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Sean Murphy *Administrator*
Michael Markwick
Human Rights Specialist

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Postscript for the Journal of Obstetrics and Gynaecology Canada: *Morgentaler* vs. Professors Cook and Dickens

Sean Murphy, Administrator
Protection of Conscience Project

Introduction

An article about the morning after pill by law professors RJ Cook and BM Dickens in the *Journal of Obstetrics and Gynaecology Canada*[1] elicited a protest from Dr. Howard Bright of Chilliwack, B.C. Dr. Bright contested their statement that physicians are obliged to refer for treatments to which they are morally opposed. “There is no obligation to refer,” he wrote, citing the *Code of Ethics* of the Canadian Medical Association.[2]

Nonetheless, Cook and Dickens stuck to their claim. “Physicians who feel entitled to subordinate their patient’s *desire* for well-being to the service of their own personal morality or conscience,” they stated, “should not practise clinical medicine” [3] (Emphasis added).

The assertion that a patient’s *desire* should be an ordering principle in the practice of medicine has little to recommend it. More important, the arguments of Professors Cook and Dickens for mandatory referral are unsupported and even contradicted by their own legal and ethical references. Regulatory officials with the power to enforce the views of Cook and Dickens are unlikely to discover this in the pages of the *Journal*, since, by editorial fiat, the discussion was terminated with the publication of their ‘final word’ on the subject.[4] Here, then, is the postscript to the discussion, supplemented by developments in the United Kingdom and Belgium that have a bearing on the issue.

‘Referral and abandonment’

The only authority cited by Professors Cook and Dickens to support their avowal that courts “continue” to demand referral was a less than contemporary ruling in *Zimmer v. Ringrose*, a 23 year old case from the Alberta Court of Appeal.[5] The published letter from the Project pointed out that *Zimmer* addressed the failure to obtain informed consent to silver nitrate sterilization and failure to provide adequate follow-up care, not referral. The authors countered that the Administrator had misrepresented legal cases because he had failed to consider “historical background jurisprudence” that shapes court decisions. Summarizing what they believed to be the “continuing relevance of the *Zimmer* case,” they claimed that failure to refer for abortion is “negligence

close to abandonment.”

> [T]he “failure to provide adequate follow-up care” that Mr. Murphy acknowledges consisted in the defendant physician’s *failure to refer* his patient to another physician who could facilitate *the abortion she wanted*. The Court found that this failure was negligence close to abandonment . . . a wilful failure or refusal to refer . . . may justify an award of aggravated or exemplary damages. (emphasis added)[6]

However, they cited no authorities to support their understanding of the case. Moreover, the rulings followed and referred to by the Court of Appeal in *Zimmer* were about informed consent, not freedom of conscience.[7]

At the risk of once more being accused of misrepresentation, the only relevant “historical background jurisprudence” appears to be the earlier decision of the trial court in *Zimmer*, and this does not assist Cook and Dickens. The failure to provide adequate follow-up care had two elements - not one, as the authors imply. The first was the physician’s failure “to follow his patient’s progress by conducting regular medical examinations during the summer of 1973,” an omission the trial judge found to be “inconsistent with good clinical practice” that contributed to the fact that her pregnancy was not detected earlier.[8]

The second element was not the “failure to refer” alleged by the authors; the physician did *not* refuse or fail to refer the patient for abortion. In fact, she understood from him that she should have an abortion as soon as possible.[9] Nor was the issue a refusal to refer “for the abortion *she* wanted” (emphasis added). It was, rather, his decision to refer the woman for an abortion in Seattle rather than Edmonton. He testified that he advised her to get an abortion in Seattle to avoid the delay involved in Edmonton, where, he said, it was then necessary to obtain a psychiatric report to justify the procedure. He also believed that the suction procedure used in Seattle would be less traumatic for the patient than the saline method employed in Edmonton.[10]

The key fact noticed by the Court in ruling against the physician was that he “made no attempt to secure an abortion for the respondent in a hospital in Edmonton” (by, for example, referring her to a colleague) and thus failed “to display the degree of care and concern dictated by the situation.”[11]

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

> I cannot find that the [physician] made any effort to get medical and hospital care in Edmonton for the abortion and in this respect his attitude appears to have been casual. He failed to do everything he could for the welfare of his patient, and I cannot accept as true his statement to Mrs. Zimmer that she would have to be declared mentally unsound before she could be admitted to hospital in Edmonton for an abortion . . . At least. . . he should have consulted another gynaecologist in Edmonton before suggesting that she go to Seattle.[12]

In other words, having told the patient that she should get an abortion as soon as possible, he was expected to at least attempt to secure an abortion for the patient in Edmonton at the earliest opportunity. Rather than making such an attempt, he based his advice to go to Seattle on an untested assumption about the availability of the procedure. The patient took his advice and went

to Seattle, but she was found to be too far along for suction. A saline abortion was performed, and "Mrs. Zimmer was left to abort in a hotel room, unattended my medical personnel." Thus,

> [T]he respondent underwent a more painful and emotionally distressing experience than was necessary in the circumstances. Her suffering would have been substantially reduced if the appellant had discharged his duty by arranging hospital care.[13]

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

Professors Cook and Dickens' second legal claim, that the fiduciary duties of physicians requires them to subordinate their conscientious convictions to those of their patients, rests upon a more recent Supreme Court of Canada case, *McInerney v. MacDonald*. But *McInerney*[14] had absolutely nothing to do with conflicts of conscience. It concerned the duty of a physician to release a patient's medical records to her upon request. While the court noted that the fiduciary relationship between physician and patient obliged the physician to disclose the records, the nature of fiduciary relationships was not discussed at length. Moreover, the Supreme Court ruled that fiduciary relationships and obligations are "shaped by the demands of the situation"; they are not governed by a "fixed set of rules and principles". Mr. Justice La Forest, writing for the court, stated, "A physician-patient relationship may properly be described as'fiduciary' for some purposes, but not for others."[15]

In other words, that the physician patient relationship is fiduciary for the purpose of disclosing patient records does not imply that it is fiduciary for the purpose of suppressing the conscientious convictions of the physician.

Finally, the court in *McInerney* accepted the characterization of the physician-patient relationship as "the same . . . as that which exists in equity between a parent and his child, a man and his wife, an attorney and his client, a confessor and his penitent, and a guardian and his ward."[16] Pursuing the analogy, no one has ever suggested that the fiduciary obligations of parents, husbands, attorneys, confessors, and guardians require them to sacrifice their own integrity to the "desires" of others. *McInerney* does not even remotely imply that physicians have such a duty.

'The patient prevails'

The authors also insist that "in the event of differences between a physician and a patient regarding the patient's care, the patient's religious convictions prevail." Here they refer to *Malette vs. Shulman,* the case of a physician who was found liable for assault and battery because he deliberately ignored the prior written instructions of a Jehovah's Witness patient and gave her an emergency blood transfusion to save her life.[17] The court ruled that medical treatment may not be forced upon a patient if it is contrary to his religious convictions, but it did not rule that a physician may be forced to provide or refer for treatment that is contrary to his. The case demonstrates that respect for patient autonomy may prevent a physician from doing what he believes to be good, but it does not create a duty to do or facilitate what the physician believes to

be evil.

It is remarkable that Professors Cook and Dickens continue to cite these three cases, since they do not support their claims, and *McInerney* arguably contradicts them.

What of their reference to 'transcendent ethical duties'?

"Transcendent ethical duties"

Dr. John R. Williams is now Director of the Ethics Unit of the World Medical Association. He was Director of Ethics for the Canadian Medical Association in 2000, when he advised the Protection of Conscience Project that the CMA's policy of mandatory referral for abortion was dropped because there was no ethical consensus to support it.[18] Despite this, the authors allege that physicians are ethically obliged to provide "prior notice of procedures that they will not perform" when accepting patients. Absent such "prior notice," they claim that "the fiduciary duty to refer applies." This novel interpretation of the CMA's *Code of Ethics* is apparently based upon the following passages:

> Inform your patient when your personal morality would influence the recommendation or practice of any medical procedure that the patient needs or wants.[19]
>
> Having accepted professional responsibility for a patient, continue to provide services until they are no longer required or wanted; until another suitable physician has assumed responsibility for the patient; or until the patient has been given adequate notice that you intend to terminate the relationship.[20]

But the CMA *Code of Ethics* does not require that notice be given at a particular time, nor, necessarily, when a patient is first accepted. It is impossible for a physician to anticipate every demand that a patient might make of him, and both physicians and patients may, over the course of a relationship, change their respective views on a number of subjects. Moreover, technological developments may introduce new issues into an established relationship.

The authors' rigid expectation also ignores the interpretive guide provided in the preface to the CMA's *Code*:

> [The Code's] statements are general in nature, to be interpreted and applied in particular situations. Specific ethical issues such as abortion, transplantation and euthanasia are not mentioned; they are treated in appropriate detail in CMA policy statements.[21]

Finally, the CMA's more detailed treatment of abortion includes the following statements:

- A physician should not be compelled to participate in the termination of a pregnancy.
- A physician whose moral or religious beliefs prevent him or her from recommending or performing an abortion should inform the patient of this *so that she may consult another physician* (emphasis added)[22]

One looks in vain here for any evidence of the authors' alleged "fiduciary duty to refer."

'Well-being' and referral

The authors also argue from the physician's obligation "to put first the well-being of the patient," the first principle in the CMA *Code of Ethics*.

> Patients' well-being is governed by their own perceptions and convictions, not those of their physicians. Physicians cannot invoke their sense of their own well-being to deny or compromise their patients' lawful rights to care.[23]

From this they conclude - yet again - that objecting physicians "must refer their patients to those who do not object to serve the patients' wishes." But this presumes that the *Code* is self-contradictory. It ignores the fact that the principle "to put first the well-being of the patient" co-exists with other sections of the *Code* and related policies that clearly do not expect referral by conscientious objectors.

Even if the *Code* were ambiguous on the subject of referral, such ambiguity would be insufficient to conclude that it requires referral in the service of the "well-being" of the patient - especially "well-being" unilaterally and subjectively defined by the patient. For it is one thing to say that patients are the best judges of what constitutes or contributes to their own well-being, and quite another to say that they may force physicians to serve the ends that they have chosen, regardless of the physicians' conscientious convictions: to force physicians to live their lives and make moral choices in obedience to the wishes, desires and demands of someone else. That is servitude, not service. Nonetheless, the authors cite *Nancy B v Hotel Dieu de Quebec* [24] as legal authority for this line of ethical reasoning.

Concerning the relevance of *Nancy B* to the issue of conscientious objection, others do not share the authors' opinion. Consider the following comment by constitutional lawyer Iain Benson:

> The *Nancy B.* decision is not relevant to the question of conscience in relation to pharmaceutical or medical practice because the autonomous views of one person are not what is at issue in "emergency contraception" situations where a pharmacist or physician do not wish to be involved in their prescription.
>
> . . . this conflict cannot be settled by reference to one person's autonomy because two people's views or wishes (central to autonomy) are involved. That one of the people is the potential provider of the service sought is but one factor to take into account. To put the matter very clearly, let us look at what was and was not at issue in the *Nancy B.* decision.
>
> Nancy B. had Guillain-Barré syndrome and was dependent upon a respirator. She wanted her respirator shut off. None of the physicians objected to what she wanted but sought the court's decision on whether such a course was legal. This is not what is relevant to the question of conscience or religious objection to "emergency contraception." Had a physician in the *Nancy B.* case refused to be involved, say, in turning off the respirator, then the issue would have been raised

> in a relevant form. But such a factual "issue" was not present in *Nancy B.* and that case fails to provide any light on the question of the duties that exist with respect to a pharmacist who does not wish to prescribe a particular drug or physician who does not wish to perform a particular procedure or nurse who does not wish to assist with a particular course of treatment.

Turning to the issue of accommodating conscientious objectors, Benson reminds the reader that the practice of medicine "is always a two-way street."

> Yes, the patient or "client" has his or her autonomy; but so, too, does the practitioner. There is no good reason (except perhaps one grounded in an anti-religious bias) to advocate that a patient's autonomy should trump the autonomy of the professional health-care worker just because the two views conflict. What is needed . . . is an examination of how to accommodate conscience and religious views within the contemporary technocratic and often implicitly anti-religious paradigm of certain aspects of modern medicine.
>
> . . . The real issue, where there is a conflict of views between people regarding involvement with a procedure or drug, is not settled by reference to one person's "autonomy" but by reference to another principle, that of "justice" (defined as "rendering a person their due…"). For it is there, in the order of justice, that competing claims must be reconciled in a manner that accords with the rule of law (including professional ethics and respect for professional disagreement), the provision of health-care and the developed understanding of a civil society.[25]

The final word on *Nancy B*. is best left, for the present, to Professor Dickens. He did not discover a duty to refer when expatiating upon the ruling in 1993. In fact, he included a comment in his concluding remarks that is difficult to reconcile with his most recent position:

> [The ruling] is respectful of Nancy B.'s choice of death, approves a process of death that cares for her comfort and dignity, does not speak of a right to die, *and shows care too for the caregiver's comfort and conscience, empowering without ordering the physician to act.*[26] (emphasis added)

'Your wish is my command'

The authors attribute to Chief Justice Dickson of the Supreme Court of Canada the notion that a woman's *desire* - not need - is of "key importance" in establishing abortion as a fundamental human right. They suggest that this principle can be found in his remark in *R v. Morgentaler* that forcing a woman to carry a child to term "unless she meets certain criteria unrelated to her own priorities and aspirations" interferes profoundly with her body and is "a violation of the security of the person."[27]

For present purposes it is unnecessary to explore the ramifications of medical practice based on satisfying patient desires rather than meeting patient needs. It is enough to notice that, in the passage quoted, Chief Justice Dickson was addressing himself only to the meaning to be given to the phrase "the security of the person" in Section 7 of the *Charter of Rights and Freedoms*. The passage does not provide the key to resolving a conflict between a patient demanding an abortion

and a physician unwilling to facilitate the procedure for reasons of conscience.

In fact, in *R v. Morgentaler* neither Chief Justice Dickson nor Mr. Justice Lamer, who joined in his reasons for judgement, considered principles associated with freedom of conscience, nor did Justices McIntyre and La Forest. But other judges did, and it is regrettable that Professors Cook and Dickens overlooked their opinions in their attempt to explain how *R v. Morgentaler* should be applied in cases of conscientious objection to medical procedures.

Justices Beetz and Estey had the least to say on the subject. They observed that the law could not compel hospitals to form therapeutic abortion committees “any more than it could force a physician to perform an abortion” because the decision to form committees, like a decision to perform an abortion, “is, in part, one of conscience, and, in some cases, one which affects religious beliefs.”[28]

Madame Justice Bertha Wilson reflected more broadly on the nature and importance of freedom of conscience, arguing that “an emphasis on individual conscience and individual judgment . . . lies at the heart of our democratic political tradition.”[29] Wilson held that it was indisputable that the decision to have an abortion “is essentially a moral decision, a matter of conscience.”

> The question is: whose conscience? Is the conscience of the woman to be paramount or the conscience of the state? I believe. . . that in a free and democratic society it must be the conscience of the individual. Indeed, s. 2(*a*) makes it clear that this freedom belongs to "everyone", i.e., to each of us individually.[30]

Here she was not discussing whether or not the conscience of a woman should prevail over that of an objecting physician, but how the conscientious judgement of an individual should stand against that of the state. Her answer was that, in a free and democratic society, “the state will respect choices made by individuals and, to the greatest extent possible, will avoid subordinating these choices to any one conception of the good life.”[31]

Moving closer to the heart of the matter, Wilson insisted that an individual must never be treated as a means to an end - especially an end chosen by someone else, or by the state. One of her reasons for striking down legal restrictions on abortion was that, through the law, the state was ‘taking sides’ on what is essentially a moral question that should be left to private judgement. She rejected the idea that the state should endorse and enforce “one conscientiously-held view at the expense of another,” for that is “to deny freedom of conscience to some, to treat them as means to an end, to deprive them . . .of their ‘essential humanity’.”[32]

This is hardly a stepping stone to the kind of simplistic ‘your wish is my command’ solution advocated by Professors Cook and Dickens. Indeed, it is ironic that Madame Justice Wilson’s reasoning in *R v. Morgentaler* so eloquently undermines their position. Following Madame Justice Wilson, for a regulatory authority or professional association to endorse and enforce the conscientiously-held view of the patient at the expense of physicians is to deny freedom of conscience to physicians, to treat them as means to an end, to deprive them of their “essential humanity.”

Belgium and the United Kingdom: referral for euthanasia

Belgium legalized euthanasia (not assisted suicide) in September, 2002. The Euthanasia Act (S. 14) provides that physicians cannot be compelled to perform euthanasia and other persons cannot be forced to assist in it. It also requires that a physician who declines to perform euthanasia must transfer the patient's medical file to a physician or person designated by the patient if requested to do so, but there is no requirement to refer or otherwise actively facilitate the procedure.[33]

The Project has frequently argued that if physicians can be compelled to refer for abortion or contraception or other morally controversial services, one ought to expect that they will be forced to refer for legalized euthanasia or assisted suicide. This is precisely what has happened in Belgium. A joint Policy Statement on End of Life Decisions and Euthanasia signed by the Belgian Association of General Practitioners, the Academy at the Catholic University of Leuven and the Academy for Knowledge at the University of Ghent affirmed that physicians who object to euthanasia are obliged to help patients find a colleague who will provide the service.[34]

A different approach is evident in the United Kingdom. A euthanasia bill proposed by Lord Joffe included a provision that required an objecting physician to refer a patient for euthanasia. The British House of Lords' Select Committee studying the bill took oral and written evidence from numerous sources that protested the compulsory referral provision, testifying, one might say, to widespread understanding and acceptance of the principle of vicarious moral responsibility.[35] Moreover, the parliamentary Joint Committee on Human Rights advised the Select Commitee that a mandatory requirement to refer patients for euthanasia was probably a violation of the *European Convention on Human Rights*.[36] Ultimately, Lord Joffe agreed to delete the provision for this reason.[37]

Summary

This paper is confined to a review of the cases cited by Professors Cook and Dickens and their reasoning from them on the subject of referral for morally controversial procedures. Apart from brief reference to recent Belgian and British developments, no attempt has been made to marshal cases and arguments that offer support for the position of physicians who refuse to refer for services to which they object. Nonetheless, even this limited review of the subject leads to a number of conclusions.

- *Zimmer v. Ringrose* is not authority for the proposition that failure to refer a patient for reasons of conscience almost amounts to abandonment.
- *McInerney v. MacDonald* is not authority for the view that physicians have a fiduciary duty to refer patients for treatment to which they object for reasons of conscience.
- *Malette vs. Shulman* does not create a duty to do or facilitate what the physician believes to be wrong.
- The ruling in *Nancy B v Hotel Dieu de Quebec* is respectful of "the caregiver's comfort and conscience, empowering without ordering the physician to act;"it does not impose a duty to refer for morally controversial procedures.
- *R v. Morgentaler* did not establish the 'desire of the patient' as a fundamental principle

governing the practice of medicine. The only references to freedom of conscience in *Morgentaler* support the view that physicians should not be forced to refer for services that they find morally objectionable.

- The authors' claim that "prior notice" is valid only if given when a patient is accepted is excessively rigid and inconsistent with the Canadian Medical Association's *Code of Ethics*.
- The first principle in the CMA *Code of Ethics*,"to put first the well-being of the patient,"co-exists with other sections of the *Code* and related policies that clearly do not expect referral by conscientious objectors. It cannot be taken out of context to fabricate a duty to refer for morally controversial procedures.
- To accept the authors' claims for mandatory referral in the case of abortion or the morning-after pill would set a precedent for mandatory referral for other controversial procedures, including euthanasia and assisted suicide
- The rejection by the British parliamentary committees of the compulsory referral provision in Lord Joffe's euthanasia bill supports the view that compulsory referral is an unjustifiable violation of freedom of conscience.

Notes

1. Cook RJ, Dickens BM, Access to emergency contraception. J. Obstet Gynaecol Can 2003;25 (11):914-6

2. Bright, H. Access to emergency contraception [letter]. J. Obstet Gynaecol Can 2004; 26(2)111

3. Cook RJ, Dickens BM, "In Response". J.Obstet Gyanecol Can, February, 2004; 26(2)112

4. There was some resistance to publishing the Project's first letter, the editor citing *Journal* policy against publishing "letters that are responses to letters of response" and the fact that the original article had appeared six months earlier (Letter from the Editor in Chief, *Journal of Obstetrics and Gynaecology Canada* to the Administrator, Protection of Conscience Project, 7 May, 2004). The Administrator did not insist upon publication, but asked if the *Journal* would publish a correction to the legal misinformation supplied by Professors Cook and Dickens (Letter from the Administrator, Protection of Conscience Project, to the Editor in Chief, *Journal of Obstetrics and Gynaecology Canada*, 14 May, 2004: http://www.consciencelaws.org/Examining-Conscience-Legal/Legal31a.html). This led to the appearance of the Project's letter (http://www.consciencelaws.org/Conscience-Archive/Commentary/Conscience-Commentary-2004-01-to-06.html) with the rejoinder by Cook and Dickens and the announcement by the editor that the subject was closed. The Administrator later supplied the *Journal's* editor with the present information and repeated his previously expressed concerns about misleading legal claims. Unwilling to seem disrespectful of editorial autonomy, he limited himself to the suggestion that Professors Cook and Dickens might be allowed to write at greater length in the *Journal* in future, since they had suggested that they had

not had the scope "for fully referenced legal or ethical reasoning." (Letter from the Administrator, Protection of Conscience Project, to the Editor in Chief, *Journal of Obstetrics and Gynaecology Canada*, 8 August, 2005: http://www.consciencelaws.org/Examining-Conscience-Legal/Legal31a.html).

5. *Zimmer v. Ringrose* (1981), 124 Dominion Law Reports (3d) 215 (Alberta Court of Appeal)

6. Cook RJ, Dickens BM, Access to emergency contraception [letter] J.Obstet Gynaecol Can 2004; 26(8):706.

7. *Riebl v. Hughes* (1980), 114 DLR (3rd) 1, (1980) 2 SCR 880, 14 CCLT 1, 33 NR, 361; *Hopp v. Lepp* (1980), 112 DLR (3d) 67, (1980) 2 SCR 192, (1980) 4 WWR 645, 22 AR 361, 13 CCLT 66, 32 NR 145, followed; *Trogun v. Fruchtman* (1973), 207 NW 2d 297; *Downer v. Veilleux* (1974), 322 A. 2d 82, referred to.

8. *Zimmer v. Ringrose* (1981), 124 DLR (3d) 225-226 (Alberta Court of Appeal); *Zimmer v. Ringrose* (1978), 89 Dominion Law Reports (3d) 657 (Alberta Supreme Court)

9. *Zimmer v. Ringrose* (1981), 124 DLR (3d) 219 (Alberta Court of Appeal); *Zimmer v. Ringrose* (1978), 89 DLR (3d) 649 (Alberta Supreme Court)

10. *Zimmer v. Ringrose* (1981), 124 DLR (3d) 219 (Alberta Court of Appeal); *Zimmer v. Ringrose* (1978), 89 DLR (3d) 649 (Alberta Supreme Court)

11. *Zimmer v. Ringrose* (1981), 124 DLR (3d) 226 (Alberta Court of Appeal)

12. *Zimmer v. Ringrose* (1978), 89 DLR (3d) 657-658 (Alberta Supreme Court)

13. *Zimmer v. Ringrose* (1981), 124 DLR (3d) 226 (Alberta Court of Appeal); *Zimmer v. Ringrose* (1978), 89 DLR (3d) 657 (Alberta Supreme Court)

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

15. Recalling an earlier case (*Canson Enterprises Ltd. v. Boughton & Co.* [1991] 3 S.C.R. 534),

16. Quoting LeBel, J. in *Henderson v. Johnston*, [1956] O.R. 789 at p. 799.

17. *Malette v. Shulman* (1990), 67 DLR (4th) 321 (Ont. Court of Appeal)

18. Telephone conversation between Dr. John R. Williams and the Project Administrator, April, 2000.

19. *Code of Ethics* of the Canadian Medical Association (October 15, 1996), 8; *Code of Ethics* of the Canadian Medical Association (Update 2004), 12.

20. *Code of Ethics* of the Canadian Medical Association (October 15, 1996), 10. The *Code of Ethics* of the Canadian Medical Association (Update 2004), 19 substitutes "reasonable" for "adequate" notice.

21. *Code of Ethics* of the Canadian Medical Association (October 15, 1996). The preface has been replaced in the 2004 Update of the *Code* with abbreviated introductory remarks, including a statement that adverts to the relevance of other CMA policies: "The Code*, together with CMA policies on specific topics*, constitutes a compilation of guidelines that can provide a common ethical framework for Canadian physicians." (emphasis added)

22. Position of the Canadian Medical Association on Induced Abortion (15 December, 1988) http://www.cma.ca/index.cfm/ci_id/3218/la_id/1.htm (Accessed 2005-06-11)

23. Cook RJ, Dickens BM, Access to emergency contraception [letter] J.Obstet Gynaecol Can 2004; 26(8):706

24. *Nancy B v Hotel Dieu de Quebec* (1992), 86 DLR (4th) 385 (Quebec Superior Court)

25. Benson, Iain T., *"Autonomy", "Justice" and the Legal Requirement to Accommodate the Conscience and Religious Beliefs of Professionals in Health Care* (Revised March 2001) http://www.consciencelaws.org/Examining-Conscience-Issues/Legal/Articles/Legal04.html#autonomy

26. Dickens, Bernard M., "Medically Assisted Death: Nancy B. v. Hotel-Dieu De Quebec."38 McGill L.J. 1053

27. *R. v. Morgentaler* (1988) 44 DLR (4th) 385 (Supreme Court of Canada)

28. *R. v. Morgentaler* (1988)1 S.C.R 95-96 (Supreme Court of Canada) http://www.lexum.umontreal.ca/csc-scc/en/pub/1988/vol1/html/1988scr1_0030.html (Accessed 7 June, 2005)

29. *R. v. Morgentaler* (1988)1 S.C.R 165 (Supreme Court of Canada) http://www.lexum.umontreal.ca/csc-scc/en/pub/1988/vol1/html/1988scr1_0030.html (Accessed 7 June, 2005)

30. *R. v. Morgentaler* (1988)1 S.C.R 175-176 (Supreme Court of Canada) http://www.lexum.umontreal.ca/csc-scc/en/pub/1988/vol1/html/1988scr1_0030.html (Accessed 7 June, 2005)

31. *R. v. Morgentaler* (1988)1 S.C.R 166 (Supreme Court of Canada) http://www.lexum.umontreal.ca/csc-scc/en/pub/1988/vol1/html/1988scr1_0030.html (Accessed 7 June, 2005)

32. *R. v. Morgentaler* (1988)1 S.C.R 178-179 (Supreme Court of Canada) http://www.lexum.umontreal.ca/csc-scc/en/pub/1988/vol1/html/1988scr1_0030.html (Accessed 7 June, 2005)

33. The Belgian Act on Euthanasia of 28 May, 2002, Section 3§1. Unofficial translation by Dale Kidd under the supervision of Prof. Herman Nys, Centre for Biomedical Ethics and Law, Catholic University of Leuven, Belgium. *Ethical Perspectives* 9 (2002) 2-3, p. 182. http://www.kuleuven.ac.be/cbmer/viewpic.php (Accessed 2005-10-27)

34. Standpunt over medische beslissingen rond het levenseinde en euthanasie [Policy Statement on End of Life Decisions and Euthanasia]. In Flemish and English at http://www.consciencelaws.org/Examining-Conscience-Background/Euthanasia/BackEuthanasia09.html.

35. United Kingdom Parliament, House of Lords Select Committee on Assisted Dying for the Terminally Ill Bill. Selections from the First Report: Examination of Witnesses http://www.consciencelaws.org/Examining-Conscience-Legal/Legal29.html

United Kingdom Parliament, House of Lords Select Committee on Assisted Dying for the Terminally Ill Bill. Selections from the First Report: Written Evidence http://www.consciencelaws.org/Examining-Conscience-Legal/Legal30.html

36. United Kingdom Parliament, House of Lords Select Committee on Assisted Dying for the Terminally Ill Bill: First Report, Chapter 7, Conclusions, Paragraph 261. http://www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/8610.htm (Accessed 2005-10-25)
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