Religiously Discordant, Legally Consistent, and Ethically Ambiguous:

The College of Physicians and Surgeons of Ontario's Approach to Conscientious Objection

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Abstract

The College of Physicians and Surgeons of Ontario (CPSO) recently published its revised policy, "Physicians and the Ontario *Human Rights Code*," which establishes professional guidelines pertaining to conscientious objection. Insofar as it compels complicit action on the part of objecting physicians, the policy has engendered controversy within religious, legal and bioethical communities in Canada. To provide insight into this debate, my dissertation examines the CPSO's guidelines through the lenses of Roman Catholicism, Canadian law and the ethical framework of principlism. Whereas analysis reveals tension between the CPSO's position and the Roman Catholic doctrines on conscience and cooperation in evil, general consistency exists between the policy statement and the treatment of conscience and religion within Canadian jurisprudence. Through the lens of principlism, consistency between the policy statement and the principles of respect for autonomy, beneficence and justice is punctured by ambiguity between the CPSO's position and the principle of nonmaleficence, as well as conflict between the guidelines and respect for physician autonomy.

Abrégé

Le «College of Physicians and Surgeons of Ontario» (CPSO) a récemment publié une version révisée de la politique "Physicians and the Ontario *Human Rights Code*," qui établit les lignes directrices professionnelles portant sur l'objection de conscience. Dans la mesure où elle exige une action de la part des médecins, la politique a engendré une controverse à travers les communautés religieuses, légales et bioéthiques canadiennes. Afin de donner un aperçu de ce débat, ma dissertation examine les lignes directrices du CPSO selon les perspectives du Catholicisme Romain, de la loi Canadienne et du cadre éthique principisme. Bien que certaines analyses révèlent des tensions entre la position du CPSO et la doctrine Catholique Romaine sur la conscience et la coopération en mal, il existe une cohérence générale entre la politique et le traitement de la conscience ainsi que de la religion dans la jurisprudence canadienne. Dans l'optique du principisme, la constance entre l'affirmation de la politique et les principes du respect de l'autonomie, de la bienfaisance et de la justice est ponctuée par une ambiguïté entre la position du CPSO et le principe de la non malfaisance, de même qu'un conflit entre les lignes directrices et le respect de l'autonomie des médecins.

Introduction:

Conscientious Objection and Health Care Policy in Canada

Within the context of medicine, the issue of conscientious objection emerges when there is a conflict between a health care practitioner's professional obligations, on the one hand, and the practitioner's personal conscience on the other.[1] This conflict can cause the health care practitioner to refrain, on grounds of conscience, from fulfilling his or her professional obligations (as determined by medical standards of due care and patient expectations).[2] Numerous members of a health care team can experience discord between their professional obligations and the dictates of their consciences, including physicians, nurses, occupational and respiratory therapists, social workers and pharmacists. Examples of conscientious objection include the following: the refusal to perform or assist in an abortion due to the belief that it constitutes murder; a pharmacist's refusal to fill a prescription for post-coital contraception on the grounds that its use amounts to abortion, and by extension, murder; the refusal by a Roman Catholic doctor to prescribe contraception to adults on the basis of the Church's condemnation of contraceptive sexual acts; the refusal to provide a terminally ill patient with possibly life-prolonging treatment on the grounds that it is a misuse of resources and is unlikely to bring about net benefit for the patient; the refusal to cease life-prolonging care despite the patient's request to stop treatment because the physician believes it constitutes abandonment and therefore violates her professional duties; the refusal to provide assisted reproductive technologies to

same-sex couples on the grounds that it is "unnatural" and "wrong"; and the refusal to use certain medicines (such as growth hormones) for enhancement rather than treatment on the grounds that medicine should be distributed according to need, not want.[3]

Although not a comprehensive list, the above examples demonstrate the wide range of situations in which conscientious objection can arise, and the diversity of potential reasons behind such refusals to provide medically indicated and legal care.[4] Far from being limited to religious and moral beliefs, conscientious objection can stem from various other factors, including concern for social and distributive justice as well as practitioners' own perception of their professional responsibilities. Significant controversy has developed surrounding the issue of conscientious objection in medicine to the extent that it pits practitioners' right to work and live according to their deeply held conscientious beliefs against patients' right to access medical care. Participants in the debate have put forth a multitude of arguments both in favour and against granting health care professionals the right to deny care on grounds of conscience.

Beyond the argument that defying the dictates of one's conscience is extremely distressing and precipitates strong feelings of guilt, common arguments in favour of practitioners' right to conscientious objection include those grounded in ethical relativism, the toleration of moral diversity, respect for health care practitioners' autonomy and respect for moral integrity.[5] The argument from ethical relativism is based on two premises. The first premise holds that the truth-value or validity of an ethical statement is contingent upon the ethical framework

from within which the ethical statement is made. The second maintains that there are several different frameworks that are applied in ethical deliberation and none is more valid than the others. Thus, when ethical judgments emanating from different frameworks collide, it is impossible to value or place one judgment above the other(s). In the context of conscientious objection, an ethical relativist who accepts the medical profession's standard of care in a given situation might conclude that the moral framework underpinning this standard of care is no more valid than the moral framework behind the practitioner's conscientious objection. Consequently, the ethical relativist may conclude that the practitioner's objection deserves respect.[6]

Alternatively, according to the principle of toleration of moral diversity, "we should tolerate the moral views of others and not attempt to impose our ethical beliefs on them."[7] This principle largely stems from a current lack of common moral ground within post-industrial democratic societies from which to adjudicate disagreements and differences among citizens.[8] Belief in the principle of toleration may derive from various sources, such as ethical relativism, the liberal ideal of respect for individual freedom and citizens' right to self-determination. In cases of conscientious objection, this principle implies that objecting practitioners should not be forced to abandon their ethical standards and adopt the prevailing ethical views within their professions.[9]

The third argument in support of conscientious objection holds that forcing practitioners to defy their consciences violates their autonomy.[10] Despite the fact that respect for *patient* autonomy and self-determination has remained a

dominant ethical principle in Western medical practice since the early 1970s,[11] health care practitioners and patients have equal claims to respect for their autonomy by virtue of their capacity as human beings for rational judgment and the expression of their preferences, values and choices.[12] Accordingly, this argument asserts that physicians should have the right to determine which medical procedures they will personally provide to patients.[13] Finally, the fourth argument from respect for moral integrity maintains that by stating a conscientious objection to a particular medical procedure, the practitioner is not merely asserting that the procedure in question in unethical. Instead, this appeal to conscience is an attempt to preserve the practitioner's moral integrity.[14] For health care professionals to claim that their moral integrity is at stake by way of conscientious objection implies that they have core ethical values, which are integral to their personal identity, and that to perform the procedures to which they object would contravene these core ethical values and severely disrupt their self-understanding.[15]

Turning now to the opposite side of the debate, common arguments against conscientious objection in medicine include claims that there is no right to be admitted into the health care professions or particular specializations therein, that conscientious objection causes inequity, inefficiency and inconsistency in the delivery of health care, that conscientious objection can lead to discrimination and that it disregards patient autonomy. With regards to the first argument, Piers Benn aptly states, "Just as a declared pacifist is unlikely to be admitted to the Army, so an aspiring doctor might not be admitted into a particular area within medicine if

she declared herself unwilling to do what is normally required by the job. And whatever the merits of her conscientious position, her rights are not violated if she is denied entry to her preferred area because no such right existed in the first place."[16] The argument that individuals have no right to work in the various health care professions or specializations therein can be extended beyond the medical realm. At a societal level, this claim asserts that there is no right to be admitted to any particular profession or line of work. What typically qualifies individuals for specific jobs is their ability and willingness to perform the duties that a job entails. Hence, if an individual is unable or unwilling to complete the tasks associated with a particular line of work, it follows that he or she is not considered a viable candidate. This is true whether the factor(s) inhibiting an individual's ability and/or willingness to fulfill an occupation's requirements are physical, psychological, emotional or social in nature.

The second argument focuses on three potential ramifications of allowing health care practitioners the right to conscientious objection—namely, inefficiency, inequity and inconsistency. The claim that conscientious objection generates inefficiency points to the fact that health care professionals' refusal to provide medically indicated and legal services to patients can cause delays in patients' receipt of care. Faced with health care providers' refusals to provide treatment, patients are typically forced to "shop around" among health care workers to receive the services to which they are entitled under their health care system.[17] Inequity, on the other hand, arises when practitioners' conscientious objections result in denial of treatment. For those patients who are unaware or less

informed of their entitlements in terms of health care, practitioners' conscientious objections to providing particular services may be misinterpreted to imply that these services are simply inaccessible, period. Such misunderstanding consequently deters these patients from seeking treatment from other health care professionals, and ultimately results in their failure to receive services to which they are entitled.[18] Lastly, the claim that conscientious objection produces inconsistency pertains to health care contexts wherein only certain values and commitments qualify as valid grounds for practitioners' conscience-based refusals to provide services. The privileging of some personal values and commitments over others generates a hierarchical ordering of beliefs, and ultimately limits the right to conscientious objection to those health care practitioners whose conscientiously held beliefs have been deemed legitimate.[19]

The third claim against allowing for conscientious objection in medical contexts maintains that a practitioner's conscience-based refusal to provide a medically indicated care can constitute an act of discrimination. In applying this argument, it is important to recognize that conscientious objection *does not necessarily* engender the discriminatory delivery of health care; rather, discrimination is limited to instances where practitioners' refusals disproportionately affect a certain segment (or certain segments) of society.[20] For instance, a physician's conscientious objection to provide same-sex couples with assisted reproductive technologies because the physician believes homosexuality is a sin effectively constitutes discrimination on the basis of sexual orientation. Another example is the physician who refuses to care for individuals over the age

of 75 because the physician believes that treating people in this age bracket is a waste of financial and medical resources. This second case involves the discriminatory distribution of health care of the basis of age (also known as "ageism").

The fourth argument from respect for patient autonomy is one of the most prevalent in the debate surrounding conscientious objection due to the principle of autonomy's predominant position within Western medical practice.[21] According to this argument, health care practitioners should be denied the right to conscientious objection because such denial infringes on patients' right to self-determination and impedes their ability to make autonomous decisions with regards to their health and well-being.[22] This argument directly confronts the argument in support of conscientious objection grounded in respect for *physician* autonomy, and it is at this point of conflict that much of the controversy surrounding conscientious objection is played out.

The strength of conflicting claims involved in the controversy surrounding conscientious objection has pushed some participants in the debate to search for a degree of compromise between practitioners' right to work and live according to their deeply held conscientious beliefs and patients' right to access medical care. In his article, "Conscientious Refusal by Physicians and Pharmacists: Who is Obliged to Do What, and Why?" Dan Brock attempts to strike such a balance by identifying the (limited) conditions under which physicians' and pharmacists' conscientious refusals are compatible with their professional obligations of care. He labels this balancing act "the conventional compromise."[23] According to the

conventional compromise, a physician/pharmacist who has a serious moral objection to providing a service to a patent is not required to do so *only if the following three conditions are met*: 1) the physician/pharmacist informs the patient about the morally contentious service if it is medically relevant to the patient's medical condition; 2) the physician/pharmacist refers the patient to another professional willing and able to provide the service; and 3) the referral does not impose an unreasonable burden on the patient.[24] However, it is important to note that even though satisfying these conditions is necessary to excuse physicians and pharmacists from providing services to which they object, it is not always sufficient.[25] Cases in which Brock believes his three conditions are insufficient to excuse practitioners include instances of conscientious objection that violate legal requirements of social justice (i.e., where services are denied on discriminatory grounds) and when conscientious objection is incompatible with the fulfillment of central responsibilities of the physician's professional role (i.e., an emergency room physician who, as a Jehovah's Witness, conscientiously refuses to provide her patients with blood transfusions on the grounds that it will rob them of eternal salvation).[26]

Although Brock's conventional compromise aims at reducing health care providers' participation in the acts to which they conscientiously object, its conditions nonetheless demand a certain level of complicity on the part of objecting practitioners.[27] Concern over complicity pertains to both informing patients of treatment options to which the practitioner morally objects and providing patients with referrals for these procedures, inasmuch as informing and

referring causally contribute to the increased probability that the act in question will take place.[28] Although the moral implications of such indirect participation may seem trivial to some, a recent study by Farr Curlin and colleagues identified concern over complicity among conscientiously objecting physicians in the United States.[29] This study revealed that many practicing physicians in the U.S. do not consider themselves obligated to disclose information about, or refer patients for, morally contentious medical procedures.[30] Based on their results, more than 40 million Americans (14% of patients) may be cared for by physicians who do not believe that they are obligated to disclose information about medically available treatments they consider objectionable, and nearly 100 million Americans (29% of patients) may be cared for by physicians who do not believe that they have an obligation to refer their patients to other health care providers for these treatments.[31] These numbers could have serious implications, seeing that the proportion of physicians who reported objecting to certain treatments in the survey was substantial.[32]

Despite what appears to be strong concern for complicity among conscientiously objecting physicians in the U.S., however, current health care policy in Canada has adopted regulations pertaining to the issue of conscientious objection that mirror the conditions set out in Brock's conventional compromise. The College of Physicians and Surgeons of Ontario's (CPSO) recently published statement, "Physicians and the Ontario *Human Rights Code*," is one such policy.[33]

The restriction of physicians' right to conscience in Ontario

The Ontario *Human Rights Code* (the '*Code*') is a provincial law that affords equal rights and opportunities to every citizen in the province without discrimination in specific areas such as jobs, housing and services.[34] The *Code* aims to prevent discrimination and harassment on the following fifteen grounds: race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, family status, disability, receipt of public funds (in relation to accommodation only), and record of offenses (in relation to employment only).[35] In June 2008, major amendments to the *Code* came into effect. In reaction to these changes, the CPSO published a revised version of its policy, "Physicians and the Ontario *Human Rights Code*," in order to clarify physicians' obligations under the amended *Code* and the CPSO's corresponding expectations.[36] The CPSO's response was precipitated by its obligation to consider the *Code* when determining whether physician conduct has breached professional standards.[37]

The policy statement is divided into two main sections. The first section addresses physicians' obligations under the *Code* to provide medical services without discrimination, while the second defines physicians' duty to accommodate the disabilities of patients or individuals who wish to become patients.[38] Echoing section 1 of the *Code*, the CPSO's policy clearly states: "[P]hysicians cannot make decisions about whether to accept individuals as patients, whether to provide existing patients with medical care or services, or whether to end a physician-patient relationship on the basis of the individual's or

patient's race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, family status and/or disability."[39] In its subsection entitled, "Moral or Religious Beliefs," the policy follows up on the above statement with the warning, "If physicians have moral or religious beliefs which affect or may affect the provision of medical services, the College advises physicians to proceed cautiously with an understanding of the implications related to human rights."[40] Noting that the law in this area is unclear, it informs its members that the Ontario Human Rights Commission or Tribunal may consider decisions to restrict medical services offered, to accept individuals as patients or to end a physician-patient relationship that are based on physicians' moral or religious beliefs to be contrary to the *Code*.[41] As guidelines for physicians attempting to navigate this uncertain terrain, the CPSO lists its expectations for physicians who limit their practice, refuse to accept individuals as patients, or end a physician-patient relationship on the basis of moral or religious beliefs. Physicians are expected to do the following:

> 1) Communicate clearly and promptly about any treatments or procedures the physician chooses not to provide because of his or her moral or religious beliefs.
>
> 2) Provide information about all clinical options that may be available or appropriate based on the patient's clinical needs or concerns. Physicians must not withhold information about the existence of a procedure or treatment because providing that procedure or giving advice about it conflicts with their religious or moral beliefs.
>
> 3) Treat patients or individuals who wish to become patients with respect when they are seeking or requiring the treatment or procedure. This means that physicians should not express personal judgments about the beliefs, lifestyle, identity or characteristics of a patient or an individual who wishes to become a patient. This also means that physicians should not promote their own religious beliefs when interacting with patients, nor

> should they seek to convert existing patients or individuals who wish to become patients to their own religion.
>
> 4) Advise patients or individuals who wish to become patients that they can see another physician with whom they can discuss their situation and in some circumstances, help the patient or individual to make arrangements to do so.[42]

These professional standards represent the CPSO's attempt to balance the rights of physicians and those of patients in accordance with the principles set out in the *Code*.

Though these guidelines ostensibly remove the duty of physicians to participate directly in the provision of medical services to which they conscientiously object on moral or religious grounds, they compel a level of complicit action on the part of objecting physicians akin to Brock's conventional compromise. Consequently, significant controversy has arisen surrounding the CPSO's policy statement. Several individuals and organizations have strongly objected to the guidelines, accusing the CPSO of failing to protect physicians' right to freedom of religion and conscience in requiring its members to facilitate the medical services they find morally reprehensible by providing information and, in some instances, referrals to other physicians who are willing and able to perform the procedure.[43] They argue that forcing even indirect participation in immoral acts infringes physicians' legal rights, and requires them to violate their religious and moral integrity. A further objection stems from respect for physician autonomy. Forcing physicians to act against their consciences negates their right to self-determination and transforms them into silent technicians. Some of these

opponents subsequently call for the expansion of physicians' right to conscientious objection to include matters of complicity.[44]

In light of the controversy generated by the CPSO's expectations, the following chapters provide religious, legal and ethical insight into the debate surrounding the CPSO's stance on conscientious objection by examining its policy statement through the lenses of Roman Catholicism, Canadian law and the ethical framework of principlism. This analytical triptych reveals some of the ideological underpinnings of the CPSO's guidelines by identifying points of consistency and tension between its policy statement, on the one hand, and the Roman Catholic tradition, the Canadian legal system and the principlist context, on the other. Chapter 1 approaches the CPSO's policy statement from a Roman Catholic perspective, guided by the following question: To what extent do the CPSO's guidelines coincide or conflict with the Roman Catholic doctrines on conscience and cooperation in evil? The first section of this discussion addresses the Roman Catholic formulation of conscience, specifically its nature, function, formation and authority. Examined in lights of this doctrine, it is clear that the CPSO's requirements pertaining to conscientious objection conflict with the primacy and authority attributed to conscience within the Roman Catholic tradition, and are thereby indefensible from the latter's perspective. The second section turns to the traditional doctrine on cooperation in evil, distinguishing among various types of formal and material cooperation in order to assess the acceptability of the CPSO's expectations relating to full disclosure and patient referral. The principle of double effect is developed as part of this discussion

insofar as Roman Catholicism applies it in conjunction with the doctrine on cooperation in evil in order to determine whether specific instances of mediate material cooperation are morally justifiable. Here, my analysis shows that participation in patient referral constitutes formal cooperation and is therefore unjustifiable from a Roman Catholic perspective in cases where the referral pertains to a morally illicit procedure. Conversely, the comprehensive disclosure of treatment options qualifies as mediate material cooperation and is justifiable under the principle of double effect, so long as such participation does not involve intrinsically evil acts and serious consideration is afforded to the element of scandal.

Chapter 2 provides a legal analysis of the CPSO's policy with specific reference to the constitutional right of freedom of conscience and religion established in section 2(a) of the *Canadian Charter of Rights and Freedoms*, as well as Canadian citizens' protection from discrimination under human rights legislation. This chapter focuses on the following question: To what extent does the CPSO's policy statement coincide or conflict with the conceptualization and treatment of conscience and religion within Canadian constitutional and administrative law? The discussion first addresses five prevailing trends in the law's interaction with conscience and religion that have emerged in recent legal scholarship, and subsequently examines whether these themes are evident in the CPSO's approach to conscientious objection. These trends are: 1) the conflation of "conscience" and "religion" in section 2(a) analysis and the subsequent assimilation of the freedom of religion into freedom of conscience; 2) the law's

characterization of religion as a matter of autonomous choice; 3) the restriction of religion to the private sphere; 4) the subordination of religious values to the civic values of the state in cases where the two value systems collide; and 5) equal concern for the principles of liberty and equality in relation to religious freedom. Examined in light of these themes, my analysis demonstrates that the CPSO's conceptualization and treatment of conscience and religion is generally consistent with that of the current Canadian legal system. The CPSO's policy statement clearly reflects the first four themes, as it conflates religiously and non-religiously motivated conscientious objection (thereby assimilating the categories of religion and conscience), posits religion as autonomous choice, excludes religious expression from physicians' freedom of religion and relegates religion to the private sphere, and subordinates religious interests to those of the patient and the state. The sole point of inconsistency pertains to the fifth trend, inasmuch as the CPSO's treatment of physicians' right to religious freedom negates concern for religious equality.

Chapter 3 examines the CPSO's position on conscientious objection from within the ethical framework of principlism, as developed in the work of philosophers Tom L. Beauchamp and James F. Childress. The following question serves to guide the discussion: To what degree do the CPSO's requirements of full disclosure and patient referral—in spite of a physician's conscientious objection—coincide or conflict with the four principles of respect for autonomy, nonmaleficence, beneficence and justice developed in Beauchamp and Childress' formulation of principlism? The first section of this chapter looks at Beauchamp

and Childress' explication of the above four principles and includes the issues of informed consent and medical paternalism as they relate to the principles of respect for autonomy and beneficence, respectively. The second section consists of my bioethical analysis of the CPSO's policy statement, wherein two fictional case models help structure the discussion by effectively highlighting the ethical dilemmas that can arise in relation to the issues of disclosure and referral in situations of conscientious objection. Though the issue of conscientious objection produces several ethical dilemmas between conflicting ethical principles, my analysis reveals some consistency between the CPSO's policy requirements of disclosure and referral, on the one hand, and the principles of respect for autonomy, beneficence and justice on the other. The expectation that conscientiously objecting physicians fully disclose treatment options and refer patients for the procedures to which they object is consistent with the principle of autonomy to the extent that these requirements respect patients' capacity for autonomous choice, including the ability to act on these choices. Moreover, the CPSO's policy requirements reflect the principle of beneficence inasmuch as they respect patient choice as an expression of personhood, and coherence with the principle of justice is manifested in the fact that both policy requirements help maintain an equitable standard of access to health care.

Despite this consistency, however, there is substantial ambiguity surrounding the relationship between the CPSO's stance on conscientious objection and the principle of nonmaleficence. By attempting to ensure that physicians fully inform their patients of treatment options and provide patient

referrals for the medical procedures to which they conscientiously object, the CPSO's requirements minimize the possibility that patients will experience significant obstacles in accessing medically indicated care that is most consistent with their values and preferences. This, in turn, may reduce the detrimental implications that delays and denial of treatment can have on patients' physical, psychological and emotional well-being. Yet, by virtue of the fact that instances of conscientious objection often involve contentious medical procedures of which the benefits and burdens are unclear, it is impossible to definitively determine whether facilitating patient access to such contentious medical treatment is in fact in accordance with the principle of nonmaleficence. A physician's conscience-based refusal to provide a certain service may in fact be protecting patients from harm. The consistency between the CPSO's policy and the ethical framework of principlism is also punctured by a conflict between the policy's requirements and the principle of respect for *physician* autonomy. In spite of the coherence between the CPSO's position and respect for patient autonomy, forcing objecting physicians to disclose treatment options to which they object and refer patients for such procedures effectively denies these physicians their right to autonomous choice and self-determination.

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[1] Piers Benn, "Conscience and Health Care Ethics," in *Principles of Health Care Ethics*, 2nd ed., edited by Richard E. Ashcroft, Angus Dawson, Heather Draper and John R. McMillan, 345-350 (Chichester: John Wiley & Sons, Ltd., 2007) 345.

[2] Ibid.

[3] Ibid., 347; and Dan W. Brock, "Conscientious Refusal by Physicians and Pharmacists: Who is Obliged to Do
What, and Why?" *Theoretical Medicine and Bioethics* 29, no. 3 (2008): 188.

[4] "Medically indicated care" refers to any legal medical service that most other members of the conscientious objector's profession would deem reasonable or appropriate for the patient's condition if they had no moral objection to it.
[5] Mark R. Wicclair, "Conscientious Objection in Medicine," *Bioethics* 14, no. 3 (2000): 210-5.
[6] Ibid., 210.
[7] Ibid., 210-1.
[8] Ibid.
[9] Ibid.
[10] Ibid., 212.
[11] See Howard Brody, "The Physician-Patient Relationship," in *Medical Ethics*, 2nd ed., edited by Robert M. Veatch, 75-101 (Sudbury, MA: Jones and Bartlett Publishers, 1997) 76.
[12] Edmund D. Pellegrino, "Patient and Physician Autonomy: Conflicting Rights and Obligations in the Physician-Patient Relationship," *Journal of Contemporary Health Law & Policy* 10, no. 1 (1994): 58-63.
[13] Physicians' right to determine what procedures they will *personally* provide to patients does not negate patients' right, as autonomous agents, to determine which legal medical procedures they wish to receive. Instead, physicians' equal claim to autonomy and self-determination implies that if a physician is unwilling to provide a particular medical service, his/her patients must seek another health care provider who is willing and able to provide the service, should they desire it.
[14] Wicclair, "Conscientious Objection in Medicine," 213-4.
[15] Ibid., 214. In his discussion of the supporting arguments for physicians' right to conscientiously deny patients the medical services that they find morally illicit, Wicclair dismisses the first three arguments from ethical relativism, toleration of moral diversity and respect for practitioners' autonomy in favour of the fourth argument grounded in respect for moral integrity. However, Wicclair limits physicians' right to conscientious objection on grounds of moral integrity to those objections that are based in core ethical values corresponding to one or more core values in medicine. For his full discussion, see 213-221.
[16] Benn, "Conscience and Health Care Ethics," 349.
[17] Julian Savulescu, "Conscientious Objection in Medicine," *British Medical Journal* 332, no. 7536 (2006): 295.
[18] Ibid.
[19] Ibid.
[20] Addressing the issue of conscientious objection in its response to the CPSO's draft policies relating to establishing and ending physician-patient relationships, the Ontario Human Rights Commission (OHRC) expresses concern regarding the fact that conscientious objection in health care can have discriminatory effects relating to sex, gender identity, sexual orientation, marital status and disability (among other things). It subsequently asserts, "Allowing refusal of healthcare based on personally held religious beliefs would deny the equality rights of those requiring this essential service. A physician's denial of services or refusal to provide a woman with information relating to contraception or abortion, for example, would be discriminatory based on sex, as only women can become pregnant." See Ontario Human Rights Commission, *Submission of the Ontario Human Rights Commission to the College of Physicians and Surgeons of Ontario Regarding the Draft Policies Relating to Establishing and Ending Physician-Patient Relationships*, Ontario Human Rights Commission Web site, 14 February 2008, http://www.ohrc.on.ca/en/resources/submissions/surgeons (accessed 23 April 2010) para. 42.
[21] See Brody, "The Physician-Patient Relationship," 76; and Pellegrino, "Patient and Physician Autonomy," 47.
[22] Pellegrino, "Patient and Physician Autonomy," 58. It should be noted that although I have taken this argument from Pellegrino's work, he is not a proponent of this position. Instead, he identifies the current emphasis on patient autonomy within Western medical ethics as a serious threat to

physicians' right to conscientious objection and subsequently argues for placing patient and physician autonomy on equal footing. See 58-63.

[23] Brock, "Conscientious Refusal," 194-197.

[24] Ibid.

[25] Ibid., 194.

[26] Ibid.

[27] Ibid., 196. "Complicity" is concerned with both the performance of an act and the *facilitation of another's performance of an act* that one finds morally objectionable. See Thomas May and Mark P. Aulisio, "Professional Morality and Professional Obligations: Rights of Conscience and Informed Consent," *Perspectives in Biology and Medicine* 52, no. 1 (2009): 31.

[28] Brock, "Conscientious Refusal," 197.

[29] Farr A. Curlin, Ryan E. Lawrence, Marshall H. Chin and John D. Lantos, "Religion, Conscience, and Controversial Clinical Practices," *New England Journal of Medicine* 356, no. 6 (2007): 593-600.

[30] Curlin et al. conducted a cross-sectional survey of a stratified random sample of practicing U.S. physicians from all specialties by mail (a total of 1144 of 1820 physicians responded to the survey). The primary criterion variables were physicians' judgments about their ethical rights and obligations when patients request a legal medical procedure to which the physician objects for religious or moral reasons. Procedures included administering terminal sedation in dying patients, providing abortion for failed contraception and prescribing birth control to adolescents without parental approval. See 594-5.

[31] Ibid., 595-7.

[32] 52% of the physicians in this study reported objections to abortion for failed contraception and 42% reported objections to contraception for adolescents without parental consent. See 597-9.

[33] College of Physicians and Surgeons of Ontario, *Physicians and the Ontario* Human Rights Code, Policy Statement #5-08, College of Physicians and Surgeons of Ontario Web site, December 2008, http://www.cpso.on.ca/policies/policies/default.aspx?ID=2102. On January 1, 2010, the College of Physicians and Surgeons of Alberta adopted regulations pertaining to conscientious objection among its members that are almost identical to those of the CPSO's policy statement. See College of Physicians and Surgeons of Alberta, "Moral or Religious Beliefs Affecting Medical Care," in Health Professionals Act *Standards of Practice* (Consolidation), College of Physicians and Surgeons of Alberta Web site, 1 January 2010, http://www.cpsa.ab.ca/Resources/standardsofpractice.aspx, 34.

[34] Ontario Human Rights Commission, *Guide to Your Rights and Responsibilities Under the Human Rights Code*, Ontario Human Rights Commission Web site, 15 January 2009, http://www.ohrc.on.ca.

[35] *Human Rights Code*, R.S.O. 1990, c. H.19.

[36] "Understanding Your Legal Obligations Under the *Human Rights Code*: New Policy Provides Physicians With Guidance," *Dialogue* 4, no. 5 (2008): 9. Available online at http://www.cpso.on.ca/policies/publications/dialogue/default.aspx?id=2826 (accessed 26 April 2010).

[37] College of Physicians and Surgeons of Ontario, *Physicians*, 2.

[38] This dissertation focuses on the first section of the CPSO's policy statement insofar as the controversy surrounding this document relates to the CPSO's expectations laid out in this part.

[39] College of Physicians and Surgeons of Ontario, *Physicians*, 2. Section 1 of the *Code* states: "Every person has a right to equal treatment with respect to services, goods and facilities, without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, family status or disability."

[40] College of Physicians and Surgeons of Ontario, *Physicians*, 3.

[41] Ibid.

[42] Ibid., 4. For the purposes of this dissertation, the CPSO's fourth expectation is understood as a clear duty to refer patients in situations of conscientious objection since its ambiguity effectively leaves the door open for the CPSO to apply it as a definite obligation of patient referral in any and all cases of conscientious objection.

[43] See Michèle Boulva, "Response to the Draft CPSO Policy Entitled 'Physicians and the Ontario *Human Rights Code*'," Catholic Organization for Life and Family Web site, 17 September 2008, http://www.colf.ca/mamboshop/index.php?option=com_content&task=view&id=172&lang=enc (accessed 23 April 2010); Thomas Collins, "Archbishop Collins' Letter to CPSO on Conscience," Canadian Federation of Catholic Physicians' Societies Web site, 12 September 2008, http://www.canadiancatholicphysicians.com/mainmenu.html (accessed 23 April 2010); Raymond J. de Souza, "Human Rights Disease Has Been Stabilized, Not Cured," *National Post*, 19 September 2008, http://network.nationalpost.com/np/blogs/fullcomment/archive/2008/09/19/father-raymond-j-de-souza-human-rights-disease-has-been-stabilized-not-cured.aspx (accessed 23 April 2010); Will Johnston, "Re: Draft Policy Document, 'Physicians and the Ontario *Human Rights Code*'," Canadian Physicians for Life Web site, 11 September 2008, http://www.physiciansforlife.ca/html/conscience/articles/CPSOSept1108Submission.html (accessed 23 April 2010); Will Johnston, "Re: Proposed Changes to College Human Rights Policy – 'Physicians and the Ontario *Human Rights Code*'," Canadian Physicians for Life Web site, 18 August 2008, http://www.physiciansforlife.ca/html/conscience/articles/CPSOSubmission.html (accessed 23 April 2010); Joanne McGarry, "Submission re: *Physicians and the Ontario* Human Rights Code," Protection of Conscience Project Web site, 12 September 2008, http://www.consciencelaws.org/Examining-Conscience-Ethical/Ethical78c.html (accessed 23 April 2010); Terrence Prendergast and Reuven P. Bulka, "Rabbi Bulka & Archbishop Prendergast Declaration to CPSO," Canadian Federation of Catholic Physicians' Societies Web site, 11 September 2008, http://www.canadiancatholicphysicians.com/mainmenu.html (accessed 23 April 2010); Ruth A.M. Ross, "Proposed Draft Policy of the College of Physicians and Surgeons of Ontario: Submission of the Christian Legal Fellowship," Protection of Conscience Project Web site, undated, http://www.consciencelaws.org/Examining-Conscience-Ethical/Ethical78c.html (accessed 23 April 2010); Lee Duigon, "Canadian Doctors Warned to 'Set Aside' God's Law," Protection of Conscience Project Web site, 9 September 2008, http://www.consciencelaws.org/Examining-Conscience-Ethical/Ethical78e.html (accessed 23 April 2010); John B. Shea, "Physicians and the Ontario *Human Rights Code*," Catholic Insight Web site, 18 September 2008, http://catholicinsight.com/online/bioethics/article_848.shtml (accessed 23 April 2010); Margaret Somerville, "Denying Doctors Free Conscience Unconscionable," Protection of Conscience Project Web site, undated, http://www.consciencelaws.org/Examining-Conscience-Ethical/Ethical78d.html#Denying_doctors_free_conscience_unconscionable (accessed 23 April 2010); and Iain T. Benson, "Physicians, Patients, Human Rights, and Referrals: A Principled Approach to Respecting the Rights of Physicians and Patients in Ontario," Centre for Cultural Renewal Web site, 12 September 2008, http://www.culturalrenewal.ca/qry/page.taf?id=135 (accessed 23 April 2010).

[44] This is a very brief overview of the negative reactions precipitated by the CPSO's policy statement. A more detailed discussion of these responses is included throughout the body of this dissertation.

Considerable Tension:

Examining the CPSO's Policy Statement from within the Roman Catholic Moral Tradition

After the College of Physicians and Surgeons of Ontario (CPSO) publicly circulated the draft policy statement, "Physicians and the Ontario *Human Rights Code*,"[1] numerous religious organizations and individuals released heated responses to the CPSO's guidelines surrounding the issue of conscientious objection.[2] Although these publications were addressed specifically to the draft version, several of the concerns expressed in these documents remain pertinent to the final version of the CPSO policy statement that was published by the CPSO in December 2008.[3] Prevalent among the respondents' submissions is the concern that the professional expectations laid down by the CPSO constitute an unjustified infringement of physicians' constitutional rights. Writing on behalf of the Christian Legal Fellowship, Ruth Ross accuses the policy guidelines of unreasonably interfering with the constitutional right to freedom of religion and conscience guaranteed under section 2(a) of the *Canadian Charter of Rights and Freedoms*, insofar as it forces physicians to act against their individual consciences. She further maintains that this infringement is not justified under the limitation clause of section 1.[4] In accordance with Ross' accusation, Archbishop Terrence Prendergast and Rabbi Dr. Reuven P. Bulka assert that the CPSO's requirements go against the text and spirit of the Canadian constitution and are thus "fundamentally and shamefully un-Canadian." [5]

A second critique expressed in the responses issued from religious groups and individuals is that it is unreasonable to expect physicians to completely separate their private beliefs and commitments from their public roles and actions. Human beings live their lives on a continuous spectrum between the public and the private, where there is continuous and inevitable interaction between public and private spheres of an individual's life.[6] This point may be particularly true for physicians and other health care professionals who have chosen to devote their lives to medicine and healing as a result of their religious commitment to help others. Here, religious convictions are not something optional or disconnected from the professions these individuals practice.[7] The CPSO's failure to adequately recognize the seriousness and obligatory nature of religious commitments is another criticism that is put forth by the Chalcedon Foundation.[8] In its submission, the Foundation critiques the policy's use of the words "personal beliefs" to describe Christians' absolute obligation to obey the laws of God.[9] Lee Duigon, writing for the Foundation, articulates the distinction between personal beliefs and religious obligations: "We can set aside a 'personal belief" without offending God; but we cannot under any circumstances set aside God's commandments."[10]

The Catholic Organization for Life and Family (COLF) worries that the policy redefines and narrows the role of the physician vis-à-vis the patient within society in such a way that physicians are transformed into silent technicians.[11] This concern is expressed in relation to the third College expectation that requires physicians to refrain from "express[ing] personal judgments about the beliefs,

lifestyle, identity or characteristics of a patient or an individual who wishes to become a patient."[12] COLF argues that this vaguely worded prohibition effectively takes away from the "never do harm" precept of the Hippocratic Oath, and moves toward a marketplace philosophy wherein the customer is always right. This is a highly dangerous shift in the physician-patient relationship inasmuch as the customer is sometimes wrong in health-related matters, and such instances of error in clinical contexts can lead to severely harmful consequences.[13]

Religious opponents of the CPSO's position on conscientious objection also stress that the majority of cases that the policy statement aims to address involve a patient's *preference* for a medical procedure that will subjectively enhance one's quality of life or remove an impediment to a desired lifestyle, with no "credible claim of medical emergency" or necessity.[14] Finally, respondents criticize the CPSO's failure to recognize that referring someone for a procedure means medical and ethical implication in the procedure. Will Johnston views the CPSO's fourth policy requirement as giving rise to "de facto participation via coerced referral," and subsequently asserts that "[i]t is not the responsibility of any physician to manage, promote, or enhance access to a procedure which he or she finds medically harmful and morally repugnant."[15] Likewise, COLF affirms that "[t]he requirement that a physician must provide information about access to another physician who would provide the service is unacceptable, because it requires the physician to cooperate with the procuring of a service that he cannot morally support."[16]

As evinced by the above-noted array of concerns, the CPSO's position on matters of conscientious objection has aroused a significant amount of controversy among religious organizations, communities and individuals across Canada. This controversy has subsequently occasioned the present analysis of the CPSO's policy statement from within the Roman Catholic tradition.[17] This chapter focuses on the following question to guide its discussion: To what extent does the policy statement, "Physicians and the Ontario *Human Rights Code*," coincide or conflict with Roman Catholic doctrines on conscience and cooperation in evil? The first section of this chapter addresses the Roman Catholic formulation of conscience, including its nature, function, formation and authority. When examined in light of this doctrine, it is clear that the CPSO's requirements pertaining to conscientious objection conflict with the primacy and authority attributed to the Roman Catholic formulation of conscience and are thereby indefensible from within the Roman Catholic tradition. The second part looks at the traditional doctrine on cooperation in evil, delineating among the various forms of formal and material cooperation in order to assess the acceptability of the CPSO's expectations relating to the full disclosure of treatment options and patient referral. The principle of double effect is also developed as part of this discussion insofar as the Roman Catholic tradition applies it in conjunction with the doctrine on cooperation in evil in order to determine whether certain instances of mediate material cooperation are justifiable. My analysis of the CPSO's policy requirements according to the doctrine on cooperation in evil and, by extension, the principle of double effect, shows that participation in patient referral qualifies

as formal cooperation and is consequently unjustifiable from a Roman Catholic perspective in cases where the referral pertains to a morally illicit procedure. The comprehensive disclosure of treatment options, however, constitutes mediate material cooperation and is justifiable according to the principle of double effect, so long as serious consideration is given to the element of scandal, and cooperation does not involve an intrinsically evil act.

Conscience and Roman Catholicism

In the *Catechism of the Catholic Church*, conscience is defined as "a judgment of reason whereby the human person recognizes the moral quality of a concrete act that he is going to perform, is in the process of performing, or has already completed. In all he says and does, man is obliged to follow faithfully what he knows to be just and right. It is by the judgment of his conscience that man perceives and recognizes the prescriptions of the divine law."[18] The intimate connection between human conscience and the precepts of divine law is eloquently reaffirmed in the Second Vatican Council's document *Gaudium et Spes*, which Pope Paul VI promulgated,

> In the depths of his conscience, man detects a law which he does not impose upon himself, but which holds him to obedience. Always summoning him to love good and avoid evil, the voice of conscience when necessary speaks to his heart: do this, shun that. For man has in his heart a law written by God; to obey it is the very dignity of man; according to it he will be judged. Conscience is the most secret core and sanctuary of a man. There he is alone with God, Whose voice echoes in his depths.[19]

As the above excerpts effectively demonstrate, Roman Catholicism has a well-developed doctrine on the phenomenon of conscience. This section provides an

overview of this doctrine by examining the nature, function, formation and authority of conscience. The last subsection on authority addresses the Church's position regarding conscientious objection within the field of medicine, and leads into my evaluation of the CPSO's policy in light of the Roman Catholic tradition's formulation of conscience. Before beginning, however, the range of this discussion must be clarified.

This section focuses on the official position of the Roman Catholic Church, as reflected in the teachings and views upheld by the Papacy and the Congregation for the Doctrine of the Faith (CDF).[20] The primary documents examined in relation to the Roman Catholic formulation of conscience include those published by the office of the Holy See and the CDF from the time of the Second Vatican Council to the present.[21] The work of St. Thomas Aquinas also contributes to this discussion on conscience due to Aquinas' prominent stature as a theologian and his highly influential position in the history and formation of Roman Catholic doctrine.[22] Moreover, throughout his examination of the moral life, Aquinas systematically addressed the issue of conscience—including its nature, function, formation and authority—at several points during his career.[23]

The nature and function of conscience: The medieval tradition accorded two levels to the phenomenon of conscience. Mainstream scholasticism found expression for these two levels in the concepts of "synderesis" and "conscientia."[24] According to Aquinas, synderesis is the habit of first principles of the practical order and predisposes human beings toward the good.[25] This habit is

divinely endowed in all human persons and is one of the inherent human capacities stemming from reason.[26] The first principles consist of the natural law, that which is a reflection of God's eternal law in a rational creature.[27] It is through the eternal law that God moves and directs all things to their natural ends, and human beings to their final end in the beatific vision.[28] These principles are permanent and unchanging.[29] In his *De Veritate*, Aquinas articulates the primacy of synderesis, proclaiming that "[synderesis] is the knowledge of the first general principles, in reference to which everything else which is known is examined and by reason of which every truth is approved and every falsehood rejected."[30]

Insofar as the natural law is the reflection of God's eternal law, synderesis cannot err. Aquinas also notes that if it could err, there would be no certainty in the whole body of practical knowledge that must be deduced by human rational capacities according to its first principles.[31] However, this being said, synderesis can be extinguished in certain cases and this can subsequently lead to morally illicit actions. Complete interference with one's rational capacities blocks synderesis. This occurs in individuals who do not have the use of free choice or of reason because of an injury to their rational capacities. Synderesis can also be extinguished whenever one makes a conscious decision to act against its universal judgment in a given situation. In this second instance, it is the moral agent's decision to *ignore* the precepts of the natural law that darkens synderesis.[32] Lastly, although Aquinas does not expound the content of synderesis in great detail, he formulates the primary precept of the natural law as "good should be done and

pursued, and evil is to be avoided."[33] In this, all other axioms of the natural law are grounded.[34]

"Conscientia" is the second component attributed to the phenomenon of conscience. According to Aquinas, this element is an act—namely, the application of knowledge to a particular human action.[35] The act of conscience is said to witness, bind, incite, accuse, excuse, torment or rebuke.[36] Moreover, this application of knowledge to individual cases can occur in three ways. In the first, the application of knowledge is said to occur insofar as we recognize that we have done or not done something.[37] In a second way, it is through the act of conscience that we judge whether something should be done or not done. It is here that the act of conscience has a legislative function in dictating the moral acceptability of a future action, and it is accordingly said to bind or incite the human person, depending on the case.[38] Finally, in a third way, the act of conscience judges that an act already committed is either good or bad. Here it plays a judicial role and is said to either defend and excuse or accuse and rebuke, depending on the nature of the action.[39] Note that the application of natural law to individual cases only occurs in the second and third instances.[40]

Whereas synderesis consists of humans' knowledge of first order principles that are universal and unchanging, an act of conscience is the human application of the natural law to a given situation and is consequently susceptible to error. Thus, while synderesis is infallible, the act of conscience can be mistaken.[41] Error can arise in two ways. There can be an error in the manner in which the precepts of natural law are applied and/or deduced (i.e., from false

premises), or by applying incorrect or inapplicable first principles to a given situation (i.e., invalid reasoning).[42] It follows that humans have a crucial responsibility to properly form their consciences, slowly becoming aware of the natural law endowed in human nature through the habit of synderesis and learning the correct manner in which to apply the first order principles of synderesis to particular acts.

The formation of conscience: Within the Roman Catholic tradition, the formation of human conscience requires dedicated participation on the part of the moral agent. In *Veritatis Splendor*, Pope John Paul II reminds his audience that the duty to form the individual conscience requires making it "the object of a continuous conversion to what is true and to what is good," and further involves a sort of connaturality between man and the true good, which develops through virtuous attitudes of the person.[43] Since the Second Vatican Council, there has been a growing debate within Roman Catholicism on the proper formation of conscience, wherein some moral theologians have moved to subjectivize and relativize the phenomenon of conscience.[44] Prior to this shift, the dominant view within Catholic doctrine affirmed the Magisterium's role and responsibility to teach objective moral truth according to natural law and enable its followers to recognize the moral truth in particular situations.[45] A clear example of this move to dissent from the Church's objective teachings on morality in favour of a more subjective understanding of conscience occurred in the early 1990s. At this time, three German bishops from the Upper Rhine province established "principles of

pastoral care" by which divorced and remarried Roman Catholics could receive Holy Communion, so long as the couple's consciences were clear. These "principles" were highly contentious and problematic inasmuch as the Church, accepting the teachings of Christ on marriage, does not recognize divorce. Those who presume to attempt marriage after receiving a civil divorce without an ecclesiastical annulment are viewed as being in an objectively adulterous relationship.[46]

Although this shift toward subjectivity and relativism in Roman Catholic perceptions of conscience has been associated with a deterioration of morality amongst members of the Church and further understood as symptomatic of individuals' growing inability to objectively discern good from evil,[47] it has also been framed in much more optimistic terms. In her book, *Confronting the Truth: Conscience in the Catholic Tradition*, Linda Hogan recognizes the dominant trend within Roman Catholic morality as the move toward personal autonomy and responsibility, arguing "what *Veritatis Splendor* views as a radical growth of relativism and subjectivism can also be seen as an attempt to redefine Christian morality with the emphasis on the duties and responsibilities of individuals to shape their own moral lives."[48] Hogan proceeds in distinguishing between legalistic and personalist models of morality currently found within the Roman Catholic tradition. The legalistic model, she thinks, is characterized by an emphasis on church teaching as the central way by which the objective dimensions of morality are known. It is within this first model that the Magisterium is regarded as the primary vehicle of moral truth and the existence of

absolute and universal moral principles is affirmed. Alternatively, according to Hogan, the personalist model emphasizes the individual autonomy and responsibility of people in moral matters and focuses on conscience as the mediator of the divine moral law while rejecting the existence of absolute principles.[49] Rather than creating an antagonistic dualism between objectivism and subjectivism in relation to the formation of conscience, Hogan observes that the two models share a common vision or morality insofar as they both involve objective and subjective discernment. The disagreement simply relates to the manner in which the individual knows the objective elements of natural law. Whereas her legalistic model stresses that they are known through the teaching of the Magisterium, her personalist model insists on the individual as the primary interpreter.[50]

Although the debate on the proper formation of conscience has yet to be resolved within the Roman Catholic tradition, the present discussion upholds the Magisterium's authority in the teaching of objective moral truths by virtue of the fact that the Papacy and the CDF have consistently affirmed this position since the time of the Second Vatican Council.[51] In *Dignitatis Humanae*, Pope Paul VI states:

> In the formation of their consciences, the Christian faithful ought carefully to attend to the sacred and certain doctrine of the Church. For the Church is, by the will of Christ, the teacher of the truth. It is her duty to give utterance to, and authoritatively to teach, that truth which is Christ Himself, and also to declare and confirm by her authority those principles of the moral order which have their origins in human nature itself.[52]

Moreover, in his encyclical letter, *Veritatis Splendor*, Pope John Paul II reaffirms the objective nature of moral truth and the Magisterium's role in enlightening the natural law inherent in all human persons:

> [T]he authority of the Church, when she pronounces on moral questions, in no way undermines the freedom of conscience of Christians. This is so not only because freedom of conscience is never freedom "from" the truth but always and only freedom "in" the truth, but also because the Magisterium does not bring to the Christian conscience truths which are extraneous to it; rather it brings to light the truths which it ought already to possess, developing them from the starting point of the primordial act of faith. The Church puts herself always and only at the *service of conscience*, helping it to avoid being tossed to and fro by every wind of doctrine proposed by human deceit (cf. *Eph* 4:14), and helping it not to swerve from the truth about the good of man, but rather, especially in more difficult questions, to attain the truth with certainty and to abide in it.[53]

According to the CDF, all Roman Catholics have an obligation to believe both what the Magisterium teaches by its infallible "extraordinary" pronouncements and the guidance of its ordinary teaching in the formation of their consciences. Infallible "extraordinary" pronouncements are revealed truths solemnly defined by the authority of the pope, such as the pronouncement made at the Council of Trent forbidding the practice of polygamy among Christians.[54] The Magisterium's ordinary teachings are those revealed truths that are taught by the moral majority of bishops with the pope throughout the world. The commandment that forbids adultery is an example of this type of revealed truth, for although no pope or ecumenical council has ever solemnly defined adultery, the Magisterium has always taught this commandment as revealed.[55] Finally, truths that are not revealed, but are so intricately connected with revelation that to deny them is equivalent to denying revealed truth, must also be accepted in faith and followed

in the formation of one's conscience. These truths include the validity of the sacraments as performed today in the Church. Denying this amounts to denying the revealed truth that God provided the Church to administer his sacraments.[56]

The authority of conscience: The judgment of conscience has an imperative character; humans are obliged to act in accordance with it.[57] Aquinas articulates that conscience is binding to the extent that an individual must carry out an act in accordance with conscience in order to achieve the ultimate end of human existence, the beatific vision.[58] Even when conscience is mistaken, humans are nonetheless required to act according to its dictates because its contents are put forward and believed to be true. However, it is important to recognize that following one's conscience does not necessarily ensure that one's actions are good. Aquinas simply establishes that neglect of one's conscience inevitably results in sin.[59] For an act to be morally good, it is insufficient for the moral agent to apprehend it as good. It must also *be good objectively* (i.e., in accordance with the first principles of the natural law). Both the subjective and the objective elements must be present in the act.[60] Thus, it is crucial that one properly form his or her conscience according to the Magisterium's teachings on truth.

In some instances of mistaken conscience, ignorance can excuse the individual from sin. It is at this point in its doctrine on conscience that the Roman Catholic tradition delineates between culpable and inculpable ignorance. Distinguishing between these two types of ignorance, Aquinas provides the following example:

> [I]f erring reason tell a man that he should go to another man's wife, the will that abides by that erring reason is evil; since this error arises from

> ignorance of the Divine Law, which he is bound to know. But if a man's reason, errs in mistaking another for his wife, and if he wish to give her her right when she asks for it, his will is excused from being evil: because this error arises from ignorance of a circumstance, which ignorance excuses, and causes the act to be involuntary.[61]

If a person acts according to a conscience that is mistaken with regards to a precept that he or she is required to know, then the individual is not excused from committing a sinful act.[62] However, if ignorance arises with regards to some circumstance, and without any negligence, then the individual who acts in accordance with this erroneous conscience is excused from sin.[63]

It follows from the imperative nature of conscience that individuals should never be forced to act contrary to the dictates of their consciences. Rather, moral agents should be given the opportunity to conscientiously object and this objection should be respected unconditionally.[64] In his encyclical, *Evangelium Vitae*, Pope John Paul II calls for conscientious objection in relation to the practices of abortion and euthanasia,

> Abortion and euthanasia are thus crimes which no human law can claim to legitimize. There is no obligation in conscience to obey such laws; instead there is a grave and clear obligation to oppose them by conscientious objection. From the very beginnings of the Church, the apostolic preaching reminded Christians of their duty to obey legitimately constituted public authorities (cf. Rom 13:1-7; 1 Pet 2:13-14), but at the same time it firmly warned that "we must obey God rather than men" (Acts 5:29).[65]

More than a moral duty, conscientious objection is perceived as a basic and essential human right that should be protected by civil law.[66] Consequently, the opportunity to refuse to take part in the phases of consultation, preparation and execution of acts that violate one's conscience should be guaranteed to health care personnel and the directorial staff in health care institutions.[67]

Martyrdom is closely associated with conscientious objection. The Roman Catholic tradition views it an extremely honourable characteristic of human beings to obey God rather than civil authorities, and be willing to accept martyrdom as a consequence of dissent.[68] The holy men and women of the Old and New Testaments are considered as such because they chose to die rather than act contrary to their faith and the commands of their conscience.[69] For, "[m]artyrdom, accepted as an affirmation of the inviolability of the moral order, bears splendid witness both to the holiness of God's law and to the inviolability of the personal dignity of man, created in God's image and likeness."[70] Therefore, following the example of the martyrs (albeit to a much lesser degree), physicians and health care personnel must be willing to sacrifice professional positions and opportunities for career advancement should their conscientious objections be denied or ignored.[71]

The Roman Catholic doctrine on conscience and the CPSO's policy requirements: In light of the above overview on conscience, it is clear that the CPSO's expectations with regards to matters of conscientious objection conflict with the rights and authority accorded to individual conscience within the Roman Catholic tradition. Moral agents are expected to follow the dictates of their consciences, for "conscience is said to bind in so far as one sins if he does not follow his conscience."[72] Even though abiding by one's conscience does not guarantee that one's actions are right and good (one's conscience could be mistaken due to culpable ignorance), disobeying one's conscience inevitably results in sin. Thus,

if a physician conscientiously objects to participating in a certain medical procedure—where participation may include informing the patient of a treatment option to which the physician objects and assisting in the process of referral to a willing physician—to coerce the physician to participate is unjustifiable. Furthermore, to the extent that the act of conscience is informed by the natural law divinely endowed in all human persons in the habit of synderesis, forcing a physician to act against the commands or injunctions of his or her conscience is an affront to God.

Whether the physician's conscientious objection constitutes a good act depends on whether the physician's conscience has been formed in accordance with the precepts of natural law as expounded by the Magisterium of the Church. However, the moral nature of the physician's objection does not affect the fundamental fact that, within the Roman Catholic tradition, the right to object on grounds of conscience is viewed as a basic human right that should be protected by civil law. An important doctrinal teaching of the Church that relates to the CPSO's position on matters of conscience and should contribute to the formation of physicians' individual consciences is that of cooperation in evil. Insofar as some physicians may object to providing patients with information pertaining to medical procedures that they find morally objectionable, and/or participating in patient referrals for such procedures on grounds of complicity,[73] the elements of the Roman Catholic doctrine on cooperation can help physicians recognize whether objection to these types of *de facto* participation constitutes an objectively good act of conscience. Therefore, it is to the task of examining the

CPSO's policy requirements within the framework of the Roman Catholic doctrine on cooperation in evil that the discussion now turns.

Cooperation in evil

In the fourth edition of *Health Care Ethics: A Theological Analysis*, authors Benedict Ashley and Kevin O'Rourke articulate the principle of legitimate cooperation as follows:

> To achieve a well-formed conscience, one should always judge it unethical to cooperate formally with an immoral act (i.e., directly to intend the evil act itself), or even to cooperate materially (i.e., to provide means necessary to the act) if this cooperation is immediate (i.e., if one acts as an instrumental agent of the principal agent of the evil act). One may sometimes, however, judge it to be morally permissible or even obligatory to cooperate materially and mediately (i.e., before or after the evil act, but not as an instrumental agent of the principal agent of the evil act), depending on the degree of the good to be achieved or evil avoided by the cooperation.[74]

Ashley and O'Rourke's formulation clearly demonstrates that the Roman Catholic doctrine on cooperation in evil consists of several types of participatory action and the intention and circumstances surrounding an act of cooperation must be carefully analyzed in order to determine its moral character. This section therefore provides a breakdown of the various forms or degrees of cooperation, beginning with the main distinction between formal and material cooperation. The principle of double effect and the element of scandal are also examined in connection to material cooperation because they are key factors in determining whether an act of mediate material cooperation is morally justifiable. This section concludes with my evaluation of the CPSO's policy requirements in light of this doctrine, focusing on the CPSO's expectations regarding full disclosure of treatment

options and referral to a willing physician.[75] The present discussion on cooperation draws from a broader array of works than does the overview of Roman Catholicism's doctrine on conscience. Whereas the section on conscience utilizes official documents and the work of St. Aquinas as its sources due to the specific scope of its discussion, the relative consistency within the Roman Catholic tradition relating to the doctrine on cooperation renders the restriction of scope unnecessary.

Formal and material cooperation: Intention is particularly important in the Roman Catholic moral tradition, and it is with regards to the element of intention that the doctrine on cooperation in evil delineates between formal and material cooperation.[76] In this context, "formal" refers to the essential nature or constitution of a thing, concept or action.[77] Applied to an act of cooperation, it denotes a form of participation that relates to the very essence of the evil act—namely, a sharing of the intent of the principal agent who performs the action.[78] By virtue of the fact that the sharing of intent is understood as the approval of the evil action itself, formal cooperation in evil is always forbidden.[79] In the words of Pope John Paul II, "Christians, like all people of good will, are called upon under grave obligation of conscience not to cooperate formally in practices which, even if permitted by civil legislation, are contrary to God's law. Indeed, from the moral standpoint, it is never licit to cooperate formally in evil."[80] An example of this type of cooperation is the person who is associated with an abortion clinic and approves or encourages the practice of abortion. Whether the individual is

physically involved in the abortion procedure does not change the formal level of cooperation so long as the evil intention is present.

Material cooperation occurs when the individual who participates in evil does not share the intention of the principal agent who performs the sinful act and neither accepts nor approves of the sin being committed.[81] In such instances, the principal agent is believed to use the good or indifferent action of the cooperator in the performance of his or her own immoral deed.[82] There is a further distinction to be made between immediate material cooperation and mediate material cooperation. The former denotes the type of participation whereby the individual cooperates in evil by contributing to circumstances that are essential to the act in question.[83] An example of immediate material cooperation is the anesthesiologist who, following his or her job requirements, puts patients to sleep before sterilization procedures even though he or she morally objects to human sterilization itself. The latter form of cooperation occurs in situations where complicity is limited to the non-essential circumstances of the act in question.[84] The nurse who morally opposes abortion yet cares for a woman after an abortion procedure due to his or her job requirements is not intrinsically involved in the evil act and therefore only cooperates in a mediate material manner.[85] Although formal cooperation in evil is always illicit, mediate material cooperation is allowed in some situations so long as the assisting or facilitating deed is good (or at least indifferent). In addition, there must be a proportionately serious reason for cooperating, as well as serious concern for the element of scandal involved.[86] In other words, allowing mediate material cooperation in the sinful act of another

involves the application of the principle of double effect plus concern for scandal. Hence, before moving to examine the CPSO's policy requirements with reference to the doctrine on cooperation, it is first necessary to define the principle of double effect and the element of scandal within Roman Catholicism.

The principle of double effect: The principle of double effect validates the good actions of moral agents, regardless of foreseen but unintended evil effects, provided that the intended good effect is of such merit that its omission would be too great a sacrifice for preventing the attendant evil effects.[87] Stated in its entirety, the principle of double effect holds: "An action, good in itself, which has two effects, an intended and otherwise not reasonably attainable good effect, and a foreseen but merely permitted concomitant evil effect, may licitly be placed, provided there is a due proportion between the intended good and the permitted evil."[88] Important exceptions to this rule, however, are intrinsically evil acts. Pope John Paul II makes this point clear in *Veritatis Splendor*,

> Reason attests that there are objects of the human act which are by their nature "incapable of being ordered" to God, because they radically contradict the good of the person made in his image. These are the acts which, in the Church's moral tradition, have been termed "intrinsically evil" (*intrinsece malum*): they are such *always and per se*, in other words, on account of their very object, and quite apart from the ulterior intentions of the one acting and the circumstances. Consequently without in the least denying the influence on morality exercised by circumstances and especially by intentions, the Church teaches that "there exist acts which *per se* and in themselves, independently of circumstances, are always seriously wrong by reason of their object."[89]

If the object of a human action is intrinsically evil, it is impossible to justify formal or material cooperation under any circumstance or for any motive.[90]

The principle of double effect consists of five components. The first element states that the action, which has two effects, must be good in itself or at least indifferent. The three conditions that determine the morality of an act are the objective nature of the act, the circumstances under which it is performed and the intention of the moral agent performing the act. In order for an act to be considered good, it must qualify as good on all three counts.[91] The principle's second element refers specifically to the good effect, indicating that it must be the only intended effect of the action. Moreover, if the good effect can be attained through alternative means without causing the evil effect, the moral agent is obligated to choose the alternative course of action.[92] The evil effect is the focus of the third component to the extent that it is merely permitted as a possible side effect of the good action.[93] Fourth, there must be no causal relationship between the good and bad effects (i.e., the evil effect cannot be the cause of the good effect). If there is such a relationship, the evil effect is directly intended as the means to the contemplated end.[94] Finally, proportionate reason constitutes the fifth component. The good merited through the action must compensate for the evil that is permitted or tolerated.[95] Therefore, in considering whether an instance of mediate material cooperation is morally licit, the agent must first determine that the moral nature of the act itself is good, ensure that the good effect is the only effect intended while the evil effect is merely tolerated as a possible indirect consequence, rule out the potential for a causal relationship between effects, and make certain that there is proportionate reason for allowing the evil effect.

Scandal: The last factor to consider before examining the CPSO's policy is the element of scandal that can arise in situations of cooperation in evil. In the Roman Catholic moral tradition, scandal is defined as some word or deed, whether of omission or commission, that is evil or has the appearance of evil, and subsequently proves an occasion of sin to others.[96] An example of this factor is a Roman Catholic physician who informs her patients of abortion as a medical option without explicitly stating her moral objections to the procedure. This constitutes scandal because her patients could understand her presentation of abortion as an available medical option to signify approval of the procedure itself, and subsequently lead them to abort their pregnancies. Mediate material cooperation is thus permissible only as long as the cooperator *explicitly* expresses personal objections to the available medical procedures that are morally illicit.

The Roman Catholic doctrine on cooperation in evil and the CPSO's policy requirements: In order to evaluate the CPSO's controversial expectations pertaining to conscientious objection through the lens of the Roman Catholic doctrine on cooperation in evil, my analysis addresses the policy requirements relating to patient referral and the full disclosure of treatment options in turn. Both actions constitute a different type of cooperation, each with a distinct corresponding moral status. The act of providing patent referrals for morally illicit medical procedures is a clear example of formal cooperation, as the referral represents assent to the evil intention of the physician who eventually performs the sinful action.[97] It follows that, inasmuch as formal cooperation is indefensible

in all circumstances, the CPSO's expectation that objecting physicians assist patients in attaining referrals for medical procedures to which they conscientiously object is unjustifiable.

Physicians' duty to disclose information regarding all available and appropriate clinical options based on the patient's needs and concerns, however, is a form of mediate material cooperation that is justifiable in cases where intrinsically evil acts are not involved and the opportunity for scandal is avoided.[98] If a patient opts for a medical procedure to which his or her physician conscientiously objects after the physician has informed the patient of all treatment possibilities, the physician's act of fully disclosing treatment options qualifies as material cooperation since the physician does not share in the evil intention of the principal agent committing the sinful act. Rather, in the contemporary practice of Western medicine, such comprehensive disclosure of treatment options is meant to allow for patients to consent to medical intervention in a fully informed and free manner.[99] Furthermore, this instance of material cooperation is mediate in degree because the informing physician's participation is limited to the non-essential circumstances of the act in question. Providing a patient with information pertaining to an evil course of treatment is by no means a necessary condition for the patient to receive the treatment. Finally, disclosing all available and appropriate clinical options constitutes legitimate mediate material cooperation that is justified under the principle of double effect, so long as the physician notifies the patient of any personal objections to certain procedures in order to avoid opportunity for scandal. This duty of disclosure is morally

justifiable under the principle of double effect in light of the legal and moral obligation of informed consent that requires patients to be fully informed of all available treatment options.[100]

The five conditions of double effect are met in the following manner. First, the act of informing the patient of all clinical options is good in itself.[101] The physician is helping the patient retain his or her agency, in what can be a very vulnerable situation, by facilitating the patient's autonomous and fully informed decision with regards to medical treatment. Second, the intended effect of facilitating an autonomous and fully informed decision cannot be attained without first disclosing all of the clinical options to the patient. Third, although the possibility that the patient will chose an illicit course of treatment (evil effect) may be foreseen, it stands as an indirect consequence of full disclosure. Fourth, there is no causal relationship between effects and fifth, the good effect of facilitating a fully informed decision outweighs the potential evil effect of the patient choosing an illicit treatment option insofar as physicians have the fundamental duty to respect their patients' right to autonomous choice.[102] In the words of philosophers Beauchamp and Childress, "Respect for autonomy is not a mere *ideal* in health care; it is a professional *obligation*. Autonomous choice is a *right*—not a *duty*—of patients."[103] Thus, from a Roman Catholic perspective, whereas assisting in patient referral is unjustifiable in cases of morally illicit procedures, because there is an element of sharing in the evil intent of the principal agent, informing a patient of all available clinical options is justified

under the principle of double effect provided that the attending physician explicitly states any moral objections.

Conclusion

The proceeding analyses of the CPSO's policy in light of the Roman Catholic doctrines on conscience and cooperation in evil identify several points of tension between the Roman Catholic tradition and the CPSO's position on matters of conscientious objection. The CPSO's expectations regarding conscientiously objecting physicians conflict with the rights and authority accorded to individual conscience within Roman Catholicism. Moral agents must always follow the dictates of their consciences. To coerce, by threat of professional sanction, conscientiously objecting physicians to participate in the medical procedures to which they object is thus unjustifiable from a Roman Catholic perspective.

Furthermore, according to the doctrine on cooperation in evil, it is indefensible for a physician to cooperate in patient referrals that involve morally illicit medical treatments. Providing referrals constitutes formal cooperation and signifies approval of the evil action itself. On the other hand, fully informing patients of all available treatment options qualifies as an instance of mediate material cooperation that is justifiable under the principle of double effect (by virtue of the moral and legal principle of informed consent), so long as careful consideration is given to the element of scandal and cooperation does not involve an intrinsically evil act. Therefore, for the CPSO's policy to become consistent with the moral framework of Roman Catholicism, significant changes that

acknowledge and respect the imperative nature of individual conscience and the inexcusable level of cooperation involved in patient referrals for morally illicit medical procedures are required.

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[1] See College of Physicians and Surgeons of Ontario, *Draft: Physicians and the Ontario* Human Rights Code, 2008, available online at http://www.craigburrell.ca/files/HumanRightsDRAFT_08.pdf (accessed 23 April 2010).

[2] See Michèle Boulva, "Response to the Draft CPSO Policy Entitled 'Physicians and the Ontario *Human Rights Code*'," Catholic Organization for Life and Family Web site, 17 September 2008, http://www.colf.ca/mamboshop/index.php?option=com_content&task=view&id=172&lang=enc (accessed 23 April 2010); Thomas Collins, "Archbishop Collins' Letter to CPSO on Conscience," Canadian Federation of Catholic Physicians' Societies Web site, 12 September 2008, http://www.canadiancatholicphysicians.com/mainmenu.html (accessed 23 April 2010); Raymond J. de Souza, "Human Rights Disease Has Been Stabilized, Not Cured," *National Post*, 19 September 2008, http://network.nationalpost.com/np/blogs/fullcomment/archive/2008/09/19/father-raymond-j-de-souza-human-rights-disease-has-been-stabilized-not-cured.aspx (accessed 23 April 2010); Will Johnston, "Re: Draft Policy Document, 'Physicians and the Ontario *Human Rights Code*'," Canadian Physicians for Life Web site, 11 September 2008, http://www.physiciansforlife.ca/html/conscience/articles/CPSOSept1108Submission.html (accessed 23 April 2010); Will Johnston, "Re: Proposed Changes to College Human Rights Policy – 'Physicians and the Ontario *Human Rights Code*'," Canadian Physicians for Life Web site, 18 August 2008, http://www.physiciansforlife.ca/html/conscience/articles/CPSOSubmission.html (accessed 23 April 2010); Joanne McGarry, "Submission re: *Physicians and the Ontario* Human Rights Code," Protection of Conscience Project Web site, 12 September 2008, http://www.consciencelaws.org/Examining-Conscience-Ethical/Ethical78c.html (accessed 23 April 2010); Terrence Prendergast and Reuven P. Bulka, "Rabbi Bulka & Archbishop Prendergast Declaration to CPSO," Canadian Federation of Catholic Physicians' Societies Web site, 11 September 2008, http://www.canadiancatholicphysicians.com/mainmenu.html (accessed 23 April 2010); Ruth A.M. Ross, "Proposed Draft Policy of the College of Physicians and Surgeons of Ontario: Submission of the Christian Legal Fellowship," Protection of Conscience Project Web site, undated, http://www.consciencelaws.org/Examining-Conscience-Ethical/Ethical78c.html (accessed 23 April 2010); Lee Duigon, "Canadian Doctors Warned to 'Set Aside' God's Law," Protection of Conscience Project Web site, 9 September 2008, http://www.consciencelaws.org/Examining-Conscience-Ethical/Ethical78e.html (accessed 23 April 2010); and John B. Shea, "Physicians and the Ontario *Human Rights Code*," Catholic Insight Web site, 18 September 2008, http://catholicinsight.com/online/bioethics/article_848.shtml (accessed 23 April 2010).

[3] College of Physicians and Surgeons of Ontario, *Physicians and the Ontario* Human Rights Code, Policy Statement #5-08, College of Physicians and Surgeons of Ontario Web site, December 2008, http://www.cpso.on.ca/policies/policies/default.aspx?ID=2102. Please note that the respondents' concerns addressed in this section are those that relate to the final version of the CPSO policy statement.

[4] Ross, "Proposed Draft Policy," para. 2. Section 2(a) of the *Charter* states: "Everyone has the following fundamental freedoms: (a) freedom of conscience and religion." In some cases, the infringement of rights can be justified under section 1 of the *Charter*, which states: "The Canadian Charter of Rights and Freedoms guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society."

[5] Prendergast and Bulka, "Declaration to CPSO," para. 3.
[6] Johnston, "Re: Draft Policy Document," para. 12.
[7] Collins, "Letter to CPSO on Conscience," para. 4.
[8] The Chalcedon Foundation is a non-profit Christian Reconstructionist organization in the United States.
[9] Duigon, "Canadian Doctors Warned," para. 41.
[10] Ibid., para. 42.
[11] Boulva, "Response to the Draft CPSO Policy," para. 8.
[12] College of Physicians and Surgeons of Ontario, *Physicians*, 4.
[13] Boulva, "Response to the Draft CPSO Policy," para. 9.
[14] Johnston, "Re: Proposed Changes," para. 5; Collins, "Letter to CPSO on Conscience," para. 9.
[15] Johnston, "Re: Draft Policy Document," paras. 1, 4.
[16] Boulva, "Response to the Draft CPSO Policy," para. 5.
[17] This chapter focuses on Roman Catholicism in order to provide a workable scope for a detailed analysis. It will also allow for the study of a religious group that is at the forefront of the public debate surrounding the CPSO's policy, which has a rich tradition on conscience and the freedom thereof.
[18] *Catechism of the Catholic Church*, Vatican Web site, 1993, http://www.vatican.va/archive/ENG0015/_INDEX.HTM, n. 1778.
[19] Paul VI, *Gaudium et Spes*, pastoral constitution on the Church in the modern world, Vatican Web site, 7 December 1965, http://www.vatican.va/archive/hist_councils/ii_vatican_council/documents/vatii_cons_19651207_gaudium-et-spes_en.html, n. 16.
[20] The CDF is herein used as an official authority on the doctrine of conscience, to the extent that it is the Curial department responsible for overseeing Roman Catholic doctrine. It is important to note that Roman Catholicism's official formulation of conscience does not reflect the beliefs of all members of the Roman Catholic faith.
[21] The Second Vatican Council, also known as Vatican II, was opened under Pope John XXIII on October 11, 1962, and was closed under his successor, Pope Paul VI, on December 8, 1965.
[22] See Jean Porter, *The Recovery of Virtue: The Relevance of Aquinas for Christian Ethics* (Louisville: Westminster/John Knox, 1990) 172-179.
[23] Robert Smith, *Conscience and Catholicism: The Nature and Function of Conscience in Contemporary Roman Catholic Moral Theology* (Lanham: University Press of America, Inc., 1998) 1.
[24] Joseph Ratzinger, "Conscience and Truth," in *On Conscience* (San Francisco: Ignatius Press, 2007) 30. The delineation between two levels of conscience resulted from the earlier work of St. Jerome, particularly his commentary on the prophecy of Ezechiel. It is in this gloss that the term "synderesis" first appeared in Roman Catholic writings. For a more detailed discussion on St. Jerome's use of synderesis, see Eric D'Arcy, *Conscience and its Right to Freedom* (New York: Sheed and Ward, 1961) 15-19.
[25] Thomas Aquinas, *Summa Theologiae*, translated by Fathers of the English Dominican Province (Benziger Bros. edition, 1947) I, 79.12. Available online at http://dhspriory.org/thomas/summa/index.html (accessed 23 April 2010). John Finnis clarifies that this "habit of first principles" is not an innate *knowledge* of the first principles themselves; rather, human beings are endowed with a capacity for *understanding* (an intellectual "light") whereby they can come to identify and understand these principles as soon as they have the relevant experience of the world and of their sentient appetites. Therefore, it is this rational capacity for understanding that is innate. See John Finnis, *Aquinas: Moral, Political, and Legal Theory* (Oxford and New York: Oxford University Press, 1998) 86-90, 101 n. w.

[26] Smith, *Conscience and Catholicism*, 6. In order to clarify the somewhat elusive concept of synderesis, Joseph Cardinal Ratzinger (now Pope Benedict XVI) proposes replacing synderesis with the Platonic concept of anamnesis, the capacity to recall. Cardinal Ratzinger explains the innate nature of anamnesis in relation to the phenomenon of conscience in an essay he delivered at a workshop for bishops organized by The National Catholic Bioethics Center: "This means that the first so-called ontological level of the phenomenon conscience consists in the fact that something like an original memory of the good and true (they are identical) has been implanted in us, that there is an inner ontological tendency within man, who is created in the likeness of God, toward the divine." Ratzinger, "Conscience and Truth," 32.

[27] Aquinas states, "Wherefore, since all things subject to Divine providence are ruled and measured by the eternal law . . . it is evident that all things partake somewhat of the eternal law, in so far as, namely, from its being imprinted on them, they derive their respective inclinations to their proper acts and ends. Now among all others, the rational creature is subject to Divine providence in the most excellent way, in so far as it partakes of a share of providence, by being provident both for itself and for others. Wherefore it has a share of the Eternal Reason, whereby it has a natural inclination to its proper act and end: *and this participation of the eternal law in the rational creature is called the natural law*." *Summa Theologiae*, i. II, 91.2 (emphasis added). Participation in the natural law is restricted to rational creatures in light of the fact that Aquinas identifies law (in general) as "something pertaining to reason." *Summa Theologiae*, i. II, 90.1. For further discussion on Aquinas' formulation of the relationship between eternal and natural law, see John Finnis, *Natural Law and Natural Rights* (Oxford and New York: Oxford University Press, 1980) 398-403.

[28] Smith, *Conscience and Catholicism*, 3. In the Vatican II declaration on religious freedom, Pope Paul VI reminds his audience that "the highest norm of human life is the divine law – eternal, objective and universal – whereby God orders, directs and governs the entire universe and all the ways of the human community by a plan conceived in wisdom and love. Man has been made by God to participate in this law, with the result that, under the gentle disposition of divine Providence, he can come to perceive ever more fully the truth that is unchanging." *Dignitatis Humanae*, declaration on religious freedom, Vatican Web site, 7 December 1965, http://www.vatican.va/archive/hist_councils/ii_vatican_council/documents/vat-ii_decl_19651207_dignitatis-humanae_en.html, n. 3.

[29] Thomas Aquinas, *Questiones Disputatae de Veritate*, Questions 10-20, translated by James V. McGlynn (Chicago: Henry Regnery Company, 1953) 16.2.

[30] Aquinas, *De Veritate*, 16.2.

[31] Ibid.

[32] Aquinas, *De Veritate*, 16.3.

[33] Aquinas, *Summa Theologiae*, i. II, 94.2.

[34] Ibid.

[35] Aquinas, *De Veritate*, 17.1. It is the virtue of prudence that guides this application of knowledge. In the words of John Finnis, "*Prudentia*, directing every virtue, embodies (so to speak) as an active disposition of mind the very meaning, force, and content of the moral *ought*." *Aquinas*, 119. For more on the role of prudence, see Smith, *Conscience and Catholicism*, 23-31. Please note that conscience, as the second element attributed to the concept of conscience, will henceforth be referred to as "the act of conscience". Although cumbersome, it is important to distinguish between conscience, as the application of knowledge to individual cases, and the composite phenomenon of conscience as a whole.

[36] Aquinas, *Summa Theologiae*, I, 79.13; Aquinas, *De Veritate*, 17.1.

[37] Ibid. In this way, the act of conscience is said to witness. It is important to note that in this form of application, the act of conscience functions in a manner akin to the modern English use of "consciousness" or "awareness" and therefore lacks a moral dimension.

[38] Aquinas, *Summa Theologiae*, I, 79.13; Aquinas, *De Veritate*, 17.1.

[39] Ibid. The idea of legislative and judicial conscience has been taken from Eric D'Arcy's *Conscience and its Right to Freedom*. D'Arcy provides an overview of the historical development of judicial and legislative conscience in turn, beginning with the pagan usage of judicial conscience and progressing to St. Paul's innovative use of legislative conscience in his epistles, before examining the adoption of both by the Patristic tradition. See D'Arcy, *Conscience and its Right to Freedom*, 4-16.

[40] Aquinas, *De Veritate*, 17.1.

[41] Smith, *Conscience and Catholicism*, 12.

[42] Aquinas, *De Veritate*, 17.2.

[43] John Paul II, *Veritatis Splendor*, encyclical letter on the Church's role in moral teaching, Vatican Web site, 6 August 1993, http://www.vatican.va/holy_father/john_paul_ii/encyclicals/documents/hf_jp-ii_enc_06081993_veritatis-splendor_en.html, n. 64. "Connaturality" denotes a type of knowing that engages the individual on a preconceptual level, yielding an affective type of knowledge that is not exclusively discursive, intellectual or cognitive. It can be understood as a type of "meta-rational" knowing. See Smith, *Conscience and Catholicism*, 37.

[44] Joseph Cardinal Ratzinger powerfully terms this move the "deification of subjectivity" in his keynote address to the Fourth Bishops' Workshop of the National Catholic Bioethics Center, wherein he addresses the controversy between objective and subjective formulations of conscience within the Church. See Joseph Ratzinger, "Bishops, Theologians and Morality," in *On Conscience* (San Francisco: Ignatius Press, 2007) 51. Later on in this address, Cardinal Ratzinger humorously notes, "It is strange that some theologians have difficulty accepting the precise and limited doctrine of papal infallibility, but see no problem in granting de facto infallibility to everyone who has a conscience" 59.

[45] Linda Hogan, *Confronting the Truth: Conscience in the Catholic Tradition* (Mahwah, NJ: Paulist Press, 2000) 15.

[46] See John Haas, ed., *Crisis of Conscience* (New York: The Crossroad Publishing Company, 1996) viii. For an in-depth discussion of the increasing relativism among moral theologians and its tie to contemporary secularism, see John Haas, "Crisis of Conscience and Culture," in *Crisis of Conscience*, edited by John Haas, 21-49 (New York: The Crossroads Publishing Company, 1996).

[47] John Paul II, *Evangelium Vitae*, encyclical letter on the value and inviolability of human life, Vatican Web site, 25 March 1995, http://www.vatican.va/edocs/ENG0141/_INDEX.HTM, n. 19-20.

[48] Hogan, *Confronting the Truth*, 23.

[49] Ibid., 28-9.

[50] Ibid., 29.

[51] The Magisterium is the teaching office of the Church, consisting of the Pope and Bishops.

[52] Paul VI, *Dignitatis Humanae*, n. 14.

[53] John Paul II, *Veritatis Splendor*, n. 64.

[54] Benedict M. Ashley and Kevin D. O'Rourke, *Health Care Ethics: A Theological Analysis*, 4th ed. (Washington, D.C.: Georgetown University Press, 1997) 184.

[55] Ibid.

[56] Ibid. The CDF clearly articulates this obligation to believe and follow in faith the teachings of the Magisterium in its document, *Donum Veritatis*: "When the Magisterium of the Church makes an infallible pronouncement and solemnly declares that a teaching is found in Revelation, the assent called for is that of theological faith. This kind of adherence is to be given even to the teaching of the ordinary and universal Magisterium when it proposes for belief a teaching of faith as divinely revealed. When the Magisterium proposes "in a definitive way" truths concerning faith and morals, which, even if not divinely revealed, are nevertheless strictly and intimately connected with Revelation, these must be firmly accepted and held. When the Magisterium, not intending to act "definitively", teaches a doctrine to aid a better understanding of Revelation and make explicit

its contents, or to recall how come teaching is in conformity with the truths of faith, or finally to guard against ideas that are incompatible with these truths, the response called for is that of the religious submission of will and intellect. This kind of response cannot be simply exterior or disciplinary but must be understood within the logic of faith and under the impulse of obedience to the faith." Congregation for the Doctrine of the Faith, *Donum Veritatis*, instruction on the ecclesial vocation of the theologian, Vatican Web site, 24 May 1990, http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19900524_theologian-vocation_en.html, n. 23.

[57] John Paul II, *Veritatis Splendor*, n. 60.

[58] Aquinas, *De Veritate*, 17.3.

[59] Aquinas, *Summa Theologiae*, i. II, 19.5.

[60] D'Arcy, *Conscience and its Right to Freedom*, 90.

[61] Aquinas, *Summa Theologiae*, i. II, 19.6.

[62] Ibid. Aquinas maintains that there are commands and injunctions that human persons are obliged to know. However, he neglects to offer a list of such precepts. See *De Veritate*, 17.3. In an attempt to respond to the suggestion that a person with a culpably erroneous conscience inevitably sins (since it is mandatory to follow one's conscience, even if culpably mistaken), Aquinas expounds that such a person need only set aside the culpably mistaken conscience in order to avoid committing evil acts. Again, however, Aquinas does not specify how an individual is supposed to recognize that his or her conscience is mistaken. See Smith, *Conscience and Catholicism*, 16-17.

[63] Aquinas, *Summa Theologiae*, i. II, 19.6.

[64] Paul VI, *Dignitatis Humanae*, n. 3.

[65] John Paul II, *Evangelium Vitae*, n. 73. For more on the importance of conscientious objection within the context of health care, see the Pontifical Academy for Life, *Final Declaration by the 13th General Assembly and the International Congress on "The Christian Conscience in Support of the Right to Life"*, Vatican Web site, 15 March 2007, http://www.vatican.va/roman_curia/pontifical_academies/acdlife/documents/rc_pont-acd_life_doc_20070315_xiii-gen-assembly-final_en.html.

[66] John Paul II, *Evangelium Vitae*, n. 74.

[67] Ibid.

[68] John Paul II, *Veritatis Splendor*, n. 91.

[69] Ibid., n. 76.

[70] Ibid., n. 92.

[71] John Paul II, *Evangelium Vitae*, n. 74.

[72] Aquinas, *De Veritate*, 17.6.

[73] "Complicity" is concerned not only with the performance of an act, but also the facilitation of another's performance of an act that one finds morally reprehensible. See Thomas May and Mark P. Aulisio, "Personal Morality and Professional Obligations: Rights of Conscience and Informed Consent," *Perspectives in Biology and Medicine* 52, no. 1 (2009): 30-38.

[74] Ashley & O'Rourke, *Health Care Ethics*, 198-199.

[75] Although this section focuses on individual acts of cooperation, the Roman Catholic doctrine on cooperation in evil is frequently applied at the corporate level to health care institutions, particularly in joint venture situations where one of the corporate entities is a Roman Catholic health care institution. For more on this topic, see Russell Smith, "Formal and Material Cooperation," *Ethics & Medics* 20, no. 6 (1995), available online at http://www.consciencelaws.org/Examining-Conscience-Ethical/Ethical02.html (accessed 23 April 2010); and Committee on Doctrine of the National Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 4th ed., United States Conference of Catholic Bishops Web site, 15 June 2001, http://www.usccb.org/bishops/directives.shtml.

[76] François Pouliot, "Prudential Judgment and Cooperation with Evil in Medical Practice," in *A Matter of Conscience*, 76-95 (Ottawa: Justin Press, 2009) 88.
[77] Orville N. Griese, *Catholic Identity in Health Care: Principles and Practice* (Braintree, MA: Pope John Center, 1987) 387.
[78] Ibid.
[79] Pouliot, "Prudential Judgment," 89.
[80] John Paul II, *Evangelium Vitae*, n. 74.
[81] Pouliot, "Prudential Judgment," 89.
[82] Griese, *Catholic Identity in Health Care*, 389.
[83] Ibid.
[84] Ibid.
[85] Please note that there are additional forms of material cooperation; however, these forms extend beyond the scope of the present discussion. For a detailed discussion of the traditional Roman Catholic doctrine on cooperation in evil, see Griese, *Catholic Identity in Health Care*, 387-416.
[86] Griese, *Catholic Identity in Health Care*, 389.
[87] Ibid., 249. Aquinas is credited with the first formulation of the principle of double effect in his discussion of killing in self-defence. See *Summa Theologiae* ii. II, 64.7.
[88] Griese, *Catholic Identity in Health Care*, 246.
[89] John Paul II, *Veritatis Splendor*, n. 80. Pope John Paul II proceeds in citing several examples of intrinsically evil acts given by the Second Vatican Council: "Whatever is hostile to life itself, such as any kind of homicide, genocide, abortion, euthanasia and voluntary suicide; whatever violates the integrity of the human person, such as mutilation, physical and mental torture and attempts to coerce the spirit; whatever is offensive to human dignity, such as subhuman living conditions, arbitrary imprisonment, deportation, slavery, prostitution and trafficking in women and children; degrading conditions of work which treat labourers as mere instruments of profit, and not as free responsible persons: all these and the like are a disgrace, and so long as they infect human civilization they contaminate those who inflict them more than those who suffer injustice, and they are a negation of the honour due to the Creator." Ibid.
[90] Griese, *Catholic Identity in Health Care*, 248. See the Pontifical Academy for Life's discussion of illicit forms of formal and material cooperation in its study on the use of vaccines developed from cell lines derived from aborted foetuses. Pontifical Academy for Life, "Moral Reflections on Vaccines Prepared from Cells Derived from Aborted Human Foetuses," Children of God Web site, 9 June 2005, http://www.cogforlife.org/vaticanresponse.htm (accessed 12 October 2010).
[91] Griese, *Catholic Identity in Health Care*, 251.
[92] Ibid.
[93] Ibid., 252.
[94] Ibid.
[95] Ibid., 252-253.
[96] Ibid., 411.
[97] Please note that the use of the adjective "evil" throughout my analysis remains within the worldview of Roman Catholicism.
[98] It should be remembered that this qualification is necessary insofar as it is never justifiable to cooperate at any level with intrinsically evil acts.
[99] See Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 6th ed. (New York: Oxford University Press, 2009) 117-118.
[100] Informed consent presently dominates the Western model of clinical decision-making and is discussed at length in chapter 3 of this dissertation. For more information, see Ashley & O'Rourke, *Health Care Ethics*, 59-61; and Beauchamp & Childress, *Principles of Biomedical Ethics*, 99-148.

[101] The present discussion assumes that the patient *wants* to be informed of all available treatment options. In situations where the patient does not want full disclosure of information, the withholding of information occurs on account of patient preferences and *not* as a result of the attending physician's conscience-based objections. Therefore, in examining full disclosure of treatment options as a legitimate instance of mediate material cooperation, it is only necessary to consider cases where the patient desires access to the information.

[102] Beauchamp & Childress, *Principles of Biomedical Ethics*, 107.

[103] Ibid. Edmund Pellegrino, who staunchly asserts that patient autonomy cannot require physicians to sacrifice their personal moral integrity for what the patient may believe to be a morally good (or neutral) purpose, also maintains that physicians cannot use their claim to autonomy to violate patients' capacity for self-governing choices. According to Pellegrino, "Informed consent is an empty notion or a charade if the information on which it is based in biased in favor of the physician's preferences." See Edmund Pellegrino, "Patient and Physician Autonomy: Conflicting Rights and Obligations in the Physician-Patient Relationship," *Journal of Contemporary Health Law and Policy* 10, no. 1 (1994): 55.

General Consistency:

Looking at the CPSO's Policy Statement Through the Lens of Canadian Law

In addition to the heated responses voiced by several religious organizations and individuals in reaction to the College of Physicians and Surgeons of Ontario's (CPSO) draft policy statement that were examined in the previous chapter, prominent members of the Canadian legal community also expressed concern with regards to the CPSO's guidelines regarding the issue of conscientious objection.[1] The *Calgary Herald* published a response by Margaret Somerville shortly after the CPSO circulated its draft policy statement, wherein she expresses grave concern regarding the CPSO's treatment of physicians as mere technicians.[2] Somerville asserts that this treatment reflects the emerging view within society that expects physicians to acquiesce to their patients' demands, while refraining from bringing their moral and ethical reservations into play.[3] At a fundamental level, she argues, treating physicians as silent technicians denies the respect that is owed to physicians' ethical and moral values, as well as their freedom of conscience.[4] Moreover, this view fails to recognize the inherent moral and ethical dimensions of medical practice, and sharply contrasts the traditional concept of physicians as professionals who are legally and ethically required to rely on good professional judgment in treating their patients.[5] Finally, Somerville judiciously raises the following question in light of the CPSO's neglect of physicians' moral and ethical values: "Would any of us really want to be treated by a physician who

had complied with a directive to 'park your ethics and values with your car outside surgery'?"[6]

The CPSO's position with regards to conscientious objection similarly provoked a response from Iain T. Benson.[7] Writing on behalf of the Centre for Cultural Renewal in Ottawa, Benson denounces the CPSO's expectation that physicians assist in patient referrals—irrespective of their moral and/or religious objections—as a radical truncation of physicians' constitutional freedom of conscience and religion. He subsequently argues that there are less intrusive and destructive ways of ensuring that patients receive proper information regarding care, including referrals.[8] Benson proposes that the CPSO establish a "physician's referral service" that would direct inquiries from the public to physicians and surgeons who work in the relevant areas. The availability of alternative sources of information about physicians and their areas of practice would therefore be coming from a central source and physicians could provide this phone number to patients in handy forms (flyers, posters, etc.) that are not issue specific, thereby avoiding the moral and ethical implications of patient referral.[9]

According to Benson, one of the central policies of a free and open society is a proper recognition of *modus vivendi*—the ability to respect and organize around divergent beliefs.[10] This principle of living together in diversity stems from Canada's endorsement of accommodation for conscience and religion as a constitutional right that is equally shared by all citizens, regardless of their occupations.[11] Accordingly, attempts should be made to accommodate physicians' moral and religious beliefs up to the level of undue hardship, rather than

dismissing physicians' conscientious objections in favour of patients' demands for medical treatment.[12] Thus, whereas Somerville's response concentrates on the increasing tendency in contemporary society to deny physicians' moral agency and treat them as mere technicians, Benson identifies some of the legal issues involved in the debate over physicians' right to conscientious objection.

By virtue of the fact that the CPSO's approach to the issue of conscientious objection carries significant legal implications, the present discussion provides a legal analysis of the CPSO's policy with specific reference to the constitutional right of freedom of conscience and religion established in section 2(a) of the *Canadian Charter of Rights and Freedoms*,[13] as well as Canadian citizens' protection from discrimination under human rights legislation. This chapter focuses on the following question to guide its analysis: To what extent does the policy statement, "Physicians and the Ontario *Human Rights Code*," coincide or conflict with the conceptualization and treatment of conscience and religion within Canadian constitutional and administrative law?

Following a brief overview of the protection afforded to religion under constitutional and administrative legislation in Canada,[14] the discussion addresses five prevailing trends in the law's interaction with conscience and religion that have emerged in recent legal scholarship. It then examines whether these trends are evident in the CPSO's approach to conscientious objection.[15] The first trend consists of the conflation of "conscience" and "religion" in section 2 constitutional analyses. Since Justice Dickson first defined the constitutional guarantee of freedom of religion in the Supreme Court of Canada case, *R. v. Big*

M. Drug Mart Ltd.,[16] the courts have repeatedly failed to delineate between the freedom of conscience and the freedom of religion. As a result, the former has subsumed the latter. The second trend that emerges from the law's interaction with religion is the legal characterization of religion as a matter of autonomous choice. This trend flows from the liberal ideology that grounds the Canadian legal system, and effectively renders religion a highly individualistic phenomenon that is cut off from communal forms of religious engagement and expression. Closely related to the individualization of religion is the judiciary's move to relegate religion to the private sphere. This third trend speaks to the perception of religious expression as a threat to the liberal ideals of the state and the secularization of Canadian society. Fourth, religious values are consistently subordinated to the civic values of the state in cases where the two value systems conflict and fifth, concern for the principle of liberty is accompanied by an equally pressing concern for the principle of equality in relation to religious freedom. Even though section 2(a) of the *Charter* is written in the form of a freedom, early *Charter* jurisprudence saw the emergence of strong concerns for both principles.

Examined in light of these trends, my analysis demonstrates that the CPSO's conceptualization and treatment of conscience and religion is generally consistent with that of the current Canadian legal system. The CPSO's policy statement clearly reflects the first four trends. It conflates religiously and non-religiously motivated conscientious objection (thereby assimilating the categories of religion and conscience), posits religion as autonomous choice, excludes religious expression from physicians' freedom of religion (subsequently

relegating religion to the private sphere), and subordinates religious interests to those of the patient and the state. The sole point of inconsistency arises in relation to the fifth trend, to the extent that the CPSO's policy does not demonstrate concern for the dual principles of liberty and equality associated with religious freedom. Although the CPSO concerns itself with the former, it negates concern for the latter.

Religion in constitutional and administrative law

Canada's constitutional inheritance from the United Kingdom means that the Canadian Parliament theoretically enjoys sovereign and supreme authority over all religious institutions and individuals engaged in religious practices within the country's boarders.[17] However, the exercise of Parliament's sovereignty is limited, in part, on account of Canadian federalism's division and distribution of power between federal and provincial legislatures, each with certain exclusive jurisdictions.[18] Although the principal division of sovereignty within Canada is found in *The Constitution Act, 1867*,[19] this statute is silent regarding jurisdiction over religion, religious institutions and religious practice. As a result, it remains uncertain whether the protection of religious freedom in Canada is a federal or provincial jurisdiction.[20]

Regardless of jurisdictional ambiguity, explicit protection of religious freedom and other associated freedoms is established under *The Constitution Act, 1982*.[21] In the Preamble to *The Constitution Act, 1982*, religion is placed alongside the rule of law as a guiding principle for the interpretation of the rights

and freedoms set out in the *Charter*.[22] However, the "supremacy of God" clause, as it is commonly known, has largely been treated as an embarrassment to be ignored by the courts and academics.[23] The protection of religious freedom is thus predominantly understood in relation to section 2(a) of the *Charter*, which states: "Everyone has the following fundamental freedoms: (a) freedom of conscience and religion." In matters of religious freedom, the courts have also given secondary consideration to the following associated freedoms and legal rights: the freedom of thought, belief, opinion and expression, including freedom of the press and other media of communication;[24] the freedom of peaceful assembly;[25] the freedom of association;[26] the right to life, liberty and security of the person, and the right not to be deprived thereof except in accordance with the principles of fundamental justice;[27] and the right to equality before and under the law, and the right to the equal protection and equal benefit of the law without discrimination.[28] Finally, the constitutional guarantee of religious freedom is associated with the multicultural interpretation rule and the privileged exception for denominational schools set out in sections 27 and 29 of the *Charter*, respectively.[29]

The inclusion of limitation clauses in Canadian constitutional law implies that the rights and freedoms established in the *Charter* are not absolute; rather, the courts may determine that certain rights violations are constitutionally justifiable. The general limiting clause is found in section 1 of the *Charter*, which establishes that the rights and freedoms set out in the *Charter* are "subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society." When a court is faced with a constitutionally compromising

statute or regulation that applies generally, the proper analysis to determine whether that infringement can be justified under section 1 of the Charter is through the *Oakes* test.[30] Developed to assess legislative policies, the *Oakes* test is a two-stage analysis based on societal interests. In the first stage, the complainant must establish that the impugned legislation has infringed some part of the *Charter*. If the complainant is successful, the burden of proof shifts, in the second stage, to the government to demonstrate that the infringement or violation of the individual section of the *Charter* is nevertheless justified under the limitation clause in section 1.[31]

Protection for the freedom of religion is also found under the administrative branch of Canadian law, in both provincial human rights codes and the *Canada Human Rights Act*.[32] This legislation protects religion negatively by prohibiting the denial of rights on religious grounds. Human rights commissions and tribunals have been established at the provincial and federal levels in order to investigate and adjudicate formal human rights complaints. For example, when a formal complaint is registered at the federal level, the Canadian Human Rights Commission (CHRC) is responsible for its investigation. If the CHRC determines that the complaint is valid, it then refers the case to the Canadian Human Rights Tribunal (CHRT) for adjudication. The CHRT is a quasi-judicial adjudicative body with a statutory mandate to apply the *Canada Human Rights Act* based on the evidence presented and the case law. However, if one of the parties involved disagrees with the Tribunal's decision, it may file an appeal at the Federal Court of Canada.[33]

Whereas the analysis of rights limitation proceeds under the *Oakes* test when a court is dealing with constitutionally compromising statutes or regulations that apply generally, administrative bodies must evaluate the infringement of rights according to the doctrine of reasonable accommodation.[34] Administrative adjudication falls under reasonable accommodation because administrative bodies arbitrate challenges brought by individuals claiming that their rights are being adversely affected in connection with specific requirements under a policy or protocol, or under a specific state or administrative practice (i.e., employers who make their employees work on the Sabbath). Within the legal arena, reasonable accommodation allows for dispensations from the general application of norms or statutes in favour of an individual or a group of people threatened with discrimination on one of the prohibited grounds listed in human rights legislation and the *Charter*.[35] Involved in the creation of such exemptions is a type of "dialogue" between the affected parties, which takes into account the specific circumstances of each party and aims at reconciling their positions by finding common ground that is acceptable in light of each party's needs.[36] The duty of accommodation is limited, however, by the ability of the organization to accommodate. This ability is measured according to the criteria of undue hardship, which holds that a request for accommodation may be rejected if it leads to unreasonable costs, upsets the organization's operation, infringes on other people's rights, or hampers the maintenance of safety and public order.[37] Thus, while constitutional law analyses under the *Oakes* test are based on societal interests and are generally macrocosmic, administrative law analyses under the

principle of reasonable accommodation take into account the specific circumstances of the parties involved and are microcosmic.[38]

Prevailing trends in the law's treatment of religion and conscience

The examination of Canadian jurisprudence reveals several (overlapping) trends in relation to the law's treatment of religion and conscience. The following five subsections identify and develop these trends in turn, before the discussion proceeds to a legal analysis of the CPSO's policy statement in light of them.

(I) The conflation of "religion" and "conscience" in constitutional analysis: In *Charter* jurisprudence, the Supreme Court of Canada first interpreted the constitutional guarantee of freedom of religion in *R. v. Big M. Drug Mart Ltd.* This was a landmark case in which the Supreme Court struck down the *Lord's Day Act* for violating section 2. Speaking for the majority, Chief Justice Dickson (as he was then) articulated the following definition of freedom of religion:

> The essence of the concept of freedom of religion is the right to entertain such religious beliefs as a person chooses, the right to declare religious beliefs openly and without fear of hindrance or reprisal, and the right to manifest religious belief by worship and practice or by teaching and dissemination. But the concept means more than that.
>
> Freedom can primarily be characterized by the absence of coercion or constraint. If a person is compelled by the state or the will of another to a course of action or inaction which he would not otherwise have chosen, he is not acting of his own volition and he cannot be said to be truly free. One of the major purposes of the *Charter* is to protect, within reason, from compulsion or restraint. Coercion includes not only such blatant forms of compulsion as direct commands to act or refrain from acting on pain of sanction, coercion includes indirect forms of control which determine or limit alternative courses of conduct available to others. Freedom in a broad sense embraces both the absence of coercion and constraint, and the right

> to manifest beliefs and practices. Freedom means that, subject to such limitation as are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others, no one is to be forced to act in a way contrary to his beliefs or his conscience.[39]

Although Chief Justice Dickson did not fail to recognize grounds for the limitation of one's freedom of religion, he provided the constitutional guarantee with a very broad scope. Included within the realm of its protection are the rights to both hold religious beliefs as well as act on them, and the right to be free from direct and indirect forms of coercion. Later on in his decision, Chief Justice Dickson further alluded to the importance of the freedom of religion when he stated: "Religious belief and practice are historically prototypical and, in many ways, paradigmatic of conscientiously-held beliefs and manifestations and are therefore protected by the *Charter*."[40]

Apparent in the majority's ruling in *R. v. Big M. Drug Mart Ltd.* is the implicit conflation of religion and conscience in the Courts' section 2 analysis. In addition to positing religion as a paradigm of "*conscientiously-held* beliefs," defining religion in individualistic terms reduces it to a personal phenomenon equivalent to individual conscience and completely negates the communal aspect of religious adherence. This assimilation of religion into conscience is also apparent in the subsequent Supreme Court decision of *Syndicat Northcrest v. Amselem*,[41] wherein Justice Iacobucci defined religion in a highly personalistic manner:

> Defined broadly, religion typically involves a particular and comprehensive system of faith and worship. Religion also tends to involve the belief in a divine, superhuman or controlling power. In essence, religion is about freely and deeply held personal convictions or beliefs connected to an individual's spiritual faith and integrally linked to one's

> self-definition and spiritual fulfilment, the practices of which allow individuals to foster a connection with the divine or with the subject or object of that spiritual faith.[42]

Finally, the Supreme Court's attempt to interpret the *Charter* guarantee of freedom of conscience in *R. v. Morgentaler*[43] further exemplifies the conflation between religion and conscience.[44] Holding that the *Criminal Code* provisions controlling access to abortion infringed women's freedom of conscience, Justice Wilson asserted that "freedom of conscience and religion" should extend to "conscientiously-held beliefs, whether grounded in religion or in a secular morality."[45] This statement effectively demotes religious belief to an aspect of individual conscience, thus denying its existence and importance as a distinct phenomenon.[46] Scholars have largely criticized the legal assimilation of religion and conscience on account of this negation of religion's uniqueness and independent value, both to the individual and society.[47] Despite this assimilation, however, freedom of religion remains the central focus of *Charter* cases involving section 2(a). Consequently, the remaining four subsections examine trends that relate to the courts' treatment of religion specifically.

(II) The characterization of religion as autonomous choice: As previously mentioned, Canadian jurisprudence conceptualizes religion in a highly autonomous manner and this approach consequently leads to a jurisprudential reluctance to recognize its social and cultural dimensions.[48] This second trend flows from the liberal ideology that informs Canadian society and, by extension, its legal system. As Benjamin Berger notes, "Canadian constitutional law casts

religion in terms compatible with its own structural assumptions, as well as symbolic and normative commitments, which are themselves informed by the contemporary political culture of liberalism."[49] As an ideological framework, liberalism necessarily reflects a set of normative judgments about which principles must be protected in a given society.[50] A core set of concerns commonly associated with traditional liberal ideology consists of the high valuation of reason, a central interest in questions of individual freedom, and the view that law is a tool with which to limit the state's interference in the life of the individual.[51] The basis for liberalism's focus on the individual is its commitment to the goods of autonomy and individual liberty as mechanisms for human flourishing.[52] This notion of personal flourishing or fulfilment is exemplified in Justice Iacobucci's definition of religion in *Syndicat Northcrest v. Amselem* insofar as religion, comprised of "freely and deeply held personal convictions or beliefs," is integrally linked to "one's self-definition and spiritual fulfilment."[53]

The liberal ideal of autonomy is further evinced in *Syndicat Northcrest v. Amselem* when the Court considered the task of evaluating the validity or veracity of religious belief and practice. After establishing that "courts should avoid judicially interpreting and thus determining, either explicitly or implicitly, the content of a subjective understanding of religious requirement," the majority asserted that it was nonetheless qualified to "inquire into the sincerity of a claimant's belief, where sincerity is in fact at issue."[54] Similar to the definition of religion established by the Court, the "sincerity of belief test" renders religious belief and practice wholly autonomous phenomena, entirely apart from religious

adherents' participation in communal religious traditions and expression.[55] Finally, law's association of religion and autonomy feeds into its understanding of religion as a matter of personal *choice* rather than a compulsion.[56] Conceived in this way, religion tends to lose its place as an integral part of an individual's personal and communal identity, which in turn obscures the fact that many religious adherents cannot separate the religious from the non-religious in their lives.[57]

(III) The relegation of religion to the private sphere: The initial years of the *Charter* witnessed the establishment of an expansive definition of the freedom of religion by Chief Justice Dickson in *R. v. Big M. Drug Mart Ltd.*, while jurisprudence under provincial and federal human rights legislation also fashioned a strong requirement that employers accommodate the religious beliefs and practices of their employees.[58] Yet, legal protection of religion under constitutional and administrative law has since narrowed to the point where a thick line is now drawn between religious belief and praxis. Justices Iacobucci and Bastarache explicitly articulated this dualism in *Trinity Western University v. College of Teachers*.[59] Delineating between citizens' right to religious belief versus their right to religious practice, the Justices stated that the place to draw the line "is generally between belief and conduct."[60] They went on to assert that "[t]he freedom to hold beliefs is broader than the freedom to act on them."[61] As belief only, religion is a seen as a preference that remains unproblematic within the personal realm. However, once religious belief is manifested through action,

religion is perceived to encroach on the public realm and threaten the liberal ideals of the state.[62] In the words of Paul Horwitz, "As long as religious adherents' practices are private, or public but minimally intrusive, they are accepted; but where these conditions do not apply, where the beliefs are taken so seriously as to interfere with the liberal understanding of the public good, the liberal state views religion as a choice that is wrong, unreasonable, or dangerous, according to liberal epistemology, and so denies the possibility of co-existence."[63]

Also associated with the relegation of religion to the private sphere is the increasing secularism within Canadian society. Although secularism generally involves the concept of state neutrality and accordingly entails that the government and its institutions exist separately from religion, it is commonly understood as an anti-religious ideology that threatens the very existence of religious freedom insofar as it aims to remove all religious expression from the public sphere.[64] Secularism's strong influence on the legal system in Canada is exemplified in the courts' move to eliminate religion from pubic schools. *Zylberberg v. Sudbury Board of Education*[65] and *Canadian Civil Liberties Association v. Ontario (Minister of Education)*,[66] more commonly known as "*Elgin County*," were two key decisions of the Ontario Court of Appeal that involved challenges to the province's education regulations, which mandated Christian religious observances in public schools. Although automatic exemptions from participating in such observances were available in both cases, the courts struck down the impugned regulatory provisions on grounds of religious freedom in an effort to protect minority religious groups from mandatory state rules

reflecting the religious beliefs of the majority. The courts' ruling in both cases thereby transformed public schools from places where the wishes of parents had to be accommodated to spaces where religion now has no place.[67] In her discussion of the courts' exclusionary transformation of the public school system, M. H. Ogilvie remarks,

> The jurisprudential underpinning for the removal of religion from the public schools is the view that the state should remain neutral on religious matters and therefore state-funded schools should also remain neutral; that is, free from any religious commitment that might appear even mildly like indoctrination. But schools, like nature, abhor a vacuum, and the curriculum and the environment or the public schools are increasingly experienced by all people of faith as anti-religious rather than neutral; the values experienced there increasingly conflict with the values in the religious home or place of worship. The courts insist that neutral means secular in the narrow sense of being religion-free, but this impoverished sense, which fails to acknowledge that religion is also found in this world, results in the privatization of religion by removing it from one public place, the public school.[68]

Therefore, the concepts of state neutrality and state independence from religion are currently understood to entail religion's elimination from the public realm—this view having won out against an inclusive and nonsectarian interpretation of secularism wherein religious traditions and the state respectfully co-exist as distinct bodies in the public sphere.

(IV) The subordination of religious values to those of the state: Within any given society, there are multiple sources of authority and cultural modes of belief that make strong claims upon its citizens. This fact is particularly true for religious adherents. As Paul Horwitz aptly puts it,

> The religious believer in the modern liberal state is the servant of two masters. On the one hand, there is the web of obligations, laws and rules

> that attach to every facet of life, from prohibitions against criminal behaviour to the myriad administrative regulations encountered in the workplace. On the other, there is the compulsion to obey one's spiritual obligations, as revealed through prayer, scripture, or participation in a faith community.[69]

Consequently, the struggle faced by the courts when dealing with matters of religious freedom is one of balancing. More specifically, the courts must attempt to find some middle ground between society's need for adherence to the rule of law and the value that Canadian society places upon multiculturalism and diversity (which is associated with a commitment to religious freedom).[70] Unfortunately, efforts at achieving this balance are offset by the law's subordination of religious values and interests to those of the state. The state's superiority in the eyes of the law is exemplified in Chief Justice Beverley McLachlin's address at the "Pluralism, Religion and Public Policy" conference, held at McGill University in October 2002. In her discussion of the courts' role in creating a space for minority religious expression in Canada, McLachlin notes, "Due recognition must be given to the dignity of individuals and communities bound by a religious worldview and ethos, *but this must be done without compromising the integrity of the rule of law and the values for which it stands*."[71]

As previously mentioned, Canada is a country wherein the state is sovereign over religious institutions and individuals engaged in religious practices as a result of its constitutional inheritance from the United Kingdom.[72] It therefore follows from this historical inheritance that religious values and interests are subjugated to those of the state. This subordination is even embedded in the very balancing tool the courts use in the constitutional adjudication of rights violations.

Section 1 analysis under the *Oakes* test is framed in the evaluative language of rational liberalism and focuses substantially on the "reasonableness" of the state's goals. Under the *Oakes* test, courts must examine whether the government is pursuing a "pressing and substantial" objective, as defined in accordance with the values of a free and democratic society, and whether the law in question bears a "rational connection" to the objective being sought. Moreover, the law must impair the rights of individuals as minimally as possible and there must be proportionality between the benefit of the law and its deleterious effects.[73] In light of its focus on rationality and reasonableness, it follows that the courts are likely to privilege the state's rational claims, which are grounded in the liberal values of a free and democratic society, over the often ineffable and rationally incomprehensible claims of religious believers.[74]

Furthermore, the proportionality component of the *Oakes* test is carried out within the liberal framework of the state and the courts subsequently prioritize liberal values in determining whether the objectives of the state justify the deleterious effects of rights violations. The majority decision in the recent Supreme Court case, *Alberta v. Hutterian Brethren of Wilson Colony*, provides a clear example of the determining role liberal values play in proportionality analyses, and the concomitant subordination of religious values. Addressing the issue of whether the infringement of Colony members' right to religious freedom was justified by the public benefit conferred by the infringement,[75] Chief Justice McLachlin analyzed the harmful effects of limiting Colony members' religious freedom strictly in terms of *Charter* values, stating:

> The deleterious effects of a limit on freedom of religion requires us to consider the impact in terms of *Charter* values, such as liberty, human dignity, equality, autonomy, and the enhancement of democracy . . . The most fundamental of these values, and the one relied on in this case, is liberty – the right of choice on matters of religion. As stated in *Amselem*, *per* Iacobucci J., religious freedom "revolves around the notion of personal choice and individual autonomy and freedom" (para. 40). The question is whether the limit leaves the adherent with a meaningful choice to follow his or her religious beliefs and practices.[76]

Chief Justice McLachlin's focus on the value of autonomy points to the second trend discussed in this chapter, namely the law's characterization of religion as autonomous choice, and to the liberal underpinnings of the Canadian legal system. Autonomy is perceived as an important mechanism for human flourishing and personal fulfilment within liberal democracies, and it was therefore given primary consideration when balancing the benefits and burdens of enforcing the universal photo requirement of the Alberta licensing system. To the extent that the Court did not find the requirement to inhibit Colony members' autonomy with regards to religious practice, the benefits of enforcement were perceived to outweigh the harmful effects of restricting religious freedom in this case.[77]

Absent from the Court's proportionality test are the values and opinions of those whose rights are being violated. At the time the Supreme Court heard this case, the Hutterian Brethren of Wilson Colony maintained a rural, communal lifestyle and engaged in a variety of commercial activities.[78] Although largely self-sufficient, the community's business activities occasionally required some of its members to travel outside the Colony and these members needed driver's licences to do so.[79] Moreover, Colony members claimed that the viability of their communal lifestyle would be severely threatened if its members were denied

driver's licences on account of their refusal to have their photographs taken. According to the Colony's Secretary-Treasurer, each Colony member was assigned a specific set of responsibilities, some of which required the member to drive. If Colony members could not carry out these responsibilities, it would cause their religious commune to "function improperly, thereby eroding the fabric of [their] social, cultural and religious way of life."[80] Although Chief Justice McLachlin acknowledged that enforcing the universal photo requirement of the licensing system would impose an economic burden on the Colony insofar as it would need to hire alternative transport for their commercial dealings and other necessary services in nearby towns, she nonetheless asserted that Colony members' autonomy regarding religious practice remained uninhibited. Her analysis thus failed to take into account the social, cultural and religious meaning attached to members' assigned responsibilities (some of which required driving) and the significance of self-sufficiency to the community's identity and way of life.[81] This case therefore demonstrates the manner in which the liberal values predominate section 1 *Charter* analysis and such prioritization speaks to the law's subordination of religious values and interests to those of the state.

(V) Concern for both "liberty" and "equality" in relation to religious freedom: Although section 2(a) of the *Charter* is written in the form of a freedom, thereby implying a focus on individual liberty from government interference, a strong equity concern has also emerged within *Charter* jurisprudence.[82] In his delivery of the majority position in *R. v. Big M. Drug Mart Ltd.*, Chief Justice Dickson went

beyond establishing an expansive definition of the freedom of religion and emphasized the discriminatory aspect of the impugned legislation, which gave primacy to the Christian tradition. As Chief Justice Dickson noted,

> To the extent that it binds all to a sectarian Christian ideal, the *Lord's Day Act* works a form of coercion inimical to the spirit of the *Charter* and the dignity of all non-Christians. In proclaiming the standards of the Christian faith, the Act creates a climate hostile to, and gives the appearance of discrimination against, non-Christian Canadians. It takes religious values rooted in Christian morality and, using the force of the state, translates them into a positive law binding on believers and non-believers alike. The theological content of the legislation remains as a subtle and constant reminder to religious minorities within the country of their differences with, and alienation from, the dominant religious culture.[83]

The Sunday closing requirement of the *Lord's Day Act* not only imposed a burden on the religious practice of those who would keep Saturday as the Sabbath, it also gave Christians who honoured Sunday as the Sabbath a relative advantage over Saturday Sabbatarians. Also evident in the above comment, as well as other court decisions, is the understanding that state support for a particular religious practice is objectionable because it signals to members of religious minority groups that they are not full members of the political community, thereby contributing to their social and political marginalization.[84]

Although the courts' concern for equality among religions appears to be a positive element of the law's treatment of religion, Richard Moon identifies two key problems with the view that it is wrong for the state to support particular religious practices because it sends an unacceptable message of exclusion to non-adherents or because it involves treating some individuals less favorably than others on the basis of their faith. First, inasmuch as Canada's heritage is rooted in the Christian tradition, it seems unavoidable that Christian values and practices

will shape the public life of the community in a variety of subtle or indirect ways. Second, state support for religion can only be viewed as illegitimate if there is an alternative (i.e., non-religious values or practices that are neutral) that the state can support without sending a message of exclusion to a particular group within a larger political community.[85] Secularism relates to this second observation and, as already discussed, state attempts at neutrality and separation from religion have led to the removal of religion from the public sphere. Thus, far from granting religious traditions equality *within* society, secularism has resulted in the forced exclusion of religious worldviews from public discourse and the affirmation of a "partisan anti-religious perspective."[86] Therefore, religious freedom in *Charter* jurisprudence formally consists of the dual principles of liberty and equality, even if concern for the latter is currently manifested as the *equal exclusion* of religious traditions from the public sphere.[87]

Legal analysis of the CPSO's policy statement

In order to determine whether the CPSO's approach to the issue of conscientious objection among physicians is consistent with the treatment of religion and conscience in Canadian constitutional and administrative law, my analysis examines the CPSO's policy statement in light of the five trends outlined in the previous section—beginning with the conflation of religion and conscience. The wording of the policy statement upholds a formal distinction between moral and religious beliefs throughout the entirety of its discussion pertaining to conscientious objection. However, an implicit assimilation of religion and

conscience is nonetheless evident. In its policy statement, the CPSO addresses religion solely in relation to the personal beliefs of physicians, thereby reducing it to an individualistic phenomenon on par with individual conscience. It fails to acknowledge the important connection that physicians' religious beliefs may have to the tenets and norms of their religious communities. For, an individual's religious beliefs often reflect communal religious tenets and norms, which members uphold as absolute truths and unwavering standards.

The CPSO's assimilation of religion and conscience is further evinced insofar as it does not recognize the fact that physicians objecting on religious grounds are afforded protection under the Ontario *Human Rights Code*[88] on the basis of "creed," whereas those objecting on non-religious grounds are afforded no such protection. The Ontario Human Rights Commission (OHRC) adopts the following definition of creed in its policy on the accommodation of religious observances:

> Creed is interpreted to mean "religious creed" or "religion." It is defined as a professed system and confession of faith, including both beliefs and observances of worship. A belief in God or gods, or a single supreme being is not a requisite. Religion is broadly accepted by the Commission to include, for example, non-deistic bodies of faith, such as the spiritual faiths/practices of aboriginal cultures, as well as bona fide newer religions (assessed on a case by case basis). The existence of religious beliefs and practices are both necessary and sufficient to the meaning of creed, if the beliefs and practices are sincerely held and/or observed.[89]

Following this definition, the OHRC makes it clear that "creed" does not include secular, moral or ethical beliefs.[90] Accordingly, a duty to accommodate up to the point of undue hardship exists in cases where physicians conscientiously object on religious grounds, while the strictly "moral beliefs" of conscientiously

objecting physicians are owed *no such accommodation under the province's human rights legislation*. This duty of accommodation is affirmed by the OHRC in its submission to the CPSO regarding the establishment and termination of physician-patient relationships. Addressing the issue of physicians' refusal to provide services based on religious or moral grounds, the OHRC notes,

> The *Code* does provide for accommodation of religious belief. For example, where the physician in question is employed by an organization, the organization has a duty to accommodate his or her religious beliefs. This may take the form of ensuring that another physician is able to provide the service that the patient requires in a timely and dignified manner. However, the physician's interest in accommodation needs to be weighed against the impact on the patient. The scope of the accommodation of the physician's religious belief may need to be limited where it is not possible to provide accommodation without a discriminatory impact on the patient, such as delay or disruption of service, or the creation of a judgmental or otherwise poisoned environment for the patient.[91]

Therefore, a degree of conflation between religion and conscience—as represented by religious and moral beliefs, respectively—exists by virtue of the CPSO's failure to distinguish the differing levels of protection afforded to religious and non-religious conscientious objections under the Ontario *Human Rights Code*. Moreover, inasmuch as the policy neglects religious beliefs' protection under the *Code* and the associated duty of health care organizations to accommodate such beliefs (up to the point of undue hardship), conscientious objection on religious grounds is assimilated into the category of non-religious conscientious objection.

The CPSO's policy statement is also consistent with the second trend found in Canadian law, namely the characterization of religion as autonomous choice. The CPSO restricts its discussion of religion and religious belief to the

autonomous physician. It neglects the fact that religious beliefs and affiliations move beyond the strictly personal realm and affect self-identity and understanding among members of a broader community—whether this be a religious community, society at large, or both. Moreover, the CPSO's perception of religion as a matter of autonomous choice is apparent in the first policy requirement that establishes the expectation that physicians "communicate clearly and promptly about any treatments or procedures the physician *chooses* not to provide because of his moral or religious belief."[92] This requirement implies that physicians have the freedom to choose whether to adhere to their moral or religious beliefs and subsequently refrain from providing medical treatments that conflict with their consciences or religion. It fails to acknowledge that some individuals experience religious commitment as a compulsion, and thus do not have a choice regarding whether to follow the dictates of their religion. For such physicians, conscientious objection is divinely mandated rather than arbitrarily chosen.

Although the CPSO notes the importance that religious practices may have in the lives of physicians and their patients,[93] the third trend of privatizing religion is apparent in the policy's list of professional expectations. The CPSO's third expectation requires that physicians

> [t]reat patients or individuals who wish to become patients with respect when they are seeking or requiring the treatment or procedure. *This means that physicians should not express personal judgments about the beliefs, lifestyle, identity or characteristics or a patient or an individual who wishes to become a patient. This also means that physicians should not promote their own religious beliefs when interacting with patients, nor should they seek to convert existing patients or individuals who wish to become patients to their own religion*.[94]

In other words, physicians are allowed to have their religious beliefs so long as they keep them to themselves while acting in their professional roles. This expectation clearly reflects the distinction between belief and conduct articulated by Justices Iacobucci and Bastarache in *Trinity Western University v. College of Teachers*, where the freedom to hold religious beliefs is broader than the freedom to act on them.

The fourth trend of subordinating the interests and values of religion to those of the liberal state is also apparent in the policy's list of professional expectations. These expectations constitute the results of the CPSO's attempt to "balance" the competing interests of conscientiously objecting physicians, their patients and the state. Insofar as the second and fourth requirements mandate the full disclosure of available treatment options and assistance in patient referral, respectively, they demand certain levels of complicit action on the part of conscientiously objecting physicians.[95] This forced complicity indicates that the religious beliefs and values of objecting physicians have been subjugated to patients' interest in receiving the medical treatment they desire and the liberal state's interest in securing health care for its citizens. A more even-handed approach to this balancing act could have resulted in a form of accommodation that respects the values and beliefs of conscientiously objecting physicians while simultaneously ensuring that patients' access to care remain unaffected. The centralized "physician's referral service" proposed by Benson in his response to the CPSO's policy is one such mode of accommodation.

Finally, the fifth trend of a dual concern for the principles of liberty and

equality in relation to the freedom of religion is not reflected in the policy statement. As previously discussed, the CPSO distinguishes between religious belief and religious expression—moving to restrict physicians' freedom of religious expression while acting in their professional roles. This delineation focuses on the principle of liberty in relation to religious freedom and mirrors the Supreme Court's analysis of religious freedom in *Trinity Western University v. College of Teachers*. Yet, this is where the CPSO's consideration of religious freedoms ends. Even though the *current manifestation* of concern for religious equality in Canada—namely, the equal exclusion of religious traditions from the public sphere—is evident in the CPSO's policy to the extent that it enforces the equal exclusion of all forms of religious expression from the physician-patient relationship (on the part of physicians), the *actual concern* for religious equality that focuses on the protection of religious minorities from discrimination and marginalization is absent. The fact that the CPSO's guidelines exclude physicians' right to religious expression on an equal basis without demonstrating concern for religious equality among majority and minority religious traditions is unsurprising, however, in light of the liberal and secular values that pervade the CPSO's policy statement and the associated trends of religion's privatization and subordination previously discussed.

Conclusion

The foregoing analysis of the CPSO's policy statement demonstrates that the CPSO's approach to the issue of conscientious objection is generally consistent

with the conceptualization and treatment of religion and conscience in Canadian constitutional and administrative law. My examination of the policy statement in light of the prevailing trends that emerge in the law's treatment of religion and conscience reveals this consistency. The CPSO conflates religion and conscience by addressing religion exclusively in relation to the personal beliefs of physicians, thereby reducing it to a highly individualistic phenomenon on par with individual conscience. Moreover, the policy assimilates religious and moral beliefs by failing to distinguish between religiously and non-religiously motivated conscientious objections. Rather than recognizing the differing levels of protection afforded to each type of conscientious objection under Ontario's human rights legislation, the policy addresses all conscientious objections as a single category.

The CPSO's conceptualization of religion also coincides with Canadian jurisprudence inasmuch as it characterizes religion as a matter of autonomous choice and relegates it to the private sphere by limiting religious freedom to the right to hold religious beliefs. Furthermore, the subordination of religious values and interests to those of the state is evinced in the CPSO's professional expectations related to the full disclosure of treatment options and patient referral. The forced complicity embodied in these expectations indicates that the religious beliefs and values of objecting physicians have been subjugated to patients' interest in receiving the medical treatment they desire and the liberal state's interest in securing health care for its citizens. Lastly, the policy statement fails to demonstrate concern for the dual principles of liberty and equality associated with religious freedom in Canada. Although concern for religious liberty is present in

the CPSO's acknowledgement of physicians' right to hold religious beliefs, there is no consideration of religious equality in the sense of protecting religious minorities from discrimination and marginalization at the hands of the majority. Therefore, although the CPSO's approach to the issue of conscientious objection has generated significant backlash, its policy statement is by and large coherent with Canadian jurisprudence.

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[1] Similar to the response publications released by religious organizations and figures in reaction to the CPSO's draft policy, several of the concerns expressed by members of the legal community in reaction to the CPSO's *draft* guidelines remain pertinent to the final version of the policy statement that was published in December 2008. For the final version of the policy statement, see College of Physicians and Surgeons of Ontario, *Physicians and the Ontario* Human Rights Code, Policy Statement #5-08, College of Physicians and Surgeons of Ontario Web site, December 2008, http://www.cpso.on.ca/policies/policies/default.aspx?ID=2102.

[2] See Margaret Somerville, "Denying Doctors Free Conscience Unconscionable," Protection of Conscience Project Web site, undated, http://www.consciencelaws.org/Examining-Conscience-Ethical/Ethical78d.html#Denying_doctors_free_conscience_unconscionable (accessed 23 April 2010). Please note that this version of Somerville's response is an extended version of that published in the *Calgary Herald*.

[3] Somerville, "Denying Doctors," para. 9. As noted in chapter 1, the Catholic Organization for Life and Family also expressed this concern with respect to the CPSO's third policy requirement that prohibits physicians from expressing personal judgments about the beliefs, lifestyle, identity or characteristics of a patient or an individual who wishes to become a patient.

[4] Somerville, "Denying Doctors," para. 16.

[5] Ibid., para. 13.

[6] Ibid., para. 17.

[7] See Iain T. Benson, "Physicians, Patients, Human Rights, and Referrals: A Principled Approach to Respecting the Rights of Physicians and Patients in Ontario," Centre for Cultural Renewal Web site, 12 September 2008, http://www.culturalrenewal.ca/qry/page.taf?id=135 (accessed 23 April 2010).

[8] Benson, "Physicians," 2-3.

[9] Ibid., 3.

[10] Ibid., 4.

[11] Ibid., 5.

[12] Ibid.

[13] Part I of *The Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11. The *Canadian Charter of Rights and Freedoms* is hereinafter referred to as "the *Charter*."

[14] The law has rarely dealt with "conscience," *per se*. Therefore, "conscience" is not included in the background discussion.

[15] Discussion focuses on legislation and jurisprudence arising since the entrenchment of the *Charter* in 1982. This chapter does not draw on American legislation and jurisprudence to inform its analysis of the CPSO's policy statement because the First Amendment of the U.S. Constitution

and section 2(a) of the *Charter* are significantly different in language, substance, legal context and historical context. For more on this distinction, see Bradley W. Miller, "Justification and Rights Limitations," in *Expounding the Constitution: Essays in Constitutional Theory*, edited by Grant Huscroft, 93-115 (New York: Cambridge University Press, 2008); M. H. Ogilvie, "Between *Liberté* and *Égalité*: Religion and the State in Canada," in *Law and Religion: God, the State and the Common Law*, edited by Peter Radan, Denise Meyerson and Rosalind F. Croucher, 134-167 (New York: Routledge, 2005) 140; and M. H. Ogilvie, "Constitutional Fundamentals," chap. 4 in *Religious Institutions and the Law in Canada* (Scarborough: Carswell Thompson Professional Publishing, 1996) 90.

[16] *R. v. Big M. Drug Mart Ltd.*, [1985] 1 S.C.R. 295.

[17] Ogilvie, "Constitutional Fundamentals," 79.

[18] Ibid.

[19] *The Constitution Act, 1867* (U.K.), 30 & 31 Victoria, c. 3.

[20] It is widely understood that the jurisdiction over religion is shared in accordance with the same constitutional principles used to assess jurisdiction over the other subject matter for which no express provision is made in the written constitution. See Ogilvie, "Constitutional Fundamentals," 103.

[21] *The Constitution Act, 1982,* being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11.

[22] The Preamble to *The Constitution Act, 1982*, states: "Whereas Canada is founded upon principles that recognize the supremacy of God and the rule of law:"

[23] For details on the marginalization and dismissal of the "supremacy of God" clause, see David M. Brown, "Freedom From or Freedom For?: Religion as a Case Study in Defining the Content of Charter Rights," *University of British Columbia Law Review* 33, no. 3 (2000): 551-616; Jonathon W. Penney and Robert J. Danay, "The Embarrassing Preamble? Understanding the 'Supremacy of God' and the *Charter*," *University of British Columbia Law Review* 39, no. 2 (2006): 287-332; and Lorne Sossin, "The 'Supremacy of God,' Human Dignity and the *Charter of Rights and Freedoms*," *University of New Brunswick Law Journal* 52 (2003): 227-241.

[24] See section 2(b).

[25] See section 2(c).

[26] See section 2(d).

[27] See section 7.

[28] Section 15(1) establishes the following equality right: "Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability." Subsection 15(2) continues, "Subsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability."

[29] Section 27 states: "This Charter shall be interpreted in a manner consistent with the preservations and enhancement of the multicultural heritage of Canadians." Section 29 states: "Nothing in this Charter abrogates or derogates from any rights or privileges guaranteed by or under the Constitution of Canada in respect of denominational, separate or dissentient schools."

[30] The current section 1 constitutional analysis was first developed in the Supreme Court case, *R v. Oakes*, [1986] 1 S.C.R. 103.

[31] Miller, "Justification and Rights Limitations," 94.

[32] *Canada Human Rights Act*, R.S.C. 1985, c. H-6. Prior to 1982, these sources of law, together with the common law, comprised the legal standards for freedom of religion in Canada. See Ogilvie, "Constitutional Fundamentals," 82.

[33] Canadian Human Rights Tribunal, "Jurisdiction – Canadian Human Rights Act," Canadian Human Rights Tribunal Web site, 14 November 2007, http://www.chrt-tcdp.gc.ca/NS/about-apropos/jurisdiction-competence-eng.asp (accessed 23 April 2010).

[34] For details on this distinction, see *Multani v. Commission scolaire Marguerite-Bourgeoys*, [2006] 1 S.C.R. 256, 2006 SCC 6 at paras. 119-134; and *Alberta v. Hutterian Brethren of Wilson Colony*, 2009 SCC 37 at paras. 66-71.

[35] See *Alberta v. Hutterian Brethren of Wilson Colony* at paras. 67-68.

[36] See *Multani v. Commission scolaire Marguerite-Bourgeoys* at para. 131.

[37] Gérard Bouchard and Charles Taylor, *Building the Future: A Time for Reconciliation* (Report), Consultation Commission on Accommodation Practices Related to Cultural Differences Web site, 2008, http://www.accommodements.qc.ca/index-en.html, 63.

[38] See *Multani v. Commission scholaire Marguerite-Bourgeoys* at paras. 131-134.

[39] *R. v. Big M. Drug Mart Ltd.* at paras. 94-95.

[40] Ibid. at para. 123.

[41] *Syndicat Northcrest v. Amselem*, [2004] 2 S.C.R. 551, 2004 SCC 47.

[42] Ibid. at para. 39.

[43] *R. v. Morgentaler*, [1988] 1 S.C.R. 30.

[44] This is the only attempt the Supreme Court of Canada has made to interpret freedom of conscience under section 2 of the *Charter*.

[45] *R. v. Morgentaler* at para. 251.

[46] The Court's conflation of religion and conscience has also extended beyond the courtroom, coming to influence other areas of governmental activity. For instance, in *Building the Future: A Time for Reconciliation* (the 2008 report commissioned by the Quebec government on the issue of cultural accommodation), co-chairs Gérard Bouchard and Charles Taylor understand convictions of conscience to include, on equal footing, deep-seated religious and secular beliefs that are distinguished from the legitimate but less fundamental preferences displayed by individuals. See Bouchard and Taylor, *Building a Future*, 134.

[47] John von Heyking, "The Harmonization of Heaven and Earth?: Religion, Politics, and Law in Canada," *University of British Columbia Law Review* 33, no. 3 (2000): 678; and Paul Horwitz, "The Sources and Limits of Freedom of Religion in a Liberal Democracy: Section 2(a) and Beyond," *University of Toronto Faculty of Law Review* 54, no. 1 (1996): 45. For a discussion of the independent value of religion, see Horwitz, "The Sources and Limits," 55-56.

[48] David M. Brown, "The Courts' Spectacles: Some Reflections on the Relationship Between Law and Religion in Charter Analysis," presented at the Canadian Institute for the Administration of Justice Conference in Quebec City, 28 September 2008, available online at http://www.consciencelaws.org/Examining-Conscience-Legal/Legal46.html (accessed 23 April 2010) para.8. The profound significance of religion's communal dimension is highlighted in Alvin Esau's work on legal pluralism in Canada. In his piece, "Living by Different Law: Legal Pluralism, Freedom of Religion, and Illiberal Religious Groups," Esau stresses the importance of "inside law" for the viability and group identity of certain Anabaptist communities (as well as other traditions in Christianity, Judaism and Islam) and warns against the threat that the state's "outside law" poses to the freedom of these religious communities. (Here, "inside law" refers to a comprehensive body of norms that is considered binding on the community and takes priority over laws of the state that may be inconsistent with such norms). For details, see Alvin Esau, "Living by Different Law: Legal Pluralism, Freedom of Religion, and Illiberal Religious Groups," in *Law and Religious Pluralism in Canada*, edited by Richard Moon, 110-139 (Vancouver: UBC Press, 2008). Although the communal dimension of religion is not limited to discussions of "inside law," the idiosyncratic normative frameworks of many religious traditions are clear examples of how religion relates to individual adherents *as part of a wider religious community and culture.*

[49] Berger, "Law's Religion," 281.

[50] Benjamin Berger, "The Limits of Belief: Freedom of Religion, Secularism, and the Liberal State," *Canadian Journal of Law and Society* 17, no. 1 (2002): 45.
[51] Ibid., 42.
[52] Benjamin Berger, "Law's Religion: Rendering Culture," *Osgoode Hall Law Journal* 45, no. 2 (2007): 291.
[53] *Syndicat Northcrest v. Amselem*, at para. 39.
[54] Ibid., at paras. 50-51.
[55] Lori Beaman notes that the criterion of sincerity of belief poses numerous problems, including the problem of definition, that of authority (i.e., does the believer set the terms by which sincerity is measured or should an expert be called in to frame the basic parameters of commitment and sincerity?), and the fact that the courts cannot help but delve into the content of beliefs in the process of determining the sincerity with which they are held. For Beaman's discussion, see "Defining Religion: The Promise and Peril of Legal Interpretation," in *Law and Religious Pluralism in Canada*, edited by Richard Moon, 192-216 (Vancouver: UBC Press, 2008).
[56] Berger, "Law's Religion," 283.
[57] Horwitz, "The Sources and Limits," 26.
[58] See Brown, "Freedom From or Freedom For?" 560-583.
[59] *Trinity Western University v. College of Teachers*, [2001] 1 S.C.R. 772, 2001 SCC 31.
[60] Ibid., at para. 36.
[61] Ibid.
[62] Berger, "Law's Religion," 302.
[63] Horwitz, "The Sources and Limits," 26.
[64] According to Benson, "Once secularism is viewed for what it is, by definition as anti-religious ideology with a particular agenda, it is revealed as a principle that offers no guidance to those who wish to establish a plural and genuinely free, open democracy that respects religious liberty." See "The Freedom of Conscience and Religion in Canada: Challenges and Opportunities," *Emory International Law Review* 21 (2007): 154. It must be noted, however, that the popular conception of "secularism as a-religiousness" stands in stark contrast to Berger's formulation of "secularism as pluralism." Berger argues that secularism as pluralism operates, unnoted, in Canadian jurisprudence, the effect of which is not to prohibit participation in public debate but, on the contrary, to preserve a public space within civil society in which no single religious stance can claim supremacy. For more details, see Berger, "The Limits of Belief."
[65] *Zylberberg v. Sudbury Board of Education* (1988), 65 O.R. (2d) 641 (C.A.).
[66] *Canadian Civil Liberties Association v. Ontario (Minister of Education)* (1990), 71 O.R. (2d) 341 (C.A.).
[67] For more details on these two cases, as well as subsequent cases wherein the courts have moved to eliminate religion from the public schools system, see Brown, "Freedom From or Freedom For?" 583-594.
[68] Ogilvie, "Between *Liberté* and *Égalité*," 149.
[69] Horwitz, "The Sources and Limits," 2.
[70] Beverely McLachlin, "Freedom of Religion and the Rule of Law: A Canadian Perspective," in *Recognizing Religion in a Secular Society: Essays in Pluralism, Religion, and Public Policy*, edited by Douglas Farrow, 12-34 (Montreal & Kingston: McGill-Queen's University Press, 2004) 22. The value that Canadian society places on multiculturalism is articulated in the section 27 of the *Charter* (the "multicultural interpretation rule"). As previously stated in this chapter's overview of constitutional law, the constitutional guarantee of religious freedom established in section 2(a) is associated with this recognition of Canada's multicultural heritage in *Charter* jurisprudence.
[71] Ibid., 28 (emphasis added).

[72] Ogilvie, "Constitutional Fundamentals," 79. In Canada, state sovereignty over religion is apparent in the state's subjugation of "inside law" when arbitrating conflicts that arise within religious communities and its subsequent imposition of the state's official "outside law" throughout its adjudication. For details, see Esau, "Living by Different Law,"110-124.

[73] See *R. v. Oakes* at paras. 69-71.

[74] Horwitz, "The Sources and Limits," 33.

[75] In this case, the infringement of Colony members' right to religious freedom consisted of the Court's refusal to grant Colony members exemption from the universal photo requirement of Alberta's licensing system, even though the Hutterite religion holds that the Second Commandment prohibits members from having their photographs willingly taken. The public benefit conferred by this infringement was the reduction of identity theft associated with driver's licences.

[76] *Alberta v. Hutterian Brethren of Wilson Colony* at para. 88.

[77] Ibid. at paras. 96-99. Even though Chief Justice McLachlin acknowledged that the impugned regulation imposes a *cost* on those who choose not to have their photos taken (i.e., the cost of not being able to drive on the highway), she asserted that this cost "does not rise to the level of depriving the Hutterian claimants of a meaningful choice as to their religious practice" (para. 96).

[78] Ibid. at para. 2. The past tense is used insofar as the information pertaining to the Hutterian Brethren of Wilson Colony's lifestyle is taken from the depositions recorded in the court case itself.

[79] Ibid. at para. 8.

[80] Ibid.

[81] For details on Hutterian self-sufficiency, see "Hutterites," in *The Canadian Encyclopedia*, undated. Available online at http://thecanadianencyclopedia.com/index.cfm?PgNm=TCE&Params=A1ARTA0003929 (accessed 14 May 2010).

[82] Brad A. Elberg and Mark C. Power, "Freedom of Conscience and Religion," *Supreme Court Law Review (2d)* 28 (2005): 110.

[83] *R. v. Big M. Drug Mart Ltd.* at para. 97.

[84] Richard Moon, "Government Support for Religious Practice," in *Law and Religious Pluralism in Canada*, edited by Richard Moon, 217-238 (Vancouver: UBC Press, 2008) 222-223. Speaking from within the American legal tradition, Martha Nussbaum also associates religious equality with the protection of religious minorities. Referring to the formal separation of church and state upheld by the First Amendment, Nussbaum states, "Insofar as it is a good, defensible value, the separation of church and state is, fundamentally, about equality, about the idea that no religion will be set up as *the* religion of our nation, an act that immediately makes outsiders unequal. Hence separation is also about protecting religion – minority religion, whose liberties and equalities are always under pressure from the zeal of majorities." Martha C. Nussbaum, *Liberty of Conscience: In Defense of America's Tradition of Religious Equality* (New York: Basic Books, 2008) 11-12.

[85] Ibid., 229-230.

[86] Ibid., 231.

[87] Although the present discussion recognizes the equal exclusion of religious traditions from the public sphere as a manifestation of religious equality in itself (albeit in a negative sense), Martha Nussbaum argues that true religious equality must exist in the form of *equal religious liberty* that is protected and supported by the state. She grounds her position in the human faculty of conscience, stating, "I shall argue that the argument for religious liberty and equality in the tradition begins from a special respect for the faculty in human beings with which they search for life's ultimate meaning. This faculty was held to be present in all human beings in such a way as to make human beings equal: anyone who has it (and all humans do) is worthy of boundless respect, and that respect should be equally given to high and low, male and female, to members of the religions one likes and also to members of religions one hates. Conscience is precious, worthy

of respect, but it is also vulnerable, capable of being wounded and imprisoned. The [American legal tradition] argues that conscience, on that account, needs a protected space around it within which people can pursue their search for life's meaning (or not pursue it, if they choose). Government should guarantee that protected space." Nussbaum, *Liberty of Conscience*, 19. Thus, any form of equality that neglects the equal protection of conscience to all citizens, which includes the creation and maintenance of a space wherein citizens can pursue the dictates of their consciences, does not constitute religious equality. If follows that the *equal exclusion* of religious traditions from the Canadian public sphere does not reflect religious equality with Nussbaum's framework.

[88] *Human Rights Code*, R.S.O. 1990, c. H.19.

[89] Ontario Human Rights Commission, *Policy on Creed and the Accommodation of Religious Observances*, Ontario Human Rights Commission Web site, 20 October 1996, http://www.ohrc.on.ca, 2.

[90] Ibid.

[91] Ontario Human Rights Commission, *Submission of the Ontario Human Rights Commission to the College of Physicians and Surgeons of Ontario Regarding the Draft Policies Relating to Establishing and Ending Physician-Patient Relationships*, Ontario Human Rights Commission Web site, 14 February 2008, http://www.ohrc.on.ca/en/resources/submissions/surgeons (accessed 23 April 2010), para. 43. Here, the physician's interest in accommodation is limited according to the standard of undue hardship, which holds that a request for accommodation may be rejected if it infringes the rights of others (in this case, the right of a patient to access timely medical care in a non-judgemental clinical environment).

[92] College of Physicians and Surgeons of Ontario, *Physicians*, 4 (emphasis added).

[93] Ibid., 3.

[94] Ibid., 4 (emphasis added).

[95] Ibid., 4.

Consistency Interrupted:

A Bioethical Analysis of the CPSO's Policy Statement

The previous chapter examined Margaret Somerville's commentary regarding the College of Physicians and Surgeons of Ontario's (CPSO) draft policy statement as an example of the concern emanating from Canada's legal community with respect to the CPSO's stance on the issue of conscientious objection. However, Somerville's critique that physicians are increasingly treated as silent technicians in contemporary society extends beyond the legal community, reflecting a growing concern within the field of biomedical ethics as well. More specifically, Somerville's critique points to what bioethicist Edmund Pellegrino terms the "consumer model" of health care. In the consumer model, health care is viewed as a commodity or service to be purchased in the marketplace on the consumer's terms (i.e., in terms of the patient's personal assessment of alternative options, their costs, benefits and risks).[1] Moreover, "[t]he doctor is a provider whose task it is to provide reliable information, perhaps to advise, *but not interject her own values*. The patient's values must predominate and the doctor's moral obligations are to inform, to perform with competence and to protect and enhance the patient's capabilities for self-determination."[2] Primarily a result of the increasing emphasis placed on the principle of autonomy within bioethics over the past four decades, this framework of health care delivery has become a prevailing model of the physician-patient relationship in Western medicine.[3]

Prior to the 1970s, the health care outlook in Europe and North America was mainly that of maximizing medical benefits and minimizing risks of harm and disease.[4] Howard Brody associates the following features with this "old" construct of medical ethics. First, ethics was generally thought of as a list of do's and don'ts for the physician. Second, ethics was based on professional authority. Inasmuch as laymen did not know medicine, it was believed that they could have nothing useful to contribute to the discussion surrounding medical ethics. Physicians therefore determined their own ethical standards. Third, the primary ethical principle was benefit to the patient. So long as physicians believed that they were serving their patients' welfare, they could be justified in deceiving, coercing and doing other things to patients that would have been deemed socially unacceptable outside the physician-patient relationship.[5] The third element of Brody's description reflects the paternalistic construction of the physician-patient relationship, wherein the physician refuses to acquiesce in the wishes and preferences of the patient for the patient's benefit (or rather, for what the physician believes is in the patient's best interests).

The principle of autonomy began to gain ground in the 1970s in reaction to the prevailing paternalism in the "old" medical ethics. This transformation saw the emergence of a "new" medical ethics with the following elements. First, ethics is now thought of not merely as a list of rights and duties, but also as the study of the underlying reasons for those rights and duties. Second, individuals trained in moral reasoning, including philosophers and theologians, currently contribute to the discussion surrounding health care ethics. Physicians must be prepared to

justify their ethical views in terms that non-physicians would find rational and reasonable. Third, patient benefit has become *only one moral principle among many* and the principle of autonomy has been granted a privileged position.[6] This final element speaks to Pellegrino's articulation of the consumer model of health care delivery and, by extension, Somerville's critique of the CPSO's efforts to reduce physicians to mere technicians to the extent that they both reflect the elevated status currently granted to patient autonomy within the physician-patient relationship.

As philosophers and theologians became increasingly interested in bioethical dilemmas, they began to formulate several principles to guide ethical deliberation in medical settings.[7] The early fruits of these efforts first appeared in published form in *The Belmont Report: Ethical Guidelines for the Protection of Human Subjects of Research*, issued by the United States National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research in 1979.[8] A triad of principles was mentioned: respect for persons, beneficence and justice.[9] By virtue of its simplicity and suitability, this triad quickly found its way into the expanding body of bioethics literature and was widely adopted as a useful format for education about ethics in health care. Before long, however, the original triad of principles transformed within the bioethics community into the popular quadruplicate consisting of respect for autonomy, nonmaleficence, beneficence and justice.[10] This group of four principles is most commonly associated with the work of Beauchamp and Childress, particularly their book, *Principles of Biomedical Ethics*.[11] First published in 1978, *Principles* is currently

in its sixth edition and Beauchamp and Childress' four-principle approach remains the predominant framework in health care ethics.[12]

In order to provide a bioethical analysis of the CPSO's policy statement, "Physicians and the Ontario *Human Rights Code*,"[13] this chapter examines the CPSO's position on physicians' right to conscientious objection in light of Beauchamp and Childress' four-principle framework.[14] The following question serves to guide the discussion: To what degree do the CPSO's requirements of full disclosure and patient referral—in spite of a physician's conscientious objection—coincide or conflict with the four principles of respect for autonomy, nonmaleficence, beneficence and justice developed in Beauchamp and Childress' formulation of principlism? Following an overview of the basic elements of Beauchamp and Childress' approach to general normative ethics, the first section of this chapter looks at their explication of the four principles of respect for autonomy, nonmaleficence, beneficence and justice. The related issues of informed consent and medical paternalism are addressed in conjunction with the principles of respect for autonomy and beneficence, respectively. The second section consists of my bioethical analysis of the CPSO's policy statement, wherein I address the degree to which its requirements of full disclosure and patient referral are consistent or inconsistent with the above four principles. Two fictional case models guide my discussion insofar as they effectively highlight the ethical dilemmas that typically arise in relation to the issues of disclosure and referral in situations of conscientious objection.

Although the issue of conscientious objection among physicians gives rise to several dilemmas between conflicting ethical principles, my analysis reveals some consistency between the CPSO's policy requirements, on the one hand, and the principles of respect for autonomy, beneficence and justice on the other. The expectation that conscientiously objecting physicians fully disclose patients' options and refer patients for the procedures to which they object is consistent with the principle of respect for autonomy since these requirements respect patients' capacity for autonomous choice, including the ability to act on their choices. Moreover, inasmuch as they respect patient self-determination as an expression of personhood, the CPSO's policy requirements also reflect the principle of beneficence. Coherence with the principle of justice is reflected in the fact that both requirements help maintain an equitable standard of access to health care.

According to my analysis, however, the above-noted consistency is interrupted on two fronts. First, substantial ambiguity surrounds the relationship between the CPSO's policy requirements and the principle of nonmaleficence. By attempting to ensure that physicians fully inform their patients of options and provide patient referrals for the medical procedures to which they conscientiously object, the CPSO's requirements minimize the possibility that patients will experience significant obstacles in accessing medically indicated care that is most consistent with their values and preferences. This, in turn, may reduce the detrimental implications that delays and denial of treatment can have on patients' physical, psychological and emotional well-being Yet, by virtue of the fact that

instances of conscientious objection often involve contentious medical procedures of which the benefits and burdens are unclear, it is impossible to definitively determine whether facilitating patient access to such contentious medical treatment is in fact in accordance with the principle of nonmaleficence. A physician's conscience-based refusal to provide a certain service may in fact be protecting patients from harm. Second, the consistency between the CPSO's policy and the ethical framework of principlism is also punctured by a conflict between the policy's requirements and the principle of respect for *physician* autonomy. Despite the coherence between the CPSO's position and respect for patient autonomy, forcing objecting physicians to disclose patients' options to which they object and refer patients for such procedures effectively denies these physicians their right to autonomous choice and self-determination.

Beauchamp and Childress' approach to general normative ethics

Beauchamp and Childress' bioethical framework falls under the category of philosophical inquiry referred to as general normative ethics, which attempts to answer the question, "Which general moral norms, or principles, should we accept for the guidance and evaluation of conduct, and why?"[15] In answering this question, Beauchamp and Childress expound the theory of the Common Morality (CM). The CM represents a set of norms shared by all persons committed to morality. It is universally applicable and human conduct is properly judged by its standards.[16] The CM's universal nature is a product of its foundation in human experience and history; however, the CM is distinct from *particular moralities*

that are specific to certain cultural contexts and traditions. In other words, particular moralities encompass the CM while consisting of additional idiosyncrasies stemming from the specific contexts in which they are lived out by moral agents.[17]

Examples of the norms found in the CM include general injunctions against killing, causing pain or suffering to others, and stealing, as well as the obligation to prevent evil or harm from occurring.[18] Furthermore, the CM recognizes character traits such as benevolence, honesty and integrity.[19] The set of moral principles defended by Beauchamp and Childress' formulation of principlism functions as an analytical tool intended to express general norms of the CM that are suitable starting points for the context of biomedical ethics.[20] It is crucial to recognize that general norms are mere seeds, from which more specific rules can develop.

A further specification to be made at this point is that the principles, duties, and obligations expounded in this framework are not absolute merely because they stem from the CM, which is universal. Rather, they are of *prima facie* nature. Beauchamp and Childress espouse W.D. Ross' formulation of *prima facie* obligations, wherein an obligation is assumed to be binding unless it conflicts, on a particular occasion, with an equal or stronger obligation. Otherwise put, one must fulfill a *prima facie* obligation unless a competing moral obligation outweighs it in a particular situation. The binding force of each principle is dependent on the circumstances of a given context.[21]

As briefly alluded to in the previous paragraphs, principles do not function as precise action-guides that direct moral agents in each circumstance. They require specification in order to determine their scope in a given situation and balancing when two or more principles come into conflict with each other. Specification is a process of reducing the indeterminate character of abstract norms and generating more specific action-guiding content. Specification therefore transforms abstract norms such as principles into concrete rules.[22] Balancing, on the other hand, is concerned with the relative weights and strengths of different moral norms rather than their scope. This process involves finding reasons to support beliefs about which moral norms should prevail in situations where two or more general norms conflict.[23] Insofar as the process of balancing can become a highly subjective activity, Beauchamp and Childress list the following six conditions that should help reduce intuiting, partiality and arbitrariness in balancing: 1) good reasons can be offered to act on the overriding norm rather than on the infringed norm; 2) the moral objective justifying the infringement has a realistic prospect of achievement; 3) no morally preferable alternative actions are available; 4) the lowest level of infringement, commensurate with achieving the primary goal of the action, has been selected; 5) any negative effects of the infringement have been minimized; and 6) all affected parties have been treated impartially. Beauchamp and Childress go on to emphasize that these conditions must be met to justify the infringement of one *prima facie* norm in favour of another.[24]

Moral agents' capacity to balance several moral considerations is intricately connected to their moral character. Instead of viewing moral principles in competition with ethical theories based on moral virtues, Beauchamp and Childress stress that principles and virtues are mutually supportive rather than mutually exclusive.[25] Discussing their complementary role, Beauchamp emphasizes, "Proficient use of principles requires judgment, which depends on personal characteristics, such as a sense of personal responsibility and integrity."[26] Moreover, Beauchamp and Childress identify conscientiousness as a central virtue in medical ethics, specifying, "An individual acts *conscientiously* if he or she is motivated to do what is right because it is right, has tried with due diligence to determine what is right, intends to do what is right, and exerts an appropriate level of effort to do so."[27] Defined as such, the virtue of conscientiousness is intricately linked to the issue of conscientious objection in medicine.

Beauchamp and Childress actually address the issue of conscientious objection directly, acknowledging that even though there are strong reasons to promote conscientiousness and respect for conscience among physicians, public policy, professional colleges and institutions should seek to accommodate conscientious objection only so long as it can be done without seriously compromising patients' rights and interests.[28] At the end of their discussion on conscience and conscientiousness, they assert the following standard of care: "At a minimum, health care professionals have an ethical duty to inform prospective employers and prospective patients, clients, or customers of their conscientious objections to performing any services that could reasonably be expected. *They*

also always have an ethical duty to disclose options for obtaining legal, albeit morally controversial, services and, in many cases, a duty to provide a referral for those services."[29] Although Beauchamp and Childress clearly articulate their position with regards to the issues of full disclosure and patient referral in situations of conscientious objection, they leave out the manner in which they arrived at their conclusion (i.e., they fail to discuss in what ways the issues of disclosure and referral relate to the four principles expounded in their framework). The analysis section of this chapter thus aims to clarify Beauchamp and Childress' conclusion by providing an in-depth examination of the CPSO's policy requirements of full disclosure and patient referral in light of the principles of respect for autonomy, nonmaleficence, beneficence and justice. Before this analysis, however, the main components of these four principles must be set out.

Respect for autonomy and the ethical obligation of informed consent

Although one among four guiding principles of Beauchamp and Childress' framework, respect for patient autonomy has assumed a central position in ethical deliberation and policy development in North America. Derived from the Greek *autos*, meaning "self," and *nomos*, meaning, "rule," "governance," or "law," personal autonomy encompasses self-rule that is free from controlling outside influences and other limitations preventing meaningful and independent choice.[30] Beauchamp and Childress focus their discussion of autonomy on autonomous choice, and accordingly define the principle of respect for autonomy as the acknowledgment of a person's right to hold views, to make choices and to take

actions based on their personal values and beliefs.[31] This acknowledgment involves both a negative and a positive obligation. As a negative obligation, respect for autonomy implies that autonomous actions should not be subjected to the controlling constraints of others. As a positive obligation, the principle requires both respectful treatment in disclosing information and actions that foster autonomous decision-making. More specific rules associated with the principle of respect for autonomy include telling the truth, respecting the privacy of others, protecting confidential information, obtaining consent for interventions with patients and, when asked, helping others make important decisions.[32] With regards to this last rule, Beauchamp and Childress stress that physicians' professional obligation to respect patient autonomy does not translate into patients' mandatory duty to make autonomous choices. Rather, it points to patients' *right* to choose and, by extension, the right to delegate this choice to someone else.[33]

The doctrine of informed consent is indicative of the shift toward the principle of autonomy in health care ethics. Even though the term "informed consent" first appeared in the late 1950s, the concept did not receive significant attention until the early 1970s. By this time, emphasis had shifted from its original focus on the physician's or the researcher's obligation to disclose information to the quality of the information presented and the patient's or subject's understanding and autonomous consent.[34] Interestingly, much of the commentary on the topic of informed consent that appeared in medical literature at this time was negative. Many physicians viewed the demands of informed consent as

impossible ideals and, in some cases, detrimental to standards of patient care.[35] Yet, regardless of its negative reception among many medical professions, in 1981 the Judicial Council of the American Medical Association recognized informed consent as a basic social policy necessary to enable the patient to make autonomous decisions with regards to medical interventions. The following year, the U.S. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research published a three-volume report dealing directly with informed consent. Since the 1980s, numerous books and journal articles have been published on the topic, as well as the passage of procedure-specific informed consent laws and regulations in both Canada and the United States.[36]

Beauchamp and Childress identify seven elements of informed consent: 1) competence, to understand and decide; 2) voluntariness, in deciding; 3) disclosure, of material information; 4) recommendation, of a plan; 5) understanding, of disclosed information and recommendations; 6) decision, in favour of a plan; and 7) authorization, of the chosen plan.[37] Disclosure of material information to the patient is a primary component of informed consent insofar as patients' level of understanding and final decisions regarding medical interventions are significantly dependent on the information they receive from medical professionals. Professionals are typically obligated to disclose core information, including those facts or descriptions that patients usually consider important in deciding whether to refuse or assent to a proposed intervention, information the professional believes to be pertinent, the professional's

recommendation, the purpose of seeking consent and the nature and limits of consent as an act of authorization.[38]

There are three standards of adequate disclosure. The "professional practice standard" holds that a professional community's customary practices determine adequate disclosure, whereas the "reasonable person standard" maintains that the information to be disclosed is determined by reference to a hypothetical reasonable person. The third measure is that of the "subjective standard," wherein the adequacy of information is determined with reference to the particular needs of the individual patient. Though the subjective standard is morally preferable—since patients differ in the amount of information they wish to receive—the professional practice standard and the reasonable person standard have emerged as the two competing measures of adequate disclosure in legal disputes involving informed consent.[39] Thus, the doctrine of informed consent has been firmly established within North America since the early 1980s as the paradigm of clinical decision-making, and the principle of respect for autonomy has effectively provided ethical justification for its associated rules, policies and procedures.[40]

Nonmaleficence

The principle of nonmaleficence imposes the obligation to refrain from inflicting harm on others. In the specific context of medical ethics, it is closely associated with the maxim *Primum non nocere*, meaning, "Above all [or first] do no harm."[41] Although the concept of nonmaleficence has been explicated by the

elements of harm and injury, Beauchamp and Childress confine their discussion of the ethical principle of nonmaleficence to the former. Harm is construed in the sense of thwarting, defeating, or setting back some party's interests and such acts are typically *prima facie* wrong simply by virtue of the fact that set back the interests of the affected persons.[42] The principle of nonmaleficence supports several more specific rules, including injunctions against killing, causing pain or suffering, incapacitating others, causing offense and depriving others of the goods of life.[43]

Obligations of nonmaleficence extend beyond refrain from inflicting harm to obligations not to impose *risks* of harm. The concept of "due care" implies taking sufficient and appropriate care to avoid causing harm to a patient, as the circumstances demand of a reasonable and prudent person. Implicit in the definition of due care is the fact that the ethical obligation of nonmaleficence is partially contingent on contextual factors, for a reasonable and prudent person may determine that the circumstances of a given situation demand that a certain level of risk be imposed in order to achieve a highly important goal. Here, the goals pursued justify the risks that must be imposed to achieve those goals.[44]

Negligence is the absence of due care. In all professions, negligence involves a departure from the professional standards that determine due care in particular circumstances. The concept of negligence covers two types of situations. A professional can intentionally impose unreasonable risks of harm (i.e., advertent negligence or recklessness), or alternatively, a professional can unintentionally but carelessly impose risks of harm (i.e., inadvertent

negligence).[45] Although these categories of negligence seem rather basic and straightforward, the substantial problem of determining the scope of nonmaleficence has yet to be solved. More specifically, it is unclear to what lengths physicians and employers should go to avoid or lower risks to others.

Beneficence and medical paternalism

Whereas the principle of nonmaleficence focuses on moral agents' obligation to refrain from action, beneficence requires their active participation. According to Beauchamp and Childress, morality requires not only that moral agents treat others autonomously and refrain from harming them, but that they also contribute to the others' welfare. This active contribution falls under the principle of beneficence.[46] Though beneficence traditionally connotes acts of mercy, kindness, charity, love, altruism and humanity, within the context of principlism it includes all forms of action that are intended to benefit other people. Thus, simply put, the principle of beneficence consists of the *prima facie* obligation to act for the benefit of others.[47]

It is important to distinguish between the ideal and the principle of beneficence, for the CM does not include a principle of beneficence that requires severe sacrifice and extreme altruism. Rather, it is generally agreed that only *ideals* of beneficence encompass such extreme generosity.[48] To clarify what they mean by the principle of beneficence, Beauchamp and Childress suggest that, apart from very close moral relationships (i.e., ties of family or friendship), person X only has a *prima facie* obligation of beneficence toward person Y if each of the

following conditions is satisfied: 1) Y is at risk of significant loss of or damage to life, health, or some other major interest; 2) X's action is necessary (singly or in concert with others) to prevent this loss or damage; 3) X's action (singly or in concert with others) has a very high probability of preventing the harm; 4) X's action would not present very significant risks, costs, or burdens to X; and 5) the benefit that Y can be expected to gain outweighs any harm, costs, or burdens that X is likely to incur.[49] When each of the aforementioned conditions are satisfied, the *principle* of beneficence supports an array of moral rules, including the obligations to protect and defend the rights of others, prevent harm from occurring to others, remove conditions that will cause harm to others, help persons with disabilities and rescue persons in danger.[50]

Obligations of beneficence owed to specific parties such as children, family, friends, patients and clients depend on moral relations and/or special commitments, such as explicit promises and the acceptance of roles with accompanying responsibilities. Accordingly, there is an implicit assumption of beneficence in medical professions insofar as the promotion of patient welfare embodies medicine's goals, rationale and justification.[51] Moreover, it is commonly believed that physicians owe a large debt to society for their education and privileges, as well as to past and present patients for research and training. It follows that physicians' role of beneficent caregiver is partially rooted in the reciprocity of giving after having received.[52]

As briefly mentioned in this chapter's introduction, concern for patient welfare and benefit predominated the "old" model of medical ethics. However,

the traditional interpretation of benefiting the patient was extremely narrow to the extent that physicians relied almost exclusively on their own judgment regarding patients' best interests while disregarding their patients' input throughout the medical decision-making process. This approach to patient care stood at the centre of Western bioethics since British physician, Thomas Percival, developed the first well-formulated model of medical ethics at the beginning of the nineteenth century in his work, *Medical Ethics*. For instance, in discussing the issue of disclosure, Percival asserts,

> To a patient . . . who makes inquiries which, if faithfully answered, might prove fatal to him, it would be a gross and unfeeling wrong to reveal the truth. His right to it is suspended, and even annihilated; because, its beneficial nature being reversed, it would be deeply injurious to himself, to his family, and to the public. And he has the strongest claim, from the trust reposed in his physician, as well as from the common principles of humanity, to be guarded against whatever would be detrimental to him. . . . The only point at issue is, whether the practitioner shall sacrifice that delicate sense of veracity, which is so ornamental to, and indeed forms a characteristic excellence of the virtuous man, to this claim of professional justice and social duty.[53]

Apparent in this excerpt is the traditional elevation of beneficence and nonmaleficence above all other considerations, including concern for patient autonomy. Percival's work is monumental in the field of medical ethics, as it served as the basis for the American Medical Association's (AMA) first official code of ethics, published in 1847. His primary concern of protecting patients' health and well-being is reflected in Article I, Section 4 of the AMA's original code.

> A physician should not be forward to make gloomy prognostications because they savour of empiricism, by magnifying the importance of his services in the treatment or cure of disease. But he should not fail, on proper occasions, to give to the friends of the patient timely notice of

> danger, when it really occurs; and even to the patient himself, if absolutely necessary. This office, however, is so peculiarly alarming when executed by him, that it ought to be declined whenever it can be assigned to any other person of sufficient judgment and delicacy. For, the physician should be the minister of hope and comfort to the sick; that, by such cordials to the drooping spirit, he may smooth the bed of death, revive expiring life, and counteract the depressing influence of those maladies which often disturb the tranquility of the most resigned, in their last moments. The life of a sick person can be shortened not only by the acts, but also by the words or the manner of a physician. It is, therefore, a sacred duty to guard him carefully in this respect, and to avoid all things which have a tendency to discourage the patient and to depress his spirits.[54]

The form of beneficence exemplified in the above passages from Percival's *Medical Ethics* and the AMA's original code is commonly equated with medical paternalism.

Beauchamp and Childress define paternalism as "the intentional overriding of one person's preferences or actions by another person, where the person who overrides justifies this action by appeal to the goal of benefiting or of preventing or mitigating harm to the person whose preferences or actions are overridden."[55] Though one is inclined to immediately view paternalism as morally negative, Beauchamp and Childress emphasize the moral neutrality of their definition. The ethical nature of paternalistic actions is typically understood to hinge on whether there is a conflict between the principles of respect for autonomy and beneficence.[56] For example, since depression, drug addiction and the like substantially interfere with the exercise of a patient's autonomy, beneficent acts that are intended to protect patients suffering from these afflictions and promote their interests are generally seen as justified—whether or not they override patients' wishes and preferences. In such situations, the physician's beneficence represents *soft* paternalism insofar as the patient lacks substantial

autonomy and there is consequently no conflict between the principles of respect for autonomy and beneficence.[57] Conversely, *hard* paternalism is much more ethically controversial insofar as it involves unwelcome interventions intended to prevent or mitigate harm to others or to benefit a person, despite the fact that the party involuntarily acted upon is autonomous.[58]

At this point, it is important to deviate slightly from the work of Beauchamp and Childress and acknowledge Pellegrino's work in the area of medical paternalism because he makes an insightful distinction between paternalistic acts and beneficence that is characteristically overlooked in bioethics. Up to this point, beneficence has been presented in close connection to the concept of paternalism and, subsequently, antithetical to the principle of respect for autonomy. However, Pellegrino argues that this popular understanding is gravely mistaken. In his view, medical paternalism should never be equated with beneficence (conceptually or in practice) because it does not account for patients' preferences or values.[59] By virtue of the fact that patients' choices are expressions of their own personhood, it is severely harmful to override and disrespect the choices of autonomous patients. Only when a patient's human capacity to act autonomously is impaired may a physician resort to paternalism as a beneficent act to disregard objections to treatment.[60] Turning the commonly perceived conflict between beneficence and autonomy on its head, Pellegrino concludes that the principle of beneficence actually requires physicians to fulfill the positive obligation stemming from the principle of respect for autonomy—

namely, the duty to enhance, empower and enrich patients' capacity to act autonomously.[61]

Justice

The concept of justice is often interpreted to represent fair, equitable and appropriate treatment in light of what is due or owed to persons. Beauchamp and Childress assert that standards of justice are required whenever persons are owed benefits or burdens by virtue of their particular properties or circumstances. An injustice therefore involves a wrongful act or omission that denies individuals the resources or protections to which they have a right.[62] Distributive justice is the predominant area of justice related to the field of medical ethics and it refers to the fair, equitable and appropriate distribution of diverse benefits and burdens (such as property, resources, taxation, privileges and opportunities), determined by justified norms structuring terms of social cooperation.[63]

Acknowledging the concept of justice's broad scope, Beauchamp and Childress maintain that several formulations of the ethical principle of justice merit acceptance. They consequently outline a formal principle of justice as well as several material principles of justice. The formal principle of justice is a minimal requirement common to all theories of justice (although traditionally attributed to Aristotle), which establishes, "Equals must be treated equally, and unequals must be treated unequally."[64] This principle is "formal" because it fails to identify in which respects equals ought to be treated equally and provides no criteria for determining whether two or more individuals are in fact equal.

Material principles, on the other hand, are principles that specify the relevant characteristics for equal treatment.[65] For instance, material principles of distributive justice include the following criteria for distribution: 1) to each person an equal share; 2) to each person according to need; 3) to each person according to effort; 4) to each person according to contribution; 5) to each person according to merit; and 6) to each person according to free-market exchange. All public and institutional policies based on distributive justice are ultimately derived from the implicit or explicit acceptance of certain material principles and the rejection of others. It follows that several disputes over the right policy or method of distribution stem from rival or alternative starting points using different material principles.[66]

Bioethical analysis of the CPSO's policy statement

With an understanding of principlism's main components in hand, the discussion now shifts to examine the CPSO's policy requirements in light of the four principles of respect for autonomy, nonmaleficence, beneficence and justice. The specific focus of my analysis are the CPSO's expectations that physicians disclose options to which they conscientiously object and provide patient referrals for such procedures so that their patients can readily receive these services elsewhere. In order to determine whether the policy requirements are consistent or inconsistent with the above four principles, it is necessary to address the ethical dilemmas and implications that generally arise in relation to the issues of disclosure and patient

referral in contexts of conscientious objection. The following two case models involving the issue of abortion guide my analysis.

Case A

> *Sarah is 20 years old, lives in northern Ontario and has just learned via a home pregnancy test that she is pregnant. Although Sarah would like to have children at some point, she currently works at a small convenience store (this was the only job she could find without a high school diploma) and lacks the financial means to support a child. Her on-again, off-again boyfriend—and father of the child—adamantly refuses to have anything to do with the pregnancy or the child once it is born. Unsure of what to do, Sarah visits her doctor to confirm the pregnancy and discuss the options available to her.*
>
> *After confirming Sarah's pregnancy and listening to her deep apprehension about having the baby, Sarah's physician discusses the option of adoption. There is no mention of terminating the pregnancy, despite the fact that abortion is a treatment option covered under Canada's public health insurance system (Medicare). Sarah's physician staunchly objects to abortion on religious grounds and he believes that informing Sarah of this option would constitute indirect participation should Sarah subsequently aborts her pregnancy. As a devout Roman Catholic, he believes that all human life must be protected from the moment of conception, insofar as all human beings have an inviolable right to life. He furthermore believes that abortion is not only harmful to the fetus, but to the physical, psychological and spiritual well-being of the mother. Therefore, as Sarah's physician, he feels additionally obliged to prevent her from seeking an abortion because it would be severely harmful to her health.*
>
> *Without reason to suspect that her doctor is withholding information regarding her options, Sarah leaves her doctor's office believing that adoption is the only available alternative to raising the child on her own.*

Case B

> *Anne is 20 years old, lives in northern Ontario and has just learned via a home pregnancy test that she is pregnant. Although Anne would like to have children at some point, she currently works at a small convenience store (this was the only job she could find without a high school diploma) and lacks the financial means to support a child. Her on-again, off-again boyfriend—and father of the child—adamantly refuses to have anything to do with the pregnancy or the child once it is born. Anne visits her doctor*

to confirm the pregnancy and, once the tests come back positive, requests an abortion.

Despite the fact that abortion is a treatment option covered under Canada's public health insurance system (Medicare), Anne's physician refuses to abort the pregnancy, stating that his religious beliefs strictly forbid abortion. As a devout Roman Catholic, he believes that all human life must be protected from the moment of conception, insofar as all human beings have an inviolable right to life. He furthermore asserts that abortion is not only harmful to the fetus, but to the physical, psychological and spiritual well-being of the mother. Therefore, as Anne's physician, he feels additionally obliged to refuse her request on the grounds that it would be severely harmful to her health.

Still convinced that she wants to abort the pregnancy, Anne requests a referral to another physician who will perform the abortion. Her physician again refuses, stating that such a referral would constitute participation in the murder of her baby.

The most striking ethical dilemma in both of the above cases is the conflict between patient and physician autonomy. In the first case, Sarah's autonomy is violated when her physician neglects to inform her of the option of abortion. Failing to fully disclose all available options restricts her ability to make autonomous decisions with regards to her health and, ultimately, her future. Moreover, it explicitly breaches the doctrine of informed consent by neglecting the third element of disclosure. Regardless of which standard of disclosure is adopted, the comprehensive and unbiased disclosure of material information (including all treatment options and their associated risks and benefits) is a minimal requirement of informed consent. This requirement is clearly articulated in the Society of Obstetricians and Gynaecologists of Canada's (SOGC) clinical practice guidelines relating to induced abortions.[67] In its introduction, the

document informs practitioners of the element of disclosure that is required of them,

> Every woman seeking abortion should receive supportive and compassionate counseling on all the options available, including continuing the pregnancy and having the child adopted or seeking assistance should she wish to parent. Counseling should take place early enough to avoid any delays in the event the woman chooses to terminate the pregnancy. The [physician] should be free of personal bias and responsive to the woman's circumstances.[68]

The document further specifies the various components of disclosure that are necessary should a patient opt for abortion, stating, "If the woman chooses to terminate the pregnancy she must have the opportunity to fully understand the nature of the proposed procedure including the types of anesthesia, safety, potential immediate and long-term complications, and side effects."[69] Whether pro-choice or pro-life, physicians must honestly attempt to comprehensively disclose material information in an unbiased fashion so that patients can make informed and autonomous decisions regarding their medical care. In the words of Edmund Pellegrino, "Informed consent is an empty notion or a charade if the information on which it is based is biased in favor of the physician's preferences."[70] In the second case, Anne's autonomy is violated when her physician refuses to provide her with a referral to another physician so that she may abort her pregnancy. Although Anne has made the choice to have an abortion in this case, her physician's refusal to refer hampers her ability to *act* on her decision and thereby limits her capacity for self-determination.

In the above scenarios, both physicians deny their patients' autonomy in order to preserve their own. If Sarah's physician were forced to disclose the

option of abortion and Anne's physician were forced to provide a referral for abortion against their consciences, their own right to self-determination would be denied. Even though the principle of autonomy has shifted to the forefront of medical ethics over the past four decades, it is the patient's autonomy that garners attention while that of the physician is typically neglected. This common oversight is highly problematic inasmuch as both physicians and patients have equal claims to self-determination by virtue of their capacity as human beings for rational judgment and the expression of their preferences, values and choices. In physician-patient relationships, it is therefore unjust to categorically rank one party's right to autonomy over that of the other. When a conflict between patient and physician autonomy arises, the specific circumstances of the situation must be taken into account (including the role of other ethical principles) in order to determine whether one party's right to autonomy should prevail.

A second ethical dilemma that emerges from the case models is the conflict between physician autonomy and patient access to care. Access to care falls under the principle of justice, or more specifically, distributive justice. By neglecting to inform Sarah that abortion is an available option for pregnant women wishing to abort their pregnancies, Sarah's physician compromises her right to access the medical services that may be the most consistent with her value system and personhood. Likewise, by refusing to provide Anne with a referral to a physician willing to abort her pregnancy, Anne's physician hinders her capacity to access the medical care she desires. Despite the fact that access to abortion services is not unquestionably accepted as a *right* of patients, abortion's status as

a treatment option covered under Canadian Medicare implies that by impeding Sarah's and Anne's access to abortion, both physicians disrupt the equitable distribution of health services.[71]

The degree to which a physician's conscientious objection jeopardizes a patient's access to care is partially dependent on geographic and socioeconomic factors. For instance, a physician's conscientious refusal to provide medical services, patient referrals or material information with regards to patients' options may not seriously compromise a patient's access to care in urban settings where several drop-in clinics and medical facilities are available within a relatively short distance. However, the situation is much different in rural towns and communities where limited local medical services and geographic distance from neighboring communities can significantly restrict a patient's access to care when the local physician refuses to provide services on the basis of conscience. Therefore, an important factor to consider when attempting to resolve the dilemma between physician autonomy and distributive justice in cases of conscientious objection is the degree to which the objecting physician's refusal to provide medical services, patient referrals or material information impedes the patient's ability to access care from another medical professional.

In both case models, the relationship between the principles of physician autonomy and nonmaleficence *may* constitute a third ethical dilemma. This potential conflict is extremely unclear to the extent that research studies pertaining to the physical, psychological and emotional effects of induced abortion have produced contradictory results, the validity of which is often

questionable due to methodological flaws, political influences, and researchers' own value judgments.[72] Moreover, research involving the psychological sequelae associated with induced abortion is particularly ambiguous since psychological responses are the most complex and difficult to assess.[73] As Priscilla Coleman explains, "Due to the inherent complexity of human psychological health outcomes, such as depression and suicidal behavior, identification of a single, precise causal agent applicable to all cases is not possible. Every mental health problem is determined by numerous physical and psychological characteristics, background, and current situational factors subject to individual variation."[74] This complexity is likewise articulated in a 2008 report produced by the American Psychological Association's Task Force on Mental Health and Abortion:

> In summary, women's psychological experience of abortion is not uniform, but rather varies as a function of characteristics and events that led up to the pregnancy; the circumstances of women's lives and relationships at the time that a decision to terminate the pregnancy was made; the reasons for, type, and timing of the abortion; events and conditions that occur in women's lives subsequent to an abortion; and the larger social-political context in which abortion takes place.[75]

Thus, with an awareness of this complexity and uncertainty regarding women's responses to induced abortion, the following paragraphs summarize some of the contradictory physical, psychological and emotional outcomes that have been associated with abortion in order to highlight the fact that there is no *clear* dilemma between the principles of physician autonomy and nonmaleficence in situations where women's access to abortion services is delayed and/or denied by conscientiously objecting physicians.

The safety of abortion is greatest when performed at early gestational, with major complications occurring in less than 1% of first-trimester abortions.[76] Hence, hindering a woman's ability to access abortion services could result in a later termination of pregnancy (i.e., during her second trimester) and consequently put her physical health at greater risk. Delay or denial of abortion services may also prolong or exacerbate psychological and emotional distress among women desiring to abort their pregnancies. In a review of methodologically sound studies on the psychological responses of U.S. women after they obtained legal, nonrestrictive abortion, Adler and colleagues conclude that legal abortion of an unwanted pregnancy in the first trimester does not pose a psychological hazard for most women.[77] Instead, women most frequently reported feeling relief and happiness following the procedure, and a general trend in the studies reviewed showed decreases in psychological distress after abortion compared to before the procedure.[78] These conclusions are further supported in a review published by Dagg,[79] as well as Westhoff and colleagues' short-term study showing that women undergoing early abortion experience a marked improvement in their quality of life after the procedure.[80] Finally, among women who are denied abortion and subsequently decide to raise their child, symptoms of mental disturbance and great emotional strain may persist for an extended period of time following birth. Such psychological and emotional distress may translate into feelings of resentment toward the child.[81] Viewed in light of this research, the physicians' behaviour in the two case models places Sarah and Anne at risk of

physical, psychological and emotional harm insofar as it effectively impedes and/or denies their ability to access abortion services.[82]

In contrast to the above-noted research, however, there exists literature that attests to the harms associated with induced abortion for the women involved. In terms of physical repercussions, several complications can arise during surgical abortion procedures that can severely harm the patient, including cervical shock,[83] perforation,[84] hemorrhage,[85] and hematometra.[86] Furthermore, a study by Rooney and Calhoun marked a causal relationship between induced abortion and premature births in subsequent pregnancies,[87] while research published by Brind and colleagues, as well as Daling and colleagues identifies induced abortion as an independent risk factor for breast cancer.[88] Various studies have also linked induced abortion with psychological and emotional disturbances, such as clinical depression, anxiety disorders, sleep problems, substance use/abuse, and feelings of guilt and self-loathing.[89] This body of literature therefore conflicts with the position that the physicians' behaviour in both case models places Sarah and Anne at risk of harm; instead implying that the physicians' conscientious objections serve to protect their patients from risk of physical, psychological and emotional harm by reducing the likelihood that Sarah and Anne will access abortion services.

Lastly, a substantial issue associated with the principle of nonmaleficence in cases of abortion is the harm inflicted on the fetus. The moral status of the fetus is a highly controversial issue and there is significant disagreement with regards to a fetus' right to life. Although some individuals and groups attribute moral

worth and the right to life to human beings once they are born,[90] others firmly believe human life begins at fertilization.[91] Accordingly, these latter groups and traditions attribute full moral worth to the unborn child from the moment of conception, and induced abortion is consequently understood as the murder of an innocent human being.[92] The Roman Catholic Church is paradigmatic of this position and has repeatedly upheld this view on several occasions, including in its instruction on respect for human life in its origins and on the dignity of procreation:

> Thus the fruit of human generation, from the first moment of its existence, that is to say from the moment the zygote has formed, demands the unconditional respect that is morally due to the human being in his bodily and spiritual totality. The human being is to be respected and treated as a person from the moment of conception; and therefore from that same moment his rights as a person must be recognized, among which in the first place is the inviolable right of every human being to life.[93]

Within Roman Catholicism, human life is sacred because it involves the creative action of God and forever remains in a special relationship with the Creator. In light of this divine relationship, no one can claim the authority to directly destroy another human life.[94] The physicians' conscientious objections in the two case models are grounded in the Roman Catholic understanding of the sacredness of human life. Within this worldview, their conscience-based refusals are in accordance with the principle of nonmaleficence to the extent that they attempt to protect Sarah and Anne's unborn children by impeding Sarah and Anne's access to abortion services.

The preceding discussion of the controversial benefits and harms of induced abortion demonstrates the deep ambiguity pertaining to the relationship

between the principles of physician autonomy and nonmaleficence in the case models. In terms of conscientious objections in medicine more broadly, the risk of harm associated with restricting and/or denying a patient's access to care depends on the medical procedure involved, as well as geographic and socioeconomic conditions that may further inhibit access. Yet, by virtue of the fact that several of the procedures currently engendering conscientious objection among health care professionals involve contentious benefits and burdens, the general relationship between physician autonomy and nonmaleficence in instances of conscientious objection is likely to reflect the ambiguity identified with respect to abortion.

The last ethical dilemma that is apparent in the two case models is the conflict between patient autonomy and paternalism. In addition to justifying the incomplete disclosure of medically available options and the refusal to provide a referral on religious grounds, the physicians in both scenarios believe that abortion is harmful to the mother's physical, psychological and spiritual well-being. They subsequently feel obliged to prevent their patients from seeking and accessing abortion services, even if this requires overriding their patients' autonomy. Their behaviour qualifies as paternalistic insofar as both physicians justify intentionally overriding their patients' preferences (or potential preferences, in the context of case A) by appealing to the goal of preventing the harms they believe are associated with abortion. Moreover, both scenarios exemplify hard paternalism by virtue of the fact that Sarah and Anne are autonomous agents. I have characterized this last dilemma as one between patient autonomy and paternalism, rather than as a conflict between the principles of

patient autonomy and beneficence, in light of Pellegrino's insightful delineation between paternalism and beneficence. Beneficence necessarily involves respecting patients' capacity for autonomous choice to the extent that patients' preferences and values are expressions of their personhood and reflections of the lives they wish to lead. To ignore patient autonomy, even under the guise of beneficence, is therefore detrimental to patients' well-being.

The preceding ethical analysis of the two case models reveals that the CPSO's policy requirements of full disclosure of treatment options and patient referral are generally consistent with the principles of respect for (patient) autonomy, beneficence and justice. However, this consistency is interrupted by substantial ambiguity in relation to the principle of nonmaleficence, as well as significant tension between the CPSO's stance on conscientious objection and physician autonomy. Beginning with respect for individual autonomy and self-determination, the CPSO's requirements are consistent with patient autonomy insofar as they respect patients' capacity for autonomous choice, including the ability to act on one's choices. This is particularly true with respect to the disclosure of patients' options in light of the doctrine of informed consent. Yet, both policy requirements are highly inconsistent with physician autonomy inasmuch as forcing conscientiously objecting physicians to inform patients of treatment options which they believe to be unethical and provide patients with referrals for such medical services denies them their right to self-determination.

Second, it is unclear whether the CPSO's requirements are consistent with the principle of nonmaleficence. By attempting to ensure that physicians fully

inform their patients of their options and provide patient referrals for the medical procedures to which they conscientiously object, the CPSO's requirements minimize the possibility that patients will experience significant obstacles in accessing medically indicated care that is most consistent with their values and preferences. This will subsequently reduce the risk of harm that delays and denial of treatment may have on patients' physical, psychological and emotional well-being. However, many of the medical procedures that give rise to conscientious objection within the health care context involve contentious benefits and burdens. Subsequently, there is no guarantee that a physician's conscience-based refusal to provide services is not in fact protecting patients from harm. Ultimately, the type and degree of harm that the CPSO's requirements prevent depends on contextual factors, specifically the nature of the procedure that is delayed or denied, as well as geographic and socioeconomic conditions that may impede access to care from another physician.

Third, the CPSO's expectations that physicians fully disclose patients' options and provide patient referrals despite their conscientious objections are consistent with the principle of beneficence, to the extent that medical beneficence necessarily involves respect for patients' own choices as expressions of their personhood (i.e., respect for patient autonomy).[95] Preventing patients from making fully informed decisions with regards to their medical treatment by neglecting to fully disclose available options is disrespectful to patient autonomy inasmuch as it prohibits any sort of meaningful choice. Furthermore, refusing to refer patients for procedures that they deem to be in their best interests also fails

to respect patients' capacity for autonomous choice because it prohibits them from acting on their choices. This is not meant to imply, however, that patients' autonomous choices and requests for medical services are always justified or well informed. Rather, I am simply asserting that denying these choices and requests never qualifies as a benevolent act. Hard paternalists who justify their acts in the name of beneficence are not in fact acting benevolently because medical paternalism, by definition, involves physicians overriding their patients' preferences in favour of their own opinion of what constitutes the best interests of their patients.

Fourth, the CPSO's requirements of full disclosure and patient referral are consistent with the principle of distributive justice, as they help maintain an equitable standard of access to health care. Similar to the principle of nonmaleficence, however, the degree to which the CPSO's policy requirements protect equitable access to health care services is affected by contextual factors. Although the two case models deal exclusively with the issue of abortion (and thus seem irrelevant to contexts where abortion is illegal or not offered as a standard medical service), problems of distributive justice are precipitated whenever physicians refuse to provide services that constitute standard medical care within the parameters of their health care system. An extreme example is the emergency room physician who, as a Jehovah's Witness, conscientiously refuses to provide her patients with blood transfusions on the grounds that it will rob them of eternal salvation.

Conclusion

My analysis of the CPSO's policy requirements of full disclosure and patient referral in light of the principles of respect for autonomy, nonmaleficence, beneficence and justice identifies some consistency between the CPSO's stance on the issue of conscientious objection and the prevailing framework in medical ethics. Yet, this consistency is interrupted by substantial ambiguity between the CPSO's expectations and the principle of nonmaleficence, and conflict between the CPSO's policy requirements and the principle of physician autonomy. The expectation that conscientiously objecting physicians fully disclose options and refer patients for the procedures to which they object is consistent with the principle of autonomy since these requirements respect patients' capacity for autonomous choice, including the ability to act on these choices. Moreover, inasmuch as they respect patient choice as an expression of personhood, the CPSO's policy requirements also reflect the principle of beneficence. Finally, coherence with the principle of justice is reflected in the fact that both policy requirements help maintain an equitable standard of access to health care.

Despite this consistency, however, there is substantial ambiguity surrounding the relationship between the policy requirements and the principle of nonmaleficence. Many of the medical procedures engendering conscientious objection are highly contentious to the extent that they involve benefits and burdens that are unclear. Subsequently, it is unclear whether the CPSO's attempt at minimizing the likelihood that patients will experience obstacles in accessing medically indicated care (regardless of existing controversy surrounding its

effects) is in accordance with nonmaleficence. Lastly, there is significant contradiction between forced disclosure and referral, on the one hand, and conscientiously objecting physicians' right to self-determination, on the other. As evinced by Margaret Somerville's commentary on the CPSO's draft policy and, more specifically, her concern regarding the transformation of physicians into silent technicians, this inconsistency sits at the heart of the controversy surrounding conscientious objection in medicine. Physicians' imposed silence points to society's dismissal of their claim to autonomy, and its exclusion of physicians from the medical decision-making process.

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[1] Edmund Pellegrino, "The Four Principles and the Doctor-Patient Relationship: The Need for a Better Linkage," in *Principles of Health Care Ethics*, edited by Raanan Gillon and Ann Lloyd, 353-365 (Chichester: John Wiley & Sons Ltd., 1994) 355.

[2] Ibid., (emphasis added).

[3] Ibid.

[4] Tom L. Beauchamp, "The 'Four Principles' Approach to Health Care Ethics," in *Principles of Health Care Ethics*, 2nd ed., edited by Richard E. Ashcroft, Angus Dawson, Heather Draper and John R. McMillan, 3-10 (Chichester: John Wiley & Sons Ltd., 2007) 3.

[5] Howard Brody, "The Physician-Patient Relationship," in *Medical Ethics*, 2nd ed., edited by Robert M. Veatch, 75-101 (Sudbury, MA: Jones and Bartlett Publishers, 1997) 76.

[6] Ibid.

[7] Albert R. Jonsen, "Clinical Ethics and the Four Principles," in *Principles of Health Care Ethics,* edited by Raanan Gillon and Ann Lloyd, 13-21 (Chichester: John Wiley & Sons Ltd., 1994) 14.

[8] An electronic version of the report is available at www.emerson.edu/graduate_studies/upload/belmontreport.pdf.

[9] Ibid., 4-7.

[10] Jonsen, "Clinical Ethics," 14.

[11] Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 6th ed. (New York, NY: Oxford University Press, 2009).

[12] This is not to say that Beauchamp and Childress' framework has not been challenged or criticized. Most notable among principlism's opponents are K. Danner Clouser and Bernard Gert. They maintain that, at best, principles function as mere checklists, naming issues worth remembering when considering biomedical moral issues. At worst, principles obscure and confuse moral reasoning by their failure to be effective guidelines, and by their unsystematic use of theory. Moreover, Clouser and Gert also accuse Beauchamp and Childress of neglecting the distinction between moral rules and moral ideals, which they liken to perfect and imperfect duties, respectively. For details of their commentary, see K. Danner Clouser and Bernard Gert, "A Critique of Principlism," *The Journal of Medicine and Philosophy* 15, no. 2 (1990): 219-236; and

K. Danner Clouser and Bernard Gert, "Morality vs. Principlism," in *Principles of Health Care Ethics*, edited by Raanan Gillon and Ann Lloyd, 251-266 (Chichester: John Wiley & Sons Ltd., 1994).

[13] College of Physicians and Surgeons of Ontario, *Physicians and the Ontario* Human Rights Code, Policy Statement #5-08, College of Physicians and Surgeons on Ontario Web site, December 2008, http://www.cpso.on.ca/policies/policies/default.aspx?ID=2102.

[14] Beauchamp and Childress' "four-principle approach" is also commonly referred to as "principlism." The two terms are hereinafter used interchangeably.

[15] Beauchamp & Childress, *Principles*, 1.

[16] Ibid., 3.

[17] Ibid., 4. Professional moralities, which include ethical codes and standards of practice, are examples of particular moralities.

[18] These are "general injunctions" to the extent that exceptions are sometimes made and endorsed, depending on the circumstance at hand.

[19] Ibid., 3.

[20] Ibid., 12. Although Beauchamp and Childress' approach is most famous for its adherence to the four principles of respect for autonomy, nonmaleficence, beneficence and justice, principlism encompasses several types of moral norms (including principles, rules, obligations and rights) that vary in their specificity and, subsequently, their ability to serve as specific action-guides for moral agents.

[21] Ibid., 15.

[22] Ibid., 17.

[23] Ibid., 20.

[24] Ibid., 23. Beauchamp and Childress adopt John Rawls' model of reflective equilibrium as their approach to specifying and balancing moral principles in ethical analysis. The goal of reflective equilibrium is to match, prune and adjust considered judgments (i.e., judgments in which our moral capacities are most likely to be displayed without distortion, such as judgments regarding the wrongness of racial discrimination and religious intolerance) and their specifications to render them coherent with the premises of our most general moral commitments. For a detailed account of reflective equilibrium, see *Principles*, 381-390.

[25] Ibid., 22. This assertion is consistent with their understanding of the CM, insofar as the CM encompasses moral character traits as well as general ethical norms.

[26] Tom L. Beauchamp, "Principlism and Its Alleged Competitors," *Kennedy Institute of Ethics Journal* 5, no. 3 (1995): 193. In the same article, Beauchamp also argues for the compatibility of principlism with the ethical frameworks of Clouser and Gert's Impartial Rule Theory and Jonsen's revival of casuistry. Moreover, Pellegrino defends the complementary role of principle-based ethics and virtue ethics in the biomedical context. See Edmund Pellegrino, "Toward a Virtue-Based Normative Ethics for the Health Professions," *Kennedy Institute of Ethics Journal* 5, no. 3 (1995): 253-277.

[27] Beauchamp & Childress, *Principles*, 43.

[28] Ibid., 44-5.

[29] Ibid., 45 (emphasis added).

[30] Ibid., 99.

[31] Ibid., 103.

[32] Ibid., 104.

[33] Ibid., 107. Beauchamp and Childress specify that the obligation to respect personal autonomy does not extend to people who cannot act in a sufficiently autonomous manner and who cannot be rendered autonomous. This includes the immature, incapacitated, ignorant, coerced, or exploited. For details, see *Principles*, 105. Discussion in this paper is restricted to autonomous agents and those capable of being rendered autonomous.

[34] Ibid., 117-8.
[35] Tom L. Beauchamp and Ruth R. Faden, "Informed Consent: I. History of Informed Consent," in *Encyclopedia of Bioethics*, rev. ed., vol. 3, edited by Warren Thomas Reich (New York: Simon & Schuster MacMillan, 1995), 1235.
[36] Ibid., 1236-7. Informed consent is both an ethical and legal requirement in medical practice; however, the specific elements in each context of informed consent are slightly different. For details on both formulations of informed consent, see Tom L. Beauchamp, "Informed Consent," in *Medical Ethics*, 2nd ed., edited by Robert M. Veatch, 185-208 (Sudbury, MA: Jones and Bartlett Publishers, 1997).
[37] Beauchamp & Childress, *Principles*, 120-1.
[38] Ibid., 121.
[39] Ibid., 122-4. Legal exceptions to the rule of informed consent allow the health professional to proceed without consent in cases of emergency, incompetence and waiver. One additional exception to the medical requirement of informed consent that has generated significant controversy is the therapeutic privilege, which states that a physician may legitimately withhold information when he or she believes (on sound medical judgment) that divulging the information would potentially harm a depressed, emotionally drained, or unstable patient. For details, see *Principles*, 124.
[40] It should be noted that the preceding section has focused exclusively on the element of disclosure involved in the ethical obligation of informed consent because it is pertinent to my analysis of the CPSO's policy requirements. For an in-depth discussion of several other elements of informed consent, see *Principles,* 117-135.
[41] Ibid., 149.
[42] Ibid, 152. Harmful actions can involve justifiable setbacks to another's interests and are therefore not wrong. However, such exceptions are uncommon. Examples include cases of justified punishment of physicians for incompetence or negligence and justified demotion of an employee for poor job performance.
[43] Ibid., 153.
[44] Ibid.
[45] Ibid., 154.
[46] Ibid., 197.
[47] Ibid.
[48] Ibid., 198.
[49] Beauchamp & Childress, *Principles*, 202.
[50] Ibid., 199.
[51] Ibid., 205.
[52] Ibid., 206.
[53] Tom L. Beauchamp, "The 'Four-Principles' Approach," in *Principles of Health Care Ethics*, edited by Raanan Gillon, 3-12 (New York: John Wiley & Sons Ltd., 1994) 5.
[54] American Medical Association, *Code of Ethics of the American Medical Association* (Chicago: American Medical Association Press, 1847). Available online at http://www.ama-assn.org/ama/upload/mm/369/1847code.pdf.
[55] Beauchamp & Childress, *Principles*, 208.
[56] Ibid.
[57] Ibid., 209.
[58] Ibid., 210. In contrast to much of the literature on paternalism, Beauchamp and Childress argue that, in addition to cases of soft paternalism, some instances of hard paternalism in health care can be justified. They provide the following list of conditions that must be satisfied in order to justify acts of hard paternalism: 1) a patient is at risk of a significant, preventable harm; 2) the paternalistic action outweighs its risks to the patient; 3) the projected benefits to the patient of the

paternalistic action outweigh its risks to the patient; 4) there is no reasonable alternative to the limitation of autonomy; and 5) the least autonomy-restrictive alternative that will secure the benefits and reduce the risks is adopted. See 216.

[59] Edmund Pellegrino, "Patient and Physician Autonomy: Conflicting Rights and Obligations in the Physician-Patient Relationship," *Journal of Contemporary Health Law and Policy* 10, no. 1 (1994): 50.

[60] Ibid. Here, Pellegrino accepts the popular position regarding the moral justifiability of soft paternalism.

[61] Ibid., 51.

[62] Beauchamp and Childress, *Principles*, 241.

[63] Ibid. Theories of distributive justice aim to identify and connect personal characteristics with morally justifiable distributions of benefits and burdens. Such theories include utilitarian, libertarian, communitarian, egalitarian and cosmopolitan theories. For details, see *Principles,* 244-248.

[64] Ibid., 242.

[65] Ibid.

[66] Ibid., 243.

[67] Society of Obstetricians and Gynaecologists of Canada, "Induced Abortion Guidelines," *Journal of Obstetrics and Gynaecology Canada* 184 (2006): 1014-1027.

[68] Ibid., 1015.

[69] Ibid.

[70] Pellegrino, "Patient and Physician Autonomy," 55. It is interesting to note that Pellegrino, who staunchly asserts that patient autonomy cannot require physicians to sacrifice their personal moral integrity for what the patient may believe to be a morally good (or neutral) purpose, maintains that physicians cannot use their claim to autonomy to violate patients' capacity for self-governing choices. Thomas May and Mark P. Aulisio articulate this same argument in "Personal Morality and Professional Obligations," *Perspectives in Biology and Medicine* 52, no. 1 (2009): 30-38.

[71] Although problems of distributive justice do not arise in relation to abortion where abortion is illegal or simply not offered as a standard medical service, they are just as readily precipitated when a physician refuses to prescribe contraceptives to sexually active women, refuses to provide women with referrals for contraceptives or fails to mention contraceptives with patients asking about birth control in a health care system that considers contraceptives a standard medical service.

[72] Vignetta E. Charles, Chelsea B. Polis, Srinivas K. Sridhara, and Robert W. Blum, "Abortion and Long-Term Mental Health Outcomes: A Systematic Review of the Evidence," *Contraception* 78 (2008): 436; Susan A. Cohen, "Abortion and Mental Health: Myths and Realities," *Guttmacher Policy Review* 9, no. 3 (2006): 8; Henry P. David, "Abortion in Europe, 1920-91: A Public Health Perspective," *Studies in Family Planning* 23, no. 1 (1992): 11; Brenda Major, Catherine Cozzarelli, M. Lynne Cooper, Josephine Zubek, Caroline Richards, Michael Wilhite, and Richard H. Gramzow, "Psychological Responses of Women After First-Trimester Abortion," *Archives of General Psychiatry* 57 (2000): 777; David M. Fergusson, L. John Horwood, and Joseph M. Boden, "Abortion and Mental Health Disorders: Evidence from a 30-Year Longitudinal Study," *The British Journal of Psychiatry* 193 (2008): 444; and APA Task Force on Mental Health and Abortion, *Report of the APA Task Force on Mental Health and Abortion*, American Psychological Association Web site, 2008, http://www.apa.org/pi/wpo/mental-health-abortion-report.pdf, 15-20.

[73] David, "Abortion in Europe," 11.

[74] Priscilla K. Coleman, "Does Abortion Cause Mental Health Problems?: The Evidence through an Objective Scientific Lens as opposed to the APA's Recent Analysis," American Association of Pro-life Obstetricians and Gynecologists Web site, September 2009, http://www.aaplog.org (accessed 21 July 2010), para. 1.

[75] APA Task Force on Mental Health and Abortion, *Report*, 10.

[76] Carolyn Westhoff, Lucy Picardo and Ellen Morrow, "Quality of Life Following Early Medical or Surgical Abortion," *Contraception* 67 (2003): 41. In an article examining the effects of abortion on public health in Europe published in the early 1990s, Henry P. David compares rates of maternal death associated with abortion versus those associated with pregnancy or childbirth. He goes so far as to conclude that in European countries where induced abortion is legal and is performed under regulated conditions by trained personnel using vacuum aspiration in the first trimester of pregnancy, abortion is actually safer than childbirth. See David, "Abortion in Europe," 8.

[77] Nancy E. Adler, Henry P. David, Brenda N. Major, Susan H. Roth, Nancy F. Russo, and Gail E. Wyatt, "Psychological Responses After Abortion," *Science* 248, no. 4951 (1990): 41.

[78] Ibid., 43. Despite the general trends observed in their review, Adler and colleagues nonetheless recognize that some case studies do document negative psychological sequelae among women following abortion procedures. Adler and colleagues subsequently propose the following aspects of the "abortion experience" as contributing factors to such distress: ambivalence regarding the want of pregnancy; conflict about the meaning of abortion and its relation to deeply held values and beliefs, perceived social stigma, or lack of support; the decision process itself; perceived social support; and coping processes and expectations. For details, see Adler et al., "Psychological Responses After Abortion," 42.

[79] See Paul K. B. Dagg, "The Psychological Sequelae of Therapeutic Abortion – Denied and Completed," *American Journal of Psychiatry* 148 (1991): 578-585.

[80] Westhoff et al., "Quality of Life," 41-47.

[81] Dagg, "The Psychological Sequelae," 582-3.

[82] It should be noted that for the purpose of my discussion regarding the psychological and emotional effects of delaying and denying access to abortion, Sarah's severe apprehension about giving birth is likened to the desire to abort a pregnancy. Both involve significant mental and emotional disturbance that is drawn out or exacerbated when pregnancy is prolonged.

[83] Cervical shock is a vasovagal reaction consisting of a temporary fall in blood pressure (with pallor, fainting, sweating and nausea) that is usually limited to a few minutes. Society of Obstetricians and Gynaecologists of Canada, "Induced Abortion Guidelines," 1021.

[84] Depending on the site of injury, perforation can lead to a hematoma or intra-abdominal bleeding causing severe pain (in some instances, a hysterectomy may be required to manage bleeding). Alternatively, perforation can cause external bleeding. In the past, such external bleeding has led to deaths several hours or even days after an unrecognized low cervical perforation. Society of Obstetricians and Gynaecologists of Canada, "Induced Abortion Guidelines," 1021.

[85] "Hemorrhage" is another term for excess bleeding.

[86] Also known as "Post-Abortion Syndrome," hematometra refers to the accumulation of blood and clots in the uterine cavity, requiring immediate re-evacuation of the uterus. Society of Obstetricians and Gynaecologists of Canada, "Induced Abortion Guidelines," 1021.

[87] Brent Rooney and Byron C. Calhoun, "Induced Abortion and Risk of Later Premature Birth," *Journal of American Physicians and Surgeons* 8, no. 2 (2003): 46-49.

[88] Joel Brind, "Induced Abortion as an Independent Risk Factor for Breast Cancer: A Critical Review of Recent Studies Based on Prospective Data," *Journal of American Physicians and Surgeons* 10, no. 4 (2005): 105-110; Joel Brind, Vernon M. Chinchilli, Walter B. Severs, and Joan Summy-Long, "Induced Abortion as an Independent Risk Factor for Breast Cancer: A Comprehensive Review and Meta-Analysis," *Journal of Epidemiology and Community Health* 50 (1996): 481-496; and Janet R. Daling, Kathleen E. Malone, Lynda F. Voigt, Emily White, and Noel S. Weiss, "Risk of Breast Cancer Among Young Women: Relationship to Induced Abortion," *Journal of the National Cancer Institute* 86, no. 21 (2004): 1584-1592. For more on the association between induced abortion and breast cancer, see Paul Ranalli, "Induced Abortion and Breast Cancer," Canadian Physicians for Life Web site, undated,

http://www.physiciansforlife.ca/html/life/abortion/articles/inducedabortioncancer.html (accessed 14 July 2010).

[89] Priscilla K. Coleman, "Resolution of Unwanted Pregnancy During Adolescence through Abortion versus Childbirth: Individual and Family Predictors and Consequences," *Journal of Youth and Adolescence* 35, no. 6 (2006): 903-911; Priscilla K. Coleman, "The Uniquely Destructive Psychological Experience of Elective Abortion: Comparisons with Other Forms of Perinatal Loss and Delivery of an Unwanted Pregnancy," *Association for Interdisciplinary Research in Values and Social Change Research Bulletin* 17, no. 6 (2004): 1-8; Priscilla K. Coleman, Vincent M. Rue, David C. Reardon, and Jesse Cougle, "State-Funded Abortions vs. Deliveries: A Comparison of Outpatient Mental Health Claims over Four Years," *American Journal of Orthopsychiatry* 72, no. 1 (2002): 141-152; Jesse Cougle, David C. Reardon, and Priscilla K. Coleman, "Depression Associated with Abortion and Childbirth: A Long-Term Analysis of the NLSY Cohort," *Medical Science Monitor* 9, no. 4 (2003): CR105-112; and Fergusson et al., "Abortion and Mental Health Disorders," 441-451. For a list of recent studies pertaining to the psychological harms of induced abortion, see "Psychology of Abortion Studies Published Since 2002," American Association of Pro-life Obstetricians and Gynecologists Web site, 2008, http://www.aaplog.org (accessed 21 July 2010).

[90] For instance, see James W. Walters, "Is Koko a Person?" College and University Dialogue Web site, 2006, http://dialogue.adventist.org/articles/09_2_walters_e.htm (accessed 21 July 2010).

[91] For instance, see Association of Prolife Physicians, "When Does Human Life Begin?" Association of Prolife Physicians Web site, undated, http://www.prolifephysicians.org/lifebegins.htm (accessed 21 July 2010); and *Catechism of the Catholic Church*, Vatican Web site, 1993, http://www.vatican.va/archive/ENG0015/_INDEX.HTM, n. 2270.

[92] Association of Prolife Physicians, "When Does Human Life Begin?" para. 12.

[93] Congregation for the Doctrine of the Faith, *Donum Vitae*, instruction on respect for human life in its origin and on the dignity of procreation, Vatican Web site, 22 February 1987, http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19870222_respect-for-human-life_en.html, para.18.

[94] *Catechism*, n. 2258.

[95] I am herein espousing Pellegrino's argument that the principle of beneficence actually requires physicians to fulfill the positive obligation stemming from the principle of respect for autonomy—namely, the duty to enhance, empower and enrich patients' capacity to act autonomously. See Pellegrino, "Patient and Physician Autonomy," 51.

Conclusion:

Revelation of Legal & Ethical Underpinnings

As evinced by the plenitude of comments and concerns precipitated by the College of Physicians and Surgeons of Ontario's (CPSO) policy statement, the issue of conscientious objection among Canadian physicians is a highly contentious topic with significant implications for both practitioners and patients. Although the CPSO's policy reflects an attempt to strike a balance between physicians' right to conscience and patients' right to access medical care, many consider the CPSO's efforts unsatisfactory insofar as their guidelines compel a level of complicit action among conscientiously objecting physicians. For some practitioners, informing patients of treatment options to which they object and providing referrals for these procedures constitute immoral participation in acts that they find reprehensible. In light of this controversy, the preceding chapters have aimed to provide religious, legal and ethical insight into the debate surrounding the CPSO's position on conscientious objection by examining its policy statement through the three lenses of Roman Catholicism, Canadian law and the ethical framework of principlism.

Focusing on the Roman Catholic doctrines on conscience and cooperation in evil, the first chapter demonstrated a high degree of tension between the CPSO's policy requirements and the Roman Catholic moral tradition. According to the latter, moral agents must always follow the dictates of their consciences, irrespective of whether their consciences are correct or mistaken. Even though

obedience does not guarantee that one's actions are right and good, denial of one's conscience inevitably results in sin. Thus, to coerce, by threat of professional sanction, conscientiously objecting physicians to participate in the medical procedures to which they object is unjustifiable. Moreover, according to the Roman Catholic doctrine on cooperation in evil, it is indefensible for physicians to cooperate in patient referrals that involve morally illicit procedures since providing such referrals constitutes formal cooperation and reflects approval of the evil action itself. The full disclosure of treatment options, however, is a form of mediate material cooperation that is justifiable under the principle of double effect in light of the moral and legal requirement of informed consent in medical decision-making (so long as careful consideration is afforded to the element of scandal and the contentious treatment at issue is not an intrinsically evil act). Hence, by virtue of the considerable tension between the CPSO's stance on conscientious objection and the doctrines on conscience and cooperation in evil within Roman Catholicism, it is unsurprising that the CPSO's policy statement has provoked significant concern from members and organizations within the Roman Catholic tradition.

Shifting lenses, the second chapter examined the CPSO's policy statement from within the Canadian legal system and revealed a general consistency between the conceptualization and treatment of religion and conscience in Canadian constitutional and administrative law, on the one hand, and the CPSO's approach to conscientious objection on the other. The CPSO's policy statement clearly reflects four of the five prevailing trends related to the law's interaction

with religion and conscience that have recently emerged in legal scholarship. It conflates religiously and non-religiously motivated conscientious objection (thereby assimilating the categories of religion and conscience), posits religion as autonomous choice, excludes religious expression from physicians' freedom of religion (relegating religion to the private sphere) and subordinates religious interests to those of the patient and the state. The only element of inconsistency arises from the fact that the CPSO's treatment of physicians' right to religious freedom negates concern for religious equality. Therefore, despite the considerable backlash that the CPSO's policy statement has generated, it enjoys firm grounding in Canadian jurisprudence.

Finally, the third chapter looked at the CPSO's position on conscientious objection from within the ethical framework of principlism, as developed by Beauchamp and Childress. Although several ethical dilemmas between conflicting ethical principles are evident in cases of conscientious objection, close analysis identified some consistency between the CPSO's policy requirements, on the one hand, and the ethical principles of respect for autonomy, beneficence and justice on the other. The expectation that conscientiously objecting physicians fully disclose treatment options and refer patients for the procedures to which they object corresponds with the principle of respect for autonomy, as these requirements honour patients' capacity for autonomous choice (including the ability to act on these choices). Inasmuch as they respect patient choice as an expression of personhood, the policy requirements also reflect the principle of beneficence. Coherence with the principle of justice is apparent to the extent that

the policy's requirements help sustain equitable access to health care. This consistency is interrupted, however, by the ambiguity surrounding the principle of nonmaleficence in instances of conscientious objection, and a serious element of tension between the CPSO's guidelines and the principle of respect for autonomy. In light of the uncertainty that often surrounds the medical procedures to which physicians conscientiously object in terms of the benefits and burdens involved, it is impossible to definitively determine whether facilitating patient access to such procedures is in fact in accordance with physicians' obligation to refrain from harming patients. Moreover, compelling full disclosure and patient referral among conscientiously objecting physicians effectively denies them *their* right to self-determination and excludes them from the medical decision-making process. Thus, even though certain elements of the principlist framework solidly support the CPSO's approach to conscientious objection, there remains reason for concern from a principlist perspective regarding the CPSO's policy statement. It remains unclear whether the CPSO's requirements enable or prevent harm from coming to patients, while the autonomy of physicians has been left by the wayside.

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