"NO MORE CHRISTIAN DOCTORS"
Crusade Against NFP-only Physicians

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Abstract

A 25 year old woman could not obtain a prescription for contraceptives at a clinic because the physician did not prescribe them for reasons of "medical judgment as well as professional ethical concerns and religious values." She obtained the prescription at a clinic two minutes away. A crusade was started against the physician and two colleagues with the same views. Crusaders argued that in a 'secular' state health care system, physicians should be forbidden to act on their moral or religious beliefs.

Physicians who refuse to prescribe contraceptives face a difficult challenge, since aggressive contraceptive promotion has left most people unaware of alternatives. Further, the social progress of women is widely attributed to contraceptives, so that failure to provide them risks an adverse reaction. Nonetheless, based on a respectful understanding of female fertility cycles and other factors, plausible reasons can be given to justify refusal to prescribe contraceptives and recommendation of Natural Family Planning.

The Supreme Court of Canada has acknowledged that secularists are believers, no less persons with religious beliefs. There is no legal warrant for the idea that a secular state must be purged of the expression of religious belief. The claim that a secular state or health care system is "faith-free" is radically false. Both religious belief and secularism can result in narrow dogmatism and intolerance, as demonstrated by the crusade against the physicians.

Since the practice of medicine is an inescapably moral enterprise, every decision concerning treatment is a moral decision. Since the practice of morality is a human enterprise, the secular public square is populated by people with many moral viewpoints. To discriminate against religious belief is a distortion of liberal principles. Moreover, if religious believers can be forced to do what they believe to be wrong, so can non-religious believers. This would establish a destructive and dangerous 'duty to do what is wrong.'

It is essential to maintain the integrity of physicians and well-being of patients. After abortion was legalized, a difficult compromise emerged that safeguards both, while protecting the community against a purported 'duty to do what is wrong.' However, some people are trying to entrench that duty in medical practice, moving from a purported duty to provide or facilitate abortion to a duty to kill or facilitate the killing of patients by euthanasia. It is unacceptable to compel people to commit or even to facilitate what they see as murder, and punish or penalize them if they refuse. It is equally unacceptable

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to insist that physicians must not act upon beliefs, because it is impossible; one cannot act morally without reference to beliefs. Such policies are inconsistent with the central place occupied by individual conscience and judgment in a liberal democracy.

Freedom of conscience can be adequately accommodated in a society characterized by a plurality of moral and political viewpoints if appropriate distinctions are made. The first of these is the distinction between the exercise of perfective freedom of conscience: pursuing an apparent good - and preservative freedom of conscience: refusing to participate in wrongdoing. The state can sometimes legitimately limit perfective freedom of conscience by preventing people from doing what they believe to be good, but it does not follow that it is equally free to suppress preservative freedom of conscience by forcing them to do what they believe to be wrong.

To force people to do something they believe to be wrong is always an assault on their personal dignity and essential humanity, and it always has negative implications for society. It is a policy fundamentally opposed to civic friendship, which grounds and sustains political community and provides the strongest motive for justice. It is inconsistent with the best traditions and aspirations of liberal democracy, since it instills attitudes more suited to totalitarian regimes than to the demands of responsible freedom. Even the strict approach taken to limiting other fundamental rights and freedoms is not sufficiently refined to be safely applied to limit freedom of conscience in its preservative form. Like the use of potentially deadly force, if the restriction of preservative freedom of conscience can be justified at all, it will only be as a last resort and only in the most exceptional circumstances.

That a young woman had to drive around the block to fill a birth control prescription does not meet this standard

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Part 1: The making of a story

What happened

On the morning of 29 January, 2014, a 25 year old married woman went to Care-Medics Medical Centres in Ottawa, a walk-in clinic that she claims she had frequented for about two years. She wanted a prescription for birth control pills. After giving her health number to the receptionist, she sat down and waited until she was called. When she told the receptionist why she was there, she was advised that it was not possible to have the prescription filled. The young woman was surprised and asked why. The receptionist pointed to "a stack of letters" on the desk. The woman picked one up and began to read it.

> Dear Patient:
>
> Please be advised that because of reasons of my own medical judgment as well as professional ethical concerns and religious values, I only provide one form of birth control, Natural Family Planning. In addition, I do not refer for vasectomies, abortions, nor prescribe the morning after pill or any other artificial contraception. If you are interested in the latter, please be aware that you may approach your own family doctor or request to be seen by another physician. . .[1]

Although she had attended the clinic for two years, this was the first time that this had happened, and she was understandably surprised. The receptionist told her that she could return the next day and see a different physician, but the woman explained that she could not do so because she was working. The receptionist advised her that she would have to go elsewhere if she wanted the prescription filled, as the physician was the only one available that day.

> It almost felt like I was doing something wrong. I felt truly embarrassed having to leave in front of a group of people because of something that someone thinks is shameful and not right.
>
> I had to go out of my way and find another clinic. Luckily for me, there was one not too far away. I still couldn't even believe what happened. I even mentioned it to the receptionist at the other clinic, and she was just as shocked as I was.[2]

The "other clinic" was the Sunrise Medical Centre in the Loblaws Store across the street on Merivale Road - a two minute drive. There was a pharmacy in the store, so presumably she had the prescription filled there.[3] In brief, a young woman was refused a birth control prescription at one clinic, but obtained the prescription and pills at another clinic and pharmacy two minutes away.

A happy ending?

That she had no difficulty obtaining her pills is not surprising, since, in the words of the Medical Officer of Health and the President of the Academy of Medicine of Ottawa, birth control services are "widely available" in the city. They encouraged anyone wanting the services to visit Ottawa Public

Health's Sexual Health Centre, family doctor "or the drop-in services available at more than 20 satellite locations . . . throughout the city." In fact, they urged people to "emphasize and celebrate" the wide availability of birth control services, the morning after pill, referrals for abortion, and vasectomies.[4]

This could have been the end of the story. It was in the case of another patient, who said that, two years earlier, she had crossed the same street to the same clinic for her birth control prescription.[5] It could even have been a happy ending. The physician in question was not forced to do something contrary to his medical judgment . . . professional ethical concerns and religious values." The young woman obtained the birth control pills she wanted. The Medical Officer of Health was presented with an opportunity to advertise his products and services. In his view, people in Ottawa even had reason to celebrate.

The gathering storm

Within a few days it became apparent that some people did not want the story to end there, did not want the story to end happily, and were in no mood to celebrate. In consequence, the story is continuing - in a sense. What actually happened has faded into the background, overwritten by pages of self-righteous indignation and outrage expressed in the expletives, exclamation marks, and acronyms of social media, and the more solemn judgments passed by various commentators consulted by mainstream media.

The story is no longer about a young woman who had to drive around the block to another clinic for her birth control pills. It is, rather, a story about a growing Canadian phenomenon: an obsessive fear and seething contempt for people who express and actually live by moral, ethical or religious beliefs. Not all of them, mind you: only those deemed heretical by secularist authorities and a secularist clergy that includes prominent academics, professionals, regulatory bureaucrats and pundits.

The phenomenon is exemplified by the witch-hunt whipped up in Montreal after two daycare workers were seen wearing niqabs (gasp) in a public place (double gasp, with stress on *public*) on an outing with the children in their care (triple gasp: post to Facebook, call the government).[6] It is exemplified by Quebec's proposed *Charter of Secularism*,[7] which the government of Quebec touts as the "solution" to "problems" like women who draw gasps because of what they are wearing rather than what they are not wearing. And it is exemplified by the new story in Ottawa that has supplanted the original, and that is proving to be much more interesting.

The crusade

It started innocently enough. The young woman was so taken aback by having been refused the prescription that, soon afterward, she posted a photo of the physician's letter on her Facebook page, with a note about it. In an account posted a few days later, she said that she did so "just to get a general idea to see if this is even legal."[8]

> Got turned away at my normal clinic becuase the doctor has moral issues with giving perscriptions for birth control. . .can doctors in a public clinics actually do this? [sic][9]

The first response from a 'friend' (12:44 pm) was "That's really bizarre!"[10]

Within minutes, another 'friend' advised her to "post that ____ on Reddit. Unacceptable!"[11]

Other similar comments followed. Then:

> Don't know how Canada is but isn't there a separation of church and state? Since you have socialized health care he gets payed by the state [s]o his religion shouldn't be able to have anything to do with it. [sic][12]

The young woman responded immediately, "Yes! Exactly! I believe your right." [sic][13]

A group that describes itself as "pro-choice" (though not, apparently, in favour of choices it dislikes)[14] posted a copy of the physician's letter on its Facebook page that afternoon:

> This was sent to us anonymously by a woman in Ottawa.
> So, yes - this is real.
> Yes - this is a real doctor.
> No - You are not in a time warp.
> (Feel free to circulate widely as a reminder to folks that we must remain forever vigilant).[15]

The responses were not long in coming. Outraged Facebookers called the physician a "jerk,"[16] a "complete anachronism,"[17] "disgusting,"[18] incompetent,[19] "unethical and unprofessional,"[20] a "worthless piece of ____,"[21] a "crummy doctor,"[22] "an idiot,"[23]and described him as - *judgemental*.[24]

"Goofballs like this," wrote one, "are the best walking arguments for the birth control they don't believe in."[25]

"He should move to the states, or maybe Dubai, where he will be among his own kind."[26]

The call to be "forever vigilant" appealed, naturally enough, to the vigilante set.

> I think that women should start going in looking for prescriptions for The Pill. You know, just a top up till their family doctor can see them again.[27]

We see hear (with appropriate winds and nods - "you know" -) a fairly obvious suggestion that women should go to the clinic and make gratuitous requests for birth control pills, knowing they will be refused, for the sole purpose of fabricating complaints against the physician to the College of Physicians and Surgeons and Ontario Human Rights Commission.

For, in the view of the fuming Facebookers, "The only sane solution is to revoke his licence unless he agrees to perform the duties for which he is being paid,"[28] because he had chosen "the wrong damned profession,"[29] he had "no business practicing [sic] family medicine"[30] and "does not deserve to practice in Canada. PERIOD."[31] A number urged that formal complaints be lodged against him, suggesting he was guilty of professional misconduct and even unlawful discrimination.[32]

"If this guy is still employed, and complaints aren't filed against him," wrote one, "then mission failed."[33]

The 'pro-choice' group assured their correspondent that they had received "lots of word" that people were calling the physician's clinic, the College of Physicians and Surgeons, and the Ontario Human

Rights Commission.[34]

The young woman was delighted with the results and congratulated the 'pro-choice' group on its handiwork.

> Thanks for posting my letter and getting the word out! It means a lot and I truely hope this gets spread nation wide! Keep fighting the good fight! [sic][35]

The 'other'

A member of the *Ottawa Citizen* editorial board picked up on the Facebook feeding frenzy. By late afternoon the day after the young woman went to the clinic, news that three physicians in Ottawa would not fill birth control prescriptions was on the front page.[36]

The appearance of the column increased the young woman's enthusiasm for what seems to have become her cause:

> This is so wacky!! But im so amazed that it was printed in the citizen!! Keep posting people and get the word out!! Keep your morals at home![37]

Of course, the young woman and her supporters - now including commentators on the *Citizen* website and elsewhere - were not keeping *their* morals at home. The warning, "Keep your morals at home!" was not meant for adherents of the gospel according to received opinion, but for people like the three physicians, who question that gospel: the heretics.

"THREE of them at the same clinic?" gasped one of the Facebookers.[38]

It is instructive, here, to change the emphasis: "Three of THEM at the same clinic?"

Them. THREE of THEM. That is, not one of US, but one of those OTHERS. From such a perspective, it isn't surprising that one of the Facebookers suggested that the physician should move elsewhere, "maybe Dubai," where he could "*be among his own kind*." Nor is it surprising that the case should be cited as "a perfect example" demonstrating the need for laws like the *Quebec Charter of Secularism*.[39]

The new story

This is the new story, and it is far more interesting than the story about the young woman who had to drive around the block to get her birth control pills. In fact, the original story - what actually happened - was not told on the 'pro-choice' Facebook page, nor in the *Ottawa Citizen* article. It was not what *actually* happened that sparked the outpouring of self-righteous and often venomous denunciation.

What triggered the preaching of the crusade was news that three Ottawa physicians had told their patients that they would not recommend, facilitate or do what they believed to be immoral, unethical, or harmful. Consulted by the *Ottawa Citizen* columnist, officials from the Canadian Medical Association and the College of Physicians and Surgeons of Ontario seemed unsure about whether or not there is room for that kind of integrity in the medical profession.[40] A few days later, a reporter with the *Medical Post* expressed doubt that it was even legal.[41]

We leave the officials pondering the problem presented by public displays of physician integrity, and return to the physician in question: that "disgusting", "incompetent unethical and unprofessional" "worthless piece of ____" who had so provoked the Facebookers by implicitly challenging some of their cherished dogmas. The morning after the *Ottawa Citizen* article appeared, one of his patients offered the following comment on the 'pro-choice' group Facebook page:

> This is my family doctor and I know he doesn't prescribe birth control pills it is the first thing he told me when I went for my first appointment. And it is true he said it was because of his religion I told him I could not care less because I have a hysterectomy and that I hope it doesn't bother him that I am an Atheist, it did not bother him at all. Here is the thing, I have been going to doctors for 25 years with the same problem and this Doctor figured out my problem in the first appointment with him, he is an excellent doctor. But I will agree with everyone that when he first told me about not prescribing birth control pills I thought that was very weird. But I do owe this Doctor my life.[42]

We find in this comment by a grateful patient something that will inform the next stage of this discussion. It is her reflection on her own response when the physician explained that he did not prescribe contraceptives: "I thought that was very weird."

Notes

In some cases, names have been replaced with blanks to preserve the privacy of the individuals concerned.

1. Letter, "Dear Patient."
(http://www.consciencelaws.org/images/2014-02-birthcontrolletter.jpg)

2. Desjardins K.. (Also known as "K___ A___") *IT HAPPENED TO ME: I Asked for Birth Control and Got a Form Letter Saying "No."* 4 February, 2014
(http://www.xojane.com/it-happened-to-me/it-happened-to-me-my-doctor-refused-to-refill-my-birth-control) Accessed 2014-02-08

3. On her Facebook page, K___ A___ stated that she went to "loblaws beside fit4less." K___ A___, 29 January, 2014. 12:52 pm.
(https://www.consciencelaws.org/background/procedures/birth002-B.aspx) Accessed 2014-02-08. The Care Medics clinic in this case is at 1375 Baseline Rd. in Ottawa. There is a Loblaws Store at 1460 Merivale Rd. next to a *Fit 4Less* at the same address. The Sunrise Medical Centre is located inside the Loblaws Store, as is a pharmacy. Google Maps indicates that the distance from Care Medics clinic to the Loblaws Store on Merivale Rd. is 1.1km, a two minute drive or seven minute walk. See Appendix "A".

4. Levy I. (Medical Officer of Health, Ottawa) and Abdullah A. (President, Academy of Medicine, Ottawa), *Letter to the Ottawa Citizen*, 1 February, 2014.

5. S____ C____. 30 January, 2014: 7:03 am | 7:05 am. Radical Handmaids (http://www.consciencelaws.org/background/procedures/birth002-C-02.aspx) Accessed 2014-02-08

6. Selley C. "Quebec's latest niqab panic." *National Post*, 23 November, 2013 (http://fullcomment.nationalpost.com/2013/11/23/chris-selley-quebecs-latest-niqab-panic/) Accessed 2014-02-08

7. Bill n°60 : *Charter affirming the values of State secularism and religious neutrality and of equality between women and men, and providing a framework for accommodation requests* (http://www.assnat.qc.ca/en/travaux-parlementaires/projets-loi/projet-loi-60-40-1.html) Accessed 2014-02-11

8. Desjardins K.. *IT HAPPENED TO ME: I Asked for Birth Control and Got a Form Letter Saying "No."* 4 February, 2014 (http://www.xojane.com/it-happened-to-me/it-happened-to-me-my-doctor-refused-to-refill-my-birth-control) Accessed 2014-02-08

9. K___ Autumn, 29 January, 2014 (http://www.consciencelaws.org/background/procedures/birth002-B.aspx#post-001) Accessed 2014-02-08

10. S____ M_____. 29 January, 2014, 12:44 pm. (http://www.consciencelaws.org/background/procedures/birth002-B.aspx#post-001) Accessed 2014-02-08

11. B_____ S_____. 29 January, 2014, 12:51 pm. Expletive deleted. (http://www.consciencelaws.org/background/procedures/birth002-B.aspx#post-001) Accessed 2014-02-08

12. S_____ B_____. 29 January, 2014, 2:23 pm. (http://www.consciencelaws.org/background/procedures/birth002-B.aspx#post-001) Accessed 2014-02-08

13. K___ A___, 29 January, 2014, 2:36 pm. (http://www.consciencelaws.org/background/procedures/birth002-B.aspx#post-001) Accessed 2014-02-08

14. Radical Handmaids: *About.* "The Radical Handmaids are pro-choice activists who love CanLit and really outrageous hats." (http://radicalhandmaids.com/about/) Accessed 2014-02-08

15. Radical Handmaids Facebook Page, 29 January, 2014 (http://www.consciencelaws.org/background/procedures/birth002-C-01.aspx) Accessed 2014-02-10

16. J___ R____, 29 January, 2014, 5:50 pm.
(http://www.consciencelaws.org/background/procedures/birth002-C-01.aspx) Accessed 2014-02-10

17. D___ D___ B___, 29 January, 2014, 5:58 pm
(http://www.consciencelaws.org/background/procedures/birth002-C-01.aspx) Accessed 2014-02-10

18. A___ R___, 29 January, 2014, 6:29 pm
(http://www.consciencelaws.org/background/procedures/birth002-C-01.aspx) Accessed 2014-02-10

19. M___ A___, 29 January, 2014, 7:19 pm
(http://www.consciencelaws.org/background/procedures/birth002-C-01.aspx) Accessed 2014-02-10

20. M___ A___, 29 January, 2014, 8:54 pm
(http://www.consciencelaws.org/background/procedures/birth002-C-01.aspx) Accessed 2014-02-10

21. M___ C___, 29 January, 2014, 8:57 pm. (Expletive deleted)
(https://www.facebook.com/RadicalHandmaids) Accessed 2014-02-10

22. S___ W___, 29 January, 2014, 9:36 pm
(http://www.consciencelaws.org/background/procedures/birth002-C-01.aspx) Accessed 2014-02-10

23. L___ J___ M___, 30 January, 2014, 9:24 am
(http://www.consciencelaws.org/background/procedures/birth002-C-03.aspx) Accessed 2014-02-10

24. T___ D___, 30 January, 2014, 4:25 am; C___ B___, 30 January, 2014, 5:07 am
(http://www.consciencelaws.org/background/procedures/birth002-C-02.aspx) Accessed 2014-02-10

25. J___ L___, 29 January, 2014, 10:10 pm
(http://www.consciencelaws.org/background/procedures/birth002-C-01.aspx) Accessed 2014-02-10

26. T___ M___, 29 January, 2014, 6:56 pm
(http://www.consciencelaws.org/background/procedures/birth002-C-01.aspx) Accessed 2014-02-10

27. C__ F___, 30 January, 2014, 6:53 am
(http://www.consciencelaws.org/background/procedures/birth002-C-02.aspx) Accessed 2014-02-

10

28. J___ O___, 30 January, 2014, 1:38 pm
(http://www.consciencelaws.org/background/procedures/birth002-C-03.aspx);
R___ L___ 29 January, 2014, 7:32 pm
(http://www.consciencelaws.org/background/procedures/birth002-C-01.aspx);
K___ N___ H___, 30 January, 2014, 11:48 am
(http://www.consciencelaws.org/background/procedures/birth002-C-03.aspx);
L___ C___ 31 January, 2014, 7:52 am.
(http://www.consciencelaws.org/background/procedures/birth002-C-04.aspx) Accessed 2014-02-10

29. K___ B___, 29 January, 2014, 7:56 pm
(http://www.consciencelaws.org/background/procedures/birth002-C-01.aspx) Accessed 2014-02-10

30. A___ M___ 29 January, 2014, 7:41 pm
(http://www.consciencelaws.org/background/procedures/birth002-C-01.aspx) Accessed 2014-02-10

31. R___ V___, 29 January, 2014, 7:52 pm
(http://www.consciencelaws.org/background/procedures/birth002-C-01.aspx) Accessed 2014-02-10

32. D___ M___, 30 January, 2014, 5:41 am
(http://www.consciencelaws.org/background/procedures/birth002-C-02.aspx);
N___ P___, 30 January, 2014, 8:12 am
(http://www.consciencelaws.org/background/procedures/birth002-C-02.aspx);
M___ C___, 30 January, 2014, 3:04 pm
(http://www.consciencelaws.org/background/procedures/birth002-C-03.aspx); A___ O___, 31 January, 2014, 5:26. (http://www.consciencelaws.org/background/procedures/birth002-C-04.aspx) Accessed 2014-02-10

33. N___ P___ 30 January, 2014, 8:40 am.
(http://www.consciencelaws.org/background/procedures/birth002-C-02.aspx) Accessed 2014-02-10

34. Radical Handmaids, 30 January, 2014, 8:45 am
(http://www.consciencelaws.org/background/procedures/birth002-C-02.aspx) Accessed 2014-02-10

35. K___ A___ Facebook Comment 30 January, 2014 11:24 am.
(http://www.consciencelaws.org/background/procedures/birth002-C-03.aspx) Accessed 2014-02-08

36. Payne E. "Some Ottawa doctors refuse to prescribe birth control pills." *Ottawa Citizen*, 30 January, 2014 (http://www.ottawacitizen.com/news/Some+Ottawa+doctors+refuse+prescribe+birth+control+pills/9450917/story.html) Accessed 2014-02-08

37. K___ A___ Facebook Comment 31 January, 2014. (http://www.consciencelaws.org/background/procedures/birth002-B.aspx#post-004_) Accessed 2014-02-08

38. C___ F___, 30 January, 2014, 5:35 pm. (http://www.consciencelaws.org/background/procedures/birth002-C-03.aspx) Accessed 2014-02-08

39. Gagnon S. "Contrary to democracy." Letter to the editor, Ottawa Citizen, 1 February, 2014.

40. Payne E. "Some Ottawa doctors refuse to prescribe birth control pills." *Ottawa Citizen*, 30 January, 2014 (http://www.ottawacitizen.com/news/Some+Ottawa+doctors+refuse+prescribe+birth+control+pills/9450917/story.html) Accessed 2014-02-08

41. Glauser W. "Ottawa clinic doctors' refusal to offer contraception shameful, says embarrassed patient." *Medical Post*, 5 February, 2014

42. M___ C___, 31 January, 2014, 7:16 am (http://www.consciencelaws.org/background/procedures/birth002-C-04.aspx) Accessed 2014-02-08

"NO MORE CHRISTIAN DOCTORS"

Crusade Against NFP-only Physicians

Part 2: Medical judgement and professional ethical concerns

"I thought that was very weird."

The patient who said that she owed her life to the physician whom others were calling a disgusting, incompetent, unethical jerk considered him an excellent doctor. However, she was as puzzled as the crusading Facebookers by his refusal to prescribe contraceptives. She understood it to be related to his religious views, but it was, she thought, "very weird." However, having had a hysterectomy, she was not concerned about it and did not pursue it further.

Her reaction is hardly surprising.

The contraceptive culture

The birth control pill hit the market in about 1960 and became increasingly available as time went on. The advent of "the pill" was soon followed by an exponential increase in out-of-wedlock births and eventually by legalization of abortion, from which point the number of abortions also dramatically increased. (See Appendix "D"). Despite the fact that medical professionals involved in family planning had long known that contraception was associated with abortion rates,[1] the demand for abortion following legalization caught the medical establishment off guard.[2] It appears that many attributed the increase to the surfacing of patients who would otherwise have sought clandestine abortions.[3]

In any case, the continuing escalation of out-of-wedlock births and demands for abortion reinforced the establishment view that these problems could only be solved by the wider use of contraception. Hence, the pharmaceutical industry and medical establishments in the developed world have made a variety of contraceptives increasingly available and have marketed them so aggressively that most people are unaware that there are any alternatives. In fact, most people have been convinced that a *failure* to use manufactured contraceptives of some kind is highly irresponsible. In addition, the social progress made by women in the last decades, especially their greater participation the job market, is widely attributed to their use of manufactured contraceptives.

As a result, abortion is now widely viewed and officially recognized as a 'backup' for failed contraception, and both have been linked in many minds to the social and economic well-being of women,[4] even as many people continue to advocate contraception because they claim it reduces abortion.

Challenging the culture

The consequence of all of this is that physicians or other health care workers who object to prescribing or dispensing contraceptives for reasons of conscience face an enormous challenge. Many people conclude that they are not only ignorant of the facts of life, so to speak, but also medically or scientifically ignorant and profoundly disrespectful of women. This largely explains the surprise of the young woman who had to drive around the block for her birth control pills and the vehement reaction of the Facebook crusaders. By and large, they have grown up in a culture shaped

by the widespread and unquestioning use of manufactured contraceptives. They instinctively perceive any contrary viewpoint to be "very weird" - or worse.

This kind of insular upbringing affects not only patients, but colleagues, physician regulators, government officials, bureaucrats, lawyers and judges, many of whom may be called upon to respond to complaints about an objecting physician. They have no difficulty understanding that reasonable people may have moral or ethical objections to abortion, euthanasia, or the amputation of healthy body parts. However, even the fairest and most well-intentioned of them may well be mystified when faced with a physician who challenges the acceptability of contraception. One might as well ask perennial desert dwellers for an opinion about what kind of snow is best suited for building igloos.

Introducing a different perspective

This affects the approach of the Protection of Conscience Project in responding to the attacks being made on the three physicians in Ottawa. The Project does not take a position on the morality of services or procedures, but focuses, instead, on supporting freedom of conscience. This works well enough when people appreciate the basis for the position taken by objectors on familiar contentious subjects, like assisted suicide.

However, this is insufficient when, as in the present case, an attack on freedom of conscience resembles a religious crusade, when, with supreme self-righteous confidence, people demand absolute conformity to dogmas like 'the right to choose' or 'secularism,' when they urge the professional excommunication of dissenting physicians, and when they treat unfamiliar world-views as dangerous heresies that must be driven from the public square.

In this situation, what is needed at the outset is not a call to arms, but an invitation to consider a different perspective. That is the purpose of this part of the Project's response. The goal here is not to convince others that an objector's viewpoint is correct, but to demonstrate that it is sufficiently plausible to warrant the deference customarily accorded in liberal democracies to thoughtful and considered dissent.

In the beginning

The original story about the young woman who had to drive around the block for her birth control pills began with a letter, and the story that displaced the original and became an epic of sorts began with the same letter. Now that the dust of the crusading host has abated somewhat, we can return to the beginning of both stories and read the letter once again: this time, attentively.

The physician states that the only kind of birth control he provides is Natural Family Planning, and that he will not prescribe or refer for artificial contraception, abortion, vasectomies, or the morning after pill. He offers three reasons for his practice, not one: "medical judgement," "professional ethical concerns," and "religious values." Religious belief is not offered as the first reason, nor as the exclusive reason; none of the three reasons offered need exclude the others.

Since all of the services he declines to provide and the single kind of service he will provide all involve the control of human fertility, we must assume that the control of human fertility is the focus of the medical judgement, professional ethical concerns and religious values to which he refers.

Medical judgement

We will begin where the physician begins: with medical judgement pertaining to human fertility. The essentials are set out in general terms in Appendix "E."

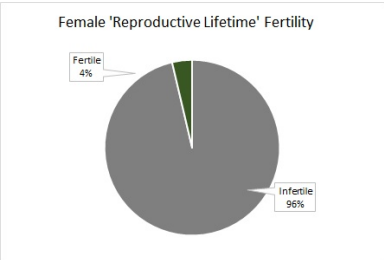
The physician in this case implies that, in his *medical* judgement, Natural Family Planning (NFP) is not only preferable to contraception, but is the only *medically* appropriate means to control human fertility. The physician's mention of medical judgement was almost completely ignored by the Facebookers. Only one referred to it, and that was for the sole purpose of mockery - as if the very possibility of adverse medical judgement were absurd, and the reference to it by the physician a disingenuous subterfuge.[5] This illustrates that, for them, as for most, belief in the necessity and goodness of manufactured contraceptives that has been encouraged by the state, pharmaceutical industry and medical establishment has assumed the character of unquestioned and even unquestionable dogma. And that, in turn, suggests an explanation for the vehemence of their reaction.

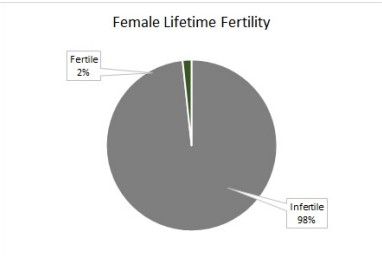
Now, sound medical judgement begins with and remains focused on the patient and is exercised respectfully. It must be informed by correct science, avoiding or minimizing foreseeable risks or harm. It must seek a reasonably effective response to the needs of the patient, the anticipated benefits of which outweigh potential risks or harms. Medical judgement requires the reasonable exercise of discretion, which is shaped and refined by clinical wisdom born of experience. More could be added, but these elements are essential.

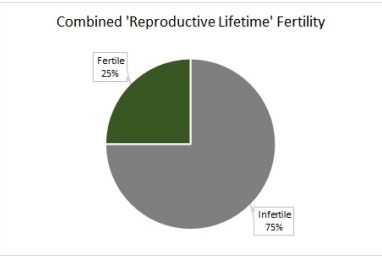
Relying on these criteria, we can ask the relevant question. Is there a plausible justification for the physician's medical judgement that NFP is preferable and that contraception should be avoided?

The patient and establishment practice

The majority of physicians favour the control of fertility by contraception, post-coital intervention and sterilization, and many recommend and facilitate abortion when these measures fail. It is instructive, at this point, to reproduce three of the charts from Appendix "E".







With these charts in view, note that women who do not wish to become pregnant are advised by most physicians that they should take a birth control pill *every* day or use some form of contraception *every* time they have sexual intercourse, and that if *ever* they have "unprotected" intercourse they should forthwith take the morning after pill. Notice the assumptions: that it is possible for a woman to become pregnant 365 days a year, and possible for a woman to become pregnant every time she has sexual intercourse.

The patient and alternative medical judgement

The comparative charts make it abundantly clear that these assumptions cannot possibly be derived from female physiology or fertility cycles. A woman can conceive only during a 12 to 24 hour period during each menstrual cycle, and she can become pregnant as a result of sexual intercourse during only about 25% of her reproductive lifetime, but she is advised to use contraceptive drugs or devices every day, 100% of the time, if she wishes to avoid pregnancy. Thus, the design and recommended use of contraceptives appear to reflect male physiology and fertility. Moreover, much of current contraceptive practice appears to reflect the assumption that normal, healthy female physiology and fertility present problems that have to be solved.

Beginning with a focus on the patient, one might propose a basic premise: women are not men.

If this premise is accepted, it implies that the human male is not the paradigm in whose likeness the human female ought to be remade for her own good or that of the community. From the fact that a man can never become pregnant from an act of sexual intercourse, it does not follow that a woman is defective because she can, and that medical intervention is required to correct the purported defect.

If this premise is accepted, it implies that a woman who comes to a physician should receive medical treatment and health care that reflects her physiology, including her fertility pattern. It implies that it is not appropriate to provide a woman with reproductive health care that is based on male reproductive physiology and fertility, nor to act as if female physiology and fertility are pathological conditions requiring treatment with drugs, medical appliances or surgery.

The principal Natural Family Planning methods - the Billings Ovulation Method, the Sympto-Thermal Method and Creighton Method - all demand that a physician recognize and respect a woman's actual physiology and fertility pattern, and not offer treatment or advice based on male physiology and fertility. NFP methods are unquestionably patient-centred, and do not treat women like men.

Science, establishment practice and alternative medical judgement

There is no doubt that contraception and related practices are well-grounded in science, but so, too, are the principal Natural Family Planning methods, so this element in the formation of medical judgement cannot be decisive in and of itself.

However, it should be noted that the principal NFP methods are not only informed by scientific investigation of human fertility and make use of its findings; practitioners communicate those findings to patients. This is what makes it possible for them to teach women and men how to recognize the days when sexual intercourse may result in conception, so that they can avoid or achieve a pregnancy. Since the Society of Obstetricians and Gynaecologists acknowledges that most women are not well informed about their fertility cycles,[6] a physician who opts for NFP rather than contraception can reasonably cite this as a factor influencing his medical judgement.

Avoiding harm, establishment practice and alternative medical judgement

It is widely recognized that the use of commonly recommended contraceptives entails a variety of side effects and health risks. A recently published paper[7] identified six:

I) The BCP is a human carcinogen in women[125-127], in men [128] (through environmental

contamination) and in offspring [129] (through vertical transmission).

ii) The BCP significantly increases the risk of cardiovascular events [130], hypertension [131, 132], and cerebrovascular disease [133].

iii) The BCP is a significant determinant of diminished and irreversible female sexual dysfunction [134, 135].

iv) The BCP exerts an adverse effect on mood in some women [136, 137].

v) The BCP is a widespread and escalating endocrine disrupting contaminant in the ecosystem and domestic water supply [128, 138, 139]

vi) Some BCPs increase the risk of adverse birth outcomes and allergy in offspring of users [140, 141]

Certainly, side effects and risks are associated with any medical intervention and have to be balanced against benefits for the patient. Moreover, the significance and probability of the side effects and risks associated with contraceptives may be disputed.

However, no health risks or adverse side effects are associated with the practice of Natural Family Planning. Of interest here are the comments in the guidelines of the Society of Obstetricians and Gynaecologists of Canada. The only identified "risk" is the "high probability of failure with all fertility awareness methods if they are not used consistently and correctly." On the other hand, the guidelines acknowledge "non-contraceptive benefits":

> Women who monitor or chart their fertility signs often have greater awareness of their own gynaecological health and are better able to discern the difference between normal and abnormal cervical secretions. As well, charting fertility signs can alert women to factors that may contribute to infertility, such as anovulation. Incorporating this information into family planning programs generally would greatly benefit women.[8]

Thus, a physician might plausibly conclude that it is medically inappropriate to recommend procedures or treatments that are known to involve risks for the patient when there are reasonably effective alternatives that do not, and which, moreover, offer additional health benefits for patients.

Effectiveness, establishment practice and alternative medical judgement

The effectiveness of manufactured contraceptives is not disputed, but neither is the effectiveness of the principal Natural Family Planning methods, if used consistently and correctly. They compare favourably to the effectiveness of manufactured contraceptives, although "typical use" effectiveness is less well established for the Billings Ovulation Method (See Appendix "D2"). In fact, the Society of Obstetricians and Gynaecologists of Canada states that it is a "myth" that NFP is unreliable: "These methods can be quite reliable when used correctly."[9]

In addition, instruments that can accurately identify times when pregnancy can occur have been on the market for some time. Cost is a factor affecting their availability, but their effectiveness in birth control is comparable to that of manufactured contraceptives. One such instrument is included in Chart D2.1.1.

The effectiveness of NFP (correctly and consistently applied) is not widely known, as is reflected by

one of the first comments on the 'pro-choice' Facebook page:

> OMG. This is a recent letter?? The name for "Natural Family Planning" is "parenthood"![10]

It is true that pregnancy can result if NFP methods are used, but that is also true of manufactured contraceptives, and more often than might be expected. A recent report states that 66% of women who had abortions in the United Kingdom were practising contraception; 40% of the contraceptors were using the birth control pill.[11]

This introduces another factor that might reasonably affect medical judgement. Acknowledged experts known to be supportive of contraception have repeatedly acknowledged that women who use contraceptives are much more likely to have abortions than women who do not.[12] If a physician believes that abortions are medically undesirable (an issue well beyond the scope of this paper) this might tip an otherwise even balance against contraception.

Professional ethical concerns

While the physician's letter notes that he has "professional ethical concerns" that are related to the control of human fertility, the generality of the statement and the broad range of issues that might be covered by it preclude close consideration of all that this might entail. Nonetheless, professional ethical concerns are usually connected to medical judgement, so we might usefully consider the first three sections of the *Code of Ethics* of the Canadian Medical Association in light of the foregoing discussion.[13]

#1. Consider first the well-being of the patient

What constitutes or contributes to the "well-being" of a patient is largely determined by a competent patient, not by a physician, though a physician may well contribute to the patient's decision. However, it does not follow that a physician is always obliged to agree with the patient's decision or to give effect to it. What happens in the case of such disagreements is largely dependent upon patient and physician concerned and their respective evaluations of what is at stake.

More relevant here is the obligation of the physician to offer the patient his best medical judgement about a recommended course of treatment or action, and, in so doing, select treatments that avoid or minimize health risks or adverse side effects. In light of the discussion about medical judgement, it is not unreasonable to think that professional ethical concerns related to the first section of the CMA *Code of Ethics* might be engaged in a decision by a physician to offer Natural Family Planning and decline to offer contraceptive services.

#2. Practise the profession of medicine in a manner that treats the patient with dignity and as a person worthy of respect

A physician who subscribes to this provision may well give effect to it by providing a woman with assistance in controlling her fertility that is informed and shaped by female physiology and fertility. Similarly, he might consider an attempt to treat female fertility according to the paradigm of male fertility a violation of this section of the *Code*.

#3. Provide for appropriate care for your patient . . .

What is expected here is that the physician should offer treatment and care that he deems to be appropriate. As indicated by the foregoing discussion, a physician might put this section of the *Code* into practice precisely by declining to provide contraceptive services and offering NFP instead.

Discrimination

In 2008, the Ontario Human Rights Commission attempted unsuccessfully to suppress freedom of conscience in the medical profession through the College of Physicians and Surgeons of Ontario.[14] In view of the Commission's demonstrated hostility to freedom of conscience among health care workers and its inquisitorial powers,[15] it is appropriate to consider one final point under this head: the ethical obligation of physicians to refrain from illegal discrimination.

It is occasionally alleged that refusing to prescribe, provide or refer for contraceptives constitutes illegal discrimination against women. Assuming that a physician is motivated by the kind of alternative medical judgement described above, such a claim in this context is not only implausible, but incoherent.

It would imply that a physician who offers medical advice and assistance to a woman that is guided by and fully respects her physiology and fertility cycles is treating her unfairly. It would imply that a physician who helps a woman to avoid or achieve pregnancy by helping her to understand her own reproductive physiology is failing to treat her as a unique individual. Ultimately, it would imply that a physician is a bigot if he insists that women are not men, and should not have to make do with fertility control techniques that assume the normative value of male reproductive physiology and treat female reproductive physiology as a birth defect.

Beyond the absurdity involved in such claims, they are also dangerous, because they invite human rights bureaucrats to substitute their opinions for those of medical professionals in medical decision-making.

Case study

Having reflected upon what might inform the medical and professional ethical judgement of an NFP-only physician, we can return to the letter that set activist drums beating in the nation's capital and consider the judgement passed upon it by one of their number:

> Any female doctor who wrote this, as well as any MALE doctor who wrote this, as well as any other NON BINARY GENDER TYPE DOCTOR who would DARE send any patient this notice does not deserve to practice in Canada. PERIOD.[16]

They expect the College of Physicians and Surgeons of Ontario and other regulatory authorities across the country to compel NFP-only physicians to "stand and deliver" when patients demand contraceptives, or revoke their licences to practise. It seems that nothing short of that will satisfy them. This expectation can be considered within the context of a hypothetical case study.

The accused

A physician entering practice in Ontario acknowledges that men and women may have reasons for avoiding pregnancy. He wishes to assist his patients in controlling their fertility, and considers the

range of birth control measures available.

He observes that the design and recommended use of contraceptives appear to reflect male physiology and fertility patterns. He notes that officially recommended contraceptive practice seems to assume that normal, healthy female physiology and fertility present problems that have to be solved, if not pathological conditions. His research confirms that some of the most common and highly recommended contraceptives are associated with a variety of adverse side effects and health risks, though their frequency and significance are subjects of some dispute.

The physician believes that it is medically inappropriate and disrespectful to recommend or provide a woman with contraceptive methods that suppress her normal, healthy bodily functions. He believes that a physician's practice should reflect the fact that a woman is a woman, and not a man - let alone a defective man. He wishes to provide women with assistance with fertility control that is scientifically sound and effective, but also responsive to and respectful of female reproductive physiology.

Having heard about Natural Family Planning as a result of a controversy in Ottawa, he researches the Billings Ovulation Method, the Sympto-Thermal Method and Creighton Method. He learns that all of the methods are responsive to and respectful of both male and female reproductive physiology, that they have a sound scientific basis, and that no health risks are associated with their use. He finds that, if used correctly and consistently, they are as effective as manufactured contraceptives.

The physician learns that NFP instructors teach women and men about human fertility and how they can recognize the days when sexual intercourse may result in conception, so that they can avoid or achieve a pregnancy. He knows that most women are not well informed about their fertility cycles, so he values the fertility awareness instruction offered by NFP. He also recognizes the non-contraceptive benefits associated with NFP that have been acknowledged by the Society of Obstetricians and Gynaecologists of Canada.

Based on all of this, he concludes that he will offer his patients only Natural Family Planning, and will not prescribe, recommend or refer for contraceptives. Knowing that this approach will be unexpected, he ensures that patients are aware of his position in advance and that potential patients are notified by means of a notice in his waiting room, a practice required of another physician by the College of Physicians and Surgeons of Ontario.[17] While willing to explain his position during clinical encounters and to provide information about other forms of birth control, he understands that some patients may be inconvenienced and annoyed if they are told about his policy only after waiting for an appointment. He hopes the notice will minimize inconvenience for patients who want only manufactured contraceptives.

The accusers

One day, a young woman comes to his clinic to get a prescription for the birth control pill. She is surprised and annoyed by the notice posted in the waiting room. She crosses the street to get her prescription at another clinic, and then posts an account of her experience on Facebook. In short order, the physician learns that he is a "jerk," a "complete anachronism," "disgusting," incompetent, "unethical and unprofessional," a "worthless piece of ____," a "crummy doctor," "an idiot," and a judgemental "goofball."

The College

The College of Physicians receives complaints that the physician's NFP-only policy and notice to patients is unacceptable, and demands that his licence to practise medicine be revoked.

For present purposes, it is sufficient to consider some of the questions raised by the complaints and demands of the accusers.

Is the physician in the case study a "jerk"? Is he "disgusting"? Is he an "idiot"? A "goofball"?

More specifically, within the context of the College's mandate, is the physician in the case study "unethical and unprofessional"? Is he a "crummy doctor"? Is there evidence that he is incompetent? Can the College demonstrate that his reasoning is unsound? That he is misinformed, or uninformed? Has the physician in the case study demonstrated conduct or attitudes unbecoming a member of the profession?

Is it fit, proper and right that the physician in the case study - and those like him - should be driven from the practice of medicine if they insist that their medical judgement, formed in the manner described here, should be respected, even if it differs from that of the establishment?

Diversity, respect and tolerance

At this stage there is no question of the accommodation of religious belief. We are simply considering how a different perspective might yield a different approach to fertility control and produce alternative medical and professional ethical judgements. Moreover, the case study has taken a bare-bones approach to the issue; in an actual case an accused physician would likely have much more to say.

However, the expectations and demands of the accusers notwithstanding, it appears that a medical judgement formed in the manner described here is sufficiently plausible to warrant the respect customarily accorded to divergent opinions and practice within the medical profession, and to the tolerance citizens of a liberal democracy have a right to expect.

We have not yet come to the issue of freedom of conscience. That cannot be taken up until we have considered the third reason offered by the Ottawa physician for his practice: "religious values."

Notes

1. As early as 1932, a physician observed that women practising contraception seemed naturally to seek an abortion if contraception failed. "Contraceptive measures are undoubtedly one factor in lowering the incidence of demand for abortion, and within recent years I have been rather impressed with the attitude of mind of the woman, who has practised contraception and who has failed to attain her object. Such woman seems to feel that she has a right to demand the termination of an unwanted pregnancy. The criminal aspect of the matter does not appear to enter her mind at all." Whitehouse B. "A paper on indications for induction of abortion. Br Med J. 1932 August 20; 2(3737): 337–341. (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2521538/?page=2/) Accessed 2014-02-14

Four years later Dr. Raymond Pearl (for whom the Pearl Index is named) observed that frequency of abortion was "three to four or more times greater, generally speaking, among contraceptors

than among non-contraceptors." and that "white married women . . .who practise contraception . . .resort to criminally induced abortions about *three times* as often proportionately as do their comparable non-contraceptor contemporaries." He concluded that perhaps three quarters of criminal abortions were attributable to the birth controllers and the current imperfections in the technique of their art." Pearl R. *The Natural History of Population*. London: Oxford University Press, 1939) p. 222, 240-241.

According to a study published in 1940 by Margaret Sanger's Clinical Research Bureau, 41 percent of the pregnancies of contracepting women were ended by abortion, but only 3.5 percent of non-contracepting women resorted to the procedure. Stix RK, Notestein F. Controlled Fertility: An Evaluation of Clinic Studies. Baltimore: William and Wilkins, 1940, p. 79-87. Cited in Whitehead KD, "Do Sex Education and Access to Contraception Cut Down on Abortion?" FCS Quarterly, Vol. 21, No. 3, Summer, 1998 (http://2786.datatrium.com/fcs/PDFFiles/v21n3sum1998.pdf) Accessed 2014-02-14)

By 1955, Planned Parenthood concluded that there was still no evidence that increased availability of contraception would reduce the illegal abortion rate. Dr. Alfred Kinsey reminded a Planned Parenthood conference that "we have found the highest frequency of induced abortion in the group which most frequently uses contraceptives." Calderone M. (Ed.) *Abortion in the United States*. New York: Harper and Row, 1958, p. 157. Cited in Whitehead KD, "Do Sex Education and Access to Contraception Cut Down on Abortion?" FCS Quarterly, Vol. 21, No. 3,Summer, 1998 (http://2786.datatrium.com/fcs/PDFFiles/v21n3sum1998.pdf) Accessed 2014-02-14)

Almost thirty years later, Planned Parenthood officials acknowledged that pregnant women who use contraception were more likely to have abortions than those who were not, and associated an increase in contraceptive use with an increase in abortion. Tietze C. "Abortion and Contraception" in Sachev P. Abortion: Readings and Research. Toronto: Butterworths, 1981, p. 54-60. Potts M. "Abortion and Contraception in Relation to Family Planning Service" in Hodgson J. (Ed.) *Abortion and the Politics of Motherhood*. Berkeley: University of California Press, 1984, p. 112. Both quoted in Whitehead KD, "Do Sex Education and Access to Contraception Cut Down on Abortion?" FCS Quarterly, Vol. 21, No. 3,Summer, 1998 (http://2786.datatrium.com/fcs/PDFFiles/v21n3sum1998.pdf) Accessed 2014-02-14)

2. "Therapeutic abortion: Government figures show big increase in '71." CMAJ, 20 May, 1972, Vol. 106, 1131. Lewis TLT. *The Abortion Act*. Br Med J. 1969 January 25; 1(5638): 241–242 (http://pubmedcentralcanada.ca/pmcc/articles/PMC1982054/pdf/brmedj02016-0075.pdf) Accessed 2014-02-14

3. Hordern A. Legal Abortion: *The English Experience*. Oxford: Pergamon Press, 1971, p. 102.

4. Ann Furedi the chief executive of the British Pregnancy Advisory Service, told New Zealanders that abortion is required as a part of family planning programmes because contraception is not always effective. She noted that abortion rates do not drop when more

effective means of contraception are available because women are no longer willing to tolerate the consequences of contraceptive failure. *Abortion a necessary option: advocate*. 18 October, 2010, TVNZ. (http://tvnz.co.nz/health-news/abortion-necessary-option-advocate-3839309) Accessed 2014-02-15.

Over twenty years ago, the U.S. Supreme Court stated that "for two decades of economic and social developments, people have organized intimate relationships and made choices that define their views of themselves and their places in society, in reliance on the availability of abortion in the event that contraception should fail. The ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives." *Planned Parenthood of Southeastern Pa. v. Casey* - 505 U.S. 833 (1992), p. 856 (http://supreme.justia.com/cases/federal/us/505/833/case.html) Accessed 2014-02-15

5. L__J__M___, 30 January, 2014, 10:15 am. (http://www.consciencelaws.org/background/procedures/birth002-C-03.aspx)

6. Black A, Francoeur D, Rowe T. *Canadian Contraception Consensus*. SOGC Practice Guideline No. 143- Part 3 of 3 (April, 2004) Chapter 9, p. 365 (http://sogc.org/guidelines/canadian-contraception-consensus-part-3-of-3-replaces-131aug-2003-and-49-sept-1996/) Accessed 2014-02-11

7. Genuis SJ, Lipp C. Ethical Diversity and the Role of Conscience in Clinical Medicine. Int J Family Med. 2013;2013:587541 (http://www.hindawi.com/journals/ijfm/2013/587541/) Accessed 2014-02-15

8. Black A, Francoeur D, Rowe T. *Canadian Contraception Consensus*. SOGC Practice Guideline No. 143- Part 3 of 3 (April, 2004) Chapter 9, p. 365 (http://sogc.org/guidelines/canadian-contraception-consensus-part-3-of-3-replaces-131aug-2003-and-49-sept-1996/) Accessed 2014-02-11

9. Black A, Francoeur D, Rowe T. *Canadian Contraception Consensus*. SOGC Practice Guideline No. 143- Part 3 of 3 (April, 2004) Chapter 9, p. 365 (http://sogc.org/guidelines/canadian-contraception-consensus-part-3-of-3-replaces-131aug-2003-and-49-sept-1996/) Accessed 2014-02-11

10. M___ L___, 29 January, 2014, 5:55 pm. (http://www.consciencelaws.org/background/procedures/birth002-C-01.aspx) Accessed 2014-02-10)

11. *Women trying hard to avoid unwanted pregnancy, research shows*. British Pregnancy Advisory Service news release, 4 February, 2014 (http://www.bpas.org/bpasknowledge.php?year=2014&npage=0&page=81&news=624) Accessed 2014-02-15

12. See notes 1, 4

13. Canadian Medical Association, *CMA Code of Ethics* (Update 2004) (http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf) Accessed 2014-02-15

14. Protection of Conscience Project, Ethics: Resisting Ethical Aggression. Notable Challenges - *Physicians and the Ontario Human Rights Code*. (http://www.consciencelaws.org/ethics/ethics-challenges-003.aspx)

15. Murphy S. *The New Inquisitors*. Protection of Conscience Project (31 August, 2008) (http://www.consciencelaws.org/law/commentary/legal036.aspx)

16. R___ V___, 29 January, 2014, 7:52 pm (http://www.consciencelaws.org/background/procedures/birth002-C-01.aspx) Accessed 2014-02-10

17. In 2002 the College formally approved a written notice to patients and directed that it be made available in the physician's waiting room. Citing the Canadian Medial Association's *Code of Ethics*, the notice conveyed in explict terms the physician's religiously based objection to providing or arranging for abortions, or for prescriptions for birth control for unmarried patients, or Viagra for unmarried men. Murphy S. *Ontario College of Physicians and Surgeons accommodates Christian physician*. Protection of Conscience Project, August, 2002 (http://www.consciencelaws.org/repression/repression017-003.aspx)

"NO MORE CHRISTIAN DOCTORS"
Crusade Against NFP-only Physicians

Part 3: "Religious values"

The flashpoint

The zeal and self-righteousness of the furious Facebookers in preaching the crusade against the three physicians was noted in Part 1. Part 2 suggested, in passing, that their passionate reaction might be accounted for by a dogmatic belief that manufactured contraceptives are good and necessary forms of health care, and that there are no reasonable alternatives to them. Consequently, that a physician might refuse to provide contraceptives on the basis of *medical* judgement they seem to have found completely incomprehensible. Certainly, they ignored the physician's references to "medical judgement" and "professional ethical concerns."

Instead, what generated the most frequent and heated anathemas from the crusaders is the third reason the physician offered for his position - "religious values." The possibility of an adverse medical judgement about contraceptives was beyond their imaginings, but they were infuriated by a refusal based on *religious* values. *That* they understood only too well. *That* was heresy.

What *everybody knows* (or ought to)

Afer all, *everybody knows* that a *good* physician should be "more than happy to leave her religious beliefs out of her medical practice."[1] It is simply *obvious* that "faith doesn't have a damn thing to do with practicing medicine."[sic]

> If you were a trauma surgeon at the ER you'd have to save a person's life even if they were a convicted murderer or rapist, your personal values be damned. The same should apply with family physicians.[2]

And when the state is responsible for delivering health care, and people pay for it through their taxes, *everybody knows* that they have a *right* to get what they pay for "within the limits of legality," and that "birth control and vasectomies are LEGAL."[3]

Moreover, when taxpayers are financing health care, *everybody knows* that "religion has NO PLACE in there."[4]

> A tax-funded professional may make recommendations based on their personal beliefs, but should never be permitted to refuse legal and efficient procedures which align with their patient's personal beliefs.[5]
>
> These doctors . . . should be reminded that their salary is paid by our taxes and our health system is a publicly regulated system. As such, they cannot impose their religious beliefs, they must stay neutral.[6]

Certainly, all Canadians are entitled to hold personal opinions and beliefs - even *religious* beliefs, but *everybody knows* that "we live in a society where religion is supposed to be a PRIVATE MATTER and not to be imposed on other people."[7]

Everybody knows that "Canadians do not have the right to bring their religious beliefs into the workplace,"[8] that Canadians "are NOT entitled to let their opinion interfere with their work,"[9] and

can't let "moral issues" or religious beliefs keep them from doing their jobs.[10]

> . . . He accepted a job as a doctor. He refuses to fulfil his duties as a doctor. The reasons are irrelevant and the religious belief trump card has no place in society, especially with occupations which serve the diverse public. . . [11]

Since it is so *obvious* that medical practitioners have no business acting on "personal religious beliefs," the 'solution' to the 'problem' posed by physicians who refuse to do what they believe to be immoral is just as obvious: "NO MORE CHRISTIAN DOCTORS."[12]

Dogmatic secularism

What we see in these comments parallels what was described in Part 2 with respect to the contraceptive culture. Just as the opinions and beliefs of the young woman and her supporters have been shaped from infancy by a dominant contraceptive culture, they have also been brought up in the 'religion' of secularism. They have learned the secularist catechism off by heart because they have heard its lessons repeatedly from the pulpits of the state, political and academic institutions, the media, and from innumerable itinerant preachers evangelizing through popular culture.

That is why they are so quick to defend the dogmas of secularism when they are challenged by people of other faiths, and why their response seems driven by religious fervour, even though they would almost certainly deny that there is anything religious about their beliefs.

And that may be so. Their beliefs might be agnostic, or atheistic, or secularist. Some might even describe themselves as religious believers who subscribe to secularism. What matters is that, like it or not, admit it or not, they are all believers.

Take, for example, Dr. James Robert Brown. In 2002, Dr. Brown, a professor of science and religion of the University of Toronto, offered a simple solution for health care workers who don't want to be involved with things like abortion or contraception. These "scum" - that was his word - should "resign from medicine and find another job." His reasoning was very simple.

> Religious beliefs are highly emotional - as is any belief that is affecting your behaviour in society. You have no right letting your private beliefs affect your public behaviour.[13]

Of course, Dr. Brown was doing precisely that. He was acting publicly upon *his* private belief that health care workers should not be allowed to act publicly upon *their*s. And the Facebook crusaders did the same thing; they acted publicly on *their* beliefs, some of them in a "highly emotional" manner. What principled reason can be given to justify the claim that one may be guided by non-religious beliefs in public discourse, but not by religious beliefs? That "highly emotional" beliefs are acceptable if they are *not* religious, but unacceptable if they are? Surely, the relevant issue is not whether the belief is religious or non-religious, but whether it is true, or sound, or reasonable, or coherent.

Everyone is a believer

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.

This applies no less to "secular" ethics than to religious ethics. A secular ethic may be independent of religion,[14] but it is not faith-free, nor is it beyond the influence of faith. On the contrary: a secular ethic, like any ethic, is faith-based. 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.

"Seeing through the secular illusion"

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. Nonetheless, as Dr. Iain Benson observes in *Seeing through the secular illusion*, religious believers in many countries face an "exclusionist attitude," a point well illustrated by the crusade against the three physicians. He explains:

> Those with a religious belief instead of an atheist or agnostic belief are discriminated against, as their beliefs apparently falling outside of the 'secular' and hence 'rational' realm of thought. However, much of this discrimination rests on the understanding of secular and the place of belief within society. Two things need to be recognised - 1) that we are all believers in something; it is not a question of whether we believe, but what we believe in. 2) That in the secular sphere, correctly understood as it is now under Canadian law, is inclusive of people of religious belief and that they therefore should have equality under the law and be placed at no disadvantage as against non-religious believers.[15]

Dr. Benson goes on:

> If 'secular' means 'the opposite of religious' . . . and if the public realm is defined in terms of the 'secular,' then the public sphere has only one kind of believer removed from it - the religious believers. I suggest that this way of using 'secular' is deeply flawed and will tend to lead us in the direction of religious exclusivism.[16]

Of particular interest is Dr. Benson's reference to the meaning of secular "correctly understood as it is now under Canadian law." He is referring to a part of the Supreme Court of Canada ruling in which the nine justices were unanimous in holding that "secular" *includes* religious belief:

> In my view, Saunders J. below erred in her assumption that 'secular' effectively meant 'non-religious'. This is incorrect since nothing in the *Charter*, political or democratic theory, or a proper understanding of pluralism demands that atheistically based moral positions trump religiously based moral positions on matters of public policy. I note that the preamble to the *Charter* itself establishes that '... Canada is founded upon principles that recognize the supremacy of God and the rule of law'. According to the reasoning espoused by Saunders J., if one's moral view manifests from a religiously grounded faith, it is not to be heard in the public square, but if it does not, then it is publicly acceptable. The problem with this approach is that everyone has 'belief' or 'faith' in something, be it atheistic, agnostic or religious. To construe the 'secular' as the realm of the 'unbelief' is therefore erroneous. Given this, why, then, should the religiously informed conscience be placed at a public

> disadvantage or disqualification? To do so would be to distort liberal principles in an illiberal fashion and would provide only a feeble notion of pluralism. The key is that people will disagree about important issues, and such disagreement, where it does not imperil community living, must be capable of being accommodated at the core of a modern pluralism.[17]

Thus, the Supreme Court of Canada has acknowledged that secularists, atheists and agnostics are believers, no less than Christians, Muslims, Jews and persons of other faiths. The notion that a secular state or a secular health care system (tax-paid or not) must be purged of the expression of religious belief is legally suspect, and the claim that a secular state or a secular health care system is "faith-free" is radically false.

The danger of secular authoritarianism

More than that, it is dangerous. It overlooks the possibility that some secularists - like some religious believers - can be uncritical and narrowly dogmatic in the development of their ethical thinking, and intolerant of anyone who disagrees with them. They might see them as heretics who must be driven from the professions, from the public square, perhaps from the country: sent to live across the sea with their "own kind."

On that point, it is essential to note that a secular ethic is not morally neutral.[18] The claim that a secular ethic is morally neutral is not merely fiction. It is, as Professor Jay Budziszewski says, "bad faith authoritarianism . . . a dishonest way of advancing a moral view by pretending to have no moral view."[19]

By pretending, for example, that one can practise medicine in a morally "neutral" fashion, or, as it was more colourfully expressed by a Facebooker, that "faith doesn't have a damn thing to do with practicing medicine."

The practice of medicine as a moral enterprise

The example given by this Facebooker actually proves the point he was attempting to deny. An emergency physician who intervenes to save the life of a convicted murderer is not being morally "neutral." Most people would describe his action as 'good' or moral because he is saving someone's life. They would say he acts immorally if he fails or refuses to intervene. To say that one must act "neutrally" in such a situation would be to say that a physician might choose to intervene - or not - and that either choice would be equally acceptable. Note, too, that the physician is in no way implicated or complicit in murder because he saves a murderer's life, but that the case would be quite different if he were to give someone a prescription for a lethal drug to kill someone else. Conscientious objection might arise in the latter case, but not in the former.

The practice of medicine is an inescapably moral enterprise precisely because physicians are always seeking to do some kind of good and avoid some kind of evil for their patients.[20] However, the moral aspect of practice as it relates to the conduct and moral responsibility of a physician is usually implicit, not explicit. It is assumed, not stated. It is normally eclipsed by the needs of the patient and exigencies of practice. But it is never absent; every decision concerning treatment is a moral decision, whether or not the physician specifically adverts to that fact.

This point is frequently overlooked when a physician, for reasons of conscience, declines to

participate in or provide a service or procedure that is routinely provided by his colleagues. They may be disturbed because they assume that, in making a moral decision about treatment, he has done something unusual, even improper. Seeing nothing wrong with the procedure, they see no moral judgement involved in providing it. In their view, the objector has brought morality into a situation where it doesn't belong, and, worse, it is *his* morality.

In point of fact, the moral issue was there all along, but they didn't notice it because they have been unreflectively doing what they were taught to do in medical school and residency, and what society expects them to do. Nonetheless, in deciding to provide the procedure they also *implicitly* concede its goodness; they would not provide it if they did not think it was a good thing to do. What unsettles them is really not that the objector has taken a moral position on the issue, but that he has made an *explicit* moral judgement that differs from their *implicit* one.

This initial reaction is not surprising, and it can have positive results if it leads to respectful discussion among colleagues. On the other hand, there is a tendency in some quarters to adopt the pretence that no "real" moral issues are involved, or that physicians are obliged to follow "the ethics of the profession" or directives from state agencies which are (erroneously) said to be "neutral." For example, in 2008 the Ontario Human Rights Commission attempted to enforce its belief that physicians "must essentially 'check their personal views at the door' in providing medical care,"[21] and the Facebook crusaders are attempting the same power play. This is precisely the bad faith authoritarianism described by Professor Budziszewski.

The practice of morality as a human enterprise

That everyone is a believer reflects the fact that the practice of morality is a human enterprise,[22] but it is not a scientific enterprise. The classic ethical question, "How ought I to live?" is not a scientific question and cannot be answered by any of the disciplines of natural science, though natural science can provide raw material needed for adequate answers.

Answers to the question, "How ought I to live?" reflect two fundamental moral norms; do good, avoid evil. These basics have traditionally been undisputed; the disputes begin with identifying or defining good and evil and what constitutes "doing" and "avoiding." Such explorations are the province of philosophy, ethics, theology and religion, and, internationally, religion continues to be the principal means by which concepts of good and evil and right and wrong conduct are sustained and transmitted. Nonetheless, since the practice of morality is a human enterprise, reflections about morality and the development and transmission of ideas about right and wrong also occurs within culture and society outside the framework of identifiable academic disciplines and religions.

In consequence, the secular public square is populated by people with any number of moral viewpoints, some religious, some not: some tied to particular philosophical or ethical systems, some not: but all of them believers. As the Supreme Court of Canada has acknowledged, rational democratic pluralism must make room for all of them. To single out and exclude religious belief as a legitimate ground for conscientious objection would, as the court stated, "distort liberal principles in an illiberal fashion."

A duty to do what is wrong

More important in the present context - if religious belief can be excluded as a legitimate ground for conscientious objection, so can every form of non-religious belief. If it is legitimate to compel religious believers to do what they believe to be wrong, then it is equally legitimate to compel non-religious believers to do what they think is wrong. It would, in principle, establish a duty to do what is believed to be wrong.

For Andrei Marmor, "a duty to do what is wrong is surely an oxymoron,"[23] and most people would agree, as did Dr. John Williams, then Director of Ethics for the Canadian Medical Association. Speaking in 2002 of physicians who decline to provide or refer for contraceptives for religious reasons, he said, "[They're] under no obligation to do something that they feel is wrong."[24]

Despite this, attempts to impose a duty to do what is wrong is characteristic of attacks on freedom of conscience among health care workers. For example, the 2010 McAfferty report to the Parliamentary Assembly of the Council of Europe stated that the Social, Health and Family Affairs Committee was "deeply concerned about the increasing and largely unregulated occurrence" of the exercise of freedom of conscience in Europe. According to the Committee, too many European citizens in positions of responsibility were refusing to do what they believed to be gravely wrong. The Committee recommended that member states adopt "comprehensive and clear regulations" to address this problem.[25]

When discussion about difficulties associated with the exercise of freedom of conscience in health care is repeatedly characterized as "the problem of conscientious objection,"[26] it becomes clear that the underlying premise is that people and institutions ought to do what they believe to be wrong, and that refusal to do what one believes to be wrong requires special justification. This is exactly the opposite of what one would expect. Most people believe that we should *not* do what we believe to be wrong, and that *refusing* to do what we believe to be wrong is the norm. It is wrongdoing that needs special justification or excuse, not refusing to do wrong.

A troubling inversion

The inversion is troubling, since "a duty to do what is wrong" is being advanced by those who support the "war on terror." They argue that there is, indeed, a duty to do what is wrong, and that this includes a duty to kill non-combatants and to torture terrorist suspects.[27] The claim is sharply contested,[28] but it does indicate how far a duty to do what is wrong might be pushed. We will next consider an early effort to establish this purported duty in Canada, its rejection by the medical profession, and the difficult compromise that was made possible as a result.

Notes

1. L___ T___, 30 January, 2014, 4:25 am
(http://www.consciencelaws.org/background/procedures/birth002-C-02.aspx)

2. M___ J___ C___ P___ 29 January, 2014, 2:55 pm
(http://www.consciencelaws.org/background/procedures/birth002-B.aspx#post001)

3. C___ F___, 29 January, 2014, 7:04 pm
(http://www.consciencelaws.org/background/procedures/birth002-C-01.aspx)

4. C___ F___, 29 January, 2014, 9:50 pm
(http://www.consciencelaws.org/background/procedures/birth002-C-01.aspx);
S___ B___ 29 January, 2:35 pm
(http://www.consciencelaws.org/background/procedures/birth002-B.aspx#post001)
Gagnon S. "Contrary to democracy." Letter to the editor, *Ottawa Citizen*, 1 February, 2014.

5. C___T____, 29 January, 2014, 10:20 pm
(http://www.consciencelaws.org/background/procedures/birth002-C-01.aspx)

6. Gagnon S. "Contrary to democracy." Letter to the editor, *Ottawa Citizen*, 1 February, 2014.
M___ A___, 29 January, 2014, 7:19 pm
(http://www.consciencelaws.org/background/procedures/birth002-C-01.aspx)

7. C___ F___, 29 January, 2014, 9:45 pm
(http://www.consciencelaws.org/background/procedures/birth002-C-01.aspx)

8. T___ M____, 29 January, 6:56 pm
(http://www.consciencelaws.org/background/procedures/birth002-C-01.aspx)

9. M___ V___, 30 January, 2014, 5:21 am
(http://www.consciencelaws.org/background/procedures/birth002-C-02.aspx);
M___ A___, 29 January, 2014, 7:19 pm
(http://www.consciencelaws.org/background/procedures/birth002-C-01.aspx)

10. B___ A___ D___, 29 January, 2014, 2:45 pm
(http://www.consciencelaws.org/background/procedures/birth002-B.aspx#post001)

11. J___ O___, 30 January, 2014, 1:38 pm
(http://www.consciencelaws.org/background/procedures/birth002-C-02.aspx)

12. S___W___, 31 January, 4:48 am
(http://www.consciencelaws.org/background/procedures/birth002-B.aspx#post-004_)

13. "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 C. "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/repression017-001.aspx)

14. Singer P. *Practical Ethics* (2nd Ed.). Cambridge: Cambridge University Press, 1993, p. 3; Kreeft P. *Fundamentals of the Faith*. San Francisco: Ignatius Press, 1988, p. 74-80. On line (Chapter 11) as "The Uniqueness of Christianity." (http://www.catholiceducation.org/articles/apologetics/ap0228.htm) Accessed 2007-11-08

15. Benson, I.T., *Seeing Through the Secular Illusion* (July 29, 2013). NGTT Deel 54 Supplementum 4, 2013. Available at SSRN: http://ssrn.com/abstract=2304313 (Accessed 2014-02-18)

16. Benson, I.T., *Seeing Through the Secular Illusion* (July 29, 2013). NGTT Deel 54 Supplementum 4, 2013. Available at SSRN: http://ssrn.com/abstract=2304313 (Accessed 2014-02-18)

17. *Chamberlain v. Surrey School District No. 36* [2002] 4 S.C.R. 710 (SCC), para. 137 (http://scc-csc.lexum.com/scc-csc/scc-csc/en/item/2030/index.do?r=AAAAAQALIm1hbmRhdG9yeSIAAAAAAAAB) Accessed 2014-02-19. Dr. Benson adds: "Madam Justice McLachlin, who wrote the decision of the majority, accepted the reasoning of Mr. Justice Gonthier on this point thus making his the reasoning of all nine judges in relation to the interpretation of 'secular.') Benson I.T., *Seeing Through the Secular Illusion* (July 29, 2013). NGTT Deel 54 Supplementum 4, 2013. Available at SSRN: http://ssrn.com/abstract=2304313 (Accessed 2014-02-18)

18. The distinction between ethics and morality is mainly a matter of usage. Recent trends identify ethics as the application of morality to a specific discipline, like medicine or law. In a broader and older sense, ethics is concerned with how man ought to live, while the study of morality focuses on ethical obligations. See the entry on "Ethics and Morality" in Honderich T. (Ed.) *The Oxford Companion to Philosophy* (2nd Ed.) Oxford: Oxford University Press, 2005.

19. "The question of neutrality has been profoundly obscured by the mistake of confusing neutrality with objectivity... neutrality and objectivity are *not* the same... objectivity is possible but neutrality is not. To be neutral, if that were possible, would be to have no presuppositions whatsoever. To be objective is to have *certain* presuppositions, along with the manners that allow us to keep faith with them." Budziszewski J., "Handling Issues of Conscience." *The Newman Rambler*, Vol. 3, No. 2, Spring/Summer 1999, P. 4. (http://www.consciencelaws.org/ethics/ethics007.aspx)

20. Maddock J.W. *Humanizing health care services. The practice of medicine as a moral enterprise*. J Natl Med Assoc. 1973 November; 65(6): 501–passim. PMCID: PMC2609038 (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2609038/?page=1) Accessed 2014-02-18

21. *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 2008-08-31

22. This presumption obviously underlies standard bioethics texts. See, for example, Beauchamp TL, Childress JF, *Principles of Biomedical Ethics* (7th ed) New York: Oxford University Press, 2013

23. Marmor A. *Law in the Age of Pluralism*. New York: Oxford University Press, 2007, p. 218

24. Mackay B. *Sign in office ends clash between MD's beliefs, patients' requests*. CMAJ January 7, 2003 vol. 168 no. 1 (http://www.cmaj.ca/content/168/1/78.2.full) Accessed 2014-02-16

25. *Report, Social Health and Family Affairs Committee, Women's access to lawful medical care: the problem of unregulated use of conscientious objection.* Doc. 12347 (20 July, 2010) Explanatory memorandum by Mrs. McCafferty, Part 1, paragraph 2, note 5 (Joanna Mishtal). (http://assembly.coe.int/Documents/WorkingDocs/Doc10/EDOC12347.pdf) Accessed 2010-10-04.

26. Cannold L. "The questionable ethics of unregulated conscientious refusal." *ABC Religion and Ethics*, 25 March, 2011. (http://www.abc.net.au/religion/articles/2011/03/25/3174200.htm)" Accessed 2013-08-11

Human Rights Council, Twentieth session, Agenda items 2 and 3: *Annual Report of the Office of the United Nations High Commissioner for Human Rights- Technical guidance on the application of a human rightsbased approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality* (2 July, 20012) para. 61, 30 (http://www2.ohchr.org/english/issues/women/docs/A.HRC.21.22_en.pdf) Accessed 2013-08-11

O'Rourke A, De Crespigny L, and Pyman A. "Abortion and Conscientious Objection: The New Battleground" (July 10, 2012). *Monash Law Review* (2012) Vol 38(3): 87-119. (http://ssrn.com/abstract=2262139) Accessed 2013-08-18

Finer L., Fine JB., "Abortion Law Around the World: Progress and Pushback." *American Journal of Public Health*, Apr 2013, Vol. 103 Issue 4, p. 585. (http://connection.ebscohost.com/c/articles/85594202/abortion-law-around-world-progress-pushback) Accessed 2013-08-18

Human Rights Council, 23nd Session - June 3, 2013. Agenda Item 3: Presentation of Reports by the Special Rapporteur on Violence against Women. *Oral Statement: Center for Reproductive Rights*. (http://issuu.com/acpdcanada/docs/statement_by_crr-sri__id_with_sr_on)" Accessed

20-13-08-11

27. Gardner J. *Complicity and Causality*, 1 Crim. Law & Phil. 127, 129 (2007). Cited in Haque, A.A. "Torture, Terror, and the Inversion of Moral Principle." *New Criminal Law Review*, Vol. 10, No. 4, pp. 613-657, 2007; Workshop: Criminal Law, Terrorism, and the State of Emergency, May 2007. (http://ssrn.com/abstract=958059) Accessed 2014-02-19

28. Haque, A.A. "Torture, Terror, and the Inversion of Moral Principle." *New Criminal Law Review*, Vol. 10, No. 4, pp. 613-657, 2007; Workshop: Criminal Law, Terrorism, and the State of Emergency, May 2007. (http://ssrn.com/abstract=958059) Accessed 2014-02-19

"NO MORE CHRISTIAN DOCTORS"
Crusade Against NFP-only Physicians

Part 4: A difficult compromise

Review

Part 1 described how a story that might have had a happy ending was eclipsed by the preaching of a crusade against three NFP-only physicians. Based on a letter from one of the physicians, Part 2 explored possible grounds for medical judgement and professional ethical concerns that might lead a physician to adopt NFP-only practice. Part 3 explained the common standing of a physician's religious beliefs vis-à-vis non-religious beliefs within a secular public square. It introduced but did not elaborate upon the subject of freedom of conscience, making note that those attacking freedom of conscience for health care workers are, in their focus on a so-called "problem of conscientious objection," attempting to establish a 'duty to do what is wrong'.*

Such an attempt was made in Canada in the years following the legalization of abortion. It was rejected by members of the medical profession, who refused to support the attack on physician freedom of conscience. The rejection was the condition necessary to sustain the compromise that allowed physicians who refused to participate in abortion to continue to preserve their integrity in practice even as abortion rates increased dramatically. The story begins, ironically, with high praise for freedom of conscience.

Early promises of tolerance

Abortion law reform advocates frequently portrayed themselves as champions of freedom of conscience. In 1965, for example, the *Globe and Mail* demanded liberalization of the law "to enable doctors to perform their duties according to their conscience and their calling."[1]

Two Private Members Bills on abortion were introduced in1967.[2] M.P. Grace MacInnis, sponsor of one of the bills, assured the committee that "nobody would be forcing abortion procedures on anybody else," suggesting that abortion should be up to the individual conscience.[3]

The Omnibus Bill introduced in 1967 included what later became Canada's new abortion law. It did *not* include a protection of conscience clause. Nonetheless, the Canadian Welfare Council stated:

> 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.[4]

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

* Since the Project does not take a position on the morality of morally contested procedures, a 'duty to do what is wrong' refers, in this paper, to 'wrong' as understood from the perspective of the person on whom the duty is purported to lie.

> admit that it should exempt those who object to being involved in procuring abortions.[5]

A protection of conscience clause was proposed when the Omnibus Bill returned to the Commons the following year.[6] Justice Minister John Turner responded that the conscience clause was unnecessary because 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.[7]

The protection of conscience clause was rejected, and abortion was legalized and regulated.[8] If health care workers and institutions and people objecting to the procedure had not been promised or led to believe that they would not be compelled to provide abortions, it is highly doubtful that the abortion law would have passed in 1969.

Broken promises

However, beginning in 1970, the promises made by abortion law reform advocates concerning respect for freedom of conscience began to be broken.[9] Five years after the abortion bill passed, the *Globe and Mail* (that erstwhile champion of freedom of conscience) complained:

> . . . hospital boards should never have been allowed a choice in the matter. The Government should . . . require hospitals which receive public grants to establish abortion committees.[10]

It appears that the change of attitude was caused by a dramatic yearly increase in abortion rates which continued for a decade, and an expansion of the grounds for abortion to include non-medical social reasons. The broadened grounds for abortion and continuing increases in the abortion rate increased the likelihood of conscientious objection to the procedure. It also brought raging controversy. This is the background for the development of Canadian Medical Association (CMA) policies on abortion and freedom of conscience for physicians, described in detail in Appendix "F."

Preserving physician integrity

When the law passed, the CMA's response was based on the premise that physicians would be permitted to provide abortions, but would not be forced to do so. This was reflected in the 1970 revision of its *Code of Ethics*. A new section, made necessary by the legalization of abortion, required physicians to disclose personal moral convictions that might prevent them from recommending a procedure to patients, but did not require the physician to refer the patient or otherwise facilitate the morally contested procedure. The arrangement preserved the integrity of physicians who did not want to be involved with abortion, while making patients aware of the position of their physicians so that they could seek assistance elsewhere.

Very likely in response to increasing demand for abortion, and perhaps influenced by a lobby convinced that all physicians were obliged to facilitate it, for a brief period the Association modified the 1970 policy by adding a requirement that an objecting physician "advise the patient of other sources of assistance." This move toward mandatory referral survived only a year. The 1970

wording was restored in June, 1978, because of the backlash from members of the Association who refused to accept the principle that they could be ordered to violate their conscientious convictions.

Since that time, in the face of repeated efforts to impose a 'duty to do wrong' on physicians, the Canadian Medical Association has maintained the position summed up by Dr. John R. Williams, then CMA Director of Ethics and now Director of Ethics for the World Medical Association:[11] "[Physicians are] under no obligation to do something that they feel is wrong."[12]

Patient-centred medical practice and health care

While maintaining the personal and professional integrity of the physician is essential, it is equally essential to attend to the well-being of the patient. The years immediately following the legalization of abortion were particularly challenging, since objecting physicians and other health care workers had to find ways to adapt their practices to respond to both the expectations of their patients and of their professions.

What has emerged over the years can be described as a difficult compromise: "difficult" because it has had a difficult birth, and difficult because it requires continuous effort. It safeguards the legitimate autonomy of the patient by giving effect to the principle of informed medical decision making. "Legitimate" here refers to a limit placed on patient autonomy: physicians cannot be made to do what they believe to be wrong. This safeguards not only the physician, but the community, since it would be dangerous to adopt the principle that a community, a profession or the state can force people to do what they believe to be wrong.

While the difficult compromise was developed because of conflicts caused by legalization of abortion, it provides a template for a response to conflicts in relation to other morally contested procedures. Here we return to the patient, though not specifically to the young woman who had to drive around the block for her birth control pills. The subject here is how a physician who has ethical, moral or religious reasons for refusing to prescribe contraceptives can respond to patients who, given the dominant contraceptive mindset, are likely to be looking for and expecting to be provided with hormonal contraceptives or sterilization.

Caveats

Everything that might be said in support of the preservation of personal integrity and protection of conscience in health care presumes a competent, caring, patient-centred approach to medical practice and health care. This must be emphasized and occasionally re-emphasized, since a continuing emphasis on developing and articulating a defence of freedom of conscience for health care workers can inadvertently encourage an inappropriate defensive attitude toward patients. Of course, crusades of the type launched in Ottawa and suggestions that women should fabricate complaints against objecting physicians are unhelpful in establishing the relationship of trust that ought to characterize physician-patient relationships.

What follows is provided to facilitate reflection and discussion about how physicians who decline to provide or facilitate contraception for reasons of conscience can respond ethically to patients seeking assistance with fertility control. Actual professional and legal requirements will vary from one jurisdiction to another and obviously take precedence over anything suggested here. The references

provided are not offered as definitive authorities, but as illustrations of the compatibility of the suggested approach with professional expectations.

Finally, it is impossible to anticipate all of the situations and personalities a physician may encounter in his practice, so it is impossible to make hard-and-fast rules about what should or should not be said, or to provide a script to be followed.

Physician preparation

The physician should keep up to date on subjects related to birth control through continuing medical education (formal and informal).[13] This is necessary because new information may cause him to modify his position. Moreover, the subject may come up in relation to the clinical management of contraceptive methods of birth control prescribed by others. Finally, he must be in a position to adequately explain the options available to a patient in order to satisfy the principle of informed consent.

The physician should be prepared to provide and articulate and cogent rationale for his practice policies, should the need arise, and to re-evaluate his position in light of new information or the circumstances of a particular patient.

Communication

If a complaint arises in connection with a physician's refusal to provide certain services or procedures for reasons of conscience, it is frequently caused by a failure to communicate effectively. This includes not only the communication of information, but conveying a sense of respect and caring that is consistent with competent, patient-centred medical practice.[14] A failure in communication is not necessarily the fault of the physician, since the patient is a partner in dialogue and shares responsibility for its success. However, it is presumed that the physician normally has a greater responsibility for the success of a physician-patient conversation.[15] The physician should consult with like-minded colleagues. They may be able to suggest communication strategies that have proved successful in different circumstances.

Clinical settings

A family physician has the opportunity to discuss limits to his practice when he accepts a patient. Continuing contacts while providing medical care provide the opportunity for physician and patient to get to know one another, and for the patient to develop trust in the physician in response to practical demonstrations of the physician's interest in her welfare. This kind of established relationship is less likely to break down if a difference of opinion arises over treatment. A walk-in clinic is more likely to bring together a physician and patient who have different views about the morality of some procedures or services, and who have not had the opportunity to develop a relationship that will sustain successful communications if these differences become an issue.

Notice

It is common ground that conflicts should be avoided - especially in circumstances of elevated tension - and that they often can be avoided by timely notification of patients, erring on the side of sooner rather than later. However, it is unreasonable to expect physicians to anticipate, in advance, every conceivable request that might be made by patients.

The interests of patients and physicians are best served by open and continuing communication, not inflexible notification protocols. On the part of the physician, this involves a special responsibility to be attentive to the spoken and unspoken language of the patient, and to respond in a caring and truthful manner. Notice should be given when it would be apparent to a reasonable and prudent physician that a conflict is likely to arise.[16] In some cases - but not all - this may be when a patient first presents or is accepted. The same holds true for notification of patients when a physician's views change significantly.

However, it is more important in walk-in clinics to make some kind of notice available in the waiting room to advise patients of practice limitations.[17] This minimizes inconvenience to patients, who may immediately decide to go elsewhere if they wish to avail themselves of services not available from the physician. It also minimizes the likelihood of misunderstandings between a walk-in clinic physician and a patient who do not have an established relationship. The notice should be in the languages common among patients attending the clinic. Suggestions for increasing the effectiveness of notices are included in Appendix "G".

Consultations and informed consent

While advance notice to patients and screening by receptionists make it less likely that an NFP-only physician will be consulted by patients seeking contraceptives, the subject may come up in relation to the clinical management of contraceptive methods of birth control prescribed by others. Further, a patient who has made an appointment because of an initial interest in NFP may, in the course of the consultation, decide against it. Finally, a variety of circumstances may lead patients using NFP to consider other options.

To simplify matters, assume that a physician who declines to provide contraceptives is consulted by a woman seeking assistance with birth control who is not aware of the physician's practice limitations. Presumably, discussion of birth control would follow the taking of a medical history, and would begin with an assessment of the patient's awareness of the various methods of birth control available, and any initial preference she might have.

Much of what follows depends upon the patient's knowledge. Physicians are expected to provide patients with accurate information about all legal options available to them, the effectiveness of the methods, adverse effects or risks associated with each, benefits associated with each, and other information that someone in the position of a patient would reasonably want to know. In some cases the physician might have to provide a great deal of information; in others, it may simply be a matter of filling in some gaps in what the patient knows.[18] In all cases, the physician must take care to present the information in a form comprehensible to the patient.[19]

The physician must disclose whether or not his religious, ethical or other conscientious convictions influence his recommendations or practice or prevent him from providing certain procedures or services. If medical judgement rather than moral/religious conviction is his primary consideration, it may still be prudent to disclose pertinent religious or moral beliefs.[20] The reason for this is that the patient is entitled to be apprised of non-medical factors that may influence a physician's medical judgement and recommendations. The patient is also entitled to know whether or not the physician's medical evaluation of the contraceptive(s) in question is consistent with the general view of the medical profession.[21]

The physician should invite questions from the patient at different stages in the consultation to ensure that he has been correctly understood.[22] The goal is to ensure that the patient has sufficient information and understanding to make an informed decision about what kind of birth control she wishes to use. With respect to any reference to his conscientious convictions, unless the patient questions him, asks for further explanation, or otherwise indicates that she does not understand his position, the physician need not and probably should not expand upon the basis for his own position. To do so would likely invite the accusation that he is "preaching."[23]

Anatomically accurate, life-size or scale models, graphics, charts or tables may facilitate communication. The physician might prepare a pamphlet to give the patient during or after a discussion. This would help the patient to recall the conversation accurately if she wishes to give the matter further thought.

It is up to the patient, following the consultation, to decide whether or not she wishes to accept the physician's recommendation to use a natural family planning method. If she prefers to use a contraceptive method, she must be advised that she may approach other physicians or seek them from other sources, such as public health clinics.[24]

An objectionable approach

It is instructive to compare this approach with one described by one of the commentators on the 'pro-choice' Facebook page:

> My doctor has told me to my face that it is my womanly duty to have children and she will never condone me to prevent the birth of a child in any way. She also said she would not sign the vasectomy papers for my husband to get one. . .She lectures me often when I go in. She has 3 or 4 kids and says she is not done.[25]

Assume, for present purposes, that this brief narrative is an essentially accurate summary of the physician's conduct. Assume, as well, that the physician has religious or moral objections to contraception, abortion, and contraceptive sterilization, all of which are morally contested procedures that she may decline to provide or facilitate. Finally, assume that the physician believes, for moral or religious reasons, that women should have many children.

Nonetheless, what is described here is conduct unacceptable in ethical medical practice. While a physician is obliged to disclose the existence of moral or religious convictions that would influence her recommendations or preclude the provision of certain procedures, the disclosure must be respectful of the patient and must not take the form of "preaching" or "lecturing." Such a disclosure is meant to be about what a physician will not do and why, not about what the patient should do. Further: while it is not inconceivable that, in some circumstances, a physician might disclose some personal information or experience in a manner supportive of a patient, to set oneself up as a kind of role model ('you should have as many children as I do') is highly objectionable.

Sustaining the compromise

While the exercise of freedom of conscience by physicians and other health care workers must be supported and defended, it is equally necessary to support and defend patient-centred practice and respect for the principle of informed medical decision-making. The fulfilment of this dual obligation

requires patience, perseverance, honesty and good will, and it may sometimes entail difficulty or misunderstanding.

Notes

1. "Free the Doctor",Globe and Mail, 18 May, 1965. Quoted in de Valk A. *Morality and Law in Canadian Politics: The Abortion Controversy*. Dorval, Quebec: Palm Publishers, 1974, p. 18
Two years later an editorial in the *Globe* stated that the Government had decided "that where religious moralities conflict, the State should support none, but leave the choice to individual conscience. It is a policy that should also be followed with abortion." "Now the job is to be done, let it be done right", *Globe and Mail*, 21 December, 1967. Quoted in de Valk, *supra*, p. 56

2. One of these had a conscience clause almost identical to that in the British *Abortion Act*. 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. 679, paragraph 19.

3. Quoted in de Valk, *supra*, p. 44-45

4. 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

5. 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. 676

6. The Progressive Conservatives and Creditistes put forward seven amendments intended to guarantee the right of conscientious objection to individuals or institutions. It was agreed that debate on one amendment would dispose of all seven. The clause had been proposed M.P. Robert McCleave, who was *in favour* of legalizing abortion. (*Hansard- Commons Debates*, 28 April, 1969, p. 8069)
What was then debated was to the following effect:

> Nothing in the new law shall be construed as obliging any hospital to establish a therapeutic abortion committee, or any qualified medical practitioner to procure an abortion, or any member of a hospital staff to assist in abortion. (A sub-amendment was added to the original amendment. The paraphrase reflects the effect of both. (See *Hansard-Commons Debates*, April 28, 1969, p. 8056, 8063)

7. *Hansard-Commons Debates*, April 28, 1969, p. 8058-8059

8. *Hansard- Commons Debates*, 28 April, 1969, p. 8087.

9. A little over a year after abortion was legalized, British Columbia Health Minister Ralph Loffmark told the Annual General Meeting of the British Columbia Medical Association that “all hospitals which ban abortions on religious grounds may be forced to change their policies.” The

chairman of the BCMA hospital committee said that he believed most of his colleagues would support the requirement, but it was acknowledged that the law permitted but did not require provision of abortions. *B.C. M.A. Annual Meeting*: CMAJ November 21, 1970, Vol. 103, 1223 (http://pubmedcentralcanada.ca/pmcc/articles/PMC1930622/?page=6) Accessed 2013-02-22

A 1975 biography of Dr. Henry Morgentaler described how he and his staff performed an abortion on a shouting, squealing 16 year old severely retarded girl who could not understand what was happening. Pelrine, Eleanor Wright, *Morgentaler: The Doctor Who Couldn't Turn Away*. Gage Publishing, 1975, p. 55. Over twenty years later, as if demonstrating that Dr. Morgentaler was just a little ahead of his time, a Quebec Court ordered the abortion and sterilization of a mentally ill woman who was not capable of requesting or consenting to the procedures. Murphy S. *Conscience or Contempt of Court? Court orders abortion of woman*. (http://www.consciencelaws.org/background/procedures/abortion004.aspx) Protection of Conscience Project.

Between 1977 and 1984, nurse Linda Bradley was denied employment at four British Columbian hospitals because she did not want to assist with abortions. Desperate, she sacrificed her convictions to get a job at the Richmond General Hospital. She lost it after refusing to assist at the hysterotomy of a mother, five and a half months pregnant. Murphy S. *Nurse Refused Employment, Forced to Resign: A Two Tiered System of Civil Rights.* Protection of Conscience Project (http://www.consciencelaws.org/repression/repression003.aspx)

BC welfare worker Cecilia Moore was fired in 1985 for refusing to authorize payment for an abortion that would have been illegal under the law as it then stood. Murphy, S. *"Insubordination."*(http:\\www.consciencelaws.org/repression/repression010.aspx)

Three transition house workers in Ontario were fired - with the government's approval - for refusing to refer women for abortions. Kennedy F. "Sweeney Defends Firings:Transition house workers fired, denied benefits for 'misconduct'". *The Interim*, March, 1989 (http:\\www.consciencelaws.org/repression/repression004.aspx)

In 1992, BC Health Minister Elizabeth Cull ordered 33 British Columbian hospitals to perform abortions. Hawkins A. "BC stamps out choice: Orders hospitals to do abortions; taxpayers to fund them. *The Interim,* 20 April, 1992. (http://www.theinterim.com/issues/abortion/bc-stamps-out-choice-orders-hospitals-to-do-abortions-taxpayers-to-fun-them/) Accessed 2010-05-18

Over thirty years after the promises were made, postpartum nurses at Foothills Hospital in Calgary were told that they would have to be involved with late term abortions, regardless of their moral convictions. Ko M. "Personal Qualms Don't Count: Foothills Hospital Now Forces Nurses To Participate In Genetic Terminations." *Alberta Report*, April 12, 1999. (http://www.consciencelaws.org/repression/repression001.aspx)

10. *Globe and Mail*, 18 January 1974. Quoted in de Valk, *supra*, p. 137

11. Carleton University, Centre on Values and Ethics. *John R. Williams, Curriculum Vitae.* (http://www3.carleton.ca/cove/cv/Williams.html) Accessed 2014-02-22

12. Mackay B. *Sign in office ends clash between MD's beliefs, patients' requests*. CMAJ January 7, 2003 vol. 168 no. 1 (http://www.cmaj.ca/content/168/1/78.2.full) Accessed 2014-02-16

13. Canadian Medical Association *Code of Ethics* (2004): "6. Engage in lifelong learning to maintain and improve your professional knowledge, skills and attitudes." (http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf) Accessed 2014-02-22)

14. College of Physicians and Surgeons of Ontario, *Physicians and the Ontario Human Rights Code* (2008). "Treat patients or individuals who wish to become patients with respect when they are seeking or requiring the treatment or procedure. This means that physicians should not express personal judgments about the beliefs, lifestyle, identity or characteristics of a patient or an individual who wishes to become a patient. This also means that physicians should not promote their own religious beliefs when interacting with patients, nor should they seek to convert existing patients or individuals who wish to become patients to their own religion." (http://www.cpso.on.ca/Policies-Publications/Policy/Physicians-and-the-Ontario-Human-Rights-Code) Accessed 2014-02-22

15. Canadian Medical Association *Code of Ethics* (2004): "22. Make every reasonable effort to communicate with your patients in such a way that information exchanged is understood." (http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf) Accessed 2014-02-22)

College of Physicians and Surgeons of Ontario, *Physicians and the Ontario Human Rights Code* (2008). "The College expects physicians to communicate decisions they make to end a physician-patient relationship, refrain from providing a specific procedure, or to decline to accept an individual as a patient, and the reasons for the decision in a clear, straightforward manner. Doing so will allow physicians to explain the reason for their decision accurately, and thereby avoid misunderstandings." (http://www.cpso.on.ca/Policies-Publications/Policy/Physicians-and-the-Ontario-Human-Rights-Code) Accessed 2014-02-22

16. Canadian Medical Association *Code of Ethics* (2004): "12. Inform your patient when your personal values would influence the recommendation or practice of any medical procedure that the patient needs or wants." (http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf) Accessed 2014-02-22)

College of Physicians and Surgeons of Ontario, *Physicians and the Ontario Human Rights Code* (2008). "Communicate clearly and promptly about any treatments or procedures the physician chooses not to provide because of his or her moral or religious

beliefs."(http://www.cpso.on.ca/Policies-Publications/Policy/Physicians-and-the-Ontario-Human-Rights-Code) Accessed 2014-02-22

17. Mackay B. *Sign in office ends clash between MD's beliefs, patients' requests*. CMAJ January 7, 2003 vol. 168 no. 1 (http://www.cmaj.ca/content/168/1/78.2.full) Accessed 2014-02-16

18. Canadian Medical Association *Code of Ethics* (2004): "21. Provide your patients with the information they need to make informed decisions about their medical care, and answer their questions to the best of your ability." (http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf) Accessed 2014-02-22)

College of Physicians and Surgeons of Ontario *Physicians and the Ontario Human Rights Code* (2008). "Provide information about all clinical options that may be available or appropriate based on the patient's clinical needs or concerns. Physicians must not withhold information about the existence of a procedure or treatment because providing that procedure or giving advice about it conflicts with their religious or moral beliefs." (http://www.cpso.on.ca/Policies-Publications/Policy/Physicians-and-the-Ontario-Human-Rights-Code) Accessed 2014-02-22

Murray B. "Informed Consent: What Must a Physician Disclose to a Patient?" American Medical Association Journal of Ethics, *Virtual Mentor*. July 2012, Volume 14, Number 7: 563-566. (http://virtualmentor.ama-assn.org/2012/07/hlaw1-1207.html) Accessed 2014-02-22

19. See note 15.

20. Guidelines (like those below) typically require disclosure when a recommendation or practice is or would likely be influenced by a belief. However, a physician's decision or recommendation may be justified solely on medical grounds without reference to beliefs. The practical difficulty in a practice and disciplinary environment hostile to religious belief is that a failure to disclose a belief may invite the adverse inference that the physician failed to disclose beliefs that were 'really' shaping his decision making, especially if the medical grounds are contested by establishment opinion.

Canadian Medical Association *Code of Ethics* (2004): "12. Inform your patient when your personal values would influence the recommendation or practice of any medical procedure that the patient needs or wants." (http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf) Accessed 2014-02-22)

College of Physicians and Surgeons of Ontario, *Physicians and the Ontario Human Rights Code* (2008). "Communicate clearly and promptly about any treatments or procedures the physician chooses not to provide because of his or her moral or religious beliefs."(http://www.cpso.on.ca/Policies-Publications/Policy/Physicians-and-the-Ontario-Human-Rights-Code) Accessed 2014-02-22

21. Canadian Medical Association *Code of Ethics* (2004): "45. Recognize a responsibility to give generally held opinions of the profession when interpreting scientific knowledge to the public; when presenting an opinion that is contrary to the generally held opinion of the profession, so indicate." (http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf) Accessed 2014-02-22)

22. See note 15.

23. College of Physicians and Surgeons of Ontario, *Physicians and the Ontario Human Rights Code* (2008). ". . .physicians should not promote their own religious beliefs when interacting with patients, nor should they seek to convert existing patients or individuals who wish to become patients to their own religion." (http://www.cpso.on.ca/Policies-Publications/Policy/Physicians-and-the-Ontario-Human-Rights-Code) Accessed 2014-02-22

24. Canadian Medical Association *Code of Ethics* (2004): "24. Respect the right of a competent patient to accept or reject any medical care recommended. 26. Respect your patient's reasonable request for a second opinion from a physician of the patient's choice." (http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf) Accessed 2014-02-22)

College of Physicians and Surgeons of Ontario, *Physicians and the Ontario Human Rights Code* (2008). "Advise patients or individuals who wish to become patients that they can see another physician with whom they can discuss their situation and in some circumstances, help the patient or individual make arrangements to do so." (http://www.cpso.on.ca/Policies-Publications/Policy/Physicians-and-the-Ontario-Human-Rights-Code) Accessed 2014-02-22

25. L___ S___, 30 January, 5:39 pm & 5:46 pm (http://www.consciencelaws.org/background/procedures/birth002-C-03.aspx)

"NO MORE CHRISTIAN DOCTORS"
Crusade Against NFP-only Physicians

Part 5: Crossing the threshold

A dangerous idea

The difficult compromise described in Part 4 safeguards the legitimate autonomy of the patient and preserves the integrity of the physician, but it also protects the community against the temptation to give credence to a dangerous idea: that a learned or privileged class, a profession or state institutions can legitimately compel people to do what they believe to be wrong - even gravely wrong - and punish them if they refuse.

This, perhaps, was what was troubling a member of the Council of the College of Physicians of Ontario when, in September, 2008, the Council was considering a demand from the Ontario Human Rights Commission that the College suppress freedom of conscience among physicians. He drew his colleagues' attention to a chilling *New England Journal of Medicine* article by Holocaust survivor, Elie Wiesel: *Without conscience*.[1] It was about the crucial role played by German physicians in supporting Nazi horrors. "How can we explain their betrayal?" Wiesel asked. "What gagged their conscience? What happened to their humanity?"[2]

Alexander Solzhenitsyn, reflecting on the same questions, suggested an answer:

> Physics is aware of phenomena which occur only at threshold magnitudes, which do not exist at all until a certain threshold encoded by and known to nature has been crossed. . . .Evidently evildoing also has a threshold magnitude. Yes, a human being hesitates and bobs back and forth between good and evil all his life. . . But just so long as the threshold is not crossed, the possibility of returning remains, and he, himself is still within reach of hope. But when, through the density of evil actions, the result either of their own extreme degree or of the absoluteness of his power, he suddenly crosses that threshold, he has left humanity behind, and without, perhaps, the possibility of return.[3]

Current threats to freedom of conscience in health care

It is thus of grave concern that some activists, influential academics, powerful interests, state institutions and professional organizations have been working steadily to develop and entrench a 'duty to do what is wrong' in medical practice. The unsuccessful 1977 attempt to force physicians to facilitate what they believed to be wrong by changing the CMA *Code of Ethics* presaged their efforts. However, current 'duty to do what is wrong' activism is more widespread, more influential, more determined, more organized and better funded: sometimes tax-funded. Tactics have included, on occasion, publication of misleading claims[4] and misrepresentations of law in professional journals.[5]

True to its roots, the present movement is driven by a determination to compel physicians and other health care workers to provide, participate in or facilitate abortion, contraception and related procedures. As a rule, they have been reluctant to demand that objecting physicians must actually perform or provide the procedures to which they object for reasons of conscience, usually for purely practical reasons.[6] The more common approach, usually presented as a "compromise," is to compel

objecting health care workers to refer patients for or otherwise facilitate the morally contested procedures or services.

Referral and moral complicity

In her book, *Conflicts of Conscience in Health Care: An Institutional Compromise*, Holly Fernandez Lynch cites and quotes several commentators to the effect that a physician who objects to a procedure for reasons of conscience should refer a patient to a willing provider.[7] However, she also notes opposing arguments,[8] and acknowledges that the issue is "among the more difficult aspects of the conscience clause debate:" in the words of one clearly frustrated professor, "absolutely intractable."[9] This is because, as Fernandez Lynch acknowledges, referral imposes "the serious moral burdens of complicity."[10]

Long-standing legal, religious and moral principles hold that we can be held responsible for the actions of someone else. As a matter of law, for example, one can be charged for bank robbery if one assists the robber by providing the weapon used, even if one is absent when the robbery occurs; employers may be civilly liable for misconduct by their employees that they could have prevented.

For further discussion, see *The Problem of Complicity*; *Referral: A False Compromise*; *The Problem of Unregulated Conscientious Objection*. (All available on the Protection of Conscience Project website)

Other examples can be cited to demonstrate that the principle of vicarious moral responsibility is widely accepted, deeply entrenched, and, if anything, becoming more important as people more fully appreciate the interconnectedness of the world.[11] Health care workers who refuse to refer patients for something they judge to be wrong are not demonstrating excessive scrupulosity, but an adherence to the same principle that guides their fellow citizens in other situations. They are refusing to participate in wrongdoing. What counts as "participation" has been considered by the American Medical Association in its policy on capital punishment; it includes even offering advice or merely attending an execution.[12]

Dr. Charles Bernard, President and Director General of the Collège des médecins du Québec has concisely stated and appears to agree with the reasoning of physicians who refuse to refer for or facilitate morally contested procedures:

> [I]f you have a conscientious objection and it is you who must undertake to find someone who will do it, at this time, your conscientious objection is [nullified]. It is as if you did it anyway. / [Original French] Parce que, si on a une objection de conscience puis c'est nous qui doive faire la démarche pour trouver la personne qui va le faire, à ce moment-là, notre objection de conscience ne s'applique plus. C'est comme si on le faisait quand même. [13]

Of course, if it is legitimate to force physicians to help patients obtain morally contested services or procedures like abortion, then it is legitimate to force objecting physicians to help patients obtain euthanasia and assisted suicide. One of the leading Canadian proponents of this view is Professor Jocelyn Downie of Dalhousie University.

Mandatory referral

Mandatory referral for abortion

In 2006 Jocelyn Downie was one of two law professors who wrote a guest editorial in the *Canadian Medical Association Journal* claiming that physicians who refuse to provide abortions for reasons of conscience had an ethical and legal obligation to refer patients to someone who would. This elicited a flood of protest, and the CMA reaffirmed its position that objecting physicians were *not* obliged to refer for the procedure, repeating the affirmation in 2008. The negative response to the editorial from the medical profession convinced Professor Downie that policy reform by the CMA was unlikely, so she turned her attention to provincial regulatory authorities to persuade them to force the medical profession to conform to her views.[14] (See Appendix "F")

Mandatory referral for assisted suicide/euthanasia

Professor Downie was also a member of the "expert panel" of the Royal Society of Canada that, five years later, recommended legalization of assisted suicide and euthanasia. The panel conceded that health care workers may object to providing euthanasia or assisted suicide, and that compelling them to do so might constitute a limitation of their "liberty or freedom of conscience and religion." For these reasons, Professor Downie and her expert colleagues recommended that health care professionals who object to euthanasia and assisted suicide should be compelled to refer patients to someone who would provide the procedures.[15] Their explanation:

> Today's procedural solution to this problem is, in Canada as well as many other jurisdictions, that health care professionals may provide certain reproductive health services that some religious health care professionals object to on conscientious grounds, however, they do not have to provide those services, in case the provision of those services would violate their conscience. Such objecting health care professionals are required to transfer an assistance seeking person on to other health care professionals who will provide the required services in a timely manner. The underlying rationale for this procedural solution lies in this kind of reasoning: If only health care professionals are permitted to provide assistance but they are not obligated to do so, then their autonomy is not limited but the autonomy of those seeking assistance could potentially be unfairly limited. Hence the requirement on conscientious objectors to refer assistance seekers to colleagues who are prepared to oblige them.[16]

Two points warrant attention here.

The first is that the panel argued that, *because* it is agreed that we can compel objecting health care professionals to refer for abortion, we are justified in forcing them to refer for euthanasia.

The second and more remarkable point is that, outside of Quebec, there is, in fact, *no* agreement that objecting health care professionals should be compelled to refer for abortions. Given the repudiation of her views by the CMA, Professor Downie must have been aware of that. This inconvenient fact was left out, apparently to make it appear that compulsory referral for euthanasia and assisted suicide is an entirely reasonable and uncontested "procedural solution" to the "problem" caused by people

who refuse to do what they believe to be wrong. Presumably this accounts for the absence of any cited reference to back up their assertion.

Quebec Bill 52: Mandatory referral for euthanasia

An Act respecting end-of-life care (Bill 52) is intended to permit physicians, in defined circumstances, to kill their patients as part of the redefined practice of medicine.[17] Submissions to a Quebec National Assembly Legislative Committee indicate that officials representing the profession are prepared to do so.[18]

Quebec is the only province in which the regulatory authority demands that objecting physicians assist patients to obtain the morally contested procedure. The *Code of Ethics* of the Collège des médecins du Québec demands that physicians who are unwilling to provide a service for reasons of conscience must "offer to help the patient find another physician."[19] The gloss provided by the Collège mentions abortion and contraception and emphasizes the demand for active assistance by the physician.[20]

However, strictly speaking, the *Code* requires an offer of help, but does not specify what constitutes "help," nor does the gloss specify what is considered satisfactory assistance. In the Project's experience, physicians who wish to avoid becoming morally complicit in a procedure are usually willing to provide a patient with general information, such as the address of a registry of physicians maintained on the website of a regulatory authority. It could be argued that this suffices for compliance with the *Code*.

Testimony by officers of the Collège des médecins du Québec before the Committee on Health and Social Services of the Quebec National Assembly was unclear on this point. Dr. Charles Bernard, President and Director General of the Collège, considered conscientious objection to euthanasia to be analogous to conscientious objection to abortion.[21] As noted above, he believes that referral results in moral culpability. Thus, he was pleased with the provision in the bill that requires an objecting physician to notify the institutional director of professional services, who is expected to find a replacement, because he felt that solved the problem of complicity, at least for the objecting physician.[22] Dr. Michelle Marchand referred to "an obligation to transfer" (l'obligation de transférer), but she, too, was pleased with the idea of collective or institutional rather than individual responsibility.[23]

On the other hand, Claude Ménard, representing the Provincial Association of User Committees, insisted that health care professionals "must refer a user who wants to access terminal palliative sedation or medical assistance to die to another professional. . . even in private practice,"[24] while Diane Lavallée of Quebec Association of Health Facilities and Social Services, noting the requirement in the physicians' *Code of Ethics*, said that the Association did not want objecting physicians relieved of the duty to help the patient find a doctor willing to provide euthanasia.[25]

Professor Downie also testified before the committee, but the issues of conscientious objection and referral were not raised.

Two perspectives on killing patients

As a matter of Canadian constitutional law, Bill 52 does not affect Canadian criminal law. Hence, no matter what the Bill purports to do, killing patients under the conditions specified by the act

would constitute first degree murder (murder that is "planned and deliberate"[26]) and anyone counselling, aiding, abetting the killing (by referral, for example) would be considered a party to the offence.[27]

Now, if the bill becomes law, it is not inconceivable (and this is the hope of the Quebec government) that a court might rule that killing a patient in accordance with the Act is not murder under the criminal law. An undetermined number of physicians and health care workers would then begin or continue with killing patients under the terms of the law, in the belief that what they were doing was not only legal, but morally acceptable. In a sense, this would not be remarkable, because that sort of thing has happened in the past, and it is happening now, in Belgium and the Netherlands, for example.

Nonetheless, there is no doubt that most of those opposed to the bill in principle would, despite the ruling of the court, continue to consider euthanasia to be (morally) planned and deliberate murder. Having this view, it would come as no surprise if they were to refuse to kill patients or refuse to encourage or facilitate the killing of patients by counselling, referral or other means. And this would not be remarkable, because this has also happened in the past.

Normalizing mandatory participation in killing

It is at this point that one realizes the unique character of the 'duty to do what is wrong' movement, exemplified by Professor Downie and enshrined in the Collège des médecins du Québec *Code of Ethics*. Recall that, for Professor Downie and the other Royal Society panel of experts (and those who share their views) it is not sufficient to simply *encourage and allow* willing health care professionals to kill patients. They demand that health care professionals be *compelled* to participate in and facilitate the killing of patients - even if they believe it to be wrong, even if they believe it to be murder - and that they should be punished if they refuse to do so. This is quite extraordinary, even if there are precedents for it.

Killing is not surprising; even murder is not surprising. It has even been said that there is something uniquely human about murder. But to hold that the state or a profession can, in justice, compel an unwilling soul to commit or even to facilitate what he sees as murder, and justly punish or penalize him for refusing to do so - to make that claim takes us beyond Solzhenitsyn's threshold.

What about contraception?

Returning to the subject at hand, one might ask what connection exists between forcing an objecting physician to refer for or otherwise help a patient obtain contraception, forcing him to refer or help a patient to obtain an abortion, and forcing him to refer for or facilitate euthanasia and assisted suicide.

The connection between compulsory referral for abortion and compulsory referral for euthanasia has been made abundantly clear by Jocelyn Downie, the Royal Society panel of experts, and the gloss on the Collège des médecins du Québec *Code of Ethics* provided by the Collège.

The connection to contraception becomes obvious once one recognizes that, if one can legitimately force a physician to facilitate the killing of patients, it is rather difficult to explain why he should not also be forced to prescribe or at least refer for contraceptives.

Moreover, if one admits that it is unjust to force unwilling physicians to kill their patients or find someone who will, one arrives at the brink of a slippery slope. It might lead to an admission that

objecting physicians should not be forced to provide or refer patients for abortion - or contraceptives. The whole tapestry of the 'duty to do what is wrong' movement might begin to unravel. From their perspective, perhaps it seems better to cross Solzhenitsyn's threshold.

Notes

1. Email to the Administrator, Protection of Conscience Project, from P__ H__ (present at College Council meeting 18 September, 2008) (2014-02-11, 10:10 am)

2. Wiesel E. *Without Conscience*. N Engl J Med 352;15 april14, 2005 (http://www.nejm.org/doi/full/10.1056/NEJMp058069) Accessed 2014-02-24

3. Solzhenitsyn A.I. *The Gulag Archipelago, 1918-1956: An Experiment in Literary Investigation. I-II*. (Trans. Thomas P. Whitney) New York: Harper & Row, 1974, p. 174-175

4. Murphy S. "Conscientious Objection as a Crime Against Humanity." *Protection of Conscience Project*, 10 April, 2009. (http://www.consciencelaws.org/law/commentary/legal038.aspx)

5. Murphy S. *Postscript for the Journal of Obstetrics and Gynaecology Canada: Morgentaler vs. Professors Cook and Dickens*. Protection of Conscience Project, 25 November, 2005 (http://www.consciencelaws.org/law/commentary/legal030-001.aspx)

6. In the case of abortion or any other surgical procedure, an objecting physician is unlikely to have the experience necessary to develop the technical skills required for safe and proficient practice. Moreover, patients may be reluctant to submit to the knife in the hands of a practitioner known to be wholly unwilling to provide a procedure.

7. Fernandez-Lynch H. *Conflicts of Conscience in Health Care: An Institutional Compromise.* Cambridge, Mass.: The MIT Press, 2008, p. xii-xiii (hereinafter "*Conflicts*.") p. 231-232

8. *Conflicts*, p. 229-231

9. *Conflicts*, p. 233. Quoting Veatch, Robert M., *The Patient-Physician Relation: The Patient as Partner, Part 2*. Bloomington Indiana University Press, 1991, p. 152

10. *Conflicts*, p. 229

11. The increasing popularity of 'ethical investment' reflects a belief that one is responsible for the good or the harm that flows indirectly from one's financial participation in a company. Many people adopt ethical investment as a strategy to preserve their personal integrity, whether or not their investment choices actually influence corporate policies. Similarly, a 44% increase in the sale of "fair trade" products in the United States is attributed to the exercise of 'social conscience' by more and more people who do not want to indirectly support unfair labour practices through their purchases. "I want to look good," explained one fair trade supporter, "but I don't want to feel guilty."Kim G. "Fashion conscience:clothing and accessories are becoming

both free-trade and chic." *Sacramento Bee*, 30 July, 2005. (http://www.sacbee.com/content/business/story/13316724p-14158839c.html) Accessed 2005-07-31

12. AMA policy forbids physician participation in executions, and defines participation as (1) an action which would directly cause the death of the condemned; (2) an action which would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned; (3) an action which could automatically cause an execution to be carried out on a condemned prisoner. Among the actions identified by the AMA as "participation" in executions are prescribing or administering 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. 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. American Medical Association Policy E-2.06: Capital Punishment (http://www.ama-assn.org/ama1/pub/upload/mm/369/e206capitalpunish.pdf) Accessed 2014-02-24

13. Committee on Health and Social Services of the Quebec National Assembly, Consultations & hearings on Quebec Bill 52: College of Physicians of Quebec (Tuesday 17 September 2013 - Vol. 43 no. 34) (http://www.consciencelaws.org/background/procedures/assist009-001.aspx#154)

14. "(We decided to proceed by way of these provincial regulatory bodies rather than the CMA, in part, because of the negative reaction of the CMA to the Rodgers/Downie editorial, which made policy reform by the CMA seem unlikely.)" McLeod C, Downie J. "Let Conscience Be Their Guide? Conscientious Refusals in Health Care." *Bioethics* ISSN 0269-9702 (print); 1467-8519 (online) doi:10.1111/bioe.12075 Volume 28 Number 1 2014 pp ii–iv

15. Schuklenk U, van Delden J.J.M, Downie J, McLean S, Upshur R, Weinstock D. *Report of the Royal Society of Canada Expert Panel on End-of-Life Decision Making* (November, 2011) p. 101 (http://rsc-src.ca/sites/default/files/pdf/RSCEndofLifeReport2011_EN_Formatted_FINAL.pdf) Accessed 2014-02-23

16. Schuklenk U, van Delden J.J.M, Downie J, McLean S, Upshur R, Weinstock D. *Report of the Royal Society of Canada Expert Panel on End-of-Life Decision Making* (November, 2011) p. 62 (http://rsc-src.ca/sites/default/files/pdf/RSCEndofLifeReport2011_EN_Formatted_FINAL.pdf) Accessed 2014-02-23

17. However, Bill 52 does not actually require or authorize the killing of patients. The actual killing of patients under the conditions specified in the bill cannot become part of medical

practice in Quebec unless the medical profession itself (broadly speaking) agrees. Murphy S. *Redefining the practice of medicine: winks and nods and euthanasia in Quebec.* Protection of Conscience Project. (http://www.consciencelaws.org/law/commentary/legal068-001.aspx)

18. Protection of Conscience Project, *Consultations & hearings on Quebec Bill 52. September-October, 2013* (http://www.consciencelaws.org/background/procedures/assist009.aspx)

19. Collège des médecins du Québec, *Code of Ethics of Physicians*, para. 24 (http://www.cmq.org/en/Public/Profil/Commun/AProposOrdre/~/media/Files/ReglementsANG/cmqcodedeontoan.ashx?61323) Accessed 2013-06-23

20. "For example, a physician who is opposed to abortion or contraception is free to limit these interventions in a manner that takes into account his or her religious or moral convictions. However, the physician must inform patients of such when they consult for these kinds of professional services and assist them in finding the services requested." Collège des médecins du Québec, *Legal, Ethical and Organizational Aspects of Medical Practice in Québec.* ALDO-Québec, 2010 Edition, p. 156. (http://www.canadianopenlibrary.ca/SwfDocs/231/231229.pdf) Accessed 2013-06-23

21. Committee on Health and Social Services of the Quebec National Assembly, Consultations & hearings on Quebec Bill 52: *College of Physicians of Quebec* (Tuesday 17 September 2013 - Vol. 43 no. 34)
(http://www.consciencelaws.org/background/procedures/assist009-001.aspx#141b)

22. Committee on Health and Social Services of the Quebec National Assembly, Consultations & hearings on Quebec Bill 52: *College of Physicians of Quebec* (Tuesday 17 September 2013 - Vol. 43 no. 34)
(http://www.consciencelaws.org/background/procedures/assist009-001.aspx#154)

23. Committee on Health and Social Services of the Quebec National Assembly, Consultations & hearings on Quebec Bill 52: *College of Physicians of Quebec* (Tuesday 17 September 2013 - Vol. 43 no. 34)
(http://www.consciencelaws.org/background/procedures/assist009-001.aspx#156)

24. Committee on Health and Social Services of the Quebec National Assembly, Consultations & hearings on Quebec Bill 52: *Provincial Association of User Committees* (Wednesday, 25 September 2013 - Vol. 43 no. 38)
(http://www.consciencelaws.org/background/procedures/assist009-020.aspx#012)

25. Committee on Health and Social Services of the Quebec National Assembly, Consultations & hearings on Quebec Bill 52: *Quebec Association of Health Facilities and Social Services* (Wednesday, 25 September 2013 - Vol. 43 no. 38)
(http://www.consciencelaws.org/background/procedures/assist009-017.aspx#008)

26. *Criminal Code* (R.S.C., 1985, c. C-46) (Hereinafter "CC") Section 231(2). (http://laws-lois.justice.gc.ca/eng/acts/C-46/page-115.html#docCont) Accessed 2014-02-24

27. CC, Section 21(b). (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-6.html#h-5) Accessed 2013-06-17; CC, Section 21(c). (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-6.html#h-5) Accessed 2013-06-17; CC, Section 22 (http://laws-lois.justice.gc.ca/eng/acts/c-46/page-6.html#h-5) Accessed 2013-06-17

"NO MORE CHRISTIAN DOCTORS"
Crusade Against NFP-only Physicians

Part 6: Avoiding authoritarian 'solutions'

The centrality of the human person

The definitions of "health" and "harm" are determined by underlying beliefs about the nature of the human person.[1] There can be no agreement about what is beneficial or harmful for the patient without first agreeing upon that. A definition or belief about the human person is necessary to assess benefits and harms, and thus shapes the approach to every moral or ethical problem in medicine.

These beliefs may take scientific and medical information into account, but they are not and cannot be scientific, since questions about human personhood are beyond the scope of science.[2] An underlying non-scientific 'belief system' thus inescapably informs the practice of all physicians, including their notions of "health" and "harm."

Explicit faith, hidden faith

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. Such underlying beliefs are frequently unexamined. Hence, when a public and practical expression of a religious belief generates a conflict between a religious believer and a secularist, the conflict often arises because of a clash between the explicit faith of the religious believer and the hidden faith of the secularist.

In such situations, precisely because the faith-assumptions of the secularist are not explicit (and may not be recognized even by the secularist) , the controversy is often erroneously portrayed as a conflict between believers and non-believers: between religious belief and science ('real' facts): between religious belief and reason ('real' knowledge): or between religious belief and the secular (the 'real' world).

Forms of rationalism, scientific materialism and secularism that claim exclusive access to reality deny the capacity of conscience or religion to grasp what is real. The assumption here may be that reason (and perhaps only reason employing empirical science) is "the *only valid* way of human knowing, and, consequently, the only appropriate tool to explore non-scientific questions, such as profound ethical issues."[3] Thus, conscience and religion are relegated to the purely subjective, personal sphere, because it is assumed that they produce "mere" belief, which must give way before "real" knowledge produced by forms of rational enquiry in which conscience and religion play no part.[4]

Such an outlook involves a truncated view of reality, for human dignity, justice, equality, courage, prudence, mercy, beneficence, non-maleficence, and love - to name but a few realities that most people acknowledge- are not amenable to the methods of empirical science nor adequately approached by means of reason alone.[5]

An understanding of any of these things involves belief. They may be religious beliefs held to be divinely revealed, the beliefs of principled moralists (whether religious, atheistic or agnostic) who

derive them from various sources, or the beliefs of the indifferent, who absorb them from traditions they do not understand, or from Facebook. But controversies on all such subjects arise from differences in belief, not conflicts between belief and scientific facts, or between superstition and knowledge, or between myth and reality.[6]

Impossible demands

Hence, the demand that physicians must not be allowed to act upon beliefs is unacceptable because it is impossible; one cannot act morally without reference to beliefs. Relevant here is a comment by Professor Margaret Somerville. "In ethics," she writes,"impossible goals are not neutral; they cause harm."[7]

The demand that physicians must not be allowed to act upon "personal" or "religious" beliefs heard with increasing frequency and stridency in public discourse - is equally unacceptable. The demand, framed in this way, with an emphasis on "personal" or "private" morality, is an attempt to discredit them precisely because theirs is a minority view. But this approach cuts both ways. The beliefs of many conscientious objectors, while certainly personal or private 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 theirs is a 'private' morality, that of those who differ with them is not less so.

Avoiding authoritarian 'solutions'

Of greater interest in the present context are the sometimes explicit accusations that physicians who act on "personal" beliefs are narrow-minded, eccentric, and even selfish. Such allegations provide an additional reason for caution, for they too often reflect an attitude more appropriate to a totalitarian state than to a liberal democracy: that physicians have a duty to do what they believe to be wrong, that they must always set aside their own conscientious convictions in order to conform to the expectations of the patient, or the profession, or the state, the better to serve as an instrument to achieve ends chosen by others.

But Madame Justice Bertha Wilson, in *R. v. Morgentaler*, stressed that "an emphasis on individual conscience and individual judgment . . . lies at the heart of our democratic political tradition."[8] She insisted that an individual must never be treated as a means to an end - especially an end chosen by someone else, or by the state. One of her reasons for striking down legal restrictions on abortion was that, through the law, the state was 'taking sides' on what is essentially a moral question that should be left to private judgement. She rejected the idea that 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'."[9]

Crusaders in high places, joined now by handmaidens on Facebook, are demanding that physicians, as a matter of principle and even as a matter of law, can be compelled to do what they believe to be wrong, and that they can be punished if they do not. It is the position of the Project that this is a blasphemy against the human spirit. Applying to such demands the words of Alexander Solzhenitsyn, "To this putrefaction of soul, this spiritual enslavement, human beings who wish to be human cannot consent."[10]

Freedom of conscience in health care: distinctions and limits[11]

This does not, of course, dispose of the practical question of how freedom of conscience can be rationally and adequately accommodated in a society characterized by a plurality of moral and political viewpoints and conflicting demands. Ultimately, like the difficult compromise achieved by the Canadian Medical Association, this is a work in progress. Nonetheless, it is possible to propose some foundational principles that provide some guidance.

Perfective Freedom of Conscience

A traditional view holds that one who freely chooses a moral good - say, helping someone in need - perfects himself/herself to the extent that what is chosen is truly good and not just apparently so. A moral pluralist might say that the free choice of a desired good actualizes personal autonomy and thus contributes to an ultimate end described as self-fulfilment. The decision to pursue an apparent good in either case can be called an exercise of perfective freedom of conscience because it is potentially perfective of the human person.

Preservative Freedom of Conscience

On the other hand, one who refuses to participate in wrongdoing - refusing an invitation or pressure to steal, for example - preserves his own integrity, even though he does not achieve the kind of personal growth that might be possible by doing some positive good. A moral pluralist might hold that such a refusal preserves rather than develops personal autonomy. Thus, a decision to avoid an apparent evil can be described as an exercise of preservative freedom of conscience.

The problem of limits

It is generally agreed that the state may limit the exercise of freedom of conscience if it is objectively harmful, or if the limitation serves the common good. While there is disagreement about how to apply these principles, they are seen at work when the law refuses to countenance human sacrifice in religious worship or when it limits the practice of medicine to qualified professionals rather than faith healers.

Such limitations may interfere with some of the aspirations of citizens or their pursuit of moral perfection but are not necessarily inconsistent with democratic freedom or human dignity. Certainly, restrictions may go too far; they might fail to demonstrate sufficient understanding and respect for human freedom and dignity, even if they do not subvert them entirely. But no polity could long exist without restrictions of some sort on human acts, so some limitation of perfective freedom of conscience is not unexpected.

If the state can legitimately limit perfective freedom of conscience by preventing people from doing what they believe to be good, it does not follow that it is equally free to suppress preservative freedom of conscience by forcing them to do what they believe to be wrong. There is a significant difference between preventing someone from doing the good that he wishes to do and forcing him to do the evil that he abhors.

Protecting fundamental goods

By its nature, perfective freedom of conscience demands much more of society than preservative freedom of conscience. Limiting perfective freedom of conscience may prevent people from

perfecting themselves, fulfilling their personal aspirations, or achieving some social goals. This may do them some wrong; that is why democratic regimes have been increasingly inclined to err on the side of freedom, demanding that restrictions on freedom of conscience must be demonstrably necessary, narrowly framed, and strictly construed. But if it does them some wrong, it does not necessarily do them an injury.

In contrast, to force people to do something they believe to be wrong is always an assault on their personal dignity and essential humanity, even if they are objectively in error; it is always harmful to the individual, and it always has negative implications for society. It is a policy fundamentally opposed to civic friendship, which grounds and sustains political community and provides the strongest motive for justice. It is inconsistent with the best traditions and aspirations of liberal democracy, since it instills attitudes more suited to totalitarian regimes than to the demands of responsible freedom.

This does not mean that no limit can ever be placed on preservative freedom of conscience. It does mean, however, that even the strict approach taken to limiting other fundamental rights and freedoms is not sufficiently refined to be safely applied to limit freedom of conscience in its preservative form. The stakes are far too high. Like the use of potentially deadly force, if the restriction of preservative freedom of conscience can be justified at all, it will only be as a last resort and only in the most exceptional circumstances.

Notes

1. One must distinguish between human *being* and human *person*. In Canadian law, *human being* is defined by section 223 of the Criminal Code as a child who has "completely proceeded, in a living state, from the body of its mother". Canadian jurisprudence indicates that the term *human person* and *human being* (as defined in section 223) are synonymous. There are historical, legal and political reasons for this, but we are not, in the present context, concerned with law. The subject here is the relationship between science and philosophy.

2. It is the province of science to determine when a human individual begins to *be* - that is, to exist. The existence of a human *being* is a purely biological matter. Standard texts on human embryology are clear on this point. However, science cannot determine what moral obligations are called forth by the existence of a human being. Equally important, while science can establish that a human *being* is in existence, it cannot determine that the individual is a human *person*. That is a philosophical question, and science is not competent to decide philosophical questions. Its correct and limited role is to provide factual data that philosophers and ethicists incorporate into their deliberations.

3. Somerville M. "Why are they throwing brickbats at God?" *MercatorNet* (1 June, 2007) (http://www.mercatornet.com/articles/why_are_they_throwing_brickbats_at_god/) Accessed 2007-07-05.

4. As, for example suggested by John Rawls' "veil of ignorance". Rawls J. *A Theory of Justice*. Cambridge, Mass.: Harvard University Press, 1971

5. "We have multiple ways of human knowing in addition to reason, all of which are essential to ethics. They include history (human memory) — this is beautifully encapsulated in aboriginal people's practice in making ethical decisions of looking back seven generations. Imagination and creativity — looking forward seven generations to try to assess the ethical acceptability of the impact of what we plan to do on future generations. Intuition — especially moral intuition. Common sense. Experiential knowledge — including what we can know, as the gym teachers tell us, by listening to our bodies. And "examined" emotions, to name just some." Somerville M. "Why are they throwing brickbats at God?" *MercatorNet* (1 June, 2007) (http://www.mercatornet.com/articles/why_are_they_throwing_brickbats_at_god/) Accessed 2007-07-05.

6. Which is not to say that questions of fact and distinctions between knowledge and belief are irrelevant in such disputes.

7. Somerville M. "Why are they throwing brickbats at God?" *MercatorNet* (1 June, 2007) (http://www.mercatornet.com/articles/why_are_they_throwing_brickbats_at_god/) Accessed 2007-07-05.

8. *R. v. Morgentaler* (1988)1 S.C.R 30 (Supreme Court of Canada) (http://scc-csc.lexum.com/scc-csc/scc-csc/en/item/288/index.do) Accessed 2014-02-24

9. *R. v. Morgentaler* (1988)1 S.C.R 178-179 (Supreme Court of Canada) (http://scc-csc.lexum.com/scc-csc/scc-csc/en/item/288/index.do) Accessed 2014-02-24

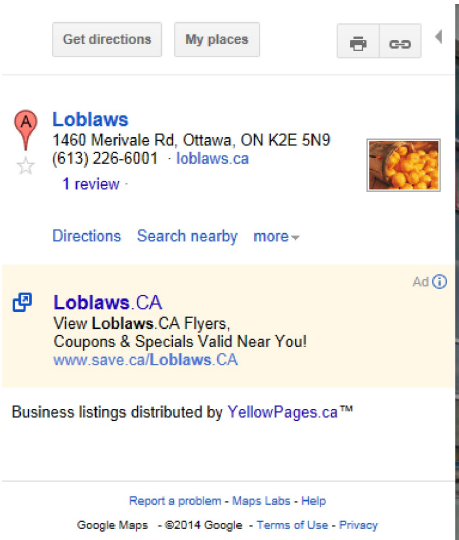
10. Solzhenitsyn, Alexander, "As Breathing and Consciousness Return." In *From Under the Rubble*. Bantam Books (USA & Canada) 1976, p. 23

11. This section of the paper draws from an extended discussion of the subject in Murphy S, Geunis S.J. *Freedom of Conscience in Health Care: Distinctions and Limits*. J Bioeth Inq. 2013 Oct; 10(3): 347-54 (http://rd.springer.com/article/10.1007/s11673-013-9451-x#)

APPENDIX "A"

"I had to go out of my way and find another clinic.
Luckily for me, there was one not too far away."

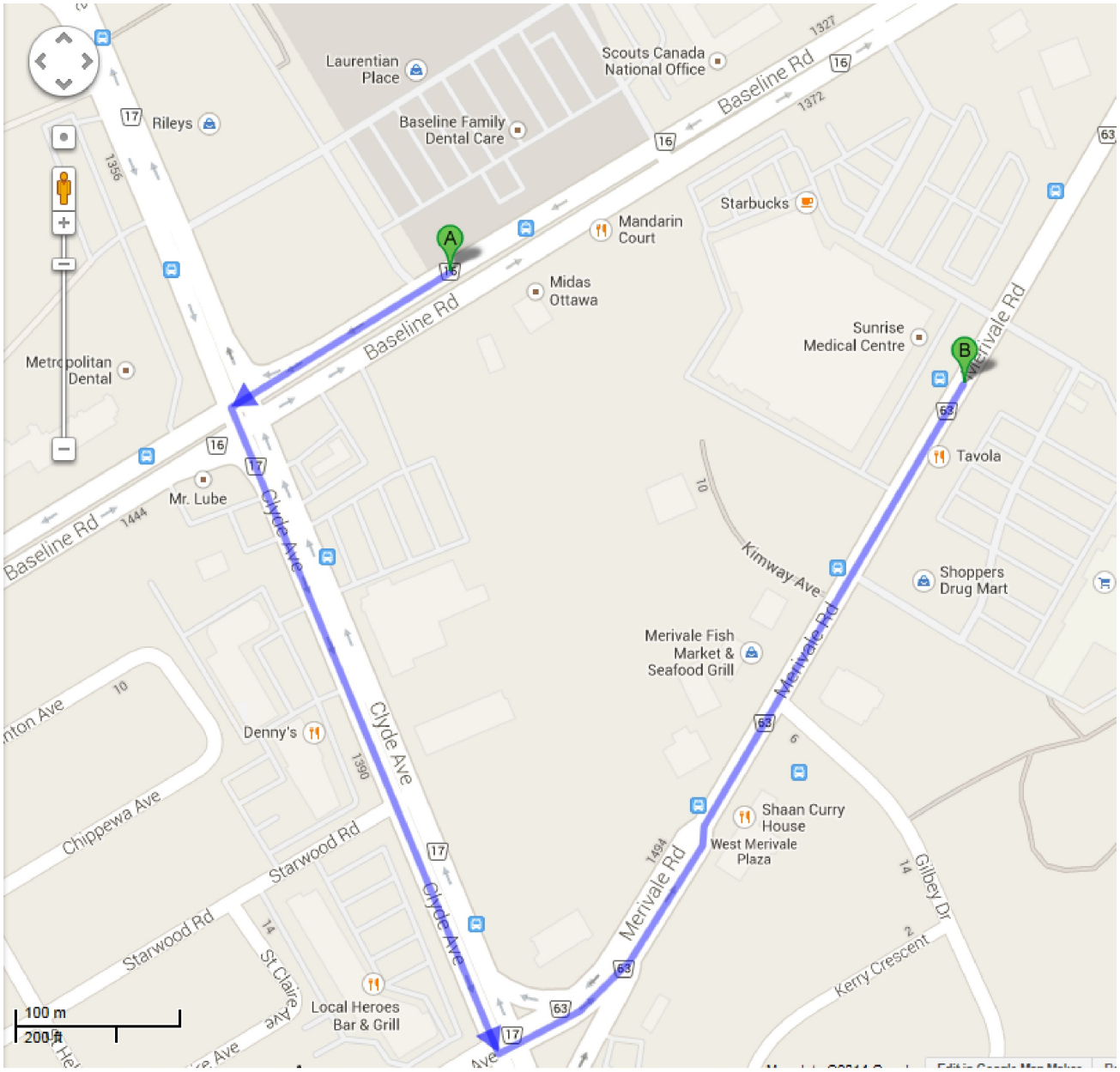
Identification of the Loblaws Store where the prescription was obtained



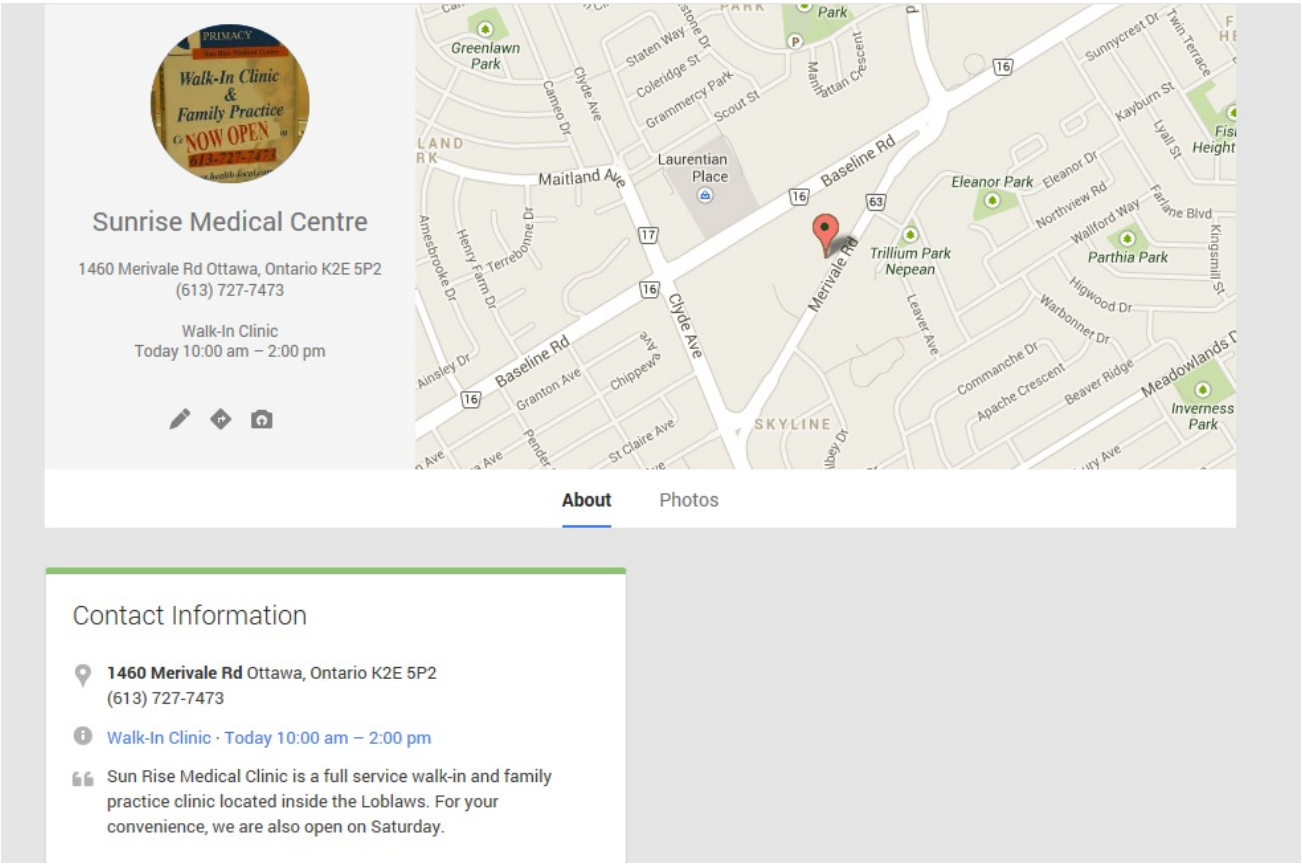
Map showing relative location of clinics

A: Care-Medics Medical Centres

B: Loblaws Store with Sunrise Medical Centre and pharmacy



Sunrise Medical Centre



APPENDIX "B"

K___ A___ Facebook Page Timeline

See the timeline at

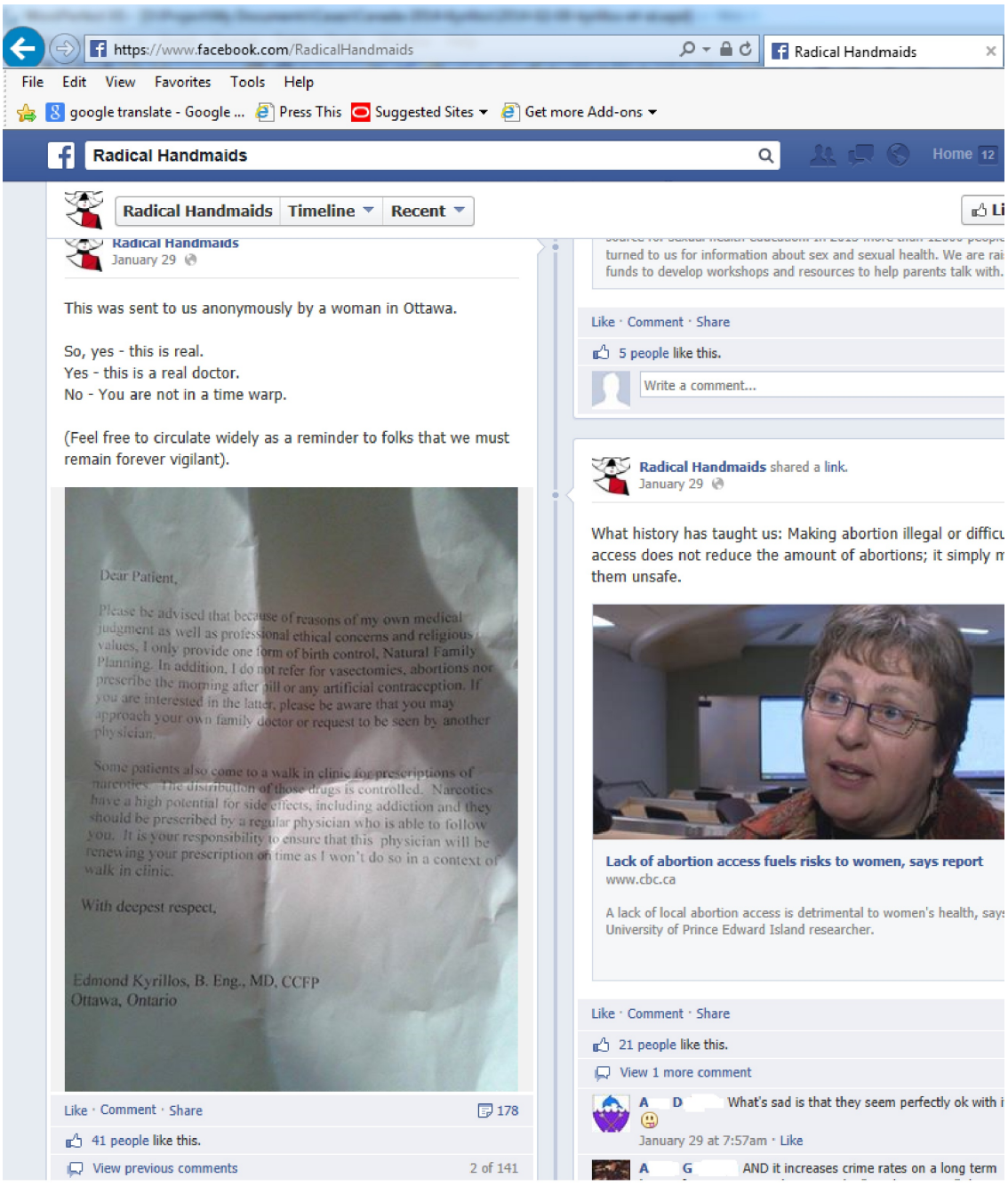
- http://www.consciencelaws.org/background/procedures/birth002-B.aspx

APPENDIX "C"

Radical Handmaids Facebook Page Timeline

See the timeline at

- http://www.consciencelaws.org/background/procedures/birth002-C-01.aspx



Accessed 2014-02-10

APPENDIX "D"
STATISTICS

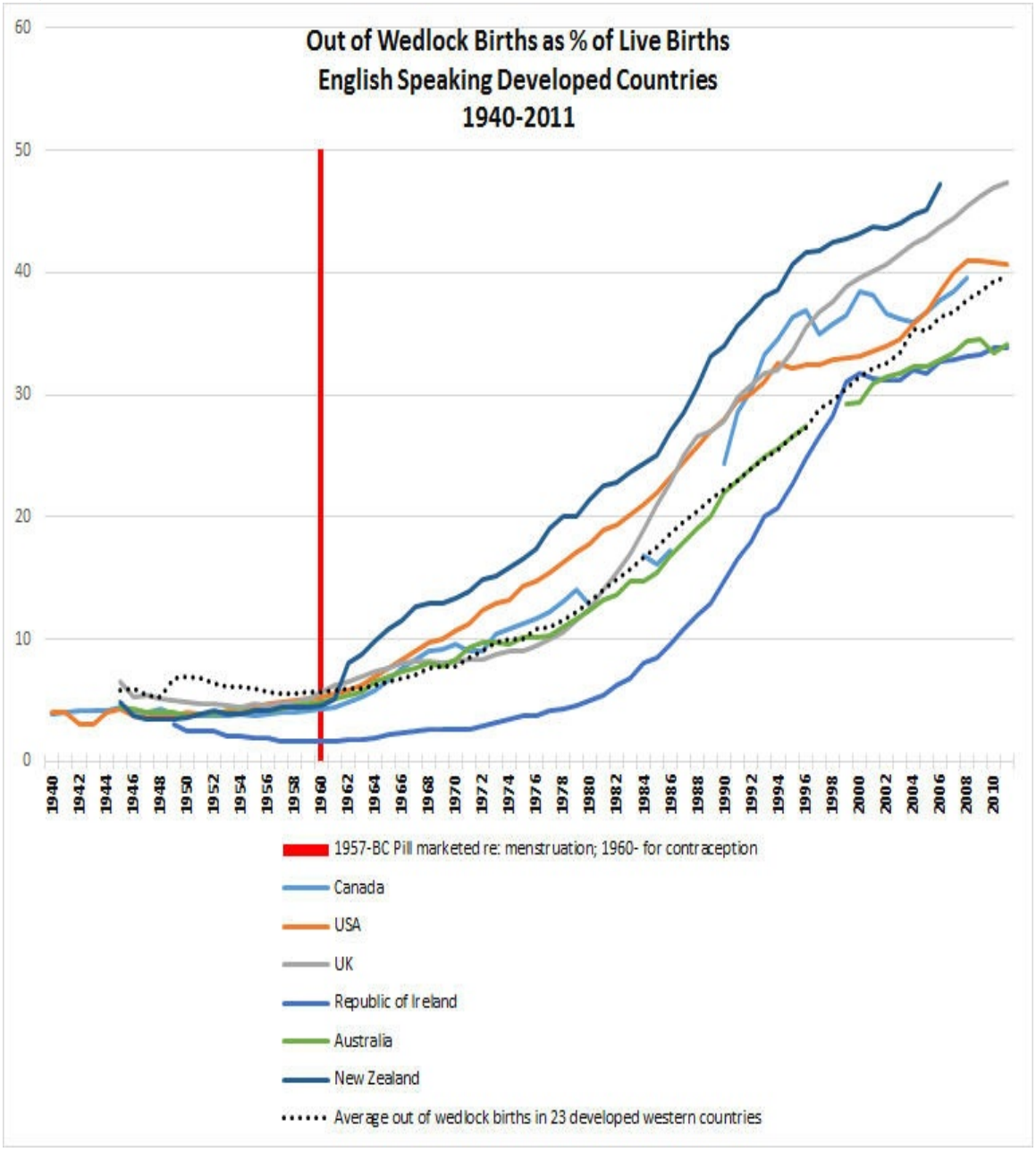
D1. Trends: Out-of-Wedlock Births, Abortion
English speaking and Nordic countries (1940-2011)

Introduction

What is provided here is not exhaustive. It is intended only to provide the reader with sufficient information to understand the factors and issues likely to be involved when health care workers decline to provide contraception services for reasons of conscience.

D1.1 Out of Wedlock Births (English speaking countries)

Figure D1.1.1

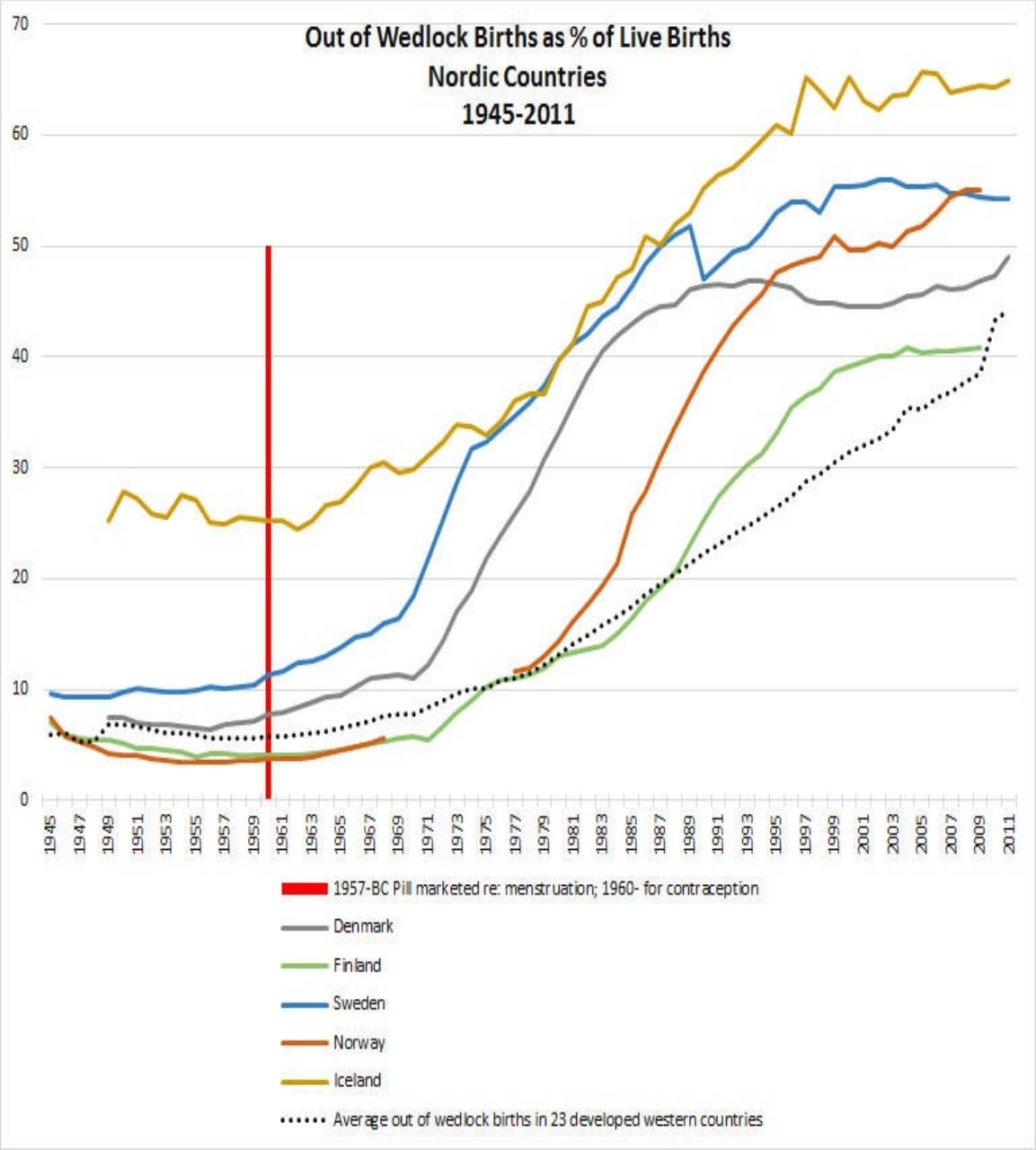


D1. Trends: Out-of-Wedlock Births, Abortion

English speaking and Nordic countries (1940-2011)

D1.1 Out of Wedlock Births (Nordic Countries)

Figure D1.1.2



D1. Trends: Out-of-Wedlock Births, Abortion

English speaking and Nordic countries (1940-2011)

D1.1 Out of Wedlock Births

Sources:

Oxford University, Department of Social Policy and Intervention, Births outside marriage per 1000 live births ('illegitimacy ratio'), developed countries 1945 - 2009. (http://www.spi.ox.ac.uk/fileadmin/documents/excel/Illegittrends__1_.XLS) Accessed 2013-07-02

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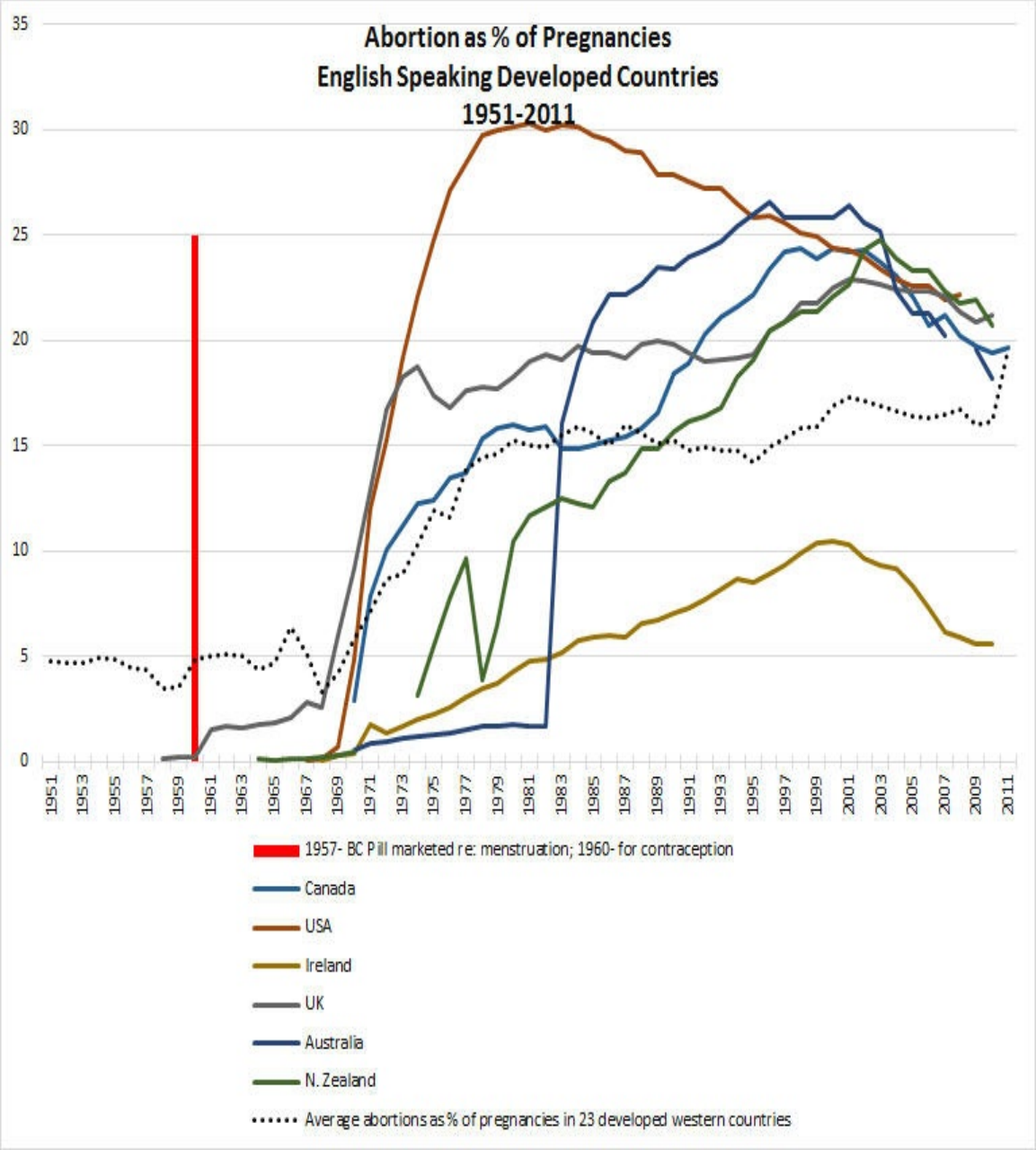
D1. Trends: Out-of-Wedlock Births, Abortion

English speaking and Nordic countries (1940-2011)

D1.2 Abortion (English speaking countries)

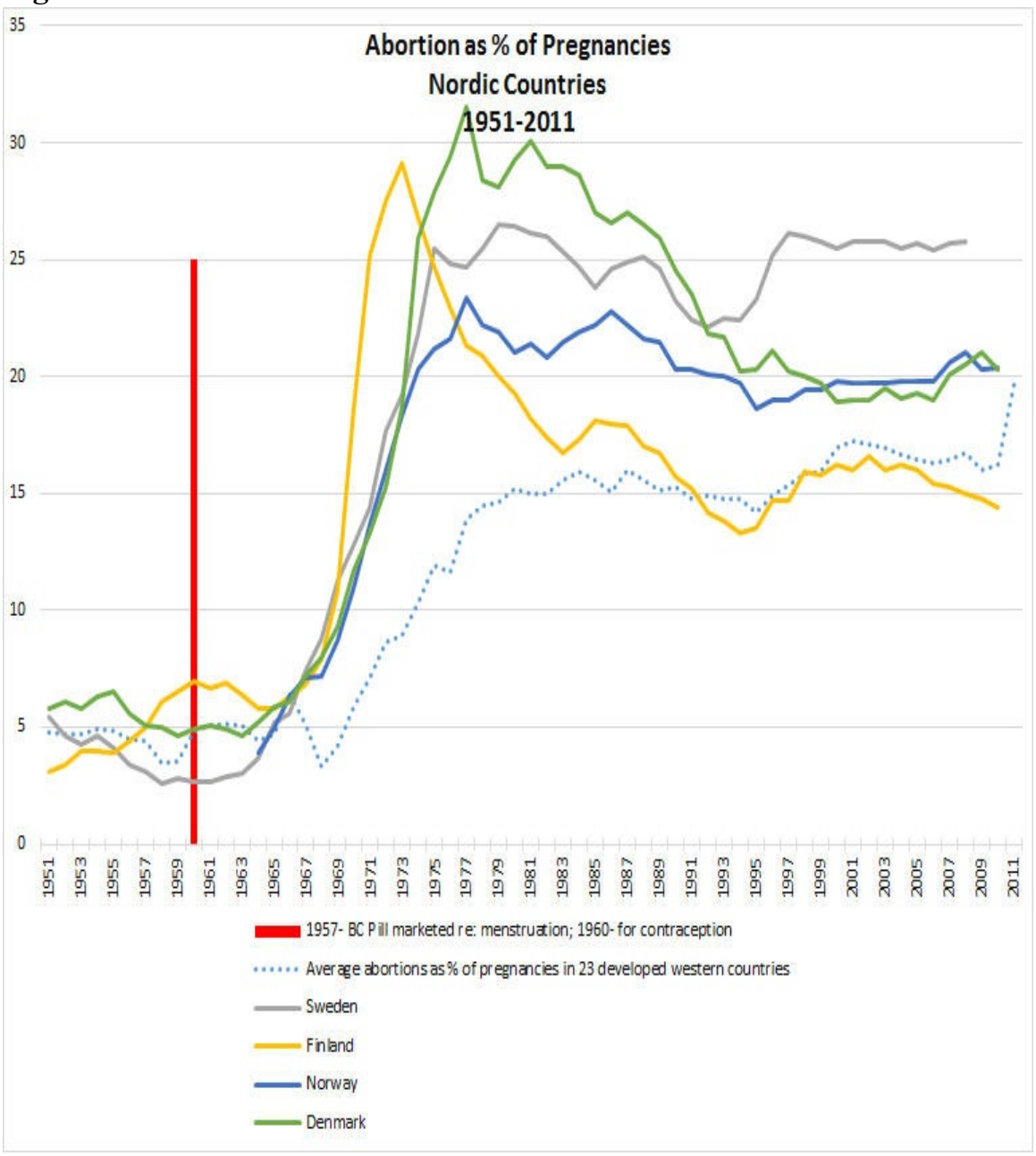
Figure D1.2.1



D1. Trends: Out-of-Wedlock Births, Abortion
English speaking and Nordic countries (1940-2011)

D1.2 Abortion (Nordic countries)

Figure D1.2.2



D1. Trends: Out-of-Wedlock Births, Abortion
English speaking and Nordic countries (1940-2011)

D1.2 Abortion

Sources:

Note: *Abortion statistics are tendentious and can be difficult to evaluate, especially where (as in Canada) state authorities adopt policies to keep them secret. A single source (WR Johnston Archive) has been used for most of the statistics used in these tables to minimize anomalies that might arise from using different sources with different standards. Spot checks of the sources cited in Johnston confirm that his tables are supported by the sources.*

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Social Inquiry Society of Ireland ,Vol. XXXVI (Presidential Address read before the Society, 31May 2007) Table H: Number of legal abortions carried out on Irish women in England and Wales, 1970-2005. p. 217.

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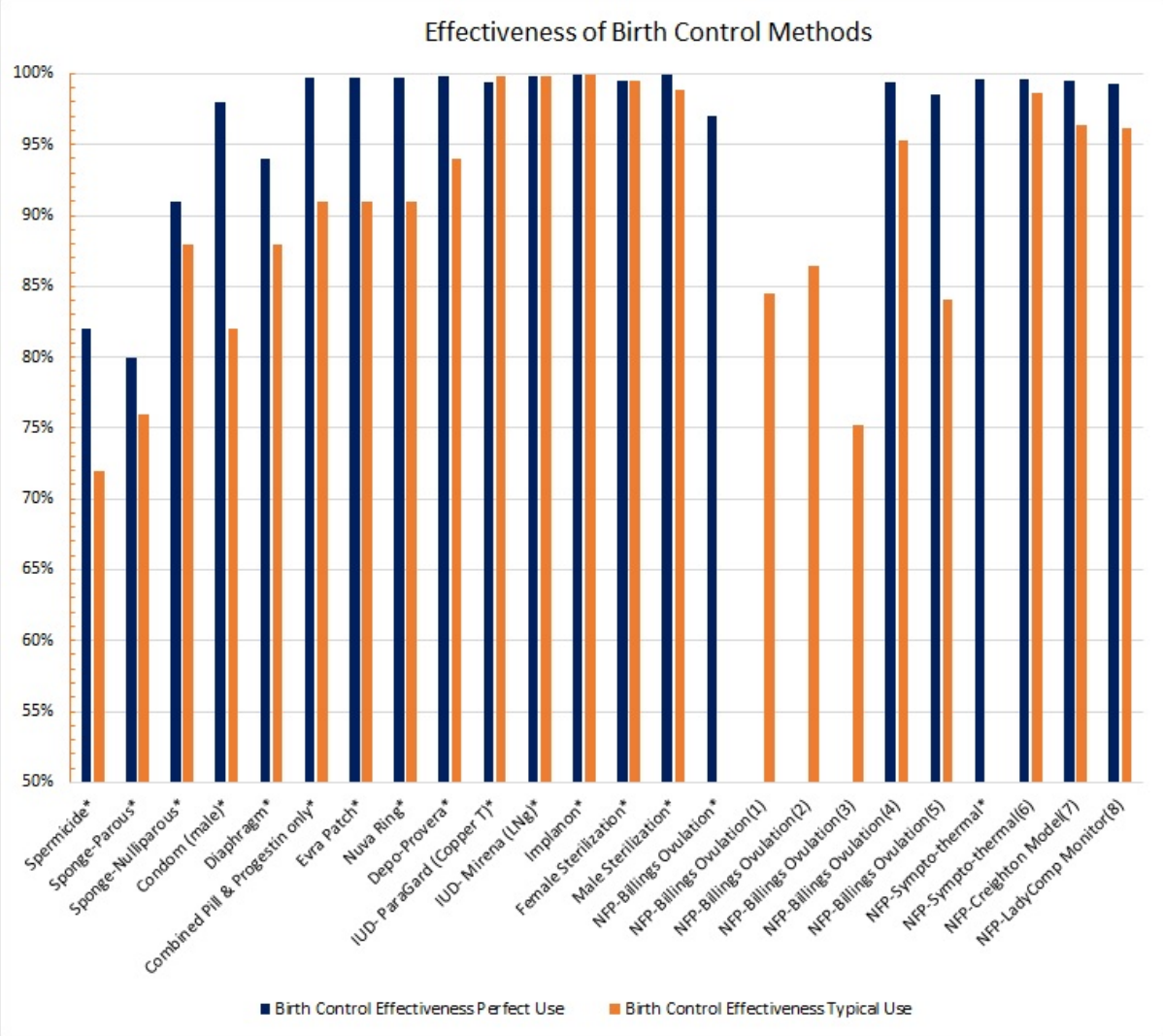
D2. Effectiveness of Birth Control Methods

Introduction

What is provided here is not exhaustive. It is intended only to provide the reader with sufficient information to understand the factors and issues likely to be involved when health care workers decline to provide contraception services for reasons of conscience.

D2.1. Effectiveness

D2.1.1 Chart



D2.1. Effectiveness

D2.1.2 Table

Birth Control Effectiveness		
Method	**Perfect Use**	**Typical Use**
Spermicide*	82.00%	72.00%
Sponge-Parous*	80.00%	76.00%
Sponge-Nulliparous*	91.00%	88.00%
Condom (male)*	98.00%	82.00%
Diaphragm*	94.00%	88.00%
Combined Pill & Progestin only*	99.70%	91.00%
Evra Patch*	99.70%	91.00%
Nuva Ring*	99.70%	91.00%
Depo-Provera*	99.80%	94.00%
IUD- ParaGard (Copper T)*	99.40%	99.80%
IUD- Mirena (LNg)*	99.80%	99.80%
Implanon*	99.95%	99.95%
Female Sterilization*	99.50%	99.50%
Male Sterilization*	99.90%	98.85%
NFP-Billings Ovulation*	97.00%	
NFP-Billings Ovulation(1)		84.50%
NFP-Billings Ovulation(2)		86.40%
NFP-Billings Ovulation(3)		75.20%
NFP-Billings Ovulation(4)	99.40%	95.30%
NFP-Billings Ovulation(5)	98.50%	84.10%
NFP-Sympto-thermal*	99.60%	
NFP-Sympto-thermal(6)	99.60%	98.60%
NFP-Creighton Model(7)	99.50%	96.40%
NFP-LadyComp Monitor(8)	99.30%	96.20%

D2.1 Effectiveness

Sources:

*Trussell J. Contraceptive Efficacy. In Hatcher RA, Trussell J, Nelson AL, Cates W, Kowal D, Policar M. *Contraceptive Technology: Twentieth Revised Edition*. New York, NY: Ardent Media, 2011. Cited in *Contraceptive Technology*, Table 3-2: Percentage of women experiencing an unintended pregnancy during the first year of typical use and the first year of perfect use of contraception, and the percentage continuing use at the end of the first year. United States. (http://www.contraceptivetechnology.org/wp-content/uploads/2013/09/CTFailureTable.pdf) Accessed 2014-02-13

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D2.2 Method of Measurement

Pearl Index

The number of pregnancies resulting from the use of a birth control method per 100 woman years of exposure.

If 100 women use a product / method for one year -

- 15 pregnancies after one year = 85% effectiveness (15% pregnancy rate)
- 10 pregnancies after one year = 90% effectiveness (10% pregnancy rate)
- 5 pregnancies after one year = 95% effectiveness (5% pregnancy rate)Note -

While the pregnancy rate remains the same, the number of pregnancies continue to increase over time. That is -

5 pregnancies after one year = 95% effectiveness (5% pregnancy rate)

= 10 pregnancies after two years

= 15 pregnancies after three years

= 20 pregnancies after four years, etc.

D2.3 Definitions

Perfect Use/Method Effectiveness

- Refers to the effectiveness of a method or product when it is used consistently and exactly as directed. In the case of manufactured products (such as condoms), this includes the correct storage of the product.

Actual/Typical Use/Use Effectiveness

- Refers to the effectiveness of a method or product as it is typically or actually used.Variations in effectiveness result from a number of factors, including
  - product quality
  - drug interactions
  - failure to use consistently as directed
  - population group differences (age, marital status,etc.)

D3. Hospital wait times in Ottawa region (2013/2014)

Nov/Dec 2013 Jan 2014	Surgery/Imaging Wait Times for 9 out of 10 Patients (Up to- days)						Up to- Days
Hospital Site	**Breast Cancer***	**Prostate Cancer***	**Cardiac (Angioplasty)***	**Cardiac (Bypass)***	**CT Scan***	**MRI Scan***	**Abortion****
Provincial	36	87	18	48	42	69	
Ottawa Average	29	76	23	87	68	52	42
Children's Hospital of Eastern Ontario					91	44	
University of Ottawa Heart Institute			23	87	23		
Hopital Montfort	28				42	48	
Ottawa Hospital	30	90			78	60	
Queensway Carleton Hospital	29	62			105	56	

Sources:

**Ontario Wait Times: Wait Times for Surgery, MRIs and CTs*
Ontario Ministry of Health and Long Term Care.
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University of Ottawa (http://www.med.uottawa.ca/sim/data/Abortion_e.htm) Accessed 2018-02-21

January, 2014	Average Time Spent in Emergency Room	
Hospital Site	**Complex Conditions (Hours)**	**Minor/Uncomplicated Conditions (Hours)**
Provincial	5.8	2.2
Ottawa Average	6.38	2.92
Children's Hospital of Eastern Ontario	3.6	2.5
Hopital Montfort	7.8	2.8
Ottawa Hospital- Civic Campus	7.8	3
Ottawa Hospital- General Campus	7	2.8
Queensway Carleton Hospital	5.7	3.5

January, 2014	**Average Time Spent in Emergency Room**
Source: *Ontario Wait Times: Emergency Room Section*. Ontario Ministry of Health and Long Term Care. (http://edrs.waittimes.net/en/PublicMain.aspx) Accessed 2014-03-10	

APPENDIX "E"
HUMAN FERTILITY CYCLES

Introduction
What is provided here is not exhaustive. It is intended only to provide the reader with sufficient information to understand the factors and issues likely to be involved when health care workers decline to provide contraception services for reasons of conscience.

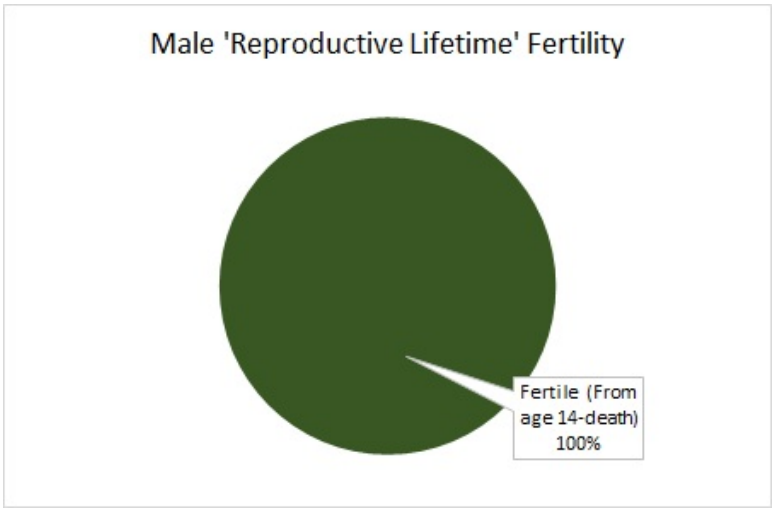
E1. Male fertility

Sperm production
Sperm production begins during puberty, generally between the ages of 10 and 15. For present purposes an approximate age of 14 is a satisfactory estimate.[1] From that point until death, sperm production is continuous.

Sperm lifespan
Sperm that is not ejaculated is reabsorbed by the body.[2] Outside the body, the lifespan of sperm depends upon the environment. In a hostile environment, sperm will die rapidly, though it may live a few hours in seminal fluid.[3] In a supportive environment, sperm can live five to seven days, though five days seems to be the commonly accepted upper limit.[4]

Male fertility during reproductive lifespan
Since sperm production is continuous from puberty until death, fertility during a man's reproductive lifespan can be represented by a pie chart illustrating fertility for 100% of that period (Chart E1.1). Male fertility can also be represented by a pie chart illustrating fertility as a percentage of the average male lifespan (Chart E1.2).

Chart E1.2



E2. Female fertility

Ovulation

A woman actually begins the production of oocytes during her development as a foetus. By puberty she has about 400,000 primary oocytes in her ovaries. The popular term for an oocyte (primary or secondary) is "egg," so that term is used here.[5] Ovulation - release of the egg from the ovary- occurs during each menstrual cycle. The age at which the first and last menstrual cycles occurs is quite variable. For present purposes we assume they begin at about age 12, and end at about age 50.

Egg lifespan

After ovulation an egg must be fertilized within 12 to 24 hours, or fertilization cannot take place and it will die. Thus, for reproductive purposes, the lifespan of an egg can be said to be 12 to 24 hours.[6]

Female fertility during reproductive lifespan

From the beginning of sperm production at puberty until death, a man has the capacity to cause a pregnancy 24 hours a day, 365 days a year. In contrast, a woman can become pregnant only for a 12 to 24 hour period following ovulation during each menstrual cycle. The enormous difference between the male and female fertility pattern becomes more readily apparent when the female pattern is illustrated by a pie chart.

Calculations to produce the chart begin by calculating an approximate reproductive lifespan, assuming that ovulation begins at about age 12, and ends at about age 50.

50-12 = 38 years

Assume 13 cycles per year.

38 X 13 = 494 cycles in a lifetime.

IN EACH CYCLE

Assume egg present one day

494 cycles X 1 = 494 days

Expressed as years

494 days / 365 days = about 1.4 years.

Expressed as a percentage of average reproductive lifespan (38 years)

= about 4% (Chart E2.1)

Expressed as a percentage of women's average lifespan (83 years)

= about 2% (Chart E2.2)

Chart E2.1

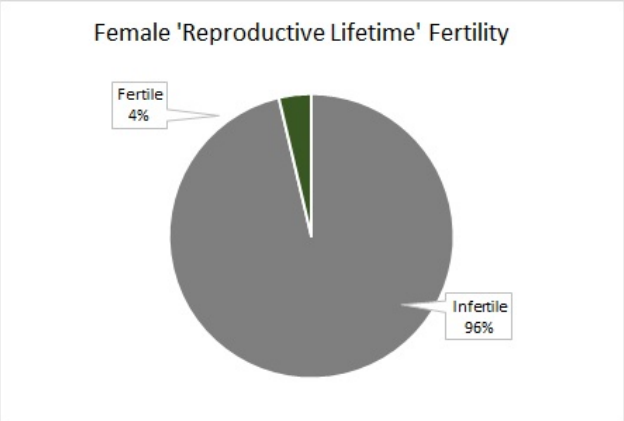
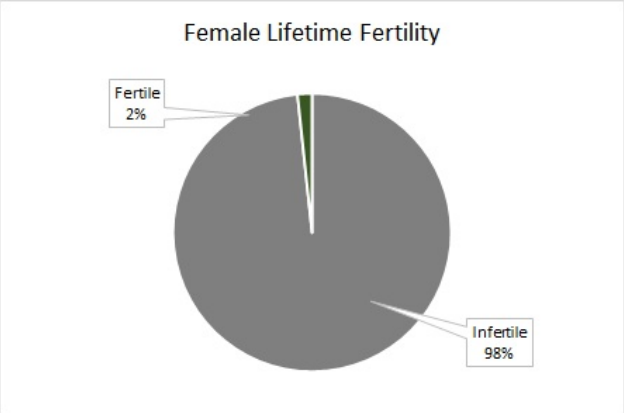


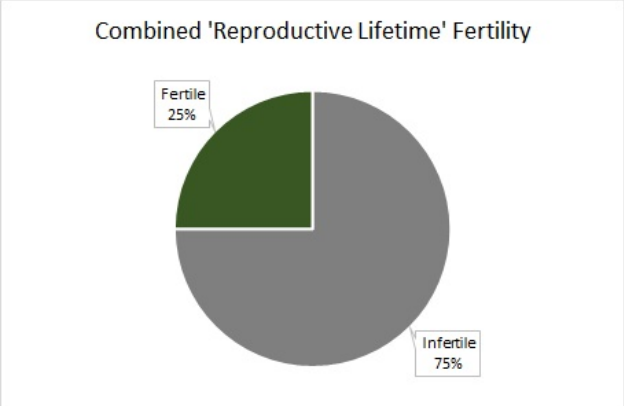
Chart E2.2



E3. Combined fertility

Effect of cervical mucus

Chart E3.1



While fertilization can occur during only a 12-24 hour time-span during each menstrual cycle, or about 4% of a woman's reproductive lifespan, this does not mean that she can become pregnant only if sexual intercourse occurs while the egg is available for fertilization.

The reason for this is that the lifespan of sperm in the female reproductive tract increases dramatically in the presence of a specific kind of cervical mucus produced in the days leading up to ovulation. This mucus will sustain viable sperm for three to five or even seven days.[4] It is, in fact, essential if fertilization is to occur. In the presence of this sperm-supportive mucus, sexual intercourse on a Wednesday (before ovulation) can result in a pregnancy after ovulation on Saturday.

We can illustrate the combined fertility pattern using a pie chart. We begin the calculations as we did above, assuming a 38 year reproductive lifespan with 13 reproductive cycles per year, yielding 494 cycles in a lifetime.

IN EACH CYCLE

Assume seven days combined fertility

494 cycles X 7= 3,458 days

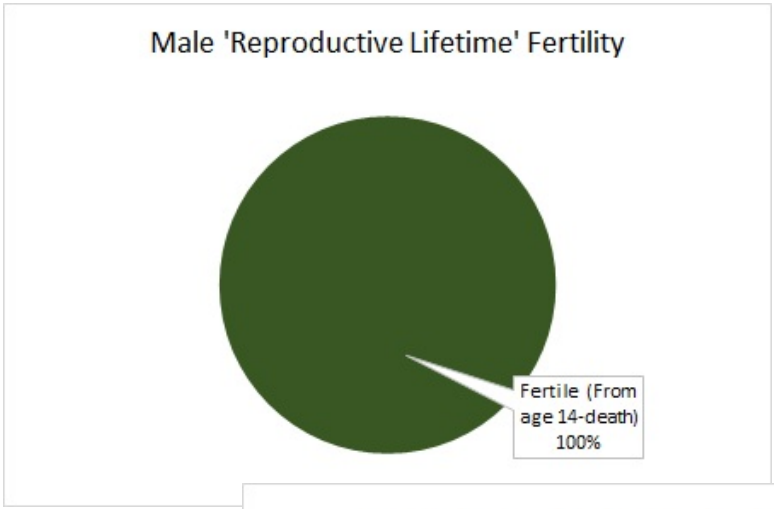
Expressed as years

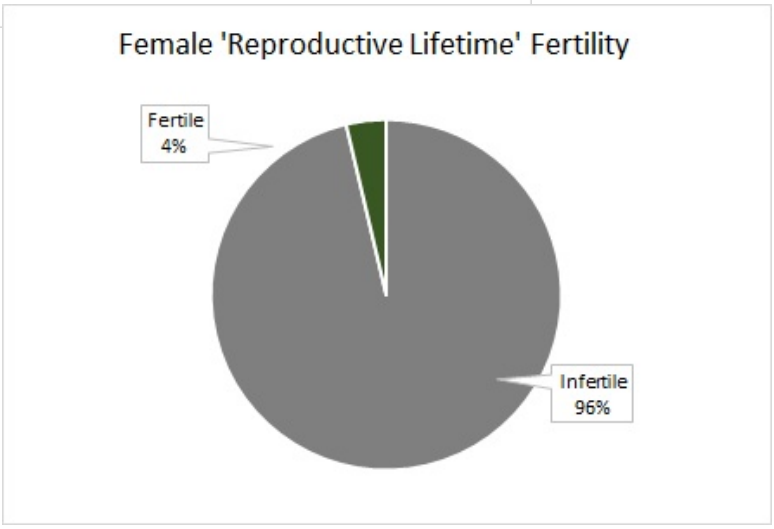
3,458 days / 365 days = about 9.5 years

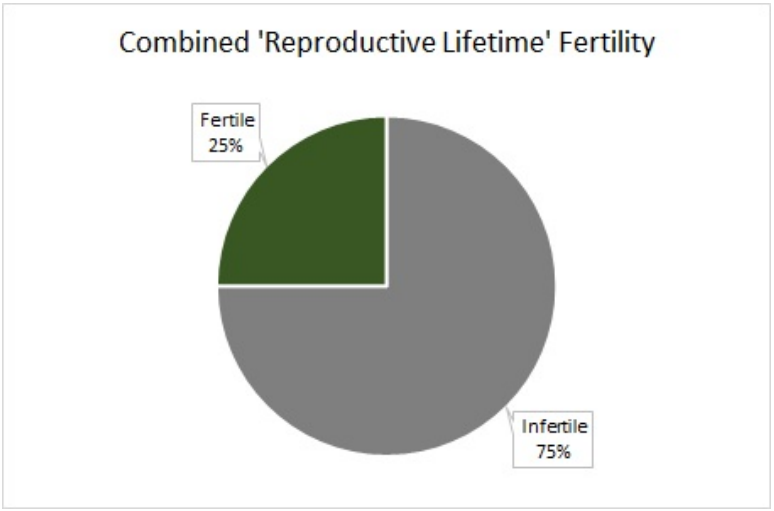
Expressed as percentage

= about 25% (Chart E3.1)

4. Comparing Male, Female and Combined Fertility Patterns







Notes

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2. WEBMD, Birth Control Health Center: *Vasectomy.* (http://www.webmd.com/sex/birth-control/vasectomy-14387) Accessed 2014-02-13

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APPENDIX "F"
THE DIFFICULT COMPROMISE
Canadian Medical Association, Abortion and Freedom of Conscience

CMA and abortion law reform

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

1970 revision of the *Code of Ethics*

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

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

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

Increasing abortion rates and increasing controversy

As in other countries, legalization of abortion was followed by a dramatic yearly increase in abortion rates which continued, in Canada, for a decade.[4] (Appendix "D1": Figure D1.2.1) CMA delegates approved abortion for "non-medical social grounds" in 1972, and by 1974 it had become clear that most abortions were being performed for "non-medical - social, psycho-social or socioeconomic - reasons."[5]

The broadened grounds for abortion and continuing increases in the abortion rate increased the likelihood of conscientious objection to the procedure. It also brought raging controversy. In 1975 the CMA Director of Communications disclosed that the Association was being inundated with letters about abortion from physicians and the public,[6] one of which expressed realistic pessimism about the situation:

> [T]he CMA is composed of physicians who hold strongly opposing opinions on the morality of therapeutic abortion. Consequently, it will be impossible to find a compromise that will satisfy all members of the association.[7]

Contrary to the smug assertion made by the chairman of the ethics committee five years earlier, it had become obvious that abortion was not "like any other surgical procedure."[8]

Delegates at the 1976 Alberta Medical Association annual general meeting saw a need to reaffirm its policy that "no pressure be applied against physicians or hospitals that do not conduct abortions,"[9] which suggests that such pressures were being felt. Certainly, there is evidence in the professional

literature of the period from the United States and the United Kingdom that collisions were occurring between those demanding the provision of abortion and those refusing to provide them.[10]

1977 revision of the *Code of Ethics*

In June, 1977, the CMA General Council, the governing body of the Association, revised Section 15 of the *Code of Ethics*, which, seven years earlier, had introduced the requirement that physicians notify patients of "personal" moral beliefs that might prevent them from recommending a procedure.

The Council's discussion seems to have been long and emotional.[11] The revised version stated:

> 15. An ethical physician, when his personal ethic prevents him from recommending some form of therapy will so acquaint his patient and will advise the patient of other sources of assistance.[12]

It is not clear whether or not the revision was presented to and approved by the annual general meeting following the General Council sessions, since the *Canadian Medical Association Journal* report of the AGM the following month described it as "uncontroversial meeting by the standards of some CMA annual gatherings," with only "mild discussion" of contentious topics.[13]

In any case, it soon became obvious that the revision had made things worse. In January, 1978, blaming "incorrect mass media news stories" for "spreading confusion," the CMA's hapless Director of Communications had to issue a clarification.

> The *Code of Ethics* does not require a physician whose personal morality prohibits him from counselling, recommending or arranging an abortion to refer a patient seeking that service to a physician who will definitely, without question, provide the service desired. Indeed, such action would be contrary to the intent of the Ethics Committee that proposed the change. . .
>
> Prior to the June 1977 meeting of General Council, a physician with a conflict of interest (professional vs personal interest position) because of his personal morality, was required to inform the patient, and nothing more. The Ethics Committee recognized that,on occasion, this could result in a patient being (de facto) abandoned - a result that was not in keeping with the tenets of the profession. The intent of the change was to place responsibility on the physician, not only to inform the patient of the conflict of interest created by his moral position, but also to help the patient find other sources of assistance.
>
> The physician might refer the patient to a colleague without such a conflict of interest, to a social agency, to a clergyman for religious counselling, to all three or to other sources of assistance. The revised section of the *Code of Ethics* does not suggest or state that he must refer the patient to a colleague who is in favour of abortion on demand. Indeed, CMA policy clearly opposes such an approach. The Association has encouraged physicians to bring unbiased professional judgement to bear on each individual case. He should avoid the simplistic role of dispenser of a service desired or thought to be desired, by the patient.[14]

The attempt at clarification did not help. The revised policy continued to be highly divisive, generating "confusion and dismay" within the Association.[15] The focus of much of the concern was

the apparent intention to force objecting physicians to become morally complicit in abortion by facilitating the procedure:

> If we are required by the code of ethics to direct our patients to other sources for obtaining an abortion, I believe the physician is, in fact, condoning the abortion and is therefore in contravention of his own personal morality. This means that a physician with a conscience is asked to select for the patient a person he possibly regards as a murderer, and this is a great, if not greater, offence to his conscience than if he did the deed himself. With the current publicity given to abortion facilities I do not believe it is necessary to torture our colleagues in this way.[16]

> . . . No patient has the right to anything other than what a physician can in his conscience do. To ask for more is to ask for his cooperation in performing an act that he deems an act of killing an innocent human being. . .I find it intolerable that the CMA is telling me I may not follow my conscience in this most serious matter.[17]

The accusation of "abandonment" was strenuously rejected as at least an exaggeration, and as an injustice,[18] and the illusion of moral neutrality ridiculed:

> . . .we are told to bring "unbiased professional judgement to bear on each individual case." How can there be an unbiased position in this situation? The only stance that could approach an unbiased position is to have no moral conviction and assume "the simplistic role of dispenser of a service", a position we are told to avoid. . . . [19]

These arguments were supported by the Newfoundland Medical Association, which passed a resolution to that effect "because many physicians might have moral and religious objections to passing their patients on as well as to recommending abortions themselves." The Ontario Medical Association also expressed reservations about the provision.[20]

1978: revision rejected, wording restored

The problem was brought to the meeting of the General Council in June, 1978. After a debate that saw objecting physicians compared to "bigoted moralists," by a vote of 81 to 68 the Council restored the original wording of the provision under section 16 of the *Code of Ethics*:[21]

> 16. An ethical physician, when his personal morality prevents him from recommending some form of therapy which might benefit his patient will so acquaint the patient;[22]

Many years later, a physician who was among those present agitating for the amendment told the Project Administrator that he and his colleagues were adamant that no physician who objected to abortion would be forced to refer for the procedure under any circumstances and were supported by legal counsel,[23] so the amendment by the General Council probably avoided a major confrontation on the floor of the Annual General Meeting.

In 1988, after the Supreme Court of Canada struck down all legal restrictions on abortion, the CMA revisited its policies on the procedure. It maintained its policy on referral; objecting physicians were obliged to disclose their views to patients so that they might consult other physicians, but there was no requirement that they facilitate the procedure by referral.[24]

The wording of the *Code* remained unchanged until 1990, when a reference to "religious conscience was added and the section re-numbered.[25] A 1996 revision dropped reference to religion but maintained the policy.[26] The 2004 edition of the *Code* (now in force) introduced "values language" and again re-numbered the provision, but the policy remained intact.[27]

"No ethical consensus" to support mandatory referral

In 2000, the Project Administrator wrote to the Canadian Medical Association concerning its policy on referral for abortion. In a subsequent telephone conversation, Dr. John R. Williams, then CMA Director of Ethics, confirmed that the Association did not require objecting physicians to refer for abortion. He explained that the CMA had once had a policy that required referral, but had dropped it because there was "no ethical consensus to support it." This was clearly a brief reference to the short-lived 1977 revision of the *Code of Ethics* and ensuing controversy. Two years later, speaking of physicians who decline to provide or to refer for contraceptives for religious reasons, he said, "[They're] under no obligation to do something that they feel is wrong."[28]

Policy reaffirmed

In a guest 2006 editorial in the *Canadian Medical Association Journal,*[29] Professors Sanda Rodgers of the University of Ottawa and Jocelyn Downie of Dalhousie University complained that "[s]ome physicians refuse to provide abortion services and refuse to provide women with information or referrals needed to find help elsewhere."

The authors almost (but not quite) asserted that physicians opposed to abortion would "withhold a diagnosis," "delay access," "misdirect women," and "provide punitive treatment." They inserted, in the midst of this list, the imaginary offence of "failing to provide appropriate referrals:" imaginary, because, as noted above, the Canadian Medical Association did not require referral for abortion, and none of the cases that had been proposed by some of the authors' like-minded colleagues supported such a claim.[30] Nonetheless, they insisted that refusal to refer for abortion constituted malpractice and could lead to "lawsuits and disciplinary proceedings."

This passage accomplished three remarkable things, all in one breath: it subtly impugned the integrity of objecting physicians; it associated conscientious objection with "punitive treatment" and other unethical practices; and it enveloped conscientious objection to abortion in an atmosphere of menace. It was a masterful symphony of accusatory innuendo, contrived connections, and strategic omissions. An unprepared reader might have overlooked the lyrical niceties, but the melody - "thou shalt refer or else" - was unmistakable.

The editorial triggered a flood of letters from protesting physicians and other concerned correspondents, but the authors did not retreat from their position, insisting that a "duty to refer" could be derived from the CMA *Code of Ethics* and *Policy on Induced Abortion* - a tendentious argument at best, dependent upon their peculiar interpretation of the documents.[31] Dr. Jeff Blackmer, CMA Director of Ethics, reaffirmed Association policy that referral was not required,[32] and the CMAJ declared the subject closed.

The negative response to the editorial from the medical profession convinced Professor Downie that policy reform by the CMA was unlikely, so she turned her attention to provincial regulatory

authorities to persuade them to use the law to force the medical profession to conform to her expectations.[33]

In a 2008 interview, Dr. Bonnie Cham, Chair of the CMA Ethics Committee, noted that the CMA had considered freedom of conscience in health care, "including the impact of offering and not offering abortion services." She reaffirmed the organization's support for "the identifiable minority" of physicians who do not agree with abortion, and observed that there is still "a minority who would not refer" for abortion.[34]

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

> Section 16 is the latest version of the CMA's statement on personal morality. The difficulties which arose with the previous statement are attributable to the failure to recognize that a physician's moral beliefs are paramount. A code of ethics can never require someone to carry out what he believes to be an immoral act.[35]

Notes

1. Canadian Medical Association *Code of Ethics* (1965) Transcribed from the original by A. Keith W. Brownell MD, FRCPC and Elizabeth "Libby" Brownell RN, BA (April 2001) (http://www.cma.ca/multimedia/CMA/Content_Images/Inside_cma/Ethics/Code-of-Ethics/1965.pdf) Accessed 2014-02-22

2. *The Physician and the Liberal Society: Understanding in Winnipeg*. Association News, CMAJ July 18, 1970, Vol. 103, p. 195 (http://pubmedcentralcanada.ca/picrender.cgi?artid=525625&blobtype=pdf) Accessed 2014-02-22

3. Canadian Medical Association *Code of Ethics* (1970) Transcribed from the original by A. Keith W. Brownell MD, FRCPC and Elizabeth "Libby" Brownell RN, BA (April 2001) (http://www.cma.ca/multimedia/CMA/Content_Images/Inside_cma/Ethics/Code-of-Ethics/1970.pdf) Accessed 2014-02-22

4. The number of abortions increased from 11,152 in 1970 to almost 39,000 in 1971, an increase from a rate of 3.0 to 8.3 per 100 live births.
[*Therapeutic abortion: government figures show big increase in '71*. CMAJ May 20, 1972, Vol. 106, 1131 (http://pubmedcentralcanada.ca/picrender.cgi?artid=520297&blobtype=pdf)]

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

CMA President Bette Stephenson stated that the CMA was concerned about the abortion rate and "most disturbed . . . that even more abortions are being performed . . .than are indicated in the alarming figures released by Statistics Canada." [Stephenson B. *Abortion: an open letter.* CMAJ, 22 February, 1975, Vol. 112, 492

(http://pubmedcentralcanada.ca/pmcc/articles/PMC1956171/)]

In 1976 there were about 54,500 abortions (14.9/100 live births). [E.M.R., *1976 advance report on abortion compares statistics with 1975.* CMAJ, January 7, 1978 Vol. 118, 76 (http://pubmedcentralcanada.ca/pmcc/articles/PMC1880452/)]
All accessed 2014-02-22.

5. Geekie D.A. *Abortion: a review of CMA policy and positions*. CMAJ September 7, 1974, Vol. 111, 474-477(http://pubmedcentralcanada.ca/pmcc/articles/PMC1947796/) Accessed 2014-02-22

6. Geekie D.A. *Abortion: a review of CMA policy and positions*. CMAJ September 7, 1974, Vol. 111, 474-477(http://pubmedcentralcanada.ca/pmcc/articles/PMC1947796/) Accessed 2014-02-22

7. Gibbard B. Letter to the editor. CMAJ, January 7, 1975, Vol. 112, 25-27 (http://pubmedcentralcanada.ca/pmcc/articles/PMC1956037/) Accessed 2014-02-22

8. A letter to the CMAJ in 1977 repudiated the idea. "This view ought to be demolished. It is clear from nearly any angle that this problem is not simple; it is a complex social, religious and moral issue. It deeply affects our legal system and the civil rights of our citizens. Krass M.E. *Letter to the editor*. CMAJ, August 6, 1977, Vol. 117, 220-221 (http://pubmedcentralcanada.ca/pmcc/articles/PMC1879659/?page=1) Accessed 2014-02-22

9. Geekie D.A., *Alberta medical association annual meeting quiet - by western standards*. CMAJ November 6, 1976 Vol. 115, 908-910 (http://pubmedcentralcanada.ca/pmcc/articles/PMC1879110/) Accessed 2014-02-22

10. Protection of Conscience Project, Bibiliography: *Periodicals, 1970-1974* (http://www.consciencelaws.org/bibliography/periodicals-1970-74.aspx)

11. Describing the 1978 Council meeting that saw provision revert to its former wording, the CMAJ stated: "The major part of the debate concerned the wording of the paragraph of the *Code of Ethics* that deals with personal morality.unlike last year, the discussion was brief and free of emotion." *Ethics problem reappears*. CMAJ, July 8, 1978, Vol. 119, 61-62 (http://pubmedcentralcanada.ca/pmcc/articles/PMC1818280/) Accessed 2014-02-22

12. Geekie D.A. *Abortion referral and MD emigration: areas of concern and study for CMA*. CMAJ, January 21, 1978, Vol. 118, 175, 206 (http://pubmedcentralcanada.ca/pmcc/articles/PMC1880354/) Accessed 2014-02-22

13. *Quebec City is a lively place, CMA annual meeting delegates discover.* CMAJ July 9, 1977, Vol. 117, 63. (http://pubmedcentralcanada.ca/pmcc/articles/PMC1879626/) Accessed 2014-02-22

14. Geekie D.A. *Abortion referral and MD emigration: areas of concern and study for CMA*. CMAJ, January 21, 1978, Vol. 118, 175, 206 (http://pubmedcentralcanada.ca/pmcc/articles/PMC1880354/) Accessed 2014-02-22

15. Forster J.M. *Letter to the editor.* CMAJ, April 22, 1978, Vol. 118, 888 (http://pubmedcentralcanada.ca/picrender.cgi?artid=401123&blobtype=pdf) Accessed 2014-02-22

16. Forster J.M. *Letter to the editor.* CMAJ, April 22, 1978, Vol. 118, 888 (http://pubmedcentralcanada.ca/picrender.cgi?artid=401123&blobtype=pdf) Accessed 2014-02-22

17. Shea J.B. Letter to the editor. CMAJ, April 22, 1978, Vol. 118, 890 (http://pubmedcentralcanada.ca/picrender.cgi?artid=401123&blobtype=pdf) Accessed 2014-02-22)

18. Shea J.B. Letter to the editor. CMAJ, April 22, 1978, Vol. 118, 890 (http://pubmedcentralcanada.ca/picrender.cgi?artid=401123&blobtype=pdf); Firth S.T. Letter to the editor. CMAJ, April 22, 1978, Vol. 118, 895 (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1818224/) Accessed 2014-02-22

19. Firth S.T. Letter to the editor. CMAJ, April 22, 1978, Vol. 118, 895 (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1818224/) Accessed 2014-02-22

20. *Ethics problem reappears.* CMAJ, July 8, 1978, Vol. 119, 61-62 (http://pubmedcentralcanada.ca/pmcc/articles/PMC1818280/) Accessed 2014-02-22

21. *Ethics problem reappears.* CMAJ, July 8, 1978, Vol. 119, 61-62 (http://pubmedcentralcanada.ca/pmcc/articles/PMC1818280/) Accessed 2014-02-22

22. Canadian Medical Association *Code of Ethics* (1978) Transcribed from the original by A. Keith W. Brownell MD, FRCPC and Elizabeth "Libby" Brownell RN, BA (April 2001) (http://www.cma.ca/multimedia/CMA/Content_Images/Inside_cma/Ethics/Code-of-Ethics/1978.pdf) Accessed 2014-02-22

23. Telephone conversation between the Administrator of the Protection of Conscience Project and Dr. W. K., 15 August, 2012.

24. The following parts of the policy statement are of particular interest with respect to freedom of conscience:

- A physician should not be compelled to participate in the termination of a pregnancy.
- No patient should be compelled to have a pregnancy terminated.
- A physician whose moral or religious beliefs prevent him or her from recommending or performing an abortion should inform the patient of this so that she may consult another

physician.

- No discrimination should be directed against doctors who do not perform or assist at induced abortions. Respect for the right of personal decision in this area must be stressed, particularly for doctors training in obstetrics and gynecology, and anesthesia.
- No discrimination should be directed against doctors who provide abortion services.
- Abortion services should meet specific standards in the areas of informed choice, medical and surgical procedures, nursing and follow-up care.

Canadian Medical Association Policy: *Induced abortion*. Approved by the CMA Board of Directors, December 15, 1988. (http://www.cma.ca/index.php/ci_id/3218/la_id/1.htm) Accessed 2014-02-21

25. "16. An ethical physician when his personal morality prevents him from recommending some form of therapy which might benefit his patient will so acquaint the patient." Canadian Medical Association *Code of Ethics* (1990) Transcribed from the original by A. Keith W. Brownell MD, FRCPC and Elizabeth "Libby" Brownell RN, BA (April 2001) (http://www.cma.ca/multimedia/CMA/Content_Images/Inside_cma/Ethics/Code-of-Ethics/1990.pdf) Accessed 2014-02-22

26. "8. Inform your patient when your personal morality would influence the recommendation or practice of any medical procedure that the patient needs or wants." Canadian Medical Association *Code of Ethics* (1996) (http://www.cma.ca/multimedia/CMA/Content_Images/Inside_cma/Ethics/Code-of-Ethics/1996.pdf) (Transcribed 10 March, 2001) Accessed 2014-02-22

27. "12. Inform your patient when your personal values would influence the recommendation or practice of any medical procedure that the patient needs or wants." Canadian Medical Association *Code of Ethics* (2004) (http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf) Accessed 2014-02-22

28. Mackay B. *Sign in office ends clash between MD's beliefs, patients' requests*. CMAJ January 7, 2003 vol. 168 no. 1 (http://www.cmaj.ca/content/168/1/78.2.full) Accessed 2014-02-16

29. Rodgers S. Downie J. *Abortion: Ensuring Access*. CMAJ July 4, 2006 vol. 175 no. 1 doi: 10.1503/cmaj.060548 (http://www.cmaj.ca/content/175/1/9.full) Accessed 2014-02-23

30. Including *Zimmer v. Ringrose* (1981), 124 Dominion Law Reports (3d) 215 (Alberta Court of Appeal); *Zimmer v. Ringrose* (1978), 89 Dominion Law Reports (3d) 657 (Alberta Supreme Court); *McInerney v. MacDonald* (1992), 93 Dominion Law Reports (4th) 415 (Supreme Court of Canada); *Malette v. Shulman* (1990), 67 DLR (4th) 321 (Ont. Court of Appeal); *Nancy B v Hotel Dieu de Quebec* (1992), 86 DLR (4th) 385 (Quebec Superior Court); *R. v. Morgentaler* (1988)1 S.C.R 95-96 (Supreme Court of Canada). See Murphy S. *Postscript for the Journal of Obstetrics and Gynaecology Canada: Morgentaler vs. Professors Cook and Dickens.* Protection

of Conscience Project, 25 November, 2005
(http://www.consciencelaws.org/law/commentary/legal030-001.aspx)

31. Rodgers S. Downie J. *Access to abortion: The authors respond*. CMAJ February 13, 2007 vol. 176 no. 4 doi: 10.1503/cmaj.1060202 (http://www.cmaj.ca/content/176/4/494.full) Accessed 2014-02-23

32. Blackmer J. *Clarification of the CMA's position on induced abortion*. CMAJ April 24, 2007 vol. 176 no. 9 doi: 10.1503/cmaj.1070035 (http://www.cmaj.ca/content/176/9/1310.1.full) Accessed 2014-02-22

33. "(We decided to proceed by way of these provincial regulatory bodies rather than the CMA, in part, because of the negative reaction of the CMA to the Rodgers/Downie editorial, which made policy reform by the CMA seem unlikely.)" McLeod C, Downie J. "Let Conscience Be Their Guide? Conscientious Refusals in Health Care." *Bioethics* ISSN 0269-9702 (print); 1467-8519 (online) doi:10.1111/bioe.12075 Volume 28 Number 1 2014 pp ii–iv

34. "10 questions with CMA's ethics champion Dr. Bonnie Cham." (Questions 6, 9) *Medical Post*, 25 September, 2008.

35. Mellor C. *The Canadian Medical Association Code of Ethics Annotated for Psychiatrists.* Canadian Psychiatric Association - Position Papers, p. 4 of 6. Approved by the Board of Directors of the Canadian Psychiatric Association in October, 1978. (http://www.capda.ca/docs/default-source/ethics-codes-and-practice-guidelines-for-assessment/canadian-psychiatric-association-the-cma-code-of-ethics-annotated-for-psychiatrists-1978.pdf?sfvrsn=2) Accessed 2014-02-22

APPENDIX "G"

NOTICES TO PATIENTS

Notices to patients may be posted in waiting or consulting rooms or made available in other ways. Written notices have some natural limitations. Some steps can be taken to make them more effective, and other alternatives or additional steps can be considered.

G1. Reading skills and language

G1.1 Some thought should be given to patients who cannot read or whose reading skills are such that they will not attempt to read a notice or may not understand it. This problem is more likely to surface unexpectedly with new patients.

G1.2 Practices are, to some extent, already addressing the needs of patients whose first language is not English. Translation of notices will benefit patients who do not read English, especially when only one or two languages other than English are predominant in a practice.

G2. Accepting new patients

G2.1 The process of accepting new patients can be modified to identify reading and language difficulties that may be of broader concern, as well as issues concerning scope of practice and freedom of conscience.

G2.2 When a patient is accepted, clerical staff should ascertain whether or not the patient is fluent in English or has difficulty reading. The latter is often a sensitive issue, and some assistance in developing an effective and respectful approach might be had from community organizations that support the development of literacy.

G2.3 An intake form that is completed by new patients might include a place for the patient to check off topics that the patient would like to discuss with a physician. The topics might include those that are of concern to the physician for reasons of conscience, as well as others that experience suggests; a blank space can be left for self-generated topics. This would allow the physician to identify and discuss sensitive issues with each new patient.

G2.4 An intake form could be provided in precisely the same format in different languages, so that the physician and clerical staff would be able to understand most of the responses by referring to the English form (or a form in their own language).

G2.5 Some patients may require assistance in completing the form. If that assistance is not provided by the physician during the initial interview or consultation, it should be provided by clerical staff. In that case, the need to preserve patient privacy must be considered in policies and design of office space and waiting room.

G3. Re-directing patients

G3.1 A pamphlet advising patients how to locate other physicians or access other health care services could be made generally available in the waiting room. Clerical staff approached by patients as a result of a posted notice could offer such a pamphlet, perhaps reducing the amount of time needed to deal with the request and minimizing intrusion on patient privacy.