From Expectation to Demand: A Coming Conflagration?

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Introductory Remarks

On behalf of the Protection of Conscience Project I thank Physicians for Life for honouring the Project with the invitation to come to this forum.

More than that, I thank you for being here. I'll echo Dr. John Patrick's words last night; the good news is here. You have no idea how important you are and how much it means to me to see you.

People of my generation and even my parents' generation have tended to be of the opinion that our society and political institutions are, if not the ultimate expression of the goods that democracy has to offer, at least the next best thing to it. But the oldest modern democracy is only a little over 200 years old. And if you think that slavery is incompatible with true democracy, then true democratic government emerged less than 150 years ago. Finally, if you think that true democracy demands universal adult suffrage, a few of the patients you'll encounter are older than true democracy in Canada.

Perhaps some of your professors or preceptors are as well.

My point is that, in historical terms, modern democracy is still in diapers. We like to think that we're experts in the field, that the rest of the world ought to look to us to see democracy in its most perfect and final form.

But - a question. Is it not possible that, as a nation, we are toddlers who have not yet developed the kind of moral balance demanded by the nature of democratic government? We have an appetite for freedom, to be sure, but what kind of freedom? For what purpose? As CS Lewis observed, the kind of things that citizens in a democracy naturally like are not necessarily the things that will best preserve democracy.[1]

What kind of freedom do we seek? For what purpose? You have to seek the answers to those questions, among others.

Now, that obligation falls to every generation. But there are times when that obligation has special significance. I believe that we are living in one of those times. I believe that this obligation has come to you in a special way, all

unlooked for, as the ring came to Frodo Baggins, and that, like him, you will be asked to shoulder unexpected burdens, and go off on unexpected adventures.

Are you up for it? I think you are.

Now, to business.

Caveat

First, I want to emphasize that everything I say about the preservation of personal integrity and protection of conscience in health care presumes the kind of caring physician-patient relationship and dialogue that were recommended and modelled for you yesterday by Doctors Reynolds and Genuis.

Next, you should be aware that the Project is not out to restrict or eliminate abortion or anything else. We do not take a position on the objective morality or desirability of a procedure or service. Instead, the Project simply acknowledges that some activities are morally controversial, and argue that people should not be forced to participate in them, or discriminated against because they refuse to do so for reasons of conscience. For this reason, the Project cannot be described as a pro-life initiative, though that is often how it is perceived. It differs in that way from Physicians for Life.

However, like Physicians for Life, the Project is a non-denominational initiative that operates within a secular framework. The Advisory Board includes scholars from different countries, rom Judaeism, Christianity and Islam.

Presentation topics

I am going to touch on some developments especially relevant to freedom of conscience in health care, with a focus on the last two years, and then deal briefly with the positions of Colleges of Physicians and Surgeons in Canada.

A World Tour: 2006 to 2008

So what of the last couple of years?

In January, 2006 the Washington Post reported that debate about freedom of conscience in health care was "gaining new prominence" and "intensifying" in the United States. More than a dozen states were considering protective legislation, and about half that number had drafted laws specifically for pharmacists.[2]

By the end of 2007, one bioethics site noted that freedom of conscience in healthcare had been "a hot bioethical topic" during the year. It predicted that it would "remain in the spotlight for 2008."[3] As everyone here knows, it has certainly been in the spotlight in Ontario, courtesy the Ontario Human Rights Commission and the College of Physicians and Surgeons.[4] But that controversy is only part of a bigger picture that I hope to outline for you.

You may notice I said the Ontario controversy "is" part of the picture. The spotlight caught the College and the OHRC like deer in the headlights in August and September, but the controversy is

far from over. An American observer, Wesley Smith, believes that issues of conscience will "likely . . . become one of the most heated bioethical controversies in the years to come." Just last week, he warned: "Expect the fight over conscience to become a political conflagration."[5]

From a certain perspective, this can be seen as one of those good-news, bad-news stories. The good news is that I am not a medical student or health care professional. The bad news is that you are. You can take that as a feeble attempt at humour, or as the frank opinion of an increasing number of highly influential people.

Won't prescribe contraceptives or facilitate abortion because of your moral or religious view? Then it's bad news that you are medical students. Scum like you - that's the word used by a University of Toronto professor - scum like you, he said, should resign from medicine and find another job.[6] Resign, and get another job. I've heard that statement, over and over again, often from people reputed to be progressive, tolerant and enlightened citizens of the true north strong and free.

Using a few items from the Breaking News section of the Project site, I'll take you on a quick world tour to see what might have contributed to Wesley Smith's grim prognosis.

First, and most recent: Australia.

Catholic hospitals in the Australian state of Victoria may close as a result of a new law that makes referral for abortion mandatory.[7]

Crossing the Pacific to North America, many of you will have heard about the California case in which a lesbian sued two Christian doctors who refused to artificially inseminate her. What you may not know is that the physicians not only referred her for the treatment, but paid some of the expenses incurred as a result. Her argument is that referral was not good enough because race and sexual inclinations are equivalent. Since physicians cannot refuse to treat kidney disease in a patient because of his race, they cannot refuse to inseminate a woman in a lesbian relationship. Even referral is held to be a violation of human rights.[8]

Here, in Canada, St. Elizabeth's Hospital in Humboldt, Saskatchewan stopped contraceptive tubal ligations because they were contrary to Catholic teaching. Two physicians then resigned in protest.[9] A woman complained to the provincial Human Rights Commission that denial of tubal ligation was discrimination based on gender and religion. The Saskatchewan Catholic Health Corporation had to pay almost $8,000.00 to settle the complaint.[10] Ultimately, the hospital's Catholic affiliation was ended and control of the hospital was transferred to a regional health authority.[11]

Across the Atlantic, the opposition to abortion that is a feature of indigenous African culture is in conflict with documents like the Maputo Plan of Action and the Maputo Protocol, all of which are intended to establish abortion (and other things) as legal rights.[12]

Last year, the Committee for the Elimination of Discrimination Against Women (CEDAW) asked Polish representatives "[h]ow many doctors had been suspended or fired because they refused to perform abortions?" The question appeared to reflect an expectation that such practices should be the

norm.[13]

In Portugal, abortion up to ten weeks gestation was legalized in 2007.[14] As a result of widespread conscientious objection, the Portuguese Health Minister ordered the Portuguese Medical Association to remove the prohibition of abortion from its code of ethics.[15] He insisted that it was unacceptable for codes of ethics to "go against the general law of the country."[16] The Association eventually deleted direct reference to abortion in the code. The new language affirms that life is the highest value and cannot be interrupted after it begins, but the Association has adopted a neutral position as to when life begins.[17]

Just next door, the Spanish Socialist Workers' Party's platform includes plans to restrict freedom of conscience for medical professionals.[18]

In northern India a judge gave a deadline to employees of the Medical Health Department to bring ten people in to be sterilized. Catholic teachers were ordered to promote sterilization among their pupils and their families.[19] Nurses at a convention in Bangalore reported that they were being forced to pariticpate in abortions, and that some who refused had been forced to resign.[20]

A young nurse in Pakistan who refused to perform an abortion on two women was gang raped by three men from their families. The Punjab Health Association stated that this was not the first such incident.[21]

Other contexts

As you can see, conflicts of conscience most commonly arise within the context of reproductive health care. But that is hardly the only context.

Belgium. In 2007, the ruling party announced that it would force every hospital in the country to provide euthanasia or to refer patients to facilities that would do so. The party was willing to tolerate conscientious objection by physicians on condition that they refer them for euthanasia provided by more willing colleagues.[22] The party was merely following the lead of the Flemish GP's association and the Universities of Ghent and Louvain, which had jointly recommended mandatory referral for euthanasia.[23] By the way, the reasoning in their joint statement precisely parallels the reasoning of preceptors who failed a medical student on an obstetrics rotation because he was unwilling to refer for abortion or the morning after pill.

Several articles in a 2006 number of the *Journal of Medical Ethics* discuss the use of patients in persistent vegetative states as experimental subjects. Some authors asserted that they would be especially useful in studies of the long-term effects of animal organ transplants.[24]

What to do if a patient wants a prostitute and isn't able to arrange for one himself? The Douglas hospice in Oxford, England, made the necessary connections. The hospice foundress explained: "It is not our job to make moral decisions for our guests." No paternalism here, to be sure, but certainly the suggestion that a physician who truly respects patient autonomy will help him to find a 'sex trade worker.'[25]

But what if the patient is urgently in need of the kind of sexual health care provided by prostitutes, and timely access to a prostitute is not possible? What duty of care does the physician owe to the patient in such circumstances? The mantra, "patient centred care" suggests an answer. So, too, does the refer-or-provide-it-yourself model that the establishment favours for other kinds of reproductive health care. That is part of the noble calling of a physician, isn't it? To sacrifice oneself for the good of the patient?[26]

Responses to contentious services

You will have noticed the frequent reference to "rights" in this whirlwind sampling. It's now time to see something of what lies behind all of this.

People commonly respond to a morally contentious service in one of three ways:

1. The first is to consider it a legitimate medical service without restriction or qualification, like palliative care.
2. The second is to consider it a medical service that is legitimate in some circumstances but not in others.
3. The third is to reject it absolutely, as something that should never be done.

Two of the three possible responses can give rise to conscientious objection by health care personnel. Hence, one ought to heed the advice of the British Medical Journal; when legalization of a contentious medical procedure is contemplated, it would be prudent to first consider how many health care professionals are willing to assist with it.[27]

Failure to take this advice has consequences, and these consequences have become especially evident in the case of abortion, which we might take as an exemplar of contentious procedures. We have seen what happened in Portugal. Spain has found few physicians willing to perform the procedure.[28] That there are not enough physicians willing to provide abortions is a frequent complaint of American abortion rights activists.[29]

The reluctance of many health care workers to participate is complicated by the fact that many of those who are willing to provide the service in some circumstances are unwilling to do so in others. The response to what they consider late term abortions[30] is frequently adverse,[31] so that women wanting late term abortions may have to travel from one country to another.[32] Late term abortions can even lead to resignations[33] and threats of legal action.[34] Further: gestational age is only one of the factors that can give rise to conscientious objection.[35] And even after legalization, opposition to abortion does not necessarily diminish over time.[36]

Four stage progression

First Point: expectation vs. reality

I suggest that this demonstrates that the *British Medical Journal* was right. An expectation that medical personnel will provide or facilitate abortions runs up against the fact that a not insignificant

number of them - in some circumstances, even a majority - are unwilling to do so for reasons of conscience.

This is the first point I want to draw to your attention: that there is a fundamental conflict between the expectation that health care workers will provide abortions, and the reality that many of them may be unwilling to do so.

Second Point: expectations rise

My second is that this expectation is not static; it tends to rise. It is fuelled by continuing pressure to legalize abortion, liberalize existing abortion laws and expand abortion services, so it is continually colliding with resistance and opposition to abortion, especially in countries that have strong cultural and religious traditions against the practice.[37]

Third Point: expectation to demand

My third point is that rising *expectation* that health care workers will provide abortions tends to evolve into a *demand* that they do so: that they should have no choice in the matter.[38]

Now, advocates of safe and legal abortion have campaigned for years using slogans like 'freedom of choice.' They describe themselves as 'pro-choice' rather than 'pro-abortion,' and protest vigorously against what they perceive as attempts to 'impose morality.' So one would think that these activists would be among the first to defend freedom of choice for health care workers. In principle, it should not be at all difficult to move from,"If you are against abortion, don't have one," to, "If you are against abortion, don't do one."

Remarkably, this is not the case. What others call "conscience clauses" they call "refusal clauses"[39] "denial clauses"[40] or "patient abandonment clauses;"[41] conscientious objection, in their view, is "denying access to medical care."[42] They want all medical students trained in the procedure,[43] and, at a minimum, demand that health care workers who object to abortion refer patients to someone who will provide the service.[44] They lobby vigorously against freedom of conscience legislation,[45] and tactics can extend to misrepresenting the ethical and legal obligations of health care workers.[46] They will even incite complaints against conscientious objectors.[47]

In short, many "pro-choice" activists do not support freedom of choice, unless it is a choice of their choosing. Instead, they contribute substantially to the dynamic by which expectation evolves into demand. Such groups are typically well-funded, well-connected within the professions of health care and law, command the attention of politicians and policy makers, and have a significant impact in the media.[48] Unfortunately, their views are often supported by state institutions and the media.[49]

Fourth Point: from demand to right

Recall my first point: an expectation that health care workers will provide abortion vs. the reality that many are unwilling to do so.

My second: rising expectation collides with opposition.

Third: rising expectation evolves into demand.

We have not yet done with the progression; there is one more stage. When the demand is resisted - as it continues to be - demand evolves into a claim of rights.[50]

I am not now talking about the earliest use of rights language. When the National Association for the Repeal of Abortion Laws opened its doors in the United States in 1969, the claim that abortion was a right was directed only at the repeal of laws against abortion, so that women would be free to seek abortions and physicians free to provide them.[51] At that time there were repeated assurances that "nobody would be forcing abortion procedures on anyone else."[52]

I am not now talking about "rights language" from this early period, but about current claims of rights that, contrary to early activist promises, are meant to force health care workers and institutions to provide or at least facilitate abortions. One of the most important 'movers and shakers' in this field is the Center for Reproductive Rights,[53] an American advocacy group described in internal documents as an organization "comprised largely of economically advantaged white women."[54]

Center for Reproductive Rights

Actually, as the name of the Center implies, current rights claims involve more than abortion; the Center's agenda includes, among other things, the legal enforcement of what it describes as inalienable sexual rights.[55] In this it is allied with the International Planned Parenthood Federation, which recently issued a declaration on sexual rights.[56]

The ultimate goal of the Center, Planned Parenthood and their allies is to establish what the Center calls "hard norms" - treaty-based international laws[57] - that recognize access to abortion as a fundamental human right.[58] It plans to develop a "culture of enforcement" that will compel governments to respect this 'right'[59] and enforce it against third parties - *you*.[60] Even as it works toward this end, it is cultivating "soft norms" in the form of statements by international, regional, and intergovernmental bodies.[61]

Should the Center be successful it acknowledges that it will have effected "profound social change."[62] It will also have destroyed almost all hope of respect for freedom of conscience in health care. For if refusal to facilitate abortion were to become, in law, an offence like racial discrimination, conscientious objection would be prohibited, just as racial discrimination is now prohibited.[63]

Since the stakes are so high, I want to draw your attention to some key features of the Center's strategy, notably its focus on securing a following among social, political, academic and professional elites.[64] The medical profession is one of the "key sectors"[65] that figures prominently in this strategy; so, too, does the legal community.[66] The approach is summed up in a question ,"How can we influence the people who influence the legal landscape around reproductive rights?"[67]

The courtship of the elites occurs in academic, professional and bureaucratic communities, largely out of the public eye, thus avoiding what one memo calls "nasty opposition."[68] This is especially important if professionals and academics may be more sympathetic to the CRR agenda than ordinary people.[69] An internal memo values the "stealth quality to the work," through which the Center

achieves "incremental recognition of values without a huge amount of scrutiny from the opposition."[70]

Despite an admission that a 'right' to abortion *cannot* be found in existing international instruments, the Center and its allies argue that it is implicit in other internationally recognized rights, such as the right to life, liberty and security, and rights to privacy and freedom from discrimination.[71] They hope to secure "hard norms" by having binding treaties or protocols interpreted in this way,[72] in the expectation that other adjudicators will find such rulings persuasive.[73]

The Center's cultivation of "soft norms" is a very similar process, but takes place not only in adjudicative bodies but in international conferences that produce non-binding but persuasive opinions.[74] As "soft norms" quietly accumulate it becomes easier for the Center to claim that they represent an emerging consensus that should be codified in binding "hard norms."[75] The development of "soft norms" is of great moment for freedom of conscience in health care because they will likely have the most immediate impact on conscientious objectors.

Professional associations, educational and regulatory authorities and influential individuals can support the CRR's work by developing "soft norms" closer to home. Colleagues, academics, med school professors and preceptors will argue that the provision of abortion or, at least, referral for abortion, is an expected or even legally required standard of care.[76] Ethicists and professional journals not infrequently express opinions hostile to freedom of conscience,[77] as do individual health care practitioners.[78]

If such claims are repeated often enough by influential persons - even if the claims are false or exaggerated - they gradually assume the character of a new norm. This new norm will be implemented by the disciplinary apparatus of self-governing professions as a standard of care: first, by pressure, in the form of pointed suggestions, informal cautions and official guidance. Many objectors, fearing more serious consequences, may be reluctant to dispute or resist. Medical students are most vulnerable to this kind of pressure.

Eventually, an objector will be charged for professional misconduct.[79] It is quite likely that members of the professional tribunal hearing the case will, by that time, have already been convinced of the new rights-based standard of care, or will have been prepared to accept the claims of experts called to testify to it. Should they ratify it by ruling against the objector they will create a new "soft norm" that the CRR can use in other fora in its continuing quest for international "hard norms."

What can be done?

Well, what can be done about this?

I suggest three things: resist, counter and protest.

Resist pressure to conform to expectations that contradict your fundamental beliefs. This implies that you must know what you believe, why you believe it, and what practical implications flow from

it. For example: if you refuse to prescribe contraceptives to unmarried patients, you must be prepared to explain what you mean by "married." Christian marriage? Religious marriage? Non-religious marriage? Marriage before a marriage commissioner? Common law marriage?

Resist, and counter.

Counter the pressure. This implies that you must understand the arguments being made against your position, and that you can respond with arguments that make a plausible case for accommodating it.

Resist, counter and protest.

Protest the pressure. Speak out. Write letters. Use petitions. Make submissions. The strategy employed by the Center and its allies depends, to a significant degree, on creating the false impression that there is a 'soft norm' supported by a consensus among People Who Matter. Use every opportunity to demonstrate that no such consensus exists.

As an example of what can be done, and of the kind of work the Project does to support you, I will close with an extract from the submission to the College of Physicians and Surgeons of Ontario. But first, Colleges of Physicians in Canada.

Policies of Canadian Colleges of Physicians

As I remarked last night, even Henry Morgantaler supports freedom of conscience for physicians with respect to actually performing abortion,[80] so you won't find any of the Colleges requiring that. Their attitudes are conveniently demonstrated by their policies on referral.

The Project has corresponded with Colleges of Physicians in British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, New Brunswick and Nova Scotia on issues relevant to freedom of conscience for physicians. We have been unsuccessful in engaging Colleges in Prince Edward Island and Newfoundland, and cannot correspond with Quebec authorities because what French I have would only be useful in starting a fight in a bar.

Briefly, only Quebec and Nova Scotia require objecting physicians to facilitate or refer for procedures to which they object for reasons of conscience. The situation in Quebec may be influenced by civil jurisprudence that is based on the Code Napoleon rather than common law. The referral requirement in Nova Scotia was set out in a bulletin that predated the adoption of the Canadian Medical Association's *Code of Ethics* by the Nova Scotia College. Since the CMA position on referral - that it is not required[81] - is not set out in the CMA Code, it would be useful to seek clarification of the College's present position. For this purpose, it would be helpful if a medical student or physician in Nova Scotia were to write to the College, or ask that the Project do so on his behalf.

Project Submission

Returning to the advice to resist, counter and protest, what follows is an example of the work done

by the Project, in the form of an extract from the Project submission to the College of Physicians and Surgeons of Ontario.

IV. The human person

The integrity of the human person

IV.1 The physician, a unique some*one* who identifies himself as "I" and "me,"[82] has only *one* identity, served by a single conscience that governs his conduct in private and professional life. This moral unity of the human person is identified as integrity, a virtue highly prized by Martin Luther King, who described it at as essential for "a complete life."[83]

> [W]e must remember that it's possible to affirm the existence of God with your lips and deny his existence with your life. . . . We say with our mouths that we believe in him, but we live with our lives like he never existed . . . That's a dangerous type of atheism.[84]

IV.2 Against this, some writers have invoked the venerable concept of self-sacrifice. "Professionalism," Professor R. Alta Charo suggests rhetorically, ought to include "the rather old-fashioned notion of putting others before oneself."[85]

IV.3 But self-sacrifice, in the tradition of King, Gandhi and Lewis, while it might mean going to jail or even the loss of one's life, has never been understood to include the sacrifice of one's integrity. To abandon one's moral or ethical convictions in order to serve others is prostitution, not professionalism. "He who surrenders himself without reservation," warned C.S. Lewis, "to the temporal claims of a nation, or a party, or a class" - one could here add 'profession' - "is rendering to Caesar that which, of all things, emphatically belongs to God: himself."[86]

IV.4 The integrity or wholeness of the human person was also a key element in the thought of French philosopher Jacques Maritain. He emphasized that the human person is a "whole, an open and generous whole" that to be a human person "involves totality."[87]

> The notion of personality thus involves that of totality and independence; no matter how poor and crushed a person may be, as such he is a whole, and as a person subsists in an independent manner. To say that a man is a person is to say that in the depth of his being he is more a whole than a part and more independent than servile.[88]

IV.5 This concept is not foreign to the practice of modern medicine. Canadian ethicist Margaret Somerville, for example, asserts that one cannot overemphasize the importance of the notion of 'patient-as-person' and acknowledges a "totality of the person" that goes beyond the purely physical.[89]

The dignity and inviolability of the human person

IV.6 "Man," wrote Maritain, "is an individual who holds himself in hand by his intelligence and his will."

> He exists not merely physically; there is in him a richer and nobler existence; he has spiritual superexistence through knowledge and through love.[90]

IV.7 Applying this principle, Maritain asserted that, even as a member of society or the state, a man "has secrets that escape the group and a vocation which the group does not encompass."[91] His whole person is engaged in society through his social and political activities and his work, but "not by reason of his entire self and all that is in him."[92]

> For in the person there are some things - and they are the most important and sacred ones - which transcend political society and draw man in his entirety above political society - the very same whole man who, by reason of another category of things, is a part of political society.[93]

IV.8 Even as part of society, Maritain insisted, "the human person is something more than a part;"[94] he remains a whole, and must be treated as a whole.[95] A part exists only to comprise or sustain a whole; it is a means to that end. But the human person is an end in himself, not a means to an end.[96] Thus, according to Maritain, the nature of the human person is such that it "would have no man exploited by another man, as a tool to serve the latter's own particular good."[97]

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

> To the right of the individual to be treated as an end, which entails his right to the full development and expression of his personality, all other rights and claims must, the democrat holds, be subordinated. I do not know how this principle is to be defended any more than I can frame a defence for the principles of democracy and liberty.[98]

In company with Maritain, Professor Joad insisted that it is an essential tenet of democratic government that the state is made for man, but man is not made for the state.[99]

IV.10 To reduce human persons to the status of tools or things to be used for ends chosen by others is reprehensible: "very wicked," wrote C.S. Lewis.[100] Likewise, Martin Luther King condemned segregation as "morally wrong and awful" precisely because it relegated persons "to the status of things."[101]

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

> . . . we must never treat a person as a means to an end. This principle has a universal validity. Nobody can use a person as a means towards

> an end, no human being, nor yet God the Creator.[102]

IV.12 Maritain, Joad, Lewis, King and Wojtyla reaffirmed in the twentieth century what Immanuel Kant had written in the eighteenth: "Act so that you treat humanity, whether in your own person or in that of another, always as an end and never as a means only."[103]

Human dignity and freedom of conscience

IV.13 Perhaps ironically, this was the approach taken when Madame Justice Bertha Wilson of the Supreme Court of Canada addressed the issue of freedom of conscience in the landmark 1988 case *R v. Morgentaler*. Madame Justice Wilson argued that "an emphasis on individual conscience and individual judgment . . . lies at the heart of our democratic political tradition."[104] 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.[105]

IV.14 "Everyone" includes every physician. But, at this point in the judgement, Wilson was not discussing whether or not the conscience of a woman should prevail over that of an objecting physician, but how the conscientious judgement of an individual should stand against that of the state. Her answer was that, in a free and democratic society, "the state will respect choices made by individuals and, to the greatest extent possible, will avoid subordinating these choices to any one conception of the good life."[106]

IV.15 Quoting the above passage from Professor Joad's book, Wilson approved the principle than a human person must never be treated as a means to an end - especially an end chosen by someone else, or by the state. Wilson rejected the idea that, in questions of morality, the state should endorse and enforce "one conscientiously-held view at the expense of another," for that is "to deny freedom of conscience to some, to treat them as means to an end, to deprive them . . .of their 'essential humanity'."[107]

IV.16 In the tradition of Kant, C.S. Lewis, Martin Luther King, Cyril Joad and Karol Wojtyla, and following Madame Justice Wilson, for the OHRC or the College of Physicians and Surgeons to demand that physicians provide or assist in the provision of procedures or services that they believe to be wrong is to treat them as means to an end and deprive them of their "essential humanity."

IV.17 The OHRC proposes physicians, as a matter of principle and even as a matter of law, can be compelled to do what they believe to be wrong, and that they can be punished if they do not. It is the position of the Project that this is a blasphemy against the human spirit. Applying to the Commission's demands the words of Alexander Solzhenitsyn, "To this putrefaction of

soul, this spiritual enslavement, human beings who wish to be human cannot consent."[108]

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25. "Sister Frances described Mr Wallis as "delightful, intelligent and aware young man". "I know that some people will say 'You are a Christian foundation. What are you thinking

about?'. But we are here for all faiths and none," she said. "It is not our job to make moral decisions for our guests. We came to the conclusion that it was our duty of care to support Nick emotionally and to help ensure his physical safety." Payne, Stewart, "Hospice helped dying man lose his virginity." *The Telegraph*, 31 January, 2007. (http://www.telegraph.co.uk/news/uknews/1540753/Hospice-helped-dying-man-lose-his-virginity.html) Accessed 2008-11-28.

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

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

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

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

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

31. A survey conducted in 1998, years afer legalization of abortion in the United States, found that most of the 1,200 nurses surveys wanted as little to do with abortion as possible. Poggenpoel, M., Myburgh, C., & Gmeineer, A., (1998, September). "One voice regarding the legislation of abortion: Nurses who experience discomfort." *Curationis*, pp. 2-7. Cited in Marek, Marla J., "Nurses' Attitudes Toward Pregnancy Termination in the Labor and Delivery Setting." JOGNN, 33, 472-479; 2004

32. The reluctance of Scots physicians to provide abortions after 15 weeks gestation has resulted in women travelling to England for the procedure. "Ian Jones, chief executive of the BPAS . . . admitted that it could be difficult to find doctors and nurses, particularly in the west of Scotland, who were prepared to work at the clinic. He said the fact that so many women needed to travel to England for late abortions reflected the fact that medical staff in Scotland do not want to perform them." Templeton, Sarah Kate, "Private firm plans Scottish abortion clinic." *The Sunday Herald*, 19 January, 2003. (http://www.findarticles.com/p/articles/mi_qn4156/is_20030119/ai_n9627244/pg_2) Accessed 2006-06-13). On the other hand, abortions can be obtained in some locations very late into pregnancy. Foster, Kate, "Hospital Admits Abortion At 34 Weeks." *Scotland on Sunday*, 10 April 2005. (http://scotlandonsunday.scotsman.com/index.cfm?id=378472005) Accessed 2006-06-13.

A shortage of willing Canadian physicians caused women from Ontario and Quebec to go to the United States for late term abortions. Quebec Health Minister Philippe:"'In Quebec, our doctors at the present time don't feel comfortable doing abortions later than 22 weeks. From 20 to 22 weeks they're all done in Sherbrooke, after that we still don't have the capacity to do them here.'" "Quebec hopes to offer late-term abortions." *CBC News*, 10 September, 2004. (http://www.cbc.ca/story/canada/national/2004/09/10/abortions_lateterm040910.html) Accessed 2006-06-13.

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

11 February, 2005 (http://www.statcan.ca/Daily/English/050211/d050211a.htm) Accessed 2006-06-13.

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

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

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

34. "Consultants opposed to the killing of the twin, who had been diagnosed with a serious but operable heart defect, have threatened to bring a legal action for unlawful killing against the Royal Victoria Infirmary in Newcastle." "Doctors Revolt over Last-Minute Abortion of Twin." *British Nursing News On Line*, 10 November, 2002. (http://www.bnn-online.co.uk/news_datesearch.asp?SearchDate=10/Nov/2002&Year=2002) Accessed 2006-06-13.

35. Dr. Ward's survey of Western Cape physicians found that half would not do abortions for non-lethal congenital abnormalities. More important was his finding that 46% would refuse to perform abortions for socio-economic reasons; less than a third were willing to do so. Ward, Harvey, *Are State Doctors in the Western Cape willing to implement the Choice of Termination of Pregnancy Act of 1996? An opinion survey conducted in the Western Cape in November 1997*. In fulfillment for the requirements of the FCOG (S.A.) part 2. (http://www.consciencelaws.org\Examining-Conscience-Background\Abortion\BackAbortion15.html)

95% to 99% of nurses surveyed in the California study I have mentioned would refuse involvement in sex selective abortion; the rate of objection to selective reduction in multifetal pregnancies ranged from 71% to 92%. Marek, Marla J., "Nurses' Attitudes Toward Pregnancy

Termination in the Labor and Delivery Setting." JOGNN, 33, 472-479; 2004. The range in both cases reflects responses that differed according to gestational age.

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

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

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

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

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

37. Sometimes this collision is unintended. In England, for example, the Royal College of Nursing general secretary has suggested an expanded role for nurses in abortion. She stated that the organization wants to increase access to abortion in the early stages of pregnancy "and allow

nurses greater involvement in providing services." While the general secretary affirmed the right of nurses to refuse to participate, she does not appear to have recognized that expecting more nurses to participate in abortion will increase the probability of pressure on conscientious objectors. "RCN Says No Need for Change in Abortion Law." *RCN News Release*, 30 June, 2005 (http://www.rcn.org.uk/news/display.php?ID=1600&area=Press) Accessed 2006-06-12.

38. The Center for Reproductive Rights secret policy - exposed by CFAM, despite threats of civil action - is based on this.

39. *Refusal Clauses: A Threat to Reproductive Rights*. Planned Parenthood, (http://www.plannedparenthood.org/pp2/portal/files/portal/medicalinfo/birthcontrol/fact-041217-refusal-reproductive.xml) Accessed 2006-06-13.

Refusal to Provide Medical Services. National Abortion Rights Action League (http://www.prochoiceamerica.org/choice-action-center/in_your_state/who-decides/nationwide-trends/refusal-to-provide-medical.html) Accessed 2006-06-13.

40. *The Contraception Report: A State by State Review of Access to Contraception*. NARAL Foundation, 2001, p. 11. (Available through http://www.popline.org/docs/274304).

41. Quoting Nancy Yanofsky of the ProChoice Resource Center. Good, Regan, "Pharmacies New Reproductive Rights Battleground." Wenews, 13 August, 2002. (http://www.womensenews.org/article.cfm/dyn/aid/1003) Accessed 2006-06-27.

42. "Pro-Choice Michigan's executive director, Rebekah Warren, said 'these big, blanket conscience clauses really could deny patients access to the medical care that they need, to the information that they need and to referrals that they need.'" Komp, Catherine, "'Conscience Clauses' Could Usher Healthcare Access Crisis." *New Standard*, 29 March, 2006. (http://newstandardnews.net/content/?action=show_item&itemid=3007) Accessed 2006-03-30.

43. The executive director of the New York affiliate of the National Abortion and Reproductive Rights Action League, Ms. Kelli Conlin, said she wanted to be sure that all of New York's mayoralty candidates were "committed to ensuring that medical residents at city hospitals were trained in abortion procedures." Bumiller, Elisabeth, "Abortion Rights Leader Mulling Endorsement in Mayoral Race." *New York Times*, 6 April, 2001 (http://www.nytimes.com/2001/04/06/nyregion/06ABOR.html?searchpv=nytToday) Accessed 2006-06-13.

"Joyce Arthur, a spokesperson for the Pro-Choice Action Network in Vancouver, says all students, including pro-life ones, should be compelled to learn about abortions and refer patients to pro-choice doctors, whether they like it or not. 'It's sort of an obligation that they learn about

this basic and very common medical procedure,' she says. She adds that if prolifers cannot stomach this, then 'they shouldn't be a doctor,' and they'd have to find a different profession." O'Neill, Terry, "Should doctors be forced to abandon their faith?" *Western Standard* Magazine, 2004 (http://www.consciencelaws.org\Repression-Conscience\Conscience-Repression-35.htm)

A trustee of the Center for Reproductive Rights stated: "Abortion is a medical procedure and all medical students who are in the OB/GYN specialty should be required to learn the procedure. Medical school curricula must address this." *The Center for Reproductive Rights: Summary and Synthesis of Interviews* (E2545) (See note 53).

A journalist researching Medical Students for Choice noted that its brochure outlined the goal of having "all medical students train to be abortionists." Edwards, *Greg J., Medical Students for Choice: Pro-choice group at UBC hard to locate, unless you're a fan.* (http:\\www.consciencelaws.org\Examining-Conscience-Background\Abortion\BackAbortion30.html)

Medical Students for Choice Policy encourages medical schools to include the following in their curriculum for **all students** (emphasis added)
:

- didactic instruction on the public health, social and historical context of abortion
- medical and surgical abortion techniques
- pre- and post-abortion management
- pregnancy-options and contraceptive counseling.

Medical Students for Choice Policy on Abortion Training (http://www.ms4c.org/policy.htm) Accessed 2006-06-13.

44. McLeod, Carolyn, "Demanding Referral in the Wake of Conscientious Objection to Abortion." In Cohen, JC and Keelan, JE (Eds.) *M C I S B R I E F I N G S: Comparative Program on Health and Society, Lupina Foundation Working Papers Series 2004–2005* (January, 2006). Munk Centre for International Studies, University of Toronto. (http://www.utoronto.ca/cphs/WORKINGPAPERS/CPHS2004_WorkingPapers.pdf) Accessed 2006-04-07.

45. The *Abortion Non-Discrimination Act* (USA) was added to an omnibus spending bill, which passed the House of Representatives in November, 2004. The amendment was attacked by ostensibly 'pro-choice' groups, including Planned Parenthood, the National Organization for Women (NOW) and the National Abortion Rights Action League (NARAL). *'Pro-choice' groups attack freedom to choose: NARAL, NOW and Planned Parenthood* (November, 2004) (http://www.consciencelaws.org\Project\Repression-Conscience\Conscience-Repression-39.htm)

46. During a CTV News interview on 2 June, 2001, the executive director of Planned Parenthood in Calgary, Alberta, claimed that physicians who object to abortion for reasons of conscience are ethically obliged to refer patients for abortion. The assertion was false. Murphy, Sean, "Planned Parenthood and "Anti-Choice" Rhetoric." Protection of Conscience Project (http://www.consciencelaws.org/Conscience-Archive/Commentary/Conscience-Commentary-2004-07-to-12.html#Planned Parenthood and Anti-Choice Rhetoric)

47. Toneguzzi, Maria, "Planned Parenthood Targets 'Anti-choice' Docs." *Calgary Herald*, 19 August, 2004.

Planned Parenthood Alberta, *Be Aware of Anti-Choice Doctors and Radiologists* (http://www.plannedparenthoodalta.com/education/abortion_opt.htm) Accessed 2004-08-28.

"Abortion groups are launching a campaign to name doctors who refuse to help women seeking terminations. . . In an even more aggressive move, patients are being urged to report to the General Medical Council (GMC) doctors who refuse to play any role in terminations." Templeton, Sarah Kate, "Abortion lobby in campaign to expose pro-life doctors." *The Sunday Times*, 17 July, 2005 (http://www.timesonline.co.uk/article/0,,2087-1697523,00.html) Accessed 2006-06-13.

Foster, Charles, "Conscientious objection to abortion - ethics, polemic and law." *Triple Helix*, Autumn, 2005 (http:\\www.consciencelaws.org\Examining-Conscience-Legal\Legal33.html)

48. For example, the Center for Reproductive Rights Board of Directors includes:

Executive Committee Members
Nicki Nichols Gamble (Vice Chair), Former President and CEO, Planned Parenthood of Massachusetts
Francis W. Hatch, III (Vice Chair), Chairman, The John Merck Fund
Betsy K. Karel (Chair), Board Chair, Trellis Fund
Nancy J. Northup (Ex-Officio 1/13/03), President, Center for Reproductive Rights

General Members
Laurie G. Campbell (Treasurer and Chair of Finance Committee)
Jane E. Hodgson, MD, MS, FACOG, Founding Fellow, America College of Obstetricians and Gynecologists
Sylvia A. Law, Elizabeth K Dollard Professor of Law, Medicine and Psychiatry, New York University Law School
Marcie J. Musser, Vice President and Treasurer of the Board, General Service Foundation
Nafis Sadik, MD, Special Envoy for United Nations, Secretary General for HIV/AIDS

in Asia and Pacific
Sheldon J. Segal, PhD, MD, FRCOG (Secretary), Distinguished Scientist, The Population Council
Marshall M. Weinberg, Board Member, American Jewish Joint Distribution Committee
The Center for Reproductive Rights Board of Directors - Primary Affiliation Information (E2547) (See note 53).

In Canada, the following individuals are among those active against freedom of conscience in health care:

Jocelyn Downie, B.A. (Queen's) 1984; M.A. (Queen's) 1985; M.Litt. (Cambridge) 1990; LL.B. (Toronto) 1993; LL.M. (Michigan) 1996; S.J.D. (Michigan) 1999

- Canada Research Chair in Health Law and Policy
  Professor, Faculties of Law and Medicine, Dalhousie University
  (http://law.dal.ca/Faculty/Full_Time_Faculty/Bios/Jocelyn_Downie/index.php) Accessed 2008-12-02

Bernard Dickens, LL.B. King's College, University of London, 1961; Barrister, English Bar (Inner Temple), 1963; LL.M. King's College, University of London, 1965; Ph.D. (Criminology Division of Law), King's College, University of London, 1971; Barrister & Solicitor, Ontario Bar, 1977; LL.D. (Medical Jurisprudence) University of London, 1978;

- Professor Emeritus of Health Law and Policy, Faculty of Law, University of Toronto
  Professor Emeritus, Faculty of Medicine, University of Toronto
  Professor Emeritus, Joint Centre for Bioethics, University of Toronto

Other Current Appointments include:

- Chair, Research Ethics Board, Health Canada, Ottawa
  Departmental Editor for Ethics, American Journal of Public Health
  Member, Standing Committee on Ethics, Canadian Institutes of Health Research
  Member, Committee on Ethical Aspects of Human Reproduction & Women's Health, International Federation of Gynaecologists and Obstetricians (FIGO)
  Member, Editorial Advisory Board, Bibliography of Bioethics, Kennedy Institute of Ethics,
  Georgetown University, Washington, D.C.

Awards:

- F.R.S.C. Royal Society of Canada, 1998
  O.C. Officer of the Order of Canada, 2006
  LL.D. (Honoris Causa), University of Sherbrooke, 2007

(http://www.cihrt.nl.ca/pdf/Bio%20of%20Bernard%20M.%20Dickens.pdf) Accessed 2008-12-02

Rebecca Cook, J.S.D. 1994, LL.M. 1988 (Columbia University, School of Law); J.D. 1982 (Georgetown University Law Center); M.P.A. 1973 (Harvard University, Kennedy School of Government) M.A. 1972 (Tufts University, Fletcher School of Law and Diplomacy); A.B. 1970 (Barnard College, Columbia University); Attorney 1983 (Washington, D.C. Bar)

- Faculty of Law Professor in International Human Rights, University of Toronto
  Co-Director, International Programme on Reproductive and Sexual Health Law
  Professor, Faculty of Medicine, Department of Health Policy, Management and Evaluation

- 1999 Fellow, Royal Society of Canada
  1998 Ludwik and Estelle Jus Memorial Human Rights Prize, University of Toronto
  1997 Certificate of Recognition for Outstanding Contribution to the Promotion of Women's Health, awarded by the International Federation of Gynecologists and Obstetricians

(http://www.law.utoronto.ca/faculty_content.asp?profile=14&perpage=151&cType=facMembers&itemPath=1/3/4/0/0) Accessed 2008-12-02

Sanda Rodgers, B.A. (Case Res.), LL.B. (McGill), B.C.L. (ibid.), LL.M. (Mtl.), of the Bar of Ontario, Full Professor

- Professor and former Dean of the Faculty of Law, University of Ottawa; Shirley Greenberg Professor in Women and the Legal Profession; recipient of the Women Lawyers Association Award for Outstanding Contribution to the Legal Profession and the Ottawa Women's Choice Award for Outstanding Contributor to Gender Equity.
- In 2000 she was an Elected Bencher: Law Society of Upper Canada .She is an expert in Canadian health law, more particularly in women's reproductive health; an Adjudicator under the Grandview Agreement between Ontario and the Grandview Survivors Group and was the sole Adjudicator of the Agreement for Compensation for the Sir James Whitney School for the Deaf.
- She was a Commissioner, Ontario Law Reform Commission and a Consultant to the Royal Commission on New Reproductive Technologies and the Krever Commission on Confidentiality of Health Information, among others. She is a member of the Board of Directors of the Court Challenges Programme.

(http://www.commonlaw.uottawa.ca/index.php?option=com_content&task=view&id=1767&Itemid=161&pid=161&lang=en) Accessed 2008-12-02

49. ". . . hospital boards should never have been allowed a choice in the matter. The Government should . . . require hospitals which receive public grants to establish abortion committees." *Globe and Mail*, 18 January 1974. Quoted in de Valk, Alphonse, *Morality and Law in Canadian Politics: The Abortion Controversy*. Dorval, Quebec: Palm Publishers, 1974, p. 137

A Chinese doctor testifying before an Australian Senate Committee in 1999 stated that conscientious objection to the state's "one-child-policy"was not allowed, and that doctors who refused to perform abortions would go to jail. *Chinese health care workers and the 'one-child' policy:China (1983-1999)* Protection of Conscience Project (http://www.consciencelaws.org\Repression-Conscience\Conscience-Repression-13.html)

"Feminist organizations in Equador have set up tribunals operating within the legal framework of the government which will investigate violations of 'gender rights' including the 'refusal to perform legal abortions.'" (*Inter Press Service*, December 17 1999) (http://www.lifesite.net/ldn/1999/dec/99122204.html) Accessed 2006-06-13.

While visiting East Timor in 2000, Dr. Robert Walley of MaterCare International was alarmed by the conduct of officials from the World Health Organization and CNRT, and "struck by how aggressive they were in imposing their views and their values on the people." He found that Timorese doctors felt "oppressed," and were concerned about the secrecy of WHO and CNRT activities. "They asked for help in developing a separate Catholic system which would provide care in accordance with the values of the Timorese people." "Urgent letter from Dr. Robert Walley for help". *Catholic Insight*, October, 2000, Vol. VIII, No. 8, p. 4. (http://www.consciencelaws.org\Examining-Conscience-Background\Abortion\BackAbortion08.html)

Arthur Schafer, director of the Centre for Professional and Applied Ethics at the University of Manitoba, asserted that conscientious objectors who refuse "legal services" (ie., the 'morning after pill') to patients who have nowhere else to go should leave the profession, apparently settling an ethical problem by appealing to law. Jacobs, Mindelle, "Pharmacists want right of refusal," *Edmonton Sun*, 16 April, 2000

In 2001 the French senate passed a law to compel French Polynesia to publicly fund abortions, despite objections from the Polynesian government that the law was contrary to the territory's religious traditions. The law was affirmed by the French Constitutional Council. "Parish court rules French Polynesia must pay for abortion." *LifeSiteNews.com*, 6 July, 2001. (http://www.lifesitenews.com/ldn/2001/jul/01070602.html) Accessed 2008-11-30

Consider an article in *The Guardian* newspaper in Britain. None of six women interviewed had had medical reasons for abortion, and not one of them said that she had encountered any difficulty obtaining an abortion, but the author asserted that physicians opposed to abortion are "able to block access to services on the basis of moral opposition." Shabi, Rachel, "One in Three." *The Guardian*, 12 October, 2002 (http://www.guardian.co.uk/weekend/story/0,3605,809069,00.html#article_continue) Accessed 2006-06-13).

In 2005 a group of European experts demanded that physicians who object to abortion for reasons of conscience should be compelled to refer patients to someone who will provide the procedure. Their opinion concerned a concordat between the Slovak Republic and the Holy See that would have protected freedom of conscience in the Republic.
Opinion No. 4-2005: The Right to Conscientious Objection and the Conclusion by EU Member States of Concordats with the Holy See. EU Network of Independent Experts on Fundamental Rights, 14 December, 2005, p. 20
(http://ec.europa.eu/justice_home/cfr_cdf/doc/avis/2005_4_en.pdf) Accessed 2008-11-30.

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

51. Similarly, in Canada, Toronto's *Globe and Mail*, advocated legalization of abortion "to enable doctors to perform their duties according to their conscience and their calling." Editorial, "Free the Doctor." *Globe and Mail*, 18 May, 1965. Quoted in de Valk, Alphonse, *Morality and Law in Canadian Politics: The Abortion Controversy*. Dorval, Quebec: Palm Publishers, 1974, p. 18. Two years later the *Globe* argued that, in the case of abortion, "where religious moralities conflict, the State should support none, but leave the choice to individual conscience." Editorial, ["Now the job is to be done, let it be done right." *Globe and Mail*, 21 December, 1967. Quoted in de Valk, *supra*, p. 56

52. The assurance given by a Canadian M.P. to a parliamentary committee studying her private member's bill to legalize abortion. Quoted in de Valk, *supra*, p. 44-45. Similar assurances came from the Canadian Welfare Council: "At the risk of labouring the obvious, no woman will be required to undergo an abortion, no hospital will be required to provide the facilities for abortion, no doctor or nurse will be required to participate in abortion." *Standing Committee on Health and Welfare, Minutes of Proceedings and Evidence, Appendix "SS": Canadian Welfare Council Statement on Abortion to the House of Commons Standing Committee on Health and Welfare.* February, 1968, p. 707.
(http://www.consciencelaws.org/Documents/1968-02-13%20Health-Welfare%20App%20SS.pdf)
Nor was the Catholic Hospital Association concerned: "We note that there is no question of [our hospitals] being obliged to change their present norms of conduct. On the contrary, proponents of a 'liberalized' abortion law admit that it should exempt those who object to being involved in procuring abortions." *Standing Committee on Health and Welfare, Minutes of Proceedings and Evidence, Appendix "QQ": Brief submitted by the Catholic Hospital Association of Canada . . . on the Matter of Abortion*. February, 1968, p. 8058-8059.
(http://www.consciencelaws.org/Documents/1968-02-08%20Health-Welfare%20App%20QQ.pd

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Canadian Prime Minister John Turner rejected a protection of conscience amendment to the government bill legalizing abortion because, he said, the proposed law imposed no duty on hospitals to set up committees, imposed no duty on doctors to perform abortions, and did not even impose a duty on doctors to initiate an application for an abortion. *Hansard- Commons Debates*, 28 April, 1969, p. 8069.
(http://www.consciencelaws.org/Documents/1969-04-28%20Hansard.pdf)

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

The documents cited herein are:
International Legal Program Summary of Strategic Planning: Through October 31, 2003 (E2535)

ILPS Memo # 1- International Reproductive Rights Norms: Current Assessment (E2535-E2538);
ILPS Memo #2- Establishing International Reproductive Rights Norms: Theory of Change (E2538-E2539).

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

DLPS Memo #1- Future of Traditional Abortion Litigation (E2539-2540);
DLPS Memo #2- Report to Strategic Planning Participants From Systematic Approach Subgroup (E2540-E2541).
DLPS Memo #3- Report to Strategic Planning Participants From "Other Litigation" Subgroup (E2541-E2542).

Program Strategies and Accomplishments (E2543)
The Center for Reproductive Rights: Summary and Synthesis of Interviews (E2543-2546)
The Center for Reproductive Rights Board of Directors - Primary Affiliation Information (E2547)

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

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

56. International Planned Parenthood Federation, "Sexual rights: an IPPF declaration." Adopted May, 2008. (http://www.c-fam.org/docLib/20081113_SexualRightsIPPFdeclaration.pdf) Accessed 2008-11-28.

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

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

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

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

"The Center needs to continue its advocacy to ensure that women's ability to choose to terminate a pregnancy is recognized as a human right." *ILPS Memo # 2*, E2539

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

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

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

61. "Supplementing . . .binding treaty-based standards and often contributing to the development of future hard norms are a variety of 'soft norms.' These norms result from interpretations of human rights treaty committees, rulings of international tribunals, resolutions of inter-governmental political bodies, agreed conclusions in international conferences and reports of special rapporteurs. (Sources of soft norms include: the European Court of Human Rights, the CEDAW Committee, provisions from the Platform for Action of the Beijing Fourth World

Conference on Women, and reports from the Special Rapporteur on the Right to Health.)." *ILPS Memo # 1*, E2535

62. *ILPS Memo # 2*, E2538.

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

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

65. *ILPS Memo #2*, E2538)

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

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

68. *ILPS Memo #1*, E2538

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

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

71. *ILPS Memo #1*, E2536

72. *ILPS Memo #1*, E2537 - E2538

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

74. *ISLP Memo #1*, E2535, E2538.

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

76. University of Toronto law professors asserted in the *Journal of Obstetrics and Gynaecology Canada* that conscientious objectors "should not practise clinical medicine." Cook RJ, Dickens BM, "In Response". J.Obstet Gyanecol Can, February, 2004; 26(2)112 The statement was unsupported by their legal references, and one of which, arguably, contradicted it. The *Journal* reluctantly published a response from the Project, accompanied by a rebuttal from the authors, and thereupon closed the discussion. The legal claims made in the rebuttal proved to be even more problematic than their original article, but the *Journal* has not published a further review by the Project. So readers of the *Journal* will never know, for example, that the leading case cited by the professors *against* freedom of conscience actually supports the view that physicians should *not* be forced to refer for services that they find morally objectionable. Murphy, Sean, *Postscript for the Journal of Obstetrics and Gynaecology Canada: Morgentaler vs. Professors Cook and Dickens*. Protection of Conscience Project (http://www.consciencelaws.org\Examining-Conscience-Legal\Legal30.html)

Charo, R. Alta J.D., The Celestial Fire of Conscience: Refusing to Deliver Medical Care N Eng J Med 352:24, June 16, 2005 (http://content.nejm.org/cgi/content/short/352/24/2471??eaf) Accessed 2008-09-13.

Gordon, Michael, "Belief systems and the professional caregiver." *Medical Post*, October 19, 2004 Volume 40 Issue 39 (http://www.medicalpost.com/mpcontent/article.jsp?content=20041017_121632_4724) Accessed

McLeod, Carolyn, "Demanding Referral in the Wake of Conscientious Objection to Abortion." In Cohen, JC and Keelan, JE (Eds.) *M C I S B R I E F I N G S: Comparative Program on Health and Society, Lupina Foundation Working Papers Series 2004–2005* (January, 2006). Munk Centre for International Studies, University of Toronto. (http://www.utoronto.ca/cphs/WORKINGPAPERS/CPHS2004_WorkingPapers.pdf) Accessed 2006-04-07.

77. Writing in the *Canadian Pharmaceutical Journal* in 2000, an ethicist implied that there is no right to conscientious objection, and insisted that pharmacists must ensure that patients "are provided with recognized pharmacy services, despite personal religious or moral objections." The article was cited at a subsequent Canadian Pharmacy Association conference, where pharmacists who spoke on behalf of conscientious objectors were told by more than one colleague that they should leave the profession. Murphy, Sean, *In Defence of the New Heretics: A Response to Frank Archer.* Protection of Conscience Project. (http://www.consciencelaws.org\Conscience-Archive\Documents\New-Heretics-Conscience.html)

At a 2002 ethics conference in Vancouver hosted by regulatory authorities and professional associations, an ethicist speaking at a plenary session asserted that abortion was a 'legitimate' medical service, and that a patient's wish to have one would take precedence over the 'personal morality' of the physician. When, in private conversation after the session, the Project Administrator reminded him that the Canadian Medical Association did not require referral for abortion because no ethical consensus existed on the subject, the ethicist explained that he had meant to offer only a personal opinion, and that he could be wrong. Of course, that was not the impression he had left with the audience. Letter from the Administrator, Protection of Conscience Project, to the BC College of Family Physicians, 28 April, 2002

Thompson, Polly, The public trust and access to medication, *Canadian Pharmaceutical Journal*, October, 2004, Vol. 137, No. 8. (http://www.pharmacists.ca/content/cpjpdfs/oct04/Editorial-October04.pdf) Accessed 2006-06-13.

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79. Parallel litigation can also be initiated outside the professions in quasi-judicial forums, like human rights tribunals, especially if professional regulatory forums are perceived to be less

receptive to the complainant's case.

80. **Should doctors be allowed to conscientiously object to performing an abortion?** Yes. One fundamental reason is that doctors should not be obliged to do things which they don't approve of themselves, and secondly, a more practical reason, a doctor who doesn't believe in it is more likely not to do a good job. *National Review of Medicine*, Vol. 5, No. 1, "The Morgentaler decision turns 20." (Interview with Dr. Henry Morgentaler) 15 January, 2008. (http://www.nationalreviewofmedicine.com/issue/interview/2008/5_interview_01.html) Accessed 2008-11-28

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See also "Responses to *Abortion: ensuring access*." Protection of Conscience Project, 2006 (http://www.consciencelaws.org/Conscience-Archive/Commentary/Conscience-Commentary-2006-07-to-12.html#Responses_to_Abortion:_Ensuring_Access__).

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