Freedom of conscience: "the heart of our democratic political tradition"

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Introduction

Reporting on controversies over freedom of conscience in Canada and the United States last year, *National Post* reporter Charles Lewis asked the question, "as our society becomes increasingly rights-focused, is there less tolerance for acts of conscience?"[1]

Lewis' article was titled, "The next moral quagmire: conscience."

I don't suppose that mud wrestling was on your professional horizons when you were called to the bar. Nonetheless, on behalf of the Protection of Conscience Project, welcome to the quagmire.

I believe that your practical work in defending freedom of conscience and religion will take the form of correspondence, negotiation and litigation with professional health care bodies.[2] What I propose to do is offer material that can be employed to persuasive effect in all of these activities.

Freedom of conscience and abortion law reform

We will start with a review of some social and political history.

I'll take you back to the mid-1960's, when Canada was moving toward liberalization of its abortion law, and the word "conscience" did not inspire fears of drowning in quicksand. In fact, respect for freedom of conscience was a prominent theme in public discourse.

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."[3]

Two Private Members Bills on abortion were introduced in1967.[4] 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.[5]

The Omnibus Bill introduced in 1967 included what later became Canada's new abortion law. It did *not* include a protection of conscience clause.

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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.[6]

Nor was the Catholic Hospital Association concerned:

> We note that there is no question of [our hospitals] being obliged to change their present norms of conduct. On the contrary, proponents of a 'liberalized' abortion law admit that it should exempt those who object to being involved in procuring abortions.[7]

A protection of conscience clause was proposed when the Omnibus Bill returned to the Commons the following year.[8] 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.[9]

The protection of conscience clause was rejected, and abortion was legalized and regulated.[10] The following year, Dr. Henry Morgentaler, annoyed by continuing legal restrictions on abortion, expressed his defiance in an article titled, "A Physician and his Moral Conscience"[11]

Of course, Dr. Morgentaler was not the only one unhappy with the new law, and the continuing moral controversy about abortion has been a fact of Canadian life and medical practice ever since. Since this is so well known, I will, for the moment, use abortion as an exemplar of contentious procedures. A review of the history of the past forty years will, I submit, disclose a pattern that is highly significant with respect to freedom of conscience in health care.

Progression of conflict

First Stage: expectation vs. reality

An expectation that medical personnel will provide or facilitate abortions runs up against the fact that many are unwilling to do so. That there are not enough physicians willing to provide abortions is a frequent complaint of abortion rights activists in the United States[12] and Canada.[13]

The reluctance of many health care workers is complicated by the fact that many of those willing to provide abortion in some circumstances are unwilling to do so in others. Their response to what they consider late term abortions[14] is frequently adverse,[15] so that women wanting late term abortions may have to travel from one country to another.[16] This is true even in Quebec,[17] where Premier Jean Charest, following a unanimous motion in the National Assembly, recently declared abortion to be "an inalienable right."[18] But gestational age is only one of the factors that can give rise to conscientious objection.[19] And even after legalization, opposition to abortion does not necessarily diminish over time.[20]

This my first point: that there is a conflict between the expectation that health care workers will provide abortions, and the reality that many of them may be unwilling to do so.[21]

Second Stage: expectations rise

But expectations are not static. In the second stage, expectations tend to rise. They are fuelled by continuing pressure to legalize abortion, liberalize existing abortion laws and expand abortion services, so that they continually collide with resistance and opposition, especially in countries that have strong cultural and religious traditions against the practice.[22]

Third Stage: expectation to demand

In the third stage, rising *expectation* that health care workers will provide abortions tends to evolve into a *demand* that they do so. This is especially true where (as in Canada) the state has assumed responsibility for providing health care. This has been affirmed by Dr. Preston Zuliani, the President of the College of Physicians and Surgeons of Ontario.[23]

And here we return to the promises made in the 1960's by those advocating legalization of abortion.

No hospital will be required to provide the facilities for abortion.

. . . no doctor or nurse will be required to participate in abortion

. . . nobody would be forcing abortion procedures on anybody else

. . . no woman will be required to undergo an abortion

But five years after abortion was legalized, 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.[24]

In fact, since the early 1970's, every one of these promises made by abortion law reform advocates has been broken.[25]

Fourth Stage: from demand to right

Recall the first stage: expectations that health care workers will provide abortion encounter the reality that many are unwilling to do so.

The second: expectation rises and collides with opposition.

The third stage: rising expectation evolves into demand.

There is one more stage. Demand evolves into a claim of rights.[26]

Early rights claims were directed only at the repeal of abortion laws, so that women would be free to seek abortions and physicians free to provide them.[27] I am not now talking about "rights language" from this early period, but about current claims of rights that are meant to force health care workers and institutions to provide or at least facilitate abortions.

Activists world-wide[28] are attempting to establish "hard norms" - treaty-based international laws[29] - that recognize access to abortion as a fundamental human right.[30] They plan to develop a "culture of enforcement" that will compel governments to respect this 'right'[31] and enforce it against health care workers and institutions.[32] This is precisely what the Ontario Human Rights Commission was trying to do in 2008.

Even as they work toward this end, activists are cultivating "soft norms" in the form of statements by international, regional, and intergovernmental bodies.[33] One might include among "soft norms" editorials and columns in professional journals. As "soft norms" quietly accumulate it becomes easier to claim that they represent an emerging consensus that should be codified in binding "hard norms."[34] The recent statements by the Quebec National Assembly and Premier of Quebec will, no doubt, contribute nicely to this project.

Should they be successful they will have destroyed almost all hope of respect for freedom of conscience in health care. For if, as Jean Charest claims, abortion is an "inalienable right," then refusal to facilitate abortion would become, in law, an offence like racial discrimination, and conscientious objection would be prohibited, just as racial discrimination is now prohibited. Canadian Professor Bernard M. Dickens has gone so far as to suggest that refusing to refer for abortion is a crime against humanity analogous to torture,[35] a claim that is making the rounds elsewhere.[36] Jean Charest might not go that far, but, if he really meant what he said, he will at least take steps to force all Quebec health care workers and institutions to remove their gestational limits on abortion, now commonly about 14 weeks.[37]

This four stage progression with respect to abortion, often assisted by abortion rights activists, can also be observed outside North America. Examples ready to hand come from the United Kingdom,[38] Switzerland,[39] Australia,[40] Africa, [41] Poland,[42] Portugal,[43] Spain,[44] India,[45] Pakistan,[46] and Colombia,[47] not to exclude others.

Other controversial procedures

I have thus far confined the review to abortion, using it as a convenient example for the purpose of illustration. But if objecting health care workers can be forced to provide or facilitate abortions, they can also be forced to provide or facilitate other morally controversial procedures.

Such as?

In alphabetical order:

Adult female circumcision[48]

Amputation of healthy body parts[49]

Artificial reproduction, including production of children

- for single women[50]
- for homosexual couples[51]
- for tissue donation[52]

- and of children of dead parents[53] or with handicaps to match those of their parents[54]

Assisted suicide[55, 56]

Causing death of non-dying patients by starvation and dehydration[57]

Contraception

Contraceptive sterilization [58]

Cosmetic surgery[59]

Embryonic stem cell research

Eugenics[60]

Euthanasia[61]

Human experimentation, including the use of pvs patients[62] and sham surgery[63]

Infant male circumcision[64]

Infanticide[65]

Sex change surgery[66]

The list is, quite possibly, incomplete. The references to female circumcision and the amputation may raise some eyebrows. How could these be considered legitimate medical procedures? The most frequent reasons given are patient autonomy and harm reduction. If someone is determined to cut off a foot or a leg, better it be done by a competent surgeon than have a desperate patient attempt it himself or go to some back alley amputationist.[67] One law professor has implied that surgeons who refuse to perform adult female circumcision are abandoning the patient, and even cited an opinion that refusing to perform the surgery is discriminatory.[68] The same sorts of things are said with respect to assisted suicide.[69]

Most of these procedures are already accepted or have at least some support among establishment academics and professional authorities. Further: the progression leading to claims of rights that we have seen with respect to abortion can also be observed with respect to assisted suicide,[70] artificial reproduction,[71] contraception,[72] contraceptive sterilization,[73] sex change surgery[74] and euthanasia.[75]

Is there less tolerance?

Return to Charles Lewis' question in the light of these developments: "[A]s our society becomes increasingly rights-focused, is there less tolerance for acts of conscience?"

I have mentioned Bernard Dickens' notion that refusing to refer for abortion is a crime against humanity. Others claim that it is immoral not to clone human beings,[76] reckless to have a child without genetic screening,[77] and wicked to refuse a request for assisted suicide.[78]

The answer, it seems, is a qualified "yes." There does seem to be less tolerance for acts based on some kinds of conscientious convictions.

The fundamental question

I have given you a precis waggishly called, "Fencing for Freedom," which briefly considers claims often encountered in arguments about freedom of conscience in health care. However, fencing with opponents about the definition of "abandonment" or the nature of fiduciary duties, while necessary, does not get us very far. The fundamental issue in protection of conscience work may be phrased as a question:

> Upon what principle consistent with the best traditions of liberal democracy should individuals be forced to give up their own convictions and made to act upon the contrary moral beliefs of another person, an institution, or the state?

Opponents of freedom of conscience must be confronted with this question, and this should remain the focus of correspondence, negotiation and litigation.

In addition, it is necessary to articulate the importance of freedom of conscience and the goods that it serves, a subject that has been sorely neglected. One author who has made a recent and significant contribution on this topic is Holly Fernandez Lynch, a lawyer who, two years ago, published *Conflicts of Conscience in Health Care: An Institutional Compromise*. She focuses exclusively on physicians,[79] and an attentive reading of the book must take into account the effects of two underlying elements: some form of anti-religious prejudice, and dogmatic moral pluralism.[80] Nonetheless, readers will welcome many of the author's trenchant observations and the book has much to offer. There is an extensive review of the book on the Project website.

Today, however, I want to draw to your attention what Fernandez Lynch has to say about the goods served by freedom of conscience, and to another lesson that can be taken from her work.

Re: *Conflicts of Conscience in Health Care*

While she does not argue from a Catholic or even religious perspective, she introduces her book, *Conflicts of Conscience in Health Care: An Institutional Compromise*, with a statement from Pope John Paul II:

> . . . to refuse to take part in committing an injustice is not only a moral duty, it is also a basic human right. Were this not so, the human person would be forced to perform an action intrinsically incompatible with human dignity, and in this way human freedom itself, the authentic meaning and purpose of which are found in its orientation to the true and the good, would be radically compromised.[81]

The author believes that freedom of conscience for physicians and the provision of legal medical services are both important social goals, and that they are not incompatible.[82] Ultimately, quoting the Protection of Conscience Project,[83] she affirms that all legitimate concerns can be met by "dialogue, prudent planning, and the exercise of tolerance, imagination and political will."[84]

Overview

The author suggests the following explanation of the current controversy. She observes that physicians act as "gatekeepers" to medical services, but an objecting physician may sometimes be the only available "gatekeeper" who can open the gate to a desired service. Her solution: tell patients

about other gates and gatekeepers, redistribute them, and, if necessary, provide more gates and more gatekeepers.[85] Or, to paraphrase anti-euthanasia activists, if access is the problem, eliminate barriers to access, not objecting physicians.[86]

Fernandez Lynch identifies two key conditions for compromise: avoiding harm to patients,[87] and ensuring "access to desired services,"[88] including a guarantee of access to abortion,[89] whether for medical or social reasons.[90] She suggests that the public will support freedom of conscience for objecting physicians as long as the services to which they object can be obtained elsewhere.[91] Indeed, she describes concerns about patient access as lying "at the very heart of the conscience clause debate."[92]

The reasons for compromise

The author identifies "the driving force and strongest argument" for preserving freedom of conscience for physicians.[93] One word sums it up: ignorance. More specifically, the ignorance consequent upon moral pluralism - which she celebrates- [94] and her view - but by no means hers alone - that "no one has special access to knowledge about what is right and wrong."[95]

Fernandez Lynch admits that if we do not know what is truly right and truly wrong, we cannot accuse an objecting physician of wrongdoing. Her clarity on this point is refreshing.

> If we cannot be ***completely*** sure that ***we*** have gotten it right . . . there is a ***distinct*** possibility that the ***refusers*** are right, leaving no legitimate grounds on which to exclude them from the profession. The problem is that ***we often just do not know.*** (emphasis added)[96]

Preserving moral diversity

In this situation, the just and prudent course, she argues, is to preserve moral diversity by protecting freedom of conscience. She believes that this will ensure a continuing debate within the medical profession, inspired by the collision of conflicting ideas, thus helping us to avoid error and to identify "the most accurate version of moral truth."[97]

Preserving access to services

She acknowledges that some people would like to force objecting physicians out of the profession to ensure access to services.[98] But she challenges this approach on its own terms.

Suppose that a patient who is denied a service sues a physician or makes a formal complaint. The physician would probably continue to refuse.[99] If the patient obtains the service at all, it will be through a willing physician, and it will not be because of the complaint or lawsuit. The objecting physician might be suspended or struck from the register, or leave the specialty or the profession. In all such cases, access to medical services will suffer.[100]

If the *real* goal is to ensure access to services, says the author, punishing unwilling physicians is likely to be counterproductive. If the *real* goal is to ensure access - not to punish objecting physicians - that goal is best served by connecting patients with physicians willing to help them.[101]

The social goods of freedom of conscience in medicine

Turning to the social goods served by freedom of conscience, Fernandez Lynch suggests that "patients may prefer to be treated by physicians with similar values." Physician-patient matching based on shared values would minimize the likelihood of conflict, and might well contribute significantly to meeting patient needs.[102] This can be understood as simply another aspect of culturally competent medical practice.

In addition to what might be called the argument from ignorance, Fernandez Lynch asserts that physicians cannot be expected to "check their personal religious and moral beliefs at the door"[103] since "the segmentation of one's personality demanded by secularization may be utterly impossible."[104] Such a policy would turn physicians into technical automatons who are fully responsive to patient requests but "detached from potentially appropriate moral qualms." This, she says, would "corrode the humanity and compassion patients expect and need from their doctors."[105]

She points out that society has not been well served by physicians without moral qualms,[106] and asks the reader to imagine the consequences if only "morally insensitive" applicants were admitted to medical practice. It would, she believes, lead to a shortage of physicians. And she is concerned that such a policy could destroy the reputation of the profession. She warns that people might come to view physicians as they view lawyers.[107]

In sum, physician freedom of conscience, she says, provides important social goods. She argues that the costs of suppressing it would outweigh the benefits, and that denying it to physicians might actually diminish patient access to services.

Limitations of the book

The author warns the reader that her book is not about moral philosophy.[108] She does not try to understand the origin of conscience, does not attempt to define it, and does not consider its nature.[109] Nor does she, at any point, consider the origin, definition, or nature of freedom. She explains that she wants to leave philosophy to philosophers, and that her book has a strictly "legal trajectory."[110]

As a result, the best and most patient of readers will, reaching the end of the book, have no clear idea about what all of it means. We cannot possibly know whether or not what the author proposes will safeguard freedom of conscience if we do not know what it is.[111]

The nature of the book

It does no disservice to the author to acknowledge what she, herself, admits. In her view, the heart of the conscience clause debate is patient access to services.[112] She has written a book about how to help patients obtain services when some of the gatekeepers who control access to them are uncooperative.[113] It is not a book about freedom of conscience. She has observed how conscience operates in the medical environment, and concludes that we do not need philosophy to solve access problems. All we need is a strategy.

Granted: the strategy she proposes is very promising in its broad outlines, and I again emphasize that the book has much to offer. But it is necessary to raise the discussion to a new level, or, rather, to go deeper and see what underlies a work that purports to have a strictly legal trajectory.

A new level of discussion

The first step in this process is to recognize that philosophy cannot be left to philosophers. That is impossible. Every proposal for the just ordering of society rests upon some kind of philosophy or constellation of philosophical ideas. That is why, despite the author's disclaimer that she is leaving philosophy aside, social contract theory[114] permeates the book.[115] It is also why the author has, in the Project's view, failed to correctly identify the central issue.

Professionalism is not the centre

Fernandez Lynch asserts that everything relevant to the discussion of freedom of conscience in health care turns on a correct understanding of medical professionalism.[116] However, as she develops her proposal, we find that she is unable to find a standard that can be used to decide what services ought to be guaranteed by a regulatory authority.[117] She struggles - without success - to find broadly acceptable definitions for concepts like "harm,"[118] "needs and preferences"[119] - even "emergency."[120] She remarks that it is impossible even to agree on what services are "controversial."[121]

Defining these terms is absolutely essential for working out the practical details of any compromise, but theories of professionalism have nothing to offer in this respect. It turns out that everything does not turn on a correct view of professionalism. Everything - including one's view of professionalism - turns on an adequate understanding of the nature of the human person.

This is not a scientific issue,[122] nor is it a legal issue, the concept of legal personhood notwithstanding. This is a philosophical issue. Reasoning from different beliefs about what man is and what is good for him leads to different definitions of "need,"different understandings of "harm,"different concepts of right and wrong, and, ultimately, to different ethical conclusions. We cannot agree upon what is good or bad for the patient - or the physician - without first agreeing upon the nature of the human person. That is what determines not only how we define medical necessity or emergency, but how we approach every moral or ethical problem in medicine - including freedom of conscience.[123]

Everything proposed by Fernandez Lynch is based on the understanding of the human person that she brings with her to the table to discuss the terms of her compromise. And this is very evident in *Conflicts of Conscience in Health Care*, beginning with the statement from Pope John Paul II in the introduction. The author seems to have agreed with this statement without comprehending its full significance, especially for lawyers concerned about human rights.[124] I now propose to explain that significance in a series of four hypotheses.

First hypothesis: the person is at the centre

First: fundamental disagreement about the nature of the human person is what lies at the centre of disputes about freedom of conscience. The nature of the human person - not professionalism - must be the focus of our attention.

And when we shift our focus to the notion of the human person that informs her work, we discover that Fernandez Lynch identifies autonomy as the essential characteristic of the human person.[125]

One increases one's autonomy by being "empowered" to get what one wants or to do what one

wants. For this, freedom of choice is essential;[126] one must eliminate factors that might restrict freedom of choice, like restrictive laws or beliefs.[127] Even religious beliefs are understood and valued primarily as expressions of autonomy.[128]

The pursuit of autonomy is potentially limitless, but resources and opportunities are finite. Thus, human interactions come to be seen primarily in terms of power.[129] People can, of course, consent to co-operate with one another to satisfy their respective interests.[130]

But the key word is consent. Consent justifies any action that might otherwise be held to violate personal autonomy,[131] like euthanasia.[132] Autonomy is violated when consent is improperly obtained,[133] but also whenever someone's interests are adversely affected without his consent.[134]

Finally, when pursuit of personal autonomy is the dominant ethic, it is socially critical to maintain a balance of power. Hence, maintaining equality - understood as an equitable balance of power - becomes the dominant concern.[135]

Second hypothesis: the ideology of the autonomous person

It is reasonable to believe that the emphasis placed on power and autonomy in contemporary thought is the product of an ideology, as defined by Hannah Arendt: a system of thought in which everything that needs to be explained can be explained "in the consistent process of logical deduction" from a single controlling idea.[136] And with this we come to the second hypothesis. The ideology of the autonomous person (to give it a name), while it fits well with utilitarianism and social contract theory, does not comport with the concept of the human person that informs the statement by John Paul II that introduces the book. It does not have room for all that is contained in concepts of the human person that come to us from the patrimony of great religious and philosophical traditions.

Historical notes

The third hypothesis is best understood in an historical context.

Our modern notion of freedom of religion could not take root in Europe prior to the Reformation. From that point it became possible to think of freedom of religion in some form, and increasingly necessary to do so as an important element in maintaining civil order. Freedom of conscience was the necessary (though not sufficient) condition for the exercise of freedom of religion, since the decision to convert from one religion to another depended on the judgement of conscience.

For the next four hundred years, freedom of religion made its way forward in the realms of politics and law, but freedom of conscience lingered in the provinces of philosophy and theology. Thus, when "freedom of conscience"appeared in the statutes and constitutions of this period, it was - almost without exception - always in its Reformation context, directly linked to freedom of religion.

The proclamation of the *Universal Declaration of Human Rights* in 1948 marked the first time that freedom of conscience and freedom of religion were clearly distinguished in law.[137] Since that time, it has appeared in numerous national constitutions that used the *Declaration* as a template.

But the *Declaration* had a limitation that has been inherited by subsequent constitutions and charters. French philosopher Jacques Maritain, one of the driving forces behind the *Declaration*, identified it at the time. He explained that the *Universal Declaration of Human Rights* was, in a sense, only an

action plan. It was an agreement only about how people and states ought to behave. There was no agreement about why they should behave that way: no agreement about the nature of the human person, and - important in the present context - no agreement about the origin, definition or nature of freedom of conscience.[138]

Maritain was, nonetheless, optimistic, convinced that much could be accomplished.[139] But his optimism was also based on a key premise: that no "genuine democracy" would demand conformity to "any philosophic or any religious creed." Such demands, made by totalitarian states, had produced, he said, only an "inhuman counterfeit of civilization."[140]

Third hypothesis: rights charters transformed.

What Maritain appears not to have foreseen is a possibility that is stated here as a third hypothesis: that charters and bills of rights can be used to impose precisely the kind of ideological conformity Maritain feared. This can be done by changing the understanding of the human person upon which the definition and interpretation of human rights depends. Not one word of the law need be changed to accomplish this; it will continue to appear to protect fundamental rights and freedoms. But this will be true *in fact* only if the concept of the human person that informs the official interpretation of the law is at least adequate.

Fourth hypothesis: charters of destruction

With the fourth hypothesis comes controversy. If the underlying concept is not adequate - and especially if it is erroneous - human rights law will not sustain or protect authentic human rights and freedoms. Quite the reverse. It will become an instrument of their destruction, working through the key disciplines of education, law and medicine.

In this case, the effect on the body politic will be analogous to the effects of HIV on the immune system. Institutions meant to preserve and protect human society will not just fail. Like infected immune cells, they will become the very means by which that failure spreads. Ultimately, they will produce the kind of oppressive counterfeit of democracy that Maritain feared. Perhaps John Paul II had something like this in mind when he observed that a democracy without values can easily become an "open or thinly veiled totalitarianism."[141] Perhaps a post-modern culture naturally produces a post-democratic regime.

Canadians tend to be of the opinion that our country is a model of democracy the rest of the world would do well to imitate. We like to think that we're experts in the field, that the rest of the world ought to look to us to see democracy, if not in its most perfect and final form, at least in its maturity. But the oldest modern democracy is only a little over 200 years old; in historical terms, modern democracy is still in diapers. Is it not possible that, as a nation, we are toddlers who have not yet developed the kind of moral balance demanded by the nature of democratic government? We have an appetite for freedom, to be sure, but what kind of freedom? For what purpose? As CS Lewis observed, the kind of things that citizens in a democracy naturally like are not necessarily the things that will best preserve democracy.[142]

"Managing" rights

In the 60 years since the proclamation of the *Universal Declaration of Human Rights*, the phrase

"freedom of conscience" has been cut and pasted into countless charters and bills of rights, but there is yet no common and coherent agreement about what freedom of conscience is, and how it relates to the good of the human person and human society. This cannot continue indefinitely. We are approaching a time when a handful of academics, medical bureaucrats and judges will be asked to impose their notions of freedom of conscience upon their fellow citizens, and manage the exercise of that freedom in the presence of conflicting claims. "[W]hen courts engage in this "managing" exercise," says Mr. Justice David M. Brown of the Ontario Superior Court of Justice, "they do not operate as philosophically-neutral actors."

> Instead, the case law reveals that they perform the "managing" exercise through philosophical lenses that are not blank, but reflect philosophical choices which inform their balancing task.

Mr. Justice Brown warns that "philosophical perspectives - stated or unstated" influence the outcome of cases dealing with freedom of conscience or religion.[143] This is also true of decision-making by adjudicators and functionaries of professional medical bodies. Despite claims to the contrary, their decisions - like Fernandez Lynch's book - do not have "a strictly legal trajectory."

Thus, when you correspond with them, negotiate with them, or meet them in litigation, it will be critical to remind them that the philosophical perspectives they bring to bear on the issues must be informed by an adequate understanding of the nature of the human person as it relates to freedom of conscience.

What follows is an account of the human person that is consistent with the best of our political, legal and religious traditions.

The human person

Integrity

The health care worker has only *one* identity, served by a single conscience that governs his conduct in private and professional life.[144] This moral unity of the human person is identified as integrity, a virtue highly prized by Martin Luther King Jr., who described it at as essential for "a complete life."[145]

The integrity or wholeness of the human person was also a key element in the thought of Jacques Maritain,[146] who held that "in the depth of his being he is more a whole than a part and more independent than servile."[147]

This concept is not foreign to the practice of modern medicine. Canadian ethicist Margaret Somerville, for example, asserts that one cannot overemphasize the importance of the notion of 'patient-as-person' and acknowledges a "totality of the person" that goes beyond the purely physical.[148]

Dignity and inviolability

Maritain would agree. "Man," he wrote, "exists not merely physically; there is in him a richer and nobler existence"[149]

Applying this principle, Maritain asserted that, even as a member of society or the state, a man "has secrets that escape the group and a vocation which the group does not encompass."[150] His whole person is engaged in society through his social and political activities and his work, but "not by reason of his entire self and all that is in him."[151]

"For in the person," he said, "there are some things - and they are the most important and sacred ones - which transcend political society and draw man in his entirety above political society."[152]

A part exists only to comprise or sustain a whole; it is a means to that end. But even as part of society, Maritain insisted, "the human person is something more than a part;"[153] he remains a whole, and must be treated as a whole.[154] The human person is an end in himself, not a means to an end.[155] Thus, according to Maritain, the nature of the human person is such that it "would have no man exploited by another man, as a tool to serve the latter's own particular good."[156]

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

> To the right of the individual to be treated as an end, which entails his right to the full development and expression of his personality, all other rights and claims must, the democrat holds, be subordinated. I do not know how this principle is to be defended any more than I can frame a defence for the principles of democracy and liberty.[157]

Like Maritain, Professor Joad insisted that it is an essential tenet of democratic government that the state is made for man, but man is not made for the state.[158] To reduce human persons to the status of tools or things to be used for ends chosen by others is reprehensible: "very wicked," wrote C.S. Lewis.[159] Likewise, Martin Luther King Jr. condemned segregation as "morally wrong and awful" precisely because it relegated persons "to the status of things."[160]

Polish philosopher Karol Wojtyla (later Pope John Paul II):

> . . . we must never treat a person as a means to an end. This principle has a universal validity. Nobody can use a person as a means towards an end, no human being, nor yet God the Creator.[161]

Maritain, Joad, Lewis, King and Wojtyla reaffirmed in the twentieth century what Immanuel Kant had written in the eighteenth: "Act so that you treat humanity, whether in your own person or in that of another, always as an end and never as a means only."[162]

Human dignity and freedom of conscience

This was the approach taken by Madame Justice Bertha Wilson of the Supreme Court of Canada when she addressed the issue of freedom of conscience in the landmark 1988 case *R v. Morgentaler*. Madame Justice Wilson argued that "an emphasis on individual conscience and individual judgment . . . lies at the heart of our democratic political tradition."[163] Wilson held that it was indisputable that the decision to have an abortion "is essentially a moral decision, a matter of conscience."

In a free and democratic society, she wrote, "the state will respect choices made by individuals and, to the greatest extent possible, will avoid subordinating these choices to any one conception of the good life."[164]

Quoting Professor Joad - the same passage that I have just quoted - Madame Justice Wilson

approved the principle that a human person must never be treated as a means to an end - especially an end chosen by someone else, or by the state. She rejected the idea that, in questions of morality, the state should endorse and enforce "one conscientiously-held view at the expense of another," for that is "to deny freedom of conscience to some, to treat them as means to an end, to deprive them . . .of their 'essential humanity'."[165]

Conclusion

In the tradition of Kant, C.S. Lewis, Martin Luther King Jr., Cyril Joad and Karol Wojtyla, and following Madame Justice Wilson, to demand that health care workers provide or facilitate procedures or services that they believe to be wrong in order to serve ends chosen by another is to treat them as means to an end and deprive them of their "essential humanity."

The Ontario Human Rights Commission has proposed that, as a matter of principle and even as a matter of law, health care workers can be compelled to do what they believe to be wrong, and that they can be punished if they do not. This drives a knife into "the heart of our democratic political tradition," and it is blasphemy against the human spirit. In the words of Alexander Solzhenitsyn, "To this putrefaction of soul, this spiritual enslavement, human beings who wish to be human cannot consent."[166]

Recalling the trademark scene from an old television series, your mission, should you decide to accept it, is to convince the Canadian establishment that this is a plausible view of the human person, and to remind judges and professional bodies that they must leave room in this country for more than one understanding of the human person - for more than one philosophy of life.

Thank you.

Notes

1. Lewis, Charles, The next moral quagmire: conscience. Politics collides with freedom of workers' beliefs. *National Post*, 4 April, 2009 (http://www.nationalpost.com/related/topics/story.html?id=1462831) Accessed 2010-05-19

2. There are four kinds of professional medical organizations significant for our purposes today: regulatory authorities (like Colleges of Physicians and Surgeons), professional specialist associations (like the Society of Obstetricians and Gynaecologists Canada), professional interest associations (the Canadian Medical Association), and federations of regulatory authorities (like the Federation of Medical and Regulatory Authorities of Canada.. Comparable entities in the legal profession are the provincial law societies, specialist associations like the Advocates' Society, interest groups like the Canadian Bar Association and the Federation of Law Societies of Canada.

Professional regulatory authorities include Colleges of Physicians and Surgeons, Colleges of Pharmacists, etc. (See Royal College of Physicians and Surgeons, Provincial Medical Regulatory (Licensing) Authorities (http://rcpsc.medical.org/links/provli_e.php) Accessed 2010-05-20. These bodies are creatures of statute, sometimes specific to the profession, sometimes omnibus statutes that provide the ground rules for the regulation of all health care professions. They have the power to develop standards of practice or care and codes of ethics, and can enforce compliance with their standards and codes through disciplinary bylaws. They are analogous to the law societies that govern the legal profession in each province, like the Law Society of Upper Canada.

The second group includes a variety of professional specialist associations, like the Royal College of Physicians and Surgeons of Canada, which is concerned primarily with medical education, the Society of Obstetricians and Gynaecologists Canada or the British Columbia College of Family Physicians.(See Royal College of Physicians and Surgeons, *National Specialist Societies* (http://rcpsc.medical.org/links/nss_e.php) Accessed 2010-05-20) These associations have no regulatory authority and membership is voluntary, but they can develop professional standards or guidelines for their specialty. While binding only on their members, these standards tend to have wider influence. In particular, they are likely to inform the decisions of regulators as to what constitutes an appropriate standard of care. Further, they can actively influence public perceptions and policy through the media and contacts with governments. Analogous entities in the legal profession include the Advocates' Society or the Quebec Association of Family Law Practitioners.

The Canadian Medical Association and its provincial counterparts are representative of the third kind of professional organization: a generalist group that represents the interests of its members to governments and the public at large. The actual political and professional influence of these organizations depends upon their ability to speak credibly on behalf of a significant proportion of a given profession. Their counterparts in the legal profession are the Canadian Bar Association and similar provincial organizations.

The fourth category, the smallest, is comprised of federations of regulatory authorities, like the

National Association of Pharmacy Regulatory Authorities (NAPRA) and the Federation of Medical and Regulatory Authorities of Canada (FMRAC). These groups attempt to develop common policies on matters relevant to practice across the country, such as common standards for licensing and registration. Membership is comprised of representatives from the provincial regulatory bodies, not of individuals. The comparable institution for the legal profession is the Federation of Law Societies of Canada.

3. "Free the Doctor",Globe and Mail, 18 May, 1965. Quoted in de Valk, Alphonse, *Morality and Law in Canadian Politics: The Abortion Controversy*. Dorval, Quebec: Palm Publishers, 1974, p. 18 Two years later 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

4. 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.

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

6. *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

7. *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

8. 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)

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

10. *Hansard- Commons Debates*, 28 April, 1969, p. 8087. Senator Haidasz had long since achieved a strong pro-life reputation.

11. The article appeared anonymously in *The Humanist*. See Pelrine, Eleanor Wright, *Morgantaler: The Doctor Who Couldn't Turn Away*. Canada: Gage Publishing, 1975, P. 79

12. "Abortion-Care Education Is Deficient in U.S. Health Professional Training." *Joint Announcement from Ibis Reproductive Health, the National Abortion Federation, and the Abortion Access Project*, 9 May, 2006. (http://www.prochoice.org/news/releases/20060509.html) Accessed 2006-07-02.

Finer, Lawrence B., and Henshaw, Stanley K., "Abortion Incidence and Service in the United States in 2000." *Perspectives on Sexual and Reproductive Health*, Vol. 35, No. 1 January/February, 2003 (http://www.guttmacher.org/pubs/journals/3500603.html) Accessed 2008-11-30.

Ceci Connolly , Ceci, "Number of Abortion Providers At Its Lowest in Three Decades." *Washington Post*, 22 January, 2003 (http://www-tech.mit.edu/V122/N65/Abortion.65w.html) Accessed 2006-07-02.

13. Shaw, Jessica, Reality Check: a close look at accessing abortion services in Canadian hospitals. Canadians for Choice, 2006. (http://www.canadiansforchoice.ca/report_english.pdf) Accessed 2010-05-19. While such claims must be taken with a grain of salt, about 60% of 170 Canadian obstetrician/gynaecologists who responded to a survey last year reported that they did not do abortions. About half of these were motivated by "personal beliefs." McAllister, Joe, "Most Canadian ob/gyns don't perform abortions." *Medical Post*, 18 August, 2009. (http://www.canadianhealthcarenetwork.ca/physicians/clinical/health-index-therapeutics/obstetricsgynecology/obgyn-most-canadian-obgyns-dont-perform-abortions-1984) Accessed 2010-05-19

14. What constitutes a late term abortion is a somewhat subjective question. If we take fetal viability as a marker for what constitutes a 'late term' abortion, statistics in the United Kingdom show that as many as 50 babies survive abortions each year in the United Kingdom. Rogers, Lois, "Fifty babies a year are alive after abortion." *The Sunday Times*, 27 November, 2005. (http://www.timesonline.co.uk/article/0,,2087-1892696,00.html) Accessed 2006-06-13.

The British Medical Association has had to adopt policies to protect abortion survivors. [BMA Annual Representative Meeting, 2004: "That this Meeting calls upon the MSC and BMA to work with the GMC, NHS and appropriate Royal Colleges to ensure that babies born alive as a result of termination of pregnancy procedures receive the same full neonatal care as that available to other babies." (http://www.bma.org.uk) Accessed 2006-06-13.

15. A survey conducted in 1998, years afer legalization of abortion in the United States, found that most of the 1,200 nurses surveys wanted as little to do with abortion as possible. Poggenpoel, M., Myburgh, C., & Gmeineer, A., (1998, September). "One voice regarding the legislation of abortion: Nurses who experience discomfort." *Curationis*, pp. 2-7. Cited in Marek, Marla J., "Nurses' Attitudes Toward Pregnancy Termination in the Labor and Delivery

Setting." JOGNN, 33, 472-479; 2004

Doctors at a hospital in Lyon, France, resigned *en masse* when administrators instructed them to implement a new law raising the gestational limit for abortion from 10 to 12 weeks. A study by the Jérôme Lejeune Foundation of the situation in Lyon found "intense reluctance" among doctors to carry out the later term abortions. "French Doctors Rethinking Abortions in Face of New Law: At One Hospital, Physicians Quit en Masse." *Zenit,* 7 November, 2001. (http://www.zenit.org/english/visualizza.phtml?sid=12237) Accessed 2006-06-13.

Abortion is legal in Viet Nam. It is reported that "psychological trauma" experienced by physicians "could emerge as an important issue with the rapidly increasing number of people seeking to have abortions. " Dr. Nguyen Thi Hong Minh, director of the Central Obstetrics and Gynecology Hospital in Hanoi, described her adverse reaction to having to perform abortions at 20-22 weeks gestation. There was no indication in the report that physicians were compelled to provide abortions "Doctors under pressure as abortion demand goes up." Than Nien News, 15 March, 2010 (http://www.thanhniennews.com/2010/Pages/Doctors-under-pressure-as-abortion-demand-goes-up.aspx) Accessed 2010-05-21

Opposition to late term abortion can even lead to threats of legal action by concerned physicians. "Doctors Revolt over Last-Minute Abortion of Twin." *British Nursing News On Line*, 10 November, 2002. (http://www.bnn-online.co.uk/news_datesearch.asp?SearchDate=10/Nov/2002&Year=2002) Accessed 2006-06-13.

16. The reluctance of Scots physicians to provide abortions after 15 weeks gestation has resulted in women travelling to England for the procedure. "Ian Jones, chief executive of the BPAS . . . admitted that it could be difficult to find doctors and nurses, particularly in the west of Scotland, who were prepared to work at the clinic. He said the fact that so many women needed to travel to England for late abortions reflected the fact that medical staff in Scotland do not want to perform them." Templeton, Sarah Kate, "Private firm plans Scottish abortion clinic." *The Sunday Herald*, 19 January, 2003. (http://www.findarticles.com/p/articles/mi_qn4156/is_20030119/ai_n9627244/pg_2) Accessed 2006-06-13).

On the other hand, abortions can be obtained in some locations very late into pregnancy. Foster, Kate, "Hospital Admits Abortion At 34 Weeks." *Scotland on Sunday*, 10 April 2005.(http://scotlandonsunday.scotsman.com/index.cfm?id=378472005) Accessed 2006-06-13.

By 2002 there had been a 578 percent increase in the numbers of abortions performed at 20 to 21 weeks gestation in Canada. "Discovery of birth defects leads to abortions: study." CBC News. 28 March, 2002 (http://www.cbc.ca/story/news/national/2002/05/28/abort020528.html) Accessed 2006-06-13). The news report, drawing on Statistics Canada figures, noted that 96.7% of abortions in 2001 were performed before the 16th week. Since there were 105,154 abortions in 2001, about 3,480 abortions were performed after the 16th week: about nine per day. *The Daily*, 11 February, 2005 (http://www.statcan.ca/Daily/English/050211/d050211a.htm) Accessed 2006-

06-13.

Two to three abortions performed up to and beyond 24 weeks gestation were reported to be occurring each week in an Alberta hospital, many resulting in live births of infants. Ko, Marnie, "Down the Slope to Infanticide: Nurses At Foothills Hospital Rebel Over The Horrifying Results Of Late-Term 'Genetic Terminations.'" *Alberta Report Newsmagazine* May 3, 1999. (http://www.consciencelaws.org\Repression-Conscience\Conscience-Repression-02.html)

And, for the same reason, a district health board in New Zealand has decided to subsidize travel to Australia for women who want second trimester abortions. "Royal College calls for conscience decision on second trimester abortions." *Radio New Zealand*,11 March, 2006 (http://www.radionz.co.nz/news/bulletins/radionz/200603110838/2911d527) Accessed 2006-03-11.

17. A shortage of willing Canadian physicians caused women from Ontario and Quebec to go to the United States for late term abortions. Quebec Health Minister Philippe:"'In Quebec, our doctors at the present time don't feel comfortable doing abortions later than 22 weeks. From 20 to 22 weeks they're all done in Sherbrooke, after that we still don't have the capacity to do them here.'" "Quebec hopes to offer late-term abortions." *CBC News*, 10 September, 2004.

(http://www.cbc.ca/story/canada/national/2004/09/10/abortions_lateterm040910.html) Accessed 2006-06-13. A 2006 report from Canadians for Choice referred to the arrangement. Shaw, Jessica, Reality Check: a close look at accessing abortion services in Canadian hospitals. Canadians for Choice, 2006, p. 34. (http://www.canadiansforchoice.ca/report_english.pdf) Accessed 2010-05-19 According to the Canadians for Choice directory, only one abortion facility in Quebec performs abortions beyond 16 weeks gestation, and none beyond 21 weeks. (http://www.canadiansforchoice.ca/directory/qc.html) Accessed 2010-05-19

18. Peritz, Ingrid Peritz, and Séguin, Rhéal, "Quebec MNA's challenge Harper's abortion stance. " Globe and Mail, 19 May, 2010 (http://www.theglobeandmail.com/news/politics/quebec-demands-pm-clear-up-abortion-ambiguity/article1574440/) Accessed 2010-05-19

19. Dr. Ward's survey of Western Cape physicians found that half would not do abortions for non-lethal congenital abnormalities. More important was his finding that 46% would refuse to perform abortions for socio-economic reasons; less than a third were willing to do so.

Ward, Harvey, *Are State Doctors in the Western Cape willing to implement the Choice of Termination of Pregnancy Act of 1996? An opinion survey conducted in the Western Cape in November 1997*. In fulfillment for the requirements of the FCOG (S.A.) part 2. (http://www.consciencelaws.org\Examining-Conscience-Background\Abortion\BackAbortion15.html)

95% to 99% of nurses surveyed in the California study I have mentioned would refuse involvement in sex selective abortion; the rate of objection to selective reduction in multifetal pregnancies ranged from 71% to 92%. Marek, Marla J., "Nurses' Attitudes Toward Pregnancy Termination in the Labor and Delivery Setting." JOGNN, 33, 472-479; 2004. The range in both

cases reflects responses that differed according to gestational age.

20. For example: a study in the United Kingdom found that nurses developed increasingly negative attitudes to abortion the longer they worked in units where it was provided. Marshall, S.L., Gould, D. & Roberts, J. (1994) "Nurses' attitudes towards termination of pregnancy." *Journal of Advanced Nursing*, 20, 567-576. Cited in Marek, Marla J., "Nurses' Attitudes Toward Pregnancy Termination in the Labor and Delivery Setting." JOGNN, 33, 472-479; 2004

Abortion had been legal in Britain for over a generation when a third of junior doctors were reported to be conscientious objectors to the procedure. Saunders, Peter, "Conscientious Objection to Abortion." *Triple Helix*, Winter, 2001. (http://www.consciencelaws.org/Examining-Conscience-Background/Abortion/BackAbortion36.html#001 Saunders 99)

The Spanish pro-life group Provida reported that, a year after abortion was legalized in Spain, only 2 out of 100 gynaecologists in a Madrid hospital were willing to perform them. By 2004, abortions had been performed by only one doctor at the largest hospital in Valencia. Catholic News Agency, *96% of gynecologists in Spain refuse to perform abortions* (http://www.catholicnewsagency.com/new.php?n=856) Accessed 2006-06-13.

A survey by *RN* magazine disclosed that the number of nurses who refused to work in a unit where abortions were performed had increased over ten years from 48% to 61%. Ventura, M.J. (1999) "Where nurses stand on abortion." RN, 62(3), 44-48. Cited in Marek, Marla J., "Nurses' Attitudes Toward Pregnancy Termination in the Labor and Delivery Setting." JOGNN, 33, 472-479; 2004.

Recent Californian research found rates of conscientious objection among nurses ranging from 23% to 99%, depending upon the reasons for the procedures. Moreover, two hospitals declined to participate in the survey because of fear that it would "stir up negative feelings" among staff: this, thirty years after the legalization of abortion in the United States. Marek, Marla J., "Nurses' Attitudes Toward Pregnancy Termination in the Labor and Delivery Setting." JOGNN, 33, 472-479; 2004.

On the other hand, other researchers have noted that experience has led to the development of more positive attitudes toward the procedure. See Meta Hammarstedt, Lars Jacobsson, Marianne Wulff and Ann Lalos, *Views of midwives and gynecologists on legal abortion – a population-based study*. Acta Obstetricia et Gynecologica Scandinavica, Volume 84 Page 58 - January 2005 doi:10.1111/j.0001-6349.2005.00695.x Volume 84 Issue 1: "The more experience of working with legal abortion, especially current experience, the less restrictive gynecologists and midwives are in their views. Compared with previous studies, staffs have become more liberal in their attitudes toward abortion and the relevant legislation."

21. A classic example is provided by developments in Spain. The Spanish pro-life group Provida reported that, a year after abortion was legalized in Spain, only 2 out of 100 gynaecologists in a Madrid hospital were willing to perform them. By 2004, abortions had been performed by only one doctor at the largest hospital in Valencia. Catholic News Agency, *96% of*

gynecologists in Spain refuse to perform abortions
(http://www.catholicnewsagency.com/new.php?n=856) Accessed 2006-06-13.

Five years later the Spanish Minister of Justice, Francisco Caamano said that "there is no room for conscientious objection to abortion" in the country. Collegial Medical Organization President Dr. Juan Jose Rodriguez Sendin has rejected the Minister's assertion, stating that doctors will exercise their freedom to refuse to perform abortions whether the government likes it or not. The Minister's statement also brought a rebuke from the Association for the Defense of Conscientious Objection. "Spain's Justice Minister says doctors not allowed to object to abortion." Catholic News Agency, 14 August, 2009.
(http://www.catholicnewsagency.com/news/spains_justice_minister_says_doctors_not_allowed_to_object_to_abortion/) Accessed 2010-05-20.

Responding to the Minister of Justice, Dr. Esteban Rodriguez of Right to Life (Derecho a Vivir) in Spain said that objecting physicians would go to jail rather than perform abortions. He criticized the "totalitarian intentions" of the government. "Gynecologists in Spain plan to choose jail before performing an abortion." Catholic News Agency, 20 August, 2009.
(http://www.catholicnewsagency.com/news/gynecologists_in_spain_plan_to_choose_jail_before_performing_an_abortion/) Accessed 2010-05-20

22. Sometimes this collision is unintended. In England, for example, the Royal College of Nursing general secretary has suggested an expanded role for nurses in abortion. She stated that the organization wants to increase access to abortion in the early stages of pregnancy "and allow nurses greater involvement in providing services." While the general secretary affirmed the right of nurses to refuse to participate, she does not appear to have recognized that expecting more nurses to participate in abortion will increase the probability of pressure on conscientious objectors. "RCN Says No Need for Change in Abortion Law." *RCN News Release*, 30 June, 2005 (http://www.rcn.org.uk/news/display.php?ID=1600&area=Press) Accessed 2006-06-12.

23. "In our society, we all pay taxes for this medical system to receive services," said Dr. Preston Zuliani, the President of the College of Physicians and Surgeons of Ontario. "And if a citizen or taxpayer goes to access those services and they are blocked from receiving legitimate services by a physician, we don't feel that's acceptable." Laidlaw, Stuart, College of physicians debates doctors' rights to refuse treatments." *Toronto Star*, 18 September, 2008 (http://www.thestar.com/living/article/500852) Accessed 2008-09-21

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

25. In 1992, BC Health Minister Elizabeth Cull ordered 33 British Columbian hospitals to perform abortions. Hawkins, Anthony, "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

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, Sean, *Nurse Refused Employment, Forced to Resign: A Two Tiered System of Civil Rights.* http://www.consciencelaws.org\Repression-Conscience\Conscience-Repression-03.html

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, Marnie, "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-Conscience\Conscience-Repression-01.html

BC welfare worker Cecilia Moore was fired for refusing to authorize payment for an abortion that would have been illegal under the law as it then stood. Murphy, Sean, *"Insubordination."*(http:\\www.consciencelaws.org\Repression-Conscience\Conscience-Repression-10.html)

Three transition house workers in Ontario were fired - with the government's approval - for refusing to refer women for abortions. Kennedy, Frank, "Sweeney Defends Firings:Transition house workers fired, denied benefits for 'misconduct'". *The Interim*, March, 1989 (http:\\www.consciencelaws.org\Repression-Conscience\Conscience-Repression-04.html)

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, Sean, *Conscience or Contempt of Court? Court orders abortion of woman*. (http://www.consciencelaws.org\Examining-Conscience-Issues\Background\Abortion\BackAbortion04.html)

26. The progression is neatly illustrated by the name changes of a prominent American abortion advocacy group: from the "National Association for the Repeal of Abortion Laws" (1969) to the "National Abortion Rights Action League" (1973) to the "National Abortion and Reproductive Rights Action League" (1993). *Key Moments in NARAL Pro-Choice America's History* (http://www.prochoiceamerica.org/about-us/learn-about-us/history.html) Accessed 2006-06-22.

27. Recall the *Globe and Mail's* plea that abortion be legalized "to enable doctors to perform their duties according to their conscience and their calling."

Editorial, "Free the Doctor." *Globe and Mail*, 18 May, 1965. Quoted in de Valk, Alphonse, *Morality and Law in Canadian Politics: The Abortion Controversy*. Dorval, Quebec: Palm Publishers, 1974, p. 18.

28. One of the most important 'movers and shakers' in this field is the Center for Reproductive Rights. CRR documents obtained by the Catholic Family and Human Rights Institute (CFAM) were entered in the United States Congressional Record (p. E2535 to E2547) on 8 December, 2003, to forestall efforts by the Center to suppress dissemination of the documents through litigation. They are available on the Protection of Conscience Project website at (http://www.consciencelaws.org/Conscience-Archive/Documents/CRRSecretStrategy.pdf)

The documents cited herein are:

International Legal Program Summary of Strategic Planning: Through October 31, 2003 (E2535)

ILPS Memo # 1- International Reproductive Rights Norms: Current Assessment (E2535-E2538);

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

Domestic Legal Progam Summary of Strategic Planning Through October 31, 2004 (E2539)

DLPS Memo #1- Future of Traditional Abortion Litigation (E2539-2540);

DLPS Memo #2- Report to Strategic Planning Participants From Systematic Approach Subgroup (E2540-E2541).

DLPS Memo #3- Report to Strategic Planning Participants From "Other Litigation" Subgroup (E2541-E2542).

Program Strategies and Accomplishments (E2543)

The Center for Reproductive Rights: Summary and Synthesis of Interviews (E2543-2546)

The Center for Reproductive Rights Board of Directors - Primary Affiliation Information (E2547)

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

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

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

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

"The Center needs to continue its advocacy to ensure that women's ability to choose to terminate

a pregnancy is recognized as a human right." *ILPS Memo # 2*, E2539

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

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

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

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

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

35. Dickens, Bernard M. "Informed Consent": Chapter 5 in Downie, Joceyln, Caulfield, Timothy and Flood, Colleen (Eds.) *Canadian Health Law and Policy* (2nd Ed.). Toronto: Butterworths, 2002, p. 149. The claim is examined and rejected in Murphy, Sean, *Conscientious objection as a 'crime against humanity.'* (http://www.consciencelaws.org\Examining-Conscience-Legal\Legal38.html)

36. Amnesty International claims that a Nicaraguan law against abortion violates the *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*. The charge is completely at odds with the definition of "torture" used in the *Convention*, but consistent with attempts to characterize conscientious objection to abortion as a crime against humanity. Amnesty International, *The Impact of the Complete Abortion Ban in Nicaragua: Briefing to the United Nations Committee Against Torture.* London, 2009 (http://www.amnesty.org/en/library/asset/AMR43/005/2009/en/3394566e-4045-43f7-902c-b9f50181fcf5/amr430052009en.pdf) Accessed 2010-05-21; *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*. (http://www2.ohchr.org/english/law/cat.htm) Accessed 2010-05-21; Murphy, Sean, *Conscientious Objection as a Crime Against Humanity* (http://www.consciencelaws.org\Examining-Conscience-Legal\Legal38.html)

37. According to the Canadians for Choice directory, only one abortion facility in Quebec performs abortions beyond 16 weeks gestation, and none beyond 21 weeks. (http://www.canadiansforchoice.ca/directory/qc.html) Accessed 2010-05-19

38. "It was quite a surprise, back in 1973, to be informed by an eminent professor of obstetrics and gynaecology . . .that as a Roman Catholic specialist, that "there is no place for to practice within the National Health Service unless you are prepared to change your views or to re-specialise in another field." . . .as a consequence became unemployed with a wife and three children and had to leave country, home and family in order to practise my chosen specialty in full freedom." Walley, R. L., *Question of Conscience.* THE FUTURE OF OBSTETRICS AND GYNAECOLOGY: The Fundamental Right To Practice and be Trained According to Conscience: An International Meeting of Catholic Obstetricians and Gynaecologists. (http://www.consciencelaws.org\Repression-Conscience\Conscience-Repression-27.htm)

39. Waldis, Niklaus, *Personal Experience in Switzerland in 1989*. THE FUTURE OF OBSTETRICS AND GYNAECOLOGY: The Fundamental Right To Practice and be Trained According to Conscience: An International Meeting of Catholic Obstetricians and Gynaecologist. (http://www.consciencelaws.org\Repression-Conscience\Conscience-Repression-43.htm)

40. Catholic hospitals in the Australian state of Victoria may close as a result of a new law that makes referral for abortion mandatory. "State of Victoria, Australia demands referral, performance of abortions." Protection of Conscience Project (http://www.consciencelaws.org/Repression-Conscience/Conscience-Repression-51.html)

41. The opposition to abortion that is a feature of indigenous African culture is in conflict with documents like the Maputo Plan of Action and the Maputo Protocol, all of which are intended to establish abortion (and other things) as legal rights. *Maputo Plan of Action for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health Rights*, 2007-2010. African Union, Special Session of the African Union Conference of Ministers of Health, Maputo, Mozambique 18-22 September, 2006 (http://ec.europa.eu/europeaid/where/worldwide/health/documents/maputo_poa_en.pdf) Accessed 2008-11-28.

Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa. African Union, 2nd Ordinary Session of the Assembly of the Union, Maputo, 11 July, 2003 (http://www.achpr.org/english/women/protocolwomen.pdf) Accessed 2008-11-28.

42. In 2007 the Committee for the Elimination of Discrimination Against Women (CEDAW) asked Polish representatives "[h]ow many doctors had been suspended or fired because they refused to perform abortions?" The question appeared to reflect an expectation that such practices should be the norm. "Progress made in mainstreaming gender equality into Poland's national legislation, women's anti-discrimination committee told." UN General Assembly WOM1591, Dept. Of Public Information, 16 January, 2007. (http://www.un.org/News/Press/docs/2007/wom1591.doc.htm) Accessed 2008-11-28.

43. In Portugal, abortion up to ten weeks gestation was legalized in 2007. As a result of widespread conscientious objection, the Portuguese Health Minister ordered the Portuguese Medical Association to remove the prohibition of abortion from its code of ethics. He insisted that it was unacceptable for codes of ethics to "go against the general law of the country." The Association eventually

deleted direct reference to abortion in the code. The new language affirms that life is the highest value and cannot be interrupted after it begins, but the Association has adopted a neutral position as to when life begins. "Portugal moves to legalize abortion." Catholic Culture, *Catholic World News Feature Stories*, 12 March, 2007. (http://www.catholicculture.org/news/features/index.cfm?recnum=49798) Accessed 2008-11-28.

Hoffman, Matthew Cullinan, "Portuguese Government Orders Doctors to Remove Anti-Abortion Restrictions from Code of Ethics: Portuguese Bar Association denounces decision as 'arrogant and overbearing.'" *LifeSiteNews.com*, 22 October, 2007 (http://www.lifesitenews.com/ldn/2007/oct/07102203.html) Accessed 2008-11-28.

Almeida, Henrique, "Portugal doctors stand by anti-abortion principles." *Reuters,* 15 November, 2007 (http://www.reuters.com/article/latestCrisis/idUSL15906281) Accessed 2008-11-28.

Hoffman, Matthew Cullinan, "Portuguese Government to Prosecute Doctors Group Over 'Illegal' Anti-Abortion Ethics Policy." *LifeSiteNews.com*, 22 November, 2007 (http://www.lifesitenews.com/ldn/2007/nov/07112201.html) Accessed 2008-11-28.

Hoffman, Matthew Cullinan, "Portuguese Physicians Capitulate to Pressure to Change Ethical Code to Allow Abortions." *LifeSiteNews.com*, 11 July, 2008 (http://www.lifesitenews.com/ldn/2008/jul/08071116.html) Accessed 2008-11-28.

44. The Spanish pro-life group Provida reported that, a year after abortion was legalized in Spain, only 2 out of 100 gynaecologists in a Madrid hospital were willing to perform them. By 2004, abortions had been performed by only one doctor at the largest hospital in Valencia. Catholic News Agency, *96% of gynecologists in Spain refuse to perform abortions* (http://www.catholicnewsagency.com/new.php?n=856) Accessed 2006-06-13.

Five years later the Spanish Minister of Justice, Francisco Caamano said that "there is no room for conscientious objection to abortion" in the country. Collegial Medical Organization President Dr. Juan Jose Rodriguez Sendin has rejected the Minister's assertion, stating that doctors will exercise their freedom to refuse to perform abortions whether the government likes it or not. The Minister's statement also brought a rebuke from the Association for the Defense of Conscientious Objection. "Spain's Justice Minister says doctors not allowed to object to abortion." Catholic News Agency, 14 August, 2009. (http://www.catholicnewsagency.com/news/spains_justice_minister_says_doctors_not_allowed_to_object_to_abortion/) Accessed 2010-05-20.

Responding to the Minister of Justice, Dr. Esteban Rodriguez of Right to Life (Derecho a Vivir) in Spain said that objecting physicians would go to jail rather than perform abortions. He

criticized the "totalitarian intentions" of the government. "Gynecologists in Spain plan to choose jail before performing an abortion." Catholic News Agency, 20 August, 2009. (http://www.catholicnewsagency.com/news/gynecologists_in_spain_plan_to_choose_jail_before_performing_an_abortion/) Accessed 2010-05-20

45. Nurses at a convention in Bangalore reported that they were being forced to pariticpate in abortions, and that some who refused had been forced to resign."Catholic nurses under pressure to assist abortions." *Spero News*, 18 May, 2006 (http://www.speroforum.com/site/article.asp?idCategory=33&idsub=122&id=3632) Accessed 2008-11-28.

46. A young nurse in Pakistan who refused to perform an abortion on two women was gang raped by three men from their families. The Punjab Health Association stated that this was not the first such incident. Wilkinson, Isambard, "Nurse raped for refusal to carry out abortions." *The Telegraph*, 27 February, 2006 (http://www.telegraph.co.uk/news/worldnews/asia/pakistan/1511624/Nurse-raped-for-refusal-to-carry-out-abortions.html) Accessed 2008-11-28.

47. In 2008, the Saint Ignatius University Hospital (Hospital Universitario San Ignacio) in Colombia refused to provide a eugenic abortion. The Colombian government announced that it would fine the hospital the equivalent of about $5,100.00 for refusing to provide the procedure. [Hoffman, Matthew Cullinan, "Colobmbian Government Fines Catholic Hospital for Refusing to Perfomr Abortion." *LifeSite News*, 12 May, 2009. (http://www.lifesitenews.com/ldn/2009/may/09051215.html) Accessed 2010-05-20

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(http://www.dakotavoice.com/2009/10/lesbians-christian-fertility-doctors-settle-out-of-court/) Accessed 2010-05-21

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Widow wins access to dead husband's sperm. ABC News Online http://www.abc.net.au/news/newsitems/200512/s1534882.htm (Accessed 2006-07-01)

54. Mundy, Liza, "A World of Their Own: In the eyes of his parents, if Gauvin Hughes McCullough turns out to be deaf, that will be just perfect." Washington Post, 31 March, 2002 (http://www.washingtonpost.com/ac2/wp-dyn?pagename=article&contentId=A23194-2002Mar27&notFound=true) Accessed 2006-07-01

55. The University of Pennsylvania had what it called an "Assisted Suicide Consensus Panel". It decided that nurses, social workers and *clergy* should participate in assisted suicide. And the clergy were not there to give the last rites, but to help patients work through the decision to kill themselves. Malugani, Megan, "Nurses, Social Workers May Have Role in Assisted Suicide, Ethics Panel Says: MDs Alone Are 'Not Sufficient' for Best Care". *WebRN News*, March 22, 2000 (Oakland, Calif.)

56. Montana judge ruled that the state constitution not only provided a "right" to assisted suicide, but that this legal right "necessarily incorporates the assistance of his doctor, as part of a doctor-patient relationship, so that the patient can obtain a prescription for drugs that he can take to end his own life, if and when he so determines." Montana First Judicial District Court, Lewis and Clark County, Cause No. ADV-2007-787, *Robert Baxter et al v. State of Montana*, Decision and Order, 5 December, 2008. (http://www.compassionandchoices.org/documents/McCarter_Opinion_Montana.pdf) Accessed 2009-07-15.

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Subsequently, the nuns caring for her refused to do so. White, Hilary, "Italian Nuns Refuse to

Kill Eluana Englaro." LifeSite News, 17 November, 2008 (http://www.lifesitenews.com/ldn/2008/nov/08111701.html) She died in February, 2009 a few days after food and fluids were stopped and doctors began to remove life support, in the midst of a national controversy. Owen, Richard, "'Right to ie' Coma woman Eluana Englaro dies." The Times, 10 February, 2009 (http://www.timesonline.co.uk/tol/news/world/article5697099.ece) Accessed 2010-05-21

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Helen McCrave, a woman in the United Kingdom was told that her IVF treatment would be delayed for an indeterminate period because she does not have blonde hair and blue eyes. The conditions for treatment include a requirement that she donate some of her eggs to the IVF facility, but the demand was for eggs from blonde, blue-eyed donors. McNeil, Rob, "IVF help 'only if you are a blonde'." *Evening Standard* (London), 15 July, 2004 (http://www.findarticles.com/p/articles/mi_qn4153/is_20040715/ai_n12095591) Accessed 2006-07-01)

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J Thompson, *Relatives of the living dead*. J. Med. Ethics, Oct 2006; 32: 607 - 608.

N Levy, A Ravelingien, J Braeckman, F Mortier, E Mortier, and I Kerremans, *Respecting rights ... to death*. J. Med. Ethics, Oct 2006; 32: 608 - 611.

63. American surgeons have carried out sham operations, which involved drilling holes in patients' skulls, as placebo surgery designed to test the effectiveness of a new treatment for Parkinson's disease. "Doctors Drill into Patients' Heads in Placebo Surgery." (http://www.independent.co.uk/atp/INDEPENDENT/NEWS/P5S4.html) Accessed 29 Sept., 1999

64. St. Vincent Hospital, Santa Fe, New Mexico and Nurses District 1199, New Mexico, Memorandum of Understanding for Circumcision Procedure, 31 January, 1995. (http://www.consciencelaws.org\Conscience-Policies-Papers\PPPSettlements04.htm)

65. University of Manchester Professor John Harris, a member of the British Medical Association's ethics committee, justifies infanticide as a logical extension of late term abortion. "There is no obvious reason why one should think differently, from an ethical point of view, about a fetus when it's outside the womb rather than when it's inside the womb." *UK medical ethicist: Infanticide 'justifiable' - Government adviser suggests acceptable to kill babies with 'defects' soon after birth.* World Net Daily, 25 January, 2004. (http://www.worldnetdaily.com/news/article.asp?ARTICLE_ID=36763) Accessed 21 September, 2005

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67. In 1997 and 1998, Dr. Robert Smith, a surgeon at the Falkirk and District Royal Infirmary in Scotland, performed single leg amputations on two men. There was nothing wrong with their legs. Both men suffered from a disorder called apotemnophilia, or Body Integrity Identy Disorder (BIID). Dr. Smith was concerned that if he did not perform the amputations the patients might resort to back street amateurs, or attempt amputations themselves, thereby putting their health and lives at risk. "I have very serious concerns that they will either go to unlicensed practitioners and there are practitioners advising on the Internet to provide this service. They may take the law into their own hands, they may lie under a railway line, on a railway line and be run over by a train. They use shotguns and shoot their limbs off and they are really quite a desperate bunch." *Complete Obsession*. BBC2, 9:30pm, 17 February, 2000. http://www.bbc.co.uk/science/horizon/1999/obsession_script.shtml (Accessed 2006-07-13)

Similarly, one of the patients whose leg was removed said that some people seeking amputations "simulate accidents" and "others turn to back-street operators." 'No regrets' for healthy limb amputee . BBC News, 6 February, 2000, 15:43 GMT. BBC News, http://news.bbc.co.uk/1/hi/scotland/632856.stm (Accessed 2006-07-15)

68. Cantor, Julie D., When an Adult Female Seeks Ritual Genital Alteration: Ethics, Law and the Parameters of Participation. *Plastic and Reconstructive Surgery*, 117(4), 1 April, 2006, 1158-1164

69. "If the patient were to have no assistance from his doctor, he may be forced to kill himself sooner rather than later because of the anticipated increased disability with the progress of his disease, and the manner of the patient's death would more likely occur in a manner that violates his dignity and peace of mind, such as by gunshot or by an otherwise unpleasant method, causing undue suffering to the patient and his family." Montana First Judicial District Court, Lewis and Clark County, Cause No. ADV-2007-787, *Robert Baxter et al v. State of Montana*, Decision and Order, 5 December, 2008. (http://www.compassionandchoices.org/documents/McCarter_Opinion_Montana.pdf) Accessed 2009-07-15.

70. The legalization of assisted suicide in Washington state is generating attacks on health care workers unwilling to be involved with the procedure. The first patient to ask for a lethal prescription could not find a physician willing to provide it before he died. His granddaughter complained that Spokane area hospitals "do not provide support or direction of any kind" for assisted suicide. She is urging citizens to contact legislators to demand "access to all our rights according to the law." The implication is that institutions and/or health care workers should be forced to participate in assisted suicide. Bean, Leah, "Death with Dignity a Law, but unavailable." *The Spokesman Review*, 26 April, 2009 (http://www.spokesman.com/stories/2009/apr/26/death-with-dignity-a-law-but-unavailable/) Accessed 2010-05-22

71. The Center For Reproductive Rights (CRR) supported a legal challenge to the Costa Rican ban on *in vitro* fertilization launched by ten infertile Costa Rican couples. CFAM Friday Fax, December 30, 2004, Volume 8, Number 2 (http://www.c-fam.org/publications/id.387/pub_detail.asp) Accessed 2010-05-21

According to statistics from the Human Fertilisation and Embryology Authority (HFEA), between 1992 and 2002 the total number of IVF births to British women of all ages trebled. *Dozens of babies being born to mothers over 50.* The Telegraph, 8 May, 2006. (http://www.telegraph.co.uk/health/main.jhtml?xml=/health/2006/05/08/nbaby07.xml) Accessed 2006-07-01

"Murderer wins right to be a father." *BBC News*, 5 December, 2007. (http://news.bbc.co.uk/2/hi/uk_news/england/humber/7128145.stm) Accessed 2010-05-22

Canadian courts have ruled that public funding is not required for *in vitro fertilization*. *Cameron v. Attorney General* of Nova Scotia [1999] NSJ No. 297 (September 14, 1999), leave to appeal to the Supreme Court of Canada denied. Moulton, Donna Lee, "Supreme Court refuses to hear MD's fertility case." Canadian Medical Association Journal, 3 October, 2000 163(7) (http://www.cmaj.ca/cgi/content/full/163/7/872) Accessed 2010-05-24

However, political pressure for public funding continues. See Nisker, Jeff, "Distributive Justice and Infertility Treatment in Canada." J Obstet Gynaecol Can 2008;30(5):425–431 (http://www.sogc.org/jogc/abstracts/full/200805_HealthPolicy_1.pdf) Accessed 2010-05-21.

Citing Nisker, a guest editorial in the SOJC's *Journal* argues for public funding on the grounds

that patients suffering from infertility deserve publicly funded access to IVF because "[t]hey've already paid their taxes." Hughes, Edward, "Access to Effective Infertility Care in Canada." J Obstet Gynaecol Can 2008;30(5):389–390. (http://www.sogc.org/jogc/abstracts/full/200805_Editorial_1.pdf) Accessed 2010-05-22.

Society of Obsetrticians and Gynaecologists of Canada, *SOGC calls on all provinces and territories for full funding of IVF treatments*. News Release, 22 March, 2010. (http://www.sogc.org/documents/medStatementIVFInsuredBenefit100322.pdf) Accessed 2010-05-24

72. Canning, Cheryl, "Doctor's faith under scrutiny:Barrie physician won't offer the pill, could lose his licence." *The Barrie Examiner*, 21 February, 2002. (http://www.consciencelaws.org/Repression-Conscience/Conscience-Repression-17.html)

73. St. Elizabeth's Hospital in Humboldt, Saskatchewan stopped contraceptive tubal ligations because they were contrary to Catholic teaching. Two physicians then resigned in protest. A woman complained to the provincial Human Rights Commission that denial of tubal ligation was discrimination based on gender and religion. The Saskatchewan Catholic Health Corporation had to pay almost $8,000.00 to settle the complaint. Ultimately, the hospital's Catholic affiliation was ended and control of the hospital was transferred to a regional health authority. Deibert, "Dave, Sask. doctors resign over tubal ligation policy." *Victoria Times Colonist*, 21 December, 2006. (http://www.canada.com/victoriatimescolonist/news/story.html?id=cb8de414-4e21-4c36-a4d5-97b690397465&k=4800) Accessed 2008-11-28.

"Woman given settlement after being denied tubal ligation." *CBC News*, 13 September, 2007. (http://www.cbc.ca/canada/saskatchewan/story/2007/09/13/tubal-ligation.html) Accessed 2008-11-28. French, Janet, "Region to control Humboldt hospital." *The StarPhoenix*, 20 September, 2007. (http://www.canada.com/saskatoonstarphoenix/news/local/story.html?id=e092dbc1-4289-47e9-8455-5632ad6f2e12) Accessed 2008-11-28.

74. *L. v. Lithuania*, (Application No. 27527/03) 11 September, 2007, European Court of Human Rights (http://legacy.lclark.edu/faculty/tomas/objects/Lithuania_Case.pdf) Accessed 2010-05-22

75. In 2007, the ruling party announced that it would force every hospital in the country to provide euthanasia or to refer patients to facilities that would do so. The party was willing to tolerate conscientious objection by physicians on condition that they refer them for euthanasia provided by more willing colleagues. "Hospitals must provide euthanasia." *Expatica*, 18 April, 2007 (http://www.expatica.com/be/articles/news/hospitals-must-provide-euthanasia-38857.html) Accessed 28 November, 2008.

76. Professor Ian Wilmut, who cloned Dolly, the sheep, argues that cloning human embryos to treat illnesses is a good idea, but adds that it would be immoral *not* to do so. *Cloning 'could beat gene disease'.* BBC News, 5 June, 2006. (http://news.bbc.co.uk/go/pr/fr/-

/1/hi/health/5047674.stm) Accessed 2006-07-01

77. "Eventually," said Professor Greg Stock of the University of California, "it will be thought as reckless to have a child without genetic screening as to have a child without pre-natal screening, as happens today." *Daily Express*, 25 October, 2000. (http://www.lineone.net/express/00/10/25/news/n1520_d.html) Accessed October, 2000

78. In addition to arguing that physicians and nurses should encourage terminally ill patients to consider suicide, Baroness Mary Warnock has stated that "it is a genuinely wicked thing" for them to disregard explicit requests for assisted suicide. The remarks were made during a debate at All Soul's Unitarian Church in Belfast, Northern Ireland. *Belfast Newsletter*, 6 January, 2009 (http://www.newsletter.co.uk/news/Ignoring-a-death-wish-is.4845993.jp) Accessed 2010-05-21

79. Fernandez-Lynch, Holly, *Conflicts of Conscience in Health Care: An Institutional Compromise.* Cambridge, Mass.: The MIT Press, 2008, p. xii-xiii

80. Some physicians, she says, assert that it would be wrong for them to do X, but not wrong for someone else. Sincerely motivated by nothing more than a personal "idiosyncratic understanding of morality," they make no broader moral claims (p. 23). It appears that they attract the author's sympathetic notice because they do not challenge the hegemony of moral pluralism.

But Fernandez Lynch seems troubled by physicians who are adhere to what they consider to be "God's absolute standards" that apply to everyone. She observes that they not only refuse to provide a service they believe is wrong, but say that no one else should provide it either (p. 24). She seems to agree that this reflects an agenda that is really "all about the control of others."(p. 23)

Here the author has fallen into absurdity. Anyone who believes that something is truly wrong - murder, for example - will also believe that no one should do it. The author herself takes exactly this position with respect to discrimination (". . . preferences based on racist, sexist, homophobic, or other sorts of bigoted views can be appropriately excluded from legitimate discourse as entirely illogical and not even arguably correct." p.92; ". . . invidious discrimination is clearly an evil . . ." p. 155; ". . . preferences based on racist, sexist, homophobic, or other sorts of bigoted views can be appropriately excluded from legitimate discourse as entirely illogical and not even arguably correct." p. 92)

Elsewhere, in a passage that could have been written by an objecting physician, she asserts, as a matter of "fact," that "there is never an obligation to participate in genuine wrongdoing."

> It is certainly the case that no professional obligation could rightfully include a duty to engage in true moral transgressions, regardless of voluntary entry into a profession or the existence of a professional monopoly. (p. 201. Similarly, she agrees that a physician would be justified in refusing to assist a patient to do something "truly wrong." p. 84).

However, she immediately denies that physicians should be allowed to act on these principles. That would, she claims, "permit the physician's conscience to become a law unto itself" and

impose views on patients "with which they may reasonably disagree."(p. 201)

It would seem to follow from the author's reasoning that a physician must not be forced to provide a service he believes to be immoral, but must not be allowed to assess the morality of the service he is asked to provide. He is free to act on his conscience - except in questions of morality. This kind of incoherent conclusion is the result of the corrosive effect of the author's espousal of moral pluralism, which precludes any personal identification of *genuine* wrongdoing or *true* moral transgression. What begins as a high-sounding statement of moral principle at once dissolves into meaningless cant.

This incoherence also undermines her principal argument for maintaining moral diversity in the profession. As noted above, she posits that the debate engendered by such diversity will allow us to "siphon out the most accurate version of moral truth."(p. 85) But we cannot recognize "the most accurate version of moral truth" unless (a) moral truth exists, and (b) we least have an accurate idea of what it looks like. If moral truth does not exist, or if we cannot recognize it, no amount of debate within the profession will tell us whether or not we have "the most accurate version" of it.

The most plausible explanation for this lapse is anti-religious prejudice, if not against religion generally, then against religions that profess the kind of moral certitude that the author demonstrates when she denounces racial discrimination. Her position seems to be that moral absolutism is acceptable as long as it does not depend on religious belief.

81. John Paul II, *Encyc. Evangelium Vitae* (25 March, 1995) 74. (http://www.vatican.va/edocs/ENG0141/__PS.HTM) Accessed 2009-09-16) Fernandez Lynch describes this as "a powerful statement about the nature of conscience, complicity in morally objectionable actions, and avoidance of injustice," generally acceptable to religious and nonreligious people alike, regardless of their political views. Fernandez-Lynch, Holly, *Conflicts of Conscience in Health Care: An Institutional Compromise.* Cambridge, Mass.: The MIT Press, 2008, p. 1. (hereinafter "*Conflicts*.")

82. *Conflicts*, p. 33, 241, 257

83. Murphy, Sean, *Service or Servitude: Reflections on Freedom of Conscience for Health Care Workers.* (http://www.consciencelaws.org/Examining-Conscience-Ethical/Ethical48.html)

84. *Conflicts*, p. 256

85. *Conflicts*, p. 146, 165-193

86. To accomplish this, the author suggests that a designated institution ensure access to services through effective distribution of health care resources and connect patients with willing physicians. *Conflicts*, p. 14, 74-75, 97, 112, 146, 165-193

87. *Conflicts*, p. 24, 99, 256

88. *Conflicts*, p. 56, 80, 245

89. *Conflicts,* p. 129, 172

90. *Conflicts*, p. 167, 227. Note that she rejects the demand that all physicians should be made to achieve technical competence in the procedure. This requirement, too, would seriously undermine the compromise she proposes. *Conflicts*, p. 205

91. *Conflicts* , p. 75. She later cites a survey that found "four out of five women supported policies allowing individual pharmacists to refuse to dispense contraceptives when the pharmacy bore the obligation of assigning another employee to fill the prescription." The results were reversed when the obligation was removed. *Conflicts*, p. 104

92. *Conflicts*, p. 99

93. *Conflicts,* p. 84

94. However, the author perceptively notes that the pursuit of moral pluralism has generated conflict, which many have tried to avoid by forcing people "to restrict their beliefs to their personal lives." *Conflicts*, p. 22

95. *Conflicts*, p. 135

96. *Conflicts*, p. 85. That is because, she says, the moral questions involved often cannot be answered by "empirical testing or any other comprehensive doctrine for distinguishing right from wrong." (*Conflicts*, p. 84.) "No one can empirically prove that abortion kills a person with full moral status," she writes, "or that contraception is an offense against God." (*Conflicts*, p. 148) Similarly - though she does not say it - no one can, in her terms, prove that abortion does *not* kill a person with full moral status, or prove that contraception is *not* an offense against God.

97. *Conflicts*, p. 85.

98. Identifying Julian Savulescu and Rosamund Rhodes in particular. *Conflicts*, p. 58, 62

99. *Conflicts*, p. 101

100. *Conflicts*, p. 80

101. *Conflicts*, p. 206-207, 214

102. *Conflicts*, p. 87-88, 90-93

103. *Conflicts*, p. 10

104. *Conflicts*, p. 22-23

105. *Conflicts*, p. 80-81. "Society benefits from having morally serious people in the profession who are unwilling to just follow orders and who contribute to the rich moral debate that helps avoid blindly accepting the normative permissibility of whatever is technically possible and has not been legally prohibited." *Conflicts*, p. 86

106. Consider, as the author does, the Tuskegee study: almost 400 black men in Alabama, deceived and denied treatment for syphilis so that physicians could study the disease. *Final Report of the Tuskegee Syphilis Study Legacy Committee* (May 20, 1996). University of Virginia, Claude Moore Health Sciences Library. (http://www.hsl.virginia.edu/historical/medical_history/bad_blood/report.cfm) Accessed 2009-09-17.

She also refers to human experimentation on concentration camp inmates during the Holocaust (Lifton, Robert Jay, The Nazi Doctors: Medical Killing and the Psychology of Genocide. New York: Basic Books, 2000) and the participation of physicians in abusive interrogations and torture Conflicts, p. 82, citing Matthews, Richard G., "Indecent Medicine: In Defense of the Absolute Prohibition against Physician Participation in Torture," Am. J. Bioethics 6, no.3 (2006):W34

Or consider Canadian physicians, who, executing orders from the Alberta Eugenics Board, sterilized over 4,500 Albertans purported to be "mentally defective." Some of these people were also used as guinea pigs in drug tests and as sources of tissue for research. Marsh, James H., Eugenics: Keeping Canada Sane. *The Canadian Encyclopaedia* (http://www.thecanadianencyclopedia.com/index.cfm?PgNm=ArchivedFeatures&Params=A2126) Accessed 2009-09-17. *Muir v. The Queen in right of Alberta*, 132 D.L.R. (4th) 695. Court File No. 8903 20759, Edmonton, Alberta. Court of Queen's Bench, Veit J. January 25, 1996

107. *Conflicts*, p. 82. Instead, the author adopts the reasoning of attorney Howard Lesnick: "A polity that encourages its citizens to bring to bear their own serious moral reflections on the morally significant decisions they face will be more likely to grow in justice and humanity."

Lesnick argues that the "varying religious scruples" of individual professionals act as "a counsel of restraint" in the prevailing pluralist ethos, and that this has a broader social value. Lesnick, Howard, "The Religious Lawyer in a Pluralist Society," *Fordham Law Review* 66 (1998), 1469, 1489-1490. Lesnick, Howard, "The Religious Lawyer in a Pluralist Society," *Fordham Law Review* 66 (1998), 1469, 1489-1490. Quoted in *Conflicts*, p. 81. Fernandez Lynch identifies a social benefit provided by objecting physicians as their "counsel of restraint" in the face of demands spawned by technological developments. *Conflicts*, p. 81.

108. *Conflicts*, p. xii

109. All she offers is speculation that conscience is "a slippery concept," something in the way of an "ethical tug", a "motivator," some fuzzy feeling, or an "interior voice." *Conflicts,* p. 35, citing [n61, p 270] Eisgruber, Christopher L., Sager, Lawrence G. "The Vulnerability of Conscience: The Constitutional Basis for Protecting Religious Conduct." U. Chi. L. Rev. 61 (1994): 1245, 1291; "[T]he interior, quintessentially human voice that speaks to us of goodness

and duty, the voice we must obey if we are to keep our integrity." *Conflicts,* p. 35, quoting Hasson, Kevin Seamus, *The Right to be Wrong: Ending the Culture War over Religion in America*. San Francisco, CA: Encounter Books, 2005. p. 14.

110. *Conflicts*, p. xii

111. The author states that her solution "preserves the moral integrity of physicians in most circumstances."(*Conflicts*, p. 10) But how can we be sure of this, if we don't know what freedom of conscience is or how it relates to moral integrity? For example, having frequently referred to the importance of personal or moral integrity, the author nonetheless asserts that, in what she calls 'hard cases', the personal integrity of a physician "can be outweighed by the need for professional integrity." (*Conflicts*, p. 196-197) And what could "moral integrity" possibly mean within the context of moral pluralism?

112. *Conflicts*, p. 24, 99

113. *Conflicts*, p. 224

114. "Contract, social: The imaginary device through which equally imaginary individuals, living in solitude (or, perhaps, nuclear families) , without government, without a stable division of labour or dependable exchange relations, without parties, leagues, congregations, assemblies or associations of any sort, come together to form a society, accepting obligations of some minimal kind to one another, and immediately or very soon thereafter binding themselves to a political sovereign who can enforce those obligations." Honderich, Ted (Ed.) *The Oxford Companion to Philosophy* (2nd Ed.) Oxford: Oxford University Press, 2005. p. 174

115. *Conflicts*, p. 6, 10, 13, 43, 47, 49, 52, 54, 57, 58, 70-75, 86, 88-89, 111, 120, 123, 124, 132, 136,156, 197, 199, 207, 250

116. *Conflicts*, p. 13, 38-39, 43

117. *Conflicts*, p. 121-127

118. *Conflicts*, p. 127-129

119. *Conflicts*, p. 130-132

120. *Conflicts*, p. 133, 226-229

121. *Conflicts*, p. 133

122. 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. However, science cannot determine what moral obligations are called forth by the existence of a human being, nor can it 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. Irving, Dianne N., "When do Human Beings Begin? 'Scientific' Myths and Scientific Facts." International Journal of Sociology and Social Policy 1999, 19:3/4:22-47 (http://www.consciencelaws.org\Examining-Conscience-Background\GenScience\BackGenScience01.html)

123. Fernandez Lynch encountered this assertion more than once while researching the book, but does not appear to have recognized its significance. She cited a paper by the Project Administrator as an example of an unworkably broad understanding of "needs," apparently because the paper did not specifically define "needs." The point of the paper, however, (and the reason for the absence of the kind of definition she was seeking) is precisely the point here: that such a definition presumes some kind of underlying definition of the human person. *Conflicts*, p. 130-131; Murphy, Sean, *Freedom of Conscience and the Needs of the Patient.* Presented at the Obstetrics and Gynaecology Conference New Developments - New Boundaries in Banff, Alberta (November 9-12, 2001). (http:\\www.consciencelaws.org\Examining-Conscience-Ethical\Ethical23.html).

Exactly same point was made in a second paper [Murphy, Sean, *Service or Servitude: Reflections on Freedom of Conscience for Health Care Workers*. (http:\\www.consciencelaws.org\Examining-Conscience-Ethical\Ethical48.html)] cited and quoted twice by the author (*Conflicts*, p. 8, 256).

124. *Conflicts*, p. 14-15. This probably explains why Fernandez Lynch later applies a statement from Pope John Paul II in support of the polemical assertion that "physicians cannot be permitted to hold physicians hostage to their personal moral beliefs. (*Conflicts*, p. 99; p. 284, n.1; also referred to without citation at *Conflicts*, p. 14-15) "John Paul II observed that 'freedom of conscience does not confer a right to indiscriminate recourse to conscientious objection. When an asserted freedom turns into license or becomes an excuse for limiting the rights of others, the state is obliged to protect, also by legal means, the inalienable rights of its citizens against such abuses.'" The fragment of text chosen by the author is misleading because she has taken it is seriously out of context. Her claim that the Pope "was referring to the dangers of political fundamentalism in denying human rights" is a manifestly inadequate gloss of complex document about freedom of conscience. No on actually familiar with the writings and thought of John Paul II would have attempted such a spurious association. For the source (incorrectly cited by Fernandez Lynch) see John Paul II, *If You Want Peace, Respect the Conscience of Every Person*. Message for the XXIV World Day of Peace, 1 January, 1991. (http://www.vatican.va/holy_father/john_paul_ii/messages/peace/documents/hf_jp-ii_mes_08121990_xxiv-world-day-for-peace_en.html) Accessed 2010-05-26

125. Fernandez Lynch apparently sees the origin of the current controversy as a conflict between physician and patient autonomy, describing the patient autonomy movement as a "challenge to the autonomy of physicians." (*Conflicts*, p. 22) This is at least in part because some prominent commentators have explained it in those terms. Proponents of what she calls the "patient-centric" approach, she says, leave little or no room for physician autonomy (*Conflicts*, p. 61). In contrast, she quotes Edmund Pellegrino's assertion that an attack on physician

autonomy is an assault on ”an essential part of the person’s humanity. . .”. (*Conflicts*, p. 67, quoting Pellegrino, Edmund D., “Patient and Physician Autonomy: Conflicting Rights and Obligations in the Physician Patient Relationship,” J. Contemp. Health Law & Policy 10 (1993) 47, 58-59.) She focuses on finding ways to “protect the autonomy of both parties” and “preserve the autonomy of all interested individuals” (*Conflicts*, p. 87, 99). When she argues for that objecting physicians should violate their convictions in hard cases, she appeals to the principle of autonomy: their autonomous decision to enter the profession, and the lesser autonomy of patients (*Conflicts*, p. 196-198). Similarly, she justifies limitations on freedom of conscience by describing them as “essential to the protection of patient autonomy, safety or serious medical interests.”(*Conflicts*, p. 229*)* It is significant that the author repeatedly emphasizes the need to preserve autonomy rather than integrity, and places autonomy - not integrity - on par with safety and “serious medical interests.” The author’s views reflect the dominant position that autonomy has achieved in contemporary thought.

126. When working out the ethical problem of conscientious objection in hard cases, the author conducts the discussion entirely within the framework of autonomy and choice, concluding that freedom of conscience should be subordinated when it is necessary to preserve freedom of choice for the patient. (*Conflicts*, p. 196-199) Elsewhere she asserts that patient choice must not be compromised by physician views about what services are appropriate or optimal.(*Conflicts*, p. 203)

127. In the author’s case, consider her prejudice against religious beliefs that purport to be based on absolute standards of right and wrong. (*Conflicts*, p. 23-24)

128. The author refers to the importance of “moral autonomy” *Conflicts*, p. xiii-xiv, 7, 196) and agrees with John Rawls that moral pluralism is beneficial because it permits individuals “to pursue their own conceptions of the good.” (*Conflicts*, p. 22) The tendency of the law to identify religious belief as an expression of personal autonomy is discussed in Berger, Benjamin, L., Law's Religion: Rendering Culture. *Osgoode Hall Law Journal*, Vol. 45, No. 2. (http://papers.ssrn.com/sol3/papers.cfm?abstract_id=961031) Accessed 2009-09-22. This is also discussed in Brown, Mr. Justice David, *The Courts' Spectacles: Some Reflections on the Relationship between Law and Religion in Charter Analysis - Reasonable Accommodation and Role of the State: A Democratic Challenge.* CIAJ Conference, 24 September, 2008, Quebec City. (http://www.consciencelaws.org\Examining-Conscience-Legal\Legal46.html).

129. The author describes monopoly control of power as characteristic of professionalism (*Conflicts*, p. 10, 69-70, 79, 86, 132, 214), and identifies power and admiration as forms of compensation formerly paid to physicians as part of a purported social contract (*Conflicts*, p. 46). Physician power is offered as one of the explanations for the comparatively recent development of controversy about freedom of conscience in health care (*Conflicts*, p. 19), and resistance of physicians to the patient autonomy movement is explained as an attempt by the profession “to reclaim some of its lost power.” (*Conflicts*, p. 22) The author validates professional ethics to the extent that they have “developed as part of the negotiation of power with the public.” (*Conflicts*, p. 136)

130. Hence the centrality of social contract theory in the author's approach.

131. The author asserts that failure to obtain the consent of the victims is "a major reason" for the historical and professional condemnations of the conduct of Nazi physicians during the Holocaust and of American researchers involved in the Tuskegee experiment, though this is not stated clearly as her own view. (*Conflicts*, p. 82) She questions the idea that consent is always sufficient to justify a procedure, but the discussion is inconclusive. (*Conflicts*, 83). However, when she later justifies the suppression of what she calls the "moral autonomy" of an objecting physician in a hard case, she does so precisely because of the physician's alleged implied consent to subordinate his "personal integrity" to "professional integrity" upon entering the profession. Alternatively, she alleges that he has a duty to consent in such circumstances. (*Conflicts*, p. 196-197) This seems inconsistent with her earlier rejection of the "consent paradigm" of medical professionalism (Conflicts, p. 48-57) That conclusion, however, was based on her belief that physicians could not be shown to have consented to meet all patient demands, not on rejection of the notion of justification by consent.

132. Canada's Chief Justice based a right to assisted suicide (distinguished from murder only by consent) on the fundamental importance of individual autonomy and self-determination" and "the promotion of individual autonomy." *Re: Rodriguez and Attorney-General of British Columbia et al; British Columbia Coalition of People with Disabilities, et al, Intervener*, 107 DLR (4th) 342, Supreme Court of Canada

133. *Conflict*s, p. 223

134. Thus, the author claims that if a large number of physicians were to refuse to provide services demanded by the public, they would act improperly by exercising legislative power without the consent of the governed. (*Conflicts*, p. 69) It would, she asserts, be "an illegitimate imposition of views" on those who disagree. (*Conflicts*, p. 86) Similarly, she describes conscientious objection in hard cases as a political act that usurps legitimate government authority. (*Conflicts*, p. 201)

135. The author appears to accept the view that there is no moral equality (of persons) in the absence of a balance of power (*Conflicts*, p. 198, quoting Fenton and Lomasky). "T]he power imbalance inherent in the doctor-patient relationship," (*Conflicts*, p. 238) has become a dominant theme not only in the medical profession, but in other disciplines. Consider, for example, the themes of power and control reflected in the philosophy of the McMaster University School of Social Work: "As social workers, we operate in a society characterized by power imbalances that affect us all. These power imbalances are based on age, class, ethnicity, gender, geographic location, health, physical ability, race, sexual preference and income. We see personal troubles as inextricably linked to oppressive structures. We believe that social workers must be actively involved in the understanding and transformation of injustices in social institutions and in the struggles of people to maximize control over their own lives."
(http://www.socsci.mcmaster.ca/socwork/) Accessed 2007-11-13

136. Arendt, Hannah, "Ideology and Terror: A Novel Form of Government." The citations and quotes attributed to her are from this chapter, which was added to the 1958 edition of her 1951 book, *The Origins of Totalitarianism.*
(http://www.cooper.edu/humanities/core/hss3/h_arendt.html) Accessed 2007-11-08

137. *The Universal Declaration of Human Rights*, Article 18. Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance.
(http://www.un.org/en/documents/udhr/) Accessed 2009-12-11

138. Maritain, Jacques, *Man and the State*. Chicago: University of Chicago Press, 1951, p. 77

139. Maritain, Jacques, *Man and the State*. Chicago: University of Chicago Press, 1951, p. 77-78

140. Maritain, Jacques, *Man and the State*. Chicago: University of Chicago Press, 1951, p. 110

141. John Paul II, Encyclical *Centesimus Annus* (1991) 46.
(http://www.vatican.va/holy_father/john_paul_ii/encyclicals/documents/hf_jp-ii_enc_01051991_centesimus-annus_en.html) Accessed 2007-11-15

142. Lewis, C.S., *Screwtape Proposes a Toast and Other Pieces*. London and Glasgow: Collins (Fontana Books) 1974, p. 18, 25

143. Brown, Mr. Justice David, *The Courts' Spectacles: Some Reflections on the Relationship between Law and Religion in Charter Analysis - Reasonable Accommodation and Role of the State: A Democratic Challenge.* CIAJ Conference, 24 September, 2008, Quebec City.
(http://www.consciencelaws.org\Examining-Conscience-Legal\Legal46.html)

144. Maritain, Jacques (John J. Fitzgerald, trans.) *The Person and the Common Good*. Notre Dame, Indiana: University of Notre Dame Press, 2002, p. 36, 43, 45

145. King, Martin Luther, Sermon: *The Three Dimensions of a Complete Life.* New Covenant Baptist Church, Chicago, Illinois, 9 April 1967.
(http://www.stanford.edu/group/King/publications/sermons/670409.000_The_Three_Dimensions_of_a_Complete_Life.htm) Accessed 2005-08-02.

"[W]e must remember that it's possible to affirm the existence of God with your lips and deny his existence with your life. . . . We say with our mouths that we believe in him, but we live with our lives like he never existed . . . That's a dangerous type of atheism." King, Martin Luther, Sermon: *Rediscovering Lost Values*. 2nd Baptist Church, Detroit 28 February, 1954
(http://www.stanford.edu/group/King/publications/sermons/540228.001_Rediscovering_Lost_Values.html) Accessed 2005-08-02.

146. He emphasized that, for even the poorest and most downtrodden man, to be a human person "involves . . .totality and independence." Maritain, Jacques (John J. Fitzgerald, trans.) *The Person and the Common Good*. Notre Dame, Indiana: University of Notre Dame Press, 2002, p. 59; Maritain, Jacques (Doris C. Anson, trans.) *The Rights of Man and Natural Law*. New York: Gordian Press, 1971, p. 3, 9

147. Maritain, Jacques (Doris C. Anson, trans.) *The Rights of Man and Natural Law*. New York: Gordian Press, 1971, p. 3-4

148. Somerville, Margaret, *Death Talk: The Case Against Euthanasia and Assisted Suicide*. Montreal & Kingston: McGill-Queens University Press, 2001, p. 191-192.

149. Maritain, Jacques (Doris C. Anson, trans.) *The Rights of Man and Natural Law*. New York: Gordian Press, 1971, p. 3.

150. Maritain, Jacques (Doris C. Anson, trans.) *The Rights of Man and Natural Law*. New York: Gordian Press, 1971, p. 18.

151. Maritain, Jacques (John J. Fitzgerald, trans.) *The Person and the Common Good*. Notre Dame, Indiana: University of Notre Dame Press, 2002, p. 71; Maritain, Jacques (Doris C. Anson, trans.) *The Rights of Man and Natural Law*. New York: Gordian Press, 1971, p. 14.

152. Maritain, Jacques (John J. Fitzgerald, trans.) *The Person and the Common Good*. Notre Dame, Indiana: University of Notre Dame Press, 2002, p. 73; Maritain, Jacques (Doris C. Anson, trans.) *The Rights of Man and Natural Law*. New York: Gordian Press, 1971, p. 15-17, 76.

153. Maritain, Jacques (Doris C. Anson, trans.) *The Rights of Man and Natural Law*. New York: Gordian Press, 1971, p. 11.

154. Maritain, Jacques (John J. Fitzgerald, trans.) *The Person and the Common Good*. Notre Dame, Indiana: University of Notre Dame Press, 2002, p. 58.

155. Maritain, Jacques (Doris C. Anson, trans.) *The Rights of Man and Natural Law*. New York: Gordian Press, 1971, p. 65.

156. Maritain, Jacques (Doris C. Anson, trans.) *The Rights of Man and Natural Law*. New York: Gordian Press, 1971, p. 65.

157. Joad, C.E.M., *Guide to the Philosophy of Morals and Politics*. London: Gollancz Ltd., (1938), p. 803. Quoted in *R. v. Morgentaler* (1988)1 S.C.R 30 at p. 178. (http://scc.lexum.umontreal.ca/en/1988/1988rcs1-30/1988rcs1-30.html) Accessed 2008-09-10.

158. Joad, C.E.M., *Guide to the Philosophy of Morals and Politics*. London: Gollancz Ltd., (1938), p. 805. Cited in *R. v. Morgentaler* (1988)1 S.C.R 30 at p. 178.

(http://scc.lexum.umontreal.ca/en/1988/1988rcs1-30/1988rcs1-30.html) Accessed 2008-09-10. See Maritain, Jacques, *Man and the State.* Chicago: University of Chicago Press, 1951, p. 13.

159. Lewis, C.S., "The Humanitarian Theory of Punishment." In Hooper, Walter (Ed.) *C.S. Lewis: First and Second Things*. Glasgow: William Collins & Sons, 1985, p. 101.

160. King, Martin Luther, *Letter from Birmingham Jail*, 16 April, 1963. (http://www.nobelprizes.com/nobel/peace/MLK-jail.html) Accessed 2005-08-02.

161. Wojtyla, Karol, *Love and Responsibility*. San Francisco: Ignatius Press, 1993, p. 27.

162. Kant, Immanuel, *Fundamental Principles of the Metaphysic of Morals*. (http://www.gutenberg.org/dirs/etext04/ikfpm10.txt) Accessed 2008-09-10. Quoted in *The Internet Encyclopedia of Philosophy*, "Immanuel Kant (1724-1804) Metaphysics" (http://www.iep.utm.edu/k/kantmeta.htm) Accessed 2008-09-10.

163. *R. v. Morgentaler* (1988)1 S.C.R 30 (Supreme Court of Canada) (http://scc.lexum.umontreal.ca/en/1988/1988rcs1-30/1988rcs1-30.html) Accessed 2008-09-10.

164. *R. v. Morgentaler* (1988)1 S.C.R 30 (Supreme Court of Canada) (http://scc.lexum.umontreal.ca/en/1988/1988rcs1-30/1988rcs1-30.html) Accessed 2008-09-10.

165. *R. v. Morgentaler* (1988)1 S.C.R 30 (Supreme Court of Canada) (http://scc.lexum.umontreal.ca/en/1988/1988rcs1-30/1988rcs1-30.html) Accessed 2008-09-10.

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