SUBMISSION
TO
THE ALL-PARTY OIREACHTAIS COMMITTEE
ON THE CONSTITUTION

PROTECTION OF CONSCIENCE PROJECT
19 June, 2000

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Tacaíocht do chonsias
Tacaíocht choinsiasa

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7120 TOFINO ST., POWELL RIVER, B.C., CANADA V8A 1G3 - TEL: (604) 485-9765

19 - 06 - 2000

Do-An Toireachtas-fo-choiste illphairti ar an Mbunreacht
Do Brian O lionnachain, Cathaoirleach

A Mhic ui Lionnachain,

Ar do chaothúlacht, abair le do chómhleacaithe ar an gcóiste, chomh sasta is ataim gur lig sibh dom mo smaointe I scribhinn, a chur ós bhur gcómhair mar gheall ar chosantacht choinsiasa. Treaslaim gur pribhléid é, duine mar mise, nach mbainneann le H-Éirinn,bheith I ndon comhra libh faoi bhur mBunreacht agus faoi bhur diospóireacht inmheanach.

Ní faoi geinmhilleadh,ach faoi saoirse choinsiasa, chomh fada is a bhaineann sé le cursai leighis faoi lathair, ata na smaointe seo. Mo lean-na h-argointi faoi chúrsai léighis go dtí seo-ni raibh siad riamh curtha, ionas go mbeadh,mar deir diad (seal mhachnamh stuamtha), agus mar gheall air sin ni raibh aon mhachnamh deanta ar na rudai a tharlaionn dóibh siud ata in aghaidh geinmhilleadh de réir choinsiasa.

Níl sé deacair a thuiscint cén fáth a tharla se seo. Núair ata na hargointi seo in aghaidh go leor daoine (mar ata leirithe ag Dr. Declan Keane) - tá sé soileir nach mbéidh aon duine ina aghaidh. Ní mar sin ata sé ins an domhain mór, mar ata leirithe ag cúrsai an tsaol.

Tá suil agam go mbéidh sé seo mar chabhair ag an bhfo-chóiste agus go mbéidh cosaint choinsiasa mar bharr-chlarr in Éirinn.

Is mise
Le mór-mheas,
Sean Murphy

Protection of Conscience Project

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7120 TOFINO ST., POWELL RIVER, B.C., CANADA V8A 1G3 - TEL: (604) 485-9765

19 June, 2000

The All-Party Oireachtais Committee on the Constitution,
Fourth Floor, Phoenix House,
7-9 South Leinster Streets,
Dublin 2
Republic of Ireland
ATTN: Mr. Brian Lenihan, TD, Chairman

Dear Mr. Lenihan:

Please convey my thanks to the members of the Committee for the generosity they have displayed in allowing me to make a written submission concerning protection of conscience. I recognise that it is a privilege for someone who is not a citizen to address a committee of a national government concerning its own constitution and laws.

This submission is not about abortion, but about freedom of conscience in relation to morally controversial medical procedures. Unfortunately, discussions about such procedures have not always been accompanied by sufficient reflection about their impact on those who object to them for reasons of conscience.

It is not difficult to understand why this has occurred. When the procedure in question is objectionable to large numbers of people (as indicated in the testimony of Dr. Declan Keane), it is usually assumed that no one would be forced to participate in it. Experience indicates that, in the long run, this is not the case.

I hope that this submission will assist the Committee with its work, and that protection of conscience will receive due consideration in future developments in Ireland.

Sincerely,
Sean Murphy,
Administrator

NOTE
RE: REFERENCES AND DOCUMENTATION

The on-line version of the submission is available to Committee members at

www.consciencelaws.org/archive/coiste_uile-phairti_an_oireachtais.html

By using hyperlinks in the text, the on-line version provides quick access to most of the documents cited.

The written submission uses end notes that provide abbreviated internet addresses for these documents. In order to directly access the document, a reader working from the written submission must include the full URL when entering the document address in a browser. For example:

Abbreviated Form	**Reader Must Type**
/Crimes01.html	www.consciencelaws.org/Crimes01.html
/ExaminingtheIssues/Ethical/Articles/Ethical01.html	www.consciencelaws.org/ExaminingtheIssues/Ethical/Articles/Ethical01.html

The on-line version of the submission will be linked to the Project site and made available to the public on 23 June.

SUBMISSION
TO
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I. The Protection of Conscience Project

The Project is a non-denominational, non-profit initiative supported by a project team and advisory board. The Project

> "advocates for protection of conscience legislation;
>
> "promotes clarification and understanding of the issues involved to assist in reasoned public discussion;
>
> "acts as a clearing house for reports from people who have been discriminated against for reasons of conscience, directing them to legal assistance and other support when possible.

The advisory board consists of seven people with advanced degrees in law, medicine, political science, philosophy and theology; it includes directors of bioethics institutes in Australia and the Netherlands. The advisors reflect the non-denominational character of the Project. (See Appendix)

Our website (www.consciencelaws.org) serves as an electronic journal and archive. It includes the text of existing and proposed legislation and policies, and news, articles, essays and background information relating to rights of conscience.

The Project does not direct or manage protection of conscience initiatives. Instead, for the benefit of people working for or in need of protection of conscience, it provides information, offers suggestions, encourages co-operation and facilitates communication.

Accordingly, this submission will advance principles and refer to experience that the Committee may wish to consider within an Irish context, but it will not suggest specific measures . If there is or will be a need for protection of conscience legislation in Ireland, that need will have to be articulated by Irish citizens, and laws and policies framed according to the circumstances prevailing in Ireland.

Note that the Project does not address substantive questions about the morality of controversial procedures, except to the extent that it is necessary to explain the position of conscientious objectors.

II. The Need for Protection of Conscience Laws

Protection of conscience laws ensure that people cannot be forced to participate in medical procedures to which they object for reasons of conscience. Such laws are needed because powerful interests have been inclined to force health care workers and others to participate, directly or indirectly, in morally controversial procedures. In the case of abortion, this has led to discrimination against conscientious objectors, who have been denied employment, dismissed or otherwise penalized because they have declined to participate. Some examples from the period 1977-2000[1]:

> A registered nurse was refused employment at four hospitals because she was unwilling to assist in abortion. She finally agreed to do so, but was forced to resign after refusing to assist at the hysterotomy of a woman who was 5 ½ months pregnant. She eventually left the profession. (1977-1984, British Columbia, Canada)[2]
>
> A social assistance worker was fired because she refused to approve payment for an abortion that would have been illegal under the law as it then stood. (An interview with the worker, whose parents are from Ireland, appeared in a September, 1993 edition of *The Irish Democrat*). (1985, British Columbia, Canada)[3]
>
> A hospital aide was dismissed because she refused to clean abortion instruments. (1986, Indiana, USA)[4]
>
> Three counsellors at a home for battered women were dismissed because they declined to refer women for abortions, and denied three weeks of unemployment insurance benefits because they had lost their jobs through misconduct . The firings were defended by the provincial Minister of Community and Social Services. (1988, Ontario, Canada)[5]
>
> 21 out of 30 paediatric nurses resigned following the amalgamation of hospitals, and ensuing management demands that they participate in abortions. (1988, Ontario, Canada)[6]
>
> Eight nurses at a hospital refused to participate in abortions following hospital restructuring. They were told to leave their department (obstetrics) or seek work elsewhere. Their professional association sided with hospital management. The nurses spent five years and thousands of dollars to secure an agreement that acknowledged their freedom of conscience. One nurse had died and others developed stress-related illnesses by the time the case was settled. (1993-1999, Ontario, Canada)[7]

> Nurses at a hospital were made to participate in genetic terminations - the abortion of late term infants diagnosed with serious disorders. Some of the infants were born alive; one survived 12 hours, during which time nurses took turns rocking it, but were forbidden to feed it.[8] A child who survived similar treatment at Vancouver General Hospital recently received a damage settlement from the hospital- almost 13 years later[9]. To prevent such complications, the Alberta College of Physicians and Surgeons recently authorized doctors to inject potassium chloride into the heart of a seriously malformed fetus to prevent its live birth during genetic termination . The measure does not alleviate the moral conflict faced by conscientious objectors in such circumstances. (1999-2000, Alberta, Canada)[10]
>
> In a bulletin to its members, a College of Pharmacists stated: The moral position of an individual pharmacist, if it differs from the ethics of the profession, cannot take precedence over that of the profession as a whole. The College cautioned them that future pharmacy services might expand to include preparation of drugs to assist voluntary or involuntary (sic) suicide, cloning, genetic manipulation, or even execution. (British Columbia, 2000)[11]

These cases concern abortion, and most of the existing protection of conscience laws were drafted with abortion in mind. However, this is largely an accident of history, a result of the legalisation (by statute or judicial fiat) of what was understood to be a contentious medical practice. It would be a serious mistake to associate a need for protection of laws only with abortion and (in countries with large Catholic populations) artificial contraception or contraceptive sterilisation.

Developing technology and a number of social trends promise to generate *more* moral controversy, not less. Disputes are already underway about the ethics of various forms of artificial reproduction, eugenics, genetic engineering, embryonic experimentation, organ harvesting and tissue trafficking. Lobbies for the legalisation of assisted suicide and euthanasia have been successful in some jurisdictions and continue to be persistent in others, with serious consequences for those who are expected to deliver these services.

III. Predicting the Future: Attitudes in Ireland and Canada

The evidence received by the Committee from Dr. Declan Keane, Master of the National Maternity Hospital, Holles Street, included reference to the extent of opposition to abortion in the Irish medical profession:

> . . .the people who would be asked to carry out the terminations of pregnancy are the gynaecologists in this country, and as I've mentioned already, you know, for religious, moral and ethical reasons most of my colleagues would be extremely unhappy to be asked to do so. In fact most, I am sure, would not do it. . . I would think the vast majority of my gynaecology colleagues would be conscientious objectors to taking any part in that.[12]

Given the prevalence of this view, is it likely that abortion could become so common in Ireland that conscientious objectors would suffer the kind of discrimination illustrated by the cited cases? It hardly seems so. Yet, contrast the cited cases (all but one of which are Canadian) with the following statement from a Canadian physician:

> ...I was a Public Health officer in [British Columbia] from 1961 to 1966. In 1962, I believe it would be, Dr. _____, who was Director of V.D. control, proposed giving birth control pills to [city] prostitutes to prevent them giving birth to congenital syphilitic babies. This was before birth control pills were legal in Canada.
>
> There were about twenty medical officers there, and I spoke out against the proposal, saying that if it was adopted the next step would be to abort any pregnancies that occurred. I was laughed to scorn! [It was said that] No Canadian doctors would ever do abortions.[13]

No one present at that meeting - including the speaker - would have believed that a provincial College of Physicians and Surgeons would one day approve the lethal injection of infants *in utero* as a standard procedure in genetic terminations . Nor was it predicted, when the sale of contraceptives was decriminalized in Canada, that pharmacists who declined to dispense contraceptives and abortifacient drugs would eventually be attacked in newspaper editorials.[14]

An additional factor for the Committee to consider is extra-territorial pressure that may be brought to bear through international agreements like the Convention for the Elimination of All Forms of Discrimination Against Women. The Committee overseeing the implementation of that Convention has stated that refusal to provide abortion for reasons of conscience is an

infringement of women s reproductive rights . [15]

IV. Factors Contributing to Intolerance

Four factors appear to contribute to the increasing intolerance of conscientious objection among health care workers. To the extent that they are operative in Ireland, they warrant the attention of the Committee.

The most important of these is what author Lois Sweet calls **secular fundamentalism**. Secular fundamentalists hold that it is wrong to allow law or public policy to be influenced by religious belief, or by morality derived from religious belief. Typically, they assert that only scientific (meaning empirical) knowledge is factual, and that human society is best served if its laws are based upon neutral facts rather than subjective belief - especially religious belief.[16]

Yet they are believers; they cannot be otherwise. They believe that human dignity exists, that all men are equal, that human life is worthy of respect, that killing is justified when . . ., etc. These are first principles that must be accepted on faith, not facts established by scientific study. Even if they explicitly profess atheism and agnosticism, secular fundamentalists have faith. That God does not exist, or has nothing to do with man's daily life, or cannot be known, are properly religious or theological propositions maintained by faith, not by empirical evidence.

Nonetheless, secular fundamentalists persist in the belief that they do not believe - that they *know*. More important, they believe (for they cannot know) that theirs is that special kind of knowledge required for the just ordering of society, and that only people who share their understanding - who believe what they believe - can be trusted to manage public affairs. When this hidden faith becomes dominant among governing elites, they not only dismiss critiques of law or public policy that are informed by religious convictions, but tolerate religiously motivated acts only to the extent that they are consistent with what social critic Iain Benson has described as "the hidden faith of this new secularity."[17]

The hidden faith of governing elites in modern society is as great a threat to freedom of conscience and religion as was the manifest faith of governing elites in days gone by. Fire, dungeon and sword are out of fashion, but in these more comfortable times, compliance can often be secured by threatening economic and social penalties, or by professional excommunication imposed by licensing authorities.

Note that many of these authorities adhere to **bioethics principlism**, a theory that attempts to apply four "principles of biomedical ethics": non-maleficence, beneficence, justice and autonomy. These first principles - statements of faith - are expressed in the Four Commandments: do no harm, do good, be fair, and respect patient choices. Problems arise, however, because the application of the Four Commandments is impossible without defining

what is meant by harm, by good, and by fairness. Is causing the death of the patient doing good ? Is prolonging life doing no harm ? Answers to such questions depend primarily upon one s understanding of the nature of the human person, the nature of human relationships and concepts of right and wrong. When the hidden faith of the secular fundamentalist yields answers that differ substantially from the faith-based answers of a religious believer, the conflict is likely to end up in court.

Here one meets again the notion of **personal autonomy**, derived in many cases from bioethics principlism.[18] Autonomy is held to be among the defining characteristics of the human person, essential for human happiness, and inseparable from personal dignity. The achievement of personal autonomy is therefore the most important goal of personal development, and the enhancement of personal autonomy one of the most important functions of law, medicine and education. Taken to its logical conclusion, this can transform the traditional obligation to meet the needs of a patient into an obligation to fulfil the patient s *wishes*. The following extract from the Ontario College of Nurses ethical guidelines illustrates this transformation; note the consequences for conscientious objectors.

> ...When a client's wish conflicts with a nurse's personal values, and the nurse believes that she or he cannot provide care, the nurse needs to arrange for another caregiver and withdraw from the situation. If no other caregiver can be arranged, the nurse must provide the immediate care required. If no other solution can be found, the nurse may have to leave a particular place of employment in order to adhere to her or his moral values.[19]

One gains personal autonomy by gaining personal power - the ability to get what one wants or to do what one wants. The watchword is *empowerment*, and all social interactions are interpreted as products of power-based relationships. Conflicts that are actually conflicts of faith - hidden or explicit - are often recast as disputes about power, to be resolved by applying notions of equality to achieve a balance of power.[20]

Personal autonomy is not violated so long as parties to social interaction consent to what is done. It is violated only when something is done without consent, or when consent is improperly obtained. On the other hand, consent will suffice to justify any action which might otherwise be held to violate personal autonomy. In law and in bioethics, the axiom of the autonomous person and the corollary of justification by consent are used to support mercy killing and assisted suicide[21]. Logically, they can be extended to support any other morally controversial procedure.

Socialized medicine has been and continues to be a great benefit to many people, but little attention has been paid to the **dynamic of expectation** that arises following legalisation of a

controversial procedure, especially when the state assumes primary responsibility for the delivery of health care. In the first place, there is an assumption that citizens are entitled to demand from health care providers what they have paid for through taxes. The assumption becomes an expectation when health care providers are perceived to be state employees because private health care has been prohibited or rendered impracticable. Moreover, as the guarantor of a *de facto* social contract for health care, the state is expected to enforce the terms of the contract against reluctant employees and other health care providers.

V. A Plea for Freedom of Conscience

Supporting the drive for personal autonomy is an understanding of freedom primarily as freedom *from* : freedom from restraint, from rules, from direction, from guidance, from immutable principles. People are encouraged to determine the course of their lives and assert who they are by breaking away from moral imperatives and institutions that are perceived to impose constraints or limit freedom of choice. This is not the freedom sought by this submission.

What is sought is freedom *for* : for discerning the good that needs to be done, for choosing the good, for doing good. Such freedom is onerous, for it implies an obligation to distinguish true goods from false, higher goods from lesser. It demands that one form convictions about what is truly good, and live accordingly.

Certainly, this can generate conflict among people pursuing different notions of the good , but the remedy for this is not to have governing elites or a governing majority impose a hidden faith that the good does not exist, or that it cannot be identified, or, perhaps, that the good consists of the pursuit of power in order to maximize personal autonomy.

Instead, we are called to develop the charity, the patience, and the skills necessary to live together peacefully. Above all, we must learn to talk to each other about faith -*all* faith - hidden, explicit, religious, and non-religious.

> Once we realize that everyone necessarily operates out of some kind of faith assumptions, we stop excluding analysis of faith from public life. We cannot simply banish religious faiths from our common conversations about how we ought to order our lives together while leaving unexamined all those implict faiths in such areas as public education, medicine, law or politics. . .
>
> So let us banish this notion of a faith-free secular once and for all. Everyone believes . The question is, what do we believe in and for what reasons?[22]

This is the kind of dialogue encouraged by the Project. Protection of conscience laws provide an opportunity for it to develop.

VI. Practical Points

Laws should be drafted in such a way that they are not easily made obsolete by technological progress.

Experience suggests that protection of conscience legislation is best enacted before or at the time of the legalization of any morally controversial medical procedure. Once a procedure has been legalized, the dynamic of expectation and a process of desensitization make it more difficult to enact protective laws.

An adequate law should protect conscientious objectors from coercive hiring or employment practices, discrimination, and other forms of punishment or pressure. It should also include protection from civil liability, clear enforcement mechanisms and penalties for violators.

It is prudent to consider special protection for those who are especially vulnerable to discriminatory or coercive practices, such as students, or applicants for employment or professional status or privileges. However, draftsmen should ensure that protection is extended to as many people or classes of people as possible.

It is important to recognize that a compromise that involves mandatory referral is unacceptable to many conscientious objectors because they believe that referral is a culpable form of participation in the objectionable act.

Note: The Project website includes a Model Statute and the text of several legislative proposals, as well as existing protection of conscience statutes from different jurisdictions. It does not advocate a specific form of law.

Notes

1. In reviewing the Canadian cases, note that abortion was regulated by therapeutic abortion committees in the period between 1977 and 1988; since that time it has been unrestricted.

2. *Nurse refused employment, forced to resign*. /Crimes03.html

3. *Worker fired for refusing payment for illegal abortion.* /Crimes10.html

4. *Hospital aide fired for refusing to clean abortion instruments.* /Crimes09.html

5. *Transition house works fired, denied benefits for misconduct* . /Crimes04.html

6. *21 out of 30 paediatric nurses resign.* /Crimes05.html

7. *Five year struggle for freedom of conscience takes toll*. /Crimes06.html, /Crimes07.html

8. *Genetic terminations at Foothills Hospital.* /Crimes01.html
Down the slope to infanticide. /Crimes02.html

9. *Baby left to die at Vancouver General Hospital.*
/ExaminingtheIssues/Background/Abortion/BackAbortion02.html

10. Walker, Robert MDs face Internet restrictions: Prescription ban Canadian first . *The Calgary Herald* 10 June, 2000

11. *College of Pharmacists of British Columbia Bulletin*, March/April 2000, Vol. 25, No. 2: Ethics in Practice: Moral Conflicts in Pharmacy Practice .
The Registrar of the College later explained that the term involuntary suicide was a mistake; the term intended was involuntary *euthanasia* . Letter dated 9 May, 2000, from the Registrar of the College of Pharmacists of British Columbia to the Project Administrator.

12. /ExaminingtheIssues/Background/Abortion/BackAbortion05.html

13. Letter to the Project Administrator dated 2 July, 1995

14. It's the 21st century, right? Not if the Manitoba Pharmaceutical Association has its way. Bowing to pressure from the Concerned Pharmacists for Conscience, it wants to drag us back into the 19th, 18th or maybe the 17th century. How else to interpret its announcement that it has adopted a policy which allows pharmacists to refuse to dispense certain drugs for reasons of conscience? Pharmacological farce , Winnipeg Sun, 6 June, 2000

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15. *United Nations Report of the Committee on the Elimination of Discrimination against Women* (Eighteenth and nineteenth sessions) General Assembly Official Records, Fifty-third session Supplement, No. 38 (A/53/38/Rev.1) Page 20, Para. 109. /ExaminingtheIssues/Background/Abortion/BackAbortion06.html

16. For the insights into secular fundamentalism the author is indebted to Iain Benson, B.A. (Hons.), M.A. (Cantab.), LL.B, Director of the Centre for Cultural Renewal (Formerly the Centre for Renewal in Public Policy). His analysis of the subject has just appeared in the University of British Columbia Law Review. He has written a popular summary of the main points in the Law Review article in *There are no Secular Unbelievers*, which appeared in Centre Points:Vol. 4, No. 1, Spring, 2000, the newsletter of the Centre for Cultural Renewal. See this piece at /ExaminingtheIssues/Ethical/Articles/Ethical10.html

17. Benson, Iain T., "Notes Towards a (Re) Definition of the "Secular" (2000) 33 U.B.C. Law Rev. 519 -549, Special Issue: "Religion, Morality, and Law", p. 521

18. Irving, Dianne N., *Which Medical Ethics for the 21st. Century?* Address to the John Carroll Society, Washington, D.C., May 14, 1999. /ExaminingtheIssues/Ethical/Articles/Ethical01.html

19. Quoted in *Bishop protests on behalf of nurses.* /ExaminingtheIssues/Background/Abortion/BackAbortion03.html

20. Benson, Iain T., Notes Towards a (Re)Definition of the Secular , UBC Law Review,

21. *Re: Rodriguez and Attorney-General of British Columbia et al; British Columbia Coalition of People with Disabilities et al, Intervenors*, 107 D.L.R. (4th) 342- Supreme Court of Canada

Chief Justice Lamer (dissenting): "...the common law recognized the fundamental importance of individual autonomy and self-determination in our legal system...it is now established that patients may compel their physicians not to provide them with life-sustaining treatment...and patients undergoing life support treatment may compel their physicians to discontinue such treatment...The rationale underlying these decisions is the promotion of individual autonomy..."

Justice McLachlin (dissenting): "I see this...as a case about the manner in which the state may limit the right of a person to make decisions about her body...It is part of the persona and dignity of the human being that he or she have the autonomy to decide what is best for his or her body...the law draws a distinction between suicide and assisted suicide...The effect of this distinction is to prevent people like Sue Rodriguez from exercising the autonomy over their bodies available to other people."

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22. Benson, Iain T., There are No Secular Unbelievers . *Centre Points*, Vol. 4, No. 1, Centre for Cultural Renewal, Ottawa: Spring, 2000, p. 3. /ExaminingtheIssues/Ethical/Articles/Ethical10.html

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APPENDIX

Project Advisory Board

Janet Ajzenstat, B.A., M.A., Ph.D; Associate Professor, Department of Political Science, McMaster University, Hamilton, Ontario, Canada
Professor Ajzenstat teaches public law and political philosophy. Her most recent books are "Canada's Founding Debates" (edited with Paul Romney, Ian Gentles, and William D. Gairdner [Stoddart 1999]),ÿÿand "Canada's Origins" (edited with Peter J. Smith [Carleton University Press, 1995]).ÿÿShe is associated with the Centre for Renewal in Public Policy and the Dominion Institute.ÿÿIn 1988-89 she was Executive Director of the Human Life Research Institute (now the Barrie de Weber Institute). Her most recent contribution to reports forÿÿthe Institute is "Going It Alone", (co-authored with Elizabeth Cassidy, Elise Carter, and Gerald Bierling) a study of pregnant, unmarried women who have chosen to continue their pregnancies.

Dr. Shahid Athar, M.D., F.A.C.E.; Clinical Associate Professor of Internal Medicine and Endocrinology, Indiana School of Medicine, Indianapolis, Indiana, U.S.A.
Dr. Athar was born at Patna, India. He did his medical training in Karachi, (Pakistan), Chicago, (Illinois), and at Indiana University.ÿÿHe is a U.S. Citizen and lives in Indianapolis with his wife and four children.ÿÿDr. Athar edited "Islamic Perspectives in Medicine", and has written and published over 110 articles on Islam.ÿÿHis numerous books include "Health Concerns for Believers", "Reflections of an American Muslim", and "Sex Education- An Islamic Perspective".ÿÿHis collection of English poems, "Reflections in Love", was released in 1999 by Watermark Press.

Dr. Athar is an alternate delegate to UN (NGO) for World Muslim Congress, past chair of the Interfaith Alliance, an active member of Council For National Interest, Christian & Muslims For Peace, Amnesty International, Physicians For Human Rights, lslamic Medical Association, Solidarity International For Human Rights.ÿÿHe was nominated for 1992 Jefferson Award and received Diamond Award for outstanding volunteerism from the "United To Serve America". He is listed in the International Directory of Specialists in Islamic Studies published from Rabbat, Morocco, 1991, and North American Muslim Resource Directory, 1994.ÿÿDr. Athar is currently the elected vice-president of the Islamic Medical Association of North America and the Chair of its Medical Ethics Committee.

J. Budziszewski, Ph.D; Associate Professor, Departments of Government and Political Philosophy, University of Texas (Austin), U.S.A.
Dr. Budziszewski, a specialist in ethical and political philosophy, is the author of five academic books, most recently "The Revenge of Conscience: Politics and the Fall of Man" (1999) and

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"Written on the Heart: The Case for Natural Law"(1997).ÿÿHe has contributed numerous articles and reviews to both scholarly and popular periodicals, including "First Things", the "American Journal of Jurisprudence", the "Journal of Politics", the "American Political Science Review", the "Weekly Standard", the"National Review", and Public Choice".ÿÿÿÿ

Among his topics are natural law, virtue ethics, Christian faith, and the problem of tolerance.ÿÿIn his latest book, "The Revenge of Conscience: Politics and the Fall of Man", Dr. Budziszewski inquires into the cultural pathologies which flow from the repression of moral knowledge -- from trying to convince ourselves that we do not know what we really do.

Dr. John Fleming, B.A., Th.L. (Hons), Ph.D.; Director, Southern Cross Bioethics Institute, Adelaide, Australia
Dr. John Irving Fleming is a bioethicist, a former Dean and Vice-Master of St. Mark's College in the University of Adelaide.ÿÿHis Ph.D thesis was titled Human Rights and Natural Law: An Analysis of the consensus gentium and its Implications for Bioethics.ÿÿDr. Fleming is a former Anglican priest.ÿÿMarried, with three children, a papal dispensation permitted his ordination in the Catholic Church (Diocese of Adelaide) in 1995.ÿÿHe became a Corresponding Member of the Pontifical Academy for Life (Vatican) the following year.ÿÿ

Dr. Fleming was a member of UNESCO's International Bioethics Committee from 1993-1996.ÿÿ He is currently an associate member of the European Association of Centres of Medical Ethics, and a member several organizations in the field of bioethics, including the International Bioethics Association, the Australian Bioethics Association, and the South Australian Council on Reproductive Technology.ÿÿIn 1999 he joined the Biotechnology Consultative Group (BIOCOG), which provides advice to the Australian Federal Government.

Since 1995 Dr. Fleming has been a member of the Advisory Board for the Centre for International and Cross-Cultural Studies, University of South Australia. He was an elected delegate to the Australian Constitutional Convention in February, 1998.ÿÿDr. Fleming has been Director of Southern Cross Bioethics Institute since 1987.

Henk Jochemsen, PhD; Director, Prof.dr. G.A. Lindeboom Institute, Amsterdam, Netherlands
Professor Henk Jochemsen (1952) studied Molecular Biology at the Agricultural University in Wageningen. The work for his PhD thesis concerned a subject in pre-clinical cancer research at the State University in Leiden (1979). From 1980-1986 he and his family pioneered in student work in Paraguay with the International Fellowship of Evangelical Students. In addition to the student work, Professor Jochemsen lectured in Molecular Biology at The National University in Asuncion for five years, and Christian Ethics at a Bible College in Asuncion for two years.

After his return to the Netherlands (1986) he became involved in the Prof.dr. G.A. Lindeboom Institute, a private centre for medical ethics that was being founded at that time. Since 1987 he has been the director of this Institute. In this capacity he has written and (co)edited articles, reports and books, mainly in Dutch. He has been a guest teacher of medical ethics at a theological college for several years and has given lectures on various medical ethical themes both in the Netherlands and at international conferences and courses.
Professor Jochemsen is a member of the ethics commission of the Federation of Associations of Patients with Congenital Diseases, and advisor of a few other organisations in health care in the Netherlands. From 1992-1996 he was a member of the Board of Administration of the European Association of Centres of Medical Ethics. Currently he is an Advisory Board member of the Center for Bioethics and Human Dignity (Trinity International University, Bannockburn, IL) and a member of the European Editorial Board of `Ethics and Medicine'. He has held the Lindeboom chair for medical ethics at the Free University in Amsterdam since January 1, 1998.
Since the beginning of 1996, as a board member, Professor Jochemsen has coordinated the research at another private ethical institute, the Institute for Culture Ethics, at Amersfoort. He is a member of the Aid Commission of the Christian Reformed Churches in the Netherlands. He and his wife, Marieke Kok, have three children.

David Novak, A.B., M.H.L., Ph.D.; J. Richard and Dorothy Shiff Chair of Jewish Studies, University of Toronto, Ontario, Canada.
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