

Conflicts of conscience:

Respect, restraint and reasonable accommodation for Canadian health care professionals

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ABSTRACT

This paper discusses ethical and legal arguments surrounding conscience-based objections and the corresponding refusal to treat in response to controversial medical procedures. The author unpacks the “right to conscientious refusal” into its component legal relationships and argues that proponents of conscientious objection in health care have inaccurately applied the freedom of conscience and religion. In this paper, the author canvasses various legal mechanisms for the protection of conscience in Canada. Opposed to the introduction of procedure-based “protection of conscience acts” and additional conscience clauses in Canadian legislation, the author argues that the exercise of conscience-based actions or more precisely, the refusal to act, is sufficiently and appropriately protected under the existing law in Canada.

Cette thèse traite des arguments éthiques et légaux qui entourent les objections de conscience et le refus de traiter dans le contexte des procédures médicales controversées. L’auteur délimite le droit de refuser de traiter dans son contexte légal et argumente que les partisans de l’objection consciencieuse qui œuvrent dans le domaine de la santé appliquent incorrectement la liberté de conscience et de religion. Dans cette thèse, l’auteur analyse de divers mécanismes pour la protection de la conscience au Canada. Opposée à l’introduction de « lois pourtant sur la protection de la conscience » qui sont procédurales et des clauses de conscience dans la législation canadienne, l’auteur argumente que l’exercice des actes fondés dans la conscience ou plus précisément, le refus d’agir, est suffisamment protégé par la loi existante au Canada.

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TABLE OF CONTENTS

<i>ACKNOWLEDGEMENTS</i>	<i>page</i> iii
<i>AUTHORITIES</i>	v
INTRODUCTION	1
I: THE LANGUAGE OF CONSCIENCE AND LEGAL RELATIONS	9
a) Rights, freedoms and other legal claims	10
b) Conscience and conscientiousness	15
i) <i>Conscience begins internally</i>	17
ii) <i>Conscience guides decision-making and reflection in the individual</i>	19
iii) <i>The content of conscience in the context of health care is informed by many sources</i>	24
c) Disobedience, objections and refusals	25
II: CONSCIENCE LAWS	35
a) Freedom of Conscience and Religion	35
b) Conscience Clauses	46
c) Protection of Conscience Laws	55
III: CONSCIENTIOUS REFUSAL, CANADIAN LAW AND POLICY	63
a) The scope and limits of conscientious refusal	65
i) <i>Level of involvement in care and treatment</i>	67
ii) <i>Nature of and motivation for refusal</i>	69
b) Human dignity and the right to autonomy	74
c) Non-discrimination and reasonable accommodation in employment law	78
d) Avoiding conscientious refusal	86
CONCLUSION	96
APPENDIX A	100
BIBLIOGRAPHY	107

AUTHORITIES

Table of Statutes

	<i>Page(s)</i>
<i>Abortion Act</i> , UK Statutes 1967, ch. 87 (as amended)	49-53
<i>Access to Abortion Services Act</i> , R.S.B.C. 1996 c. 1 337/95	54
<i>British Columbia Human Rights Code</i> , R.S.B.C. 1996, c. 210.	82
<i>Canadian Bill of Rights</i> , S.C. 1960, c. 44.	12
<i>Canadian Charter of Rights and Freedoms</i> , Part I of <i>The Constitution Act</i> , 1982, being Schedule B to the <i>Canada Act</i> 1982 (U.K.), 1982, c. 11	4, 12-13, 31, 35-42, 44, 54, 61, 74-76, 97
<i>Canada Evidence Act</i> , R.S., 1985, c. C-5	47
<i>Immunization of School Pupils Act</i> , R.S.O. 1990, c. I-1	46
<i>Income Tax Act</i> , R.S.C., 1985, c. 1 (5th Supp.) as amended.	43
<i>Lord's Day Act</i> , R.S.C. 1970, c. L-13	37

Table of Cases

	<i>Page(s)</i>
<i>671122 Ontario Ltd. v. Sagaz Industries Canada Inc.</i> , [2001] 2 S.C.R. 983, 2001 SCC 59.	79
<i>B. (R.) v. Children's Aid Society of Metropolitan Toronto</i> [1995] 1 S.C.R. 315	40
<i>Barr v. Matthews</i> , (2000) 52 BMLR 217 (UK)	50-52, 90
<i>Benitez v. North Coast Women's Care Medical Group, Inc.</i> , (2003) 106 Cal. App. 4th 978 (US)	70, 93
<i>Bolam v. Friern Hospital Management Committee</i> , (1957) 1 BMLR 1 (UK)	52

<i>Bolitho v. City and Hackney Health Authority</i> , (1992) 13 BMLR 111 (UK)	52
<i>British Columbia (Public Service Employee Relations Commission) v. British Columbia Government and Service Employees' Union (B.C.G.S.E.U.) (Meiorin Grievance)</i> , [1999] 3 S.C.R. 3	80, 84
<i>Central Okanagan School District v. Renaud</i> , [1992] 2 S.C.R. 970.	85
<i>Edward Books and Art Ltd. v. R.</i> , [1986] 2 S.C.R. 713	38
<i>Fleming v. Reid</i> (1991), 4 O.R. (3d) 74 (O.C.A.)	76
<i>Jacinto v. Mexico</i> , (2007) Case 161-02 Report No.21/07	45
<i>Janaway v. Salford Area Health Authority</i> , [1989] AC 437 (UK H.L.)	68
<i>Jones v. CHE Pharmacy</i> (2001), 29 C.H.R.R./93 (B.C.H.R.T.)	82-83
<i>Korn v. Potter</i> (1996), 134 D.L.R. (4th) 437 (B.C.S.C.)	63, 71
<i>Malette v. Shulman</i> , (1990), 72 O.R. (2d) 417 (O.C.A.).	76
<i>McInerney v. MacDonald</i> , [1992] 2 S.C.R. 138	72
<i>Moore v. B.C. Ministry of Social Services</i> (1992), 17 C.H.R.R. D/426 (B.C.H.R.C)	84
<i>Multani v. Commission scolaire Marguerite-Bourgeoys</i> , 2006 SCC 6, [2006] 1 S.C.R. 256	39-41
<i>Norberg v. Wynrib</i> , [1992] 2 S.C.R. 226	72
<i>O'Sullivan v. M.N.R.</i> , [1990] 2 C.T.C. 2500 (T.C.C.)	43
<i>O'Sullivan v. M.N.R.</i> (No. 2), [1992] 1 FC 522, 84 D.L.R. (4th) 124 (Fed. Ct. Trial Div.)	43
<i>Ontario Human Rights Commission and O'Malley v. Simpson-Sears Ltd.</i> , [1985] 2 S.C.R. 536	80
<i>Pichon and Sajous v. France</i> , Application No. 49853/99 (2 October 2001) (E.C.H.R.)	45
<i>Prior v. Canada</i> , [1989] F.C.J. No. 903 (F.C.A.)	43

<i>R. v. Big M Drug Mart Ltd.</i> , [1985] 1 S.C.R. 295	37, 43, 97
<i>R. v. Bluske</i> (1948), 90 C.C.C. 203 (O.C.A.)	47
<i>R. v. Dawson</i> , [1968] 4 C.C.C. 33 (B.C.C.A.)	47
<i>R. v. Morgentaler</i> , [1988] 1 S.C.R. 30	49, 54, 74, 75
<i>R. v. Nitsiza</i> , 2001 NWTSC 34	47
<i>R. v. Oakes</i> , [1986] 1 S.C.R. 103	13, 39, 41
<i>R. v. Videoflicks Ltd.</i> (1984), 48 O.R. (2d) 395 (O.C.A.)	41
<i>Rodriguez v. British Columbia (Attorney General)</i> , [1993] 3 S.C.R. 519	60
<i>Roe v. Wade</i> (1973) 410 U.S. 113 93 S. Ct. 705; 35 L. Ed. 2d 147	53
<i>Ross v. New Brunswick School District No. 15</i> , (1996) 1 S.C.R. 825.	40, 44
<i>Saumur v. City of Quebec</i> , [1953] 2 S.C.R. 299	14
<i>Syndicat Northcrest v. Amselem</i> , 2004 SCC 47, [2004] 2 S.C.R. 551	38, 42, 43, 99

INTRODUCTION

The conflict between the medically and legally sanctioned treatments sought by patients and the personal beliefs of those who control access to those procedures continues to challenge both medical ethics and the law. While the most obvious examples of refusal to treat in the health care context surround a physician's direct involvement in end of life and reproductive decision-making, incidences of conscientious refusal in health care are not limited to those circumstances. The headlines which follow are just a sample of the situations encountered of late: paramedic refuses to transport patient for an abortion; doctors refuse artificial insemination to a lesbian; pharmacist refuses morning-after pill to rape-victim; anesthetist refuses to assist in vasectomy; and doctor refuses to prescribe Viagra to bachelors and birth control pill to unwed young women.¹ With advances in medicine and social development, the variety of examples appears endless and unpredictable.

Recently, retired general practitioner Dr. John Scotson set out many of the key tensions at issue in conscientious objection in the health care context in the following letter addressed to the editor of the British Medical Journal:

What is conscience but that which recognises the distinction between good and evil with the will to do the right one and avoid the other the norms of society or Parliamentary decrees cannot change what is intrinsically evil into something which is good...Medical intervention should never be undertaken if it is in itself immoral. So many medical disasters from history can be cited when doctors have done what was legal but morally wrong.

It is indeed the duty of every doctor to have a well formed conscience and act according to the dictates of that conscience. For instance, if the conscience of the

¹ "Quand les croyances entravent la pratique médicale" *Cyberpresse* (28 August 2006) online: <<http://www.cyberpresse.ca/article/20060828/CPACTUEL03/60828103>>.

doctor prohibits him or her to kill either before or after birth then the conscience should be obeyed without regard to legality or current medical practice.

What is ethics for if we discard the value of good conscience.²

This letter was just one of a barrage of letters to the editor following the publication of a bold article by Julian Savulescu. In his article, Savulescu declared there to be no place for conscientious objectors in the medical profession.³ I have reproduced Dr. Scotson's eloquent and impassioned letter as it displays some of the issues, values, moral judgments and misconceptions that shape this subject.

This paper examines conscientious refusal in health care from legal, ethical and policy perspectives and considers whether a guarantee to conscientious refusal ought to be explicitly incorporated into Canadian law. Is express legislation the answer to protecting the moral integrity of a minority who cannot and, in a diverse and tolerant society, are not required to agree? Can "freedom of conscience" be sufficient justification for refusing to treat? Would it be justified to compel a physician to perform a procedure that is in direct conflict with his or her beliefs? It is unlikely that satisfactory answers can be found for these broad questions in a factual vacuum. Alternatively, is there an existing arsenal of legal defences in Canadian law to protect against any incursions on conscience in the health care context? This paper suggests that once the rhetoric and emotionally-charged arguments are put aside, the proper characterization of any legitimate relief sought by "conscientious

² John H. Scotson, Letter to the Editor, *British Med. J.* (6 February 2006) "Good and evil – its recognition". Online: *British Medical Journal* <<http://www.bmj.com>>.

³ Julian Savulescu "Conscientious objection in medicine" (2006) 332 *British Med. J.* 294.

refusers” is protection from coercion and discrimination which may arise as a consequence of refusal to participate in an objectionable procedure. In that case, there are already legal mechanisms in place in Canada.

The first chapter of this paper sets out the terminology used herein for considering conscientious objection: rights and freedoms; conscience, religion and ethics; and objection and refusal. This paper argues that it is neither accurate, nor constructive, for proponents of the positive exercise of conscientious objection by health care providers to simply assert the freedom of conscience and religion. So-called “conscientious objectors” in health care are seeking more than the freedom to think, worship and conduct oneself at will according to those beliefs. In today’s language of “rights”, the true meaning of freedom is commonly neglected. When the technical language of law is unpacked and the rhetoric of rights stripped away, protection for the exercise of conscientious refusal belongs under the umbrella of autonomy rights, and the relief sought by “conscientious refusers” is protection from discrimination. Moreover, any right to conscientious objection is, and should remain, limited by the prescriptions of law that are necessary to protect public safety, order, health or morals or the fundamental rights and freedoms of others.

Conscience guides and compels individuals to do what they believe to be “right”. The presumption in this paper is that individual conscience must be protected. However, many unsettled questions remain: why is it justified, how far should the protection extend, what are the limits and by what legal mechanisms. The health care context provides a multi-

dimensional backdrop for the examination of the legal and ethical aspects of conscientious objection.

By no means a new concept, conscientious objection can be traced for centuries and was first understood as an extension of the protection granted to minority groups in an age of religious intolerance. In modern times, conscientious objection is a somewhat generic term which may refer to the grant of an enlightened state which recognizes and respects its citizens' independent moral capacity. In the health care context, "conscientious refusal" more accurately describes the actions of health care providers when their beliefs are at odds with their patients' requests for a treatment or procedure that is both legally permitted and medically accepted as the standard of care.

The second chapter of this paper examines what I have termed the "conscience laws". These laws comprise the common legal arguments made in support of conscientious refusal: most commonly, the freedom of conscience and religion as enshrined in the *Canadian Charter of Rights and Freedoms*,⁴ along with "conscience clauses" and proposals for stand-alone "protection of conscience statutes".

This paper argues that freedom of conscience and religion is not only inherently limited, but also that, in Canada, it is further restricted by Section 1 of the *Charter* and, furthermore, a *Charter* challenge would be misdirected without explicit legislation requiring

⁴ *Canadian Charter of Rights and Freedoms*, Part I of *The Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11 [*Charter*].

controversial medical procedures to be performed. Can “conscience clauses” or a “protection of conscience act” appropriately address conscientious refusal in the health care context?

The second part of this paper will discuss these various forms of conscience laws, consider examples of existing domestic conscience clauses in other contexts, identify the limitations of these legal mechanisms in light of international examples and discuss the general limits to the exercise of conscientious refusal in health care from an ethical and legal standpoint.

The final chapter of this paper will review the scope and limits of conscientious refusal in health care and examine current alternative means for resolution of conflicts of conscience relevant to the Canadian experience. This portion of the paper suggests that established principles of medical ethics and existing Canadian legal mechanisms adequately protect those individuals whose consciences would compel their refusal to perform requested procedures. This part will consider the laws intended to protect the autonomy of the individual and the laws intended to protect against discrimination in Canada. Additionally, conflicts of conscience may be avoided through professional regulation and policy changes, private and collective employment contractual arrangements, administrative intervention and referral at the earliest stages of treatment in the most controversial areas of health care. Most importantly, honest and open communication between health care providers and their patients will serve as a vital component to any proposed or existing model.

Historical debates regarding conscientious refusal usually reflect a situation where the conflict lies between an individual’s moral imperative and the demands of a state or society

as a whole. In the health care context, an act of conscientious refusal pits the mores and legal rights of one individual against another. Where there is the additional dimension of the doctor–patient relationship, injury does not end with the act of refusal and the autonomy of one runs counter to the autonomy of the other. Where one questions whether the autonomy of an individual should be sacrificed for the autonomy of another, the ethical deadlock cannot be satisfactorily resolved by ethics alone nor by the adversarial system of courts. Instead, alternative solutions such as protocols for reasonable accommodation at a practical level should be actively instituted by the state, professional associations and health care institutions as a way of alleviating or avoiding situations where conflicts of conscience may arise at the earliest possibility. Health care is not simply between the physician and the patient. It also involves institutions and administrators, as well as other actors, among them, nurses, technicians, paramedics, pharmacists and maintenance staff.

In the end, this paper is structured on three basic themes: respect, restraint and reasonable accommodation. Respect for human dignity demands the protection of religious or conscientiously held convictions of a minority as well as respect for the human dignity of patients who have made informed decision through a conscientious decision-making of their own. In this paper, “respect” refers to the requirement for mutual respect for human dignity.

“Restraint” refers to both the private nature of conscience and the requirement to adhere to one’s beliefs without encroaching on the rights and lives of others. “Conscientious refusers” must exercise restraint from actions which are motivated by paternalism or

prejudice. Conscientious refusal is limited to the protection of one's own conscience and the maintenance of one's autonomy in the conduct of one's life. Legitimate claims of conscientious refusal do not include so-called objections where the refuser's actions are intended to impress his or her own beliefs on others or create a situation where others would be forced to conduct themselves according to the refuser's values.

The term "restraint" may equally apply to legislative restraint and specifically, the argument against inappropriate legislative creations in this context. This paper advocates for the recognition of the freedom to live autonomously and harmoniously with others in accordance with their deepest convictions and generally free from interference and coercion. However, at the same time, general immunity from law on grounds of conscience should not be prescribed by law as such legislation would be inscrutable.

Finally, "reasonable accommodation" refers to one of the existing anti-discrimination mechanisms in law, which may already appropriately address situations of conscientious refusal as it relates to controversial health care procedures. While individuals on both sides of conflicts of conscience should exercise respect for one another and restraint in their own conduct, the entire system of health care should work together to develop policies and systems which would seek to avoid conflicts of conscience so that individuals are not required to resolve the conflict on their own. Ultimately, this paper submits that existing Canadian legal principles offer the breadth and flexibility to maintain respect and tolerance in a diverse society.

Chapter One:

THE LANGUAGE OF CONSCIENCE AND LEGAL RELATIONS

In simplest terms, conscientious objection refers to the struggle between competing moral obligations of an internal conviction and a social duty. Throughout history, conflicts of conscience have been recognized in complex and divisive issues such as military conscription, the payment of tax where the funds may be used for publicly funded abortions, and the service of jury duty where one is responsible for judging the crimes of another.

In the health care context, conscientious objection takes on a slightly different form and the terms of this debate must be defined. This chapter attempts to provide some clarification for the terminology used to discuss conscience and its place in law. Too often, the debate over conscientious objection becomes clouded by ambiguity and reflexive responses to perceived attacks on deeply-held beliefs. As has been suggested previously, “in any close reasoned problem, whether legal or non-legal, chameleon-hued words are a peril both to clear thought and to lucid expression.”⁵

Beginning with a critique of the simplistic assertion that there is a “right to conscientious objection”, I offer the following conclusions upon dissecting that phrase.

⁵ James Bradley Thayer, *Preliminary Treatise on Evidence* (1898):

“Law is not so unlike other subjects of human contemplation that clearness of thought will not help us powerfully in grasping it. If terms in common legal use are used exactly, it is well to know it; if they are used inexactly, it is well to know that, and to remark just how they are used.” As reprinted in Hohfeld, *infra* note 7.

First, this statement flaunts the rhetoric of rights in a manner which can create ambiguity and encourage non-rational responses. On their own, “rights” do not yield a solution. Instead, “rights” form part of the language to express one. Moreover, when terms are applied too broadly and without common meaning, misunderstanding rather than productive discourse ensues. Second, faith, morality, the individual and/or the community in which that individual lives, all at once, or in any combination of the above, may inform “conscience”. Whatever conscience is, and however it may be defined, it is the moral imperative directing the conduct of a person and is worthy of protection. Finally, “objection” may imply disagreement but the logical conclusion to that disagreement is unclear. Thus, the term “conscientious refusal” will be preferred as it more accurately describes the action taken in the health care context by a provider faced with a request he or she refuses to fulfill for reasons of conscience. In the end, unpacking the “right to conscientious objection” results in three separate and distinct legal relations that each require specific legal treatment: the freedom of conscience and religion, the human right of autonomy and the human right of equality/non-discrimination.

a) Rights, freedoms and other legal claims

Asserting that there is a “right” to conscientious objection based on the freedom of conscience and religion is neither accurate nor constructive. In both legal discourse and casual conversation, a “right” refers indiscriminately to a sort of legal claim which would be actionable under law. This type of claim may be contrasted against the corresponding legal “duty” and differentiated from the negative-content “freedom”. It is commonly understood

that in Anglo-American legal systems, the legal relationships of rights and duties are said to belong to individuals or “persons” and thus a private matter.⁶

According to two seminal articles by Wesley Hohfeld, published in the Yale Law Journal in 1913 and 1917, ambiguity and confusion caused by referring to legal relations too generally, as either “rights” or “duties”, can be resolved by examining the content of the legal claim.⁷ For Hohfeld, the assumption that all legal relations were either rights or duties served as one of the “greatest hindrances to clear understanding, the incisive statement and the true solution” to legal problems.⁸

Rights may be discussed and distinguished in any number of ways, such as, *in personam* and *in rem* rights (i.e. rights held against determinate persons as opposed to rights held against “the world at large”); positive and negative content rights; or active or passive rights, etc. These terms can all be used to discuss rights. In Hohfeld’s articles, it was suggested that legal relations may be identified in terms of the following juristic opposites: right / no right, privilege / duty, power / disability, immunity / liability. Equally, these eight conceptions could be understood in terms of their correlative pairings: right / duty, privilege / no right, power / liability, and immunity / disability.

⁶ *Contra* David M. Brown, “Freedom From or Freedom For?: Religion As a Case Study in Defining the Content of Charter Rights” (2000) 33 U.B.C. L. Rev. 551. Brown suggests that the Courts have misinterpreted the public civic right of religious freedom in favour of a conception of religion as a private matter.

⁷ Wesley Hohfeld, “Fundamental legal conceptions” (1913) 23 Yale Law Journal 16 and (1917) 26 Yale Law Journal 710, reprinted as David Campbell and Philip Thomas, eds. *Fundamental Legal Conceptions as Applied in Judicial Reasoning by Wesley Newcomb Hohfeld* (Classical jurisprudence series) (Aldershot: Ashgate/Dartmouth Publishing, 2001) [Hohfeld].

⁸ *Ibid.* at 11.

According to Hohfeld, a *right* or a '*claims-right*' entails a corresponding duty or legal obligation from someone else's action or inaction and is thus more clearly described as an enforceable claim against someone. With this understanding, those who assert a "right" to conscientious objection are seeking an enforceable claim against someone else; to act against the wishes or demands and assert their conscientiously-held beliefs over the life choice(s) of another. This legal right is beyond the scope envisioned under the *freedom* of conscience and religion.

Freedoms and *privileges*⁹ do not involve claims against others. Privileges designate the "mere negation of duty."¹⁰ With privileges, there are no corresponding obligations or duties from others which can be breached. Additionally, a privilege may also be considered as "freedom from duty". Thus, a person would have perfect freedom to do something so long as no one else's rights were violated by that exercise. The logical implication is that the existence of a privilege would not violate the rights of another person.

A *power* is the capacity to create or alter existing relationships involving rights and duties and is the opposite of a legal disability or *responsibility*.

⁹ *Ibid.* at 20. "Freedom", "liberty" and "privilege" have the same legal meaning which is the absence of a legal duty to do otherwise. Hohfeld preferred the term "privilege" because "liberty" often refers to the general political liberty as opposed to the legal relation between individuals. Moreover, Hohfeld expressed a preference for the term "privilege" as it is able to lend itself to the more convenient adjective of "privileged".

¹⁰ *Ibid.* at 18.

Finally, in Hohfeldian terms an *immunity* is the correlative of disability and/or no-power. The opposite of liability, immunities protect against the encroachments of government and are synonymous with exemptions. Thus, unlike a privilege which may be considered as freedom from duty, i.e. someone is free of duty, an immunity is best described as having *freed* someone from duty.

Rights, powers and immunities are usually defined or prescribed by law and therefore must be specific and detailed. Conversely, freedoms or liberties are more general and indefinite in nature; it is their limits that must be defined. When looking at the “fundamental freedoms”, the McRuer Royal Commission into Civil Rights determined:

[R]ights, duties and powers, because of their specific and definite obligatory content, belong together...and for this purpose must be contrasted with liberties, freedoms or privileges which, while they are essential concepts of a legal system, nevertheless lack the specific and detailed obligatory character of rights, duties and powers.¹¹

While the focus of the McRuer Commission was the juridical nature of the freedoms set out in the *Canadian Bill of Rights*,¹² the same inquiry may be made of the rights and freedoms later enshrined in the *Charter*. Under the *Charter*, the freedom of conscience and religion is set out in Subsection 2(a):

2. Everyone has the following fundamental freedoms:

(a) freedom of conscience and religion;¹³

¹¹ McRuer Royal Commission Inquiry into Civil Rights, Part IV No. 2 Vol 4 (1969) pp.1493-1497 as reprinted in M.L. Berlin, and W.F. Pentney, eds. *Human Rights and Freedoms in Canada: Cases, Notes & Materials* (Toronto: Butterworths, 1987) at 1-19.

¹² *Canadian Bill of Rights*, S.C. 1960, c. 44.

¹³ *Charter*, *supra* note 4, s. 2(a).

This provision is limited by both the harm principle¹⁴ as well as the operation of Section 1 of the *Charter* and the associated principles espoused by the Supreme Court of Canada in *R. v. Oakes*.¹⁵

The discussion here is not intended to detract from the importance of rights but rather to suggest that it is erroneous to view a freedom and a right as describing the same type of legal relationship. From the historical and contextual framework, a freedom and a right are two different concepts. A right has a correlative duty and a freedom does not.

Rand J. of the Supreme Court of Canada explained the relationship between civil rights and freedoms as follows:

Strictly speaking civil rights arise from positive law; but freedom of speech, religion and the inviolability of the person, are original freedoms which are at once the necessary attributes and modes of self expression of human beings and the primary conditions of their community life within a legal order. It is in the circumscription of these liberties by the creation of civil rights in persons who

¹⁴ This principle is foundational to liberal philosophy, see for example the work of John Stuart Mill, *On Liberty – John Stuart Mill On liberty and other essays* (New York: Oxford University Press Inc, 1998) at 104:

The [two] maxims [which together form the entire doctrine of this essay] are, first, that the individual is not accountable to society for his actions, in so far as these concern the interests of no person but himself. Advice, instruction, persuasion, and avoidance by other people if thought necessary by them for their own good are the only measures by which society can justifiably express its dislike or disapprobation of his conduct. Secondly, that for such actions as are prejudicial to the interests of others, the individual is accountable, and may be subjected either to social or to legal punishment, if society is of opinion that the one or the other is requisite for its protection...[...] where pursuit of legitimate interests causes “pain or loss to others or intercepts a good which they had a reasonable hope of obtaining. Such opposition of interests between individuals often arise from bad social institutions.

¹⁵ *R. v. Oakes*, [1986] 1 S.C.R. 103 [*Oakes*].

may be injured by their exercise, and by the sanctions of public law, that the positive law operates.”¹⁶

In sum, “original freedoms” such as the freedom of conscience and religion are limited and their boundaries are set by civil rights and the operation of positive law.

It should also be noted that neither moral nor human rights were originally contemplated in Hohfeld’s work. However, legal rights and legislative prescriptions are the mechanisms through which moral and human rights are given effect. Typically moral rights must be justified and claimed from society. The justification usually requires arguing that the right has been exclusively earned, purchased, inherited and/or coupled with a corresponding duty from others to respect it.

On the other hand, human rights are a modern concept, which need not be justified or claimed in the same way, and are neither exclusive nor acquired. In speaking of human rights, a claim is made that every human being is endowed with a natural dignity that entitles him or her to respect. This paper argues that the human rights of autonomy and non-discrimination form the bases for any claim to conscientious refusal and these rights may be claimed under the legal requirement for reasonable accommodation.

¹⁶ *Saumur v. City of Quebec*, [1953] 2 S.C.R. 299 at 329.

b) Conscience and conscientiousness

Conscience has become a broad term with many definitions. Most of these interpretations of conscience refer to a private function of the individual's consciousness, i.e. one's inmost thought, mind or heart; an internal conviction or mental recognition; a moral sense of right or wrong; a sense of responsibility felt for private or public actions, motives; or the faculty or principle that leads to the approval of right thought or action and condemnation of wrong.¹⁷ Similarly, *Black's Law Dictionary* defines "conscience" as follows:

1. The moral sense of right or wrong, esp. a moral sense applied to one's own judgment and actions. **2.** In law, the moral rule that requires justice and honest dealings between people.¹⁸

However, defining 'conscience' is no small feat and has challenged philosophers over the ages. For example, Hegel declared:

Conscience is the expression of the absolute title of subjective self-consciousness to know in itself and from within itself what is right and obligatory, to give recognition only to what it thus knows as good, and at the same time to maintain that whatever in this way it knows and wills is in truth right and obligatory. Conscience as this unity of subjective knowing with what is absolute is a sanctuary which it would be sacrilege to violate.¹⁹

On the other hand, Cornell suggests that conscience is much more than "an inward monitor" of how we should guide our lives or an inherent faculty "that enjoins one to conform to a

¹⁷ See The New Shorter Oxford English Dictionary on Historical Principles, Vol. 1. (Oxford: Clarendon Press, 1993) s.v. "conscience" [*OED*].

¹⁸ *Black's Law Dictionary*, 7th ed., s.v. "conscience" [*Black's*].

¹⁹ Georg W.F. Hegel, *Philosophy of Right*, trans. by T.M. Knox (Oxford: Oxford University Press, 1967) at 91.

moral law.”²⁰ For Cornell, conscience refers to “the freedom given a person in a politically liberal society to claim herself as the “self-authenticating source” of what the good life is for her.”²¹

For the purposes of this paper, it is not necessary to summarize the various and evolving explanations of conscience offered by the great thinkers throughout the ages.²² Rather, it is sufficient to identify a few key characteristics of conscience and its relationship to law.

First, conscience is internalized and sets out the moral commitments and fundamental values belonging to the individual. Second, conscience functions as a mode to reflect on one’s own acts, either hypothetical (i.e. to assist in decision making regarding future acts) or retrospective (i.e. to assess the moral value of past acts). Finally, conscience may be informed by a number of different sources; perhaps human beings have an inherent sense of right and wrong, or perhaps it may also be taught. In the health care context, medical ethics may also inform the conscience of health care providers in the performance of their work.

²⁰ Drucilla Cornell, *At the Heart of Freedom: Feminism, Sex, Equality*. (Princeton NJ: Princeton University Press, 1998) at 38.

²¹ *Ibid.*, at 37-38.

²² For a detailed discussion on the history of western thought on “conscience” see Richard J. Regan, *Private Conscience and Public Law; the American Experience* (New York: Fordham University Press, 1972) at Appendix.

i) Conscience begins internally

At first blush, there appear to be two conflicting etymologies for the Latin word “*conscientia*”. The first describes conscience as “joint knowledge” and implies a social consensus as to right and wrong.²³ The second translates conscience as “privity of knowledge” which may be interpreted as emphasizing the inner nature of conscience belonging to a discrete individual.²⁴ Conscience by this second account is defined as one’s inmost thought, mind or heart; an inward knowledge or consciousness; or an internal conviction, recognition or acknowledgment.²⁵ While this paper will be built upon the understanding of the nature of conscience arising from this account, a historical description of the relationship between conscience and religion may help to explain the discrepancy.

In the Western world, morality and the framework of the (Christian) Church and the Law were historically equated: “the central authority of the state served as a means through which the dominant religion could either assert itself or prevent the practice of other religious beliefs.”²⁶ During this time, there was no individual notion of personal belief and therefore conscience could not be conceptually accepted as existing outside a theological framework as moral action was seen to be grown from the “objective law of God.”²⁷

²³Mulford Q. Sibley, *The Obligation to Disobey: Conscience & the Law*. (New York: The Council on Religion and International Affairs, 1970) at 11 [Sibley].

²⁴ *OED*, *supra* note 17.

²⁵ *Ibid.*

²⁶ Leonard M. Hammer, *The International Human Right to Freedom of Conscience: Some suggestions for its development and application*. (Burlington: Ashgate Dartmouth, 2001) at 11.

²⁷ *Ibid.* at 12.

According to Hammer, the emerging ideas of individual moral reasoning offered by Renaissance Humanism, and later the Reformation, challenged the sovereignty of the Church over mind and spirit. However, a conscientious belief was still viewed as inseparable from the dominant religious framework:

Religious principles embodying an ultimate moral standard were the sole source of one's personal moral epistemology... While the Reformation might have challenged the autonomy of the Church, the movement could not conceive the disengagement of a conscientious belief from the religious framework. Acknowledging a person's conscience as a moral authority did not disengage one's theological beliefs that served to limit a person's intellectual capacity to comprehend the conscience.²⁸

Through the philosophical and political contributions of thinkers such as Bayle and Locke, a conception of conscience allowing for an individual approach to ethics and morals began to emerge independent of religion.²⁹ Although the epistemological and moral foundation of the Church remained intact, allowance for reasonable inquiry by the individual in the process of forming moral beliefs was acknowledged.³⁰

While conscience may originally have been conceived of within a homogenous social and religious environment – as contemplated by the idea of “joint knowledge” – intellectuals over the ages have offered an understanding of conscience involving the formation of reasonable moral beliefs as a personal matter for the individual. Acceptance of this understanding becomes vital in a world faced with religious and moral diversity.

²⁸ *Ibid.* at 13.

²⁹ *Ibid.* at 17.

³⁰ *Ibid.*

According to Kant, “every human being, as a moral being has a conscience within him originally ... [it is] an unavoidable fact.”³¹ It is against this historical philosophical backdrop that this paper adopts an inherently internalized and individualized definition of conscience and argues that conscience of the individual is the proper subject of protection.

ii) Conscience guides decision-making and reflection in the individual

Conscience is consulted when an individual is faced with a moral dilemma of “some difficulty, some perplexity or some temptation.”³² Invoking conscience in an individual’s decision-making process involves a “calculus of decision” that weighs the particular and contingent situation at hand against the individual’s hierarchy of principles and the possible consequences of action.³³ This “calculus” is in many ways both rational and arational or, put another way, reasoned and un-reasoned:

Such an application can never be wholly rational, although it must embrace rational elements if the notion of moral accountability is to have meaning. When we apply general principles to particulars, in light of assessment of consequences and logic, we are and inevitably must be uncertain about how the application should be made. Here, then, reason carries us to the brink; but we must leap across the gorge to action with more than its assistance.

[...]

Conscience is the result both of a commitment to faith (at the beginning and in the end) and of the analysis associated with reason (in the middle of its formation).³⁴

³¹ Immanuel Kant, *Practical Philosophy*, 1st ed. by Mary J. Gregor (Cambridge: Cambridge University Press, 1999) at 530 [Kant].

³² James Childress, “Appeals to Conscience” (1979) 89 *Ethics* 315 at 321-322 [Childress].

³³ Sibley, *supra* note 23 at 13.

³⁴ *Ibid.*, at 14.

Sibley suggests that a conscientious person possesses an “awareness of obligation to himself to others and to society” and thus conscientiousness signifies “a seriousness about life.”³⁵ When a person acts conscientiously it is “not merely out of self-concern but also out of concern for others ... [and] not merely out of passion but thoughtfully and deliberately.”³⁶ In this regard, reason and rational analysis are hallmarks of conscientious decision-making.

At the same time, Sibley argues that conscience is also “beyond reason” involving both intuition and “a leap of faith” at various stages in the decision making process.³⁷ Intuition derives from concepts of values and a moral understanding of right and wrong inherited from an individual’s culture, history and upbringing. In *The Ethical Imagination*, Margaret Somerville questions whether or not reason and faith are mutually exclusive “ways of knowing”. Prof. Somerville suggests that our primary decision making process may be “a gut reaction” and reason acts as a “secondary verification mechanism”.³⁸ In this way, reason permits for review near the end of the decision-making process.

“Turning to conscience” thus can be both a process of reflecting on the correct course of action in a situation and hearing the voice that commands a person to act a certain way. The definition provided for the adjective “conscientious” provides a particular insight into

³⁵ *Ibid.*

³⁶ *Ibid.*, at 18.

³⁷ *Ibid.*, at 13-14.

³⁸ Margaret Somerville, *The Ethical Imagination* (Toronto: House of Anansi Press Inc., 2006) at 30-31. Reference to Somerville, Margaret A. “Justice across the generations.” *Social Science & Medicine* 29(3) (1989):385-394

nature of conscience: “obedient and governed by a sense of duty.”³⁹ Hence, conscience is also the voice of an internal moral imperative:

When we say that we act in a certain way by reason of conscience, we supposedly are not acting out of fear, or because we are intimidated, or for purely self-regarding ends, but because – however we arrive at the judgment – a given course of conduct is morally “right.”⁴⁰

Presuming that all human beings are capable of moral reasoning, moral relativism suggests that one’s sense of right and wrong may differ between communities and between individuals. It is quite possible for actions to be performed out of conscience which others would believe to be morally “wrong”. Yet, the law which seeks to govern these individuals must be applicable to all.⁴¹ Regardless of any perceived moral virtue or vice of the act, “the mere fact that an act is performed out of conscience is surely worthy of consideration.”⁴² Cohen suggests that “[i]f, in obeying his conscience ... the genuineness of that conflict must give us pause [because] it may lead us to deeper reflection upon our own principles, and perhaps to the development of greater wisdom by all parties.”⁴³ This stance taken by Cohen reflects respect for the inherent dignity of all human beings.

³⁹ *OED*, *supra* note 17 (“Conscientious” adj. 1. obedient to conscience, (habitually) governed by a sense of duty; done according to conscience; scrupulous, painstaking or pertaining to conscience).

⁴⁰ *Sibley*, *supra* note 23 at 9.

⁴¹ Benjamin Cardozo, “The Paradoxes of Legal Science,” *Selected Writings of Benjamin Nathan Cardozo, The Choice of Tycho Brahe*, (New York: Fallon Publications, 1947) at 274: “Law accepts as the pattern of its justice the morality of the community whose conduct it assumes to regulate. In saying this, we are not to blind ourselves to the truth that uncertainty is far from banished....The law will not hold the crowd to the morality of saints and seers. It will follow, or strive to follow the principle and practice of the men and women of the community whom the social mind would rank as intelligent and virtuous.”

⁴² Carl Cohen, *Civil disobedience: conscience, tactics, and the law*. (New York: Columbia University Press, 1971) at 212.

⁴³ *Ibid.*

Conscientiousness in this light refers to turning inward to one's deeply held collection of values and beliefs to assess a given situation and discern an appropriate course of action. Conversely, "unconscientiousness" does not refer to a lack of conscience but rather the propensity not to heed its caution. According to Kant, "if someone is aware that he has acted in accordance with his conscience, then as far as guilt or innocence is concerned nothing more can be required of him."⁴⁴

Alternatively, Childress argues that conscience is usually retrospective and thus functions as a sanction and not an authority.⁴⁵ Childress suggests that conscience is most often contemplated in the negative – usually "bad conscience" – and echoes Arendt's claim that "a good conscience does not exist except as the absence of a bad one."⁴⁶ Childress argues that the rules of conscience are entirely in the negative and cites Arendt's *Crises of the Republic*:

[The rules of conscience] do not say what to do; they say what not to do. They do not spell out certain principles for taking action; they lay down boundaries no act shall transgress. They say: Don't do wrong for then you will have to live together with a wrongdoer.⁴⁷

By this account, conscience refers to reflection on an individual's own past acts, or how she will feel in the future having acted to the contrary, in relation to her own standards of judgment, and then inflicts sanctions of shame or guilt on the actor.

⁴⁴ Kant, *supra* note 31.

⁴⁵ Childress, *supra* note 32 at 318-320

⁴⁶ Hannah Arendt "Thinking and Moral Considerations: A Lecture" (1971) 38 Social Research 418 as cited in Childress, *supra* note 32 at 317

⁴⁷ *Ibid.*, at 321.

Childress' assertion is supported by historical account of the theories of conscience where in early times conscience was regarded as something which would cause a person pain if he performed a morally wrong act.⁴⁸ Only later was conscience conceived of as "a positive guide to conduct, which not only pronounced against past deeds or warned against future ones but which in addition helped guide the individual in choosing the right."⁴⁹

Perhaps conscience is not experienced as "a general and indefinite call to integrity" but has a much more specific intent (and consists of specific content) in the face of a moral quandary.⁵⁰ Persons who are forced to act contrary to the dictates of their conscience will be sanctioned by internal anguish associated with guilt or shame. As Kant wrote, the duty is not necessarily to act in accordance with conscience but rather "to cultivate one's conscience, to sharpen one's attentiveness to the voice of the inner judge, and to use every means to obtain a hearing for it."⁵¹

This understanding of conscience does not attribute precise content or even a particular source for the formation of conscience. Instead, for the purposes of this paper, conscience sets out an individual's moral commitments and fundamental values, which may or may not be associated with one's faith in religious doctrine, and functions as an internal mode of reflection on one's own acts, both hypothetical and retrospective.

⁴⁸ *Sibley, supra* note 23 at 10.

⁴⁹ *Ibid.*

⁵⁰ *Childress, supra* note 32 at 322.

⁵¹ *Kant, supra* note 31.

iii) *The content of conscience in the context of health care is informed by many sources*

Conscience creates and enforces moral obligation in the individual and thus functions as an internal form of government, i.e. “the first level of government” in society.⁵² The values and commitments which together constitute a person’s conscience may have been developed from lessons learned from experience, faith and religion, and likely something else inherent to the human individual, which would guide decision making and allow for reflection, and should be protected. In this light, the conscience of the health care provider is an amalgam of the moral commitments and fundamental values of the individual as well as the ethics adopted by and taught to the medical profession and which should be common to all health care providers.

Beyond the common sources informing an individual’s conscience as described above, in the health care context, conscience may also be informed by the basic tenets of medical ethics. The earliest recorded code of medical ethics is the Hippocratic Oath of Ancient Greece. In the recent past, the most commonly cited model of bioethical principles in Anglo-American jurisdictions is known as the “Georgetown Principles”: beneficence, non-maleficence, autonomy and justice.⁵³ These principles were one of the first attempts in applied ethics to articulate the fundamental ethical principles applicable to medicine and health care and set out the duties of health care providers to their patients.

⁵² The author is grateful to the late Mr. Justice Gonthier for suggesting this idea in conversation.

⁵³ Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 5th ed. (New York: Oxford University Press, 2001); also J. K. Mason, *Mason and McCall Smith's law and medical ethics* (Oxford: New York: Oxford University Press, 2006.)

In examining each of these principles, the following observations can be made of the “Georgetown Principles”: beneficence refers to the general duty to do good, relieve pain and suffering and save a life, if possible; non-maleficence refers to the duty to avoid harm or injury to patients; autonomy refers to respect for a patient’s autonomy;⁵⁴ and justice refers to the principle to act fairly. The Georgetown Principles have been incorporated by the Canadian Medical Association and in its *Code of Ethics*.⁵⁵

According to the CMA’s *Code of Ethics*, Canadian physicians are to consider first the well-being of the patient.⁵⁶ The second fundamental responsibility is to treat the patient with dignity and as a person worthy of respect.⁵⁷ Central to the argument in this paper is that all persons, both patient and provider, make decisions guided by conscience and are worthy of respect.

c) Disobedience, objections and refusals

There appears to be no consensus as to a precise definition of conscientious objection. Conscientious objection may arise when a person faces two conflicting moral demands – one from the conscience within and the other from the customs, expectations, or the public law of the community to which she belongs. Various political and legal theorists have offered similar but nuanced interpretations of conscientious objection, also offering terms such as

⁵⁴ In this paper, autonomy will be given broader application and should be considered also in view of autonomy of each person, health care provider or patient.

⁵⁵ Canadian Medical Association. *Code of ethics*. (Ottawa: The Association, 2004).

⁵⁶ *Ibid.*

⁵⁷ *Ibid.*

conscientious non-compliance. However most theories agree that conscientious objection should be considered distinct from civil disobedience. As will be explained, this paper prefers the narrower term of “conscientious refusal” to describe the exercise of conscientious objection in the Canadian health care context.

When faced with the conflict of competing moral duty to conscience and the obligations to society at large described above, the Rawlsian definition of civil disobedience provides that it is a “non-violent public protest designed to change legal rules considered incoherent with fundamental principles derived from community reflection on an ideal position” and refers to the manifestation of the minority’s power to participate in the political process.⁵⁸ Conversely, conscientious objection is “a public withdrawal of individuals from obedience to law due to similar activation of conscience without necessarily seeking to change it.”⁵⁹

Based on the work of Raz and Hall, Kugler provides the following definition of “conscientious objection” as a basis for his discussion: conscientious objection is “an act of violation of the law which is engendered by the violator’s belief that he is bound by a moral duty to violate the law in the circumstances.”⁶⁰ Kugler’s discussion of conscientious

⁵⁸ John Rawls, *A Theory of Justice* (Cambridge Mass: Harvard University Press, 1971) at 364 [Rawls]; see also John Rawls, Civil Disobedience in J. Arthur (ed.) *Morality and Moral Controversies* (New York: Prentice Hall, 1993) at 418: “Civil disobedience is a political act in the sense that it is an act justified which principles which define a conception of civil society and public

⁵⁹ James F. Childress, “Civil disobedience, conscientious objection and evasive noncompliance; a framework for analysis of illegal actions in health care” (1985) *J. Med. and Philos.* 63.

⁶⁰ Itzhak Kugler, “On the Possibility of a Criminal Law Defence for Conscientious Objection” (1997) 10 *Can J.L. & Juris* 387 at 388.

objection is only addressed to how law should respond to morally motivated violations of law.⁶¹ Conscientious objection where no breach of law is involved is discussed later in this paper.

For Kugler, morally motivated crimes represent a social phenomenon distinct from “normal” criminality. Kugler divides morally motivated crimes as either “revolutionary disobedience” or occurring within the existing social structure or regime. The latter variety is then further divided as being one of two breaches of law: civil disobedience and conscientious objection. Reiterating Raz’s distinction between the two, Kugler argues that while civil disobedience is essentially a political act intended to bring about change in law or policy, conscientious objection is a personal act.⁶² Kugler’s characterization of conscientious objection is determined by considering only the motive of the act:

The violator feels that should he submit to the law, in the circumstances he will be committing a moral wrong. The objector’s act is not motivated by desire to influence the whole polity, but rather by a desire to stay clean, and not perpetrate, with his own hands, a moral wrong. In effect this is an act of the individual defending himself against coercive pressures to perform what he regards as a moral wrong.⁶³

From this perspective, it is quite possible that refusal to serve, in the example of objection to military service, may constitute both an act of civil disobedience and conscientious objection.⁶⁴ Kugler further suggests that conscientious objection may be

⁶¹ *Ibid.*

⁶² *Ibid.* at 387-388; see also J. Raz, *Authority of Law: Essays on Law and Morality* (Oxford: Clarendon Press, 1979) at 263 and 276 [Raz]. R. Dworkin writes of a similar distinction with different terminology in *A Matter of Principle* (Cambridge: Harvard University Press, 1985) [Dworkin].

⁶³ *Ibid.*; see also Raz at 276 and Dworkin at 109

⁶⁴ *Ibid.*, at FN 3, see Raz at 264

divided into subcategories of passive/active and absolute/selective.⁶⁵ While Kugler discusses neither of these subcategories in detail, passive conscientious objection appears to refer to situations of refusal when the law requires some positive action. Active conscientious objection refers to the belief of moral duty to perform a certain act in the face of a law which prohibits it.

In contrast, for Cohen, an act of deliberate civil disobedience is a violation of law whereas conscientious objection is always wholly lawful. Cohen's formulation of conscientious objection only captures the passive version suggested by Kugler. Cohen defines conscientious objection as a "special expression, generally reserved to identify a special device of the body politic that ... makes it possible for those who find the acts that law requires morally intolerable to comply with the law in some alternative (and to them morally objectionable way)."⁶⁶

In this paper, I will only deal with lawful conscientious objection (or how conscientious objection may operate within the boundaries of law) thus the description provided by Cohen is somewhat more instructive. Conscientious objection from this perspective usually assumes the form of a legislative clause, known as a "conscience clause" requiring administrative procedures specified by statute to establish status: "what is legally justified by such provisions is a particular course of action given some carefully specified

⁶⁵ *Ibid.*, at 338.

⁶⁶ *Cohen*, note 41 at 42.

qualification; they never justify nor would they justify, deliberate disobedience.”⁶⁷ While conscientious objection may be considered a form of protest,⁶⁸ according to Cohen, conscientious objectors who avail themselves of these provisions do not disobey any law and are “on the contrary, meticulously law-abiding.”⁶⁹ Performance of conscientious objection does not violate the law rather the conduct is granted protection *by* the law.

Cohen’s work was situated at a time when conscientious objections were almost always considered in the context of military conscription and viewed conscientious objection as permitting a community to release certain members from the performance of an act commanded by law that was contrary to the deeply held beliefs of those members. In this regard, “conscientious objector status” is bestowed on those members upon meeting certain stipulated requirements and usually on the condition that some alternative service to the community be performed in their stead.⁷⁰ This understanding yields the commonly accepted definition of a conscientious objector: “A person who for moral or religious reasons is opposed to participation in any war, and who is therefore deferred from military conscription but is subject to serving in civil work for the nation’s health, safety or interest.”⁷¹

This type of conscientious objection requires a specific legal device which belongs to the category of immunities described by Hohfeld. No claim s-right, power or privilege is

⁶⁷ *Ibid.*, at 95.

⁶⁸ *Ibid.*, at 42.

⁶⁹ *Ibid.*, at 95.

⁷⁰ *Ibid.*, at 269.

⁷¹ *Black’s*, *supra* note 18, s.v. “conscientious objector”.

being advanced. A pacifist who avails himself of a conscience clause to avoid compulsory military service is not seeking a legal advantage nor necessarily demanding a corresponding duty from some else's action or inaction. The pacifist does not seek the power to change existing legal relationships involving rights and duties. Nor is this a legal privilege, as it is only through certain and specific legislation which the pacifist can be exempt from otherwise compulsory service. As discussed, privileges and freedoms do not require special laws only the presence of certain operative facts. Thus, conscientious objection activated by invoking a conscience clause would be an immunity according to Hohfeldian classifications.

A conscience clause does not suggest that military service is morally wrong or unacceptable. A conscience clause only negates the liability to serve and protects against the encroachment of the state to demand service; it is an exemption to an otherwise validly enacted legal requirement. Unlike a privilege which refers to basic freedom from duty, in this context, a conscience clause, if incorporated into the same statute requiring service to the state, functions as a legislative immunity which would free one from duty if invoked and if the statutory criteria are met. In another light, this concept of conscientious objection, which is established through specific legislation, releases an individual from the legal power, control or duty required from a particular legal relationship.

As suggested above, the term conscientious objection may imply a disagreement with a particular societal obligation based on a conscientious belief. However, the topic of discussion extends beyond a mere belief. The traditional definition of conscientious

objection cannot apply in the health care context in Canada as specific conscience clauses have not yet been adopted in domestic law to exempt health care providers from requirements to treat. For the most part, there is also no explicit legislation requiring a particular procedure to be provided which could be subject to *Charter* challenge. As such, the topic of discussion as it presently stands may be more precisely described as a *refusal to act* in accordance with the request of a patient which if performed, would contravene a personal or internal conviction.

I submit that “conscientious refusal”⁷² will be used in this paper because it is a more accurate description of disagreements of conscience in health care. The term describes the exercise of conscientious objection with greater precision because it carries the private objection from belief to an active and public expression of refusal, while remaining distinct from civil disobedience. Moreover, the term recognizes that the situation is slightly different from the most common understanding of “conscientious objection”. There are no conscience clauses in this context in Canada yet and the conscience of the health care provider is at odds with the statutory demands of the state to perform a particular procedure but rather with another individual. Thus, conscientious refusal in this paper is a very narrow term addressed to a private act.

⁷² This term with slightly variations in the meaning has also been used in other works such as *Rawls*, *supra* note 57 at 359-371 and in John K. Davis, “Conscientious Refusal and a Doctor’s Right to Quit” (2004) 29:1 J. Med. and Philos. 75 [Davis].

This idea of “conscientious refusal” may be comparable to the concept of “conscientious non-compliance”. “Conscientious non-compliance” describes “individual covert disobedience to law, such as the Nazi eugenic laws, for altruistic reasons, being prepared for public justification based on fundamental principle should it subsequently be required.”⁷³ Of the gamut of possible responses to moral conflict, civil disobedience provides for a public and politically motivated act; conscientious objection for a public act but for private reasons; and conscientious non-compliance may be said to provide for a covert act of objection for public reasons.

In this paper, “conscientious refusal” describes the exercise of a private belief to an active expression of refusal which is directly at odds with the rights and desires of another individual, absent coercive legislation to disobey and without any intended political statement. There will be no examination in this paper of actions intended to make a political statement. Exercises of conscientious refusal are deliberate and voluntary actions undertaken in light of conflicting demands from internal and external moral and ethical imperatives. The conflict remains a private matter between the health care provider and the demands being made by a patient.

It is important to note that “conflicts of conscience” may occur at many levels, e.g. within the individual health care provider who is trying to balance the competing obligations

⁷³ Jeremy Noakes “Nazism and Eugenics: the Background to Nazi Sterilization Law of 14 July 1933” in B.J. Bullen (ed.), *Ideas in Politics: Aspects of European History 1880-1950* (London: Taylor & Francis, 1984) at 75.

of his or her personal beliefs with the responsibility to respect the patient's requests for treatment; between provider and patient where both have considered the situation at hand with their own values and moral judgment and arrived at a different conclusion; and at a macro level, where the beliefs of a minority do not accord with generally-held societal views.

Herein, "conscientious refusal" will refer to the following: the act of a medical professional refusing to perform or participate in a specified, legally permissible and medically-indicated procedure at the request of a patient because of the procedure's incompatibility with the individual's system of beliefs which may be informed by any combination of that individual's religious, moral, ethical and personal tenets.

Without the compelling rhetoric of rights, the content of the legal claim to "a right to conscientious refusal" can be appreciated as a packaging of the freedom of conscience and religion and the human rights of autonomy and equality. The human rights of autonomy and equality form the bases for any claim to conscientious refusal and these rights may be claimed or enforced through legal mechanisms addressed to non-discrimination.

The correlative of the freedom of conscience and religion implies that there is no duty to hold and observe the same beliefs as everyone else. Given the substance of "freedom", it is more precise to assert protection for the exercise of conscientious refusal under the umbrella of autonomy rights, and more accurate to identify the relief sought by "conscientious refusers" as protection from discrimination. These concepts must be

considered separately. The right to live and act autonomously is paired with an obligation to refrain from coercing that person to act to the contrary. Respecting the autonomy of a refuser does not equate to permitting conscientious refusal in all circumstances, particularly if that act of refusal were to violate the autonomy of another e.g. for reasons of paternalism. In addition, while respecting the autonomy of a refuser implies that the refuser has the right to live and work free from discrimination, the refuser also has a correlating duty not to discriminate. Legitimate grounds for refusal must not be rooted in prejudices disguised as “conscientious” belief.

While some proponents of conscientious refusal simply assert the freedom of conscience of religion in support of their claim, others insist that specific legislative immunities are necessary to protect conscientious refusal and advocate for their adoption in Canadian law. These topics are discussed in detail in the following chapter.

Chapter Two:

CONSCIENCE LAWS

This chapter reviews the common “solutions” or defences offered in support of a right to conscientious refusal: the “conscience laws”. Upon review of the freedom of conscience and religion as it is understood in Canadian law, I argue that freedom of conscience and religion is not only inherently limited, but also that it is further limited by the application of Section 1 of the *Charter*. This part of the paper also examines proposals for “protection of conscience” laws and conscience clauses to assess their suitability to the Canadian health care context.

a) Freedom of Conscience and Religion

The *Universal Declaration of Human Rights* begins with the following statement:

All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.⁷⁴

The *UDHR* proceeds to recognize “freedom of thought, conscience and religion” in Article 18.⁷⁵ This statement of abstract ideals was later incorporated into binding international conventions. Freedom of thought, conscience and religion has been incorporated into the

⁷⁴ Universal Declaration of Human Rights, GA Res. 217(III), UN GAOR, 3d Sess., Supp. No. 13, UN Doc. A/810 (1948) 71 [*UDHR*], Art I., online: UN Office of the High Commissioner for Human Rights, <<http://www.unhchr.ch/udhr/index.htm>>.

⁷⁵ *Ibid.*, Art. XVIII.

*International Convention on Civil and Political Rights*⁷⁶ as well as various regional and national documents, including the *European Convention of Human Rights*⁷⁷ and the *Canadian Charter of Rights and Freedoms*.⁷⁸

Inherent in the nature of conscience, as discussed in Chapter One, freedom of conscience is said to protect ethical convictions.⁷⁹ Unfortunately, this notion offers very little to support an argument for the active exercise of conscientious refusal in Canada as an enforceable right. As a freedom, Section 2 of the *Charter* is not only implicitly limited by the harm principle,⁸⁰ but further limited by Section 1. Conscientious refusal is a shield to protect one's conscience from harm not a sword to permit one's beliefs to justify harm or violation of another's rights.

⁷⁶ International Covenant on Civil and Political Rights, 19 December 1966, 999 U.N.T.S.171, arts. 9-14, Can. T.S. 1976 No. 47, 6 I.L.M. 368 (entered into force 23 March 1976, accession by Canada 19 May 1976) [ICCPR], Article 18. online: United Nations High Commission for Human Rights, <http://www.unhchr.ch/html/menu3/b/a_ccpr.htm>.

⁷⁷ Convention for the Protection of Human Rights and Fundamental Freedoms, 4 November 1950, 213 U.N.T.S. 221 at 223, Eur. T.S. 5 [ECHR].

⁷⁸ While international law refers to “freedom of thought conscience and religion,” the *Charter* refers to “freedom of conscience and religion” and a separate grouping of “freedom of thought, belief, opinion and expression.” This separation may illustrate the equal weight and respect given to a religious belief and a conscientiously held belief.

⁷⁹ C.D. de Jong, *The Freedom of Thought, Conscience and Religion or Belief in the United Nations (1964-1992)* (Antwerp/Gronigen/Oxford: Intersentia/Hart, 2000) at 29. [de Jong]

⁸⁰ This limitation is explicitly incorporated in international law – e.g. The ICCPR article 18(3) states as follows:

3. Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others.

In Canada, the Supreme Court of Canada explained the limits to religious freedom and echoed the language of international law in *R. v. Big M Drug Mart Ltd.*⁸¹ as follows:

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.⁸²

Big M Drug Mart Ltd. was the first case to bring Section 2 of the *Charter* before the Supreme Court of Canada. Big M Drug Mart Ltd. was charged with unlawfully carrying on the sale of goods on a Sunday. This case challenged the constitutionality of the *Lord's Day Act*,⁸³ which was Sunday observance legislation which prohibited commercial activity on the "Lord's Day".

In *Big M Drug Mart*, the Court recognized that the ability of each citizen to make free and informed decisions is a prerequisite for the "legitimacy, acceptability, and efficacy of our system of self-government". The Court also noted that individual conscience and judgment are at the "heart of our democratic political tradition" which underlies the *Charter*.⁸⁴

The Court in its reasons *per* Dickson J. explained the freedom enshrined in paragraph 2(a) of the *Charter* as follows:

The values that underlie our political and philosophical traditions demand that every individual be free to hold and to manifest whatever beliefs and opinions his or her conscience dictates, *provided inter alia only that such manifestations do not injure his or her neighbours or their parallel rights to hold and manifest beliefs and opinions of their own*...whatever else freedom of conscience and religion

⁸¹ *R. v. Big M Drug Mart Ltd.*, [1985] 1 S.C.R. 295 [*Big M Drug Mart*].

⁸² *Ibid.* at 337.

⁸³ *Lord's Day Act*, R.S.C. 1970, c. L-13, s. 4.

⁸⁴ *Big M Drug Mart*, *supra* note 81 at 346.

may mean, it must at the very least mean this: government may not coerce individuals to affirm a specific religious belief or to manifest a specific religious practice for a sectarian purpose.⁸⁵

[emphasis added]

In addition to the inherent limitation of injury to others, the Court also suggested that government may engage in coercive action, which paragraph 2(a) might otherwise prohibit, to achieve a vital interest or objective but declined to provide guidance as to what degree.⁸⁶ Presumably, any such government action would be assessed against the criteria set out in Section 1 of the *Charter* or against administrative law principles.

In the case of *Edward Books and Art Ltd. v. R.*,⁸⁷ the Court stated that the purpose of freedom of conscience and religion is to ensure that society “does not interfere with profoundly personal beliefs that govern one’s perception of oneself, humankind, nature, and in some cases, a higher or different order of being.”⁸⁸ The Court held that the provincial Sunday closing law was found to have religious effects which infringed Section 2 of the *Charter*. However, the statute was ultimately saved under Section 1 of the *Charter*.

The test for infringement of freedom of religion was set out in *Northern Syndicat v. Amselem*.⁸⁹ As with all *Charter* cases, in order to establish a violation, a two-step analysis is required. The claimant must demonstrate infringement of a *Charter* right or freedom. If an infringement is shown, the limit must then be justified under Section 1.

⁸⁵ *Ibid.*, at 346-347.

⁸⁶ *Ibid.*

⁸⁷ *Edward Books and Art Ltd. v. R.*, [1986] 2 S.C.R. 713 [*Edward Books*].

⁸⁸ *Ibid.*, at para. 97.

⁸⁹ *Syndicat Northcrest v. Amselem*, 2004 SCC 47, [2004] 2 S.C.R. 551 [*Amselem*].

The claimant must establish a sincerely held belief or practice having a nexus with religion or is otherwise required by his or her religion. The claimant must also show that the state has interfered with his or her ability to act in accordance with that practice or belief, in a manner that is non-trivial or not insubstantial.⁹⁰ The sincerity of the belief is based on good faith and the credibility of the claimant's testimony; the claim must not be fictitious, capricious, or an artifice.⁹¹ Belief is individual and comparison with what other people of the same religion practice is not relevant.⁹²

Once infringement of the freedom has been established, the burden shifts, placing the onus on the respondents to prove that on a balance of probabilities, the infringement is reasonable and can be demonstrably justified in a free and democratic society, under Section 1 of the Charter.⁹³ The appropriate analysis to be undertaken with regard to Section 1 was set out in the case of *R. v. Oakes*.⁹⁴ The importance of the objective and the proportionality of the means chosen must be assessed. First, the legislative objective being pursued must be sufficiently important to warrant limiting a constitutional right. In addition, the means chosen by the state authority must bear a rational connection to the objective in question and minimally impair the freedom or right at issue.⁹⁵ If the infringement meets the requirements under the “*Oakes Test*”, the limit on the freedom remains constitutional.

⁹⁰ *Ibid.*

⁹¹ *Ibid.*, at para. 52.

⁹² *Multani v. Commission scolaire Marguerite-Bourgeoys*, 2006 SCC 6, [2006] 1 S.C.R. 256 at para. 35 [*Multani*].

⁹³ *Charter*, *supra* note 4, s.1.

⁹⁴ *Oakes*, *supra* note 15.

⁹⁵ *Ibid.*

To reconcile competing rights, Section 1 analysis requires a balancing of the deleterious effects of a measure against its salutary effects. Accordingly, in *B. (R.) v. Children's Aid Society of Metropolitan Toronto*,⁹⁶ a case involving Jehovah's Witnesses contesting an order authorizing a blood transfusion for their daughter, the Court acknowledged that the state may limit the freedom of religion of the parents where necessary to protect the child's life or avoid serious risk to her health.

Similarly, in *Ross v. New Brunswick School District No. 15*, pursuant to Section 1 of the *Charter*, a teacher's right to act on anti-Semitic views was limited because it compromised the right of students to a discrimination-free school environment.⁹⁷ In this case, Ross was a teacher who during his off-duty time made racist and discriminatory comments in letters to local newspapers and in a television interview. He also published anti-Semitic writings. The Supreme Court of Canada held that the school board decision's to remove him from the teaching environment and terminate his teaching job under stipulated terms was justified. Analysis under Section 1 is entirely relevant in the case of a *Charter* challenge to legislation as the provision may be used to save a legislative provision which otherwise infringes a constitutional right or freedom.

In the recent decision in *Multani v. Commission scolaire Marguerite-Bourgeoys*,⁹⁸ the majority held that the Section 1 analysis is again the appropriate mechanism by which to

⁹⁶ *B. (R.) v. Children's Aid Society of Metropolitan Toronto*, [1995] 1 S.C.R. 315.

⁹⁷ *Ross v. New Brunswick School District No. 15*, (1996) 1 S.C.R. 825. [*Ross*]

⁹⁸ *Multani*, *supra* note 94.

balance competing *Charter* rights. In concurring reasons in *Multani*, LeBel J. suggested a “simplified approach” to the *Oakes* Test based on balancing of rights, or reconciliation of guaranteed rights under the *Charter*, before applying Section 1.⁹⁹ Following this approach, in matters of competing rights, the rights at issue must be analysed, their content defined, and where relevant, the scope of the competing rights considered before resorting to justification under Section 1.¹⁰⁰ Defining the content of a right would identify internal limits of that right. According to LeBel J, the application of the *Charter* is not confined to simply the relationship between a guaranteed right of individuals and government action limiting rights.¹⁰¹ The *Charter* should be applied in such a way which would reflect the need to “harmonize values and reconcile rights and obligations”.¹⁰² Nonetheless, the majority of the Court in *Multani* has held it “sounder” to refrain from formulating internal limits to a freedom in constitutional challenges and preferred balancing competing rights under Section 1 of the *Charter*.¹⁰³

Freedom of conscience does not require the same relationship to the beliefs or creed of an organized or collective group as freedom of religion. In another Sunday shopping case, *R. v. Videoflicks Ltd.*,¹⁰⁴ Tarnopolsky J.A. of the Ontario Court of Appeal offered the following comments which are also helpful in explaining that freedom of conscience and

⁹⁹ *Ibid.*, at paras. 149-159.

¹⁰⁰ *Ibid.*, at para. 146.

¹⁰¹ *Ibid.*, at para. 147.

¹⁰² *Ibid.*

¹⁰³ *Ibid.*, at para. 109-110

¹⁰⁴ *R. v. Videoflicks Ltd.* (1984), 48 O.R. (2d) 395 (O.C.A.).

freedom of religion, as the two are understood in Canada in light of the *Charter*, are worthy of the same legal treatment:

Freedom of religion goes beyond the ability to hold certain beliefs without coercion and restraint and entails more than the ability to profess those beliefs openly. In my view, freedom of religion also includes the right to observe the essential practices demanded by the tenets of one's religion and, in determining what those essential practices are in any given case, the analysis must proceed not from the majority's perspective of the concept of religion but in terms of the role that the practices and beliefs assume in the religion of the individual or group concerned.

[...]

In my view essentially the same reasoning would apply to the fundamental freedom of conscience, except that freedom of conscience would generally not have the same relationship to the beliefs or creed of an organized or at least collective group of individuals. Nonetheless, and without attempting a complete definition of freedom of conscience, the freedom protected in s.2(a) would not appear to be the mere decision of any individual on any particular occasion to act or not to act in a certain way.

In Canadian law, freedom of conscience and religion is held to be a personal and subjective concept.¹⁰⁵ Therefore, the threshold test in the judicial analysis is one of the sincerity of the claimant.¹⁰⁶ Again, sincerity implies simply an honestly-held belief; popularity of the belief is not at issue.¹⁰⁷

¹⁰⁵ *Amselem*, *supra* note 89 at para. 42.

¹⁰⁶ *Ibid.*, at para. 51-52.

¹⁰⁷ *Ibid.*, at para. 51-52 ("That said, while a court is not qualified to rule on the validity or veracity of any given religious practice or belief, or to choose among various interpretations of belief, it is qualified to inquire into the sincerity of a claimant's belief....The Court's role in assessing sincerity is intended only to ensure that a presently asserted religious belief is in good faith, neither fictitious nor capricious and that it is not an artifice").

In addition, the claimant and the asserted objectionable requirement must be sufficiently connected. Self-proclaimed conscientious objectors have attempted to use the Courts as a forum to express their disagreement with the use of tax dollars to fund military or abortion services absent any conscience clause exemption in the *Income Tax Act*¹⁰⁸ by arguing that their freedom of conscience and religion has been violated. Such claims have been consistently rejected by the Courts on the grounds that the requirement to pay the full amount of tax, which has been lawfully assessed under the *Income Tax Act*, bears insufficient nexus to any direct or indirect participation in fiscal expenditures for military or abortion purposes.¹⁰⁹

In sum, the jurisprudence of Canada's highest court sets out the following principles on the freedom of conscience and religion: freedom is primarily characterized by the absence of coercion or constraint; freedom of conscience and religion is fundamental because it recognizes the ability of all citizens to make free and informed decisions; recognition of the freedom of conscience and religion is a statement about universal human worth and dignity; and a person possesses the freedom to hold and to manifest whatever beliefs and opinions his or her conscience dictates provided "that such manifestations do not injure his or her neighbours or the parallel rights to hold and manifest belief and opinions of their own."¹¹⁰ The threshold question to assessing the validity of an exercise of conscientious objection is sincerity. The validity of those asserted practices is not to be assessed from the perspective

¹⁰⁸ *Income Tax Act*, R.S.C., 1985, c. 1 (5th Supp.) as amended.

¹⁰⁹ *Prior v. Canada*, [1989] F.C.J. No. 903 (F.C.A.); also *O'Sullivan v. M.N.R.*, [1990] 2 C.T.C. 2500 (T.C.C.); *O'Sullivan v. M.N.R.* (No. 2), [1992] 1 FC 522, 84 D.L.R. (4th) 124 (Fed. Ct. Trial Div.)

¹¹⁰ *Big M Drug Mart*, *supra* note 83 at 337 and *Amselem*, *supra* note 91 at para. 62.

of the majority. Courts do not interpret nor arbitrate religious dogma. A legal requirement may be constitutionally invalid if a claimant is able to demonstrate that the basis for the objection is both a sincere and either a religiously motivated or conscientiously and regularly observed practice. The onus is on the claimant to establish the sincerity of his or her belief and that it is part of the set of beliefs which governs the conduct of all or most of the claimant's voluntary actions. Finally, there must be a sufficient nexus between the claimant and the activity subject to objection.

Beyond theoretical foundation, the freedom of conscience and religion as understood in Canadian law adds very little to an argument in support of a guarantee of respect for conscientious refusal in health care. Courts have justified infringement of freedom in the event of interference with another's rights, even where the actions took place in the private life of the claimant.¹¹¹ Where rights and freedoms compete, the notwithstanding clause of the *Charter* may be invoked to justify government encroachment on the freedom of conscience and religion.

Consideration of a *Charter* challenge in defence of a more robust view of freedom of conscience and religion is hypothetical at this point in time and not all that meaningful without a factual context for the discussion. Nonetheless, an explanation of the freedom of conscience and religion as understood in Canadian law may serve as a useful foundation for any proposals for active legal protection of conscience.

¹¹¹ E.g. *Ross*, *supra* note 97.

It should be noted that in other countries attempts to litigate conscientious refusal have been made without much success for the refusers.¹¹² In *Pichon and Sajous v. France*, the European Court of Human Rights held that “as long as the sale of contraceptives is legal and occurs on medical prescription nowhere other than in a pharmacy, the applicants [two pharmacists] cannot give precedence to their religious beliefs and impose them on others as justification for their refusal to sell such products.”¹¹³ In Mexico, despite a 2004 amendment to the Penal Code which forbids conscientious objection in cases where termination of pregnancy is required to safeguard the health or life of a woman, doctors still refused to provide a legal abortion to a 13-year old rape victim on the grounds of conscientious objection.¹¹⁴ *Paulina’s Case* was resolved by way of settlement.

Likely recognizing the inadequacy of the freedom of conscience and religion, advocates for laws which would explicitly permit conscientious refusal in health care argue that “protection of conscience laws” and “conscience clauses” are necessary because “powerful interests are inclined to force health care workers and others to participate directly or indirectly in morally controversial procedures.”¹¹⁵

¹¹² See also Rebecca J. Cook, Monica Arango Olaya and Bernard M. Dickens, “Healthcare responsibilities and conscientious objection” (2009) 104 Intl. J. of Gynecology and Obstetrics 249 for example from Columbia.

¹¹³ *Pichon and Sajous v. France*, Application No. 49853/99 (2 October 2001).

¹¹⁴ *Paulina Ramirez Jacinto v. Mexico*, (2007) Case 161-02. Report No.21/07. The author is grateful to Carlos Iván Fuentes for bringing this case to my attention.

¹¹⁵ Online: Protection of Conscience Project, <www.consciencelaws.org> [PCP]. Accessed on May 23, 2009.

b) Conscience Clauses

Most commonly, conscientious objection may be achieved by way a legal mechanism known as a conscience clause. These conscience clauses afford varying degrees of protection to the objector depending on the drafting and usually permit the objector to refuse to perform a particular duty upon meeting certain requirements. Refusal of service should not be considered a nullification of law but rather a special exemption granted upon demonstration of a sincerely held belief.

In Canada, a conscience clause would convey some sort of legal immunity granted by Parliament, which would exempt individuals from the performance of a mandated activity if certain criteria were met. In some situations, the claimant may be required to state their grounds for objection in order to determine if the statutory conditions are satisfied. In other situations, the conscience clause simply permits a choice between one requirement and another.

Various conscience clauses can be found in existing Canadian law. For example, provincial legislation, which requires school children to be immunized against designated diseases as a matter of public policy, also permits specific exemption on grounds of religious or conscientious refusal.¹¹⁶ In order to invoke this exemption, the parent must file “a statement of conscience or religious belief” with the proper medical officer of health.¹¹⁷ This statement must be in the prescribed form of a sworn affidavit which swears that

¹¹⁶ see e.g. *Immunization of School Pupils Act*, R.S.O. 1990, c. I-1 [*Immunization Act*]

¹¹⁷ *Ibid.*, s. 3(3).

immunization conflicts with the sincerely held convictions of the parent, based on the parent's religion or conscience.¹¹⁸

Oaths and solemn affirmations form another area where conscience clauses have been incorporated into Canadian law. Under the *Canada Evidence Act*, a person called to testify may either take an oath or make a solemn affirmation.¹¹⁹ This conscience clause is rooted in 19th century English statutes intended to ameliorate the common law rule which permitted an affirmation or declaration to substitute for the oath on the grounds of conscientious objection.¹²⁰ Section 14 of the *Evidence Act* was formerly worded as follows:

Where a person called or desiring to give evidence objects, on grounds of conscientious scruples, to take an oath...that person may make the following solemn affirmation.

Jurisprudence under this section required the prospective witness to state their grounds for objection. The Court would then determine if the statutory condition was satisfied.¹²¹ This juridical requirement was removed when the *Evidence Act* was amended in 1994 and a witness may now simply choose to affirm or swear the oath. Unlike the conscience clause for immunization of school children, the claimant is no longer required to state the grounds for his or her choice for the oath or solemn affirmation.¹²²

¹¹⁸ *Ibid.*, s. 1 “statement of conscience or religious belief”.

¹¹⁹ *Canada Evidence Act*, R.S., 1985, c. C-5, ss.14 and 15.

¹²⁰ Stanley Schiff, *Evidence in the Litigation Process* 4th ed. (Toronto: Carswell, 1993) at 225-226.

¹²¹ see e.g., *R. v. Bluske* (1948), 90 C.C.C. 203 (O.C.A.) and *R. v. Dawson*, [1968] 4 C.C.C. 33 (B.C.C.A.)

¹²² see e.g., *R. v. Nitsiza*, 2001 NWTSC 34.

There are a number of reasons why conscience clauses are ill-suited to address the problem of conscientious refusal in health care in Canada. First, in the context of providing a particular medical procedure in Canada, the demand is made by another individual not the state. Second, where rights of individuals are involved in the health care context, it is difficult to identify draft satisfactory statutory criteria to allow for exemptions on grounds of conscience. Finally, various controversial medical procedures are permitted and performed because they are not illegal, not because physicians are required to perform these particular procedures pursuant to a particular statutory decree.

Childress argues that the state should bear the burden of proof for conscientious objection not to be allowed to a particular class of objector. He postulates that the appropriate question for public policy should be: “when should (or may) we force a person to choose between the severe personal sanction of conscience and some legal sanction?”¹²³ Childress further proposes that in the judicial balance, the presumption and burdens of proof should be set in favour of conscientious objection for the following reasons:

[A] state is a better and more desirable one if it puts the presumption in favour of exemption for conscientious objection (not merely to war). It is *prima facie* a moral evil to force a person to act against his conscience although it may often be justified and even necessary. And it is unfair to the conscientious person to give him the alternatives of obedience to the law or criminal classification.¹²⁴

Childress further argues that the state must show compelling interest in denying exemption for conscientious objection:

¹²³ Childress, *supra* note 32 at 329-330.

¹²⁴ *Ibid.*

[T]he point is not that the state must not discriminate against conscience or intend to injure it... but that the state must intend that conscience not be injured even to the extent of assuming some burdens and costs to prevent such injury.¹²⁵

Notwithstanding this onus on the state, where conscientious objector status is provided by a conscience clause, the individual must bear the burden to show proof of sincerity. By this account, when enacting legislation requiring a particular duty or action to be performed, a conscience clause must be incorporated unless the state can justify denying an exemption for those whose obedience of the statutory requirement would create a conflict of conscience. An example outside of the healthcare context would be an exemption from photo identification and verification requirements for women whose faith requires them to cover their face from men other than their husbands. The legal analysis should be first to determine whether conscience has been affected, i.e. the threshold test of sincerity must be met. The burden would then shift to the state to show overriding interest.

In the health care context, the conscience clause under Section 4 of the *Abortion Act* in Britain¹²⁶ provides an interesting example as to the effectiveness, or lack thereof, of this legal mechanism. This example also illustrates why conscience clauses are not easily imported and should not be incorporated in Canadian law in its present form following the decision in *R. v. Morgentaler*.¹²⁷

¹²⁵ *Ibid.*, at 331.

¹²⁶ *Abortion Act*, UK Statutes 1967, ch. 87 (as amended) [*Abortion Act*].

¹²⁷ *R. v. Morgentaler*, [1988] 1 S.C.R. 30 [*Morgentaler*].

Under the *Abortion Act*, two doctors must certify in good faith that one of a number of specified grounds for abortion exist in order to have a legal abortion in Britain. Thus in the Britain, medical professionals are given both an important and morally burdensome role; it is the medical professional who has the key role in determining the legality of an abortion.

Despite the inclusion of a conscience clause in the *Abortion Act*, the case of *Barr v. Matthews*,¹²⁸ is an example of the Court's reluctance to rely solely on the conscience clause and instead turning to common law and ethical principles for guidance. In *Barr v. Matthews*, counsel for the plaintiff presented her case as follows:

The plaintiff's case on liability is simply that when in December 1988 she presented herself in early pregnancy to the defendant GP she sought an abortion, for which she was, by all relevant criteria an eminently proper candidate, under the law. Unknown to the plaintiff, the defendant was philosophically opposed to abortion and unwilling to facilitate one. Without disclosing this, the defendant represented things in such a way as to prevent the plaintiff from obtaining one. The fact and the manner of her doing so were quite improper, and in breach of the duty she owed to her young and vulnerable patient. The consequence was that an unwanted pregnancy, which with proper care would certainly have been terminated, continued and came to a disastrous antepartum haemorrhage, and the birth of a catastrophically brain damaged child.¹²⁹

During the proceedings, the plaintiff and her partner Lee, the child's father, testified that they attended at the doctor's office together and sought termination of the pregnancy. The plaintiff testified that after being notified of the positive pregnancy test:

I knew I wanted a termination... We both wanted a termination. We discussed no alternative to abortion.

¹²⁸ *Barr v. Matthews*, (2000) 52 BMLR 217 (UK) [Barr].

¹²⁹ *Ibid.*, at 220.

[...]

On the occasion I went with Lee to Dr Matthews I was told I was 16 weeks pregnant, and it was too late for a termination to be considered. I was not eligible for a termination. I believe she meant legally eligible. I believe it was because I was 16 weeks pregnant and it was too late for a legal termination. She commented I was a healthy, fit, 23-year-old, and I did not fit the criteria under the Abortion Act. I felt that termination was fast becoming a non option. Dr. Matthews said Dr. Turner¹³⁰ would say the same, and there was no point in seeing him. She said I was not eligible and it was too late.

On the second visit [2 days later] I expressed the desire for an abortion. I had not changed my mind. I was desperate, but knew what I wanted. I was told again that termination was not an option, but that I should consider adoption.

On the evidence presented in the case, the Court found that there might have been a “change of heart” and ultimately held that the defendant had not denied the plaintiff a termination of her pregnancy.

At the time she joined the group practice, the defendant had advised her partners that as part of her Christian belief, she believed abortion to be wrong. She had also agreed to refer patients to one of the other partners for (further) referral for termination. In her testimony, she also stated that she would not advise patients seeking abortion that she disapproved of it.

It is of interest to note that the defendant had disclosed the grounds for her refusal to her partners in the office but not to her patient. In a way, this practice could be seen as

¹³⁰ *Ibid.*, at 219 (Dr. Turner was the plaintiff’s general practitioner. On learning of her pregnancy, the plaintiff had requested to see a female doctor. As aptly noted by the Court, “It was a choice that was to have profound consequences. I have no doubt that, had the plaintiff gone to see Dr. Turner, he would have referred her for termination and termination would have been carried out. Thus would the appalling tragedy of the plaintiff’s antepartum haemorrhage, causing Sam’s severe cerebral palsy, have been avoided.”)

concealing information from patients so that they would not necessarily be able to formulate the requisite informed consent to any treatment plan recommended by the doctor. Personal views of the doctor making a recommendation may be relevant information for patients making decisions about their medical care. Despite finding no liability, the Court suggested that there “remains an anxiety that [the defendant’s] approach may have been coloured by her moral and religious views.”¹³¹ In another light, this practice of not revealing the doctor’s personal beliefs could shield an impressionable patient from the value judgments of someone in a position of authority such that the patient would be able to arrive at her own decision.¹³²

In light of existing jurisprudence,¹³³ the Court ultimately held that it was not necessary to decide whether the defendant’s view was reasonable, namely that patient was not within the criteria set out in the *Abortion Act*, despite the opinions of four experts to the contrary.¹³⁴ Having ignored any argument of ethical complicity of referral, the Court also stated it was of the view that “once a termination of pregnancy is recognized as an option, the doctor invoking the conscientious objection clause should refer the patient to a colleague at once.”¹³⁵ The Court otherwise made no comments as to the application or scope of the conscience clause.

¹³¹ *Ibid.*, at 227.

¹³² Section 12 of the CMA’s *Code of Ethics* sets out a general responsibility to inform the patient when the physician’s personal values may influence the recommendation or practice of any medical procedure that the patient needs or wants.

¹³³ *Bolam v. Friern Hospital Management Committee*, (1957) 1 BMLR 1 and *Bolitho v. City and Hackney Health Authority*, (1992) 13 BMLR 111 (UK).

¹³⁴ *Barr*, *supra* note 125 at 226.

¹³⁵ *Ibid.*, at 227.

The conscience clause in section 4 of the *Abortion Act* was likely included to enable doctors and others ¹³⁶ involved in the treatment of patients to abstain from performing the procedure, barring an emergency situation, as the procedure is both controversial and morally sensitive. Despite the same concerns about the procedure in Canada, a conscience clause cannot be simply transplanted into Canadian law. Unlike in other countries, abortion is not illegal in Canada at any point during pregnancy until the beginning of labour.

In the United Kingdom, the mother's health is paramount and the decision to terminate a pregnancy is rooted in the "right to health" and not any right of self-determination. Under the British legal system, the right to decide is transferred from the woman to the medical professionals who make the decision.

By way of contrast, in the United States, the still controversial decision of *Roe v. Wade*¹³⁷ interpreted any right to abortion as subsumed in the constitutionally-protected right to privacy. By framing abortion as a privacy right, there is no state obligation to fund abortion. Under American law, the legal right to an abortion was initially based upon the various stages of gestation: in the first trimester, it is an absolute right, during the second trimester it may be regulated by a state in order to protect the woman's health and during the third trimester restrictions may be introduced in order to protect the fetus.¹³⁸ This approach

¹³⁶ Nurses are afforded equal protection from prosecution provided the procedure is initiated and overseen by a registered medical practitioner.

¹³⁷ *Roe v. Wade* (1973) 410 U.S. 113 93 S. Ct. 705, 35 L. Ed. 2d 147.

¹³⁸ *Ibid.*

resulted from the balancing of the woman's right to privacy and the state's interest in protecting the fetus, a balance which changes as the pregnancy progresses.

Turning to the Canadian experience, the Supreme Court of Canada struck down the law criminalizing abortions in *R. v. Morgentaler* using a different approach.¹³⁹ Chief Justice Dickson and Lamer J. held that forcing a woman, by threat of criminal sanction to carry a fetus to term unless she meets certain criteria unrelated to her own priorities, is a profound interference with a woman's body and thus a violation of security of the person under section 7 of the *Charter* and that the system of therapeutic abortion committees was contrary to the principles of fundamental justice.¹⁴⁰ The majority concurred giving a variety of legal reasons. All judges, however, agreed that Parliament had the power to pass law governing abortion, provided it complied with *Charter* requirements.

Despite several attempts to legislate, no law has been enacted to address the legality of abortions since *Morgentaler*.¹⁴¹ However, even without formal legal impediment for a woman to have an abortion in Canada, abortion services are not without barriers to access. Beyond the availability of health care providers who are able and willing to perform the procedure, other barriers include the need to travel outside one's community; pro-life physicians who refuse to refer women to those who provide abortion services; lack of

¹³⁹ *Morgentaler*, *supra* note 127.

¹⁴⁰ *Ibid.*, at 56-57 per Dickson C.J., as he then was.

¹⁴¹ To the contrary, the *Access to Abortion Services Act*, R.S.B.C. 1996 c. 1 337/95 prohibits engaging in sidewalk interference, protest, physical interference with or other intimidation or harassment of a service provider, a doctor who provides abortion services or a patient in a designated access zones in British Columbia.

availability of information about abortions services; long waiting periods; hospital gestational limits on abortion services; and pro-life “counseling” centres.¹⁴²

Conscience clauses pose many legislative difficulties. Proponents of conscience clauses have not been able to identify a statutory milieu within which a conscience clause can be included. Conscience clauses are to be incorporated into a statute as a legislative immunity clause permitting “conscientious objectors” to escape the otherwise valid and justifiable demands of positive law. The legal landscape of regulated health care in Canada offers little shelter for a lone conscience clause without specific legislation requiring the performance of a particular procedure.

c) Protection of Conscience Laws

The *Protection of Conscience Project: Preserving freedom of choice – for everyone* (the “Project”) in Canada provides an internet-based resource for “people concerned about the exercise of freedom of conscience in health care”.¹⁴³ The Project’s website lists a number of failed private members’ bills introduced to Parliament which proposed amendments to the Criminal Code, ostensibly to “protect conscience”. None of which has been successfully passed into law in Canada.¹⁴⁴

¹⁴² Report of the Canadian Abortion Rights Action League “Protecting Abortion Rights in Canada” (2003), online: <<http://canadiansforchoice.ca/caralreport.pdf>>.

¹⁴³ *PCP*, *supra* note 115.

¹⁴⁴ *Ibid.*, online: <<http://www.consciencelaws.org/Proposed-Conscience-Laws/Canada/PLCanada01.html>>.

The Project has also prepared a “model statute” entitled “*An Act to Ensure Protection of Conscience in the Provision of Medical Services*” (“PCA”) which is intended to ensure that people are not “forced to facilitate practices or procedures to which they object for reasons of conscience.”¹⁴⁵ According to the website, the PCA was first drafted in 1988 (since updated) as if it were to be incorporated into provincial legislation. Its drafters also suggest that with slight changes, the PCA could be adopted as a federal statute or it could be incorporated into existing legislation.

The website proposes that this type of “protection of conscience law” is a comprehensive piece of legislation to ensure that “people cannot be forced to facilitate practices or procedures to which they object for reasons of conscience” and should further protect against civil liability. The website states that “protection of conscience laws” would prevent people from being forced to participate in medical procedures but does not make them illegal or wrong: “a Protection of Conscience Law need have no impact on the dominant moral outlook concerning procedures to which some people object.”¹⁴⁶

The PCA is drafted to be “procedure based” and over time has been updated to specify more procedures the drafters find to be objectionable. Presently the PCA includes various procedures, which are collectively termed “abortion”, “contraceptive services”, “artificial reproduction”, “genetic testing”, “capital punishment”, “embryonic

¹⁴⁵ *Ibid.*, online: <<http://www.consciencelaws.org/Protection-of-Conscience-Model-Statute.html>>. reproduced and attached as Appendix A to this paper [PCA].

¹⁴⁶ *Ibid.*, online: <<http://www.consciencelaws.org/Examining-Conscience-QA01.html>>.

experimentation”, “embryo transfer”, “eugenetic testing”, “euthanasia”, “human experimentation”, “inter-species breeding” “tissue trafficking” and “torture”. These terms are defined for the purposes of the PCA in Section 2.

Section 3 of the PCA sets out a “general protection” by proposing to make it an offence to compel another person to participate directly or indirectly in the impugned procedures. The section defines participation to include advertising, or involvement in the building, operation, maintenance, service or security of a facility where the activities will take place, involvement in the manufacture, advertising or sale of drugs or instruments intended to be used for the activities, or counselling or education of persons in a manner which indicates that the activities are “morally neutral or acceptable”.

Sections 4 to 6 of the PCA describes possible forms of “intimidation” which would be considered coercive and which could be directed toward a contractor, employee, union member, professional association member, applicant, or healthcare professional.

Section 7 of the PCA incorporates a “Saving” provision which states that the PCA would not apply if the impugned procedures comprise the principal duties of the position for which a person was hired.

Section 8 makes all contracts or agreements contrary to the PCA of no force and effect.

Section 9 and 10 of the PCA indicate that an act of coercion or “intimidation” would be treated as a provincial offence to be tried as a criminal proceeding on the criminal standard of beyond a reasonable doubt. Section 9 sets out three penalty provisions for first, second and subsequent offences; all of which set out liability for imprisonment for 6 months and fines of \$1,000, \$5,000 and \$10,000 respectively. It appears from the staged penalties of strict liability fines for subsequent offences that deterrence is a major focus of the PCA.

According to Section 11 of the PCA, on failure to meet the burden of proof at the criminal level, the Court could then order that the accused pay a stipulated fine to the “victim” if satisfied on the civil balance of probabilities that conscience has been violated. Section 12 of the PCA then provides a mechanism for the “victim” to enforce payment of the judgment through the civil courts.

Section 13 provides for a statutory limitation period.

Finally, Section 14 of the PCA restricts the powers of the courts to make any order where a person asserts reasons of conscience and Section 15 grants immunity from civil liability if conscience is asserted.

Despite a worthy intent, criticisms of the PCA as a “model statute” are numerous. First, as a result of its procedure-based structure, the PCA is arguably not directed to

protection of conscience but rather condemnation of particular procedures. While the interpretative notes of the drafters suggest that using the word “includes” would be broad enough to encompass any future technological developments,¹⁴⁷ by simply providing a laundry list of objectionable procedures, I submit that the PCA lacks the flexibility and adaptability to adequately protect conflicts of conscience as they may arise. In order to address all things the drafters find objectionable as medicine advances, constant amendments would be required. Moreover, by only protecting against forced participation in certain procedures, the PCA adopts a particular moral view.

Second, ironically, the PCA’s approach may lead to and condone intolerance. Blanket immunity from law in any form, including otherwise legally enforceable contracts, judicial orders and civil liability, solely on the grounds of conscience being asserted is overly broad and absurd. There is no indication of any limits to “conscience” in the PCA. The PCA does not provide any criteria by which claims of conscience may be assessed. Would the courts require an objective evaluation of the sincerity and depth of a claimant’s beliefs or would a subjective declaration be enough? The PCA could in fact promote intolerance and discrimination as there is no protection for patients against acts with discriminatory effects where prejudice is rationalised as conscientiously-held beliefs.

Third, the definitions provided for these objectionable services do not accord with accepted common and legal definitions of the procedures and/or recognized standards of

¹⁴⁷ *PCA*, *supra* note 145 at note 2 to the PCA as revised August 31, 2004.

care, e.g. “euthanasia” ignores the well-accepted distinctions between withholding or withdrawal of treatment, assisted suicide and euthanasia.¹⁴⁸ Further, there is no reference to emergency situations, medical necessity or futility.¹⁴⁹

Finally, the relief and the judicial procedures outlined in the PC A display a fundamental misconstruction of the Canadian legal system. Even more disturbing is the ignorance of the jurisdictional divide between civil and criminal courts. There is an incongruity for enforcement of a judgment of a criminal court through the civil courts. Further, criminal courts do not order fines to be paid to victims; fines, unlike restitution, are normally paid to the state. Moreover, the criminal sanction of imprisonment and the “special trial procedure” are unusual and probably inappropriate in that they seek to circumvent the principles of fundamental justice and the customary court procedures of both the criminal and civil courts.

The drafters’ interpretative notes state that the convoluted trial procedure, which would try the accused twice – first, on the criminal standard and then against the civil standard – is intended to “spare the accused, the state and the victim of a separate civil proceedings and provides the accused better protection of his rights than may be had in a

¹⁴⁸ Report of the Special Senate Committee on Euthanasia and Assisted Suicide, *Of Life and Death* (Ottawa: Government of Canada 1995) [*Senate Report*]; see also *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519 at paras. 172-173.

¹⁴⁹ See e.g. *Senate Report*, *ibid.* at 45: “Futility” should be construed narrowly. Thus, a futile treatment must be determined to be “completely ineffective” in the opinion of the health care team.

quasi-judicial tribunal.”¹⁵⁰ Certainly in Canada, criminal courts are never to judge on the lower civil standard.

This paper is strongly against the adoption of the PCA in its present form. Absent legislative immunity in the form of a conscience clause or statute, there is neither explicit guarantee to respect conscientious refusal at law in Canada nor any legislation to protect refusers from the consequences of their action.

Of the “conscience laws”, none really provides a satisfactory answer for supporting a guarantee to respect for acts of conscientious refusal. Freedom of conscience and religion cannot create an enforceable right from a freedom which is limited by the civil rights of others as defined by positive law. Conscience clauses require the state to force objectionable action before seeking an exemption from that particular legal requirement. And “Protection of Conscience Acts” seek an overly broad exemption from all law on grounds of conscience. The subjective nature of conscience make solutions based on “conscience” unwieldy and inscrutable.

This paper suggests that if one accepts that conscientious refusal should be respected, the relief sought by the refusers will be legal protection from coercion and discrimination as a consequence of their refusal. If that is indeed the case, there are already legal mechanisms in place in Canada. First, with the *Charter*, for example Sections 2, 7 and/or 15 may be

¹⁵⁰ *PCA*, *supra* note 144 at Note 18 to the PCA as revised August 31, 2004.

invoked to strike down any law which would compel or coerce action contrary to conscience. However, Section 1 analysis may salvage otherwise impugned legislation. Second, the provinces all have comprehensive human rights regimes to address discrimination in the workplace. Moreover, open and honest communication as well as policy-making at administrative, professional and individual levels would allow for more collaborative and constructive conflict resolution than legal confrontation or judicial intervention. The compound package of rights and freedoms suggested by a claim to conscientious refusal can be protected under the existing legal and policy mechanisms discussed in detail the following chapter.

Chapter Three:

CONSCIENTIOUS REFUSAL, CANADIAN LAW AND POLICY

This chapter considers the scope and limits of conscientious refusal in light of the obligations required by medical ethics, professional responsibilities and the law. In this chapter, the legal principles of human rights, private and public law are also examined to determine their applicability to health care providers in Canada who seek protection from discrimination or coercion where they refuse to treat based on their conscientious or religiously-held beliefs. Discrimination claims have also been made by patients against doctors who have refused to treat in the context of claims before professional boards and civil courts.¹⁵¹ This paper is focused on claims by the providers. Proponents for protection of conscience laws suggest that an “adequate” protection of conscience law should protect objectors from coercive hiring or employment practices, discrimination and other forms of punishment or pressure as well as civil liability.¹⁵²

Civil liability is a matter of harm and should not be the subject of blanket exemptions from liability. Where a person is at fault for doing harm to another, there can be no blanket immunity from civil liability simply because a person says his or her belief system made him or her do it. Any harm brought to be judged before the courts will be judged according to the rigours of law for intentional torts and negligence and assessed against the usual questions of

¹⁵¹ See for example *Korn v. Potter*, (1996), 134 D.L.R. (4th) 437 (B.C.S.C.).

¹⁵² Online: Canadian Physicians for Life,
<<http://www.physiciansforlife.ca/html/conscience/articles/conscienceproject.html>>.

causation and remoteness and the legal defences of contributory negligence, *volenti non fit injuria*, etc. As discussed in Chapter One, conscientious action implies both thoughtful consideration and that the action will be taken only after having considered the consequences of the action. This paper will not address general protection from civil liability in detail for so-called conscientious objectors who have intentionally harmed or abandoned their patient *with* regard for the consequences. Legitimate conscientious refusal is an action which would protect one's own conscience but would not require others to conduct their lives according to those beliefs. There must be neither paternalistic motivation nor discriminatory overtone to the action of refusal for any such right to be protected.

This paper argues that the remaining goals sought through a "protection of conscience law" are adequately met by existing Canadian law and will also suggest and prefer other mechanisms for avoiding or resolving conflicts of conscience in the provision of health care services. There are designated roles for the state, the profession and the individual in this argument. To support this argument, this portion of the paper will review existing Canadian laws which protect the autonomy of the individual and the laws that protect against discrimination in the employment context.

This chapter will consider alternative techniques and models for resolving conflicts of conscience at the earliest stages of treatment to alleviate conflicts of conscience in the most controversial areas of health care. There are few reported cases on conscientious refusal in Canada and elsewhere because most cases likely settle out of court. This paper suggests that

the use of the adversarial forum of courts and tribunals is harmful to the fiduciary relationship between health care provider and patient. Therefore, most importantly, this paper also suggests that conflict avoidance and/or resolution should be actively sought through honest and open communication between individual health care providers and their patients and prospective patients at the earliest opportunity. These techniques will include a greater role for the state, health care institutions and professional bodies, and require government and administrative intervention through education programs, professional regulation and policy changes in order to establish systems for referral at an institutional rather than individual level, and private and collective employment contractual arrangements.

a) The scope and limits of conscientious refusal

The scope and limits of conscientious refusal exist in a complicated web of competing obligations to self, medical ethics, professional responsibilities and the law. Cook *et al* declare that the law usually requires patient-directed care – “in accordance with their own conscientious preferences among lawful options”¹⁵³

According to Savulescu, when conscientious objection compromises the quality, efficiency or equitable delivery of medical care it should not be tolerated; public servants must act in the public interest “not their own”.¹⁵⁴ Savulescu argues that “value-driven medicine” would allow doctors to compromise the delivery of medical care to patients on

¹⁵³ Rebecca J. Cook, Bernard M. Dickens and Mahmood F. Fathalla, *Reproductive Health and Human rights: Integrating medicine, ethics and law*. (Oxford: Clarendon Press, 2003) at 89. [Cook *et al*].

¹⁵⁴ Savulescu, *supra* note 3 at 297.

conscientious grounds would open the door to “Pandora’s box of idiosyncratic, bigoted, discriminatory medicine.”¹⁵⁵

Wicclair submits that medicine as a profession is a “moral enterprise” and thus “appeals to conscience” are morally justified only if the core ethical values of the objection correspond to core medical values.¹⁵⁶ Wicclair also suggests that this position is not as invasive or burdensome as it sounds because he assumes “appeals to conscience” in medicine will likely be based on values such as life and health.¹⁵⁷ While Wicclair ultimately supports conscientious refusal in medicine, “institutional efficiency, patient autonomy, dignity and wellbeing” are all listed as limiting values and interests as they too may carry “substantial moral weight”.¹⁵⁸

Wicclair proposes five guidelines to help identify relevant considerations for whether a physician is justified in refusing to treat and assessing the validity of conscientious refusal on a case by case basis. These guidelines are summarized below:

- 1) moral weight of the claim of conscience for the physician, i.e. how central is the belief to the physician’s core ethical values?
- 2) moral weight for the medical profession, i.e. is there a departure from recognized professional norms?

¹⁵⁵ *Ibid.*

¹⁵⁶ M.R. Wicclair, “Conscientious Objection in Medicine. (2000) 14 *Bioethics* 216 [Wicclair]; see also Edmund D. Pellegrino and David C. Thomasma, “*The Virtues in Medical Practice*” (New York: Oxford University Press, 1993)

¹⁵⁷ *Ibid.*, at 217.

¹⁵⁸ *Ibid.*, at 218.

- 3) moral weight when considered in terms of the physician's conception of herself as an ethical physician;
- 4) accommodation of patients' rights and interests wherever possible; and
- 5) moral weight of the competing values and interests.¹⁵⁹

Despite efforts of academics in this field to identify various limits to the exercise of conscientious refusal, there is little comprehensive and principled analysis offered on this point. There appears to be more or less a consensus that emergency situations must be considered separately and that in general, the exercise of conscientious refusal must be assessed on a case-by-case basis. Overall, the guiding principle should remain the health of the patient.¹⁶⁰ Here, "health" is understood to be a state of physical mental and social well-being.¹⁶¹ Otherwise, a few basic guidelines may be gleaned from the literature on this topic. I will group these guidelines in the following broad categories: first, the level of involvement in care and treatment and second, the nature and basis for the refusal.

i) Level of involvement in care and treatment

Commentators and courts have been clear: the right to conscientious refusal is to be narrowly interpreted. Thus far, direct participation is required for justification of conscientious refusal. Cook *et al* list examples of unjustifiable refusals such as hospital staff

¹⁵⁹ *Ibid.*, at 218-227.

¹⁶⁰ World Medical Association *International Code of Medical Ethics*, online: <<http://www.wma.net/e/policy/c8.htm>>.

¹⁶¹ The World Health Organization's definition of "health" as per *Dickens and Cook*, *infra* note 164 at 73.

refusing to prepare operating rooms and patient care rooms, or refusing to book appointments and deliver meals.¹⁶² Further, in the case of *Janaway v. Salford Area Health Authority*, the House of Lords in the United Kingdom found the requested activity too remote to constitute participation and held that a medical secretary had no right to refuse to type an abortion referral letter.¹⁶³

Second, conscience and the freedom to manifest that conscience outwardly, as discussed in this paper, are unique to the individual. For this reason, only individuals may invoke conscientious refusal, not institutions. Where a health care service is lawful, medically indicated, and publicly funded, there is an institutional duty to provide or refer, except in the case of legislative exemption for a religiously-based hospital or other health care facility. With the same exception for legislative exemption, Dickens and Cook insist that “non-objectors” must also be protected from discrimination and afforded equal employment opportunity.¹⁶⁴

Third, as suggested by Cook *et al*, except in a medical emergency, the fiduciary relationship and corresponding obligations to existing patients as opposed to prospective patients may differ. Cook *et al* maintain that there is a duty to refer an existing patient, failing which, legal negligence or abandonment would result. However, as toward prospective patients, Cook *et al* also suggest that declining to accept the patient is sufficient

¹⁶² Cook *et al*, *supra* note 153 at 140.

¹⁶³ *Janaway v. Salford Area Health Authority*, [1989] AC 437 (HL) as cited *ibid.*, at 140, note 69.

¹⁶⁴ Bernard M. Dickens and Rebecca J. Cook, “The scope and limits of conscientious objection” *Intl. J. of Gynecology & Obstetrics* 71 (2000) 71 at 76-77 [*Dickens and Cook*].

and there is no duty to refer; “not every person has a legal right to become a patient of a chosen or accessible provider”.¹⁶⁵

ii) Nature of and motivation for refusal

As discussed in Chapter Two, the legal burden for any outward manifestation of conscience or religion is proof of sincerity and good faith which is to be proved by the claimant. A solemn declaration may adequately discharge this burden.¹⁶⁶

In this paper, I suggest the basic limitations to conscientious refusal can be rooted in the nature of the refusal and specifically, the motivation or belief that gives rise to the refusal. I argue that legitimate conscientious refusal is an action which would protect one's own conscience but would not require others to conduct their lives according to those beliefs. There must be neither paternalistic motivation nor discriminatory overtone to the action of refusal for any such right to be protected. Where the refusal is based on self-preservation and protection of conscience, it must be directed toward the procedure itself. The exceptions being as follows: first, there can be no right to refuse in an emergency and second, there can be no right to refuse where it puts patients' health at risk.

As a corollary to this proposition, there can be no right of refusal based on the class of patients and not the procedure. To refuse patients where the patient is a member of an enumerated or analogous class of person, as opposed to refusing to perform a particular type

¹⁶⁵ *Cook et al, supra* note 153 at 141.

¹⁶⁶ *Ibid.*, at 140.

of procedure, is discrimination under the law. To refuse patients based on particular personal attributes of the patient or a paternalistic motive, even where the patient is not an enumerated or analogous class of person under human rights law, is still tantamount to discrimination and no more justifiable. Patients are not required to conduct their lives in accordance with the beliefs of their doctors.

Discrimination would occur in situations where the reason for “conscientious refusal” to perform a requested procedure is based on the class of patients receiving the treatment, where the patient is a member of an enumerated class under discrimination laws, as opposed to the performance of the procedure itself. For example, in *Benitez v. North Coast Women’s Care Medical Group, Inc.*,¹⁶⁷ the plaintiff received infertility treatments for approximately one year before her doctors at the North Coast Women’s Care Medical Group refused to continue treatments because of her sexual orientation. According to the plaintiff, her health care providers informed her that they had religious-based objections which compelled them to refuse to assist homosexuals in conceiving children by artificial insemination. The doctors also refused to authorize a refill of her prescription for fertility drugs on the same grounds.¹⁶⁸ Prior to revealing her sexual orientation, the doctors did not object to providing the treatment.

¹⁶⁷ *Benitez v. North Coast Women’s Care Medical Group, Inc.*, (2003) 106 Cal. App. 4th 978 [Benitez].

¹⁶⁸ Jacob M. Appel, “May Doctors Refuse Infertility Treatments to Gay Patients?” (2006) 36: 4 Hastings Centre Report 20 [Appel].

Similarly, despite claims of conscience, for example in *Korn v. Potter*,¹⁶⁹ Canadian Courts have also found discrimination where the reason for refusal of treatment is based on certain characteristics of the patient rather than an objection to the procedure itself.

Claims of conscience motivated by paternalistic or “equivalent to discrimination” beliefs are no more defensible. I am using “equivalent to discrimination” to refer to situations where refusal is based on the personal characteristics of the patient suggesting prejudices but where the patient may not belong to an enumerated or analogous class.

There may also be areas of treatment which may be less clearly discrimination. For example, denial of a procedure based on a difference of medical opinion, such as refusing to provide an aggressive experimental treatment to a weak and elderly patient is one such grey area. Determinations of counter-indicated treatment or medical futility may require more than one opinion in practice and by law.

Setting his argument against the backdrop of the SARS epidemic, Dr. E.C. Hui, a professor of Medical Ethics & Director, Medical Ethics Unit, Faculty of Medicine, University of Hong Kong and Consultant in Clinical Ethics, Hong Kong Hospital Authority, argues that with the health care provider-patient relationship, the medical profession demands a moral obligation of self-sacrifice to serve their patients’ best interests.¹⁷⁰ Professor Hui

¹⁶⁹ *Korn v. Potter*, *supra* note 151.

¹⁷⁰ E.C. Hui, “Doctors as fiduciaries: do medical professionals have the right not to treat?” (2005) 3 *Poiesis Praxis* 256.

argues that this pledge of fidelity to the patient and society as a whole is required for membership in the profession and serves as the central obligation of the medical profession. This type of situation is not technically a conflict of conscience. However, where the source and motivation of the conscientiously held belief may be unclear, Professor Hui's comments about a growing acknowledgment of a legal fiduciary relationship in common law jurisdictions¹⁷¹ remain applicable to the legal and professional obligations. Professor Hui argues that the recognition of this fiduciary relationship may be used to enforce the duty of fidelity where tort or contractual principles may not reach.¹⁷²

Any preventable compromise to health of the patient is contrary to the basic tenets of the medical professions and therefore unacceptable. Failure to provide care in an emergency would be an unjustified use of conscience. Dickens and Cook suggest that performing the procedure even though it may be contrary to the general dictates of a particular faith may be defensible under the Roman Catholic principle of "Double Effect".¹⁷³ The doctrine of double effect permits action where harm may be caused by a "good" act. There are four conditions for the principle of double effect to apply: the act must be itself morally good or neutral; the actor permits the bad effect but does not will it (i.e. if the good could be attained without the bad, he should act accordingly); the good must flow directly from the action itself

¹⁷¹ *Ibid.* referring to the Canadian examples of *McInerney v. MacDonald*, [1992] 2 S.C.R. 138 and *Norberg v. Wynrib*, [1992] 2 S.C.R. 226 among others.

¹⁷² *Ibid.*, at 269-271.

¹⁷³ *Dickens and Cook*, *supra* note 161 at 72.

not as a result of the bad effect; and the good must outweigh the bad.¹⁷⁴ Relying on Boyle's work explaining double effect,¹⁷⁵ Dickens and Cook posit that where the secondary effect and the reasons are proper and the procedure is legitimate, conscience would not object, e.g. to ending an ectopic pregnancy or removing a cancerous testicle where a life could be saved.¹⁷⁶

The question of access is also an important limiting factor in the assessment of whether an exercise of conscientious refusal can be justified. For example, in rural areas or developing countries, failure to perform a particular procedure such as abortion in a timely fashion, could endanger women's health and lives.¹⁷⁷ Thus, the debate over acceptable limits for conscientious refusal is also influenced by available health care facilities and their capabilities and must be reviewed on a case-by-case basis.

Savulescu argues that the limited right of conscientious refusal must never compromise the "quality, efficiency or equitable delivery"¹⁷⁸ of health care services and must conform to the primary goal of medical care which is to provide for the health of its recipient under the broadest interpretation of "health". In this paper it is argued that while health care

¹⁷⁴ Adapted from F.J. Connell "Double Effect, Principle of," *New Catholic Encyclopedia* (Volume 4), (New York: McGraw-Hill, 1967) at p. 1021 as cited in the *Stanford Encyclopedia of Philosophy*. Online: <<http://plato.stanford.edu/entries/double-effect>> accessed on July 23, 2009.

¹⁷⁵ J.M. Boyle, "Toward understanding the principle of double effect" (1980) 90 *Ethics* 527, as cited in *Dickens and Cook, supra* note 161.

¹⁷⁶ *Dickens and Cook supra* note 164 at 72.

¹⁷⁷ See discussion of the South African experience in Louis-Jacques Van Bogaert, "The Limits of Conscientious objection to abortion in the developing world" (2002) 2:2 *Developing World Bioethics* 131.

¹⁷⁸ *Savulescu, supra* note 3 at 296.

must provide for the health of its recipient under the broadest interpretation of health, in Canada, health care is a system and one that is currently of state responsibility. Therefore, the burden of resolving conflicts of conscience is not to be shouldered entirely by the individual provider who feels as if he or she must refuse.

b) Human dignity and the right to autonomy

In the balancing of rights in the health care context, when a patient requests a legally permissible medical procedure or treatment, that patient seeks to exercise his or her autonomy over his or her own body in such a way that neither the state nor anyone else may unjustifiably interfere. When a health care provider refuses to perform a legal and medically-indicated procedure despite being an accepted standard of care, he or she too seeks to exercise autonomy over his or her body and the actions it would perform.

This right to autonomy is also encompassed in and forms the basic theory underlying the *Charter*. In *Morgentaler*, Wilson J. opined:

[T]he basic theory underlying the *Charter* [is] that the state will respect choices made by individuals and, to the greatest extent possible, will avoid subordinating these choices to any one conception of the good life.¹⁷⁹

As a powerful argument in support of conscientious refusal based on dignity and autonomy as well as the legal mechanism for enforcing those rights, it is particularly relevant in view of growing secularization and de-emphasis on a particular conception of “the good life”. As

¹⁷⁹ *Morgentaler*, *supra* note 127 at 166.

suggested by one commentary, the emphasis on individual autonomy “may require further elaboration in other contexts, but it is a convincing way to justify the expansion of freedom of religion in a relatively secular age.”¹⁸⁰

In his article on religion, politics and law in Canada, Professor von Heyking is critical of the notion of “individual autonomy” and argues that it reduces religion to an arbitrary choice and ignores its communal and social dimension of religion.¹⁸¹ However, the point in this paper is that conscience and religion are given equal deference at law such that individual conscience or the collective nature of religion is not a critical distinction in understanding “freedom of conscience and religion”. Whatever legal guarantees are recognized for respecting conscientious refusal will belong to an individual on a case-by-case basis. Conscience, as it is conceived of in this paper, is individual. The justification for its protection is rooted in the need to recognize and respect human worth and dignity. An individual’s conscience may be informed by collectively-held beliefs, such as religious dogma, but the source of the conscientiously-held belief is irrelevant. This equal weight and worthiness is emphasized in the comments of Wilson J. in *Morgentaler*:

It seems to me, therefore, that in a free and democratic society "freedom of conscience and religion" should be broadly construed to extend to conscientiously-held beliefs, whether grounded in religion or in a secular morality. In deed, as a matter of statutory interpretation, "conscience" and "religion" should not be treated as tautologous if capable of independent, although related, meaning.¹⁸²

¹⁸⁰ W. Black. “Religion and the Right of Equality” in AF. Bayefsky and M. Eberts, eds. *Equality Rights and the Canadian Charter of Rights and Freedoms* (Toronto: Carswell, 1985) at 178, as cited in J. von Heyking, “The Harmonization of Heaven and Earth?: Religion, Politics, and Law in Canada” (2000) 33 U.B.C. L. Rev 663 [von Heyking].

¹⁸¹ von Heyking, *ibid.*, at 665.

¹⁸² *Morgentaler*, *supra* note 127 at 179.

For patients, autonomy as a legal right has been recognized by Canadian Courts. In the Ontario Court of Appeal's decision in *Malette v. Shulman*, the Court affirmed that the rights to self-determination and bodily integrity are controlling values in our society and declared as follows:

The right to determine what shall be done with one's own body is a fundamental right in our society. The concepts inherent in this right are the bedrock upon which the principles of self-determination and individual autonomy are based.¹⁸³

Thus, a physician who knew that an unconscious patient carried a Jehovah's Witness card would not consent to a blood transfusion was liable for battery for administering a transfusion. The decision of the Ontario Court of Appeal in *Fleming v. Reid* also held that bodily integrity and personal autonomy were principles "entrenched in the traditions of our law to be ranked as fundamental and deserving of the *highest order of protection*."¹⁸⁴ [emphasis added]

The argument for autonomy can be made with equal applicability to both patient and health care provider in the context of conscientious refusal as both are deserving of respect for their inherent human worth and dignity. According to Professor Sossin at the University of Toronto, personal autonomy is one of six legal settings for discussions of human dignity by the Canadian judiciary. The others are psychological integrity, physical security, privacy,

¹⁸³ *Malette v. Shulman*, (1990), 72 O.R. (2d) 417 at para. 41.

¹⁸⁴ *Fleming v. Reid* (1991), 4 O.R. (3d) 74.

professional reputation, and personal affiliation or group identity.¹⁸⁵ Given dignity and autonomy's paramount importance as fundamental principles in our law, I submit that this is a more powerful legal argument in support of a right of conscientious refusal than freedom of conscience and religion.

It is worth noting that the legal argument for protecting autonomy in this paper is slightly different from the ethical justifications for the recognition of conscientious objection in medicine. Wicclair explored the ethical justifications for the recognition of conscientious objection which he identified as ethical relativism, toleration of moral diversity, respect for autonomy and respect for moral integrity.¹⁸⁶ Wicclair considered four justifications as arguments for the recognition of conscientious objection in medicine.¹⁸⁷ Wicclair preferred justification of conscientious objection in medicine under the heading of "respect for moral integrity"¹⁸⁸ and argued that "respect for autonomy,"¹⁸⁹ is too broad and does not provide a moral defence.¹⁹⁰

This paper begins with a presumption that protection of conscience is generally justified. I also argue that protection for autonomy is required for both patient and refuser as all individuals are entitled to the same legal rights in Canadian law. Thus, autonomy cannot

¹⁸⁵ Lorne Sossin, The "supremacy of God", Human Dignity and the *Charter of Rights and Freedoms*" Draft Paper: February 2, 2003. online:

<www.law.utoronto.ca/documents/Sossin/supremacyofgod.doc>

¹⁸⁶ Wicclair, *supra* note 156 at 205-227.

¹⁸⁷ *Ibid.*, at 210-217.

¹⁸⁸ *Ibid.*, at 216

¹⁸⁹ J.F. Daar. "A Clash at the Bedside: Patient Autonomy v. A Physician's Professional Conscience" (1993) 44 *Hastings Law Journal* 1241 as cited in Wicclair, *ibid.*

¹⁹⁰ Wicclair, *supra* note 156 at 212

yield a legal solution to conflicts of conscience. While autonomy may be an important legal argument in support of acts of conscientious refusal in health care, unfortunately, arguments based on the notion of autonomy also result in theoretical deadlock. In a factual vacuum, the autonomy of one cannot be preferred over the autonomy of another.

The only legitimate claims a health care provider may seek for him or herself in a clash of conscience is non-participation and protection from the coercion or discrimination which may result as consequences of that choice. These objectives can be achieved using legal and policy means without requiring society to favour the autonomy of one over the other. Moral integrity is left as a matter which is personal to the individual to “be true to one’s self”. Neither the state nor the courts can offer protection for moral integrity but only the environment for the individual to try to maintain it. No health care provider may have the right to dictate life choices for the patient. Equally, the only legitimate claim for the patient seeking treatment would be to have the legally permissible and medically-indicated procedure performed. Neither the patient nor an employer nor the state can compel another to participate, save and except in an emergency situation.

c) Non-discrimination and reasonable accommodation in employment law

A practical and more productive solution to resolving claims of autonomy between individuals would be to look to the relief sought by the parties: non-discrimination. Non-participation by conscientious refusers can be a simple action but it is not without consequences. The practical request made by refusers seeking respect for their decision not

to participate in a particular procedure would be protection from the consequences of the refusal to participate. Thus for health care providers who refuse to provide legally permissible and medically indicated health care services in Canada, the consequences of non-participation are usually manifest as a claim for non-discrimination in one of the following situations: the employment context, as a professional regulation issue, or as a matter of civil liability.

The employment context creates situations of legal control by the employer over an employee.¹⁹¹ In his article “*Freedom of Conscience, Employee Prerogatives, and Consumer Choice: Veal, Birth Control and Tanning Beds*”, Dieterle examines whether an employee can justifiably refuse one of the duties of his or her job and expect to remain employed in the United States.¹⁹² Through an examination of ten case studies in various employment settings, Dieterle proposes four principles which I have summarized in a matrix below (Figure 1):

	Essential Duties	“Extra” Duties
No conflict with others’ rights	Just cause	Justified refusal
Conflict with others’ rights	Just cause	Just cause

¹⁹¹ 671122 *Ontario Ltd. v. Sagaz Industries Canada Inc.*, 2001 SCC 59, [2001] 2 S.C.R. 983.

¹⁹² J.M. Dieterle, “Freedom of Conscience, Employee Prerogatives, and Consumer Choice: Veal, Birth Control and Tanning Beds” (2008) 77:2 *Journal of Business Ethics*, published online (22 Feb 2007): <www.springerlink.com>.

Figure 1 above is a simplification of Dieterle's first level analysis. Dieterle considers there to be just cause for termination where the duty being refused is an essential part of the job or where there is any interference with another's rights. Using the ten case examples, he notes that differences between the businesses themselves may affect the analysis of the legitimacy of the employees' refusals, i.e. whether the business is a public institution, non-profit organization, retail establishment, service industry open to the public or a private firm that contracts for services with other companies. In businesses directed to the public, Dieterle notes that conscientious refusal is not justified where motivated by paternalism or discrimination. The employee's position and level of authority as well as the number of other staff can also factor into the analysis.

In Canada, provincial human rights legislation creates a legal duty on an employer to accommodate varying beliefs of conscience and religion in our diverse society. This requirement overlays an additional dimension to the above matrix: the requirement for reasonable accommodation. While labour legislation may include exemptions, generally the courts and tribunals require an employer to reasonably accommodate the extent to which employees may express their religious belief in the performance of their employment duties.

The seminal case of *British Columbia (Public Service Employee Relations Commission) v. British Columbia Government and Service Employees' Union (B.C.G.S.E.U.)*

(*Meiorin Grievance*)¹⁹³ reformulates¹⁹⁴ the analysis for reasonable accommodation under human rights legislation. Where an employee first establishes a *prima facie* claim of discrimination, employers are required to justify their standards.

In *Meiorin*, the Supreme Court of Canada formulated a three-step test for determining whether an employer has established on the balance of probabilities that a *prima facie* discriminatory standard is a *bona fide* occupational requirement:

- 1) the employer must show that it adopted the standard for a purpose rationally connected to the performance of the job;
- 2) the employer must establish that it adopted the particular standard in an honest and good faith belief that it was necessary to the fulfillment of that legitimate work-related purpose; and
- 3) the employer must establish that the standard is reasonably necessary to the accomplishment of that legitimate work-related purpose.

The onus is clearly placed on the employer to demonstrate that it is impossible to accommodate individual employees sharing the characteristics of the claimant without

¹⁹³ *British Columbia (Public Service Employee Relations Commission) v. British Columbia Government and Service Employees' Union (B.C.G.S.E.U.) (Meiorin Grievance)*, [1999] 3 S.C.R. 3 [*Meiorin*].

¹⁹⁴ Prior to *Meiorin*, the “conventional approach” to applying human rights legislation in the workplace required a tribunal to decide whether the case was either “direct discrimination” or “adverse effect discrimination”. This “conventional approach” was found in the case of *Ontario Human Rights Commission and O'Malley v. Simpson-Sears Ltd.*, [1985] 2 S.C.R. 536. In *Meiorin* at para. 27, the Supreme Court held that it was unnecessary to maintain the distinction between “a standard that is discriminatory on its face and a neutral standard that is discriminatory in its effect ... [because] there are few cases that can be so neatly characterized.”

imposing undue hardship on the employer. Useful considerations for the analysis include examination of any accommodation procedures which were adopted, and the content of either a more accommodating standard which was offered, or alternatively, the employer's reasons for not offering any such standard.

In the case of *Jones v. CHE Pharmacy*,¹⁹⁵ the Tribunal found that the complainant had been wrongly dismissed for refusing to put up Christmas decorations at a Shoppers Drug Mart store in Victoria, British Columbia, where he worked. As a Jehovah's Witness, the complainant argued that decorating or participating in activities relating to the celebration of Christmas was contrary to his faith. The argument before the tribunal was that by requiring him to put up Christmas decorations, the *British Columbia Human Rights Code*¹⁹⁶ and the duty to accommodate had been contravened. Subsections 13(1) and 13(4) of the *BCHRC* stipulate as follows:

13(1) A person must not

- (a) refuse to employ or refuse to continue to employ a person, or
- (b) discriminate against a person regarding employment or a term or condition

because of the race, colour, ancestry, place of origin, political belief, religion, marital status, family status, physical or mental disability, sex, sexual orientation or age of that person or because that person has been convicted of a criminal or summary conviction offence that is unrelated to the employment or to the intended employment of that person.

[...]

(4) Subsections (1) and (2) do not apply with respect to a refusal, limitation, specification or preference based on a bona fide occupational requirement.

¹⁹⁵ *Jones v. CHE Pharmacy* (2001), 29 C.H.R.R./93 (B.C.H.R.T.) [*Jones*].

¹⁹⁶ *British Columbia Human Rights Code*, R.S.B.C. 1996, c. 210 [*BCHRC*].

The evidence at the hearing was that members of Jehovah's Witnesses "do not object to others celebrating Christmas nor do they try to hinder them" ¹⁹⁷ but that "engaging in conduct that is contrary to a Jehovah's Witness' trained conscience would be inconsistent with the faith." ¹⁹⁸

The complainant suggested that being forced to participate in Christmas celebrations may have repercussions for his place in the community:

If one of the Jehovah's Witnesses celebrated Christmas, the congregation would be concerned because it might indicate that the individual no longer wanted to share the beliefs of the Jehovah's Witnesses. The elders would discuss the matter with the individual. If the elders concluded that the individual no longer shared the beliefs of the organization, it would be a serious concern, which could lead to "disfellowship" or excommunication. ¹⁹⁹

However, significantly, the Presiding Overseer of Jones' congregation of Jehovah's Witnesses at the relevant time, also testified that conscience is a personal matter:

... Jehovah's Witnesses do not have any regulations about handling Christmas as merchandise; rather, it is *a matter of personal conscience*. One person's conscience may differ from another's. In making a decision about handling such merchandise it is important for Jehovah's Witnesses to live by their conscience, to consider the effect of their action on other Jehovah's Witnesses who might observe it, and to be mindful of their relationship to God. If a merchandiser were to feel guilt because the stocking of Christmas merchandise is contrary to their "Bible-trained conscience", then it would be wrong to stock such merchandise. ²⁰⁰
[emphasis added]

¹⁹⁷ Jones, *supra* note 195 at para. 7.

¹⁹⁸ *Ibid.*, at para. 26.

¹⁹⁹ *Ibid.*, at para. 8.

²⁰⁰ *Ibid.*, at para. 14.

This interpretation of conscience as a personal, subjective matter, which is not held to any objective, community standard, is consistent with the general understanding of conscience in Canadian law.

The early case of *Moore v. B.C. Ministry of Social Services*²⁰¹ is a pre-*Meiorin* example of reasonable accommodation in conscientious refusal. While Moore was not a health care provider, this case and its findings are directly applicable to the subject matter of this paper.

Moore was a financial aid worker for the BC Ministry of Social Services. As a devout Catholic, she declined to authorize medical coverage to a client for an abortion. Despite instructions from her direct supervisor to authorize the award in accordance with the Ministry's regulations and guidelines, she refused on the grounds of her religious belief.

In finding that there was clearly discrimination based on her religion, the British Columbia Council of Human Rights reinstated Moore and required accommodation in her placement. Without concrete evidence of undue hardship, the Council did not accept the Ministry's argument that it would have been detrimental to service delivery if Moore were to be exempted from cases involving abortions, sterilization, contraception, etc.

²⁰¹ *Moore v. B.C. Ministry of Social Services* (1992), 17 C.H.R.R. D/426 (B.C.H.R.C) [*Moore*].

While no attempts had been made to accommodate Moore, the Council also found that Moore had failed to fulfill her duty as a public servant, which was to provide services to the public without discrimination. As such she also bore some responsibility for having accepted the client's file and the award was divided in half.

With reasonable accommodation, there is an obligation for both sides to work together to find an acceptable employment arrangement. In *Central Okanagan School District v. Renaud*, the Court explained as follows:

When an employer has initiated a proposal that is reasonable and would, if implemented, fulfill the duty to accommodate, the complainant has a duty to facilitate the implementation of the proposal. If failure to take reasonable steps on the part of the complainant causes the proposal to founder, the complaint will be dismissed.²⁰²

Together these cases demonstrate that there is a significant legal requirement on employers to accommodate their employees' beliefs but also that an employee holding beliefs which may pose conflicts of conscience also has an obligation to disclose and to work cooperatively with the employer to find a reasonable employment arrangement.

Where an employee makes a request for religious accommodation, the law on the duty to accommodate in Canada may be summarized as follows:

- the employer is obligated to accommodate save and except in the event undue hardship;
- undue hardship to the employer must be proven;

²⁰² *Central Okanagan School District v. Renaud*, [1992] 2 S.C.R. 970.

- religious beliefs may include established doctrine and personal belief;
- accommodation may modify a rule or exempt an employee from compliance but there will be no protection in cases of refusal where an employee refuses to perform a *bona fide* occupational requirement; and,
- as with the law of freedom of conscience and religion, the onus is on the claimant to demonstrate sincere belief to well-known or established practice or religious requirement.

Existing Canadian provincial human rights codes prohibit against discrimination for beliefs. Further, these laws require reasonable accommodation in the employment context. Where conscientiously held beliefs may interfere with the performance of employment duties, this existing and comprehensive legal regime can adequately and appropriately address conscientious refusal in employment situations where the primary concern is coercion or discrimination. On a practical note, likely the most constructive approach would be to encourage open and honest communication with an employer to establish boundaries. In addition, an employee should advise of any requests for accommodation as soon as practicable.

d) Avoiding conscientious refusal

Where conscientiously difficult situations are central to the position's duties, non-participation or voluntary exclusion (or "mutual accommodation") are simple solutions to

perceived conflicts of conscience.²⁰³ Similarly, Davis argues that doctors have “a right to quit” (either the profession, or to repeal all or part of the relationship with a patient) which supports a qualified right to conscientious refusal.²⁰⁴ The qualifications to a right to conscientious refusal stem from what he calls “a restitution approach” to conscientious refusal: the refusal must not make the patient worse off than had he or she never gone to that doctor in the first place. With this restitution approach, the tort of abandonment is not at issue.

Referral appears to be another simple solution to avoiding conflicts of conscience. However, this “indirect participation” or facilitation of an impugned procedure is very controversial. Professors Rodgers and Downie once declared that while physicians are not required to perform abortions except in emergency circumstances, where a health care professional fails to provide appropriate referrals or otherwise prevents women from accessing abortions (through misinformation or punitive treatment based on their personal beliefs), he or she would be guilty of malpractice and would be in breach of the CMA’s *Code of Ethics*.²⁰⁵

²⁰³ Cook *et al*, *supra* note 153 at 214; see also Dickens and Cook, *supra* note 164. In “The Growing Abuse of Conscientious Objection” op-ed, (2006) 8:5 Virtual Mentor: Ethics Journal of the American Medical Association 337, Dickens and Cook also use the term “mutual accommodation” to address the withdrawal or avoidance of conflicts of conscience.

²⁰⁴ Davis, *supra* note 72.

²⁰⁵ Sanda Rodgers and Jocelyn Downie, Guest Editorial: “Abortion: ensuring access” (2006) 175:1 Can. Med. Assoc. J. 9. Online: Canadian Medical Association Journal (“CMAJ”) <<http://www.cmaj.cacgi/content/full175/1/9>>.

Letters to the editor in response to this article adamantly proclaimed that there is no duty to refer.²⁰⁶ Among these responses was a “clarification of CMA Policy” letter from Jeff Blackmer, Executive Director of Ethics, CMA (February 19, 2007),²⁰⁷ which confirmed that the CMA’s policy requires doctors to inform a patient of the reason for refusal but does not require referral itself.²⁰⁸

Whether referral amounts to indirect participation or the failure to refer violates the fiduciary duty to the patient will continue to be controversial. I propose that the following alternative techniques and models may be constructive approaches to resolving conflicts of conscience at the earliest stages of treatment and may avoid the perceived necessity for conscientious refusal.

At an institutional level, government, professional associations and institutional administrators of health care have the following duties: first, the duty to facilitate access and second, the duty to educate and provide information.

“Access” refers to access to health care services, which includes legally permissible and medically indicated procedures, even if controversial. “Access” also refers to access to

²⁰⁶ *Ibid.*, see also Will Johnston, Letter to the Editor of the CMAJ, dated July 11, 2006. Online: Canadian Physicians for Life, <www.physiciansforlife.ca/html/conscience/articles/CPLPresidentResponds.html> and Statement by the Calgary Christian Medical Society, <www.physiciansforlife.ca/html/conscience/articles/duty.html>.

²⁰⁷ *Ibid.*, <<http://www.cmaj.ca/cgi/eletters/176/4/4942/20/2007>>.

²⁰⁸ Canadian Medical Association, *Policy on Induced Abortion*. Online: <<http://policybase.cma.ca/PolicyPDF/PD88-06.pdf>>

information about health care issues, the procedures themselves, and the human rights of autonomy and equality. As affirmed by international law and echoed in the words of Pope John Paul II:

...freedom of conscience does not confer a right to indiscriminate conscientious objection. When an asserted freedom turns into license or becomes an excuse for limiting the rights of others, the State is obliged to protect, also by legal means the inalienable rights of its citizens against such abuses.²⁰⁹

From those words, I suggest that the state and appropriate institutions should take a greater role in developing systems ensuring access to these procedures instead of turning to individuals to put aside their beliefs and perform the procedure themselves or refer to a colleague.

There is a societal obligation to respect human dignity of all and a government obligation to protect it. As much as the state is obliged not to trample fundamental freedoms like conscience and religion, the state has an obligation to try to protect citizens from the harm conscientious refusal may cause. In certain areas of health care, legislation may be necessary to reduce barriers to access. In other areas of health care protocols for referral and transfer of patients should be created and maintained. Networks of doctors, clinics and hospitals could be established. Alternatively, a team approach to the practice of medicine could be adopted in certain areas. Teams would ensure a mix of professionals willing to

²⁰⁹ Pope John Paul II Address, "If You Want Peace, Respect the Conscience of Every Person," Vatican City 1991 *Message for the 24th World Day of Peace 1991*, para. 4 as cited in Judith Bueno De Mesquita and Louise Finer, "Conscientious Objection: Protecting Sexual and Reproductive Health Rights" (Colchester: University of Essex Human Rights Centre, 2008). Full text of speech available online: <http://www.vatican.va/holy_father/john_paul_ii/messages/peace/documents/hf_jp-ii_mes_08121990_xxiv-world-day-for-peace_en.html>

offer legal and medically indicated procedures in order to permit it possible conscientious refusers an opportunity not to become involved in the first place. In addition, programs for information and education should be made available to both the public and health care providers by the state and professional organizations.

These protocols and programs should be developed in consultation with the public, professional organizations and interest groups. Mutual understanding should be encouraged. An example of one such initiative is the Canadian Medical Association's *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care*.²¹⁰ This statement was developed and approved by the Boards of Directors of the Canadian Healthcare Association, the Canadian Medical Association, the Canadian Nurses Association and the Catholic Health Association of Canada and sets out guidelines for health care providers to consult in conflicts of conscience.

Looking at the example of *Barr v. Matthews*, a team approach and a system of referrals put in place by the profession could allow for reasonable accommodation and protection of conscience when properly engaged. Where a team approach is adopted, special attention should be taken in assembling a care team which would facilitate reasonable accommodation. Various health care professions may display more or less liberal attitudes toward a particular procedure. In a Danish study of 993 health care providers, the study noted that there was a tendency toward a more liberal attitude among gynecologists than

²¹⁰ Canadian Medical Association, *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care*. Online: <<http://www.cha.ca/documents/joint.htm>>.

nurses and concluded that religion and profession were determinants of attitudes toward common ethical controversies surrounding artificial reproductive procedures.²¹¹

For medical students, performance of a procedure should be differentiated from acquiring the requisite knowledge of a procedure which forms the standard of care. For example, the University of Manitoba has developed a policy for allowing students with sincerely held beliefs opposing abortion to graduate without having performed or assisted an abortion but who would not be allowed to graduate without having demonstrated the requisite knowledge of the procedure.²¹² Should an emergency arise, all medical professionals should be adequately trained and prepared. The University of Manitoba's Policy reinforces the principle that patients cannot be abandoned, that there is no right to conscientious refusal in an emergency and further that refusal cannot result in discrimination. Overall, the policy reaffirms that while conscientious objection will be respected, it must not compromise the student's medical education, professionalism or standard of care.

On an individual level, open and honest communication by any available means should be encouraged. Appropriate medical care can only be determined through open and honest communication and trust.²¹³ This paper embraces an approach which would avoid legal confrontation. This approach applies equally to the relationship between health care

²¹¹ I. de la Fuente Fonnest, *et al.*, "Attitudes among health care professionals on the ethics of assisted reproductive technologies and legal abortion" (2000) 79:1 *Acta Obstetricia et Gynecologica Scandinavica* 49.

²¹² University of Manitoba Faculty of Medicine, *UGME Conscientious Objection Policy*. Online: <<http://umanitoba.ca/faculties/medicine/education/undergraduate/index.html>>.

²¹³ see for example *McInerney v. MacDonald*, [1992] 2 S.C.R. 138

provider and patient and the one between employer and employee. I submit that an open and honest dialogue would be more constructive than a single act of refusal, without explanation, which could lead to an eventual breakdown of the relationship.

In the case of Maria Bizecki, a pharmacist in Alberta who refused to dispense the “morning-after pill” and other products to which she is morally opposed, an agreement for an acceptable working arrangement was reached only after complaints were lodged and an internal review by the Alberta College of Pharmacists was initiated in 2003.²¹⁴

When nurses at the Markham-Stouffville Hospital in Ontario refused to participate in abortion procedures as part of their duties, they filed a complaint with the Human Rights Commission. To accommodate their beliefs, the Hospital drafted a policy which permits staff with religious objection to withdraw from assisting with the procedure except where a mother’s life is in danger.²¹⁵

Where certain controversial procedures are performed in a particular work environment, prospective employees should be advised. Similarly, to learn from the example of Bizecki and the nurses of the Markham-Stouffville Hospital, acts of conscientious refusal should be *avoided* through requests and negotiations for accommodation at the *beginning* of an employment relationship. Prospective employers should disclose any essential duties of

²¹⁴ PCP, *supra* note 115. Online: <<http://www.consciencelaws.org/Conscience-Policies-Papers/PPPSettlements03.htm>>.

²¹⁵ Online: Ontario Human Rights Commission <http://ohrc.on.ca/english/publications/conflicting-rigths.shtml#_edn7#_edn7>

the position which may give rise to conflicts of conscience. So too should prospective employees identify their requisite terms of engagement.

Open communication in one form or another can also take place in the health care provider-patient relationship. Before the creation of the patient-provider relationship, for example, Appel suggests that in the *Benitez* case²¹⁶ there is evidence that the doctors failed to make full disclosure. Appel suggests that had the doctors publicized their decisions adequately, it would have been unlikely to have inconvenienced prospective patients. Upon learning of a particular view of the procedure sought, those patients would “simply go elsewhere.”²¹⁷

Once the doctor-patient relationship is established, dialogue can still be attempted as means to avoid conflicts of conscience. For example, instead of adversarial approaches, Weijer *et al.* propose that the use of conflict-resolution techniques is appropriate to demands for treatment in controversial or difficult cases.²¹⁸ While the situations discussed in that article deal with cases of medical futility, the principles of open communication and negotiation are wholly applicable to conflicts of conscience.

When faced with demands for treatment in controversial or difficult cases, Weijer *et al.* set out a number of reasons why communication is important. First, there may be a legal

²¹⁶ *Benitez*, *supra* note 166.

²¹⁷ *Appel*, *supra* note 167 at 21.

²¹⁸ C. Weijer, *et al.*, “Bioethics for clinicians: 16. Dealing with demands for inappropriate treatment” (1998) 159:7 *Can. Med. Assoc. J.* 817.

obligation to disclose what treatment will be or not be provided and the reasons why. Second, it furthers honest and open communication with the patient. Third, communication provides an opportunity to explore the motivations for the demand and offer appropriate care once the true reasons are revealed, such as counseling or other more relevant treatments. Weijer *et al.* argue that this third reason is likely the most important reason to communicate treatment (or non-treatment) decisions.²¹⁹

In sum, health care providers should make efforts to inform and adequately publicize their objections to particular procedures so that prospective patients are aware and are able to go elsewhere before a relationship is formed, only to be broken. Where a health care provider-patient relationship has already been established, there are benefits to open and honest communication.

In the example of Dr. Stephen Thomas Dawson, a Christian physician in Barrie, Ontario, this approach was adopted as an acceptable resolution to charges of professional misconduct by the Ontario College of Physicians and Surgeons. The complaints had been lodged after Dawson refused to prescribe birth control pills to four unmarried women. Dawson now posts a policy statement in the waiting room which states that he will not prescribe birth control pills to unmarried women or Viagra to unmarried men nor will he

²¹⁹ *Ibid.*, at 821.

arrange for abortions. He will not offer further information about his religious convictions except in response to queries from patients.²²⁰

I suggest that temporary removal from care for the single objectionable procedure while maintaining the ongoing relationship, if desired, is possible in this modern era of health care in Canada. An act of refusal in the form of a statement from a physician, nurse, pharmacist or technician to the effect of “as a matter of my personal beliefs and conscience, I cannot perform this procedure for you,” would not be improper, so long as there is no misleading information presented (or omitted) or passing of judgment. Additionally, initiating a dialogue if invited is encouraged. With mutual respect and recognition that both parties have conscientiously considered the procedure, the request and the refusal, in a diverse and tolerant society conscientious refusal and the subsequent action of non-participation are not necessarily damaging to the relationship so long as alternatives to care remain available.

²²⁰ *PCP*, *supra* note 115. Online: <<http://www.consciencelaws.org/Repression-Conscience/Conscience-Repression-17.html>>.

CONCLUSION

This paper is built upon the concepts of respect, restraint and reasonable accommodation. In this paper, I suggest that conscience is private to the individual and should be respected and protected in law as an extension of respect for human dignity. As discussed above, conscience creates and enforces moral obligation in the individual. Conscience may also have societal value in that it functions as an internal form of government. Conscience provides the internal mechanism for deciding what is right and wrong and then dictates a course of action for the individual to undertake. If the action mandated by conscience and the action performed are not the same, a personal sanction of internal anguish in the form of guilt or shame may be applied. It is for this reason that I argue conscience should be considered the first level of government and hence of great societal value. Assuming law to be moral and just, obedience to law in general must have some moral value, if only to follow “the golden rule” and do good to another by respecting their human worth, dignity and decisions, as one would ask to be reciprocated. Society is best served by cultivating conscience which places value on obedience to law out of respect for order and each other, rather than coercion. Such a conscience must be protected.

Respect for human dignity in a free and diverse society demands the protection of religious or conscientiously-held convictions of a minority of health care providers against the demands of an individual which are in accordance with the conventions of the majority. As declared by the Supreme Court of Canada, “a truly free society is one which can accommodate a wide variety of beliefs, diversity of tastes and pursuits, customs and codes of

conduct.”²²¹ The *Charter* shelters religious minorities from the threat of “the tyranny of the majority”, because what is held to be good or true may not be the same for all in a diverse society.²²²

“Restraint” refers to both the private nature of conscience and the requirement to adhere to one’s beliefs without encroaching on the rights and lives of others. Conscientious refusers must exercise restraint from actions which are motivated by paternalism or prejudice. Conscientious refusal is limited to the protection of one’s own conscience and the maintenance of one’s autonomy in the conduct of one’s own life. Legitimate claims of conscientious refusal do not include so-called objections where the refuser’s actions are intended to impress his or her beliefs on others or create a situation where others would be forced to conduct themselves according to the refuser’s values.

Restraint could also equally apply to an argument for legislative restraint. In the context of providing controversial medical procedures, this is a statement against creating inappropriate legislation in a misguided attempt to protect a package of rights and freedoms that is often glossed over as the “right to conscientious refusal” or to create legislation that would require health care professionals to ignore or act contrary to their own deeply-held beliefs.

²²¹ *Big M Drug Mart*, *supra* note 81 at para. 94.

²²² *Ibid.*, at para. 96.

Finally, reasonable accommodation is one of the existing anti-discrimination mechanisms in Canadian law which may already appropriately address situations of conscientious refusal as it relates to controversial health care procedures. Once conscientious refusal is unpacked into its component rights and freedoms, the law in Canada is well-equipped to address the freedom to form and hold beliefs, protect the autonomy of its citizens and guard against discriminatory practices. Furthermore, open communication and administrative policies offer a more constructive solution to conflicts of conscience than legal confrontation and judicial intervention.

Where the disagreement begins with fundamentally different moral starting points as to what procedures are “right” or “wrong”, axiomatic arguments of values and principles are interminable. On this point, MacIntyre commented as follows:

The most striking feature of contemporary moral utterance is that so much of it is used to express disagreements; and the most striking feature of the debates in which these disagreements are expressed is their interminable character. I do not mean by this just that such debates go on and on and on – although they do – but also that they apparently can find no terminus. There seems to be no rational way of securing moral agreement in our culture.²²³

Conscientious or religious freedom can no longer be based on a particular conception of the truth.²²⁴ This type of freedom now rests on the values of individual autonomy and identity – i.e. “respect for the choices made by the individual concerning spiritual or moral

²²³ Alisdair MacIntyre, *After Virtue* (Notre Dame, Ind.: University of Notre Dame Press, 1984) at 6.

²²⁴ Richard Moon. “The Secularization of Religious Freedom” (unpublished paper) Introduction to Chapter Nineteen: Freedom of Religion, The Constitutional Law Group. Bakan, et al. eds, *Canadian Constitutional Law*, 3rd ed. (Toronto: Emond Montgomery Publications Limited, 2003) 818

matters” and “respect for the individual’s deeply held views on fundamental or spiritual matters”.²²⁵ This new approach to freedom of conscience and religion requires and is characterized by tolerance. As suggested by the Supreme Court of Canada in *Amselem*:

... a multiethnic and multicultural country such as ours, which accentuates and advertises its modern record of respecting cultural diversity and human rights and of promoting tolerance of religious and ethnic minorities — and is in many ways an example thereof for other societies ... mutual tolerance is one of the cornerstones of all democratic societies. Living in a community that attempts to maximize human rights invariably requires openness to and recognition of the rights of others.²²⁶

In the end, existing Canadian legal principles offer the breadth and flexibility to maintain the respect and tolerance required for our society to live in harmony – not homogeny.

²²⁵ *Ibid.*

²²⁶ *Amselem*, *supra* note 89 at para. 87.

APPENDIX A

An Act to Ensure Protection of Conscience in the Provision of Medical Services (Draft Legislation)

source: Protection of Conscience Project
online: <<http://www.consciencelaws.org/Protection-of-Conscience-Model-Statute.html>>

1. This Act may be cited as The Protection of Conscience Act.

2. In this act, "*abortion*" includes

a) the inducement or attempted inducement of the miscarriage of a female person, whether or not she is pregnant,

b) the administration of drugs or devices to a female person or the manipulation of a female person to prevent the implantation of an early human embryo, whether or not conception has occurred,

c) in the case of a multiple pregnancy, the killing of a human embryo or foetus in the womb to reduce the number of children to be carried to term;

"*artificial reproduction*" includes the use of any sexual or asexual means of bringing about, or attempting to bring about, the formation of a human embryo, apart from an act of sexual intercourse, such as artificial insemination and in vitro fertilization, or human genetic engineering techniques, including the manipulation of genetic materials, the use of artificial genetic materials, or any combination thereof.

"*capital punishment*" means the execution of a sentence of death in accordance with military law or the law of the place where sentence is passed or to be carried out;

"*conception*" means the fertilization of a human ovum by human sperm;

"*contraceptive services*" includes the provision of drugs, devices or surgery for the purpose of preventing the fertilization of a human ovum by sexual intercourse;

"*embryonic experimentation*" includes any manipulation or surgical or pharmacological treatment of a human zygote, embryo or foetus at any time after conception, but does not include treatment which is intended to be directly therapeutic for the zygote, embryo or foetus itself;

"*embryo transfer*" includes the removal of a living human zygote, foetus or embryo from the uterus or location where it was conceived;

"*eugenic testing*" includes any form of observation or measurement, one purpose of which may be to identify illness or unwanted characteristics in a human being or in a human zygote, foetus or embryo,

so that the human being may be sterilized or killed, or the human zygote, foetus or embryo aborted or killed;

"*euthanasia*" means any act or omission, with or without the consent of the person who is the subject of the act or omission, which

- a) is apparently intended to cause the death of the person, or
- b) is apparently intended to accelerate the death of the person,

and includes the withdrawal or failure to provide artificial nutrition and hydration or ordinary medical treatment;

"*falsification*" means

- a) in the case of research data, the fabrication of research data or the deliberate introduction of bias or error into research data by any means, including addition, omission, suppression, misrepresentation, emphasis, or de-emphasis, during any phase of an experiment, including the design of the protocol, the material(s) and method(s) used, and the analysis of the data obtained;
- b) in the case of research claims, the fabrication of research claims or the deliberate introduction of bias or error into research claims by any means, including addition, omission, suppression, misrepresentation, emphasis, or de-emphasis involving: research grant applications; advertisements; computer programs; research committees; proceedings; findings; reports; publications; conferences; or other medical or research information.

"*human experimentation*" includes any manipulation or surgical or pharmacological treatment of a human being for the purpose of research, but does not include treatment which is intended to be directly therapeutic for that human being;

"*inter-species breeding*" includes fusing or attempting to fuse human gametes or genetic material with that of an animal;

"*person*" includes all juridical persons and all recognizable institutions, societies, associations, and formal or informal groups of persons, whether incorporated or not;

"*reasons of conscience*" includes adherence to

- a) religious doctrine or precept, or
- b) moral or ethical belief, or
- c) philosophical principle

that is understood by the adherent to make it wrongful for him to participate, directly or indirectly, in the activities referred to in Section 3.

"*tissue trafficking*" includes the handling, transfer, sale, barter, or giving of tissue obtained, directly or indirectly, by means of abortion, artificial reproduction, embryonic or human experimentation, embryo transfer, eugenic testing, euthanasia or inter-species breeding, or the provision of contraceptive services.

"*torture*" means any act or omission, whether or not it is legal under military law or the law in force in the place where it occurs, by which

- a)** pain is deliberately inflicted on a person, or
- b)** an attempt is made to inflict despair or mental or spiritual anguish on a person by
 - i)** deprivation of air, food, water, shelter, clothing, hygiene, privacy, companionship, sensory experience, medical treatment or religious practice, or
 - ii)** sexual touching or degradation, including seduction and exposure to pornographic or obscene materials, or
 - iii)** enforced participation in acts proscribed or thought to be proscribed by the person's religion, beliefs or moral principles, or
 - iv)** the application of mind or mood altering substances, or
 - v)** the application of extremes of temperature, light, sound, or smell or the provision of unpalatable food or drink, or
 - vi)** threats to cause death, pain or bodily harm to the person or another person, or
 - vii)** threats to do any of the above

for the purpose of punishment or personal gratification, to intimidate or coerce the person or some other person, or to obtain information or a statement.

General protection

3(1). Every one commits an offence who, by an exercise of authority or by intimidation, compels another person to participate, directly or indirectly,

- a)** in the performance of an abortion,
- b)** in artificial reproduction, capital punishment, embryonic or human experimentation, embryo transfer, eugenic testing, euthanasia or inter-species breeding, falsification, tissue trafficking, torture or the provision of contraceptive services,
- c)** in the advertising of the activities referred to in paragraphs (a) or (b), or
- d)** in the building, operation, maintenance, service or security of a facility where the activities referred to in paragraphs (a) or (b) take place or will take place, or
- e)** in the manufacture, advertising or sale of drugs or instruments intended to be used for the activities referred to in paragraphs (a) or (b), or

f) in the counselling or education of persons in a manner which indicates that the activities referred to in paragraphs (a) or (b) are morally neutral or acceptable,

when that person has indicated that he does not wish to participate for reasons of conscience.

3(2) For greater certainty, in the case of capital punishment and torture, "participation" includes

a) prior consultation or planning,

b) pronouncing death

c) providing a professional opinion or rendering medical assistance in order to prolong or facilitate the procedure or make it more effective.

Intimidation of contractors, employees and members of unions and professional associations

4. Every one commits an offence who, for the purpose of inducing another person or class of persons to participate, directly or indirectly, in the activities referred to in Section 3,

a) intimidates or attempts to intimidate or influence that person or class of persons by threats or suggestions that

i) contracts, employment, advancement, benefits, pay, or

ii) membership, fellowship or full participation in a trade union or professional association

may be adversely affected if they do not so participate,

b) disciplines, suspends or dismisses an employee or contractor, or reduces his pay or benefits or cancels his contract, or suspends or revokes or adversely affects his membership, fellowship or full participation in a trade union or professional association, for the reason that he failed or refused to participate or to agree to participate, directly or indirectly, in the activities referred to in Section 3.

Intimidation of applicants

5. Every one commits an offence who

a) suggests that participation in the activities referred to in Section 3, whether direct or indirect, is a condition of employment, contract, membership or full participation in a trade union or professional association, or of admission to a school of medicine or other educational programme,

b) refuses to employ a person or to admit him to a trade union, professional association, school of medicine or other educational programme for the reason that he refused or failed to agree to participate, directly or indirectly, in the activities referred to in Section 3.

c) refuses to employ a person or to admit him to a trade union, professional association, school of medicine or other educational programme for the reason that he refused or failed to answer questions about or to discuss his willingness to participate, directly or indirectly, in the activities referred to in Section 3.

d) adversely affects the opportunities of a person or class of persons to secure employment or admission to, or full participation in a trade union, professional association, school of medicine or other educational programme for the reason that

i) he refused or failed to agree to participate, directly or indirectly, in the activities referred to in Section 3, or

ii) he refused or failed to answer questions about or to discuss his willingness to participate, directly or indirectly, in the activities referred to in Section 3.

Intimidation of health care professionals

6. Every one commits an offence who, for the purpose of inducing a person or class of persons to participate, directly or indirectly, in the activities referred to in Section 3,

a) suggests that hospital admitting privileges, full participation in professional associations or trade unions, or other rights or privileges associated to the practice of medicine or nursing may be adversely affected if he does not so participate,

b) denies, restricts or revokes hospital admitting privileges, full participation in professional associations or trade unions, or other rights or privileges associated to the practice of medicine or nursing for the reason that he has failed or refused to agree to participate, directly or indirectly, in the activities referred to in Section 3, or

c) denies, restricts or revokes hospital admitting privileges, full participation in professional associations or trade unions, or other rights or privileges associated to the practice of medicine or nursing for the reason that he refused or failed to answer questions about or to discuss his willingness to participate, directly or indirectly, in the activities referred to in Section 3.

d) adversely affects hospital admitting privileges, full participation in professional associations or trade unions, or other rights or privileges associated to the practice of medicine or nursing for the reason that

i) he failed or refused to agree to participate, directly or indirectly, in the activities referred to in Section 3, or

ii) he failed or refused to answer questions about or to discuss his willingness to participate, directly or indirectly, in the activities referred to in Section 3.

Saving

7(1) This Act does not apply when the activities referred to in Section 3 are the principal duties of a position for which a person was hired or for which an employer is seeking an employee or contractor.

7(2) For the purpose of this section, activities are the principal duties of a position when

a) they have been previously designated in writing in advertising, contracts, job descriptions, and other instruments referring to the position, and

b) the activities will or are reasonably expected to

i) comprise more than 50% of the activities performed by the person holding that position, or

ii) generate more than 50% of the gross revenue for activities performed by the person holding that position.

7(3) Nothing in this Section shall be construed to suggest that employers or other persons in authority have a legal right to compel another person to participate in any activity to which that person has expressed objection for reasons of conscience.

7(4) A person does not 'protest' within the meaning of the Access to Abortion Services Act

a) by asserting objections, based on reasons of conscience, to activities referred to in Section 3, in order to avoid participation in such activities, or

b) by expressing objections or disapproval, based on reasons of conscience, to activities referred to in Section 3, in response to a request for counselling or advice.

Protection Against Negotiated Exemptions

8(1) No person shall circumvent this Act by negotiation of contracts or agreements contrary to it.

8(2) All agreements contrary to this Act are of no force or effect.

Penalty

9. Every one who commits an offence against this Act is liable

a) for a first offence, to imprisonment for 6 months, or to a fine of \$1,000.00, or both.

b) for a second offence, to imprisonment for 6 months, or to a fine of \$5,000.00, or both.

c) for each subsequent offence, to imprisonment for 6 months and to a fine of \$10,000.00.

Procedure on trial

10. A court that convicts or discharges an accused of an offence under this Act, shall, at the time sentence is imposed, order the accused to pay to the victim of the offence an amount by way of satisfaction or compensation for the loss of wages and benefits which resulted from the commission of the offence.

11. Where a court has not been satisfied beyond reasonable doubt that an offence has been committed, but is satisfied on the balance of probabilities that an accused engaged in conduct described in Sections 3, 4, 5, or 6, the court shall not convict the accused but shall order the accused to pay to the victim of the offence an amount by way of satisfaction or compensation for the loss of wages and benefits which resulted from the conduct.

Enforcement of judgement

12. Where an amount that is ordered to be paid under Section 9 or 10 is not paid forthwith, the victim may, by filing the order, enter as a judgement in the Supreme Court of British Columbia, the amount ordered to be paid, and that judgement is enforceable against the accused in the same manner as if it were a judgement rendered against the accused in that court of civil proceedings.

Limitation of Action

13. No proceedings shall be commenced in respect of acts which are alleged to have contravened this Act more than 2 years after the date on which the acts are alleged to have taken place.

Restriction on judicial intervention

14. An order from a court directed to any person requiring participation in any of the acts defined in Section 3 shall be deemed not to apply to any person who objects, for reasons of conscience, to participation in such acts.

Protection from civil liability

15. A person who refuses to participate, directly or indirectly, for reasons of conscience, in the activities referred to in section 3,

- a) shall not be considered negligent,
- b) shall not be considered guilty of professional misconduct,
- b) does not thereby commit a tort,

and is not liable for any damages allegedly arising from the refusal.

16. For greater certainty, a cause of action shall not arise, and damages shall not be awarded, on behalf of any person, based on a claim that, but for a refusal to act based upon reasons of conscience,

- a) a child would not have been conceived, or
- b) a child would have been aborted, or
- c) a person would have died.

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