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Submission to the College of Physicians and Surgeons of Alberta

Re: CPSA Draft Standards of Practice

8 October, 2008

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Abstract

The primary issue raised by the *Draft Standards* is whether or not a physician should be compelled to provide or facilitate a service or procedure he believes to be wrong. Put another way, does a physician's refusal to provide or facilitate something he believes to be wrong constitute professional misconduct?

A number of suggested responses to the issue are inadequate.

Despite the fact that a 'right' to abortion cannot be found in existing international instruments, current rights claims are meant to force health care workers and institutions to provide or at least facilitate abortion, contraception, and artificial reproduction. The polemics and tendentious reasoning involved in this project are disturbing. However, even if claims of 'rights' to abortion or contraception can be grounded in rights purportedly implicit in international instruments, it does not follow that they override the repeated explicit international recognition and support for freedom of conscience and religion.

It is not reasonable to address the issue by proscribing the public manifestation of religious belief. All beliefs influence public behaviour. Some of these beliefs are religious, some not, but all are beliefs. Disputes about morality are always, at the core, disputes between people of different beliefs, whether or not those beliefs are religious. The failure to acknowledge the faith-assumptions implicit in one's own position frequently leads to intolerance for opposing views, and it always makes sincere, respectful and progressive public discourse difficult.

To insist that physicians conform to a dominant 'consensus' is unacceptable, since such agreements are typically achieved by taking into account only opinions consistent with ethical, moral or religious presuppositions that are congenial to a dominant elite. The resulting 'consensus' is, in reality, simply the majority opinion of like-minded individuals, not a genuine ethical synthesis reflecting common ground with those who think differently.

To identify beliefs as 'private' or 'personal' does not help to resolve a question about the exercise of freedom of conscience. Disputes about what counts as 'private' or 'public' thus end in a stalemate.

Theories of 'contract' and 'covenant' are inadequate and can be oppressive when used as a basis for limiting freedom of conscience among health care workers. Even if one posits the existence of a 'contract' through the implementation of public health care, the suppression of freedom of conscience among health care workers was not, in fact, one of the elements in the agreement. Further: when abortion was legalized, repeated assurances were given that health care workers would not be forced to participate in the procedure. Finally, if physicians can be considered state employees, they are entitled to the same accommodation of freedom of conscience and religion to the point of undue hardship.

It is said that the fiduciary nature of the physician-patient relationship requires suppression of a physician's freedom of conscience, but this is oversimplified. The relationship is 'fiduciary' for some purposes, but not for others. No one has ever suggested that the fiduciary obligations of parents, husbands, attorneys, confessors, and guardians require them to sacrifice their own integrity to the "desires" of others, nor do physicians have such a duty.

The claim that a principled refusal to refer amounts to abandonment is not tenable. One can argue that a physician who urgently recommends a procedure to a patient has a duty to do all that he reasonably can to help the patient obtain it, and that the failure to do so might constitute negligence or abandonment. However, the same cannot be said if a physician, for reasons of conscience, refuses to recommend a procedure at all.

The fact that a procedure is legal does not impose a duty on physicians or on the profession to provide it. This is illustrated by official support for refusal to facilitate sex-selective abortion, official prohibition of physician participation in legal executions, and in the fact that surgeons are not required to amputate healthy limbs on demand.

It is not possible to balance a desire for a procedure against a physician's desire to avoid complicity in wrongdoing and live and work according to his conscientious convictions because the desires concern fundamentally different goods that are not commensurable. It may be possible to accommodate both, but the desires cannot be 'balanced.'

The statement that mandatory referral can be justified as a kind of limit to freedom would compel physicians to serve ends chosen by someone else even if he finds them abhorrent. This is a form of servitude, not service.

It is reasonable to hold that the kind of action involved in referral is the same kind of action that is defined as "participation" in professional policies prohibiting physician participation in executions and torture. The model provided by these policies indicates that, in principle, at least, it is not unreasonable for physicians to refuse to refer patients for procedures to which they object for reasons of conscience, on the grounds that referral would make them complicit in a wrongful act. This conclusion is supported by the *Draft Standards* themselves and by advice given by the Canadian Medical Protective Association.

When people cannot achieve a consensus about the morality of a procedure or about freedom of conscience for health care workers, it is frequently because they are operating from different beliefs about the nature of the human person. The failure to engage at this level will probably frustrate more superficial efforts to resolve disagreements.

A long philosophical tradition, stretching from at least Immanuel Kant to *R. vs. Morgentaler* and beyond, insists that the nature of the human person is such no one should be exploited by another by being reduced to the status of a tool or thing: that it is reprehensible to use a human person for ends chosen by others. Within this tradition, self-sacrifice, has never been understood to include the sacrifice of one's integrity. To abandon one's moral or ethical convictions in order to serve others is prostitution, not professionalism.

In the tradition of Kant, C.S. Lewis, Martin Luther King, Cyril Joad and Karol Wojtyla, and following Madame Justice Wilson in *R. vs. Morgentaler*, to demand that physicians provide or assist in the provision of procedures or services that they believe to be wrong is to treat them as means to an end and deprive them of their "essential humanity."

The *Draft Standards* [Parts 5(4), 6(1), 6(2), 7(2)a, 8(1) and 32(2)d] should be revised to ensure that the document cannot be used for this purpose.

I. Introduction

- I.1. The *Draft Standards of Practice* were published the day that news broke about a draft College of Physicians and Surgeons of Ontario policy, *Physicians and the Human Rights Code*. In the course of the ensuing controversy it became clear that the principal threat to freedom of conscience and religion for physicians emanates from human rights commissions rather than from Colleges of Physicians. Nonetheless, *Standards of Practice* being considered by the College of Physicians and Surgeons of Alberta warrant careful scrutiny in view of the news from Ontario and developments in Alberta and elsewhere.
- I.2. This submission addresses only those parts of the *Draft Standards* that could be applied to restrict or suppress the exercise of freedom of conscience of physicians in Alberta.

II. *Draft Standards in focus*

Establishing and terminating physician-patient relationships

- II.1 Dealing first with lesser issues, a physician is entitled to restrict the scope of his practice to exclude provision or facilitation of procedures or services he believes to be wrong. This may be relevant to patient selection. It should be made clear that a physician may refuse to accept a patient when it can be reasonably foreseen that an irreconcilable conflict will arise as a result of patient expectations or demands that would compromise the moral integrity of the physician. [Ref. Part 6(1)] Physicians who decline to accept a patient in such circumstances are not discriminating against the patient on prohibited grounds. Their concern is to avoid direct or indirect complicity in wrongdoing and undesirable conflict with patients, not with the personal characteristics or status of a patient. [Ref. Part 6(2)]
- II.2 If an irreconcilable conflict arises as a result of patient expectations or demands that would compromise the moral integrity of the physician, it is in the best interests of both physician and patient that the patient's care be transferred to another physician. Again, physicians who discharge of a patient in such circumstances are not discriminating against the patient on prohibited grounds. Their concern is to avoid direct or indirect complicity in wrongdoing, not with the personal characteristics or status of a patient. [Ref. Part 7(2)a]

Referral

- II.3 While a patient's reasonable request for a referral should normally be honoured, it is not reasonable to demand a referral to other health care professionals for procedures or services the physician believes to be wrong. A physician's refusal to do so should not be considered a breach of the *Standards*. [Ref. Part 5(4)]

Termination of pregnancy and birth control

- II.4 In order to preserve the right of patients to make informed decisions, physicians who believe that termination of pregnancy or some forms of birth control are not an appropriate or wise medical choice generally do not object to providing information about the procedures or methods. These physicians, however, retain the freedom to express the rationale for their reservations without exerting any emotional manipulation so that the patient clearly understands why the physician is providing the specific advice, and understands that the

advice is not based on an attitude of intolerance, disrespect or paternalism towards the patient.

- II.5 However, the requirement that a physician “ensure that the patient. . . is offered access to available medical options” is likely to be interpreted to impose a duty to refer for or otherwise facilitate procedures or services the physician believes to be wrong. Many objecting physicians would find this unacceptable. [Ref. Part 8(1)]

Duty to report a colleague

- II.6 The *Draft Standards* include a duty to report colleagues for conduct that “could place patients at risk or could generally be considered unprofessional conduct.” Among the examples of unprofessional conduct is that of a physician who “repeatedly or consistently behaves in a manner that interferes with the delivery of care to patients or the ability of other physicians or health care professionals to provide care to patients.”
- II.7 In view of the ongoing controversy over the exercise of fundamental freedoms of conscience and religion by physicians, the *Draft Standards* should make clear that this Part does not require or justify reporting a colleague who restricts the scope of his practice to exclude provision or facilitation of procedures or services he believes to be wrong. [Ref. Part 32(2)d]
- II.8 The key problem that arises in each of the draft provisions noted above is an apparent expectation that a physician facilitate something he believes to be wrong, either by providing the procedure or service directly, or by referring or otherwise assisting a patient to obtain it.

III. The issue

- III.1 The primary issue raised by the *Draft Standards* is whether or not a physician should be compelled to provide or facilitate a service or procedure he believes to be wrong. Put another way, does a physician’s refusal to provide or facilitate something he believes to be wrong constitute professional misconduct?
- III.2 The potentially problematic provisions of the CPSA *Draft Standards* noted in Part II are a particular cause for concern, not only because of recent developments in Ontario, but because they have been preceded by repeated efforts to compel health care workers to directly or indirectly participate in abortion. It is instructive to review this background before responding to the issue.

IV. Background

Alberta

- IV.1 While nurses in Alberta and elsewhere have been forced to participate directly in abortions,¹ direct participation of physicians in the procedure has not yet been required. However, since at least 1999, there have been repeated attempts to force physicians to facilitate the procedure through referral.
- IV.2 In September, 1999, Dr. E. Kretzul, a Councillor of the College, published a note in *The Messenger* in which he claimed that referral was an ethical obligation:

The College sometimes hears about physicians who are not supportive of patients requesting information or a referral regarding termination of pregnancy. In fact, individuals have informed the College that some physicians are rude and bullying to patients. . . In those circumstances where our personal morality would influence our ability to help our patient, we should refer the patient appropriately and provide all the necessary information and opportunities available.²

IV.3 The column drew a sharp retort from the President of Canadian Physicians for Life:

. . .if abortion seekers have complained of being bullied, has the College conducted diligent enquiries into such serious accusations? What was the outcome? Or is polemical hearsay the College's new standard of evidence when the target is pro-life doctors?

In plain English, independent medical professionals have no duty to refer anyone to anyone when the referral would violate the conscience and the medical good judgement of the professional. This elementary conscience protection impartially shields doctors who possess any convictions on any topic at all.³

IV.4 The Assistant Registrar of the College later admitted that complaints about physician 'moralizing' were largely hearsay "from groups who provide birth control and family planning counselling to women." First-hand accounts from individual patients were a "distinct minority" of the total.⁴

IV.5 In 2001, Planned Parenthood Alberta - coincidentally, perhaps, one of those "groups who provide birth control and family planning counselling to women" - claimed that "doctors ethically must make referrals for abortion services, whether they morally support that or not."⁵ Again, the statement was rejected by Canadian Physicians for Life:

Our correspondence with Alberta College of Physicians and Surgeons registrar, Dr. Ohlhauser, states clearly that physicians do not have a professional obligation to refer a patient for an abortion. The College requires, as does the Code of Ethics of the Canadian Medical Association, that physicians "inform a patient when their personal morality would influence the recommendation or practice of any medical procedure that the patient needs or wants."⁶

IV.6 Planned Parenthood Alberta returned to the issue again in 2004.

Guidelines from the Alberta College of Physicians and Surgeons require all doctors to provide women with information "on all options for their pregnancies including termination (abortion)" or they must refer them to another appropriate doctor or clinic. . .⁷

IV.7 Note that the previous demand for referral for the procedure had evolved into a demand for

referral for the purpose of providing a patient with “information.” The Project Administrator questioned the Assistant Registrar of the College about the meaning of this guideline:

It appears the College expects the communication of a diagnosis of pregnancy to be managed in the same way the physician would communicate a diagnosis of disease: by volunteering information about ‘treatments’ available. If I understand your policy correctly, a physician must tell a pregnant woman that she can have an abortion or put the child up for adoption, whether or not the woman has indicated an interest in either.

. . . am I correct in believing that the College requires that physicians present abortion, adoption and carrying to term as morally equivalent options? If so, it would seem to follow that the College expects a physician who is unwilling to present them as moral equivalents to ‘refer’ to another physician who will do so.⁸

IV.8 The Assistance Registrar’s answer:

Those women who plan to carry to term but not keep the child, and those seeking abortion are generally clear in expressing their choices.

Without getting into the issue of “moral equivalence” it is not our expectation that physicians will suggest to all newly pregnant women their various options including abortion and adoption.⁹

IV.9 The Administrator advised the Assistant Registrar that this approach did not seem objectionable from the perspective of freedom of conscience, and correspondence came to an end.

IV.10 The 2004 missive from Planned Parenthood opened with the following generalized smear:

There are doctors and radiologists in almost every community in Alberta who do not support a woman's right to reproductive choice. They may try to delay you from seeking appropriate services or they may scare you with misinformation about the dangers of abortion or they may impose their moral beliefs about abortion. . .¹⁰

IV.11 This kind of accusation can be unfairly made against conscientious objectors to abortion who, following guidelines from the Canadian Medical Association (CMA) and College of Physicians and Surgeons of Alberta (CPSA) inform their patients about their moral or ethical views so that the patient can seek another physician, and provide information relevant to making an informed choice about treatment options.

IV.12 In following these guidelines an objecting physician must, at all times, be respectful of the patient’s dignity, and must not be threatening, overbearing or abuse his authority by preaching or moralizing in order to influence his patient’s decision. On the other hand, objecting physicians can hardly be expected to present morally controversial procedures as

morally *uncontroversial*, or in such a way as to indicate that they approve of them or are indifferent to them (i.e., to adopt a ‘neutral’ position). Moreover, the information they reasonably believe necessary to permit the patient to make a truly “informed decision” may be more comprehensive or in other respects different from what Planned Parenthood is accustomed to provide its clients.

- IV.13 A third party hearing of this kind of exchange at second-hand, especially someone “from groups who provide birth control and family planning counselling to women,” might well stigmatize the discussion as ‘moralizing’ and providing ‘misinformation’. Partisan polemics of this sort do not provide a basis for sound policy making.

Canada

- IV.14 In late October, 2004, a student at the University of Ottawa reported that the former Dean of the Faculty of Law, Sanda Rodgers, told a group of second year students that a physician is required by law to refer patients for abortion, even if the physician objects to the procedure for reasons of conscience. The Project Administrator wrote to the Dean of the Faculty of Medicine at the University to express concern that students may have been misled.¹¹ The Dean responded to the effect that Professor Rodgers cited both the CMA position on induced abortion and the CMA Code of Ethics, neither of which require referral for abortion. “I have no reservations in concluding that Professor Rodgers has maintained equipoise in presenting this material,” he wrote, “and that no students, as you suggest, were misled.”¹²
- IV.15 However, in July, 2006, Rodgers co-authored a controversial guest editorial in the *Canadian Medical Association Journal* in which the authors asserted that refusal to refer for abortion constituted malpractice and could lead to “lawsuits and disciplinary proceedings.” This was apparently the same message said to have been delivered by Professor Rodgers to the students in 2004.¹³ The co-author was Jocelyn Downie of the Health Law Institute, Dalhousie University, Halifax, an advisor to the interim editorial board of the CMAJ.¹⁴
- IV.16 The position taken in the editorial was rejected by a number of correspondents, including the Canadian Medical Association.¹⁵ Nonetheless, Rodgers and Downie continued to assert that the CMA Policy on Induced Abortion “does not allow a right of conscientious objection in relation to referrals.”¹⁶ Their insistence on the significance of their interpretation of CMA policies is remarkable in view of a previous statement by Downie: “An individual’s conscience must always inform his or her action even in the presence of a professional code, standards or guidelines.”¹⁷
- IV.17 Other Canadian law professors, notably Rebecca J. Cook and Bernard M. Dickens, have also claimed that objecting physicians must refer patients for procedures or services they believe to be wrong. Writing in 2003 in the *Journal of Obstetrics and Gynaecology Canada* they stated: “Physicians who feel entitled to subordinate their patient’s *desire* for well-being to the service of their own personal morality or conscience should not practise clinical medicine”¹⁸ (Emphasis added). They cited an Alberta case in support of their claim that a failure to refer is negligence close to abandonment.¹⁹ The case is also cited by Dickens in a standard Canadian text on health law.²⁰

IV.18 The assertion that a patient's *desire* should be an ordering principle in the practice of medicine has little to recommend it. More important, the arguments of Professors Cook and Dickens for mandatory referral were unsupported and even contradicted by their own legal and ethical references. Regulatory officials with the power to enforce the views of Cook and Dickens will not discover this in the pages of the *Journal*, since, by editorial fiat, the discussion was terminated with the publication of their 'final word' on the subject.²¹

V. Responding to the issue

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

V.2 A physician who refuses to facilitate what he believes to be wrong is motivated by a desire to avoid complicity in wrongdoing. Part XVI addresses this problem and demonstrates that physicians who refuse to refer for abortion, birth control or other morally controversial procedures are, in this respect, acting no differently than colleagues and professional medical organizations.

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

VI. The new 'rights' language

VI.1 Cook and Dickens, with Downie, Rodgers and others, are using 'rights' language, but not the 'rights' language of the 1960's, when abortion law reform was proposed. When the National Association for the Repeal of Abortion Laws opened its doors in the United States in 1969, the claim that abortion was a 'right' was directed only at the repeal of laws against the procedure, so that women would be free to seek abortions and, as the *Globe and Mail* put it, so that physicians would be able "to perform their duties according to their conscience and their calling."²² At that time, Canadians were repeatedly assured that "nobody would be forcing abortion procedures on anyone else."²³

VI.2 Current rights claims must be distinguished from this early period. Contrary to early activist promises, current rights claims are meant to force health care workers and institutions to provide or at least facilitate abortion, contraception, and artificial reproduction, all of which remain morally controversial. A major 'mover and shaker' in this project is the Center for Reproductive Rights,²⁴ an American advocacy group described in internal documents as an organization "comprised largely of economically advantaged white women."²⁵ The Center's agenda includes, among other things, the legal enforcement of what it describes as inalienable sexual rights.²⁶

VI.3 The Center's ultimate goal is to establish what it calls "hard norms" - treaty-based international laws²⁷ - that recognize access to abortion as a fundamental human right.²⁸ It

plans to develop a “culture of enforcement” that will compel governments to respect this ‘right’²⁹ and enforce it against third parties - physicians and other health care workers.³⁰ Even as it works toward this end, it is cultivating “soft norms” in the form of statements by international, regional, and intergovernmental bodies.³¹ Professor Dickens attempt to turn conscientious objection into a crime against humanity illustrates how this can be done (See Appendix “A”).

- VI.4 Should the Center be successful it acknowledges that it will have effected “profound social change.”³² It will also have destroyed almost all hope of respect for freedom of conscience in health care. For if refusal to facilitate abortion or other morally controversial procedures were to become, in law, an offence like racial discrimination, conscientious objection would be prohibited, just as racial discrimination is now prohibited.³³
- VI.5 Cook, Dickens, Downie, Rodgers and the Ontario Human Rights Commission appear to be employing the strategy advocated by the Center. Special attention should thus be paid to key features of the Center’s strategy, notably its focus on securing a following among social, political, academic and professional elites.³⁴ The medical profession is one of the “key sectors” that figures prominently in this strategy;³⁵ so, too, does the legal community.³⁶ The approach is summed up in the Center’s question, “How can we influence the people who influence the legal landscape around reproductive rights?”³⁷

The courtship of the elites

- VI.6 The courtship of the elites occurs in academic, professional and bureaucratic communities, largely out of the public eye, thus avoiding what one memo calls “nasty opposition.”³⁸ This is especially important if professionals and academics may be more sympathetic to the CRR agenda than ordinary people.³⁹ An internal memo values the “stealth quality to the work,” through which the Center achieves “incremental recognition of values without a huge amount of scrutiny from the opposition.”⁴⁰
- VI.7 Despite an admission that a ‘right’ to abortion cannot be found in existing international instruments, the Center and its allies argue that it is implicit in other internationally recognized rights, such as the right to life, liberty and security, and rights to privacy and freedom from discrimination.⁴¹ They hope to secure “hard norms” by having binding treaties or protocols interpreted in this way,⁴² in the expectation that other adjudicators will find such rulings persuasive.⁴³
- VI.8 The Center’s cultivation of “soft norms” is a very similar process, but takes place not only in adjudicative bodies but in international conferences that produce non-binding but persuasive opinions.⁴⁴ As “soft norms” quietly accumulate it becomes easier for the Center to claim that they represent an emerging consensus that should be codified in binding “hard norms.”⁴⁵ The development of “soft norms” is of great moment for freedom of conscience in health care because they will likely have the most immediate impact on conscientious objectors.
- VI.9 Professional associations, educational and regulatory authorities and influential individuals can support the CRR’s work by developing “soft norms” closer to home - like the CPSA’s *Draft Standards of Practice*. Colleagues or academics will argue that the provision of

abortion or, at least, referral for abortion, is an expected or even legally required standard of care. Ethicists and professional journals not infrequently express opinions hostile to freedom of conscience, as do individual health care practitioners.⁴⁶ One even encounters unsubstantiated claims and dubious or false statements about the actions or ethical obligations of conscientious objectors.⁴⁷

- VI.10 If such claims are repeated often enough by influential persons - like College councillors, law professors, or former deans of law faculties - even if the claims are false or exaggerated - they gradually assume the character of a new norm. Ideally, this new norm will be implemented by the disciplinary apparatus of self-governing professions as a standard of care: first, by pressure, in the form of pointed suggestions, informal cautions and official guidance, later, in documents like the present *Draft Standards of Practice*.
- VI.11 If an objecting physician is charged for misconduct, it is quite likely that members of the professional tribunal hearing the case will have already been convinced of the new rights-based standard of care, or will have been prepared to accept the claims of experts called to testify to it. Should they ratify it by ruling against the objector, they will create a new “soft norm” that the CRR and its allies can use elsewhere in their continuing quest for international “hard norms.” It might added that the establishment or confirmation of even a “soft” norm would be oppressive in the jurisdiction bound by the decision.
- VI.12 Parallel litigation can also be initiated in quasi-judicial forums, like human rights tribunals, which, in Canada, afford complainants the advantage of cost-free, aggressive inquisitions with extraordinary powers.
- VI.13 Those concerned about freedom of conscience and religion should take note of the polemics and tendentious reasoning involved in this project (see Appendix “A”). In particular, even if claims of ‘rights’ to abortion or contraception can be grounded in rights purportedly implicit in international instruments, it does not follow that they override the repeated explicit international recognition and support for freedom of conscience and religion.

VII. Belief: religious and otherwise

Claim

- VII.1 It has become an article of faith with many, especially many holding public positions, that faith has no place in public and professional life. A convenient example is found in the dogmatic assertion by the Ontario Human Rights Commission (OHRC) of its belief that physicians “must essentially ‘check their personal views at the door’ in providing medical care.”⁴⁸ The same kind of claim has been made by the American College of Obstetrics and Gynecology through the opinion expressed by its Ethics Committee, which argues that “professional responsibilities to patients . . . must precede a provider’s personal interests” and insists that physicians are obliged to refer for morally controversial procedures and may have to personally provide them.⁴⁹
- VII.2 The more blatant OHRC claim calls to mind comments made by Dr. James Robert Brown in 2002. A professor of science and religion of the University of Toronto, Dr. Brown offered a

simple solution for health care workers who don't want to be involved with things like abortion or contraception. These "scum" - that was his word - should "resign from medicine and find another job." His reasoning was very simple.

Religious beliefs are highly emotional - as is any belief that is affecting your behaviour in society. You have no right letting your private beliefs affect your public behaviour.⁵⁰

Response

- VII.3 When Dr. Brown declared that no one should be allowed to let private belief affect public behaviour, he was doing precisely that. He was acting publicly upon *his* private belief that conscientious objectors in health care should not be allowed to act publicly upon *theirs*. Dr. Brown did not explain why this should be so, but others have made the attempt.
- VII.4 Religious beliefs, so the argument goes, are unreliable and divisive because they are unscientific, essentially 'private' and 'personal' in nature. It is said that they must be banished from public affairs in a secular society in the interests of social harmony, progress and, now, human 'rights.' Proponents of this view point to religious wars and persecutions throughout history to justify their claims. However, considered within a broader social and historical context that includes the oppressive and frequently bloody pursuit of secular objectives in the French Revolution, Stalinist Russia and Nazi Germany, the argument is unpersuasive. And it becomes even less persuasive in the case of individuals.
- VII.5 For example: after ten years of bloody wars, the ancient Indian emperor Asoka became a Buddhist, and decided that he should rule his people like a father, with "morality and social compassion." Among other things, he provided them with free hospitals and veterinary clinics, and built new roads and rest houses for travellers.⁵¹ In other words, Asoka let his private beliefs affect his public behaviour. Like Mother Teresa of Calcutta - who also let her private beliefs influence her public behaviour - Asoka is still revered in India, nicknamed "the saint."
- VII.6 Moving from ancient times into the last century, one recalls that fewer than half the Canadians who landed at Dieppe in 1942 made it back. The Royal Hamilton Light Infantry landed with 582 men; 365 were killed or taken prisoner.⁵² John Foote was honorary chaplain to the regiment. For eight hours, repeatedly exposing himself to "an inferno of fire," he assisted the Regimental Medical Officer, going out to the wounded, carrying them to shelter, and, later, carrying them on his back to evacuation landing craft. Ultimately, he chose to stay on the beach and be taken prisoner with those left behind.⁵³
- VII.7 Asoka, Mother Teresa and John Foote were religious believers, but it is false to assert that only religious believers are motivated by belief. In 1915, at Ypres, Canadian physician Francis Scrimger ordered the evacuation of his dressing station, but remained behind to stabilize a wounded officer. As shells dropped around him, demolished the building and set it on fire, he shielded his patient with his own body as he worked, and then carried the larger man to safety through an artillery barrage.⁵⁴ Foote, a Presbyterian minister, and Scrimger, "an atheist by outward appearances,"⁵⁵ both acted in accordance with their personal beliefs; both

were awarded the Victoria Cross.

- VII.8 If one accepts the logic of Professor Brown, Scrimger deserved the award but Foote did not, because Foote had no business letting his *religious* beliefs influence his public behaviour. On the other hand, the stated policy of the Ontario Human Rights Commission would deny both recognition, on the broader grounds that both failed to ‘check their personal views at the door’ when the bullets started to fly.
- VII.9 The stories of Foote and Scrimger may remind physician members of the College Council of countless colleagues in the profession who, through the centuries, have died of contagious and incurable diseases contracted because they refused to abandon their patients. Not a few of this number were motivated by personal beliefs, religious or otherwise, but the profession has never taken towards them the attitude now demanded of it by human rights commissions.
- VII.10 All public behaviour - how one treats other people, how one treats animals, how one treats the environment - is determined by what one believes. All beliefs influence public behaviour. Some of these beliefs are religious, some not, but all are beliefs. That human dignity exists - or that it does not - or that human life is worthy of unconditional reverence - or merely conditional respect - and notions of beneficence, justice and equality are not the product of scientific enquiry, but rest upon faith: upon beliefs about human nature, the meaning and purpose of life, the existence of good and evil.
- VII.11 Disputes about morality - about the morality of contraception, assisted suicide, stem cell research or artificial reproduction - are always, at the core, disputes between people of different beliefs, whether or not those beliefs are religious. “Everyone ‘believes’,” writes social critic Iain Benson. “The question is, what do we believe in and for what reasons?”
- Once we realize that everyone necessarily operates out of some kind of faith assumptions we stop excluding analysis of faith from public life. We cannot simply banish “religious” faiths from our common conversations about how we ought to order our lives together while leaving unexamined all those “implicit faiths” in such areas as public education, medicine, law or politics.⁵⁶
- VII.12 The implicit faith to which Benson refers is exemplified in a statement by the Ethics Committee of the American College of Obstetrics and Gynecology (ACOG). “Although respect for conscience is a value,” states the Committee, “it is only a *prima facie* value, which means it can and should be overridden in the interest of other moral obligations that outweigh it in a given circumstance.”⁵⁷ The Committee’s assertions about the relative importance of freedom of conscience and about what counts as overriding moral obligations are based on faith-assumptions shared by Committee members. It is implied that all reasonable people will accept those faith-assumptions, but, in fact, many reasonable people do not.
- VII.13 The failure to acknowledge the faith-assumptions implicit in one’s own position frequently leads to intolerance for opposing views, and it always makes sincere, respectful and progressive public discourse difficult. This is particularly true of discussion of freedom of

conscience in health care.

VIII. Establishment consensus and the ethics of the profession

Claim

VIII.1 It might be argued that Professor Brown's declaration expressed, not just a private conviction, but a broad public consensus, a consensus of serious establishment thinkers (like members of the OHRC or ACOG), or, perhaps, a consensus reflecting "the ethics of the profession."⁵⁸

Response

VIII.2 However, this kind of 'consensus' is typically achieved by taking into account only opinions consistent with ethical, moral or religious presuppositions that are congenial to a dominant elite. The resulting 'consensus' is, in reality, simply the majority opinion of like-minded individuals, not a genuine ethical synthesis reflecting common ground with those who think differently.⁵⁹ Unfortunately, this usually becomes clear only when documents like *Physicians and the Ontario Human Rights Code* become public knowledge, and those excluded from the table make themselves heard.

VIII.3 More to the point, to identify beliefs as 'private' or 'personal' does not help to resolve a question about the exercise of freedom of conscience. The beliefs of many conscientious objectors, while certainly personal in one sense, are actually shared with tens of thousands, or even hundreds of thousands or hundreds of millions of people, living and dead, who form part of great religious, philosophical and moral traditions. If their beliefs are 'private,' those of Professor Brown, the College Council and the OHRC are not less so. Disputes about what counts as 'private' or 'public' thus end in a stalemate.

VIII.4 The question does not turn on privacy, but truth. If the College Council possess a moral vision that is superior to that of objecting physicians, it is clear that Council's superior moral views ought to prevail. But, in that case, Council members should be able and willing to explain first, why they are better judges of morality than objecting physicians, and, second, why their moral judgement should be forced upon unwilling colleagues. Avoiding the issue by hiding behind noble sounding phrases like "the ethics of the profession" will not do.

IX. Social contract

Claim

IX.1 One frequently encounters references to a "social contract" between the medical profession and society, especially in discussions about the meaning of "professionalism."⁶⁰ The Royal College of Physicians has suggested that, in relation to medical practice, it is more accurate to speak of a "moral contract" between society and the profession.⁶¹ Others have argued that the concept of a social "covenant" provides a better framework for ethical reflection.⁶²

Response

IX.2 It is important to recognize that, whether the term of choice be contract or covenant, or the contract be social or moral, all such notions are convenient fictions. *The Oxford Companion*

to *Philosophy* makes the point:

Contract, social: The imaginary device through which equally imaginary individuals, living in solitude (or, perhaps, nuclear families) , without government, without a stable division of labour or dependable exchange relations, without parties, leagues, congregations, assemblies or associations of any sort, come together to form a society, accepting obligations of some minimal kind to one another, and immediately or very soon thereafter binding themselves to a political sovereign who can enforce those obligations.⁶³

- IX.3 Theories of ‘contract’ and ‘covenant’ are tools that can be usefully employed to explore different aspects of human relationships, but they become dangerous when they are thought to offer adequate explanations of those relationships, or when one moves from speculative discussion and analysis to the enforcement of purported obligations. It is also necessary to recall that claims about the precise content of a contract become especially intense when the parties involved disagree.

X. Social contract and socialized medicine

Claim

- X.1 Socialized medicine in Canada has been and continues to be a great benefit to many people, but little attention has been paid to the dynamic of expectation that arises when the state assumes primary responsibility for the delivery of health care. Health care providers come to be seen as state employees, and citizens begin to believe that they are entitled to demand from health care providers the services they have paid for through taxes. The President of the College of Physicians and Surgeons of Ontario offered the following comment during a recent controversy about freedom of conscience in medicine:

In our society, we all pay taxes for this medical system to receive services . . . And if a citizen or taxpayer goes to access those services and they are blocked from receiving legitimate services by a physician, we don’t feel that’s acceptable.⁶⁴

- X.2 In this case it is argued that there is an actual rather than theoretical social contract for the provision of health care, and that the state and the medical profession are parties to it. Given the nature and complexity of health care, however, much of the content of the virtual contract must remain undefined, and conflicts will arise. The problem becomes especially acute when legal but morally controversial procedures are the focus of the conflict.
- X.3 Citizens are likely to expect the state to enforce what they consider to be the terms of the contract against reluctant employees and other health care providers through institutions like the College of Physicians and human rights commissions.

Response

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

- X.5 First: the terms of the contract on this issue have never been defined or settled. It is a matter of fact that, in assisting in the birth of medicare, the medical profession did not agree that its members would, from that point, deliver every service demanded by the public, regardless of their conscientious convictions. The state, a party to the contract, can ask that it be re-negotiated, but cannot unilaterally demand that the profession “read in” non-existent provisions.
- X.6 Second: when abortion was legalized in 1969, repeated assurances were given that health care workers would not be forced to participate in the procedure.⁶⁵ In fact, the government of the day rejected a protection of conscience amendment to the bill on the grounds that it was not necessary.⁶⁶ Subsequent coercion experienced by health care workers and present attempts to force objectors to become involved with the procedure suggest that the promises made when abortion was legalized were less than sincere. Continuing the analogy of contract for the purpose of the discussion, agreements obtained by fraud are not binding.
- X.7 Third: even if physicians have become *de facto* employees of the state since the introduction of public health care, it does not follow that they cannot exercise freedom of conscience and religion. On the contrary: as employees of a “service industry,” they are entitled to the same accommodation of freedom of conscience and religion available to employees of other service industries.
- X.8 The standard is that they must be accommodated to the point of undue hardship.⁶⁷ Given the enormous resources available to their employer - the state - it is difficult to imagine under what circumstances it might experience “undue hardship” in the delivery of health care. Not incidentally, physicians are also entitled to demand that the state ensure that their workplace environments are not poisoned against them by state institutions - like human rights commissions.

XI. Fiduciary duty

Claim

- XI.1 Moving from imaginary devices to legal argument, some writers assert that the fiduciary duties of physicians requires them to subordinate their conscientious convictions to those of their patients. Professors R.J. Cook and B.M. Dickens have made this claim,⁶⁸ citing the Supreme Court of Canada case, *McInerney v. MacDonald*.⁶⁹

Response

- XI.2 However, *McInerney* had absolutely nothing to do with conflicts of conscience. It concerned the duty of a physician to release a patient's medical records to her upon request, and the nature of fiduciary relationships was not discussed at length. Moreover, the Court ruled that fiduciary relationships and obligations are “shaped by the demands of the situation”; they are not governed by a “fixed set of rules and principles.” Mr. Justice La Forest, writing for the court, stated, “A physician-patient relationship may properly be described as ‘fiduciary’ for some purposes, but not for others.”⁷⁰ In other words, that the physician patient relationship is fiduciary for the purpose of disclosing patient records does not imply that it is fiduciary for the purpose of suppressing the conscientious convictions of the physician.

XI.3 Finally, the court in *McInerney* accepted the characterization of the physician-patient relationship as “the same . . . as that which exists in equity between a parent and his child, a man and his wife, an attorney and his client, a confessor and his penitent, and a guardian and his ward.”⁷¹ Pursuing the analogy, no one has ever suggested that the fiduciary obligations of parents, husbands, attorneys, confessors, and guardians require them to sacrifice their own integrity to the “desires” of others. *McInerney* does not even remotely imply that physicians have such a duty.

XII. “Negligence close to abandonment”

Claim

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

[T]he “failure to provide adequate follow-up care” . . . consisted in the defendant physician’s *failure to refer* his patient to another physician who could facilitate *the abortion she wanted*. The Court found that this failure was negligence close to abandonment . . . a wilful failure or refusal to refer . . . may justify an award of aggravated or exemplary damages. (emphasis added)⁷²

Dickens cites *Zimmer* to the same effect in *Canadian Health Law and Policy* (2nd Ed.).⁷³

Response

XII.2 Though they refer to “historical background jurisprudence,” Cook and Dickens cited no authorities to support their understanding of the case. Moreover, the rulings followed and referred to by the Court of Appeal in *Zimmer* were about informed consent, not freedom of conscience.⁷⁴

XII.3 The only relevant “historical background jurisprudence” appears to be the earlier decision of the trial court in *Zimmer*, and this does not assist Cook and Dickens. The failure to provide adequate follow-up care had two elements - not one, as the authors imply. The first was the physician’s failure “to follow his patient’s progress by conducting regular medical examinations during the summer of 1973,” an omission the trial judge found to be “inconsistent with good clinical practice” that contributed to the fact that her pregnancy was not detected earlier.⁷⁵

XII.4 The second element was not the “failure to refer” alleged by the authors; the physician did *not* refuse or fail to refer the patient for abortion. In fact, she understood from him that she should have an abortion as soon as possible.⁷⁶ Nor was the issue a refusal to refer “for the abortion *she* wanted” (emphasis added). It was, rather, his decision to refer the woman for an abortion in Seattle rather than Edmonton. He testified that he advised her to get an abortion in Seattle to avoid the delay involved in Edmonton, where, he said, it was then necessary to obtain a psychiatric report to justify the procedure. He also believed that the suction procedure used in Seattle would be less traumatic for the patient than the saline method employed in Edmonton.⁷⁷

XII.5 The key fact noticed by the Court in ruling against the physician was that he “made no attempt to secure an abortion for the respondent in a hospital in Edmonton” (by, for example, referring her to a colleague) and thus failed “to display the degree of care and concern dictated by the situation.”⁷⁸

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

I cannot find that the [physician] made any effort to get medical and hospital care in Edmonton for the abortion and in this respect his attitude appears to have been casual. He failed to do everything he could for the welfare of his patient, and I cannot accept as true his statement to Mrs. Zimmer that she would have to be declared mentally unsound before she could be admitted to hospital in Edmonton for an abortion . . . At least. . . he should have consulted another gynaecologist in Edmonton before suggesting that she go to Seattle.⁷⁹

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

[T]he respondent underwent a more painful and emotionally distressing experience than was necessary in the circumstances. Her suffering would have been substantially reduced if the appellant had discharged his duty by arranging hospital care.⁸⁰

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

XIII. Legality

Claim

XIII.1 It is also said that health care workers cannot refuse to provide any legal procedure, as if the legality of the procedure were sufficient to impose a duty to provide it upon either the profession as a whole or individual physicians.

Response

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

XIII.3 **Sex selective abortion:** There is no law against sex-selective abortion in Canada, nor against determining the sex of an infant before birth. Nonetheless, the Deputy Registrar of the

College of Physicians and Surgeons of British Columbia was horrified in August, 2005, when he learned that a pre-natal gender testing kit was being marketed on the internet. Dr. T. Peter Seland, described gender selection as “immoral.” He explained that College policy was not to disclose the sex of a baby until after 24 weeks gestation in order to reduce the risk of gender selection, and that physicians violating the policy were liable to be disciplined by the College.⁸¹ This clearly indicates that the legality of a procedure is not reason enough to compel a health care worker to provide it.

XIII.4 **Amputation:** In 1999, Dr. Robert Smith of Scotland performed single leg amputations on two patients who desired the amputation of healthy limbs. The surgery was performed with the permission of the Medical Director and Chief Executive of the hospital, in a National Health Service operating theatre with NHS personnel, after consultation with the General Medical Council and professional bodies.⁸² The procedures were legal and even deemed ethical by regulatory authorities, but, to date, no one has argued that this is sufficient reason to oblige surgeons to amputate healthy limbs upon request, and to compel physicians to refer for such surgery.

XIII.5 **Execution:** Capital punishment is legal in a number of jurisdictions. 35 of the 38 American states that use lethal injection as a means of execution permit the participation of physicians, and 17 of them require it. “Thirteen jurors, citizens of the state, have made a decision,” explained one physician who assists with executions. “And if I live in that state and that’s the law, then I would see it as being an obligation to be available.”⁸³ The law is the law, after all. However, despite the legality of the procedure, and in defiance of the laws that actually require the attendance of physicians, the Code of Ethics of the American Medical Association forbids the participation of physicians in executions,⁸⁴ and those who ignore the ban risk losing their licenses to practise.⁸⁵ In the face of a pending decision of the American Supreme Court, a guest editorial commented on the obvious conflict between the expectations of the law and the attitude of physicians:

In their fuller examination of *Baze v. Rees*, the justices should not presume that the medical profession will be available to assist in the taking of human lives . . . The future of capital punishment in the United States will be up to the justices, but the involvement of physicians in executions will be up to the medical profession.⁸⁶

XIV. Balance

Claim

XIV.1 Referral is often explained as “striking a balance” between the interests of the physician and those of the patient.

Response

XIV.2 In cases of conscientious objection their interests cannot be balanced because they are not commensurable; they concern fundamentally different goods. A patient wants a particular product or service, but the physician wishes to avoid complicity in wrongdoing and live and

work according to his conscientious convictions. With sufficient imagination and political will one may find a way to accommodate the interests of both, but to compel the physician to do what he believes to be wrong does not achieve ‘balance’ but effects his subordination.

XV. Limits to expression

Claim

- XV.1 It is argued that there are limits to the exercise of freedom of conscience and religion, and that it is ‘appropriate’ to limit a physician’s freedom by requiring referral.
- XV.2 It has been suggested that this approach is justified by *Personal Beliefs and Medical Practice*, a policy document produced by Britain’s General Medical Council.⁸⁷ Paragraph 21 of that document asserts that an objecting physician must provide a patient with contact information for a colleague who will provide the controversial procedure. It also directs the reader to the relevant passage in an earlier publication, *Good Medical Practice (2006)*, which advises physicians that if they have declined to provide a procedure and advised a patient of his right to see another doctor, they must “ensure that arrangements are made for another suitably qualified colleague to take over” if it is not practical for the patient to do so.⁸⁸

Response

- XV.3 The CMA approved *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care*⁸⁹ is to be preferred to GMC documents on this issue.
- XV.4 The GMC documents do not appear to have taken into account evidence taken in 2004 and 2005 by the British House of Lords Select Committee on Assisted Dying for the Terminally Ill, and the conclusions of the Committee. The bill, in its original form, included a requirement that objecting physicians refer patients for euthanasia. Numerous submissions protested this provision because it made objecting physicians a moral party to the procedure,⁹⁰ and the Joint Committee on Human Rights concluded that the demand was probably a violation of the European Convention on Human Rights.⁹¹ The bill’s sponsor, Lord Joffe, promised to delete the provision in his next draft of the bill.⁹²
- XV.5 Returning to the notion that there are limits to the exercise of freedom of conscience and religion: that, as the Supreme Court put it, “the freedom to hold beliefs is broader than the freedom to act on them.”⁹³ This is hardly a new proposition. Oliver Cromwell said as much 400 years ago.

As for the People [of Ireland], what thoughts they have in matters of Religion in their own breasts I cannot reach; but shall think it my duty, if they walk honestly and peaceably, Not to cause them in the least to suffer for the same. And shall endeavour to walk patiently and in love towards them to see if at any time it shall please God to give them another or a better mind. And all men under the power of England, within this Dominion, are hereby required and enjoined strictly and religiously to do the same.⁹⁴

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

. . . I shall not, where I have the power, and the Lord is pleased to bless me, suffer the exercise of the Mass . . . nor . . . suffer you that are Papists, where I can find you seducing the People, or by any overt act violating the Laws established; but if you come into my hands, I shall cause to be inflicted the punishments appointed by the Laws.⁹⁵

- XV.6 Cromwell, the Supreme Court of Canada and the Ontario Human Rights Commission all agree that to act on beliefs is less extensive than the freedom to hold them. So, for that matter, do those who support freedom of conscience in health care. The principle is not in dispute. What is in dispute is where the line between belief and expression is to be drawn, and what is to be done with those who cross it. The Irish did not share Cromwell's views about where the line should be drawn, nor is it clear that there is anything approaching a consensus in Canada on this point. So it is instructive to remember Oliver Cromwell and the Irish when social and political elites begin to sound like the Lord Protector.
- XV.7 The statement that mandatory referral can be justified as a kind of limit to freedom amounts to this: that a physician is free to refuse to actually perform a procedure that he believes is wrong, but can be compelled to do what some other person believes is a lesser wrong, or what some other person thinks is not "really" a wrong at all. In short, the physician is to be compelled to practise according to the conscientious convictions of someone else, to serve ends chosen by someone else even if he finds them abhorrent. This is a form of servitude, not service.

XVI. The problem of complicity

- XVI.1 It appears that most people are willing to grant that a health care worker who has serious moral objections to a procedure should not be compelled to perform it or assist directly with it. However, many people find it more difficult to understand why some health care workers object to even indirect forms of involvement: why some, for example, refuse to refer patients for some morally controversial procedures.
- XVI.2 According to the ACOG Committee on Ethics, "the logic of conscience, as a form of self-reflection on and judgement about whether one's own acts are obligatory or prohibited, means that it would be odd or absurd to say, "I would have a guilty conscience if she did X."⁹⁶ It thus appears that the ACOG Committee is working from what might be called the 'Absolutionist Premise:' that someone who merely arranges for an act is absolved of moral responsibility because only someone who actually does an act is morally responsible for it.
- XVI.3 Alternatively, the ACOG may admit that some moral responsibility is incurred by referral or by otherwise facilitating a procedure, but that the degree of responsibility is sufficiently diminished in such cases that it is of no real significance. Call this the 'Dismissive Premise.'
- XVI.4 In passing, it should be noted that, on either account, the position of the Committee raises the issues discussed in Parts VII and VIII. Whether they assert that referral or facilitation do not incur moral responsibility, or that the degree of moral responsibility incurred is so minimal as

to be inconsequential, they are making a moral judgement and demanding that others adhere to it.

Complicity in torture

- XVI.5 **The Absolutionist Premise** is illustrated by the opinion of *Newsweek* columnist Jonathan Alter. In the weeks following the terrorist attacks on the United States in September, 2001, Alter argued that it was time to think about torturing terrorist suspects who might have information about plans for such horrendous crimes. He acknowledged that physical torture was "contrary to American values," but argued that torture is appropriate in some circumstances, and proposed a novel 'compromise:' that the United States turn terrorist suspects who won't talk over to "less squeamish allies,"⁹⁷ a practice known as "extraordinary rendition." The allies would then do what Americans would not, without compromising American values.
- XVI.6 Less than a year later, Canadian citizen Maher Arar, returning home from Zurich through New York, was detained, interrogated and "rendered" to Syria by U.S. authorities.⁹⁸ In Syria he was imprisoned for almost a year, "interrogated, tortured and held in degrading and inhumane conditions."⁹⁹
- XVI.7 A subsequent "comprehensive and thorough" investigation "did not turn up any evidence that he had committed any criminal offence" and disclosed "no evidence" that he was a threat to Canadian security."¹⁰⁰ A commission of inquiry was appointed to investigate "the actions of Canadian officials" in the case.¹⁰¹
- XVI.8 What was of concern to Mr. Arar, the public and the government was whether or not Canadian officials had caused or contributed to what happened to Mr. Arar, even though his deportation to Syria was effected by the United States, and Syrian officials imprisoned and tortured him. The key issue was whether or not Canada was complicit in torture.
- XVI.9 Concern about Canadian complicity surfaces repeatedly in the report of the commission of inquiry: in briefing notes to the Commissioner of the RCMP,¹⁰² in the testimony of the Canadian Ambassador to Syria,¹⁰³ in references to the possibility of RCMP complicity in his deportation,¹⁰⁴ about the perception of complicity if CSIS agents met Mr. Arar in Syria,¹⁰⁵ in the suggestion that evidence of complicity could show "a pattern of misconduct,"¹⁰⁶ and in the conclusions and recommendations of the report itself.¹⁰⁷
- XVI.10 The issue of complicity arose again in 2007 when a report in Toronto's *Globe and Mail* alleged that prisoners taken in Afghanistan by Canadian troops and turned over to Afghan authorities were being mistreated and tortured.¹⁰⁸ "Canada is hardly in a position to claim it did not know what was going on," said the *Globe*. "At best, it tried not to know; at worst, it knew and said nothing."¹⁰⁹ On this view, one can be complicit in wrongdoing not only by acting, but by failing to act, and even by silence. The *Globe* editorial brings to mind the words of Martin Luther King and Mahatma Gandhi.¹¹⁰
- XVI.11 Thus far, government officials. But the problem of complicity does not relate only to government officials. *The Lancet*, among others, has asked, "How complicit are doctors in

the abuse of detainees?”¹¹¹ and other journal articles have explored the answer with some anxiety.¹¹²

- XVI.12 The Arar Inquiry, the concerns raised by the *Globe and Mail* story about Afghan detainees and the alarm raised about physician complicity in torture make sense only on the presumption that one can be morally responsible for acts actually committed by another person. The Absolutionist Premise does not provide a plausible starting point for moral reasoning.

Complicity in capital punishment

- XVI.13 **The Dismissive Premise** is more promising. Granted that one can be morally responsible for acts actually committed by another, there may be differences of opinion about what kind of action or omission incurs such responsibility. These differences need not be thoroughly canvassed in this paper. It is sufficient to ask if the kind of action involved in referral can have that effect. That is: if a physician refers or otherwise helps a patient to obtain what he believes to be an immoral procedure, is he a culpable participant in the provision of the procedure?
- XVI.14 The issue of culpable participation in a morally controversial procedure has been considered by the American Medical Association in its policy on capital punishment.¹¹³ It forbids physician participation in executions, and defines participation as
- (1) an action which would directly cause the death of the condemned;
 - (2) an action which would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned;
 - (3) an action which could automatically cause an execution to be carried out on a condemned prisoner.
- XVI.15 Among the actions identified by the AMA as “participation” in executions are the prescription or administration of tranquilizers or other drugs as part of the procedure, directly or indirectly monitoring vital signs, rendering technical advice or consulting with the executioners, and even (except at the request of the condemned, or in a non-professional capacity) attending or observing an execution.
- XVI.16 The attention paid to what others might consider insignificant detail is exemplified in the provision that permits physicians to certify death, providing that death has been pronounced by someone else, and by restrictions on the donation of organs by the deceased.
- XVI.17 The AMA also prohibits physician participation in torture. Participation is defined to include, but is not limited to, “providing or withholding any services, substances, or knowledge to facilitate the practice of torture.”¹¹⁴ The Canadian Medical Association, while not faced with the problem of capital punishment, has voiced its opposition to physician involvement in the punishment or torture of prisoners. The CMA states that physicians “should refuse to allow their professional or research skills to be used in any way” for such purposes.¹¹⁵

Complicity and referral

- XVI.18 While referral is not mentioned in the AMA policy on capital punishment, nor in the Canadian or American policies on torture, one cannot imagine that either the AMA or CMA would agree that physicians who refuse to participate in torture or executions have the duty to refer the state “in a timely manner” to other practitioners.¹¹⁶ In fact, it is likely that both the CMA and AMA would censure a physician who did so voluntarily, on the grounds that such conduct would make him complicit in a gravely immoral act.
- XVI.19 In any case, it is reasonable to hold that the kind of action involved in referral is the same kind of action that is defined as “participation” in the AMA policies on capital punishment and torture. The model provided by the AMA policy indicates that, in principle, at least, it is not unreasonable for physicians to refuse to refer patients for procedures to which they object for reasons of conscience, on the grounds that referral would make them complicit in a wrongful act.
- XVI.20 The point here, of course, is not that capital punishment or torture are morally equivalent to artificial reproduction, contraception or other controversial medical procedures. The point is that, when professional associations are convinced that an act is seriously wrong - even if it is legal - one finds them willing to refuse all forms of direct and indirect participation in order to avoid moral complicity in the act. This is precisely the position taken by conscientious objectors in health care.

Draft Standards and complicity

- XVI.21 The *Draft Standards* themselves support the view that moral responsibility is incurred by referral.
- XVI.22 The definition of the “practice of medicine” includes, not only direct care, counsel, diagnosis and treatment, but referral. [Ref. Part 20(1)a] It would thus be inconsistent to claim that direct involvement with the patient incurs the moral responsibility attached to medical practice, but referral does not.

CMPA: referrals and complicity

- XVI.23 In 2002 the College notified practitioners that it was the opinion of the Canadian Medical Protective Association (CMPA) that referral to non-regulated health care providers exposed physicians to civil liability “if medical problems arise during, or as a result of services provided by a non-regulated health care provider.”
- XVI.24 The CMPA recommended that physicians “avoid all actions that could be construed as a patient referral to a non-regulated health care provider” - especially written referrals - and that physicians make clear to patients that it is their responsibility “to make all arrangements with the non-regulated health care provider.” Further:
- If the patient requires something in writing. . . the note should clearly indicate . . . that the physician, though not objecting, is neither referring nor recommending the patient for the treatment.¹¹⁷

- XVI.25 The opinion of the CMPA was clearly based upon the premise that referral makes a physician

complicit in what follows. The CMPA recommendations exactly parallel the position taken by physicians who refuse to refer patients for procedures or services the physicians believe to be wrong.

Complicity and dirty hands

- XVI.26 Having considered the problem of complicity, it is now worth asking why the subject of complicity in wrongful acts is not only of grave concern to ethical physicians, medical journals, and professional associations, but why it can so thoroughly arouse the public, the media, and politicians: why commissions of inquiry will so meticulously investigate the possibility of complicity, producing hundreds upon hundreds of pages of detailed analysis of the evidence taken, at no little cost to the public purse.
- XVI.27 A jaded few will respond that reports of scandal will always sell newspapers, that scandal always energizes the self-righteous (both the religious and the politically-correct varieties) and that scandal is one of the traditional weapons used against opponents by politicians of all stripes. There is some truth to this, but, going deeper into it, why is complicity in wrongdoing scandalous?
- XVI.28 The answer must be that there is something about complicity in wrongdoing that triggers an almost instinctive reaction in people, something about it that touches some peculiar, deep and almost universal sense of abhorrence. One says “almost” instinctive and “almost” universal because, of course, there have always been exceptions: Eichmanns, Pol Pots, Rwandan machete men, for example. And the degree of sensitivity varies from person to person, from subject to subject, and from one culture to another. Nonetheless, complicity in wrongdoing can be a source of scandal, a political weapon and the subject for public inquiries only because it has some real and profound significance.
- XVI.29 The nature of that significance is suggested by a number of expressions: “poisoned” fruit doctrine, “tainted” evidence, money that has to be “laundered,” and “dirty” hands. A senior Iraqi surgeon, commenting on the complicity of physicians in torture under Saddam Hussein, said that “the state wanted them to have ‘dirty hands’.”¹¹⁸ In contrast, some writers refer approvingly to a “dirty hands principle”:

Philosopher Sidney Axinn tells us the Dirty Hands principle “holds that in order to govern an institution one must sometimes do things that are immoral.” He goes on to say that advocates would claim that “we do not want leaders who are so concerned with their own personal morality that they will not do ‘what is necessary’ to ... win the battle.... We have an inept leader if we have a person who is so morally fastidious that he or she will not break the law when that is the only way to success” (Axinn, 1989: 138).¹¹⁹

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

XVI.30 The answer suggested by the Project is that the “something” is not a “thing” at all, but the human person, and that the sense of uncleanness or taint associated with complicity in wrongdoing is the natural response of the human person to something fundamentally opposed to his nature and dignity.

XVII. The needs of the patient: anthropology counts

- XVII.1 What is conducive to human well-being is determined by the nature of the human person. There can be no agreement upon what is good for the patient without first agreeing upon that. One’s understanding of the nature of the human person determines not only how one defines the needs of the patient, but how one approaches every moral or ethical problem in medicine.
- XVII.2 Reasoning from different beliefs about what man is and what is good for him leads to different definitions of “need,” different understandings of “harm,” different concepts of right and wrong, and, ultimately, to different ethical conclusions.¹²⁰
- XVII.3 Consider two different statements: (a) man is a creature whose purpose for existence depends upon his ability to think, choose and communicate; b) man is a creature for whom intellect, choice and communication are attributes of existence, but do not establish his purpose for existence. Statements (a) and (b) express non-religious belief, not empirically verified fact. Such beliefs - usually implicit rather than explicit - direct the course of subsequent discussion.
- XVII.4 Bioethicists working from (a) would have little objection to the substitution of persistently unconscious human subjects for animals in experimental research.¹²¹ Those who accept (b) would be more inclined to object.¹²² Finally, bioethicists who do not believe in ‘purpose’ beyond filling an ecological niche would dismiss the whole discussion as wrong-headed.
- XVII.5 What must be emphasized is that when people cannot achieve a consensus about the morality of a procedure, it is frequently because they are operating from different beliefs about the nature of the human person. Disagreement is seldom about facts - the province of science - but about what to believe in light of them - the province of philosophy and religion.
- XVII.6 The same thing is true of disagreements about freedom of conscience for health care workers. Returning to the point made in VII.11 to VII.13, beliefs about the nature of the human person lie at the root of any attempt to set limits to this freedom. In fact, failure to engage at this level will probably frustrate more superficial efforts to resolve the conflict.
- XVII.7 What follows is a plausible description of an aspect of the human person that is relevant to the present discussion. The threshold of plausibility ought to be sufficient, since the context for this discussion is a liberal democracy, in which there is an expectation that a plurality of more or less comprehensive world-views will be accommodated.

XVIII. The human person

The integrity of the human person

XVIII.1 The physician, a unique *someone* who identifies himself as “I” and “me,”¹²³ has only *one*

identity, served by a single conscience that governs his conduct in private and professional life. This moral unity of the human person is identified as integrity, a virtue highly prized by Martin Luther King, who described it as essential for “a complete life.”¹²⁴

[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.¹²⁵

XVIII.2 Against this, some writers have invoked the venerable concept of self-sacrifice.

“Professionalism,” Professor R. Alta Charo suggests rhetorically, ought to include “the rather old-fashioned notion of putting others before oneself.”¹²⁶

XVIII.3 But self-sacrifice, in the tradition of King, Gandhi and Lewis, while it might mean going to jail or even the loss of one’s life, has never been understood to include the sacrifice of one’s integrity. To abandon one’s moral or ethical convictions in order to serve others is prostitution, not professionalism. “He who surrenders himself without reservation,” warned C.S. Lewis, “to the temporal claims of a nation, or a party, or a class” - one could here add ‘profession’ - “is rendering to Caesar that which, of all things, emphatically belongs to God: himself.”¹²⁷

XVIII.4 The integrity or wholeness of the human person was also a key element in the thought of French philosopher Jacques Maritain. He emphasized that the human person is a “whole, an open and generous whole” that to be a human person “involves totality.”¹²⁸

The notion of personality thus involves that of totality and independence; no matter how poor and crushed a person may be, as such he is a whole, and as a person subsists in an independent manner. To say that a man is a person is to say that in the depth of his being he is more a whole than a part and more independent than servile.¹²⁹

XVIII.5 This concept is not foreign to the practice of modern medicine. Canadian ethicist Margaret Somerville, for example, asserts that one cannot overemphasize the importance of the notion of ‘patient-as-person’ and acknowledges a “totality of the person” that goes beyond the purely physical.¹³⁰

The dignity and inviolability of the human person

XVIII.6 “Man,” wrote Maritain, “is an individual who holds himself in hand by his intelligence and his will.”

He exists not merely physically; there is in him a richer and nobler existence; he has spiritual superexistence through knowledge and through love.¹³¹

XVIII.7 Applying this principle, Maritain asserted that, even as a member of society or the state, a man “has secrets that escape the group and a vocation which the group does not encompass.”¹³² 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.”¹³³

For in the person there are some things - and they are the most important and sacred ones - which transcend political society and draw man in his entirety above political society - the very same whole man who, by reason of another category of things, is a part of political society.¹³⁴

XVIII.8 Even as part of society, Maritain insisted, “the human person is something more than a part;”¹³⁵ he remains a whole, and must be treated as a whole.¹³⁶ A part exists only to comprise or sustain a whole; it is a means to that end. But the human person is an end in himself, not a means to an end.¹³⁷ 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.”¹³⁸

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

To the right of the individual to be treated as an end, which entails his right to the full development and expression of his personality, all other rights and claims must, the democrat holds, be subordinated. I do not know how this principle is to be defended any more than I can frame a defence for the principles of democracy and liberty.¹³⁹

In company with Maritain, Professor Joad insisted that it is an essential tenet of democratic government that the state is made for man, but man is not made for the state.¹⁴⁰

XVIII.10 To reduce human persons to the status of tools or things to be used for ends chosen by others is reprehensible: “very wicked,” wrote C.S. Lewis.¹⁴¹ Likewise, Martin Luther King condemned segregation as “morally wrong and awful” precisely because it relegated persons “to the status of things.”¹⁴²

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

. . . we must never treat a person as a means to an end. This principle has a universal validity. Nobody can use a person as a means towards an end, no human being, nor yet God the Creator.¹⁴³

XVIII.12 Maritain, Joad, Lewis, King and Wojtyla reaffirmed in the twentieth century what Immanuel Kant had written in the eighteenth: “Act so that you treat humanity, whether in your own person or in that of another, always as an end and never as a means only.”¹⁴⁴

Human dignity and freedom of conscience

XVIII.13 Perhaps ironically, this was the approach taken when Madame Justice Bertha Wilson of the Supreme Court of Canada addressed the issue of freedom of conscience in the landmark 1988 case *R v. Morgentaler*. Madame Justice Wilson argued that “an emphasis on individual conscience and individual judgment . . . lies at the heart of our democratic political

tradition.”¹⁴⁵ Wilson held that it was indisputable that the decision to have an abortion “is essentially a moral decision, a matter of conscience.”

The question is: whose conscience? Is the conscience of the woman to be paramount or the conscience of the state? I believe. . . that in a free and democratic society it must be the conscience of the individual. Indeed, s. 2(a) makes it clear that this freedom belongs to "everyone", i.e., to each of us individually.¹⁴⁶

XVIII.14 “Everyone” includes every physician. But, at this point in the judgement, Wilson was not discussing whether or not the conscience of a woman should prevail over that of an objecting physician, but how the conscientious judgement of an individual should stand against that of the state. Her answer was that, in a free and democratic society, “the state will respect choices made by individuals and, to the greatest extent possible, will avoid subordinating these choices to any one conception of the good life.”¹⁴⁷

XVIII.15 Quoting the above passage from Professor Joad’s book, Wilson approved the principle than a human person must never be treated as a means to an end - especially an end chosen by someone else, or by the state. Wilson rejected the idea that, in questions of morality, the state should endorse and enforce “one conscientiously-held view at the expense of another,” for that is “to deny freedom of conscience to some, to treat them as means to an end, to deprive them . . .of their ‘essential humanity’.”¹⁴⁸

XIX. Concluding summary

XIX.1 The primary issue raised by the *Draft Standards* is whether or not a physician should be compelled to provide or facilitate a service or procedure he believes to be wrong. Put another way, does a physician’s refusal to provide or facilitate something he believes to be wrong constitute professional misconduct? A number of suggested responses to the issue are inadequate.

‘Rights’ claims

XIX.2 Despite the fact that a ‘right’ to abortion cannot be found in existing international instruments, current rights claims are meant to force health care workers and institutions to provide or at least facilitate abortion, contraception, and artificial reproduction. The polemics and tendentious reasoning involved in this project are disturbing. However, even if claims of ‘rights’ to abortion or contraception can be grounded in rights purportedly implicit in international instruments, it does not follow that they override the repeated explicit international recognition and support for freedom of conscience and religion.

Religious belief

XIX.3 It is not reasonable to address the issue by proscribing the public manifestation of religious belief. All beliefs influence public behaviour. Some of these beliefs are religious, some not, but all are beliefs. Disputes about morality are always, at the core, disputes between people of different beliefs, whether or not those beliefs are religious. The failure to acknowledge the faith-assumptions implicit in one’s own position frequently leads to intolerance for opposing

views, and it always makes sincere, respectful and progressive public discourse difficult.

Consensus

XIX.4 To insist that physicians conform to a dominant ‘consensus’ is unacceptable, since such agreements are typically achieved by taking into account only opinions consistent with ethical, moral or religious presuppositions that are congenial to a dominant elite. The resulting ‘consensus’ is, in reality, simply the majority opinion of like-minded individuals, not a genuine ethical synthesis reflecting common ground with those who think differently.

Private vs. public

XIX.5 To identify beliefs as ‘private’ or ‘personal’ does not help to resolve a question about the exercise of freedom of conscience. Disputes about what counts as ‘private’ or ‘public’ thus end in a stalemate.

Contract theory

XIX.6 Theories of ‘contract’ and ‘covenant’ are inadequate and can be oppressive when used as a basis for limiting freedom of conscience among health care workers. Even if one posits the existence of a ‘contract’ through the implementation of public health care, the suppression of freedom of conscience among health care workers was not, in fact, one of the elements in the agreement. Further: when abortion was legalized, repeated assurances were given that health care workers would not be forced to participate in the procedure. Finally, if physicians can be considered state employees, they are entitled to the same accommodation of freedom of conscience and religion to the point of undue hardship.

Fiduciary duty

XIX.7 It is said that the fiduciary nature of the physician-patient relationship requires suppression of a physician’s freedom of conscience, but this is oversimplified. The relationship is ‘fiduciary’ for some purposes, but not for others. No one has ever suggested that the fiduciary obligations of parents, husbands, attorneys, confessors, and guardians require them to sacrifice their own integrity to the “desires” of others, nor do physicians have such a duty.

Negligence/abandonment

XIX.8 The claim that a principled refusal to refer amounts to abandonment is not tenable. One can argue that a physician who urgently recommends a procedure to a patient has a duty to do all that he reasonably can to help the patient obtain it, and that the failure to do so might constitute negligence or abandonment. However, the same cannot be said if a physician, for reasons of conscience, refuses to recommend a procedure at all.

Legality

XIX.9 The fact that a procedure is legal does not impose a duty on physicians or on the profession to provide it. This is illustrated by official support for refusal to facilitate sex-selective abortion, official prohibition of physician participation in legal executions, and in the fact that surgeons are not required to amputate healthy limbs on demand.

Balance

XIX.10 It is not possible to balance a desire for a procedure against a physician’s desire to avoid

complicity in wrongdoing and live and work according to his conscientious convictions because the desires concern fundamentally different goods that are not commensurable. It may be possible to accommodate both, but the desires cannot be ‘balanced.’

Limits to freedom

XIX.11 The statement that mandatory referral can be justified as a kind of limit to freedom would compel physicians to serve ends chosen by someone else even if he finds them abhorrent. This is a form of servitude, not service.

Complicity

XIX.12 It is reasonable to hold that the kind of action involved in referral is the same kind of action that is defined as “participation” in professional policies prohibiting physician participation in executions and torture. The model provided by these policies indicates that, in principle, at least, it is not unreasonable for physicians to refuse to refer patients for procedures to which they object for reasons of conscience, on the grounds that referral would make them complicit in a wrongful act. This conclusion is supported by the *Draft Standards* themselves and by advice given by the Canadian Medical Protective Association.

The human person

XIX.13 When people cannot achieve a consensus about the morality of a procedure or about freedom of conscience for health care workers, it is frequently because they are operating from different beliefs about the nature of the human person. The failure to engage at this level will probably frustrate more superficial efforts to resolve disagreements.

Service, not servitude

XIX.14 A long philosophical tradition, stretching from at least Immanuel Kant to *R. vs. Morgentaler* and beyond, insists that the nature of the human person is such no one should be exploited by another by being reduced to the status of a tool or thing: that it is reprehensible to use a human person for ends chosen by others. Within this tradition, self-sacrifice, has never been understood to include the sacrifice of one’s integrity. To abandon one’s moral or ethical convictions in order to serve others is prostitution, not professionalism: once more, servitude, not service.

Recommendation

XIX.15 In the tradition of Kant, C.S. Lewis, Martin Luther King, Cyril Joad and Karol Wojtyla, and following Madame Justice Wilson in *R. vs. Morgentaler*, to demand that physicians provide or assist in the provision of procedures or services that they believe to be wrong is to treat them as means to an end and deprive them of their “essential humanity.” The *Draft Standards* [Parts 5(4), 6(1), 6(2), 7(2)a, 8(1) and 32(2)d] should be revised to ensure that the document cannot be used for this purpose.

XX. Looking to the future

XX.1 The principle that conscientious objectors ought to be forced to refer for or otherwise facilitate a morally controversial procedure would, logically, apply to *all* controversial procedures. If for no other reason than prudent self-interest, physicians and other health care

workers who are inclined to support mandatory referral should think carefully about the broader ramifications of such a policy, especially if their own views would make them unwilling to facilitate sex-selective abortion, infant male circumcision, assisted suicide and euthanasia or even the amputation of healthy body parts.

- XX.2 That one might be forced to refer for or otherwise facilitate assisted suicide and euthanasia is not a possibility that is commonly considered, since the procedures are illegal in most jurisdictions. But laws can be changed, as they have been in the Netherlands, Belgium and Oregon, and such changes in law bring with them changes in expectations. Since late 2003, general practitioners in Belgium unwilling to perform euthanasia have faced demands that they help patients find physicians willing to provide the service. It is argued that mandatory referral for euthanasia is required by respect for patient autonomy, the paradigm of “shared decision making” and the fact that euthanasia is a legal “treatment option.”¹⁴⁹

Appendix “A”

Conscientious Objection as a Crime Against Humanity

- A.1 The ultimate goal of the U.S.-based Center for Reproductive Rights is to establish what it calls “hard norms” - treaty-based international laws¹⁵⁰ - that recognize access to abortion as a fundamental human right.¹⁵¹ It plans to develop a “culture of enforcement” that will compel governments to respect this ‘right’¹⁵² and enforce it against third parties - physicians and other health care workers.¹⁵³ Even as it works toward this end, it is cultivating “soft norms” in the form of statements by international, regional, and intergovernmental bodies.¹⁵⁴
- A.2 Professor Bernard M. Dickens appears to follow this strategy in a standard text, *Canadian Health Law and Policy*. In his chapter on Informed Consent, addressing the topic of conscientious objection and disclosure of relevant information to a patient, he notes that Canada has ratified the 1998 *Treaty of Rome* constituting the International Criminal Court. Within the context of a discussion of the refusal of physicians or institutions to advise women about the availability of the morning after pill “in order to oblige continuation of any pregnancy that may occur,” he continues:
- Articles 7 and 8 of the treaty characterize forced pregnancy following rape as a crime against humanity and as analogous to torture. Human rights commissions may share this view, reinforcing their concerns about non-disclosure constituting both discrimination against women and inhuman and degrading treatment. Accordingly, the right to object to perform or immediately participate in medical procedures on grounds of conscience carries no parallel right to refuse to inform those eligible to receive these procedures where or how they are practically accessible.¹⁵⁵
- A.3 The goal here is clear enough. Readers of *Canadian Health Law and Policy* are to be persuaded that a health care worker who declines, for reasons of conscience, to direct a patient to the morning after pill or abortion commits the offence of “forced pregnancy.” The passage is meant to convince them that, if this is not actually a crime against humanity analogous to torture, it is at least a gross violation of human rights that ought to be prosecuted by human rights commissions.
- A.4 Dickens here glosses over the distinction between “forced pregnancy following rape” (the subject of the *Treaty*) and his broader claim concerning a “medically indicated procedure” (the subject of his essay). Moreover, while he asserts only a duty of disclosure, the logic of his argument implies (as he argues elsewhere) that there is a similar duty to refer or otherwise facilitate the procedure.

The *Treaty of Rome*: “forced pregnancy” and “torture”

- A.5 What first attracts critical attention is that Dickens refers to the *Treaty of Rome* in his text, but actually cites a different document as authority for his claim that “forced pregnancy following rape” is “a crime against humanity. . . analogous to torture.”¹⁵⁶ Why cite a secondary source rather than the *Treaty* itself?
- A.6 A review of the *Treaty* suggests one possible answer.¹⁵⁷ The *Treaty* does not support Dickens’ claims. Specifically:
- In order to constitute a crime against humanity or war crime, the offence of “forced pregnancy” must be “committed as part of a widespread or systematic attack directed against any civilian population, with knowledge of the attack” [Art. 7(1)], or during war [Art. 8(2)b]
 - Pregnancy is only “forced” within the meaning of the *Treaty* if a woman is unlawfully confined after having been raped “with the intent of affecting the ethnic composition of any population or carrying out other grave violations of international law.” [Art. 7(2)f; Art. 8(2)b(xxii)]
 - The definition of “forced pregnancy” must not “in any way be interpreted as affecting national laws relating to pregnancy,” which include laws restricting or prohibiting abortion [Art. 7(2)f]
 - “Torture” is not, at any point in the *Treaty*, associated with pregnancy, whether forced or not. It is specifically defined as “the intentional infliction of severe pain or suffering, whether physical or mental, upon a person in the custody or under the control of the accused.” [Art 7(2)e]

The *Elements of Crimes*: “forced pregnancy” and “torture”

- A.7 *The Elements of Crimes* simply confirms the provisions of the *Treaty*, both with respect to torture and “forced pregnancy.” The document adds nothing that even remotely suggests that conscientious objection to medical procedures or services could be a crime against humanity, or that it is analogous to torture. Again: why cite this document in preference to the *Treaty of Rome*?
- A.8 Perhaps the answer lies, not in what *The Elements of Crimes* includes, but in what it leaves out. It leaves out reference to the *Treaty* provision that recognizes the right of states to restrict or prohibit abortion by law, which is not relevant to the purpose of the document [Art. 7(2)f]. But the provision is highly relevant to Dickens’ claim that delaying access to abortion is a violation of human ‘rights,’ since it flatly contradicts the notion that abortion is a human ‘right.’

What else has been left out

- A.9 Neither the *Treaty of Rome* nor *The Elements of Crimes* associates “forced pregnancy,” even as it is defined by the *Treaty*, with torture. It is grouped with “rape, sexual slavery, enforced prostitution . . . enforced sterilization, or any other form of sexual violence of comparable gravity,” but not with torture [Art. 7(1)g]. Nonetheless, Professor Dickens somehow manages to conclude that the documents “characterize forced pregnancy following rape . . . as analogous to torture.”
- A.10 The only possible explanation for this is that Professor Dickens considers “forced pregnancy” analogous to torture because both are included among the crimes against humanity listed in Article 7(1) of the *Treaty*. On this basis, then, every crime in the list is analogous to all of the others, so that “forced pregnancy” is analogous not only to torture, but to murder, forcible transfers of population, enforced disappearance of persons and apartheid, while murder is analogous to unlawful imprisonment, deportation, etc. If this is how Professor Dickens arrived at his singular conclusion, it is an open question whether his reasoning does a greater disservice to the law or to the English language.
- A.11 In any case, the *Treaty* itself has something to say about analogy:

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

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

Summary

- A.12 Professor Dickens very selectively borrows terms from the *Treaty of Rome*. He arranges his material to make it appear that conscientious objection that delays access to the morning after pill or abortion is actually or very nearly a crime against humanity analogous to torture, or, at least, an egregious violation of human rights.
- A.13 In addition to selective borrowing, Dickens leaves out everything necessary for a proper understanding of the *Treaty of Rome*, which, incidentally, includes everything that might cause a reader to question his claims. Finally, he directs the reader not to the *Treaty*, which includes a provision that is arguably fatal to his thesis, but to a document that omits the provision.
- A.14 Professor Dickens’ polemic seamlessly weaves the agenda of the Center for Reproductive Rights into a standard Canadian reference work. There is no doubt that this is advantageous to the Center and its allies, but it brings into question the reliability of *Canadian Health Law and Policy*. Perhaps it is time for a third and more carefully revised edition of the book.

Related documents

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

Budziszewski, J. *Handling Issues of Conscience*

(<http://www.consciencelaws.org/Examining-Conscience-Ethical/Ethical07.html>)

- *The Illusion of Moral Neutrality - Part IV*
(<http://www.consciencelaws.org/Examining-Conscience-Ethical/Ethical37.html>)

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(<http://www.consciencelaws.org/Examining-Conscience-Ethical/Ethical28.html>)

Murphy, Sean, *Belgium: mandatory referral for euthanasia*

(<http://www.consciencelaws.org/Examining-Conscience-Background/Euthanasia/BackEuthanasia08.html>)

- *Establishment Bioethics*
(<http://www.consciencelaws.org/Project/Project/Examining-Conscience-Ethical/Ethical16.html>)
- *Postscript for the Journal of Obstetrics and Gynaecology Canada: Morgentaler vs. Professors Cook and Dickens.*
(<http://www.consciencelaws.org/Examining-Conscience-Legal/Legal30.html>)
- *Service or Servitude: Reflections on Freedom of Conscience for Health Care Workers.*
Responding to: Cantor J, Baum K. *The Limits of Conscientious Objection*
(<http://www.consciencelaws.org/Examining-Conscience-Ethical/Ethical48.html>)
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(http://www.cpsa.ab.ca/publicationsresources/attachments_messengers/m73.pdf) Accessed 2008-09-27

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12. Letter from Dr. Peter Walker, Dean, Faculty of Medicine, University of Ottawa, to the Protection of Conscience Project Administrator, 4 May, 2005
13. Rodgers, S. Downie, J. "Abortion: ensuring access." *CMAJ* • July 4, 2006; 175 (1). (<http://www.cmaj.ca/cgi/content/full/175/1/9>) Accessed 2008-09-27
14. CMAJ editorial, "Editorial independence for CMAJ: signposts along the road." *CMAJ* • August 29, 2006 • 175(5), 453. Published at <http://www.cmaj.ca> on 3 August, 2008. (<http://www.cmaj.ca/cgi/content/full/175/5/453?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=signposts&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&sortspec=date&resourcetype=HWCIT>) Accessed 2008-09-27
15. Blackmer, Jeff, "Clarification of the CMA's position concerning induced abortion." *CMAJ* • April 24, 2007; 176 (9) (<http://www.cmaj.ca/cgi/content/full/176/9/1310>) Accessed 2008-09-27
16. Rodgers, S. Downie, J. "Abortion: ensuring access - the authors respond." *CMAJ* • February 13, 2007; 176 (4) (<http://www.canadianmedicaljournal.ca/cgi/content/full/176/4/494>) Accessed 2008-09-27
17. Baylis, Françoise (Ed.) *Codes of Ethics: Ethics, codes, standards and guidelines for professionals working in a healthcare setting in Canada*. Toronto: Dept. of Bioethics, The Hospital for Sick Children, 1992, Introduction
18. Cook RJ, Dickens BM, "In Response". *J.Obstet Gynecol Can*, February, 2004; 26(2)112
19. The case is *Zimmer v. Ringrose* (1981), 124 Dominion Law Reports (3d) 215 (Alberta Court of Appeal).
20. See Dickens, Bernard M. "Informed Consent": Chapter 5 in Downie, Joceyln, Caulfield, Timothy and Flood, Colleen (Eds.) *Canadian Health Law and Policy* (2nd Ed.). Butterworths, p. 149.
21. There was some resistance to publishing a first response from the Project, the editor citing *Journal* policy against publishing "letters that are responses to letters of response" and the fact that the original article had appeared six months earlier (Letter from the Editor in Chief, *Journal of Obstetrics and Gynaecology Canada* to the Administrator, Protection of Conscience Project, 7 May, 2004). The Administrator did not insist upon publication, but asked if the *Journal* would publish a correction to the legal misinformation supplied by Professors Cook and Dickens (Letter from the Administrator, Protection of Conscience Project, to the Editor in Chief, *Journal of Obstetrics and Gynaecology Canada*, 14 May, 2004: (<http://www.consciencelaws.org/Examining-Conscience-Legal/Legal31a.html>). This led to the

appearance of the Project's letter (<http://www.consciencelaws.org/Conscience-Archive/Commentary/Conscience-Commentary-2004-01-to-06.html>) with the rejoinder by Cook and Dickens and the announcement by the editor that the subject was closed. The Administrator later supplied the *Journal's* editor with *Postscript for the Journal of Obstetrics and Gynaecology Canada: Morgentaler vs. Professors Cook and Dickens*, and repeated his previously expressed concerns about misleading legal claims (Letter from the Administrator, Protection of Conscience Project, to the Editor in Chief, *Journal of Obstetrics and Gynaecology Canada*, 8 August, 2005: (<http://www.consciencelaws.org/Examining-Conscience-Legal/Legal31a.html>)).

22. "Free the Doctor", *Globe and Mail*, 18 May, 1965. Quoted in de Valk, Alphonse, *Morality and Law in Canadian Politics: The Abortion Controversy*. Dorval, Quebec: Palm Publishers, 1974, p. 18]. Two years later the *Globe* argued that, in the case of abortion, "where religious moralities conflict, the State should support none, but leave the choice to individual conscience."["Now the job is to be done, let it be done right", *Globe and Mail*, 21 December, 1967. Quoted in de Valk, Alphonse, *Morality and Law in Canadian Politics: The Abortion Controversy*. Dorval, Quebec: Palm Publishers, 1974, p. 56]

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

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

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

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

24. CRR documents obtained by the Catholic Family and Human Rights Institute (CFAM) were entered in the United States Congressional Record (p. E2535 to E2547) on 8 December, 2003, to

forestall efforts by the Center to suppress dissemination of the documents through litigation. They are available on the Project website.

(<http://www.consciencelaws.org/Conscience-Archive/Documents/CRRSecretStrategy.pdf>)

The documents cited herein are:

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

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

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

Domestic Legal Program 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)

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

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

27. “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

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

29. “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.

30. 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

31. “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

32. ILPS Memo # 2, E2538.

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

34. The Center also recognizes the importance of public opinion and public education. “Public education and awareness building” is identified as one form of advocacy (ILPS Memo # 2, E2539; DLPS Memo #2, E2540-E2541). The CRR recognizes that it is important to use arguments that are “appealing and understandable to the public” (DLPS Memo #2, E2540), and, similarly, the limited appeal of highly technical or legalistic approaches (DLPS Memo #2, E2541). It is foreseen that enforcement of new rights might require “sustained public awareness-raising campaigns” in addition to support from the medical community and others. One concern raised in the documents is the possibility that to try to formally establish “reproductive rights” in a new international instrument might, “as a matter of public perception,” undermine CRR’s claims that such rights already exist (ILPS Memo # 1, E2538). It also encourages and takes advantage of favourable domestic political developments: “. . . the national political moment may be ripe for change, with or without the influence of international standards. Such changes. . . particularly in key countries in a region, may have a catalytic effect on neighbouring countries.”

(IPLS Memo #2, E2539).

35. ILPS Memo #2, E2538)

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

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

38. ILPS Memo #1, E2538

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

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

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

42. ILPS Memo #1, E2537 - E2538

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

44. ISLP Memo #1, E2535, E2538.

45. “These lower profile victories will gradually put us in a strong position to assert a broad consensus around our assertions.” ISLP Memo #1, E2538
46. Romalis, Garson, “Current Abortion Management.” *British Columbia Medical Journal*, Dec. 1999, Vol. 41, No. 11, p. 554
- “Morgentaler calls decision to halt abortions 'disgusting.'” *New Brunswick/St. John Telegraph Journal*, 9 November, 2002
47. Kretzul, E., “Ethical responsibilities in dealing with women requesting abortion services.” *The Messenger*, No. 73, September, 1999. (http://www.cpsa.ab.ca/publicationsresources/attachments_messengers/m73.pdf) Accessed 2008-09-27.

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

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

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

49. “In an emergency in which referral is not possible or might negatively affect a patient’s physical or mental health, providers have an obligation to provide medically indicated and requested care regardless of the provider’s personal moral objections.” ACOG Opinion No. 385, *The Limits of Conscientious Refusal in Reproductive Medicine*, p. 5, recommendation 5. (http://www.acog.org/from_home/publications/ethics/co385.pdf) Accessed 2008-09-24. In assessing the scope of this claim, it is necessary to note that the statement fails to define key terms: “emergency,” “health,” “medically indicated,” and “care.” The statement is also notably broad in its unqualified reference to anything that “*might* negatively affect” the health of the

patient.

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

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

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

[<http://www.consciencelaws.org/Repression-Conscience/Conscience-Repression-17.html>]

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

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

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

54. “Realizing the dangerous situation, Scrimger organized the evacuation of the wounded to the rear, but one of his patients, Captain H. F. McDonald, had a serious head wound. Any movement before he was stabilized would likely kill him. Scrimger chose to stay behind. The shells fell

around them and then began to land on the farm. The slight, 5-foot-7-inch doctor, who weighed only 148 pounds, shielded McDonald's prone body while he worked over him. During the bombardment, the building was demolished and set on fire, but both Scrimger and McDonald survived the whirling shrapnel and exploding ammunition. Blinded by the smoke and heat of the fire, Scrimger pulled the larger, unconscious infantry officer onto his back and staggered out of the building. German infantry were advancing on the farm and the only escape was to cross the moat to the rear. Lurching to safety with McDonald on his back, Scrimger passed through the barrage, moving from shell hole to shell hole for cover. Hiding in a nearby ditch throughout the rest of the day, they avoided the enemy infantry. Captain McDonald later testified that each time the shells exploded around them, "Captain Scrimger curled himself round my wounded head and shoulder to protect me from the heavy shell fire, at obvious peril to his life. He stayed with me all that time and by good luck was not hit."

Canadian War Museum, *Backgrounder: "Francis Scrimger, V.C.*

(http://www.warmuseum.ca/cwm/media/bg_scrimger_e.html) Accessed 2008-09-11

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

56. Benson, Iain T., "There are No Secular 'Unbelievers.'" *Centrepieces* 7, Vol. 4, No. 1, Spring 2000, P. 3.

<http://www.consciencelaws.org/Examining-Conscience-Issues/Ethical/Ethical10.html>

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

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

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

(<http://www.consciencelaws.org/Conscience-Project-Reports/Report-2001-01.html>)

59. One critic outlines the extent of the penetration of bioethics principlism, as defined in the American Belmont Report: "Many colleges and universities already require a course in bioethics in order to graduate, and most medical and nursing schools have incorporated it in their curricula. Bioethics is even being taught now in the high schools. And what is being taught as bioethics are the Belmont principles, or renditions of one or more of these principles as defined in Belmont terms. Nods may be given to 'alternative' propositions here and there, but in the end it is the language of principlism which sets the standards." Irving, Dianne N., *What is "Bioethics"?*

(*Quid est "Bioethics"?*). Tenth Annual Conference: Life and Learning X (in press) University Faculty For Life, Georgetown University, Washington, D.C.

(http://www.lifeissues.net/writers/irv/irv_36whatisbioethics07.html) Accessed 2008-09-11

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

"Professionalism is also the moral understanding among medical practitioners that gives reality to the social contract between medicine and society. This contract in return grants the medical profession a monopoly over the use of its knowledge base, the right to considerable autonomy in practice and the privilege of self-regulation." *Canadian Stakeholders Coalition on Medical Professionalism*, quoted in *CMA: Medical Professionalism* http://www.cma.ca/index.cfm/ci_id/3300/la_id/1.htm (Accessed 2008-09-06)

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

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

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

62. Latimer, Elizabeth J., *Accidental patient. A doctor takes a different view*. *Can Fam Physician*. 2002 August; 48: 1295–1296. (<http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=2214087&blobtype=pdf>) Accessed

2008-09-06. James T.C, *The Patient-Physician Relationship: Covenant or Contract?* Mayo Clin Proc. 1996;71:917-918 (<http://www.mayoclinicproceedings.com/inside.asp?AID=3655&UID=>) Accessed 2008-09-07

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

64. 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

65. Canadian M.P. Grace MacInnis told a parliamentary committee studying her private member’s bill to legalize abortion that “nobody would be forcing abortion procedures on anyone else.” [Quoted in de Valk, Alphonse, *Morality and Law in Canadian Politics: The Abortion Controversy*. Dorval, Quebec: Palm Publishers, 1974, p. 44-45]

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

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

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

68. Cook RJ, Dickens BM, “In Response”. *J.Obstet Gynecol Can*, February, 2004; 26(2)112.

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

70. Recalling an earlier case (*Canson Enterprises Ltd. v. Boughton & Co.* [1991] 3 S.C.R. 534),
71. Quoting LeBel, J. in *Henderson v. Johnston*, [1956] O.R. 789 at p. 799.
72. Cook RJ, Dickens BM, Access to emergency contraception [letter] *J.Obstet Gynaecol Can* 2004; 26(8):706.
73. Dickens, Bernard M. "Informed Consent": Chapter 5 in Downie, Joceyln, Caulfield, Timothy and Flood, Colleen (Eds.) *Canadian Health Law and Policy* (2nd Ed.). Butterworths, p. 149.
74. *Riebl v. Hughes* (1980), 114 DLR (3rd) 1, (1980) 2 SCR 880, 14 CCLT 1, 33 NR, 361; *Hopp v. Lepp* (1980), 112 DLR (3d) 67, (1980) 2 SCR 192, (1980) 4 WWR 645, 22 AR 361, 13 CCLT 66, 32 NR 145, followed; *Trogun v. Fruchtmann* (1973), 207 NW 2d 297; *Downer v. Veilleux* (1974), 322 A. 2d 82, referred to.
75. *Zimmer v. Ringrose* (1981), 124 DLR (3d) 225-226 (Alberta Court of Appeal); *Zimmer v. Ringrose* (1978), 89 Dominion Law Reports (3d) 657 (Alberta Supreme Court)
76. *Zimmer v. Ringrose* (1981), 124 DLR (3d) 219 (Alberta Court of Appeal); *Zimmer v. Ringrose* (1978), 89 DLR (3d) 649 (Alberta Supreme Court)
77. *Zimmer v. Ringrose* (1981), 124 DLR (3d) 219 (Alberta Court of Appeal); *Zimmer v. Ringrose* (1978), 89 DLR (3d) 649 (Alberta Supreme Court)
78. *Zimmer v. Ringrose* (1981), 124 DLR (3d) 226 (Alberta Court of Appeal)
79. *Zimmer v. Ringrose* (1978), 89 DLR (3d) 657-658 (Alberta Supreme Court)
80. *Zimmer v. Ringrose* (1981), 124 DLR (3d) 226 (Alberta Court of Appeal); *Zimmer v. Ringrose* (1978), 89 DLR (3d) 657 (Alberta Supreme Court)
81. Lee, Jenny, "Official slams 'sex selection' blood test: Gender of fetus can be seen five weeks into pregnancy." *Vancouver Sun*, 13 August, 2005.
(<http://www.canada.com/vancouver/vancouvernews/story.html?id=1735ec8d-56cc-4510-89e8-c62c480e97b6>) Accessed 2005-10-10
82. Ramsay, Sarah, "Controversy over UK surgeon who amputated healthy limbs." *The Lancet*, Volume 355, Number 9202, 05 February 2000. Dr. Smith waived his fee and the patients paid for the surgery. (<http://www.thelancet.com>) Accessed 2001-10-04
83. Gawande, Atul, *When law and ethics collide - Why physicians participate in executions.* *N Engl J Med* 354;12 23 March, 2006, 1221-1229
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103. "The Ambassador did not consider that seeking the fruits of the Syrian interrogation made Canada complicit in obtaining information that might have been the product of torture. He reasoned that he did not ask the Syrians to continue interrogating Mr. Arar so that Canada could

obtain information. Furthermore, the Ambassador did not have any evidence that Mr. Arar was being tortured or held incommunicado. *Arar Inquiry: Vol. I*, p. 271
(http://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/maher_arar/07-09-13/www.ararcommission.ca/eng/Vol_I_English.pdf) Accessed 2008-09-08.

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

105. “Mr. Solomon prepared a draft memorandum for the Minister . . . which dealt with the upcoming CSIS trip to Syria and stated . . . “there are concerns as to whether a visit to Arar by Canadian intelligence officials may make Canada appear complicit in his detention and possible poor treatment by Syrian authorities.” *Arar Inquiry: Vol. I*, p. 309
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“Mr. Livermore testified that the original statement about the reliability of the confession and the possible complicity by Canada if CSIS was to meet with Mr. Arar was “very much on the speculative side” and “it was anticipating something that we later ironed out with CSIS, namely that they would not seek access to Mr. Arar.”
Arar Inquiry: Vol. I, p. 310
(http://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/maher_arar/07-09-13/www.ararcommission.ca/eng/Vol_I_English.pdf) Accessed 2008-09-08

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

107. “Canadian officials did not participate or acquiesce in the American decisions to detain Mr. Arar and remove him to Syria. I have thoroughly reviewed all of the evidence relating to events both before and during Mr. Arar’s detention in New York, and there is no evidence that any Canadian authorities — the RCMP, CSIS or others — were complicit in those decisions.”
Arar Inquiry: Analysis and Recommendations, p. 29

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“Although decisions to interact must be made on a case-by-case basis, they should be made in a way that is politically accountable, and interactions should be strictly controlled to guard against Canadian complicity in human rights abuses or a perception that Canada condones such abuses.” *Arar Inquiry: Analysis and Recommendations*, p. 35

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“If it is determined that there is a credible risk that the Canadian interactions would render Canada complicit in torture or create the perception that Canada condones the use of torture, then a decision should be made that no interaction is to take place.” *Arar Inquiry: Analysis and Recommendations*, p. 199

(http://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/maher_arar/07-09-13/www.ararcommission.ca/eng/AR_English.pdf) Accessed 2008-09-08

“Even if one were to accept that Canadian officials were somehow complicit in those arrests, that would not change my conclusion, based on the evidence at the Inquiry, that Canadian officials did not participate or acquiesce in the American decision to send Mr. Arar to Syria from the United States.” *Arar Inquiry: Analysis and Recommendations*, p. 271

(http://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/maher_arar/07-09-13/www.ararcommission.ca/eng/AR_English.pdf) Accessed 2008-09-08

“Information should never be provided to a foreign country where there is a credible risk that it will cause or contribute to the use of torture. Policies should include specific directions aimed at eliminating any possible Canadian complicity in torture, avoiding the risk of other human rights abuses and ensuring accountability.” *Arar Inquiry: Analysis and Recommendations*, p. 345

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“Clearly, the prohibition against torture in the Convention against Torture is absolute. Canada should not inflict torture, nor should it be complicit in the infliction of torture by others.” *Arar Inquiry: Analysis and Recommendations*, p. 346

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151. “. . . there is no binding hard norm that recognizes women’s right to terminate a pregnancy. To argue that such a right exists, we have focused on interpretations of three categories of hard norms: the rights to life and health; the right to be free from discrimination; those rights that protect individual decision-making on private matters.” ILPS Memo #1, E2536
152. “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

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“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.

153. 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

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

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