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Submission to the Dept. of Health and Human Services

Re: Draft Regulation*: Ensuring that Dept. Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices In Violation of Federal Law*

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Abstract

All beliefs - religious or not - influence public behaviour. Disputes about the morality of contraception, assisted suicide, stem cell research or artificial reproduction are always, at the core, disputes between people of different beliefs, whether or not those beliefs are religious. The failure to acknowledge the faith-assumptions implicit in one's own position frequently leads to intolerance for opposing views, and it always makes sincere, respectful and progressive public discourse difficult.

To identify beliefs as 'private' or 'personal' does not help to resolve a question about the exercise of freedom of conscience. Moreover, what passes for ethical 'consensus' is, too often, simply the majority opinion of like-minded individuals, not a genuine ethical synthesis reflecting common ground with those who think differently. When people cannot achieve a moral consensus, it is frequently because they are operating from different beliefs about the nature of the human person.

The relationship between the medical profession and society is frequently described in terms of a social or moral contract or covenant. However, while theories of 'contract' and 'convenant' can be useful analytical tools, they do not offer adequate explanations of human relationships and become oppressive when used to justify enforcement of purported obligations. Self-sacrifice 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.

Even if physicians or health care entities become *de facto* employees or agents of the state in proportion to their reliance upon public funds, it does not follow that they cannot exercise freedom of conscience and religion. Further, the fact that a procedure is legal is not sufficient to impose a duty to provide it upon either the profession as a whole or individual physicians.

In principle, it is not unreasonable for physicians to refuse to refer patients for procedures to which they object for reasons of conscience. Professional associations will refuse all forms of direct and indirect participation even in legal acts that they deem to be immoral. Referral and facilitation are the same kinds of actions defined as "participation" in the AMA policies on capital punishment and torture.

Following a long tradition that is not foreign to American thinking, to demand that physicians provide or assist in the provision of procedures or services that they believe to be wrong is offensive to human dignity and reduces them to a condition of involuntary servitude.

There are many forces at work in modern societies that threaten to force health care workers into forms of involuntary servitude. The strength of those forces in the United States will perhaps be exposed by the responses to the draft HHS regulation. The need for the regulation may, in fact, be most clearly demonstrated by the extent of the opposition it has encountered. In any case, the Protection of Conscience Project supports the draft HHS regulation in principle, and would support amendments that would make it more effective in achieving its stated goals.

I. Introduction

I.1 The Department of Health and Human Services has proposed a regulation to reinforce existing protection of conscience legislation for health care workers in the United States and has solicited comment on the proposal.[1] Decisions about a regulation touching the constitutional freedoms of American citizens and the delivery of health care in the United States properly belong to the American people and their elected representatives.

I.2. On the other hand, developments in the United States can have a significant impact far beyond its borders because of the country's geo-political, financial, technological and social pre-eminence. This is especially true in the Americas and in the English-speaking world. Thus, it is not inappropriate for the Protection of Conscience Project to offer some comments relevant to the draft regulation.

I.3 Minute criticism of the proposed regulation and its practical implications is best left to those more familiar with American legal requirements and political and social exigencies. What the Project offers is an examination of some frequently unexamined concepts and principles that lie at the root of disagreements and misunderstandings about freedom of conscience in health care.

I.4 This paper is drawn from a recent submission to the College of Physicians and Surgeons of Ontario. While developments in Ontario are not irrelevant to the discussion in the United States, an American context for this submission is provided by statement of the Ethics Committee of the American College of Obstetricians and Gynecologists (ACOG), *The Limits of Conscientious Refusal in Reproductive Medicine*.[2] The ACOG statement provides a convenient illustration of a number of the points made here.

I.5 Some elements of this submission reflect its origin in a Canadian controversy and may refer to incidents or circumstances unfamiliar to American readers. However, parallels in American life can be identified without difficulty.

II. Belief: religious and otherwise

II.1 It has become an article of faith with many, especially many holding public positions, that faith has no place in public and professional life. A convenient example is found in the dogmatic assertion by the Ontario Human Rights Commission (OHRC) of its belief that physicians "must essentially 'check their personal views at the door' in providing medical care."[3] The same kind of claim has been made by the American College of Obstetrics and Gynecology through the opinion expressed by its Ethics Committee, which argues that "professional responsibilities to patients . . . must precede a provider's personal interests" and insists that physicians are obliged to refer for morally controversial procedures and may have to personally provide them.[4]

II.2 The more blatant OHRC claim calls to mind comments made by Dr. James Robert Brown in 2002. A professor of science and religion of the University of Toronto, Dr. Brown offered a simple solution for health care workers who don't want to be involved with things like abortion or contraception. These "scum" - that was his word - should "resign from medicine

and find another job." His reasoning was very simple.

> Religious beliefs are highly emotional - as is any belief that is affecting your behaviour in society. You have no right letting your private beliefs affect your public behaviour.[5]

II.3 Now, when Dr. Brown declared that no one should be allowed to let private belief affect public behaviour, he was doing precisely that. He was acting publicly upon *his* private belief that conscientious objectors in health care should not be allowed to act publicly upon *their*s. Dr. Brown did not explain why this should be so, but others have made the attempt.

II.4 Religious beliefs, so the argument goes, are unreliable and divisive because they are unscientific, essentially 'private' and 'personal' in nature. It is said that they must be banished from public affairs in a secular society in the interests of social harmony, progress and, now, human 'rights.' Proponents of this view point to religious wars and persecutions throughout history to justify their claims. However, considered within a broader social and historical context that includes the oppressive and frequently bloody pursuit of secular objectives in the French Revolution, Stalinist Russia and Nazi Germany, the argument is unpersuasive. And it becomes even less persuasive in the case of individuals.

II.5 For example: after ten years of bloody wars, the ancient Indian emperor Asoka became a Buddhist, and decided that he should rule his people like a father, with "morality and social compassion." Among other things, he provided them with free hospitals and veterinary clinics, and built new roads and rest houses for travellers.[6] In other words, Asoka let his private beliefs affect his public behaviour. Like Mother Teresa of Calcutta - who also let her private beliefs influence her public behaviour - Asoka is still revered in India, nicknamed "the saint."

II.6 Moving from ancient times into the last century, one recalls Desmond T. Doss, a Seventh Day Adventist who refused to carry a weapon, but who "performed all of his other duties with dedication" and "was an exemplary a soldier in every other way."[7] In 1945 he rescued 75 wounded men, remaining with them in an Okinawa battle zone swept by artillery, mortar and machinegun fire, carrying them one by one to safety. Two days later be braved a shower of grenades to reach four wounded soldiers, and then made four trips under fire to evacuate them.[8] Doss, a religious believer who refused to kill anyone or even to train for killing, was known in his Division "for outstanding gallantry far above and beyond the call of duty."[9]

II.7 Asoka, Mother Teresa and Desmond Doss were religious believers, but it is false to assert that only religious believers are motivated by belief. In World War I, at the battle of Ypres, Canadian physician Francis Scrimger ordered the evacuation of his dressing station, but remained behind to stabilize a wounded officer. As shells dropped around him, demolished the building and set it on fire, he shielded his patient with his own body as he worked, and then carried the larger man to safety through an artillery barrage.[10] Doss, the Seventh Day Adventist, and Scrimger, "an atheist by outward appearances,"[11] both acted in accordance with their personal beliefs; Doss received the Medal of Honour, and Scrimger was awarded the Victoria Cross.

II.8 If one accepts the logic of Professor Brown, Scrimger deserved the award but Doss did not, because Doss had no business letting his *religious* beliefs influence his public behaviour. On the other hand, the stated policy of the Ontario Human Rights Commission would deny both recognition, on the broader grounds that both failed to 'check their personal views at the door' when the bullets started to fly.

II.9 The stories of Doss and Scrimger may remind physicians and other health care workers of countless colleagues who, through the centuries, have died of contagious and incurable diseases contracted because they refused to abandon their patients. Not a few of this number were motivated by personal beliefs, religious or otherwise.

II.10 All public behaviour - how one treats other people, how one treats animals, how one treats the environment - is determined by what one believes. All beliefs influence public behaviour. Some of these beliefs are religious, some not, but all are beliefs. That human dignity exists - or that it does not - or that human life is worthy of unconditional reverence - or merely conditional respect - and notions of beneficence, justice and equality are not the product of scientific enquiry, but rest upon faith: upon beliefs about human nature, the meaning and purpose of life, the existence of good and evil.

II.11 Disputes about morality - about the morality of contraception, assisted suicide, stem cell research or artificial reproduction - are always, at the core, disputes between people of different beliefs, whether or not those beliefs are religious. "Everyone 'believes'," writes social critic Iain Benson. "The question is, what do we believe in and for what reasons?"

> 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 "implicit faiths" in such areas as public education, medicine, law or politics.[12]

III. Implicit faiths

III.1 The implicit faith to which Benson refers is exemplified in some of the criticism levelled at the regulation. "In situational medical ethics," writes one commentator, "it is the person in crisis or need of specialized service whose conscience takes precedence."[13] This claim depends entirely upon the universal applicability of "situational medical ethics" - whatever they might be.

III.2 The American Civil Liberties Union complains that the regulation and Secretary Leavitt's comments "leave the door open as to whether institutions and individuals can refuse to provide contraception."[14] Whether or not this is true, the complaint rests on two dogmatic assumptions: that contraception is morally acceptable, and that refusing to provide it is not. What is implied is that other beliefs either do not exist or are erroneous.

III.3 "Although respect for conscience is a value," states the ACOG Ethics Committee, "it is only a prima facie value, which means it can and should be overridden in the interest of other

moral obligations that outweigh it in a given circumstance."[15] The Committee's assertions about the relative importance of freedom of conscience and about what counts as overriding moral obligations are based on faith-assumptions shared by Committee members. It is implied that all reasonable people will accept those faith-assumptions, but, in fact, many reasonable people do not.

III.4 The failure to acknowledge the faith-assumptions implicit in one's own position frequently leads to intolerance for opposing views, and it always makes sincere, respectful and progressive public discourse difficult. This is particularly true of discussion of freedom of conscience in health care.

IV. "Imposing beliefs": proxy wars and cultural conquest

IV.1 The ACOG statement affords a particularly striking example of the importance of unexamined faith-assumptions, since it clearly presumes that all forms of "reproductive health care" contemplated in the document are morally legitimate. It could not make the recommendations it does were that not the case. In effect, it denies that significant moral or ethical issues are involved in controversies about reproductive technology, abortion, research on embryos and contraception.

IV.2 Some writers claim that such controversies are not about morality or ethics at all, but about strategy - anti-abortion strategy. Professor R. Alta Charo, for example, suggests that the exercise of freedom of conscience by objecting health care workers is a "proxy war" - "an attempt at cultural conquest."[16]

IV.3 C.S. Lewis invented a name for this "modern method" of argument: 'Bulverism.' Rather than *demonstrating* that an opponent is wrong, the Bulverist *assumes*, without discussion, that he is wrong, "and then distract(s) attention from this (the only real issue) by busily explaining how he became so silly." In the words of Ezekiel Bulver, imaginary founder of this school of thought, "Assume that your opponent is wrong, and then explain his error, and the world will be at your feet."[17]

IV.4 Assume, with Professor Charo and the ACOG Committee, that abortion, contraception, artificial reproduction, etc. raise no significant moral or ethical issues because 'everyone knows' these procedures are *not* wrong. Assume, with them, that unreasoning and religious anti-abortionist sentiment is the 'real' or primary motive for opposition to the procedures. Granted such assumptions, justification for conscientious objection disappears, the fear of moral complicity through referral becomes ridiculous, and accusations that conscientious objection is actually "an attempt at cultural conquest" seem plausible. This approach would win accolades from Ezekiel Bulver.

IV.5 But Bulverism, Lewis pointed out, works both ways. Assume, against Professor Charo and the ACOG, that 'everyone knows' that abortion, contraception, artificial reproduction, etc. *are* wrong. Assume, against them, that *pro*-abortion and irreligious sentiment is the 'real' or primary motive for supporting such procedures. Granted such assumptions, the reason for conscientious objection is clear, concerns about moral complicity are logical, and it is

plausible to see in the ACOG Committee statement "an attempt at cultural conquest."

IV.6 Lewis saw Bulverism in play on both sides of all political arguments and could not, when he coined term, see how it could lead to anything other than a stalemate, or to "sheer self-contradicting idiocy."[18] Bilateral Bulverism, with its mutual accusations of "cultural conquest," does not provide a basis for resolving conflicts about freedom of conscience in health care.

V. Establishment consensus and 'the ethics of the profession'

V.1 Denying accusations of partisanship associated with abortion politics, it is sometimes argued that positions like those taken by the ACLU or the ACOG Ethics Committee represent a broad public consensus, a consensus of serious establishment thinkers, or, perhaps, a consensus reflecting "the ethics of the profession."[19]

V.2 However, this kind of 'consensus' is typically achieved by taking into account only opinions consistent with ethical, moral or religious presuppositions that are congenial to a dominant elite. The resulting 'consensus' is, in reality, simply the majority opinion of like-minded individuals, not a genuine ethical synthesis reflecting common ground with those who think differently.[20] Unfortunately, this usually becomes clear only when documents like the ACOG's *The Limits of Conscientious Refusal in Reproductive Medicine* become public knowledge, and those excluded from the table make themselves heard.

V.3 More to the point, to identify beliefs as 'private' or 'personal' does not help to resolve a question about the exercise of freedom of conscience. The beliefs of many conscientious objectors, while certainly personal in one sense, are actually shared with tens of thousands, or even hundreds of thousands or hundreds of millions of people, living and dead, who form part of great religious, philosophical and moral traditions. If their beliefs are 'private,' those of the members of the ACOG Ethics Committee or an early 21st century profession with several thousand members are not less so. Disputes about what counts as 'private' or 'public' move us no further towards a resolution of the controversy.

V.4 The question does not turn on privacy, but truth. If the ACOG Ethics Committee possesses a moral vision that is superior to that of objecting physicians, it is clear that the Committee's superior moral views ought to prevail. But, in that case, Committee members should be able and willing to explain first, why they are better judges of morality than objecting physicians, and, second, why their moral judgement should be forced upon unwilling colleagues. Avoiding the issue by hiding behind noble sounding phrases like "a physician's duty of care" or "the ethics of the profession" will not do.

VI. Social contract

VI.1 "By virtue of entering the profession of medicine," states the ACOG, "physicians accept a set of moral values - and duties - that are central to medical practice."[21] This reflects the common notion of a "social contract" between the medical profession and society, especially in discussions about the meaning of "professionalism."[22] The Royal College of Physicians

has suggested that, in relation to medical practice, it is more accurate to speak of a "moral contract" between society and the profession.[23] Others have argued that the concept of a social "covenant" provides a better framework for ethical reflection.[24]

VI.2 It is important to recognize that, whether the term of choice be contract or covenant, or the contract be social or moral, all such notions are convenient fictions. *The Oxford Companion to Philosophy* makes the point:

> Contract, social: The imaginary device through which equally imaginary individuals, living in solitude (or, perhaps, nuclear families) , without government, without a stable division of labour or dependable exchange relations, without parties, leagues, congregations, assemblies or associations of any sort, come together to form a society, accepting obligations of some minimal kind to one another, and immediately or very soon thereafter binding themselves to a political sovereign who can enforce those obligations.[25]

VI.3 Theories of 'contract' and 'covenant' are tools that can be usefully employed to explore different aspects of human relationships, but they become dangerous when they are thought to offer adequate explanations of those relationships, or when one moves from speculative discussion and analysis to the enforcement of purported obligations. It is also necessary to recall that claims about the precise content of a contract become especially intense when the parties involved disagree, and one party - like the ACOG - attempts to unilaterally "read in" obligations that other parties reject.

VI.4 Moreover, the ACOG theory that entry into a profession is conditional upon surrendering fundamental freedoms or giving up one's own moral or religious views must compete with compelling arguments to the contrary. Consider, for example, the reasoning of United States Supreme Court Justice William O. Douglas in *Machinists v Street*, 367 U.S. 740 (1961):

> Once an association with others is compelled by the facts of life, special safeguards are necessary lest the spirit of the First, Fourth, and Fifth Amendments be lost and we all succumb to regimentation. . . If an association is compelled, the individual should not be forced to surrender any matters of conscience, belief, or expression. He should be allowed to enter the group with his own flag flying, whether it be religious, political, or philosophical; nothing that the group does should deprive him of the privilege of preserving and expressing his agreement, disagreement, or dissent, whether it coincides with the view of the group, or conflicts with it in minor or major ways; and he should not be required to finance the promotion of causes with which he disagrees.
>
> In a debate on the *Universal Declaration of Human Rights*, later adopted by the General Assembly of the United Nations on December 10, 1948, Mr. Malik of [367 U.S. 740, 777] Lebanon stated what I

think is the controlling principle in cases of the character now before us:

> "The social group to which the individual belongs, may, like the human person himself, be wrong or right: the person alone is the judge."

This means that membership in a group cannot be conditioned on the individual's acceptance of the group's philosophy. Otherwise, First Amendment rights are required to be exchanged for the group's attitude, philosophy, or politics. I do not see how that is permissible under the Constitution. Since neither Congress nor the state legislatures can abridge those rights, they cannot grant the power to private groups to abridge them.[26]

VI.5 Whatever its status or authority in American jurisprudence, Justice Douglas' reasoning in *Machinists v Street* at least demonstrates that claims like those of the ACOG can be met with cogent and principled responses consistent with American political and legal traditions.

VII. Social contract and socialized medicine

VII.1 Socialized medicine in Canada 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 when the state assumes primary responsibility for the delivery of health care. Health care providers come to be seen as state employees, and citizens begin to believe that they are entitled to demand from health care providers the services they have paid for through taxes. The President of the College of Physicians and Surgeons of Ontario, the regulatory authority for physicians in the province, offered the following comment during a recent controversy about freedom of conscience in medicine:

> In our society, we all pay taxes for this medical system to receive services . . . And if a citizen or taxpayer goes to access those services and they are blocked from receiving legitimate services by a physician, we don't feel that's acceptable.[27]

VII.2 In this case it is argued that there is an actual rather than theoretical social contract for the provision of health care, and that the state and the medical profession are parties to it. Citizens are likely to expect the state to enforce what they consider to be the terms of the contract against reluctant employees and other health care providers through state regulatory authorities and human rights agencies.

VII.3 Different circumstances prevail in the United States, but, to the extent that public funds are allocated to the provision of health care, the same expectations arise. However, even if one posits the existence of a limited 'social contract' for health care, such expectations overlook at least two key points.

VII.4 First: the terms of the virtual 'contract' have never been defined or settled. No congress of

medical professionals authorized to represent all health care workers has ever agreed, on their behalf, that they would deliver every service demanded by the public, regardless of their conscientious convictions.

VII.5 Second: even if physicians or health care entities become *de facto* employees or agents of the state in proportion to their reliance upon public funds, it does not follow that they cannot exercise freedom of conscience and religion. In jurisdictions that require the accommodation of conscientious convictions or religious beliefs of employees, the same accommodation ought to be available to individuals and health care entities. Moreover, persons who receive state welfare benefits, unemployment payments or student loans do not surrender their fundamental freedoms or rights, so it is not clear why physicians or health care entities should have to do so.

VIII. Limits to expression

VIII.1 According to the ACOG, even when one's moral integrity is at stake, there are limits to freedom of conscience.[28] This is hardly a new proposition. Oliver Cromwell said as much 400 years ago.

> As for the People [of Ireland], what thoughts they have in matters of Religion in their own breasts I cannot reach; but shall think it my duty, if they walk honestly and peaceably, Not to cause them in the least to suffer for the same. And shall endeavour to walk patiently and in love towards them to see if at any time it shall please God to give them another or a better mind. And all men under the power of England, within this Dominion, are hereby required and enjoined strictly and religiously to do the same.[29]

But to *act* upon religious belief was, for Cromwell, another matter.

> . . . I shall not, where I have the power, and the Lord is pleased to bless me, suffer the exercise of the Mass . . . nor . . . suffer you that are Papists, where I can find you seducing the People, or by any overt act violating the Laws established; but if you come into my hands, I shall cause to be inflicted the punishments appointed by the Laws.[30]

VIII.2 The ACOG agrees with Cromwell, the Supreme Court of Canada and the Ontario Human Rights Commission that "the freedom to hold beliefs is broader than the freedom to act on them."[31] So, for that matter, do those who support freedom of conscience in health care. The principle is not in dispute. What is in dispute is where the line between belief and expression is to be drawn, and what is to be done with those who cross it. The Irish did not share Cromwell's views about where the line should be drawn, nor is it clear that there is anything approaching a consensus in Canada or in the United States on this point when it comes to morally controversial medical procedures. So it is instructive to remember Oliver Cromwell and the Irish when social and political elites begin to sound like the Lord Protector.

IX. Legality

IX.1 It is also said that health care workers cannot refuse to provide any legal procedure, as if the legality of the procedure were sufficient to impose a duty to provide it upon either the profession as a whole or individual physicians. It can be shown that this is not the case.

IX.2 **Sex selective abortion:** There is no law against sex-selective abortion in Canada, nor against determining the sex of an infant before birth. Nonetheless, the Deputy Registrar of the College of Physicians and Surgeons of British Columbia was horrified in August, 2005, when he learned that a pre-natal gender testing kit was being marketed on the internet. Dr. T. Peter Seland, described gender selection as "immoral." He explained that College policy was not to disclose the sex of a baby until after 24 weeks gestation in order to reduce the risk of gender selection, and that physicians violating the policy were liable to be disciplined by the College.[32] This clearly indicates that the legality of a procedure is not reason enough to compel a health care worker to provide it.

IX.3 **Amputation:** In 1999, Dr. Robert Smith of Scotland performed single leg amputations on two patients who desired the amputation of healthy limbs. The surgery was performed with the permission of the Medical Director and Chief Executive of the hospital, in a National Health Service operating theatre with NHS personnel, after consultation with the General Medical Council and professional bodies.[33] The procedures were legal and even deemed ethical by regulatory authorities, but, to date, no one has argued that this is sufficient reason to oblige surgeons to amputate healthy limbs upon request, and to compel physicians to refer for such surgery.

IX.4 **Execution**: Capital punishment is legal in a number of jurisdictions. 35 of the 38 American states that use lethal injection as a means of execution permit the participation of physicians, and 17 of them require it. "Thirteen jurors, citizens of the state, have made a decision," explained one physician who assists with executions. "And if I live in that state and that's the law, then I would see it as being an obligation to be available."[34] The law is the law, after all. However, despite the legality of the procedure, and in defiance of the laws that actually require the attendance of physicians, the Code of Ethics of the American Medical Association forbids the participation of physicians in executions,[35] and those who ignore the ban risk losing their licenses to practise.[36] In the face of pending decision of the American Supreme Court, a guest editorial commented on the obvious conflict between the expectations of the law and the attitude of physicians:

> In their fuller examination of *Baze v. Rees*, the justices should not presume that the medical profession will be available to assist in the taking of human lives . . .The future of capital punishment in the United States will be up to the justices, but the involvement of physicians in executions will be up to the medical profession.[37]

X. The problem of complicity

X.1 Statues like those the draft HHS regulation is meant to reinforce laws that prevent health care

workers from being forced to provide procedures or services to which they object for reasons of conscience. The goal is to ensure that health care workers can avoid complicity in wrongdoing.

X.2 It appears that most people are willing to grant that a health care worker who has serious moral objections to a procedure should not be compelled to perform it or assist directly with it. However, many people find it more difficult to understand why some health care workers object to even indirect forms of involvement: why some, for example, refuse to refer patients for some morally controversial procedures.

X.3 According to the ACOG Committee on Ethics, "the logic of conscience, as a form of self-reflection on and judgement about whether one's own acts are obligatory or prohibited, means that it would be odd or absurd to say, "I would have a guilty conscience if she did X."[38] It thus appears that the ACOG Committee is working from what might be called the 'Absolutionist Premise:' that someone who merely arranges for an act is absolved of moral responsibility because only someone who actually does an act is morally responsible for it.

X.4 Alternatively, the ACOG may admit that some moral responsibility is incurred by referral or by otherwise facilitating a procedure, but that the degree of responsibility is sufficiently diminished in such cases that it is of no real significance. Call this the 'Dismissive Premise.'

X.5 In passing, it should be noted that, on either account, the position of the Committee raises the issues discussed in Parts III and IV. Whether they assert that referral or facilitation do not incur moral responsibility, or that the degree of moral responsibility incurred is so minimal as to be inconsequential, they are making a moral judgement and demanding that others adhere to it.

Complicity in torture

X.6 **The Absolutionist Premise** is illustrated by the opinion of *Newsweek* columnist Jonathan Alter. In the weeks following the terrorist attacks on the United States in September, 2001, Alter argued that it was time to think about torturing terrorist suspects who might have information about plans for such horrendous crimes. He acknowledged that physical torture was "contrary to American values," but argued that torture is appropriate in some circumstances, and proposed a novel 'compromise:' that the United States turn terrorist suspects who won't talk over to "less squeamish allies,"[39] a practice known as "extraordinary rendition." The allies would then do what Americans would not, without compromising American values.

X.7 Less than a year later, Canadian citizen Maher Arar, returning home from Zurich through New York, was detained, interrogated and "rendered" to Syria by U.S. authorities.[40] In Syria he was imprisoned for almost a year, "interrogated, tortured and held in degrading and inhumane conditions."[41]

X.8 A subsequent "comprehensive and thorough" investigation "did not turn up any evidence that he had committed any criminal offence" and disclosed "no evidence" that he was a threat to Canadian security."[42] A commission of inquiry was appointed to investigate "the actions of

Canadian officials" in the case.[43]

X.9 What was of concern to Mr. Arar, the public and the government was whether or not Canadian officials had caused or contributed to what happened to Mr. Arar, even though his deportation to Syria was effected by the United States, and Syrian officials imprisoned and tortured him. The key issue was whether or not Canada was complicit in torture.

X.10 Concern about Canadian complicity surfaces repeatedly in the report of the commission of inquiry: in briefing notes to the Commissioner of the RCMP,[44] in the testimony of the Canadian Ambassador to Syria,[45] in references to the possibility of RCMP complicity in his deportation,[46] about the perception of complicity if CSIS agents met Mr. Arar in Syria,[47] in the suggestion that evidence of complicity could show "a pattern of misconduct,"[48] and in the conclusions and recommendations of the report itself.[49]

X.11 The issue of complicity arose again in 2007 when a report in Toronto's *Globe and Mail* alleged that prisoners taken in Afghanistan by Canadian troops and turned over to Afghan authorities were being mistreated and tortured.[50] "Canada is hardly in a position to claim it did not know what was going on," said the *Globe*. "At best, it tried not to know; at worst, it knew and said nothing."[51] On this view, one can be complicit in wrongdoing not only by acting, but by failing to act, and even by silence. The *Globe* editorial brings to mind the words of Martin Luther King and Mahatma Gandhi.[52]

X.12 Americans will recall investigations or inquiries by Congressional committees that probed the complicity of government officials in alleged wrongdoing with the same care taken in Canada in the case of Maher Arar. But the problem of complicity does not relate only to government officials. *The Lancet*, among others, has asked, "How complicit are doctors in the abuse of detainees?"[53] and other journal articles have explored the answer with some anxiety.[54]

X.13 The Arar Inquiry, the concerns raised by the *Globe and Mail* story about Afghan detainees and the alarm raised about physician complicity in torture make sense only on the presumption that one can be morally responsible for acts actually committed by another person. The Absolutionist Premise does not provide a plausible starting point for moral reasoning.

Complicity in capital punishment

X.14 **The Dismissive Premise** is more promising. Granted that one can be morally responsible for acts actually committed by another, there may be differences of opinion about what kind of action or omission incurs such responsibility. These differences need not be thoroughly canvassed in this paper. It is sufficient to ask if the kind of action demanded by the ACOG Committee on Ethics could have that effect. That is: if a physician refers or otherwise helps a patient to obtain what be believes to be an immoral procedure, is he a culpable participant in the provision of the procedure?

X.15 The issue of culpable participation in a morally controversial procedure has been considered by the American Medical Association in its policy on capital punishment.[55] It forbids physician participation in executions, and defines participation as

(1) an action which would directly cause the death of the condemned;

(2) an action which would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned;

(3) an action which could automatically cause an execution to be carried out on a condemned prisoner.

X.16 Among the actions identified by the AMA as "participation" in executions are the prescription or administration of tranquillizers or other drugs as part of the procedure, directly or indirectly monitoring vital signs, rendering technical advice or consulting with the executioners, and even (except at the request of the condemned, or in a non-professional capacity) attending or observing an execution.

X.17 The attention paid to what others might consider insignificant detail is exemplified in the provision that permits physicians to certify death, providing that death has been pronounced by someone else, and by restrictions on the donation of organs by the deceased.

X.18 The AMA also prohibits physician participation in torture. Participation is defined to include, but is not limited to, "providing or withholding any services, substances, or knowledge to facilitate the practice of torture."[56] The Canadian Medical Association, while not faced with the problem of capital punishment, has voiced its opposition to physician involvement in the punishment or torture of prisoners. The CMA states that physicians "should refuse to allow their professional or research skills to be used in any way" for such purposes.[57]

Complicity and referral

X.19 While referral is not mentioned in the AMA policy on capital punishment, nor in the Canadian or American policies on torture, one cannot imagine that either the AMA or CMA would agree that physicians who refuse to participate in torture or executions have the duty to refer the state "in a timely manner" to other practitioners.[58] In fact, it is likely that both the CMA and AMA would censure a physician who did so voluntarily, on the grounds that such conduct would make him complicit in a gravely immoral act.

X.20 In any case, it is reasonable to hold that the kind of action required by *The Limits of Conscientious Refusal in Reproductive Medicine* is the same kind of action that is defined as "participation" in the AMA policies on capital punishment and torture. The model provided by the AMA policy indicates that, in principle, at least, it is not unreasonable for physicians to refuse to refer patients for procedures to which they object for reasons of conscience, on the grounds that referral would make them complicit in a wrongful act.

X.21 The point here, of course, is not that capital punishment or torture are morally equivalent to artificial reproduction, contraception or other controversial medical procedures. The point is that, when professional associations are convinced that an act is seriously wrong - even if it is legal - one finds them willing to refuse all forms of direct and indirect participation in order to avoid moral complicity in the act. This is precisely the position taken by conscientious objectors in health care.

Complicity and dirty hands

X.22 Having considered the problem of complicity, it is now worth asking why the subject of complicity in wrongful acts is not only of grave concern to ethical physicians, medical journals, and professional associations, but why it can so thoroughly arouse the public, the media, and politicians: why commissions of inquiry and Congressional committees will so meticulously investigate the possibility of complicity, producing hundreds upon hundreds of pages of detailed analysis of the evidence taken, at no little cost to the public purse.

X.23 A jaded few will respond that reports of scandal will always sell newspapers, that scandal always energizes the self-righteous (both the religious and the politically-correct varieties) and that scandal is one of the traditional weapons used against opponents by politicians of all stripes. There is some truth to this, but, going deeper into it, why is complicity in wrongdoing scandalous?

X.24 The answer must be that there is something about complicity in wrongdoing that triggers an almost instinctive reaction in people, something about it that touches some peculiar, deep and almost universal sense of abhorrence. One says "almost" instinctive and "almost" universal because, of course, there have always been exceptions: Eichmanns, Pol Pots, Rwandan machete men, for example. And the degree of sensitivity varies from person to person, from subject to subject, and from one culture to another. Nonetheless, complicity in wrongdoing can be a source of scandal, a political weapon and the subject for public inquiries only because it has some real and profound significance.

X.25 The nature of that significance is suggested by a number of expressions: "poisoned" fruit doctrine, "tainted"evidence, money that has to be "laundered," and "dirty" hands. A senior Iraqi surgeon, commenting on the complicity of physicians in torture under Saddam Hussein, said that "the state wanted them to have 'dirty hands'."[59] In contrast, some writers refer approvingly to a "dirty hands principle":

> Philosopher Sidney Axinn tells us the Dirty Hands principle "holds that in order to govern an institution one must sometimes do things that are immoral." He goes on to say that advocates would claim that "we do not want leaders who are so concerned with their own personal morality that they will not do `what is necessary' to ... win the battle.... We have an inept leader if we have a person who is so morally fastidious that he or she will not break the law when that is the only way to success" (Axinn, 1989: 138).[60]

But whichever view one takes of "dirty hands," all of these expressions convey an uncomfortable sense that something is felt to be soiled by complicity in wrongdoing. What is that something? And what is the nature of that cloying grime?

X.26 The answer suggested by the Project is that the "something" is not a "thing" at all, but the human person, and that the sense of uncleanness or taint associated with complicity in wrongdoing is the natural response of the human person to something fundamentally opposed to his nature and dignity.

XI. The needs of the patient: anthropology counts

XI.1 What is conducive to human well-being is determined by the nature of the human person. There can be no agreement upon what is good for the patient without first agreeing upon that. One's understanding of the nature of the human person determines not only how one defines the needs of the patient, but how one approaches every moral or ethical problem in medicine.

XI.2 Reasoning from different beliefs about what man is and what is good for him leads to different definitions of "need," different understandings of "harm," different concepts of right and wrong, and, ultimately, to different ethical conclusions.[61]

XI.3 Consider two different statements: (a) man is a creature whose purpose for existence depends upon his ability to think, choose and communicate; b) man is a creature for whom intellect, choice and communication are attributes of existence, but do not establish his purpose for existence. Statements (a) and (b) express non-religious belief, not empirically verified fact. Such beliefs - usually implicit rather than explicit - direct the course of subsequent discussion.

XI.4 Bioethicists working from (a) would have little objection to the substitution of persistently unconscious human subjects for animals in experimental research.[62] Those who accept (b) would be more inclined to object.[63] Finally, bioethicists who do not believe in 'purpose' beyond filling an ecological niche would dismiss the whole discussion as wrong-headed.

XI.5 What must be emphasized is that when people cannot achieve a consensus about the morality of a procedure, it is frequently because they are operating from different beliefs about the nature of the human person. Disagreement is seldom about facts - the province of science - but about what to believe in light of them - the province of philosophy and religion.

XII. The human person

The integrity of the human person

XII.1 The physician, a unique some*one* who identifies himself as "I" and "me,"[64] 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."[65]

> [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.[66]

XII.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."[67]

XII.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."[68]

XII.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."[69]

> 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.[70]

XII.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.[71]

The dignity and inviolability of the human person

XII.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.[72]

XII.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."[73] 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."[74]

> 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.[75]

XII.8 Even as part of society, Maritain insisted, "the human person is something more than a part;"[76] he remains a whole, and must be treated as a whole.[77] 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.[78] 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."[79]

XII.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.[80]

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.[81]

XII.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.[82] Likewise, Martin Luther King condemned segregation as "morally wrong and awful" precisely because it relegated persons "to the status of things."[83]

XII.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.[84]

XII.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."[85]

Human dignity and freedom of conscience

XII.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*. *Morgentaler* is, in Canada, the equivalent of *Roe vs. Wade* in the United States.

XII.14 Madame Justice Wilson argued that "an emphasis on individual conscience and individual judgment . . . lies at the heart of our democratic political tradition."[86] 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.[87]

XII.15 "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."[88]

XII.16 Quoting the above passage from Professor Joad's book, Wilson approved the principle that 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'."[89]

XII.17 This thinking can also be found in the American tradition. Commenting upon the theory that "'nondomination' is the key to American revolutionary politics," Martha C. Nussbaum agrees that "the rhetoric of the period is suffused with a hatred of servitude and an intense longing for a politics of free, non-dominated men."

> I believe, however, that one can understand this emphasis on avoiding servitude more profoundly, and in a way much more pertinent to our thought about religion, if one goes behind nondomination to the notion of human dignity. It is because human beings have a dignity, and are not mere objects, that it is bad to treat them like objects, pushing them around without their consent.[90]

XII.18 In the tradition of Kant, C.S. Lewis, Martin Luther King, Cyril Joad and Karol Wojtyla, and consistent with Nussbaum's reflection on human dignity, 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."

XII.19 It may surprise Americans to hear that the Ontario Human Rights Commission proposes that 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."[91]

XIII. Looking to the future

XIII.1 The ACOG Committee purports to define "the ethically appropriate limits of conscientious refusal in reproductive health contexts."[92] But the claim that conscientious objectors ought to be forced to refer for or otherwise facilitate a morally controversial procedure cannot be confined to "reproductive health contexts." It must, logically, apply to *all* controversial procedures. If for no other reason than prudent self-interest, physicians and other health care workers who are inclined to support mandatory referral should think carefully about the broader ramifications of such a policy, especially if their own views would make them unwilling to facilitate sex-selective abortion, infant male circumcision, assisted suicide and euthanasia or even the amputation of healthy body parts.

XIII.2 That one might be forced to refer for or otherwise facilitate assisted suicide and euthanasia is not a possibility that is commonly considered, since the procedures are illegal in most

jurisdictions. But laws can be changed, as they have been in the Netherlands, Belgium and Oregon, and such changes in law bring with them changes in expectations. Since late 2003, general practitioners in Belgium unwilling to perform euthanasia have faced demands that they help patients find physicians willing to provide the service. It is argued that mandatory referral for euthanasia is required by respect for patient autonomy, the paradigm of "shared decision making" and the fact that euthanasia is a legal "treatment option."[93]

XIV. Conclusion

XIV.1 Protection of conscience legislation can be supported for reasons of prudent self-interest. However, as intimated in Part XII, it can be more fully justified by an exploration of the relationship of freedom of conscience to the dignity of the human person. In the United States this kind of exploration might be fruitfully pursued by reflecting upon what could be implied in the Thirteenth Amendment to the Constitution, which prohibits not only slavery, but "involuntary servitude."[94] After all, as Maritain observed, servitude "can take on other shapes than that of slavery in its strict meaning." It is a form of servitude, he argued, to make one person the tool or instrument of another, to treat people as means to an end chosen by someone else.[95]

XIV.2 There are many forces at work in modern societies that threaten to force health care workers into forms of involuntary servitude. The strength of those forces in the United States will perhaps be exposed by the responses to the draft HHS regulation. The need for the regulation may, in fact, be most clearly demonstrated by the extent of the opposition it has encountered. In any case, the Protection of Conscience Project supports the draft HHS regulation in principle, and would support amendments that would make it more effective in achieving its stated goals.[96]

Related documents

Benson, Iain, *There are no secular unbelievers*
(http://www.consciencelaws.org\Examining-Conscience-Ethical\Ethical10.html)

Budziszewski, J. *Handling Issues of Conscience*
(http://www.consciencelaws.org\Examining-Conscience-Ethical\Ethical07.html)

Budziszewski, J., *The Illusion of Moral Neutrality - Part IV*
(http://www.consciencelaws.org/Examining-Conscience-Ethical/Ethical37.html)

Manning, Preston, *Pluralism, Religion and Public Policy*
(http:www.consciencelaws.org/Examining-Conscience-Ethical/Ethical28.html)

Murphy, Sean, *Belgium: mandatory referral for euthanasia*
(http://www.consciencelaws.org/Examining-Conscience-Background/Euthanasia/BackEuthanasia08.html)

Murphy, Sean, *Establishment Bioethics*
(http://www.consciencelaws.org\Project\Project\Examining-Conscience-Ethical\Ethical16.html)

Murphy, Sean, *Postscript for the Journal of Obstetrics and Gynaecology Canada: Morgentaler vs. Professors Cook and Dickens*.
(http://www.consciencelaws.org\Examining-Conscience-Legal\Legal30.html)

Murphy, Sean, *Service or Servitude: Reflections on Freedom of Conscience for Health Care Workers*. Responding to: Cantor J, Baum K. *The Limits of Conscientious Objection*
(http://www.consciencelaws.org\Examining-Conscience-Ethical\Ethical48.html)

Murphy, Sean, *The New Inquisitors*
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Murphy, Sean, *The Silence of Good People and Non-cooperation with Evil: A Response to Prof. R. Alta Charo.* Responding to Charo, R. Alta, *The Celestial Fire of Conscience-*
((http://www.consciencelaws.org\Examining-Conscience-Ethical\Ethical52.html)

Murphy, Sean, *Referral: A false compromise*
(http://www.consciencelaws.org\Examining-Conscience-Ethical\Ethical48.html)

Reynolds, Larry, *Personal Beliefs and Professional Duties: Maintaining Your Integrity*
(http://www.consciencelaws.org/Examining-Conscience-Ethical/Ethical74.html)

Saunders, Peter, Criminalising Christian behaviour - legally enforced political correctness
(http://www.consciencelaws.org/Project/Examining-Conscience-Ethical/Ethical60.html)

Notes

1. Department of Health and Human Services, 45 CFR Part 88, RIN 0991-AB48, *Ensuring that Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices In Violation of Federal Law.* Agency: Office of the Secretary. Action: Proposed Rule, p. 10-11. (http://www.hhs.gov/news/press/2008pres/08/20080821reg.pdf) Accessed 2008-09-24

2. American College of Obstetrics and Gynecology, Committee on Ethics Opinion No. 385, *The Limits of Conscientious Refusal in Reproductive Medicine* (http://www.acog.org/from_home/publications/ethics/co385.pdf) Accessed 2008-09-24

3. *Submission of the Ontario Human Rights Commission to the College of Physicians and Surgeons of Ontario Regarding the draft policy, "Physicians and the Ontario Human Rights Code."* 15 August, 2008. (http://www.ohrc.on.ca/en/resources/submissions/physur) Accessed 3008-08-31

4. "In an emergency in which referral is not possible or might negatively affect a patient's physical or mental health, providers have an obligation to provide medically indicated and requested care regardless of the provider's personal moral objections." ACOG Opinion No. 385, *The Limits of Conscientious Refusal in Reproductive Medicine*, p. 5, recommendation 5. (http://www.acog.org/from_home/publications/ethics/co385.pdf) Accessed 2008-09-24. In assessing the scope of this claim, it is necessary to note that the statement fails to define key terms: "emergency," "health," "medically indicated," and "care." The statement is also notably broad in its unqualified reference to anything that "*might* negatively affect" the health of the patient.

5. "Dr. James Robert Brown, a professor of science and religion at the University of Toronto, said he agrees with prosecuting a doctor with that sort of conflict. "Suppose someone (doctor) said, 'I'm uncomfortable with (treating) a minority,' I'd say, 'So long scum'," said Brown."

"Brown believes performing abortions and offering other forms of contraception are necessary and if Dawson won't perform them, then, Brown added, 'Fine - just resign from medicine and find another job."

"Religious beliefs are highly emotional - as is any belief that is effecting your behaviour in society. You have no right letting your private beliefs effect your public behaviour." Canning, Cheryl, "Doctor's faith under scrutiny: Barrie physician won't offer the pill, could lose his licence." *The Barrie Examiner*, February 21, 2002
[http://www.consciencelaws.org/Repression-Conscience/Conscience-Repression-17.html]

6. Asoka ascended his father's throne in 269 BC. Time-Life Books, *TimeFrame 400 BC - AD 200: Empires Ascendant*, p. 107-109

7. Joyner, James, "Desmond Doss, Pacifist Medal of Honor Recipient, Dies at 87." *Outside the Beltway*, 24 March, 2006 (http://www.outsidethebeltway.com/archives/desmond_doss_pacifist_medal_of_honor_recipient_dies_at_87/); Carlfeldt, Tim, "Medal of Honor recipient Desmond Doss, 87, dies." *Rome News-Tribune*, 23 March, 2006. (http://news.mywebpal.com/partners/680/public/news706221.html) Accessed 2008-09-22

8. Center of Military History, United States Army, *Medal of Honor Recipients, WWII, A-F* (http://www.history.army.mil/html/moh/wwII-a-f.html) Accessed 2008-09-22

9.Center of Military History, United States Army, *Medal of Honor Recipients, WWII, A-F* (http://www.history.army.mil/html/moh/wwII-a-f.html) Accessed 2008-09-22

10. "Realizing the dangerous situation, Scrimger organized the evacuation of the wounded to the rear, but one of his patients, Captain H. F. McDonald, had a serious head wound. Any movement before he was stabilized would likely kill him. Scrimger chose to stay behind. The shells fell around them and then began to land on the farm. The slight, 5-foot-7-inch doctor, who weighed only 148 pounds, shielded McDonald's prone body while he worked over him. During the bombardment, the building was demolished and set on fire, but both Scrimger and McDonald survived the whirling shrapnel and exploding ammunition. Blinded by the smoke and heat of the fire, Scrimger pulled the larger, unconscious infantry officer onto his back and staggered out of the building. German infantry were advancing on the farm and the only escape was to cross the moat to the rear. Lurching to safety with McDonald on his back, Scrimger passed through the barrage, moving from shell hole to shell hole for cover. Hiding in a nearby ditch throughout the rest of the day, they avoided the enemy infantry. Captain McDonald later testified that each time the shells exploded around them, "Captain Scrimger curled himself round my wounded head and shoulder to protect me from the heavy shell fire, at obvious peril to his life. He stayed with me all that time and by good luck was not hit."
Canadian War Museum, *Backgrounder: "Francis Scrimger, V.C.* (http://www.warmuseum.ca/cwm/media/bg_scrimger_e.html) Accessed 2008-09-11

11. Kingsmill, Suzanne, *Francis Scrimger: Beyond the Call of Duty.* Hannah Institute for the History of Medicine, Dundurn Press Ltd., 1991, p. 25. See also *"The greatest devotion to duty": Dr. Francis Scrimger and his Victoria Cross.* McCulloch, I. CMAJ. 1994 February 1; 150(3): 414–416. (http://www.pubmedcentral.nih.gov/pagerender.fcgi?artid=1486153&pageindex=1) Accessed 2008-09-04)

12. Benson, Iain T., "There are No Secular 'Unbelievers.'" *Centrepoints 7*, Vol. 4, No. 1, Spring 2000, P. 3.
http://www.consciencelaws.org/Examining-Conscience-Issues/Ethical/Articles/Ethical10.html

13. Swenson, Scott, "HHS Sec. Leavitt Blogs Again, Avoids Contraception Again, Still Ignores Ab-Only." *Reality Check*, 12 August, 2008 (http://www.rhrealitycheck.org/node/7884) Accessed 2008-09-24

14. Melling, Louise, "Proposed Bush Regulation Jeopardizes Women's Health.*"Feministing Community*, 26 August, 2008. (http://community.feministing.com/2008/08/proposed_bush_regulation_jeopa.html) Accessed 2008-09-21

15. American College of Obstetrics and Gynecology, Committee on Ethics Opinion No. 385 , *The Limits of Conscientious Refusal in Reproductive Medicine*, p. 3 (http://www.acog.org/from_home/publications/ethics/co385.pdf) Accessed 2008-09-24.

16. Charo, R. Alta, *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/full/352/24/2471) Accessed 2008-09-13

17. Lewis, C.S., "Bulverism: The Foundation of Twentieth Century Thought" (1941). In Hooper, Walter (Ed.) *C.S. Lewis- First and Second Things*. Willliam Collins & Sons: Glasgow, 1985, p.16

18. Lewis, C.S., "Bulverism: The Foundation of Twentieth Century Thought" (1941). In Hooper, Walter (Ed) *C.S. Lewis- First and Second Things*. Collins: Glasgow, 1985, p.17

19. For example: "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." College of Pharmacists of British Columbia Bulletin, *Ethics in Practice: Moral Conflicts in Pharmacy Practice*. March/April 2000, Vol. 25, No. 2, P. 5. For further information about the bulletin and related issues, see Project Report 2001-01, *College of Pharmacists of British Columbia: Conduct of the Ethics Advisory Committee,* 26 March, 2001. (http://www.consciencelaws.org/Conscience-Project-Reports/Report-2001-01.html)

20. One critic outlines the extent of the penetration of bioethics principlism, as defined in the American Belmont Report: "Many colleges and universities already require a course in bioethics in order to graduate, and most medical and nursing schools have incorporated it in their curricula. Bioethics is even being taught now in the high schools. And what is being taught as bioethics are the Belmont principles, or renditions of one or more of these principles as defined in Belmont terms. Nods may be given to 'alternative' propositions here and there, but in the end it is the language of principlism which sets the standards." Irving, Dianne N., *What is "Bioethics"? (Quid est "Bioethics"?)*. Tenth Annual Conference: Life and Learning X (in press)University Faculty For Life, Georgetown University, Washington, V.C. (http://www.lifeissues.net/writers/irv/irv_36whatisbioethics07.html) Accessed 2008-09-11

21. American College of Obstetrics and Gynecology, Committee on Ethics Opinion No. 385 , *The Limits of Conscientious Refusal in Reproductive Medicine*, p. 3 (http://www.acog.org/from_home/publications/ethics/co385.pdf) Accessed 2008-09-24.

22. "Medical professionalism includes both the relationship between a physician and a patient and a social contract between physicians and society." *CMA Policy: medical professionalism*. http://www.cma.ca/index.cfm/ci_id/3300/la_id/1.htm (Update 2005) P. 1 (Accessed 2008-09-06)

"Professionalism is also the moral understanding among medical practitioners that gives reality to the social contract between medicine and society. This contract in return grants the medical profession a monopoly over the use of its knowledge base, the right to considerable autonomy in practice and the privilege of self-regulation." *Canadian Stakeholders Coalition on Medical Professionalism*, quoted in *CMA: Medical Professionalism* http://www.cma.ca/index.cfm/ci_id/3300/la_id/1.htm (Accessed 2008-09-06)

"Professionalism is the basis of medicine's contract with society." "Medical Professionalism in the New Millennium: A Physician Charter." *Annals of Internal Medicine,* 5 February 2002 | Volume 136 Issue 3 | Pages 243-246 http://www.annals.org/cgi/content/full/136/3/243 (Accessed 2008-09-06)

"In Canada and the United States the social basis of the extraordinary grant of occupational authority and independence to professionalized occupations such as medicine and law has been a social contract between the profession and the public. Professionalism is the moral understanding among professionals that gives concrete reality to this social contract." Sullivan, William M., *Medicine under threat: professionalism and professional identity*. CMAJ, March 7, 2000; 162 (5) http://www.cmaj.ca/cgi/reprint/162/5/673 (Accessed 2008-09-06) Similarly, Cruess, Sylvia R. and Cruess, Richard L., *Professionalism: a contract between medicine and society.* CMAJ 7 March 2000; 162 (5) (http://www.cmaj.ca/cgi/reprint/162/5/668) Accessed 2008-09-06

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45. "The Ambassador did not consider that seeking the fruits of the Syrian interrogation made Canada complicit in obtaining information that might have been the product of torture. He reasoned that he did not ask the Syrians to continue interrogating Mr. Arar so that Canada could obtain information. Furthermore, the Ambassador did not have any evidence that Mr. Arar was being tortured or held incommunicado. *Arar Inquiry: Vol. I*, p. 271 (http://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/maher_arar/07-09-13/www.ararcommission.ca/eng/Vol_I_English.pdf) Accessed 2008-09-08.

46. "Superintendent Killam was aware that Secretary Powell had given Minister Graham the clear impression that the RCMP was complicit in Mr. Arar's deportation. However, Superintendent Killam testified that, even without making further inquiries in response to the media reports, he was able to exclude the possibility that the allegation of complicity might be true, because the allegation was inconsistent with the RCMP position."*Arar Inquiry: Vol. I*, p. 299 (http://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/maher_arar/07-09-13/www.ararcommission.ca/eng/Vol_I_English.pdf) Accessed 2008-09-08.

47. "Mr. Solomon prepared a draft memorandum for the Minister . . .which dealt with the upcoming CSIS trip to Syria and stated . . . "there are concerns as to whether a visit to Arar by Canadian intelligence officials may make Canada appear complicit in his detention and possible poor treatment by Syrian authorities." *Arar Inquiry: Vol. I*, p. 309 (http://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/maher_arar/07-09-13/www.ararcommission.ca/eng/Vol_I_English.pdf) Accessed 2008-09-08.

"Mr. Livermore testified that the original statement about the reliability of the confession and the possible complicity by Canada if CSIS was to meet with Mr. Arar was "very much on the speculative side" and "it was anticipating something that we later ironed out with CSIS, namely that they would not seek access to Mr. Arar."
Arar Inquiry: Vol. I, p. 310
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48. ". . . the intervenors suggest that the circumstances under which these individuals ended up in Syrian detention raise troubling questions about whether Canadian officials were complicit in their detention. The evidence of what happened to them could possibly show a pattern of misconduct by Canadian officials." 770 Commission of Inquiry into the Actions of Canadian Officials in Relation to Maher Arar, *Report of the Events Relating to Maher Arar: Factual Background,* Vol. II, p. 770
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49. "Canadian officials did not participate or acquiesce in the American decisions to detain Mr. Arar and remove him to Syria. I have thoroughly reviewed all of the evidence relating to events

both before and during Mr. Arar's detention in New York, and there is no evidence that any Canadian authorities — the RCMP, CSIS or others — were complicit in those decisions." *Arar Inquiry: Analysis and Recommendations,* p. 29 (http://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/maher_arar/07-09-13/www.ararcommission.ca/eng/AR_English.pdf) Accessed 2008-09-08

"Although decisions to interact must be made on a case-by-case basis, they should be made in a way that is politically accountable, and interactions should be strictly controlled to guard against Canadian complicity in human rights abuses or a perception that Canada condones such abuses." *Arar Inquiry: Analysis and Recommendations*, p. 35 (http://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/maher_arar/07-09-13/www.ararcommission.ca/eng/AR_English.pdf) Accessed 2008-09-08

"If it is determined that there is a credible risk that the Canadian interactions would render Canada complicit in torture or create the perception that Canada condones the use of torture, then a decision should be made that no interaction is to take place." *Arar Inquiry: Analysis and Recommendations*, p. 199 (http://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/maher_arar/07-09-13/www.ararcommission.ca/eng/AR_English.pdf) Accessed 2008-09-08

"Even if one were to accept that Canadian officials were somehow complicit in those arrests, that would not change my conclusion, based on the evidence at the Inquiry, that Canadian officials did not participate or acquiesce in the American decision to send Mr. Arar to Syria from the United States." *Arar Inquiry: Analysis and Recommendations,* p. 271 (http://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/maher_arar/07-09-13/www.ararcommission.ca/eng/AR_English.pdf) Accessed 2008-09-08

"Information should never be provided to a foreign country where there is a credible risk that it will cause or contribute to the use of torture. Policies should include specific directions aimed at eliminating any possible Canadian complicity in torture, avoiding the risk of other human rights abuses and ensuring accountability." *Arar Inquiry: Analysis and Recommendations*, p. 345 (http://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/maher_arar/07-09-13/www.ararcommission.ca/eng/AR_English.pdf) Accessed 2008-09-08

"Clearly, the prohibition against torture in the Convention against Torture is absolute. Canada should not inflict torture, nor should it be complicit in the infliction of torture by others." *Arar Inquiry: Analysis and Recommendations,* p. 346 (http://epe.lac-bac.gc.ca/100/206/301/pco-bcp/commissions/maher_arar/07-09-13/www.ararcommission.ca/eng/AR_English.pdf) Accessed 2008-09-08

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