligible to receive these procedures where or how they are practically accessible.[149]

A.3 The goal here is clear enough. Readers of *Canadian Health Law and Policy* are to be persuaded that a health care worker who declines, for reasons of conscience, to direct a patient to the morning after pill or abortion commits the offence of "forced pregnancy." The passage is meant to convince them that, if this is not actually a crime against humanity analogous to torture, it is at least a gross violation of human rights that ought to be prosecuted by human rights commissions.

A.4 Dickens here glosses over the distinction between "forced pregnancy following rape" (the subject of the *Treaty*) and his broader claim concerning a "medically indicated

procedure" (the subject of his essay). Moreover, while he asserts only a duty of disclosure, the logic of his argument implies (as he argues elsewhere) that there is a similar duty to refer or otherwise facilitate the procedure.

**The *Treaty of Rome*: "forced pregnancy" and "torture"**

A.5 What first attracts critical attention is that Dickens refers to the *Treaty of Rome* in his text, but actually cites a different document -*The Elements of Crimes* - as authority for his claim that "forced pregnancy following rape" is "a crime against humanity. . . analogous to torture."[150] Why cite a secondary source rather than the *Treaty* itself?

A.6 A review of the *Treaty* suggests one possible answer. The *Treaty* does not support Dickens' claims. Specifically:

- In order to constitute a crime against humanity or war crime, the offence of "forced pregnancy" must be "committed as part of a widespread or systematic attack directed against any civilian population, with knowledge of the attack" [Art. 7(1)], or during war [Art. 8(2)b]

- Pregnancy is only "forced" within the meaning of the *Treaty* if a woman is unlawfully confined after having been raped "with the intent of affecting the ethnic composition of any population or carrying out other grave violations of international law." [Art. 7(2)f; Art. 8(2)b(xxii)]

- The definition of "forced pregnancy" must not "in any way be interpreted as affecting national laws relating to pregnancy," which include laws restricting or prohibiting abortion [Art. 7(2)f]

- "Torture" is not, at any point in the *Treaty*, associated with pregnancy, whether forced or not. It is specifically defined as "the intentional infliction of severe pain or suffering, whether physical or mental, upon a person in the custody or under the control of the accused." [Art 7(2)e][151]

***The Elements of Crimes*: "forced pregnancy" and "torture"**

A.7 *The Elements of Crimes* simply confirms the provisions of the Treaty, both with respect to torture and "forced pregnancy." The document adds nothing that even remotely suggests that conscientious objection to medical procedures or services could be a crime against humanity, or that it is analogous to torture. Again: why cite this

document in preference to the *Treaty of Rome*?

A.8 Perhaps the answer lies, not in what *The Elements of Crimes* includes, but in what it leaves out. It leaves out reference to the *Treaty* provision that recognizes the right of states to restrict or prohibit abortion by law, which is not relevant to the purpose of the document [Art. 7(2)f]. But the provision is highly relevant to Dickens' claim that delaying access to abortion is a violation of human 'rights,' since it flatly contradicts the notion that abortion is a human 'right.'

**What else has been left out**

A.9 Neither the *Treaty of Rome* nor *The Elements of Crimes* associates "forced pregnancy," even as it is defined by the *Treaty*, with torture. It is grouped with "rape, sexual slavery, enforced prostitution . . . enforced sterilization, or any other form of sexual violence of comparable gravity," but not with torture [Art. 7(1)g]. Nonetheless, Professor Dickens somehow manages to conclude that the documents "characterize forced pregnancy following rape . . .as analogous to torture."

A.10 The only possible explanation for this is that Professor Dickens considers "forced pregnancy" analogous to torture because both are included among the crimes against humanity listed in Article 7(1) of the *Treaty*. On this basis, then, every crime in the list is analogous to all of the others, so that "forced pregnancy" is analogous not only to torture, but to murder, forcible transfers of population, enforced disappearance of persons and apartheid, while murder is analogous to unlawful imprisonment, deportation, etc. If this is how Professor Dickens arrived at his singular conclusion, it is an open question whether his reasoning does a greater disservice to the law or to the English language.

A.11 In any case, the *Treaty* itself has something to say about analogy:

> The definition of a crime shall be strictly construed and shall not be extended by analogy. In case of ambiguity, the definition shall be interpreted in favour of the person being investigated, prosecuted or convicted. [Art. 22(2)]

Thus, the kind of extension of meaning advocated by Professor Dickens is expressly prohibited by the *Treaty*. This, too, Professor Dickens leaves out of his essay.

**Summary**

A.12 Professor Dickens very selectively borrows terms from the *Treaty of Rome*. He arranges his material to make it appear that conscientious objection that delays access to the morning after pill or abortion is actually or very nearly a crime against humanity

analogous to torture, or, at least, an egregious violation of human rights.

A.13 In addition to selective borrowing, Dickens leaves out everything necessary for a proper understanding of the *Treaty of Rome*, which, incidentally, includes everything that might cause a reader to question his claims. Finally, he directs the reader not to the *Treaty*, which includes a provision that is arguably fatal to his thesis, but to a document that omits the provision.

A.14 Professor Dickens' polemic seamlessly weaves the agenda of the Center for Reproductive Rights into a standard Canadian reference work. There is no doubt that this is advantageous to the Center and its allies, but it brings into question the reliability of *Canadian Health Law and Policy*. Perhaps it is time for a third and more carefully revised edition of the book.

# Notes

1. Alberta College of Pharmacists, *New Code of Ethics: 60-day consultation*. (https://pharmacists.ab.ca/nPharmacistResources/CodeofEthics.aspx) Accessed 2009-02-22

2. In Canada, consider the collision between medical ethics the demands of the Ontario Human Rights Commission that occurred in Ontario in 2008.

3. "The physician, the pharmacist, the nurse should have a right to take part or not in assisting a person once he or she has reached a decision to put an end to his or her life. Should they elect not to participate, their duty to their patient requires that they refer them to health professionals who will assist them." Canadian Pharmacists Association, *Living and Dying with Dignity - Studying Euthanasia and Assisted Suicide*. (16 November, 1994) (http://www.pharmacists.ca/content/about_cpha/whats_happening/government_affairs/government_briefs_111694.cfm#pres) Accessed 2009-02-21

4. Canadian Pharmacists Association brief, *Review of Issues Surrounding Euthanasia and Physician-Assisted Suicide*. 22 February, 2000. (http://www.pharmacists.ca/content/about_cpha/whats_happening/government_affairs/government_briefs_022200.cfm) Accessed 2009-02-22

5. National Association of Pharmacy Regulatory Authorities (NAPRA), *Model Statement Regarding Pharmacists' Refusal to Provide Products or Services for Moral or Religious Reasons*.(November, 1999) (http://www.napra.ca/docs/0/95/157/165/179.asp) Accessed 2009-02-21

6. New Brunswick Pharmaceutical Society, *Model Statement Regarding Pharmacists' Refusal to Provide Products or Services for Moral or Religious Reason* (November, 1999). (http://www.nbpharmacists.ca/LinkClick.aspx?fileticket=wcx0ugUqRRE%3d&tabid=261&mid=695) Accessed 2009-02-21

7. Prince Edward Island Pharmacy Board, *Policy Statement: Statement Regarding Pharmacists' Refusal to Provide Products or Services for Moral or Religious Reasons* (June, 2000). (http://www.napra.ca/pdfs/provinces/pe/moral06200.pdf) Accessed 2009-02-21

8. " Individual pharmacists may experience conscience problems when requested to provide services to which they have a moral objection. . . . In future these services might expand to include preparation of drugs to assist voluntary or involuntary suicide, cloning, genetic manipulation, or even execution." College of Pharmacists of British Columbia, "Ethics in Practice

Moral Conflicts in Pharmacy Practice." *Bulletin*, March/April 2000, Vol. 25, No. 2. (http://www.consciencelaws.orgt/Conscience-Archive/Reports/Report-2001-01a.html#APPENDIX "B"). In subsequent correspondence with the Project, the College Registrar continued the thought in correspondence, observing, however, that "there are strong ethical arguments that could be made against participating in . . .involuntary suicide . . ." Letter from the Registrar of the College of Pharmacists of British Columbia to the Project Administrator, 19 April, 2000. This was, the Registrar later explained, a slip of the pen. What was really meant was "involuntary *euthanasia*". Letter from the Registrar of the College of Pharmacists of British Columbia to the Project Administrator, 9 May, 2000.

9. "[Objecting] pharmacists must refer patients to colleagues who will provide such services, and in the end deliver these services themselves if it is impractical or impossible for patients to otherwise received them." College of Pharmacists of British Columbia, "Ethics in Practice Moral Conflicts in Pharmacy Practice." *Bulletin*, March/April 2000, Vol. 25, No. 2. (http://www.consciencelaws.orgt/Conscience-Archive/Reports/Report-2001-01a.html#APPENDIX "B"). "[T]here is a professional obligation to refer the patient to a pharmacist who is willing to provide the service. The pharmacist shall provide the requested pharmacy care if there is no other pharmacist within a reasonable distance or available within a reasonable time willing to provide the service." College of Pharmacists of British Columbia, *Code of Ethics* , Value 8 - Obligations, (2. )
(http://www.bcpharmacists.org/legislation_standards/standards_of_practice/code_of_ethics_detailed.php) Accessed 2009-02-20

10. Cooper J, Osmond B, Rantucci M. "Emergency Contraceptive Pills- Questions and Answers". Canadian Pharmaceutical Journal 133:5, June 2000. The finding is similar to expected pregnancy rates following 'unprotected' intercourse in studies by the Population Council and World Health Organisation (6.2% and 7.4% respectively). Cited in Trussell J, Ellertson C, von Hertzen H, Bigrigg A, Webb A, Evans M, et al. Estimating the effectiveness of emergency contraceptive pills (Abstract). Contraception 2003 Apr; 67(4):259-65. (http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=12684144.) Accessed on 29 November, 2004. A website maintained by Princeton University puts the figure at 8%. See NOT-2-LATE.com - The Emergency Contraception Website. (http://ec.princeton.edu/questions/eceffect.html) Accessed 29 November, 2004.

11. "Free the Doctor",*Globe and Mail*, 18 May, 1965. Quoted in de Valk, Alphonse, *Morality and Law in Canadian Politics: The Abortion Controversy*. Dorval, Quebec: Palm Publishers, 1974, p. 18]. Two years later the *Globe* argued that, in the case of abortion, "where religious moralities conflict, the State should support none, but leave the choice to individual

conscience.”["Now the job is to be done, let it be done right", *Globe and Mail*, 21 December, 1967. Quoted in de Valk, Alphonse, *Morality and Law in Canadian Politics: The Abortion Controversy*. Dorval, Quebec: Palm Publishers, 1974, p. 56]

12. The assurance given by a Canadian M.P. to a parliamentary committee studying her private member's bill to legalize abortion. [Quoted in de Valk, Alphonse, *Morality and Law in Canadian Politics: The Abortion Controversy*. Dorval, Quebec: Palm Publishers, 1974, p. 44-45]

Similar assurances came from the Canadian Welfare Council: “At the risk of labouring the obvious, no woman will be required to undergo an abortion, no hospital will be required to provide the facilities for abortion, no doctor or nurse will be required to participate in abortion.”[*Standing Committee on Health and Welfare, Minutes of Proceedings and Evidence, Appendix "SS": Canadian Welfare Council Statement on Abortion to the House of Commons Standing Committee on Health and Welfare*. February, 1968, p. 707].

Nor was the Catholic Hospital Association concerned: “We note that there is no question of [our hospitals] being obliged to change their present norms of conduct. On the contrary, proponents of a ‘liberalized’ abortion law admit that it should exempt those who object to being involved in procuring abortions.” [*Standing Committee on Health and Welfare, Minutes of Proceedings and Evidence, Appendix "QQ": Brief submitted by the Catholic Hospital Association of Canada . . . on the Matter of Abortion*. February, 1968, p. 8058-8059]

Canadian Justice Minister John Turner rejected a protection of conscience amendment to the government bill legalizing abortion because, he said, the proposed law imposed no duty on hospitals to set up committees, imposed no duty on doctors to perform abortions, and did not even impose a duty on doctors to initiate an application for an abortion. [*Hansard- Commons Debates*, 28 April, 1969, p. 8069]

13. CRR documents obtained by the Catholic Family and Human Rights Institute (CFAM) were entered in the United States Congressional Record (p. E2535 to E2547) on 8 December, 2003, to forestall efforts by the Center to suppress dissemination of the documents through litigation. They are available on the Project website. (http://www.consciencelaws.org/Conscience-Archive/Documents/CRRSecretStrategy.pdf)

The documents cited herein are:
International Legal Program Summary of Strategic Planning: Through October 31, 2003 (E2535)
ILPS Memo # 1- International Reproductive Rights Norms: Current Assessment (E2535-E2538);

ILPS Memo #2- Establishing International Reproductive Rights Norms: Theory of Change (E2538-E2539).

Domestic Legal Progam Summary of Strategic Planning Through October 31, 2004 (E2539)
DLPS Memo #1- Future of Traditional Abortion Litigation (E2539-2540);
DLPS Memo #2- Report to Strategic Planning Participants From Systematic Approach Subgroup (E2540-E2541).
DLPS Memo #3- Report to Strategic Planning Participants From "Other Litigation" Subgroup (E2541-E2542).

Program Strategies and Accomplishments (E2543)
The Center for Reproductive Rights: Summary and Synthesis of Interviews (E2543-2546)
The Center for Reproductive Rights Board of Directors - Primary Affiliation Information (E2547)

14. Which the "Other Litigation Subgroup" believed undermined the credibility of the CRR with respect to the interests of "women of colour." DLPS Memo #3, E2541) One of the Center's trustees also expressed concern that much of the funding from individuals was coming from donors over 60 years old ( The Center for Reproductive Rights: Summary and Synthesis of Interviews, E2546)

15. ". . .both the ICPD Programme of Action and the Beijing PFA reflect an international consensus recognizing the inalienable nature of sexual rights." ILPS Memo # 1, 2537

16. "Legally binding or ''hard'' norms are norms codified in binding treaties such as the International Covenant on Civil and Political Rights (ICCPR) or the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)" ILPS Memo # 1, E2535

17. The Center acknowledges that there is no binding international legal instrument that recognizes a right to abortion. [ILPS Memo # 1, E2536]

18. "The ILP's overarching goal is to ensure that governments worldwide guarantee reproductive rights out of an understanding that they are legally bound to do so." International Legal Program Summary of Strategic Planning: Through October 31, 2003 (E2535)

"Our goal is to see governments worldwide guarantee women's reproductive rights out of recognition that they are bound to do so." ILPS Memo #1, E2537; ILPS Memo # 2, E2538.

"The Center needs to continue its advocacy to ensure that women's ability to choose to terminate a pregnancy is recognized as a human right." ILPS Memo # 2, E2539

"Advocates use of enforcement mechanisms can help cultivate a "culture" of enforcement . . ." ILPS Memo #2, E2539

Pursuing the notion that abortion is part of "the fundamental rights strand of equal protection" is one of the suggestions in the report of the "Other Litigation" Subgroup, DLPS Memo #3, E2540. To establish abortion as a "fundamental" right would give it precedence over less "fundamental" rights in cases of conflict.

19. The norms offer "a firm basis for the government's duties, including its own compliance and its enforcement against third parties." ILPS Memo #2, E2538

20. "Supplementing . . .binding treaty-based standards and often contributing to the development of future hard norms are a variety of 'soft norms.' These norms result from interpretations of human rights treaty committees, rulings of international tribunals, resolutions of inter-governmental political bodies, agreed conclusions in international conferences and reports of special rapporteurs. (Sources of soft norms include: the European Court of Human Rights, the CEDAW Committee, provisions from the Platform for Action of the Beijing Fourth World Conference on Women, and reports from the Special Rapporteur on the Right to Health.)." ILPS Memo # 1, E2535

21. ILPS Memo # 2, E2538.

22. Whether or not the effect would be absolute would depend upon the relative value assigned to freedom of conscience *vis a vis* a 'right' to abortion. If both were considered equally fundamental, some tradeoffs might be permitted.

23. The Center also recognizes the importance of public opinion and public education. "Public education and awareness building" is identified as one form of advocacy (ILPS Memo # 2, E2539; DLPS Memo #2, E2540-E2541). The CRR recognizes that it is important to use arguments that are "appealing and understandable to the public" (DLPS Memo #2, E2540), and, similarly, the limited appeal of highly technical or legalistic approaches (DLPS Memo #2, E2541). It is foreseen that enforcement of new rights might require "sustained public awareness-raising campaigns" in addition to support from the medical community and others. One concern raised in the documents is the possibility that to try to formally establish "reproductive rights" in a new international instrument might, "as a matter of public perception," undermine CRR's

claims that such rights already exist (ILPS Memo # 1, E2538). It also encourages and takes advantage of favourable domestic political developments: ". . . the national political moment may be ripe for change, with or without the influence of international standards. Such changes. . . particularly in key countries in a region, may have a catlytic effect on neighbouring countries." (IPLS Memo #2, E2539).

24. ILPS Memo #2, E2538)

25. The Center seeks ways to bring its agenda "into the mainstream of legal academia and the human rights establishment"(ILPS Memo #2, E2539), seeing the media as a way to bring it "to the attention of relevant international, regional and national normative bodies, including legislators, other government officials, local and international judicial bodies, as well as medical bodies that can influence law and policy" (ILPS Memo #2, E2539).

26. DLPS Memo #1, E2539. Answers suggested in different parts of the documents include identifying "allies in government and civil society" (ILPS Memo #2, E2539) "fostering alliances with members of civil society who may become influential on their national delegations to the UN," (ILPS Memo #2, E2539), "collaboration with NGO's engaged in establishing legal norms at the national level" (ILPS Memo #2, E2539), and "providing input to civil society or government actors" (ILPS Memo #2, E2539). Consistent with a focus on elites rather than the public, references to "workshops around the world" are made within the context of getting input from "key players" and reinforcing the interest of "allies"(ILPS Memo #1, E2538), not public education.

27. ILPS Memo #1, E2538

28. For example, when the Center seeks sexual autonomy and access to abortion for children and adolescents, it proposes to work with "major medical groups" to achieve this end, not organizations representing parents. (DLPS Memo #2, E2540)

29. Center for Reproductive Rights, Memo #1 - International Reproductive Rights Norms: Current Assessment, E2538

30. ". . . there is no binding hard norm that recognizes women's right to terminate a pregnancy. To argue that such a right exists, we have focused on interpretations of three categories of hard norms: the rights to life and health; the right to be free from discrimination; those rights that protect individual decision-making on private matters." ILPS Memo #1, E2536

31. ILPS Memo #1, E2537 - E2538

32. "Arguments based on the decisions of one body can be brought as persuasive authority to decisions made in other bodies. . . As interpretations of norms acknowledging reproductive rights are repeated in international bodies, the legitimacy of these rights is reinforced." ILPS Memo #1, E2538

33. ISLP Memo #1, E2535, E2538.

34. "These lower profile victories will gradually put us in a strong position to assert a broad consensus around our assertions." ISLP Memo #1, E2538

35. Romalis, Garson, "Current Abortion Management." *British Columbia Medical Journal*, Dec. 1999, Vol. 41, No. 11, p. 554

"Morgentaler calls decision to halt abortions 'disgusting.'" *New Brunswick/St. John Telegraph Journal*, 9 November, 2002

36. Kretzul, E., "Ethical responsibilities in dealing with women requesting abortion services." *The Messenger*, No. 73, September, 1999. (http://www.cpsa.ab.ca/publicationsresources/attachments_messengers/m73.pdf) Accessed 2008-09-27.

An instruction published in 2000 by the Ethics Advisory Committee of the College of Pharmacists of British Columbia included statements that impugned the integrity of conscientious objectors within the profession by implying that they were dishonest in dealing with patients. The Registrar of the College later acknowledged there was no evidence to support the statements, but refused to retract them and apologize. Project Report 2001-01. *RE: College of Pharmacists of British Columbia- Conduct of the Ethics Advisory Committee* (Revised 24 May, 2001) (http://www.consciencelaws.org/Conscience-Archive/Reports/Report-2001-01.html#INTRODUCTION)

The President of the American College of Obstetricians and Gynecologists made the bald assertion that objectors "should be required to refer patients to other physicians who will provide the appropriate care." Mennuti, Michael T., *Letter to American Senators from the President of the ACOG*, 30 August, 2005. *American College of Obstetricians and Gynecologists Demands Compulsory Referral* (http://www.consciencelaws.org\Repression-Conscience\Conscience-Repression-45.htm)

37. *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

38. British Columbia pharmacist Frank Arche, for example, has claimed that pharmacists are obliged to provide services "despite personal religious or moral objections." *Canadian Pharmaceutical Journal*, May 2000, Vol. 133, No. 4, p. 22-26.

39. "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]

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

41. 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.

42. "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

43. "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

44. 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

45. 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/Ethical10.html)

46. American College of Obstetrics and Gynecology, Committee on Ethics Opinion No. 385 , *The Limits of Conscientious Refusal in Reproductive Medicine*, p. 3

(http://www.acog.org/from_home/publications/ethics/co385.pdf) Accessed 2008-09-24.

47. 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)

48. 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

49. "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 Policy: 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

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Similar assurances came from the Canadian Welfare Council: "At the risk of labouring the obvious, no woman will be required to undergo an abortion, no hospital will be required to provide the facilities for abortion, no doctor or nurse will be required to participate in abortion."[*Standing Committee on Health and Welfare, Minutes of Proceedings and Evidence, Appendix "SS": Canadian Welfare Council Statement on Abortion to the House of Commons Standing Committee on Health and Welfare*. February, 1968, p. 707].

Nor was the Catholic Hospital Association concerned: "We note that there is no question of [our hospitals] being obliged to change their present norms of conduct. On the contrary, proponents of a 'liberalized' abortion law admit that it should exempt those who object to being involved in procuring abortions." [*Standing Committee on Health and Welfare, Minutes of Proceedings and Evidence, Appendix "QQ": Brief submitted by the Catholic Hospital Association of Canada . . . on the Matter of Abortion*. February, 1968, p. 8058-8059]

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

97. "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.

98. "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.

99. "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

100. ". . . 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

101. "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

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144. "Legally binding or ''hard'' norms are norms codified in binding treaties such as the International Covenant on Civil and Political Rights (ICCPR) or the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)" ILPS Memo # 1, E2535

145. ". . . there is no binding hard norm that recognizes women's right to terminate a pregnancy. To argue that such a right exists, we have focused on interpretations of three categories of hard norms: the rights to life and health; the right to be free from discrimination; those rights that protect individual decision-making on private matters." ILPS Memo #1, E2536

146. "The ILP's overarching goal is to ensure that governments worldwide guarantee reproductive rights out of an understanding that they are legally bound to do so." International Legal Program Summary of Strategic Planning: Through October 31, 2003 (E2535)

"Our goal is to see governments worldwide guarantee women's reproductive rights out of recognition that they are bound to do so." ILPS Memo #1, E2537; ILPS Memo # 2, E2538.

"The Center needs to continue its advocacy to ensure that women's ability to choose to terminate a pregnancy is recognized as a human right." ILPS Memo # 2, E2539

"Advocates use of enforcement mechanisms can help cultivate a "culture" of enforcement . . ." ILPS Memo #2, E2539

Pursuing the notion that abortion is part of "the fundamental rights strand of equal protection" is

one of the suggestions in the report of the "Other Litigation" Subgroup, DLPS Memo #3, E2540. To establish abortion as a "fundamental" right would give it precedence over less "fundamental" rights in cases of conflict.

147. The norms offer "a firm basis for the government's duties, including its own compliance and its enforcement against third parties." ILPS Memo #2, E2538

148. "Supplementing . . .binding treaty-based standards and often contributing to the development of future hard norms are a variety of 'soft norms.' These norms result from interpretations of human rights treaty committees, rulings of international tribunals, resolutions of inter-governmental political bodies, agreed conclusions in international conferences and reports of special rapporteurs. (Sources of soft norms include: the European Court of Human Rights, the CEDAW Committee, provisions from the Platform for Action of the Beijing Fourth World Conference on Women, and reports from the Special Rapporteur on the Right to Health.)." ILPS Memo # 1, E2535

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