Conscientious Objection to Effective Referral for Medical Assistance in Dying: An Analysis in Terms of Rawlsian Liberal Political Theory

By

K. Rachel Bulman

A thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Arts (MA) in Humanities

The Faculty of Graduate Studies
Laurentian University
Sudbury, Ontario, Canada

THESIS DEFENCE COMMITTEE/COMITÉ DE SOUTENANCE DE THÈSE
Laurentian Université/Université Laurentienne
Faculty of Graduate Studies/Faculté des études supérieures

Title of Thesis
Titre de la thèse Conscientious Objection to Effective Referral for Medical Assistance in Dying: An Analysis in Terms of Rawlsian Liberal Political Theory

Name of Candidate
Nom du candidat Bulman, Kama Rachel

Degree
Diplôme Master of Arts

Department/Program
Département/Programme Humanities

Date of Defence
Date de la soutenance February 27, 2020

APPROVED/APPROUVÉ

Thesis Examiners/Examinateurs de thèse:

Dr. Michael Yeo
(Supervisor/Directeur de thèse)

Dr. Mark Scott
(Committee member/Membre du comité)

Dr. Rachel Haliburton
(Committee member/Membre du comité)

Dr. Louis Groarke
(External Examiner/Examinateur externe)

Approved for the Faculty of Graduate Studies
Approuvé pour la Faculté des études supérieures
Dr. David Lesbarrères
Monsieur David Lesbarrères
Dean, Faculty of Graduate Studies
Doyen, Faculté des études supérieures

ACCESSIBILITY CLAUSE AND PERMISSION TO USE

Abstract

The recent legalization of medical assistance in dying (MAID) and the contentious mandatory effective referral policy implemented by the College of Physicians and Surgeons of Ontario (CPSO) have spurred robust legal and academic debate around the following question: to what extent should the CPSO limit physicians' ability to conscientiously object to referrals for healthcare services? Rawlsian political liberalism ranks conscience freedoms as fundamental liberties central to justice in a liberal democracy, whereas equality of access to goods or services rank secondarily. Mandatory effective referrals make unjust demands on some physicians by requiring them to take positive action against their consciences. Patients should have direct access to assenting physicians for services where fundamental moral disagreements are common, as is the case with abortion, for example. In order to protect patient autonomy, conscientious objections should be public so that patients can make informed choices about their primary healthcare providers prior to coming under their care.

Key Words

Medical assistance in dying (MAID), effective referral, Rawlsian liberal political theory, liberalism, conscientious objection, freedom of conscience

Table of Contents

Thesis Defense Committee ..... *ii*

Abstract ..... *iii*

Introduction *1*

1. Rawlsian Political Liberalism *8*

1.1 Public Reason and the Ideal of Civility **10**

1.2 Neutrality of the Liberal State **12**

1.3 The Right to Liberty and the Right to Equality **17**

2. Brief Histories of Conscientious Objection, MAID and Effective Referrals *26*

2.1 A Brief History of Conscientious Objection in Medicine **27**

2.2 MAID and Effective Referral in Ontario, Canada **33**

3. Analysis of the Arguments around Mandatory Effective Referrals for MAID *37*

3.1 The Complete Ban Arguments **37**

3.2 The Maximal Accommodation Arguments **54**

3.3 The Limited Accommodation Arguments **66**

3.4 A New Model for a Limited Right to Conscientious Objections **81**

Conclusion *90*

Bibliography *96*

Introduction

The practice of Western medicine, henceforth "medicine," is guided not only by scientific and technological advancement but also by cultural values and social norms which are subject to change over time. The recent legalization of medical assistance in dying (MAID) is an example of a fundamental change in the values that guide the practice of medicine, and this change has occurred quite rapidly in Canada. Contemporary life-prolonging medical treatments allow people to live longer than ever before while managing complex, degenerative and terminal diseases. While some patients benefit from these life-prolonging treatments, others experience protracted suffering and live with severe limits to their quality of life. Changes in the efficacy of treatments and medical interventions have led to many questions about the concept of quality of life and the extension of life at all costs. There is incredible diversity of belief about the morality and ethics of extending life, ending life through MAID, and administering toxic and lethal levels of pain medication in the face of profound suffering. Prior to the legalization of MAID, physician assisted suicide and euthanasia were criminal offences punishable by law which were understood as gross violations of the principles of medicine as a healing profession.

Rather than exploring the moral permissibility of MAID, this project will examine physicians' rights to conscientious objections in the practice of medicine through the lens of political liberal theory by focussing on a current flashpoint in both legal and academic debates: a physician's right to conscientiously object to providing an effective referral for MAID.

An *effective referral* is a timely referral that connects a patient with a non-objecting, available and accessible physician, health-care professional or agency.[1] According to the

[1] College of Physicians and Surgeons of Ontario, "Professional Obligations and Human Rights," March 2015, https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Professional-Obligations-and-Human-Rights.

College of Physicians and Surgeons of Ontario (CPSO) effective referrals are solely intended to connect patients with an assenting physician. In this way, effective referrals are different from formal referrals: whereas effective referrals prevent patients from having to use a means other than their primary care provider to find a willing physician, formal referrals typically signal an endorsement of a particular service or treatment. The effective referral policy allows conscientious objectors to refer patients indirectly through a secondary person or agency.[2] Physicians who conscientiously object to effective referrals for MAID can create obstacles for patients who may be legally eligible for and want access to the service. Some physicians may even refuse to provide patients with information about MAID due to the strength of their conscientious objections. In order to ensure patient access to MAID, the CPSO developed policies that mandate all physicians, regardless of conscientious objections, to provide effective referrals for patients who want access to legal health care services, such as MAID. The CPSO policy on effective referrals was unsuccessfully challenged in the Divisional Court of Ontario in 2018. Although it was found that effective referrals encroach on religious freedoms of physicians, the case was dismissed because these referrals were deemed to be reasonable professional obligations given that the CPSO policy is meant to ensure equitable access to legal, publicly-funded, healthcare services in Ontario.[3] The subsequent appeal to this decision was also denied.[4]

The difficulty with moral and ethical conflicts when they enter the legal system of a pluralist, liberal, political democracy is that individuals and groups hold different epistemologies,

---

[2] College of Physicians and Surgeons of Ontario, "Medical Assistance in Dying," December 2018, https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Medical-Assistance-in-Dying.
[3] *The Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario,* 2018 ONSC 579 at para 212.
[4] *Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario*, 2019 ONCA 393 at para 188.

ontologies, worldviews and concepts about the good which must be reconciled under the umbrella of the law. The extent to which the medical regulatory body can or should limit physicians' ability to conscientiously object to healthcare services, including effective referrals, based on their private conceptions of the good is the driving question of this project. This approach differs from most scholarly publications because rather than arguing for a particular moral or philosophical rationale for or against effective referrals, I am primarily concerned with Rawlsian political liberalism and how it approaches tensions between liberty and equality in a liberal democracy. With respect to MAID and effective referrals, this tension exists between physicians' conscience liberties, on the one hand, and equitable access to healthcare and patient autonomy, on the other. Given that principles of liberty and equality are frequently invoked in academic discussions on referral for MAID, it seems important to investigate these principles as they pertain to liberal democracies, like Canada. Although there are many variants of liberal theory, I've chosen Rawlsian political liberalism as the framework for this project because Rawls is the most prominent and influential liberal theorist of the last fifty years, thus any other version of liberalism will engage with Rawlsian political liberalism in some manner.

In the course of this work I will argue that mandatory effective referrals for MAID make unjust positive demands on some physicians by requiring them to take positive action against their consciences. According to Rawlsian political liberalism, conscience freedoms are fundamental liberties central to justice in a liberal democracy and equality of access to goods or services ranks secondarily to fundamental liberties. Equality of access to healthcare is an ideal that is impossible achieve and difficult to measure given the many factors that influence patient access including limited resources, geography, and highly complex contextual and physiological factors. Since equality of access cannot be guaranteed, it should not be used to justify policies

that violate the consciences of some physicians. Likewise, patient access should not form the limits of conscientious objection.

I argue that punitive limits on conscience freedoms cannot be justified since opposing moral positions on healthcare services that centre around one's concept of what constitutes a good life, or a good death, cannot be tested without relying on tradition or moral intuitionism. However, while physicians' freedom of conscience deserves protection from punitive limits, patient autonomy deserves careful consideration as well. Thus, reasonable limits to conscience objections must be put in place in order to prevent uncontrolled proliferation or accommodation of discriminatory, baseless or subversive conscience claims which compromise patient autonomy. I propose that patients should be able to get *direct* access to assenting physicians, without a referral requirement, for healthcare services where fundamental moral disagreements are likely to occur, as is the case with MAID and abortion. Allowing direct access protects patients from undue interference and unwanted moral counselling from physicians who have strong conscientious aversions to these services. Rather than seeking to enforce strict limits on conscience freedoms I propose that conscientious objections should be treated permissively up to the point of abuse; that is, until evidence emerges that a physician is abusing the system to make discriminatory, baseless or unreasonably numerous conscience claims.

I argue that some conscience claims, especially those grounded in evidence and technical expertise, may lead to positive changes in medical standards and that these kinds of conscience claims will only come to light if a process is put in place requiring physicians to justify their conscientious objections. Drawing from components of Lori Kantymir and Carolyn McLeod's model for conscientious justification, Francoise Baylis' relational conscience and Haidt's psychosocial theories of conscience, I argue that the process of justifying one's conscientious

objections can provide fruitful grounds for open discussions about the ethics of various healthcare services and will ultimately clarify how patients can best obtain access to these healthcare services in a neutral, liberal democracy. It is my position that conscience protections should prevent physicians from becoming implicated in procedures that they have conscientious objections to, but it should not give conscientious physicians a free license to attempt to "correct" the worldview of their patients. Following this argument, I will then briefly sketch out a model for how my proposed justification process could be operationalised: physicians with conscientious objections should be required to make their objections public in order allow patients to make informed choices about their primary healthcare providers prior to coming under their care. This may prevent physician-patient moral conflicts from occurring in the first place.

In order to make this argument, I will first elaborate on the concepts of liberty, equality and autonomy. In doing so, the first section of my thesis is an introduction to the Rawlsian political liberal framework and a description of how John Rawls treats liberty, equality, and autonomy. Particular attention will be given to clarifying the following: the ideal of civility and public reason, Rawls' positioning of equality below liberty when the two are in conflict, and the construction of perfectionist versus neutral liberal states. Integral to this argument is Rawls' work in *A Theory of Justice* which outlines the role of the state in maximizing individual fundamental liberties in the name of justice. His later work, *Political Liberalism*, which responds to the criticisms that his theories contain implicit biases about the notion of the individual and neutrality, will be taken up to address specific concerns that have been raised regarding his political liberalism. I will also consider the following critics of Rawlsian political liberalism: Gerald Dworkin's work on neutral and non-neutral principles will be briefly

examined to consider the "epistemological assumptions required to produce agreement on the selection of neutral principles"[5] and T.M. Scanlon's critical perspective on Rawls' political liberalism will also be examined in order to highlight concerns about the idea of the individual as a free choice-maker within a neutral liberal state. Despite these criticisms, Rawls' political liberalism continues to be a primary source for liberal political theory. To support Rawls' political liberalism, I will also consider Ronald Dworkin's work on the right to equal concern and respect in order to analyze and justify the role of civil rights within a liberal society. Using Rawls, his critics, and the work of Ronald Dworkin, I will provide an account of the contemporary liberal and democratic state. This framework will then be used in the final section of this project to critically analyze the three lines of arguments made by a number of contemporary scholars including Udo Schuklenk, Ricardo Smalling, Alberto Giubilini, Stephen Genuis, Chris Lipp, Lori Kantymir, Carolyn McLeod, Jocelyn Maclure, Isabelle Dumont, and others. Because these scholars have all written on the topic of mandatory referral for MAID and their arguments specifically reference political liberalism from very different perspectives, a clear liberal framework must first be solidified.

The second section of this thesis will draw from work by scholars such as Daniel Sulmasy, Jonathan Haidt and Francoise Baylis to outline contemporary views of conscience. I will then provide a brief history of conscientious objection in medicine by referencing legal cases in Canada and in the United States since the 1970's. I will also provide a chronology of the legalization of MAID and details about effective referral in the CPSO's Medical Assistance in Dying, Professional Obligations and Human Rights policies. This history will be sourced from

[5] Norman Daniels, ed., *Reading Rawls: Critical Studies on Rawls' A Theory of Justice* (New York: Basic Books Inc., Publishers, 1975), xxiv–xxv.

legal challenges to the Canadian Criminal Code, CPSO policies and the outcome of the *CMDS v. CPSO* Divisional Court Case and its subsequent appeal. This section will provide context for arguments made for or against mandatory effective referrals for MAID.

In the third section, I will examine the main lines of argument that exist in the literature around effective referrals for MAID with particular attention to language and assumptions about political liberalism, liberty, equality and autonomy. I outline where visions of the liberal state deviate from neutral liberalism and venture into perfectionist liberal territory, such that freedom of conscience is wrongly restricted in order to enforce a particular "liberal" worldview. I argue that this perfectionist worldview aims to push a majoritarian agenda and, as such, does not prioritize liberty nor equality of citizens in a pluralist society. I examine concerns about unreasonable proliferation of conscience claims and the use of conscience rights to mask religious subversion. I also describe religious and evidence-based arguments as tools for expanding physicians' conscience rights. Further, I analyse the legal decision in the case against the CPSO policies and examine scholarly models that reject effective referrals but propose different limits to conscientious objections. Lastly, I will describe my own position and briefly sketch out a model for how it might be put into action.

Let us turn now to a discussion on Rawlsian political liberalism in order to better define and expand upon the concepts of equality of healthcare access and fundamental liberties, like freedom of conscience, as they relate to political democracies.

1. Rawlsian Political Liberalism

MAID is legal in Canada and the professional body that regulates medical doctors in Ontario enforces a mandatory effective referral policy as a professional obligation within the publicly-funded healthcare system. When a physician's conscience is fundamentally opposed to referral for MAID, refusal to refer may be a barrier to patients seeking to access MAID. When the rights of patients and physicians come into conflict in the practice of medicine, the law will necessarily demand some sort of compromise, which may result in an encroachment onto the rights of one or both of the parties involved. Within this project, I propose that the construction of the liberal state (particularly the construction of regulatory standards in medicine) ought to follow Rawls' guidelines for a neutral liberal state which prioritizes liberty over equality, when the two come in conflict. This prioritizing of liberty is based on overlapping consensus, public reason, and the ideal of civility because these processes provide the most reasonable outcomes for all citizens. In this section, I will outline the main properties of Rawls' liberal state which, when considered in conjunction with debates around effective referrals, provide good reason to believe that mandatory effective referrals unjustly make positive demands on physicians.

While there is ongoing debate around political liberal theory, for the purposes of this research, I will draw primarily from Rawlsian liberal political theory. Rawls' first account of political liberalism was articulated in his book *A Theory of Justice*. In this work Rawls argues that justice is the sole characteristic feature of political systems that aim for of maximal liberty where multiple epistemologies, ontologies and differing conceptions of the good must coexist.[6] Rawls argues the following regarding justice as the fundamental principle driving equal liberty:

[6] John Rawls, *A Theory of Justice* (Cambridge: The Belknap Press of Harvard University Press, 1971), 214.

> [Justice] does not rely on any special moral or philosophical doctrine. It does not presuppose that all truths can be established by ways of thought recognized by common sense; nor does it hold that everything is, in some definable sense, a logical construction out of what can be observed or evidenced by rational scientific inquiry. The appeal is indeed to common sense, to general shared ways of reasoning and plain facts available to all, but it is framed in such a way so as to avoid these larger presumptions. Nor, on the other hand, does the case for liberty imply skepticism in philosophy or indifference to religion.[7]

The goals of the liberal state are to create room for freedom of thought, freedom of conscience and freedom of religion, as well as other fundamental constitutional freedoms such that the individual can determine for his or herself a particular conception of the good and pursue this to the fullest extent possible. Intrusions upon individual freedoms are therefore only justified in cases where the expression of one's conscience or religious beliefs violates the equal liberties of others. Rawlsian political liberalism considers the "coercive democratic political power of free and equal citizens as a collective body within the public" such that the legitimacy of this coercive democratic political power requires its diverse body of citizens to commit to an ideal of civility and the tenants of public reason[8] In order for political liberalism to maintain the liberties of all citizens, there must exist agreement around the main tenants of fundamental matters of basic justice and the political responsibilities of democratic citizens within a liberal democracy. According to Dworkin, "[i]t is a reasonable feature of any good society that it is self-sustaining in the sense that people who grow up in such a society will acquire a respect for and commitment to the principles which justify and regulate its existence."[9]

In the coming subsections, I will outline various debates from both T.M. Scanlon and Ronald Dworkin regarding the fundamental principles of political liberalism while simultaneously providing extended consideration of three main properties: (1) the role of public

---

[7] Rawls, 214.
[8] John Rawls, *Political Liberalism* (New York: Columbia University Press, 1993), 216–17.
[9] Gerald Dworkin, *The Theory and Practice of Autonomy* (Cambridge: Cambridge University Press, 1988), 11.

reason and civility in Rawlsian liberalism; (2) Rawls' and Dworkin's assertion that liberalism must remain both neutral and removed from moral debates; and (3) the integral protection of fundamental liberty of individual equality within the liberal state.

1.1 Public Reason and the Ideal of Civility

For Rawls, a commitment to public reason demands that citizens think outside their own comprehensive religious or personal doctrines with respect to matters of basic constitutional justice such that coercive political power should be exercised only "in accordance with a constitution the essentials of which all citizens may reasonably be expected to endorse as reasonable and rational."[10] Public reasoning for or against certain coercive measures, such as strong legislation regarding professional obligations for practicing physicians, must include justifications that rely on uncontroversial and widely accepted forms of reasoning; otherwise, it runs the risk of becoming purely rhetorical argumentation.[11] On matters of basic justice, therefore, citizens must not defer to personal reasons, to religious mandates of the church, or to scholarly, philosophical, professional or scientific deliberations. It is important to note that political liberalism as it pertains to liberty of conscience does not only protect the freedom of individual consciences, likewise it protects freedom of conscience in churches and other associations from governmental interference.[12] In this way, political liberalism acts as a barrier against coerciveness for minority groups who might otherwise be threatened by the larger majority.

Tied to the notion of public reason is the ideal of civility: the moral duty of citizens is to "be able to explain to one another on those fundamental questions how the principles and

---

[10] Rawls, *Political Liberalism*, 217.
[11] Rawls, 220, 224.
[12] Rawls, 221 (Footnote 8).

policies they advocate or vote for can be supported by the political values of public reason."[13] When a stable and well-ordered liberal democratic society faces political questions from diverse religious or deep-seated conscientious perspectives, "those of different faiths may come to doubt the sincerity of one another's allegiance to fundamental political values."[14] For Rawls, these kinds of situations, where opposing groups within society have incompatible views, require a public debate that acknowledges the comprehensive doctrines that underpin these opposing viewpoints.[15] A discussion of comprehensive doctrines, in these particularly tense situations, is required to "strengthen mutual trust and public confidence" as part of the "sociological basis encouraging citizens to honour the ideal of public reason."[16] Public reason and the duty of civility are ideals which citizens of a liberal, pluralist, political democracy must strive toward in a political sense, in order to sustain the basic justice and basic freedoms as laid out by the constitution because, without these principles, the interests of minority groups will be at risk.

Rawls argues for a neutral liberal state that protects individual liberties by separating the state from particular comprehensive doctrines and by committing to public reasoning that rejects perfectionist principles. Perfectionist principles suggest that certain personal, spiritual, religious or moral values rank higher than others because of their intrinsic value. Liberal, secular, pluralist and democratic states "do not have an agreed upon criterion for perfection that can be used as a principle for choosing between institutions."[17] Rawls comments, as follows:

> Persons join together to further their cultural and artistic interests in the same way that they form religious communities. They do not use the coercive apparatus of the state to

[13] Rawls, 217.
[14] Rawls, 248.
[15] Rawls, 249.
[16] Rawls, 249.
[17] Rawls, *A Theory of Justice*, 327.

> win for themselves a greater liberty or larger distributive shares on the grounds that their activities are of more intrinsic value. Perfectionism is denied as a political principle.[18]

It follows from this that the liberal state must therefore remain neutral and distanced from perfectionist ideals. I will provide a detailed account of liberal neutrality and various criticisms of this standard in the following section.

1.2 Neutrality of the Liberal State

Rawls' notion of neutrality, that public institutions and public policy must be designed so as to not favour any particular comprehensive doctrine, is criticized as self-contradictory by many scholars. A particularly strong claim is that Rawls' negative view and rejection of perfectionism denies that there are certain empirical qualities that are undeniable. I will give this position consideration, along with the criticism that neutrality prevents any conception of the good from actualizing, and I will ultimately conclude in line with Rawls that neutrality of the liberal state is not only possible but necessary for a just, liberal democracy.

Scanlon explains that in societies that prioritize the individual, "each party…regards his own judgment as a real citizen as a sovereign – not as infallible immune from limitations, but as the basis from which his life will be lived."[19] Because of this, Scanlon argues that perfectionist states, of the sort that Rawls' argues against, seek to produce citizens who conform to a particular ideal; however, Rawls' own principles of justice which underpin his theory of liberalism involve a certain ideal of the person, despite his attempts to prove that psychological laws will support his principles of justice in a well-ordered society.[20] Scanlon points out that the action of the psychological laws that Rawls' references is "in part dependent upon the

---

[18] Rawls, *Political Liberalism*, 329.
[19] T.M. Scanlon, "Rawls' Theory of Justice," in *Reading Rawls*, ed. Norman Daniels (New York: Basic Books Inc., Publishers, 1975), 177.
[20] Scanlon, 175.

intellectual activity of the person upon whom they are acting, but is also in large part something which happens to a person without his knowledge or rational scrutiny."[21] For Scanlon, Rawls' principles of justice are rationally justified based on the objective value of a particular ideal.[22] According to Scanlon, Rawls has not refuted perfectionism, but rather has provided an alternative ideal based on social cooperation and a particular view of justice.[23]

In *Political Liberalism*, Rawls acknowledges the criticism that liberalism cannot be neutral since liberalism prioritizes the individual. Rawls argues that,

> …ideas of the good may be freely introduced as needed to complement the political conception of justice, so long as they are political ideas, that is, so long as they belong to a reasonable political conception of justice for a constitutional regime. This allows us to assume that they are shared by citizens and do not depend on any particular comprehensive doctrine. Since the ideals connected with the political virtues are tied to the principles of political justice and to the forms of judgment and conduct essential to sustain fair social cooperation over time, those ideals and virtues are compatible with political liberalism.[24]

Thus, the neutrality of the liberal state is maintained in the sense that public institutions and public policy must be designed so as to not favour any particular comprehensive doctrine where justice as fairness provides a range of overlapping consensus for citizens with a wide range of personal comprehensive doctrines. The limits of public reason require that public policy assert only so much of a comprehensive view that can be supported by a reasonable overlapping consensus around justice. Such a view requires toleration of different or opposing comprehensive doctrines where citizens are left "to settle the questions of religion, philosophy, and morals in accordance with views they freely affirm."[25] Rawls argues that overlapping

---

[21] Scanlon, 175.
[22] Scanlon, 177.
[23] Scanlon, 179.
[24] Rawls, *Political Liberalism*, 194.
[25] Rawls, 154.

consensus is "part of a comprehensive doctrine, but it is not a consequence of that doctrine's non-political values."[26]

In maintaining neutrality, liberal, secular, pluralist democracies face considerable challenges in reconciling the multitude of individual epistemologies, ontologies and worldviews which must exist in harmony under the umbrella of law. Rationalism as an epistemological standard, coupled with the legal protection of basic liberties, aims to create a political state that is able to tolerate the greatest diversity of worldviews without dissolving into anarchy. In theory, questions of rights with respect to fundamental disagreements and intractable moral disputes must be settled in a way that does not give preference to any one particular set of values. However, implicit in liberal societies is the expectation that most citizens agree to the fundamental principles of liberty, to equal concern and respect for persons and to the commitment to public reason in order to avoid undermining communal obligations and falling into normlessness and interminable debates about values and rights. This demands a certain level of compromise from its citizens: it requires both "a willingness to listen to what others have to say" and a readiness "to accept reasonable accommodations or alterations in one's own view" in order to approach the principle of individual freedom by protecting the rights of minority groups.[27] Individuals whose conceptions of the good are closely tied to a view of subjective human experience that is radically different from rationalist epistemologies will find the compromises required by liberal societies more difficult. Rawls' theory of political liberalism makes demands on citizens that they separate their private and public comprehensive doctrines in the name of justice and liberty.

---

[26] Rawls, 155.
[27] Rawls, 253.

According to Dworkin, political liberalism demands that the government not assert a particular view of a "good" life and that legislation and law remains sensitive to protecting the fundamental principle for equal concern and respect by upholding civil rights. The neutrality of political liberalism is not without criticisms. Some will argue that political liberalism is based in skepticism of theories of the good, or that liberalism makes no room for right and wrong in political morality. Dworkin refutes this by asserting that the fundamental principle of political liberalism, equal concern and respect for persons is what is right, and that this principle is the constitutive morality of political liberalism.[28]

It is also argued that political liberalism is self-contradictory in that as a political system it must assert a particular view of the good. Dworkin refutes this position, claiming that liberalism is based on "political organization [that is] required by justice, not a way of life for individuals, and liberals, as such, are indifferent as to whether people choose to speak out on political matters, or to lead eccentric lives, or otherwise to behave as liberals as supposed to prefer."[29] By this Dworkin means that the liberal framework requires certain principles to ensure justice within the state but does not make similar impositions on individual citizens. This point also addresses criticisms that political liberalism requires a separation between private and public life: following Dworkin, within political liberalism there is no restriction on participation in political activity in political liberalism and citizens are free to immerse themselves in political communities, even communities that are intolerant or that promote a particular comprehensive political and moral ideal. While this may seem paradoxical, Dworkin importantly stresses that liberalism is a framework for the political state, not a moral guideline for individual behaviour.

---

[28] Ronald Dworkin, "Liberalism," in *Liberalism and Its Critics*, ed. Michael Sandel (New York: New York University Press, 1984), 77.
[29] Dworkin, 78.

Another criticism of political liberalism is that it denies political society from achieving what is good, which may be the highest function and justification of government. This criticism requires us to determine the "content of the respect that is necessary to dignity and independence" which Dworkin admits is extremely difficult to pin down and fraught with reasonable disagreement.[30] Conceptions of the good are bound to be influenced by socioeconomic and cultural factors, thus, it is necessary for liberal political states to protect those individuals whose ideas are not institutionally or socially reinforced by popular preference. However, if preferences are influenced by systems of distribution, rather than fully self-generated, then it is "all the more important that distribution be fair in itself, not tested by the preferences it produces."[31]

A political account of liberalism founded on justice as fairness requires that basic constitutional freedoms rank above social and economic inequalities because basic constitutional freedoms must be upheld to maintain a functioning liberal society. Basic constitutional freedoms, including freedom of conscience for all citizens, are fundamental matters of justice that can be measurably realized, whereas determining whether matters of equality are realized is far more difficult to do since "[t]hese matters are nearly always open to wide differences of reasonable opinion; they rest on complicated inferences and intuitive judgements that require us to assess complex social and economic information about topics that are poorly understood."[32] Thus, political liberalism requires agreement on fundamental constitutional matters of justice, such as freedom of conscience before and above matters of social inequality.

---

[30] Dworkin, 78.
[31] Dworkin, 78.
[32] Rawls, *Political Liberalism*, 229.

In sum, Rawls' theory of political liberalism demands that citizens separate their private and public comprehensive doctrines in the name of justice and liberty, and it further demands that the liberal state remain neutral on moral issues. However, there are challenges which arise when this neutrality does not seem possible, particularly because the state does clearly make value-based judgements, as in cases when the liberal state must determine which rights take precedent over others. The common tension between the right to liberty and the right to equality much be addressed by a political liberal framework. As Rawls' argues, within the liberal state, the right to liberty must trump the right to equality.

1.3 The Right to Liberty and the Right to Equality

The issues at the heart of the discussion around conscientious objections to referral for MAID centre around equality of access to timely care for patients, the autonomy of the patient in their healthcare decisions and freedom of conscience for physicians who object to referral for MAID. This is complicated by the fact that the right to liberty often comes into conflict with the right to equality. In MAID debates, there is often strong conflict between the freedoms of physicians and equality of patient access to healthcare. On the one hand, we have the position that physicians in a liberal democracy should not be able to conscientiously object to referrals thus protecting patients' rights to access healthcare; on the other hand, we have the argument that liberal societies have a duty to protect freedom of conscience of all citizens, including physicians. The middle ground would suggest that under particular circumstances physicians should be accommodated when they have conscientious objections, and in other circumstances, they should not. There is considerable disagreement about which particular circumstances determine when accommodation of a conscientious objection should be allowed. We are then left with a debate regarding which right takes priority: liberty or equality?

Liberalism is often described as a middle ground approach, or a balancing of extreme positions, but Ronald Dworkin rejects this characterization. For Dworkin, liberalism, as a political ideal with a wide spectrum of forms does not aim to balance extreme positions, but rather aims to step outside all positions as a neutral arbitrator concerned only with equal respect and concern for all citizens. The various forms of political liberalism depend upon the ideals of liberty and equality from different conceptions of what equality means and requires in a political democracy.[33] Following this characterization, Dworkin writes that there will always be some compromise on liberty to maintain order in society. For example, liberty to drive however and wherever one wants is restricted by traffic laws.[34] These compromises in liberties cannot be measured in the same way that other commodities are measured; we cannot say that a particular restriction on one liberty results in another (larger) gain in another liberty. Since liberty cannot be measured as such, losses and gains in liberty, even fundamental liberties, cannot form the premise of arguments for various political liberal positions.

Varying political positions tend to weigh liberty against equality because they often appear to be in conflict. Generally, more radical liberals put greater emphasis on equality, while more conservative liberals put greater emphasis on liberty. It is often supposed that a liberal, democratic government is responsible for weighing the compromises between equality and liberty in contentious political decisions. In the case of conscientious objections to referral for MAID, scholarly literature has divided arguments along this line as well, framing the question of mandatory referrals in terms of which liberties are more fundamental – freedom of conscience for physicians or equality of access and autonomy and respect for person for patients. Alternative

[33] Dworkin, "Liberalism," 62.
[34] Dworkin, 61.

to these positions, Dworkin argues that liberty is not a measurable commodity. Liberty cannot be quantified, thus relative gains and losses in liberty cannot effectively be measured. Dworkin writes "we cannot explain the difference between liberal and conservative political positions by supposing that the latter protect the commodity of liberty, valued for its own sake, more effectively than the former" rather, "fundamental liberties are important because we value something else that they protect."[35] For Dworkin, fundamental liberties protect a presupposed right to equality that underlies all liberal positions, albeit from different perspectives.

Dworkin describes equality as a political ideal based on two principles: (1) that the government must treat all citizens with equal concern and respect such that each citizen is free with equal dignity; and (2) that the government treats all citizens equally with respect to distribution of resources or opportunities.[36] These principles do not suggest that all citizens will be equal in all respects, but rather that the government has *some* role in securing the equality of various resources. For Dworkin, the first principle is constitutive and the second principle is derivative, thus the first principle of equality, that citizens deserve equal concern and respect, is more fundamental than equality of resources and opportunities.[37] The methods by which the government can or should achieve these ideals are subject to a wide variety of conceptions and prejudices that cannot be discounted, but regardless of one's position on the political spectrum, the idea that the government must treat its citizens with equal concern and respect is widely agreed upon in contemporary politics.[38] Thus, for Dworkin, "we must reject the simple idea that

[35] Dworkin, 61–62.
[36] Dworkin, 62, 63.
[37] Dworkin, 62–63.
[38] Dworkin, 63.

liberalism consists in a distinctive weighing between constitutive principles of equality and liberty" and instead spend more time considering what it means to treat citizens as equals.[39]

Dworkin lays out two fundamentally different ways to argue how the government could approach the concept of equal treatment for citizens. The first perspective argues that the government must remain neutral on the concept of what constitutes the good, such that each citizen can decide for themselves what a good life means and live according to that conception. The second perspective argues that it is impossible for the government to remain neutral. Given that equality requires underlying ideas of the good and how human beings ought to live, liberalism requires a particular vision of a good life.[40] Both Rawls and Dworkin make the argument that political liberalism as a neutral position which does not enforce a particular view of the good.

For Dworkin, the neutrality of political liberalism allows for a political morality that most people would agree upon.[41] Modern concepts of liberalism emerged in response to oppressive regimes and religious wars. Pluralist, multi-cultural, liberal democracies value political neutrality in order to allow all citizens to live according to their particular conception of the good. Citizens will naturally differ in terms of talents, abilities, inherited socioeconomic advantages, and so on, and these inequalities are far more disruptive than differences solely in preferences or tastes; in this way, equality produces non-egalitarian consequences, which is particularly evident when we consider the effects of luck, good or bad fortune, skill or talent, market demands and so on.[42] Furthermore, Dworkin argues that democracy is designed as a way

[39] Dworkin, 63.
[40] Dworkin, 64.
[41] Dworkin, 65.
[42] Dworkin, 68–69.

to empower the individual citizens within a political society. However, democratic decisions will impose the will of the majority upon all citizens, again resulting in non-egalitarian consequences for minority groups.[43] Thus, liberal societies, in order to maintain the principle of equal concern and respect for all citizens, must develop civil rights that protect the individual from disruptive inequalities and the will of the majority. Since some political decisions are antecedently likely to reflect historically-situated prejudices and external preferences, civil rights should be designed to remove these sorts of decisions from the power of majoritarian political institutions.[44]

These rights will function as trump cards held by individuals; they will enable individuals to resist particular policies or political decisions in spite of the fact that these decisions are or would be reached through the normal workings of general institutions that are not themselves challenged. The ultimate justification for these rights is that they are necessary to protect equal concern and respect; but these rights are not to be understood as representing equality in contrast to some other goal or principle served by democracy or the economic market. According to Dworkin,

> For the liberal, rights are justified, not by some principle in competition with an independent justification of the political and economic institutions they qualify, but in order to make more perfect the only justification on which these other institutions may themselves rely. If the liberal arguments for a particular right are sound, then the right is an unqualified improvement in political morality, not a necessary but regrettable compromise of some other independent goal, like economic efficiency.[45]

Dworkin points out that disagreement over which rights are necessary to maintain a liberal conception of justice is inevitable. However, when democratic politics and legislation are used as a means to reaffirm public virtues or moralistic or external preferences, the democratic

[43] Dworkin, 69.
[44] Dworkin, 70.
[45] Dworkin, 72.

process may be used to legislate a public morality, thereby violating the principle equal concern and respect for persons and ultimately reversing the premise of civil rights.[46] Political liberalism is "decidedly not some compromise or halfway house between more forceful positions but stands on one side of an important line that distinguishes it from all competitors in the group."[47] In order to remain neutral on moral issues in a pluralist democracy, where many theories of what is good and valuable in human life co-exist, political liberals must constantly analyze and re-think what political liberalism is and means. The focus of this research project is to reflect on the principles of liberalism, including an examination of the role of civil rights in this framework, and to analyze how these principles are being applied in lines of argument around effective referral for MAID.

Thus, Dworkin gives us a sense of the foundational principles of political liberalism as a system of political organization with a constitutive political morality centred on equal respect and concern for citizens. Accordingly, the derivatives of this foundational principle, in line with Dworkin's conception, suggest that the distribution of both resources and opportunities must be fair, such that those who might be subjected to prejudices or external preferences in matters of justice should have access to civil rights which protect the eccentric or those with needs that are different or special than popular, majoritarian preferences from undue imposition of the will of the majority.

With rights in mind, let us now consider the right to freedom of conscience in a liberal state. According to both Rawls and Dworkin, liberal political states should be neutral insofar as they do not value any particular comprehensive doctrine, but also, overlapping consensus about

[46] Dworkin, 72–73.
[47] Dworkin, 65.

justice as fairness and liberty as good must exist to legitimate the liberal state; and citizens must adhere to public reason and the ideal of civility in matters of basic constitutional justice. That being so, freedom of conscience as a matter of basic justice ranks very near the top in terms of fundamental liberties in a liberal state. Thus any demand on citizens to take positive actions, not merely to refrain from certain actions, but to act against their consciences directly, must be made through very powerful arguments proving that failure to act in this way would have severe detrimental effects on the fundamental liberties of others, such that this intrusion of conscience might be justified. Arguments made in the name of preserving liberty or equality in a liberal political state must not be justified by comprehensive doctrines, lest they violate the founding principles that liberal states are built upon. The role of the liberal state is not to balance extreme positions around freedom of conscience, but rather to step outside all comprehensive doctrines to assert a position that prioritizes basic justice, equal respect and concern for persons and fundamental freedoms of citizens. The liberal position is concerned only with protecting the liberties of its citizens in a way that supports justice as fairness and the overlapping consensus that exists around the political conception of justice.

For Dworkin, liberty refers to the ability to act as one wishes, with freedom from interference and the presence of options that are not closed off by other agents or social institutions.[48] However, individual citizens' values and attitudes are continuously influenced and socialized by economic institutions, mass media, familial traditions, the force of public opinion, social class, and so on.[49] Autonomy, on the other hand, involves a critical component of personhood: the "ability to reflect upon and adopt attitudes toward first-order desires, wishes and

[48] Dworkin, *The Theory and Practice of Autonomy*, 105.
[49] Dworkin, 11.

intuitions."[50] Thus, autonomous self-determination requires not only freedom from interference, but also appreciation for the process by which desires or preferences are acquired; it is "tied up with the idea of being a subject, of being more than a passive spectator or one's desires and feelings."[51] While values and attitudes are unavoidably influenced by social structures within the liberal state, autonomy remains an important component of individuality which ought to be protected by the state. The question remains as to which public values should drive this process.

The rights of the individual to self-determination are invoked by both patients and physicians in the contentious debate over mandatory effective referrals for MAID. The current system requires physicians to participate in mandatory referrals with which they may have profound conscientious disagreement, while also requiring patients in incredibly difficult life-circumstances to become dependent on physicians who may not share the same conceptions of the good. Both parties are interested in pursuing their own conception of a good life and a good death. One of the key difficulties with MAID is that it represents a recent and very rapid reversal of medical values and is an instance of the liberal state supporting regulations that enforce these medical values. The rapidity of the change matters in this case given that public reason requires us to rely on commonly accepted forms of reasoning. While a great many individuals may support MAID, it would be hasty to say that the reasoning and rationale for the practice is commonly accepted. As I will show, under the liberal framework provided by Rawls and built-upon by Dworkin, the right to liberty, including conscientious objection, must be protected in a liberal state.

---

[50] Dworkin, 15.
[51] Dworkin, 106–7.

In the following section of the thesis I will provide a review of contemporary conceptions of conscience, a brief history of conscientious objection in Canada, a summary of the chronology of the legalization of MAID in Canada and the subsequent legal challenges against the CPSO's effective referral policies. Following this exposition, I will provide a thorough outline of the three main lines of argument around effective referrals and conscientious objections in Canada, and, lastly, conclude with my recommendations.

2. Brief Histories of Conscientious Objection, MAID and Effective Referrals

Generally, conscience is understood as a form of internal moral intuition and rational reasoning that one relies upon to make decisions about what is right or wrong, good or bad, or good or evil. Conscience is informed by one's moral principles, which are, in turn, influenced by a multitude of religious, secular, social and cultural factors. A major point of disagreement about conscience occurs around the concept of objective moral truths. Most scholars agree that conscience is formal in nature because it is not tied to any particular universal moral truths, making it impossible to test for content. This particular standpoint, though popular in liberal, secular democracies is itself a constraining view of conscience. There are many individuals or groups that make claims to moral superiority or defer conscientious decisions to the moral superiority of an infallible deity or to sacred law. In fact, disagreement on this fundamental point is responsible for many intractable moral conflicts.

In this section, I will provide a philosophical consideration of the history of conscientious objection in medicine as it applies to the debate around MAID. In the first subsection, I will provide an account of the rise of conscientious objections in Western medicine. I then consider Francoise Baylis' relational view of conscience and assess the role of personal integrity and accountability to one's community. I also provide consideration of the fallibility of conscience, the importance of social feedback and the process of justifying one's conscientious beliefs as a way to promote tolerance for others and prevent moral distress. Following this discussion, in the second subsection, I will provide a short legal history of MAID and mandatory effective referrals, specifically in Ontario, Canada.

2.1 A Brief History of Conscientious Objection in Medicine

It is beyond the scope of this project to provide a comprehensive history of conscientious objections in medicine. Briefly, however, the shift from the belief that "doctor knows best" to state endorsed patient-centred care, means that physicians no longer enjoy sanctioned authoritative control over the care they provide to the public. Historically, conscientious objections have allowed medical professionals to exempt themselves from providing legal healthcare services that they disagree with on moral grounds. Conscientious objections in medicine became popular in the wake of the legalization of abortion, particularly for religious reasons. In the US, conscience clauses became increasingly incorporated into state legislation during the 1970's to protect the consciences of physicians who refuse to provide abortions.[52] In the 1990's other medical professionals, such as nurses, pharmacists, etc., also began to invoke conscientious objection to a number of services, particularly those involving contraception, abortion and fertility treatments. This proliferation of conscientious objections has extended beyond religious professionals and organizations in medicine to private industries as well. For instance, in the US some private corporations like Walmart have invoked conscientious objection clauses in order to avoid selling emergency contraception in their pharmacies.[53] In other cases, employers have conscientiously objected to including particular contraception methods as defined by the American Federal Employee Health Benefits Plan.[54]

---

[52] Hasan Shanawani, "The Challenges of Conscientious Objection in Health Care," *Journal of Religion and Health* 55, no. 2 (April 1, 2016): 386, https://doi.org/10.1007/s10943-016-0200-4.
[53] Shanawani, 386.
[54] Christian Fiala and Joyce H. Arthur, "'Dishonourable Disobedience' – Why Refusal to Treat in Reproductive Healthcare Is Not Conscientious Objection," *Woman - Psychosomatic Gynaecology and Obstetrics* 1 (December 1, 2014): 14, https://doi.org/10.1016/j.woman.2014.03.001; Kate Spota, "In Good Conscience: The Legal Trend to Include Prescription Contraceptives in Employer Insurance Plans and Catholic Charities Conscience Clause Objection Comment," *Catholic University Law Review* 52 (2003 2002): 1082.

The majority of reported conscientious objections in Canada centre around reproductive health, although it is impossible to collect data on unreported cases of conscientious objections. For example, religious or conscientious objections to performing abortions are generally unchallenged with no negative consequences for the objectors; whereas other religious objections, such as objections to providing blood transfusions, would be considered malpractice. In medical practice, conscientious objection is not viewed as civil disobedience, as in the case of refusals to participate in military service; it is instead invoked as an individual right under the Canadian Charter of Rights and Freedoms.

The philosophical tension between moral absolutism and moral relativism is avoided in Canadian law by approaching moral issues from the standpoint of "the furtherance of rights" [55] as per the Charter of Rights and Freedoms, henceforth "the Charter." By sidestepping the debate on morality, secular democracies are vulnerable to becoming breeding ground for deep suspicion and contempt between groups with conflicting moral worldviews. Rawls insists that debate on fundamental political issues should defer to public reason and should occur in public forum. Liberal, pluralist democracies, in which citizens hold beliefs based on competing or incompatible comprehensive personal doctrines, require public debate as a means of facilitating social exposure, tolerance, understanding, and epistemic humility and incentive to continue to strive toward the ideal of civility.[56] Although conscientious disagreement is likely to occur in a liberal pluralist state, conscientious behaviour is nonetheless revered as virtuous. Without conscience and a baseline of morality, there could be no state, no law, and no functioning social structure.

[55] Jocelyn Maclure and Charles Taylor, *Secularism and Freedom of Conscience* (Harvard University Press, 2011), 68.
[56] Rawls, *Political Liberalism*, 249.

Baylis' relational view of conscience acknowledges both the personal and social virtues of conscientious integrity. This relational view emphasizes the importance of reflection beyond the self by integrating conscientious reflection of the impact of one's conscientious decisions on the community.[57] This definition of conscience aligns well with the principles of political liberalism, because it emphasizes the importance of including accountability to one's community and "flexible resilience" in the face of conscientious disagreement.[58] The notion of accountability is important in terms of public reasoning as it implies that conscientious decision-making should occur in a social context, as opposed to being a completely inward or independent reflective process. This seems particularly relevant in cases where conscientious decisions will affect the lives of many people, including those who may not share the same particular worldview as the decision maker.

Liberal societies aim to preserve the freedoms and liberties of citizens so that they may arrive at their own conceptions of what is good, what is valuable, and how to live. As such, these types of societies do not enforce a particular worldview—religious, secular or otherwise—on their citizens and instead allow agency on the part of individuals in matters of conscience and morality.[59] A natural consequence of liberal principles with respect to conscience and morality, is that, unsurprisingly, there will be many different value systems, some of which may be incompatible with one another, and eventually certain value systems will come into conflict. Maclure and Taylor define this phenomenon as *moral pluralism.*[60] A liberal, secular state must remain neutral with respect to personal and communal moralities but, as Maclure and Taylor

[57] Francoise Baylis, "A Relational View of Conscience and Physician Conscientious Action," *International Journal of Feminist Approaches to Bioethics* 8, no. 1 (2015): 21.
[58] Baylis, 21.
[59] Maclure and Taylor, *Secularism and Freedom of Conscience*, 11.
[60] Maclure and Taylor, 10.

point out, it "cannot remain indifferent to certain core principles such as human dignity, basic human rights and popular sovereignty…. Although these values are not neutral, they are legitimate, because it is they that allow citizens espousing very different conceptions of the good to live together in peace."[61] In order to respect fundamental freedom of conscience in good faith requires tolerance, and beyond that, it requires commitment to the principles of public reasoning.

The majority of literature on conscience references a commitment to personal integrity and tolerance for others. According to Sulmasy:

> Conscience is the fundamental commitment to be moral: the fundamental commitment to respect others. People of conscience owe each other, first and foremost, respect for their consciences.
>
> Without conscience, no morality is possible. To have a conscience is to commit oneself, no matter what one's self-identifying moral commitments, to respect for the conscience of others. This is tolerance.[62]

Callahan suggests that conscience proper requires a wilful or active commitment to morality as well as thoughtful deliberation about intentions of action and how those actions compliment or violate one's sense of personal integrity. From this perspective conscience requires a personal commitment to engage in a ''self-conscious activity, integrating reason, emotion, and will" in the same way that one makes decisions about all things, not just moral decisions.[63] By this analysis, conscience requires a set of deeply held beliefs to which one is actively committed, and a self-awareness which allows for conscious reasoning and deliberation of these beliefs in the face of

---

[61] Maclure and Taylor, 11.
[62] Daniel P. Sulmasy, "What Is Conscience and Why Is Respect for It so Important?," *Theoretical Medicine and Bioethics* 29, no. 3 (June 1, 2008): 145, https://doi.org/10.1007/s11017-008-9072-2.
[63] Sidney Cornelia Callahan, "In Good Conscience Reason and Emotion in Moral Decision Making," 1991, 23.

moral dilemmas. That said, conscientious commitments are subject to change over time, are often dependent on recent moral decisions, and can be influenced by a variety of social factors.[64]

Social psychology research shows that morality is malleable and evolves within a social group; Haidt calls this phenomenon the "coevolution" of moral minds, which suggests that morality has a social functionalist purpose that is more influential on human behaviours than truth-seeking.[65] In fact, many scholars argue that conscience is largely a social operation that can easily be conflated with other, non-moral motives such as fear of social reprisals like loss of reputation or backlash, violence, discomfort, inconvenience or even hidden insecurities.[66] Baylis points out that reflecting on conscience from a self-oriented, individualistic lens risks a self-indulgent commitment to particular and personal moral concerns.[67] Conscience involves more than personal moral integrity and conscientious decisions that are made within public institutions cannot be explained, justified or even tolerated on purely individual terms: public reasoning demands reflection and accountability beyond the self.

Conscience is known to be fallible. One may hold poorly informed beliefs through ignorance or faulty reasoning and thus, flexible resilience is essential in the face of conscientious disagreement. Haidt's research into the conscience shows that conscientious decision making follows a pattern of an immediate, affective response to a moral dilemma followed by slower, "cooler" rational deliberation.[68] It was also noted that people generally rationalize their initial affective responses to a moral dilemma and rarely search out viewpoints or information that

---

[64] Claudia I. Emerson and Abdallah S. Daar, "Defining Conscience and Acting Conscientiously," *The American Journal of Bioethics* 7, no. 12 (December 17, 2007): 20, https://doi.org/10.1080/15265160701709974.
[65] Jonathan Haidt, "The New Synthesis in Moral Psychology," *Science* 316, no. 5827 (2007): 1001.
[66] C. D. Broad, "Conscience and Conscientious Action," *Philosophy* 15, no. 58 (1940): 118; Emerson and Daar, "Defining Conscience and Acting Conscientiously," 20.
[67] Baylis, "A Relational View of Conscience and Physician Conscientious Action," 25.
[68] Haidt, "The New Synthesis in Moral Psychology," 998.

questions their initial response. Rather, Haidt points out that people were much more likely to reconsider their moral intuitions through social interactions, debate, and discussion.[69] If conscience is understood to be a largely affective, as an individualized process of moral decision making that is subject to error, due diligence—both in terms of informing the conscience and along with the kind of reflection that Sulmasy considers essential—would require social interaction. Baylis expands upon these ideas to suggest that relational conscience requires individuals to think beyond the self and beyond religious or secular authorities in order to consider the "self-in-community," not only through rational deliberation, but also through awareness of and sensitivity to the affective responses that drive one's conscientious thinking.[70] Relational conscience is thus more than a matter of personal integrity, but also a commitment to shared interests of the community. Similarly, public reason as a principle of political liberalism demands reflection beyond the individual in order to preserve the basic fundamental principles of social justice. Additionally, true autonomy requires reflection and attention to the factors that influence one's desires, attitudes and values.[71]

Moral distress is defined as the negative psychological consequences of acting against one's conscience when institutional or legal constraints make it difficult to pursue the desired course of action.[72] Epstein and Hamric noted that nurses facing on-going or repeated incidents of moral distress demonstrated three common response patterns. The first pattern was observed in professionals who carry on with their jobs despite being required to act against their consciences. These healthcare professionals reported experiencing a numbing of their feelings, burnout,

---

[69] Haidt, 998–99.
[70] Baylis, "A Relational View of Conscience and Physician Conscientious Action," 28.
[71] Rawls, *Political Liberalism*, 217; Dworkin, *The Theory and Practice of Autonomy*, 11.
[72] Sofia Kälvemark et al., "Living with Conflicts-Ethical Dilemmas and Moral Distress in the Health Care System," *Social Science & Medicine* 58, no. 6 (March 1, 2004): 1076, https://doi.org/10.1016/S0277-9536(03)00279-X.

"compassion fatigue," or a "wearing down of moral integrity" as a protective measure against repeatedly experiencing deeply upsetting feelings of moral distress.[73] The second pattern involved resorting to conscientious objection, demanding an ethics consult, or refusing physicians' orders. It was noted that conscientious objections or refusals often occurred only after repeated exposures to morally distressing situations; it was usually not the first response to a morally distressing situation. The third pattern was emotional exhaustion in the face of on-going moral distress which led nurses to leave their jobs or the profession altogether.[74] The phenomenon of moral distress is not well studied with respect to physicians, likely because physicians generally enjoy much broader professional autonomy, but it is clear that the experience of acting against one's conscience is deeply psychologically disturbing. In the case of physicians, the constraints on their consciences would be primarily regulatory in nature, as opposed to directives from other healthcare professionals. Nonetheless, the kinds of ethical and moral dilemmas faced by physicians in their daily lives are exceedingly complex, contextual and often involve matters of life and death.

2.2 MAID and Effective Referral in Ontario, Canada

Both reflection that extends beyond the individual to consider the good of the community or society at large and thoughtful deliberation that includes an investigation of both rational and emotional qualities of conscientious decision making and reference to public reasoning are meaningful and productive approaches conscience in a pluralist, liberal democracy. Questions which will not be addressed in this project include the extent to which democratic laws are informed by divine inspirations, humanity's limited knowledge of God's will, or grounded in

---

[73] Elizabeth Gingell Epstein and Ann Baile Hamric, "Moral Distress, Moral Residue, and the Crescendo Effect," *The Journal of Clinical Ethics* 20, no. 4 (2009): 6.
[74] Epstein and Hamric, 8.

fallible human rationality, and whether law is validated by the general will through public support, the political elites or influenced by academia. From the perspective of Rawlsian political liberalism, disagreement on law and policy will always exist in liberal, democratic societies; in fact, this is desirable. Public reasoning on matters of basic constitutional justice requires agreement only on the basic tenants of justice such as freedom of conscience from coercive political power. For this project, I am concerned only with physicians with conscientious objections to MAID; I will not consider pharmacists or other healthcare providers who may be involved in the provision of MAID, although this is an area that also requires careful consideration. Here I provide a brief summary of the legalization of MAID and the development of CPSO effective referral policies. While this is not a comprehensive account, it will provide an adequate framework for the discussions in section three.

The legalization of MAID began with challenges to the Criminal Code of Canada and the Canadian Charter of Rights and Freedoms in the cases of *Rodriguez v. British Columbia Attorney General* (1993) and *Carter v. Canada* (2015). Both of these cases involved patients with terminal degenerative diseases who wished to control the circumstances of their deaths through MAID. The *Rodriguez* case application was rejected along with the subsequent appeal, with the court upholding the provision of the Criminal Code prohibiting assisted death. In the 2015 *Carter* case, the Supreme Court concluded that the Criminal Code prohibition was unjustifiably infringing upon the right to life and security of the person in section 7 of the Charter. Following this, the federal government passed Bill C-14 which amended the criminal code to decriminalize

MAID in 2016. Bill C-14 contains a preamble that states that "nothing in this act affects the guarantee of freedom of conscience and religion."[75]

All CPSO policies with respect to MAID, as well as Bill C-14, clearly state that physicians who conscientiously object to MAID are not legally obligated to provide the service. However, objecting physicians are required to make effective referrals, or take "positive action" to connect a patient with a physician, another health-care professional or an agency; however, the effective referral requirement does not demand that physicians provide a formal letter of referral nor are they required to arrange an appointment for a patient with another physician.[76] The referral may be made to any "non-objecting, available and accessible" physician, a health-care professional or an agency that provides the requested medical services or facilitates referrals for the health care service.[77] At the time of writing, the Government of Ontario is in the process of developing a Care Coordination Service to help facilitate indirect referrals, however some conscientious objectors state that this service would still violate their consciences. The CPSO clearly states that the effective referral requirement is designed to provide patients with equal access, but it does not guarantee that patients will receive the service.[78]

The CPSO's position on effective referral became a point of contention for the Canadian Medical Association (CMA), the Christian Medical and Dental Society of Canada (CMDS), the

---

[75] "An Act to Amend the Criminal Code and to Make Related Amendments to Other Acts (Medical Assistance in Dying)," SC 2016, c.3.
[76] College of Physicians and Surgeons of Ontario, "Advice to the Profession: Professional Obligations and Human Rights," accessed November 2, 2019, https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Professional-Obligations-and-Human-Rights/Advice-to-the-Profession-Professional-Obligations; College of Physicians and Surgeons of Ontario, "Professional Obligations and Human Rights."
[77] College of Physicians and Surgeons of Ontario, "Professional Obligations and Human Rights."
[78] College of Physicians and Surgeons of Ontario, "Advice to the Profession: Professional Obligations and Human Rights."

Canadian Federation of Catholic Physicians' Societies (CFCPS), and a number of individual physicians on the grounds that effective referral deprives physicians of the ability to act as individual moral agents, effectively creating a professional obligation to act against one's conscience. A lawsuit was filed against the CPSO on behalf of the CMDS, the CFCPS and five independent physicians on the grounds that effective referral violates physicians' Charter rights to freedoms of equality, religion and conscience. In January 2018, the Divisional Court of Ontario dismissed the case, stating that while the policy does encroach on physicians' rights to religious freedoms, it does so in a manner reasonably justified as a means to ensure patients' rights to equitable access to legal healthcare services in Ontario.[79] In 2019, the appeal to this decision was also denied.

Considering the Rawlsian framework I outlined in section one, and the concise summary of the history of conscientious objections and MAID provided in section two, I will now examine current debates regarding effective referrals for MAID.

[79] *The Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario,* 2018 ONCA 579 at para 212.

3. Analysis of the Arguments around Mandatory Effective Referrals for MAID

The academic, legal and grey literature on conscientious objection to effective referrals for MAID has crystallized around three lines of argument: (1) the "Complete Ban" line of argument which submits that all conscientious objections should be banned in public medicine in order to create equal access to healthcare services; (2) the "Maximal Accommodation" line of argument which suggests that physicians' Charter rights to freedom of conscience should always be protected over equality of patient access, and; (3) the "Limited Accommodation" line of argument which proposes that physicians' Charter rights to freedom of conscience should be upheld, but only in cases where patient access can be maintained. All three lines of argument reference physicians' freedom of conscience and patients' rights to equality of access as critical matters for policy making around effective referrals for MAID. In the following sections of this project I'll describe and analyze each line of argument and provide a critical analysis of their supporting claims, then I will propose a fourth line of argument to resolve some of the issues arising from these three positions.

3.1 The Complete Ban Arguments

The Complete Ban against the accommodation of conscientious objections proposes that there is no room for conscientious objection in the practice of publicly funded medicine in Canada. A major difficulty with unfettered conscientious objections is the formal nature of conscience.[80] Since conscientious beliefs cannot be rationally tested for content or sincerity, those advocating for a complete ban on conscientious objection claim that allowing conscience claims is likely to result in problems with proliferation of increasing restrictive, peculiar or bizarre conscientious

[80] Alberto Giubilini, "Objection to Conscience: An Argument Against Conscience Exemptions in Healthcare," *Bioethics* 31, no. 5 (June 1, 2017): 401, https://doi.org/10.1111/bioe.12333.

objections that limit patient access to healthcare.[81] Additionally, given the strength of some physicians' moral convictions, any sort of limit or compromise on conscience also seems impossible. Without a principled lack of limits on conscientious objections, scholars of the Complete Ban line of argument propose that professional obligations should be determined by the regulatory body and strictly adhered to by practising physicians with no room for conscientious objections. In this case, the issue of effective referral is effectively nullified since all physicians would be required to offer any service they are competent to deliver within their professional scope of practice and must also refer all eligible patients to specialists or other competent providers when necessary in order to ensure patient access to healthcare.[82]

Serious concerns about the proliferation of increasingly disruptive conscientious objections, and the potential for intrinsic discrimination in the accommodation process is one of the most convincing arguments made in the Complete Ban line of argument. Given the enormous variety of moral standpoints in a pluralist state, rationalising a limit on conscientious objections from any one particular moral standpoint will result in irrational moral intuitionism that defers to historically situated social, cultural or ethical values in some way.[83] Because of this reliance on community for the development of a moral standard, it is impossible to logically deduce strictly rational limits on conscientious objections that are based in moral common ground.

---

[81] Giubilini, 401; Udo Schuklenk, "Conscientious Objection in Medicine: Private Ideological Convictions Must Not Supercede Public Service Obligations," *Bioethics* 29, no. 5 (June 1, 2015): ii, https://doi.org/10.1111/bioe.12167.
[82] Udo Schuklenk and Ricardo Smalling, "Why Medical Professionals Have No Moral Claim to Conscientious Objection Accommodation in Liberal Democracies," *Journal of Medical Ethics* 43, no. 4 (April 1, 2017): 5, https://doi.org/10.1136/medethics-2016-103560.
[83] Alasdair Macintyre, "How Virtues Become Vices: Values, Medicine and Social Context," in *Evaluation and Explanation in the Biomedical Sciences: Proceedings of the First Trans-Disciplinary Symposium on Philosophy and Medicine Held at Galveston, May 9–11, 1974*, ed. H. Tristram Engelhardt and Stuart F. Spicker, Philosophy and Medicine (Dordrecht: Springer Netherlands, 1975), 99, https://doi.org/10.1007/978-94-010-1769-5_7.

The issue of proliferation and a lack of principled limits to conscientious objections poses a legitimate problem for accommodating conscience claims in a pluralist, liberal democracy. Alberto Giubilini describes conscience as formal in nature, "like an empty box that can be filled with various substantial moral views, none of which defines the nature of conscience."[84] According to Giubilini, the content of conscience can never be tested because it is not substantive and so any argument for conscience must be based on the value of conscience itself, not the moral content that informs it.[85] With no principled reason or method to defend conscientious objections in terms of their conscientious validity these scholars argue that evaluating both the content and the reasonableness of a conscientious objection is impossible in principled terms; thus, all conscientious objections must have an equal claim to validity even those that might seems overtly discriminatory, disruptive or bizarre.[86]

Canadian law, grounded in political secularism, explicitly acknowledges the lack of principled means for objective evaluation for religious claims and requires that the court to refrain from evaluating the intrinsic validity of freedom of religion claims.[87] In *Syndicat Northcrest v. Anselem* Justice Iacobucci writes:

> Freedom of religion under the Quebec Charter of Human Rights and Freedoms (and the Canadian Charter of Rights and Freedoms) consists of the freedom to undertake practices and harbour beliefs, having a nexus with religion, in which an individual demonstrates he or she sincerely believes or is sincerely undertaking in order to connect with the divine or as a function of his or her spiritual faith, irrespective of whether a particular practice or belief is required by official religious dogma or is in conformity with the position of religious officials. This understanding is consistent with a personal or subjective

[84] Giubilini, "Objection to Conscience," 402.
[85] Giubilini, 401.
[86] Giubilini, 406; Schuklenk and Smalling, "Why Medical Professionals Have No Moral Claim to Conscientious Objection Accommodation in Liberal Democracies," 3–4.
[87] Maclure and Taylor, *Secularism and Freedom of Conscience*, 81; Jocelyn Maclure and Isabelle Dumont, "Selling Conscience Short: A Response to Schuklenk and Smalling on Conscientious Objections by Medical Professionals," *Journal of Medical Ethics*, September 28, 2016, 2, https://doi.org/10.1136/medethics-2016-103903.

> understanding of freedom of religion…The State is in no position to be, nor should it become, the arbiter of religious dogma. Although a court is not qualified to judicially interpret and determine the content of a subjective understanding of a religious requirement, it is qualified to inquire into the sincerity of a claimant's belief, where sincerity is in fact at issue.[88]

Julian Savulescu and Udo Schuklenk argue that the only way to evaluate whether a conscientious objection is worthy of accommodation is to rely on tradition or intuition as a guide.[89] Conscientious objections that seem intuitively less obtrusive or strange are more likely to be accommodated while less familiar objections are likely to be ignored or dismissed. The result is an arbitrary permissiveness toward certain conscientious beliefs and a dismissal of others. Giubilini's argument outlines this problem as follows:

> Unless we can explain what makes certain religious views based on unproven metaphysical assumptions more reasonable, i.e. more coherent with empirical data, than other religious or metaphysical views to which we are simply less accustomed, we don't have a principle we can use to discriminate between different cases of conscientious objection.[90]

It is true that Canada has a history of discriminating against certain religious groups while giving special treatment to others.[91] For Schuklenk and Ricardo Smalling, arbitrary, preferential treatment is a form of religious privilege that not only defies principled justification, but also contradicts the principles of a secular, liberal democracy.[92] Religiously-based conscientious beliefs have historically enjoyed more serious consideration than secular conscience claims, such as moral vegetarianism, etc., but the reasons for accepting religious conscientious objections are identical to those for non-religious objections since it is impossible

---

[88] *Syndicat Northcrest v. Amselem*, 2004 SCC 47.
[89] Julian Savulescu and Udo Schuklenk, "Doctors Have No Right to Refuse Medical Assistance in Dying, Abortion or Contraception," *Bioethics* 31, no. 3 (March 1, 2017): 167, https://doi.org/10.1111/bioe.12288.
[90] Giubilini, "Objection to Conscience," 406.
[91] Paul Horwitz, "The Sources and Limits of Freedom of Religion in a Liberal Democracy: Section 2(a) and Beyond," *University of Toronto Faculty of Law Review* 54 (1996): 21.
[92] Schuklenk and Smalling, "Why Medical Professionals Have No Moral Claim to Conscientious Objection Accommodation in Liberal Democracies," 4.

to test religious claims for validity. According to Schuklenk, conscience protections in Canada "are designed to protect Christian doctors' convictions, despite feeble attempts at giving them a lick of neutrality paint."[93] This leniency is often provided for Christian objections but withheld for "foreign" religious objections and non-religious objections. The idea is generally that local, familiar Christian-based conscientious objections are reasonable, while objections grounded in other moral or conscientious commitments are deemed unreasonable. Since we are prone to this kind of implicit bias toward familiar faiths and implicit prejudice against unfamiliar beliefs, it seems correct to claim that conscience claims cannot be evaluated or weighed against each other.

The argument, then, for a complete ban on conscientious objection, based on the claim that we cannot evaluate the moral content of conscientious objections and instead may only respect the intrinsic value of conscience, seems to conclude that any and all conscientious objections would require accommodation. Since complete accommodation is problematic for patient access to healthcare, they argue that conscientious objections, insofar as we are unable to evaluate the value of their moral content, ought not to be accommodated. When it comes to unfettered proliferation of conscientious objections, we can imagine the sorts of problematic conscience claims that scholars advocating for a ban on conscientious objections are concerned about: objections to providing vaccines based on flawed or discredited research, objections to providing blood transfusions based on religious beliefs, objections to treating patients of the opposite sex or patients who have alcohol or drugs in their systems based on religious beliefs, objections to providing antibiotics based on concerns for the right to life of bacteria, and so on. There is evidence supporting concerns about at least some of these objections.

---

[93] Schuklenk, "Conscientious Objection in Medicine," ii.

Concerns about Muslim medical students with conscientious objections to contraception, treating patients of the opposite sex, providing abortions, and treating patients who are inebriated due to drug or alcohol consumption became a matter of public attention in the UK in 2011. Strickland's analysis of 733 medical students from the UK showed evidence that Muslim students did have significantly higher rates of conscientious objections, either religiously-based or otherwise, to all of the aforementioned procedures.[94] Notably, 36.0% of the Muslim medical students who responded to this UK study indicated that they have conscientious objections to performing an intimate examination of a patient of the opposite sex and 7.8% of those students indicated they would conscientiously refuse to perform this kind of examination once practising medicine.[95] In paper titled "Euthanasia," written on behalf of the CMDS, the authors, Sheila Rutledge and John Patrick, reference the 1995 Stats Canada report which lists the religious demographic of Canada as being primarily Catholic, Protestant or "No Belief" as rationale for valuing Christian principles in Canadian medicine.[96] In 2011, Stats Canada found that Christianity still made up the overwhelming majority of the population at 67.3%, but both Muslim (3.2%) and "No Religious Affiliation" (23.9%) showed notable increases[97]. While Christian ethics may currently be the most familiar to Canadians, increasing rates of globalization and immigration are likely to shift that demographic toward increasingly diverse statistics where Christian majority arguments will lose traction, and possibly even give credence to religiously-based conscience arguments from minorities with fundamentally different values.

---

[94] Sophie LM Strickland, "Conscientious Objection in Medical Students: A Questionnaire Survey," *Journal of Medical Ethics* 38, no. 1 (2012): 24.
[95] Strickland, 24.
[96] Sheila Rutledge Harding and John Patrick, "Euthanasia: Principles and Observations from a Christian Perspective," April 1995, 8, http://www.cmdscanada.org/my_folders/Resources/Euthanasia1.pdf.
[97] Statistics Canada, "Canadian Demographics at a Glance, Second Edition," June 19, 2014, https://www150.statcan.gc.ca/n1/pub/91-003-x/2014001/section03/33-eng.htm.

Another difficulty with determining limits to conscientious objections is that if an individual holds genuine and deeply-held conscientious beliefs, they will be unable to compromise on these beliefs. Schuklenk proposes that if a medical professional viewed MAID as murderous, then their moral responsibility is "barely smaller" when providing a referral versus providing the service itself.[98] The strength of one's conscientious commitments can vary, but for physicians who have particularly strong conscientious commitments, any form of compromise, including the compromise required for referral, implies culpability in the outcome of healthcare services that they find morally offensive, and is therefore a violation of conscience.[99] For proponents of the Complete Ban line of argument, the lack of principled limits to conscience claims suggests that in liberal societies, where multiple conflicting worldview and personal value systems exists, the regulatory body should determine the professional obligations of the field of the medicine and physicians should be expected to comply.

Schuklenk and Smalling point out since physicians enter the profession as autonomous adults and they are free to leave the profession at any time, there is no coercive state interference compelling these physicians to perform any particular actions that they might deem unconscionable.[100] Specifically within the Canadian healthcare system, Canadian physicians' experiences are fundamentally different from physicians under oppressive, tyrannical state control because there always exists an opportunity to change specialties or leave the

---

[98] Schuklenk, "Conscientious Objection in Medicine," ii.
[99] Stephen J. Genuis and Chris Lipp, "Ethical Diversity and the Role of Conscience in Clinical Medicine," Research article, International Journal of Family Medicine, 2013, 4–8, https://doi.org/10.1155/2013/587541; CMDS, "Letter to the CPSO," August 5, 2014, 2, http://www.cmdscanada.org/my_folders/Position_Papers/Letter_to_CPSO_August_5_2014.pdf; Albertos Polizogopoulos, "Submissions from the Christian Medical and Dental Society and the Canadian Federation of Catholic Physicians' Societies to the College of Physicians and Surgeons of Ontario," 2015, 4, http://albertosp.com/wp-content/uploads/2015/02/Submissions-of-the-CMDS-and-the-CFCPS.pdf.
[100] Schuklenk and Smalling, "Why Medical Professionals Have No Moral Claim to Conscientious Objection Accommodation in Liberal Democracies," 5.

profession.[101] In Sweden and Finland, physicians working in public healthcare are not permitted to make conscientious objections.[102] These countries employ clearly outlined job requirements for the field of medicine to which all physicians are expected to comply, or they risk being removed from the profession. Schuklenk and Smalling argue that there is no evidence to suggest that there is difficulty in recruitment of new physicians under these conditions.[103] Additionally, they claim that concerns that physicians might provide substandard care if forced to provide services they disagree with appear to be unfounded since this would result in poor patient outcomes and therefore penalties for "gross lack of professionalism."[104] It is noted in Fiala et al. that in these Nordic countries where conscientious objections are not permitted, such as Sweden, Finland and Iceland, there is a strong societal emphasis on social equality and "limited religious influence."[105] While Canadians certainly value social equality, Canadians also value liberty and diversity. The pluralism of worldviews, cultures and religions that are celebrated in Canada thrive because liberty of conscience and religion are protected from state inference.

In advocating for a complete ban on conscientious objections in Canada, along the same lines as the framework provided by these Nordic countries, Schuklenk and Savulescu point out that although physicians would not be permitted to conscientious object in their model, they would still be able to campaign for legal reform.[106] However, I have two problems with this

---

[101] Schuklenk and Smalling, 1.
[102] Christian Fiala et al., "Yes We Can! Successful Examples of Disallowing 'Conscientious Objection' in Reproductive Health Care," *The European Journal of Contraception and Reproductive Health Care* 21, no. 3 (2016): 201.
[103] Schuklenk and Smalling, "Why Medical Professionals Have No Moral Claim to Conscientious Objection Accommodation in Liberal Democracies," 6.
[104] Savulescu and Schuklenk, "Doctors Have No Right to Refuse Medical Assistance in Dying, Abortion or Contraception," 163.
[105] Fiala et al., "Yes We Can! Successful Examples of Disallowing 'Conscientious Objection' in Reproductive Health Care," 204.
[106] Savulescu and Schuklenk, "Doctors Have No Right to Refuse Medical Assistance in Dying, Abortion or Contraception," 170.

position: first, enforcing a ban on conscientious objections is the enforcement of a moral norm, not a neutral framework; second, the policy change around MAID occurred rapidly and if participation at any level is required, this would mandate positive demands on physicians in order to meet the negative demands of patients.

Following the arguments made by Shucklenk and Savulescu, it appears that banning conscientious objections would rid Western medicine of overbearing moralistic conscientious claims. However, it is important to point out that the practice of medicine can never escape ethical, cultural and social norms that influence the research and evidence used to rationalize medical decisions. Even if conscientious objections are banned from medical practice in Canada, there would still exist an absence of principled, rational reasons for the current moral norms of Western medicine. To ban all conscientious objections in medicine is to enforce an ethical stance on medical practice based on one particular comprehensive worldview. If we were to accept Schuklenk and Savulescu's position, avenues for debate would still exist in the legislative and regulatory sphere, but the day-to-day functioning of the healthcare system would be hindered by rigid laws and rules, and the lives and livelihoods of physicians would be at the mercy of changes outside their control. In the case of MAID, the rapidity of the change from MAID as a criminal offence to a legal healthcare service highlights how quickly a physician's ethical stance would be required to adjust and adhere to new legislation with no room for disagreement within the system. Without room for conscientious objections, physicians with moral aversions to certain services would be forced to act against their consciences in the name of equality of patient access to healthcare. Placing this positive demand on physicians to protect patient access requires a very strong argument; one that is much stronger than the argument for protecting physicians from negative non-interference, for example.

While patients may argue that equality of access is unfairly disrupted when a physician conscientiously objects to a service, it is important to differentiate between the positive demand on physicians to *act* against their consciences and the *inability to act* on the part of patients.[107] In demanding access to a service, patients are making a positive demand on physicians in order to access to healthcare, while physicians are making a negative claim for protection from interference from legislation that will compel them to act against their consciences.[108] Historically, the success rates of positive rights claims is lower than those making negative rights claims and positive rights claims make up less than 20% of Canadian Supreme Court cases.[109]

Additionally, patients whose access to care is denied by waitlists or provisional funding for services have historically not been successful at arguing a constitutional right to access healthcare services. For example, in the case of *Chaoulli v. Quebec*, the plaintiffs argued that excessive waitlists violated the patient's right to access public health care services. This case argued for a relaxing of prohibitions on private health care. In paragraph 104 of *Chaoulli v. Quebec*, Chief Justice McLachlin states "[t]he Charter does not confer a freestanding constitutional right to health care" but goes on to say that the government must ensure that it's healthcare scheme complies with the Charter.[110] The legalization of a service does not imply a constitutional right to patient access of that service, even in cases where access is a matter of life or death. In the case of *Flora v. Ontario Health Insurance Plan,* access to a life-saving treatment was also rejected as a constitutional right.[111] The *Flora* case involved a patient with rapidly

---

[107] Ran Hirschl, "Negative Rights vs. Positive Entitlements: A Comparative Study of Judicial Interpretations of Rights in an Emerging Neo-Liberal Economic Order," *Human Rights Quarterly* 22 (2000): 1071.
[108] Hirschl, 1071; Albertos Polizogopoulos, "Factum of the Intervener CMDS vs. CPSO," March 31, 2017, 12, https://www.jccf.ca/wp-content/uploads/2017/04/Factum-of-the-Intervener.pdf.
[109] Hirschl, "Negative Rights vs. Positive Entitlements," 1073.
[110] *Chaoulli v. Quebec*, 2005 SSC 35 at para 104.
[111] *Flora v. General Manager, Ontario Health Insurance Plan*, 2008 ONCA 538 at para 107-9.

deteriorating health on a wait list for a liver transplant. After going abroad for the transplant and paying out of pocket, the patient argued that his right to life-saving treatment was violated and that he should be reimbursed for his medical costs. His application was not successful. There are other examples with similar results.

It's clear that unlimited accommodation of conscientious objections opens the door to accommodation of unpredictable, harmful and potentially bizarre conscientious objections which may be arbitrary and impossible to defend; however, a complete ban on conscientious objection seems similarly indefensible from the perspective of public reason and the ideal of civility. A complete ban on conscientious objection relies on the assumption that the body which regulates medical practice will produce rationally defensible policies. This argument relies heavily on rationalist epistemology, whereas medical practice involves far more than just rationalism, but also humanism, empathy, and ethics. Purely rational thinking based on principled, logical deduction can justify events that have appalling moral outcomes. In this way, moral considerations including humanism and empathy must be invoked at some point in deliberations about healthcare. The argument against all conscientious objections prioritizes equality of access to public healthcare above protecting freedom of conscience. In doing so, this argument assumes a particular view about equality and how it should be implemented in a liberal state and it does so to the detriment of liberty and equal respect and concern for all citizens. The argument becomes dogmatic when it assumes that all reasonable people should arrive at the same rational conclusions about liberty and equality and how it pertains to a "good" life. It also assumes a veil of moral neutrality; however, these judgements are clearly rooted in a moral ground. It is simply the moral grounding to which we are accustomed.

It is particularly interesting when these arguments reference the goals of the liberal political state to argue for the restriction of conscientious objections in medicine. In their piece "Doctors have no right to refuse medical assistance in dying, abortion or contraception," Savulescu and Schuklenk write,

> …contraception is legal because the ability to control reproduction is one of the greatest and most valuable of human achievements. Before modern contraception, women died early, suffered from multiparity, were chained to the home, could not work or get an education. When we make contraception legal, we do not do so merely because people *ought* to be free to choose when and how many children to have. It is because it is *good* to choose this.[112]

While a great many Canadian citizens are likely to agree with Savulescu and Schuklenk about the value of contraception, political liberalism is not a tool designed to justify enforcing a majoritarian view of the good, since this would negate the purpose of public reason and the ideal of civility, which, as discussed in section one, is to protect fundamental liberties for all citizens, including those with minority worldviews. In fact, as Dworkin points out, the challenge of neutral liberal societies is not to protect the rights of those who hold majoritarian views, but rather "to protect individuals whose needs are special or whose ambitions are eccentric from the fact that more popular preferences are institutionally and socially reinforced."[113] It is particularly problematic when popular beliefs about the good are enforced by the state if it is assumed that all *reasonable* people should arrive at the same rational ideal of the good, since this kind of irreducible belief system is at odds with political liberalism, which is meant to give maximal liberty to individuals to live according to their own conceptions of the good.

There are important differences between rationalism and reasonableness. Whereas rationalism defers to logic and principled deduction, reasonableness uses logic but also considers

---

[112] Savulescu and Schuklenk, "Doctors Have No Right to Refuse Medical Assistance in Dying, Abortion or Contraception," 163.
[113] Dworkin, "Liberalism," 78.

principles of justice and fairness. Rationalism can be used to justify unreasonable ends. For instance, Savulescu and Schuklenk write,

> The patient has a right to medical attention to her symptoms and problems, but it will be for the doctor, using her expertise, skills and judgement, to decide on the most appropriate course(s) of treatment. And it will be up to the hospital or health service management to decide whether such a treatment represents good value for public money. This is a well-established principle of medical discretion.
> It is entirely clear what euthanasia is and what it will achieve. And it is likely to be very good value for public money when the alternative is continued medical or social care given against a competent patient's considered wishes.[114]

Good value for public money is one way to rationalize medical decisions, although it is arguably a dehumanizing way to arrive at medical decisions for real people in real-life circumstances. Savulescu and Schuklenk do not suggest that medical care should only consider cost-savings. However, the way in which cost-saving is rationally linked to euthanasia can be unnerving. In fact, it is not inconceivable that medical care could be reduced to a cost-benefit type of scheme where "expensive" patients might be limited in their demands on the healthcare system. Terminally ill patients require "extraordinarily expensive care" and reducing the demands on the healthcare system may become a priority with an aging demographic of Canadian citizens.[115] While health promotion, preventative measures and increased access to home-care might be the solutions of today, it is plausible to imagine a time when MAID might be presented as a "cheaper" solution for end of life care. A similar case can be found in the "fair innings" argument where quality of life and efficiency of health care are balanced using complex mathematical models to determine when the cut-off point for access to healthcare should

---

[114] Savulescu and Schuklenk, "Doctors Have No Right to Refuse Medical Assistance in Dying, Abortion or Contraception," 170.
[115] James F. Fries et al., "Reducing Health Care Costs by Reducing the Need and Demand for Medical Services," *New England Journal of Medicine* 329, no. 5 (July 29, 1993): 322, https://doi.org/10.1056/NEJM199307293290506.

occur.[116] After this stipulated cut-off age, patients are no longer eligible for any kind of public healthcare on the grounds that they've had a sufficiently long life. Cost-saving arguments are examples of rational arguments that make logical sense until they are applied in real-word situations with disturbingly dehumanizing effects. Rational arguments do not always lead to reasonable outcomes. Justifications for a complete ban on conscientious objections in medicine may very well be supported majoritarian beliefs about the good, but these views are inevitably historically, socially and culturally situated, however rational they may appear to those agree with them at the time they are proposed. This risks the faulty assumption that majoritarian views of morality taken to be natural and correct, while opposing and minority views are taken to be false; a point noted by Jonathan Hughes when he writes, "[i]t is inherent in the nature of conscientious objection that, from a society's point of view, a conscientious objector always [holds] a false moral belief."[117]

Schuklenk and Smalling argue that a blanket restriction on conscientious objection in medicine does not violate individual physicians' freedom of conscience because it limits conscientious objections only within the provision of public healthcare and does not encroach on personal expressions of conscience outside of public healthcare.[118] The professional obligations that govern the field of medicine are subject to evaluation and re-evaluation, and enforced by regulatory bodies, such as the CPSO, which operate within a liberal, democratic framework. According to champions of the Complete Ban line or argument, since physicians enter into the field of medicine voluntarily and are able to leave the field of medicine at any time, physicians

---

[116] Alan Williams, "Intergenerational Equity: An Exploration of the 'Fair Innings' Argument," *Health Economics* 6, no. 2 (1997): 129.
[117] Jonathan A. Hughes, "Conscientious Objection, Professional Duty and Compromise: A Response to Savulescu and Schuklenk," *Bioethics* 32, no. 2 (2018): 129.
[118] Schuklenk and Smalling, "Why Medical Professionals Have No Moral Claim to Conscientious Objection Accommodation in Liberal Democracies," 3.

should consider the professional obligations prior to entering practice and act according to conscience at that point.[119] The trouble with this argument is that it does not account for the rapid technological change in the field of medicine and it glosses over the fundamental shift in medical values that occurred with the legalization of MAID. The evolutionary nature of medicine and contemporary technological advancements can cause rapid policy reversals that force physicians to make fundamental changes in their guiding values, such as beneficence and non-malfeasance, as they practice medicine.[120] The availability of MAID is an example this kind of policy reversal. Prior to the legalization of MAID, MAID was not only patently illegal but was understood to be fundamentally at odds with the values of medicine in general by violating principles about preservation and respect for life. With rapid change, there needs to be room for dissent. Limiting the conscience rights of physicians denies autonomy to individuals who face complex ethical dilemmas as part of their daily professional lives by making positive demands that make place a heavy moral burden on these professionals. Furthermore, any proposed mandatory professional obligations will never be fully neutral as proposed by Savulescu and Schuklenk; in this way these scholars fail to recognize the perfectionist nature of their arguments.

To summarize, the Complete Ban line of argument contends that unfettered freedom of conscience belongs only in the individual domain since it unfairly intrudes upon patients' rights and freedoms when it constrains their access to legal healthcare.[121] Many scholars argue that

---

[119] Schuklenk and Smalling, 5; Savulescu and Schuklenk, "Doctors Have No Right to Refuse Medical Assistance in Dying, Abortion or Contraception," 168; Julie D. Cantor, "Conscientious Objection Gone Awry — Restoring Selfless Professionalism in Medicine," *New England Journal of Medicine* 360, no. 15 (April 9, 2009): 1485, https://doi.org/10.1056/NEJMp0902019.
[120] Genuis and Lipp, "Ethical Diversity and the Role of Conscience in Clinical Medicine," 7.
[121] Schuklenk and Smalling, "Why Medical Professionals Have No Moral Claim to Conscientious Objection Accommodation in Liberal Democracies," 3.

because all physicians hold a monopoly over access to healthcare services, those physicians with private, religious or secular comprehensive worldviews are able to subvert the norms of Western medicine by creating barriers for patients or by withholding information from patients about their various healthcare options.[122] There is particular concern that some physicians abuse their power as gate-keepers by imposing their particular religious or moral worldviews on their patients. For example, when it comes to deeply held religious beliefs, Shucklenk, Cantor and Charo each raise particular concerns about the transition from conscientious refusal to conscientious subversion. A practitioner may hold beliefs with such conviction that they believe participation in the service to be "evil," and so conscientious refusal is not enough. They claim this stance may lead to practitioners who block access altogether or purposely withhold information about services on conscientious grounds; these conscientious objections can operate as subversive forms of paternalism.[123]

Charo warns that, given that physicians have exclusive rights to providing the services in question, the power differential between physicians and patients and the public nature of healthcare, conscientious objections in medicine can be viewed as "an abuse of the public trust — all the worse if it is not in fact a personal act of conscience but, rather, an attempt at cultural conquest."[124] At the heart of this concern is the idea that conscientious objection is not simply a matter of individual preferences, but that some private conscientious convictions are based in moral superiority and righteous concern for the souls of patients. Abuse of conscience freedoms

---

[122] Cantor, "Conscientious Objection Gone Awry — Restoring Selfless Professionalism in Medicine," 1485; R. Alta Charo, "The Celestial Fire of Conscience — Refusing to Deliver Medical Care," *New England Journal of Medicine* 352, no. 24 (June 16, 2005): 2473, https://doi.org/10.1056/NEJMp058112; Schuklenk and Smalling, "Why Medical Professionals Have No Moral Claim to Conscientious Objection Accommodation in Liberal Democracies," 2–3.
[123] Udo Schuklenk, "Conscientious Objection in Medicine: Accommodation versus Professionalism and the Public Good," *British Medical Bulletin* 126 (2018): 54, https://doi.org/10.1093/bmb/ldy007; Charo, "The Celestial Fire of Conscience — Refusing to Deliver Medical Care," 2473.
[124] Charo, "The Celestial Fire of Conscience — Refusing to Deliver Medical Care," 2473.

might result in attempts to subvert patients' autonomous wishes or undermine access to controversial healthcare services in the healthcare system, in general. As Charo writes, some physicians will assume that their conscience ought to be "the conscience of the world" and subversion of patient autonomy can be used to enforce personal worldviews upon an unsuspecting public.[125]

It is my position that the Complete Ban line of argument raises valid concerns about uncontrolled proliferation and subversion, and I agree that patients should be free to make autonomous choices about their healthcare. I have two contentions against the Complete Ban line of argument: firstly, it makes unacknowledged assumptions about what constitutes the good that allow scholars to justify strict limits on conscience freedoms and, secondly, it incorrectly ranks the right to equality of access above the right to fundamental conscience freedoms. Disallowing conscientious objections makes unreasonable positive demands on physicians that cannot be justified using the ideal of civility and public reason. Secular democracies tend to rebuff religious objections to medical treatment as irrational or "senseless." However, some individuals holding these beliefs are strongly compelled to act according to their religious views as a matter of saving their souls.[126] For deeply religious individuals, transcendental belief informs all levels of conscience and, thus, the act of referring for lethal drugs or injections intended to cause the death of the patient is profoundly disturbing. While the religious rationale behind this conscientious objection will not resonate with all citizens of a pluralist state, all citizens can empathize with the notion of profound conscientious or moral aversion to certain acts and the psychological impacts of being forced to carry these acts out. According to Rawlsian political liberalism, freedom of conscience is a fundamental freedom that is essential

[125] Charo, 2473.
[126] Horwitz, "The Sources and Limits of Freedom of Religion in a Liberal Democracy," 24.

for justice within a society; thus, any argument for banning conscientious objections outright in unreasonable at best and illiberal at worst. Conscience freedoms should be protected but should not extend to abusive or subversive conscience claims.

3.2 The Maximal Accommodation Arguments

The Maximal Accommodation line of argument proposed by scholars and physicians such as Genuis and Lipp, and by a number of religious groups such as the Christian Medical and Dental Society of Canada (CMDS) and the Canadian Federation of Catholic Physicians' Societies (CFCPS) asserts that physicians' Charter protected conscience freedoms should be protected above equality of patient access. There is an interesting divide in the literature for this line of argument: on the one hand, there are religious physicians alongside religious medical organizations who argue against mandatory effective referrals using Charter rights to freedom of conscience to bolster their position, and, on the other hand, there are scholarly arguments which warn against the gradual erosion of conscience freedoms from a perspective of evidence-based conscientious objections. Both religiously-based and scholarly Maximal Accommodation arguments rank freedom of conscience and religion above equality of patient access. The limits to conscientious objection in religiously-based and scholarly arguments are not clearly defined: most religious arguments centre around protecting Charter rights to freedom of conscience and religion and resisting regulatory intrusions on these freedoms, while scholarly arguments appear to advocate for limits to conscientious objections based physicians' personal expertise and ability to source rational evidence to support conscience claims. In this subsection, I will begin by describing the arguments for expanding conscience freedoms made by the CMDS and CFCPS and will then turn my attention to the scholarly arguments. I will argue that, thus far, religious arguments for maximal accommodation fail to adequately protect patient rights and, if given full

provision, will ultimately result in abuse of patient autonomy and dignity since it creates room for unreasonable righteous indignation or attempts to correct patients' worldviews should patients request services that a physician is morally opposed to.

In a submission to the CPSO, the legal counsel for both the CMDS and CFCPS argue that freedom of conscience is a founding principle of liberal democracies and thus the liberal state must never force physicians with conscientious objections to act against their deeply held conscientious beliefs. As a matter of basic constitutional justice, the right to non-interference with conscience should rank higher than patients' rights to equality.[127] The CMDS and CFCPS argue that mandatory effective referrals violate the conscience freedoms of religious physicians because effective referrals do not absolve culpability for physicians with deep conscientious objections to MAID. In a letter to the CPSO, the CMDS states that their members would prefer to have a requirement to provide information about MAID to eligible patients who are interested in it rather than the mandatory referral requirement.[128] Catholic organizations take a much firmer stance, arguing that any kind of participation or help in gaining access to MAID, whether direct or indirect, is akin to facilitating evil and must be avoided as much as is legally possible.[129]

In the cases of very deeply held conscientious beliefs, no compromise on conscience is possible; indeed, this argument is made from both the Complete Ban and Maximal Accommodation perspectives. Schuklenk uses this argument to rationalize a complete ban on conscientious objections, whereas religious physicians argue for better conscience protections.

---

[127] Albertos Polizogopoulos, "Submissions from the Christian Medical and Dental Society and the Canadian Federation of Catholic Physicians' Societies to the College of Physicians and Surgeons of Ontario 'Schedule A,'" 2014, 2–11, http://albertosp.com/wp-content/uploads/2015/02/Submissions-of-the-CMDS-and-the-CFCPS.pdf.
[128] CMDS, "Letter to the CPSO," 2.
[129] Thomas Bouchard, "Moral Analysis of Conscientious Objection in Medicine," January 27, 2016, 5, https://canadiancatholicphysicians.com/wp-content/uploads/2015/02/Moral-analysis-of-consciencious-objection-in-medicine-final.pdf; John A. Di Camillo, "Understanding Cooperation with Evil," *Ethics and Medics* 38, no. 7 (July 2013): 1.

In the Factum of the Intervener, Albertos Polizogopoulos, as the representative for both the CMDS and CFCPS, as well as a number of religious physicians and organizations, writes,

> A referral is not a morally or ethically neutral action. The CPSO itself acknowledges this when it prohibits physicians not only from performing female genital mutilation, but also from referring for this procedure. A physician's obligations are mixed with a physician's own sense of consequences, and personal beliefs about right and wrong, life and death, civility and morality, conscience and religion.[130]

Pellegrino argues that Catholic physicians will not be able to compromise their religious beliefs to practice value-neutral medicine since "certain matters are so clearly prohibited as inherently wrong."[131] Pellegrino writes,

> The requirement of a secular society that physicians practice "value neutrality" is impossible to achieve. First, it is a psychological schism that violates the integrity of the person as a unity of body, soul, and psyche. What it amounts to is the elevation of secularism to the level of a social orthodoxy; thereby, violating one of the major tenets of secularism itself-that no ideology would have preference over any other. It also violates a prized precept of the secular, democratic, constitutional social order by discriminating against a significant segment of the population, and the physicians who share certain religious beliefs.[132]

Nearly all physicians who conscientiously object to informing patients of legal options, providing information about certain services, or providing referrals for certain services argue that even the slightest participation indicates complicity in a fundamentally immoral or "evil" act that is at odds with religious doctrine. It is possible that physicians who withhold information or deny access in these cases do so out of righteous concern for the patient's own good. In their letter to the CPSO regarding effective referral for MAID, the CMDS writes:

> The Christian physician comes to their vocation out of a desire to help patients and to follow in the footsteps of Jesus Christ who healed those who were sick.

---

[130] Polizogopoulos, "Factum of the Intervener CMDS vs. CPSO," para 43.
[131] Edmund D. Pellegrino, "The Physician's Conscience, Conscience Clauses, and Religious Belief: A Catholic Perspective Conference on Religious Values and Legal Dilemmas in Bioethics," *Fordham Urban Law Review* 30 (2003 2002): 239.
[132] Pellegrino, 240.

> Indeed, it is through their relationship with Christ that the Christian physician finds the source of compassion for their patient care. The privilege of following Christ comes with a responsibility, however. Jesus Christ, who is the source of boundless love, also calls us to a profound respect for human life that is a gift from God. This means that certain procedures, prescriptions and "therapies" must be avoided – for the good of the patient and the physician, who may not participate in them without affecting their relationship with Christ.[133]

The letter states that physicians must openly share their beliefs with patients and extends their call for increasing conscience freedoms to other secular and religious objectors. Of course, these kinds of views will only be shared by members of the same faith. Despite an attempt at neutral language, these sorts of conscientious objections are grounded in irreducibly religious reasons, and in moral superiority of a particular comprehensive religious worldview that seeks to prevent patients from making immoral choices.

Catholic physicians are explicitly encouraged to prevent patients from making so-called immoral choices. The National Catholic Bioethics Centre (NCBC), in their article *Transfer of Care v. Referral: A Crucial Moral Distinction*, writes, "[w]hen all else has failed, if the patient is insistent on pursuing the immoral and harmful choice, health care providers and institutions may be unable to prevent this."[134] For the CFCPS, any formal or material cooperation in services, such as abortions or medical assistance in dying, amounts to cooperation with evil.[135] In the Catholic bioethics journal, *Ethics and Medics*, DiCamillo argues that Catholic physicians have a duty to not cooperate either formally or materially with the "evil actions" of others: "others" referring to the government that legalizes the procedure in question, the patient seeking the

[133] CMDS, "Letter to the CPSO," 1.
[134] National Catholic Bioethics Center, "Transfer of Care vs. Referral: A Crucial Moral Distinction," May 2015, np, https://www.ncbcenter.org/resources/news/transfer-care-vs-referral-crucial-moral-distinction/.
[135] Bouchard, "Moral Analysis of Conscientious Objection in Medicine," January 27, 2016, 1–2.

procedure and the physicians and administrators that make the procedure available.[136] Dr. Thomas Bouchard, former president of the CFCPS, writes:

> In addition to not cooperating with evil in formal or material ways through either carrying out or referring for a morally unacceptable procedure, a physician should also consider how his advice is perceived by patients…Thus in disclosing to a patient a particular opposition, it should be done in a way that is open and honest about the information…The point of this 'giving a good witness' is to explain why you are opposed to the situation, perhaps with some objective examples why, so that the patient leaves with the knowledge of what you believe to be 'good medicine.'[137]

Bouchard specifies that any sharing of information that links a patient directly with a provider or referral service that will give access to "the immoral procedure" is unacceptable. He further suggests that "Catholic physicians should avoid as much as the law allows doing or saying anything to patients you deal with that might result in or in any way contribute to their choice of an immoral option."[138] For Bouchard, this includes even providing information about a centralized referral service. He takes up the work of Germain Grisez to advise the following:

> [Grisez] recommends that if it were necessary to recommend that a patient go elsewhere, then you could advise a patient about finding another physician though a central referral service in an indirect way, but this does not mean referring to a service that is specifically designed to give information that facilitates access to an immoral procedure.[139]

It's important to clarify here that Bouchard, Grisez and the NCBC rely on the fundamental assumption that the patient's autonomous choice is both *incorrect* and *evil*; these are decidedly not neutral terms. From this perspective, the impetus to clearly outline one's objections to the patient appears to be linked heavily with correcting the patient's worldview and

---

[136] Di Camillo, "Understanding Cooperation with Evil," 1.
[137] Bouchard, "Moral Analysis of Conscientious Objection in Medicine," January 27, 2016, 10.
[138] Germain Grisez as quoted by Bouchard, 5.
[139] Bouchard, 5.

much less about providing information about range of legal healthcare options. Thus, while the CMDS and CFCPS express an interest in protecting the consciences of their physician members, both organizations have published policy papers that express deep concerns about the good (and evils) of society and encourage their members to clearly outline to patients why a service or procedure in question is morally wrong.

The liberal use of the word "evil" to describe patients and their autonomous choices is disturbing to any individual who does not share the same beliefs or values as the objecting physician. Charo includes the following quote from C.S. Lewis in her article *The Celestial Fire of Conscience – Refusing to Deliver Medical Care,*

> Of all tyrannies, a tyranny sincerely exercised for the good of its victims may be the most oppressive. It would be better to live under robber barons than under omnipotent moral busybodies. The robber baron's cruelty may sometimes sleep, his cupidity may at some point be satiated; but those who torment us for our own good will torment us without end for they do so with the approval of their own conscience.[140]

It is also clear in the publications of the CFCPS and the NCBC that their view of the utility of conscientious objections is that they are not meant solely to protect the consciences of individual physicians, but that they should be used to prevent patients from accessing any healthcare service deemed morally wrong by the Catholic Church. Fiala and Arthur argue that the Catholic Church has "co-opted the term 'conscientious objection" as a way to expand religious freedoms into the practice of medicine.[141] For many scholars with concerns about conscientious objections, it is the religious roots of the objections and the relative inflexibility of these beliefs that makes them difficult to accommodate in public healthcare.

---

[140] Charo, "The Celestial Fire of Conscience — Refusing to Deliver Medical Care," 2473.
[141] Fiala and Arthur, "'Dishonourable Disobedience' – Why Refusal to Treat in Reproductive Healthcare Is Not Conscientious Objection," 13.

I contend that freedom of conscience should protect physicians from becoming complicit in services that violate their consciences, but it should not permit physicians the freedom to express unfettered religious beliefs in the context of the physician-patient relationship. Core standards of professionalism and patient-centred care require that physicians respect and tolerate worldviews which differ from their own. If CFCPS and CMDS disagree strongly with the premise of MAID, it is well within their rights to advocate for their religious worldviews in a liberal democracy. Even if the private expression of these beliefs is found to be intolerant and/or offensive, citizens of a pluralist state should be free to express their comprehensive doctrines without fear of reprisal; there is no reason to deny freedom to the intolerant when a society is well-ordered with a sound constitution.[142] However, it is a different matter for physicians to express private views in a professional context during the provision of public healthcare. Freedom of conscience should not be used to mask righteous disapproval of patient's autonomous choices nor as a tool for religious coaching within a setting that has a clear power differential between physician and patient.

Subversion of the effective referral policy is more than just failing to provide a service or failing to refer for a service: this subversion involves either taking action to stop patients from accessing services or attempting to convince patients of the incorrectness of their choices. When physicians with strong religious convictions around abortion, contraception or MAID take steps to prevent patients from accessing these services out of concern for patients' souls, this violates the fundamental liberties of those patients by denying them the freedom to make free medical choices according to their own ideas of the good. This is particularly concerning because often a physician's moral or religious standing is unknown to patients. If physicians do not publicize

[142] Rawls, *A Theory of Justice*, 219.

their conscientious beliefs prior to patients coming under their care, as is the current common practice, patients may face unexpected moral conflicts, feelings of shame and self-doubt, as well as delays when negotiating their healthcare, and be surprised by a physician's moral or religious judgement. In the Court of Appeal for the *CMDS v. CPSO* case, Dr. Barbara Bean described the experiences female patients facing moral conflict while seeking abortions:

> …[Patients whose physicians refused to provide assistance in accessing abortions] felt traumatized and actively denigrated by their physicians' denial of assistance. Their doctors' lack of support and lack of empathy in refusing to provide a referral for abortion care caused them to doubt their decisions to seek abortions, and to feel shame and guilt about their decisions. They deeply felt their doctors' lack of respect for them and their choices.[143]

Despite what may be the best intentions of religious physicians, correcting the moral worldview of patients is (on some level) meant to instil feelings of shame because according to the physician's belief, the patient is making a shameful, sinful, immoral, or evil choice. This is subversion of the current requirement for patient-centred medical care in Canada and a disregard of the autonomy of patients. This is not just an equality of access issue. In order to protect the autonomy and fundamental liberties of all citizens in a liberal democracy, all citizens must be given equal consideration, including patients.

While freedom of conscience is a fundamental liberty that deserves robust protections from state interference, unrestrained private expression of conscientious commitments in the provision of public healthcare cannot be justified. Of course, there will always been some physicians who are unreasonable, who may abuse their power in the physician-patient relationship to subvert patient access to services they disagree with, but these physicians demonstrate unprofessional behaviours that violate multiple professional obligations. Placing

---

[143] *Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario*, 2019 ONCA 393 at para 146.

physicians in gate-keeper roles for healthcare services that are connected to personal worldviews and moral positions about sanctity of life will inevitably lead to fundamental conscience conflicts. Having analysed the religious arguments for expanding freedom of conscience I will now turn to the scholarly arguments in the Maximal Accommodation line. I propose that patient autonomy is protected when a patient is fully aware of the conscientious commitments a prospective physician holds prior to interacting with them in the provision of healthcare. Even in rural communities where patients may have only one local physician, if that physician publicly posts their conscientious commitments, the patient can choose to take action to find a different healthcare provider if they are interested in a service to which the local physician objects.

Conscientious objections based in moral reflection, technical expertise and evidence are very different than religious conscientious objections. Conscience claims that are not rooted in religion require moral alertness and the kind of reflection that is critical for evidence-based practice in medicine. The kinds of claims made by proponents of conscientious objections for academic, scientific, and scholarly reasons rely on the fact that the best medical treatment is never certain to the extent that medical research is never completed. Furthermore, specific to the case of MAID, the effectiveness or ethical correctness of MAID in particular can never be tested since patients are forever silenced upon provision of the service. Because of the contextual nature of the physician-patient relationship and the duty of physicians to protect patients from potentially harmful state interference that puts vulnerable patients at risk, physicians must question state imposed medical treatment. Genuis and Lipp argue that relying solely on regulatory bodies to affect change in policy, without allowing for physicians to dissent from within the system, can result in policies in medicine that lag behind research or, conversely,

policies that respond too quickly to rapid changes in public demand or opinion.[144] This may result in questionable, harmful or downright dangerous policies that physicians would be forced to follow with no room for raising conscientious objections.

The arguments made by Genuis and Lipp submit that some conscientious objections should be accommodated in order to prevent standards of practice from including services that do not adhere to evidence-based medical research. It is often the case that standards of care lag behind new research. Genuis and Lipp provide a number of examples of conscientious objections based in rational deliberation, such as physicians who might conscientiously object to prescribing or referring for oral contraception due to evidence-based environmental or endocrine hazards, or physicians who might conscientiously object to hormone replacement therapy after menopause due to concerning research that indicates increased cardiovascular risks.[145] If physicians have no right to conscientiously object to referrals for services found to be harmful, this will cause a significant shift in the role of medical professionals from moral and ethical agents to "instrument[s] of the state."[146] Rigidly enforced clinical guidelines, protocols, and standards reduce the art of medical care to "cookbook medicine" where physicians are expected not to question these standards.[147] Genuis and Lipp argue that a physician objecting to a referral for a service on conscientious grounds may actually be acting according better scientific research than physicians who blindly accept protocols and standards. Since physicians, as professionals, have a duty to remain up to date with new research findings and adjust their practice accordingly,

---

[144] Genuis and Lipp, "Ethical Diversity and the Role of Conscience in Clinical Medicine," 6.
[145] Genuis and Lipp, 12.
[146] Genuis and Lipp, 5.
[147] Stephen J Genuis and Shelagh K Genuis, "Resisting Cookbook Medicine," *BMJ : British Medical Journal* 329, no. 7458 (July 17, 2004): 179.

their professional obligation is not simply to surrender to the protocols and standards of a medical profession but to continually reassess their methods of treatment.[148]

Genuis and Lipp also assert that the norms of treatment can be corrupted. Powerful corporations have deeply vested financial interests in the use and development of technologies and pharmaceuticals, and it is increasingly difficult to separate corporate influences from research and medical practice. Corporate financial investments, sponsorship of academic institutions, provision of grants to individual researchers, and financial deals between pharmaceutical companies and physicians in exchange for increased prescriptions for certain drugs are clear cut examples of corporate influence on the practice of medicine. There are many other influences which may not be as obvious. Corporate technological and pharmaceutical industries have the power to influence even "the research questions that are chosen, methodology of studies, data analysis, whether results are published, and dissemination of results".[149] These kinds of conscientious objections require further investigation since the reasons for the objection may be powerful enough to change treatment protocols or procedures. In this case, the importance of open dialogue is pressing. Rather than one physician raising objections in an isolated instance, the objection ought to be brought to light for medical and legislative communities and may inform further research questions.

Genuis and Lipp argue that there exists a continuum of strength of conscientious objections ranging from an absolute contrary position, in which physicians refuse the procedure entirely, to a preference for a similar but different course of action, such that some objectors will not have a problem referring but others will. They argue that, in a society which values

[148] Genuis and Lipp, "Ethical Diversity and the Role of Conscience in Clinical Medicine," 12.
[149] Genuis and Genuis, "Resisting Cookbook Medicine," 179.

individual liberties, it should be up to each physician to determine where their objection falls on that scale and to act accordingly.[150] These arguments point to a completely different kind of conscientious objection, an objection that is justified by reasons that will resonate with most people, on some level. These kinds of objections clearly deserve conscience protection, but it seems important that these kinds of objections be investigated further since they may point to potentially flawed medical standards. Those that argue for the expansion of conscience freedoms argue that the autonomy of patients should not be achieved by violating the consciences of physicians.

While I agree with this position, I do not agree that every physician should have an unrestricted ability to act according to their conscience. Unrestrained expression of conscience in the provision of public healthcare will lead to a number of negative outcomes, such as: 1) creating opportunities for physicians to practice medicine according to their own personal conceptions of the good in a way that is limiting or coercive for patients who do not share the same beliefs, as could be the case with religious beliefs and 2) potentially leading to uncontrolled proliferation of conscience claims to the extent that patient access to certain services becomes unpredictable and unreliable. Pellegrino writes, "[t]o practice medicine that contravenes religious teaching would be to subvert conscience to secular society and its "values," to act hypocritically, and to violate moral integrity intolerably."[151] I argue along the same lines that when religious physicians use conscientious objections to prevent patients from accessing healthcare services out of righteous concerns for their patients' souls, this is a similar form of subversion. Permitting unlimited conscience freedoms for physicians does not adequately protect

[150] Genuis and Lipp, "Ethical Diversity and the Role of Conscience in Clinical Medicine," 8.
[151] Pellegrino, "The Physician's Conscience, Conscience Clauses, and Religious Belief," 239.

the autonomy of patients. Thus, conscience freedoms must be protected as a matter of justice but clearly defined limits which prevent subversive or discriminatory objections must exist. Furthermore, in the case of evidence-based objections, requiring the physician to provide a justification for a conscientious objection could determine whether the service in question should be investigated further, or whether the objection is baseless and therefore not worthy of accommodation. This brings us to the Limited Accommodation arguments, which I will lay out next.

3.3 The Limited Accommodation Arguments

Much of the legal and scholarly literature supports a limited right to conscientious objections in medicine; however, disagreement exists around how and when to limit conscientious objections. While the CPSO does not compel physicians to provide services that they conscientiously object to, the policy on effective referral does require that physicians provide effective referrals for these services. Effective referrals are solely intended to connect patients with assenting physicians, they are not an endorsement of the service. The effective referral policy attempts to protect objecting physicians' consciences by including options for indirect effective referrals in order to distance objecting physicians as far as possible, without abandoning their patients, from the provision of MAID. The CPSO policy on effective referrals came under legal scrutiny in *CMDS v. CPSO* where the claimants argued that the policy violated their Charter rights to freedom of conscience and religion. Justice Wilton-Siegel ruled that the effective referral policy was reasonably justifiable despite encroaching on some physicians' religious and conscience freedoms because it is proportionate and fair when considering the harms to patients that could result from being denied an effective referral.

Scholarly literature, on the other hand, tends to reject the effective referral policy and proposes a much more nuanced model for accommodating conscience claims. Kantymir and McLeod argue that the effective referral policy as set out by the CPSO is not sufficient because patient access should always be maintained and conscientious referral in communities with very few or no assenting physicians will not always provide timely access for patients.[152] As such, Kantymir and McLeod argue that only justified conscientious objections that do not interfere with timely patient access are acceptable, whereas any conscientious objection that impedes patient access is not permissible. Kantymir and McLeod posit that conscientious objections should occur as exceptions to the rule, and that they ought to be justified by the objector and vetted by a panel.[153] The model put forth by Kantymir and McLeod draws from previous models such as the sincerity test as proposed by Meyers and Woods and the reasonableness test proposed by Card. These scholarly arguments posit that we should accommodate conscience objections, since conscientious objections themselves are not morally wrong, but that we must set reasonable limits to accommodations that ensure patient access and prevent abuse and proliferation.

The structure of reasonable limits must be clearly and adequately defined, as even this definition is contentious. To do so, I will begin this section by examining the arguments in support of effective referrals made in *CMDS v. CPSO* and will then turn to an analysis of the limited accommodation model proposed by Kantymir and McLeod.

In *CMDS v. CPSO*, one of the main components of the claimants' argument was that patients, as a group, do not have any Charter rights to consider in the balancing of rights and harms, because patients do not have a freestanding right to healthcare. The case against the

[152] Lori Kantymir and Carolyn McLeod, "Justification for Conscience Exemptions in Health Care," *Bioethics* 28, no. 1 (January 1, 2014): 17, https://doi.org/10.1111/bioe.12055.
[153] Kantymir and McLeod, 18.

effective referral policy concerns "the right of patients to equitable access to health care services available under our publicly-funded health care system."[154] Previous cases such as *Auton v. British Columbia*[155], *Flora v. Ontario Health Insurance Plan*[156] and *Chaoulli v. Quebec*[157] illustrate that the provinces are not bound to provide funding for or guarantee access to healthcare for patients.

According to Justice Wilton-Siegel, quotes at length for accuracy and clarity:

> First, the Applicants argue that the only *Charter* issues engaged in these proceedings are the rights of freedom of religion of the Individual Applicants and other objecting religious physicians. They suggest that, on this basis, the protection of such rights under section 2(a) of the *Charter* should govern the proportionality analysis.
>
> However, the policies are directed toward ensuring access to health care by patients who request medical procedures or pharmaceuticals to which religious physicians may object. Access to health care and, in particular, the right of patients to equitable access to health care services available under our publicly-funded health care system, are important goals in their own right.
>
> Further, in my view, the latter also engages a *Charter* right of patients. In making this statement, I do not suggest that the *Charter* confers a freestanding constitutional right to healthcare: see *Chaoulli* per Major J. at para. 104 which states that it does not. However, I do think that s. 7 of the *Charter* confers a right to equitable access to such medical services as are legally available in Ontario and provided under the provincial healthcare system. Such a right is a natural corollary of the right of each individual under s. 7 to "life, liberty and security of the person". Further, as Wilson J. noted in *R. v. Morgentaler*, [1988] 1. S.C.R. 30, s. 7 is concerned with the fundamental concepts of human dignity, individual autonomy and privacy. The right of equitable access to healthcare gives effect to such concepts within the context of a single-payer, publicly funded health care system.[158]

This statement suggests that protecting patient access to health care is a matter not only of equality of access, but also a matter of patient autonomy and the right to self-determination.

---

[154] *The Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario*, 2018 ONSC 579 at para 194.
[155] *Auton (Guardian ad litem of) v. British Columbia (Attorney General),* SCC 78 2004 at para 2.
[156] *Flora v. General Manager, Ontario Health Insurance Plan,* 2008 ONCA 538 at para 107–9.
[157] *Chaoulli v. Quebec*, 2005 SCC 35 at para 104.
[158] *The Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario*, 2018 ONSC 579 at para 193-5.

What is interesting about this position is that the corollary right to respect for persons is often invoked for both patients seeking access to MAID and physicians with conscientious objections to MAID.[159] In para 196, Justice Wilton-Siegel refers to the principles of physicians' professional and fiduciary relationship to patients in the context of publicly funded healthcare system:

> Those who enjoy the benefits of a licence to practice a regulated profession must expect to be subject to regulatory requirements that focus on the public interest, rather than the interests of the professionals themselves. In this case, physicians are assumed to accept this authority of the CPSO, including the authority of the CPSO to address the requirements of professionalism in the practice of medicine. Accordingly, physicians' *Charter* rights should be assessed against the expectation in entering the profession that such rights may be affected in the protection of the public interest.[160]

This suggests that physicians ought to practice patient-centred medicine and respect the autonomy of their patients to the greatest degree possible

The claimants argued that the referral policy was discriminatory toward religious physicians because it discourages them from acting conscientiously as per their religious beliefs and may prevent religious physicians from practising medicine. Justice Wilton-Siegel found that the referral policy provides does not imply demeaning stereotypes about conscientious objectors, that it is a neutral and rationally defensible policy designed to protect vulnerable patients and ensure access, and therefore it is not discriminatory toward religious objectors. Justice Wilton-Siegel states that physicians are not prevented from practising medicine based on their conscientious objections, but that they should consider changing specialities or moving away

---

[159] Peter West-Oram and Alena Buyx, "Conscientious Objection in Healthcare Provision: A New Dimension," *Bioethics* 30, no. 5 (2016): 337.
[160] *The Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario,* 2018 ONSC 579 at para 196.

from a single-physician practice to avoid situations where they are likely to encounter moral conflicts. He comments that:

> One of the options contemplates a physician's designate making the arrangements for a patient to see a non-objecting physician. For physicians practising in a hospital, clinic or family practice group, other options are available. These options include identification of a point person within the institution or practice group who will facilitate referrals, or provide the health care to the patient, and implementation of a triage system for matching patients directly with non-objecting physicians in the institution or practice group.[161]

The CPSO has also taken a firm stance on withholding information by clearly stating that physicians are required to inform patients of all healthcare options available to them. According to CPSO policy #2-15, *Professional Obligations and Human Rights*:

> Physicians must provide information about all clinical options that may be available or appropriate to meet patients' clinical needs or concerns. Physicians must not withhold information about the existence of any procedure or treatment because it conflicts with their conscience or religious beliefs.
>
> Where physicians are unwilling to provide certain elements of care for reasons of conscience or religion, an effective referral to another health-care provider must be provided to the patient. An effective referral means a referral made in good faith, to a non-objecting, available, and accessible physician, health-care professional, or agency. The referral must be made in a timely manner to allow patients to access care. Patients must not be exposed to adverse clinical outcomes due to a delayed referral. Physicians must not impede access to care for existing patients, or those seeking to become patients.[162]

Since all physicians must provide effective referrals for MAID, patients seeking access to the service are likely to come into contact with physicians with strong moral objections to MAID. It seems likely that a patient who encounters an objecting physician with a strong aversion to MAID will likely be directed to some form of secondary referral service of some kind, if the objecting physicians complies with the CPSO policy. This result is very similar to how a

---

[161] *The Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario*, 2018 ONSC 579 at para 33.
[162] College of Physicians and Surgeons of Ontario, "Professional Obligations and Human Rights."

centralized referral service would work. The only differences are that (1) the patient is no longer dependent upon an objecting physician for access and (2) the objecting physician is no longer required to participate in any way that might imply culpability or participation in MAID, thus protecting their consciences. If the referral policy is meant to protect patient's right to life, liberty and security, it is essential that physicians' conscience rights are similarly protected.

It is not clear to me that a patient's right to life, liberty and security of person confers equitable access to healthcare, especially when the methods for obtaining equitable access make positive demands on physicians to violate their consciences. The CPSO's mandatory effective referral policy does not guarantee equitable access to legal healthcare services since patients are never guaranteed equitable access to public healthcare in Canada. If we view equitable access as an unachievable ideal that we are striving toward, the next best thing is to develop policies that make means of accessing healthcare more efficient for patients. Again, the CPSO's effective referral policy comes up short; it does not make the process of accessing an assenting physician any more efficient than other means of access. In fact, the policy may lead to unexpected moral conflicts in the physician-patient relationship.

Avoiding moral conflicts between patients and physicians in the day-to-day practice of medicine suggests that physicians should not be required to act as gatekeepers for the kinds of services that lead to fundamental moral disagreements in pluralist societies. Patients at end-of-life are not looking for a physician's moral endorsement of MAID in the form of a referral, rather they are looking to have questions about the service answered and, if eligible, the patient will make a personal decision about whether or not to go ahead with MAID. Despite that there is no net benefit to patient access to MAID, the CPSO policy on effective referral was justified as a reasonable intrusion on physicians in the Court of Appeal. Justice Strathy states that the CPSO is

not bound to determine a minimally intrusive policy for access to MAID, so long as the policy falls in a reasonable range.[163]

> The College was not bound to accept the "lowest common denominator", whether it is labelled "self-referral" or "generalized information", when it found, through its own studies, that that model would not protect patients. I agree with the observation of the Divisional Court, at para. 174, citing to Irwin Toy Ltd. v. Quebec (Attorney General), [1989] 1 S.C.R. 927, at p. 999, that legislative action to protect vulnerable groups is not "necessarily restricted to the least common denominator of actions taken elsewhere" and that minimal impairment does not "require legislatures to choose the least ambitious means to protect vulnerable groups."[164]
>
> A measure of deference is owed to the College's policy judgment regarding how best to balance the competing interests of physicians and their patients. The Policies represent a difficult policy choice, one which the College, as a self-governing professional body with institutional expertise in developing policies and procedures governing the practice of medicine, was in a better position to make than a court.[165]

In the case of MAID, it is not clear to me that vulnerable patients would see any benefit from mandatory effective referrals over centralized self-referral services; in fact, I argue that the opposite is true. Mandating referral causes moral conflict, confusion, and delays. It seems plausible that these conflicts would exist for any healthcare service that involves sanctity of life or personal conceptions of the good. Justice Strathy writes:

> The medical procedures to which the appellants object (an objection shared to varying degrees by the individual appellants and members of the appellant organizations) include: abortion, contraception (including emergency contraception, tubal ligation, and vasectomies), infertility treatment for heterosexual and homosexual patients, prescription of erectile dysfunction medication, gender re-assignment surgery, and MAID. It is impossible to conceive of more private, emotional or challenging issues for any patient. The evidence

---

[163] *Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of* Ontario, 2019 ONCA 393 at para 152.
[164] *Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario,* 2019 ONCA 393 at para 154.
[165] *Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario*, 2019 ONCA 393 at para 155.

> establishes that these issues are difficult for patients to raise and to discuss, even with a trusted family physician.[166]

Given that these matters are so deeply related to one's personal conception of the good, it does not seem fitting that patients should have to navigate these issues through a physician gate-keeper who may hold deep, personal beliefs that are strongly opposed to these procedures. Patients will never have truly equitable access to healthcare. Additionally, in forcing referrals, the effective referral policy may create situations where upsetting moral conflicts may occur for physicians and patients alike. Returning to Rawls, equality of opportunity or access to goods and services is not an essential freedom.[167] As I laid out earlier in this project, according to Supreme Court of Canada judgements, Canadian citizens do not hold a freestanding right to equal access to healthcare.[168] Equality of access can never rank above protecting liberty of conscience because it is virtually impossible to measure whether equality of access is realized without deferring to opinion or intuitive judgements, particularly when it comes to healthcare. [169] We cannot "gain" liberty for patients by subtracting it from physicians. Additionally, by forcing referrals physicians and patients with different fundamental moral perspectives on MAID are likely to come into contact, thus leading to disruptive and unnecessary moral conflict. What, then, ought to be the model for balancing patient rights and physician rights?

There are promising guidelines laid out in recent work in this area. The model proposed by Kantymir and McLeod explores many of the problems with mandatory effective referrals and, in light of these issues, proposes a new model for approving or disallowing conscientious objections which explicitly acknowledges the difference between religious or moral convictions

---

[166] *Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario*, 2019 ONCA 393 at para 121.
[167] Rawls, *Political Liberalism*, 229.
[168] *Chaoulli v. Quebec,* 2005 SCC 35 at para 104.
[169] Rawls, *Political Liberalism*, 229.

and evidence-based conscience claims. Kantymir and McLeod raise several issues with mandatory effective referrals as a limit to conscientious objections: (1) they open the door for "conscientious referrals" whereby a physician can avoid providing a service for any reason, including discriminatory or baseless reasons, simply by referring out; (2) mandatory referrals will not necessarily preserve access in remote or rural communities; (3) mandatory referrals gloss over the issue of complicity for physicians with strong moral aversions and; (4) some conscientious objections to referrals are in fact justified, and thus referrals should not be required.[170] Rather than referring out in cases of conscientious objection, Kantymir and McLeod argue that conscientious objectors must justify their objections to a panel in order to test sincerity or reasonableness and patient access should always be maintained.

Many scholars suggest that methods for testing the sincerity of conscience claims (such that only genuine conscience claims are permitted) could be an effective tool for ensuring fair protection of rights on both sides; however, they all agree that infallible methods for testing sincerity do not exist.[171] Kantymir and McLeod point out that testing for sincerity alone opens the door to the accommodation of conscience claims that are based in discriminatory beliefs since conscientious objectors can certainly be sincere in holding deep moral convictions that are bigoted in nature; thus, the sincerity test on its own is too permissive toward conscientious objections.[172] Another method for vetting conscience claims involves testing the reasonableness of conscience claims, such that only those conscientious objections that can be justified by

---

[170] Kantymir and McLeod, "Justification for Conscience Exemptions in Health Care," 22.
[171] Maclure and Dumont, "Selling Conscience Short," 2; Jocelyn Downie and Francoise Baylis, "A Test for Freedom of Conscience under the Canadian Charter of Rights and Freedoms: Regulating and Litigating Conscientious Refusals in Health Care," *McGill Journal of Law and Health* 11 (2017): S26; Christopher Meyers and Robert D. Woods, "Conscientious Objection? Yes, but Make Sure It Is Genuine," *The American Journal of Bioethics* 7, no. 6 (2007): 20.
[172] Kantymir and McLeod, "Justification for Conscience Exemptions in Health Care," 21.

reasons acceptable to others should be accommodated.[173] Kantymir and McLeod point out that the trouble with testing reasonableness alone is that non-discriminatory, genuine conscientious objections that do not impede patient access would be denied.[174] Kantymir and McLeod put forth the "genuineness plus" model which acknowledges that conscience claims can originate from epistemically different moral frameworks: religious or secular moral doctrines that are shared only by members of the same faith, or conscience claims grounded in evidence and technical expertise.[175] Conscience claims based in doctrinal beliefs can appeal only to genuineness, while conscience claims grounded in evidence and moral reflection may appeal to both genuineness and reasonableness. Kantymir and McLeod suggest that the reasons behind conscience claims should be justified to a panel and approved either based on genuineness of the claim, with the caveat that the claim must not be grounded in discriminatory beliefs *or* for reasonableness of the conscience claim in the way suggested by Card.[176]

Advocates for the limited accommodation of conscientious objections differentiate between *conscience* which involves critical reflection, open dialogue and social feedback, and *religiosity* which involves observance of rules as per the authority of religious scripture or moral doctrines.[177] This differentiation between conscience and religiosity is the focus of Daniel Weinstock's article, *"Conscientious Refusal and Health Professionals: Does Religion Make a Difference?"* and Jocelyn Downie and Baylis's work, *"A Test for Freedom of Conscience under the Canadian Charter of Rights and Freedoms."* Weinstock argues that conscience claims based

---

[173] Robert F. Card, "Conscientious Objection and Emergency Contraception," *The American Journal of Bioethics* 7, no. 6 (June 1, 2007): 10–12, https://doi.org/10.1080/15265160701347239.
[174] Kantymir and McLeod, "Justification for Conscience Exemptions in Health Care," 21.
[175] Kantymir and McLeod, 21.
[176] Kantymir and McLeod, 21.
[177] Daniel Weinstock, "Conscientious Refusal and Health Professionals: Does Religion Make a Difference?," *Bioethics* 28, no. 1 (January 1, 2014): 14, https://doi.org/10.1111/bioe.12059; Downie and Baylis, "A Test for Freedom of Conscience under the Canadian Charter of Rights and Freedoms," S29.

in irreducibly religious or moral convictions can only be justified as reasonable if they do not impose unreasonable burdens on others who do not share the same faith, whereas conscientious convictions separated from irreducibly religious components *can* make claims to reasonableness with those who do not share the same personal, comprehensive doctrines.[178] Religion and conscience share common ground with respect to moral integrity, but that conscience is related to active, on-going, moral reflection whereas religion is based more in identity relations to a "temporally-extended, rule-governed community" and the rites, rituals, and rules of that community.[179] This separation between religion and conscience freedoms is supported by statements from the Court of Appeal in *Roach v. Canada*:

> It seems, therefore, that freedom of conscience is broader than freedom of religion. The latter relates more to religious views derived from established religious institutions, whereas the former is aimed at protecting views based on strongly held moral ideas of right and wrong, not necessarily founded on any organized religious principles.[180]

It is along these lines that Downie and Baylis argue for a clearer distinction between conscience and religion in jurisprudence. They propose that conscience freedoms be defined in a way that promotes principled consistency, value accountability and flexible resilience with respect to moral integrity as a social and personal virtue.[181] For Downie and Baylis, taking freedom of conscience seriously extends beyond individual claims to conscience protections, as a matter of nurturing moral integrity on a communal and societal level.[182] This suggests that conscientious objections in medicine, which have the potential to affect numerous patients within a

---

[178] Weinstock, "Conscientious Refusal and Health Professionals," 13.
[179] Weinstock, 11.
[180] *Roach v. Canada (The Minister of State for Multiculturalism and Citizenship),* 1994 CanLII 3453 (FCA), [1994] 2 FC 406.
[181] Downie and Baylis, "A Test for Freedom of Conscience under the Canadian Charter of Rights and Freedoms," S25.
[182] Downie and Baylis, S26.

community, should not occur in private, but should instead ought to involve a public component of accountability to the community.

Additionally, moral integrity as a social virtue also requires social feedback and open dialogue to inform individual consciences and to promote moral coevolution within a community. These components remain unacknowledged in the current effective referral policy. Theorists, philosophers and moral psychologists all agree on the fundamental importance of informing the conscience through dialogue, social interaction and respectful debate with those who hold conflicting moral viewpoints. Epistemic humility requires openness to hearing other viewpoints and moral reflection that extends beyond internal dialogue to include multiple perspectives from one's community. Conscience can be fallible; debate, discussion and justification of one's conscientious position on matters are ways to protect against errors in reasoning and slipping into moral intuitionism.

From a moral social psychology perspective, evidence clearly shows that humans rely most heavily on affective, rapid and intuitive cognition in the face of moral dilemmas. It also shows that the process of slower, rational deliberation about moral dilemmas is often heavily biased by implicit, unconscious biases and is often driven by the desire to confirm one's initial intuitions.[183] Haidt argues that the only effective way to engage rational moral deliberation in a way that truly challenges strong moral intuitions is through the process of social interaction.[184] Fitzgerald points out that even individuals who make a clear effort to avoid moral intuitionism are limited in their ability to identify implicit social biases that inform their consciences.[185] In a

[183] Haidt, "The New Synthesis in Moral Psychology," 998; Chloë Fitzgerald, "A Neglected Aspect of Conscience: Awareness of Implicit Attitudes," *Bioethics* 28, no. 1 (January 1, 2014): 26, https://doi.org/10.1111/bioe.12058.
[184] Haidt, "The New Synthesis in Moral Psychology," 999.
[185] Fitzgerald, "A Neglected Aspect of Conscience," 28.

liberal, democratic and pluralist state, where the greatest diversity of beliefs and therefore the greatest potential for intractable conflict exists, open debate designed to question and inform the conscience is essential for mutual understanding and social evolution. Weinstock states that "[g]ood democracies…require that citizens be encouraged and enabled to think for themselves about complex issues of political morality, and the guarantee of a robust right to freedom of conscience is a good way in which to elicit a morally engaged and active citizenry."[186] I believe that the justification required in Kantymir and McLeod's model is a step in the right direction because it acknowledges the importance of social feedback and open dialogue about conscience freedoms. Without the requirement of adequate justification, physicians can refer out for any service on conscientious grounds because the reasons for the referral are never recorded or investigated.

The model proposed by Kantymir and McLeod requires that conscientious objections are to be treated as exceptions requiring approval from a board or panel. They additionally argue that religious or moral objections that impede patient access should not be approved; the objector must bear the responsibility of the moral conflict in cases where patient access is at risk.[187] Furthermore, in their model, objections based in religious or moral convictions should be tested to determine if they arise from discriminatory beliefs in order to prevent oppressive or discriminatory refusals "under the guise of moral or religious freedom."[188]

A critical flaw in this model is that patients must still have timely access to the service in question for religious or morally-grounded conscientious objections to be approved.[189] The

[186] Weinstock, "Conscientious Refusal and Health Professionals," 9–10.
[187] Kantymir and McLeod, "Justification for Conscience Exemptions in Health Care," 20.
[188] Kantymir and McLeod, 22.
[189] Kantymir and McLeod, 21, 20.

burden of patient access, therefore, falls upon objecting physicians since they have voluntarily entered medicine and chosen their particular speciality. On the other hand, conscientious objections based in evidence or technical expertise should be assessed to determine whether the objection is justified; in which case, the objections might actually lead to a change in medical practice and referrals become a moot point.[190] In this way, conscientious objections that are based in evidence may expose "morally weak or corrupt norms" in medicine with the potential for positive change and advancement in standards of care.[191] In short, their argument is that patient access must be facilitated unless an evidence-based objection leads to a change in the healthcare service or the policies around this service, in general.

I agree with the requirement to justify conscientious objections because there are undeniable, valid concerns about proliferation and a lack of principled limited to conscientious objections which have been outlined by Schuklenk and other scholars in the Complete Ban line of argument; however, there are issues that arise with the proposal brought forth by Kantymir and McLeod. The use of panel reviews and appeals during the accommodation process provides opportunities for social feedback and moral coevolution around medical standards; however, as Kantymir and McLeod admit, the feasibility of vetting every individual conscientious objection, though not impossible, would require incredible resources and may create delays for physicians and patients.[192] Another issue with having a panel review for each and every conscientious objection is that it does nothing to prevent patients from coming into distressing moral conflicts with physicians who hold fundamentally different worldviews than their own. In addition to concerns about feasibility, the genuineness plus model gives too much weight to the issue of

[190] Kantymir and McLeod, 22.
[191] Kantymir and McLeod, 22.
[192] Kantymir and McLeod, 18.

timely patient access. Genuine moral objections would only be permitted for cases where patient access is maintained and for evidence-based objections. Accommodation of evidence-based objections, however, suggests that there are legitimate medical concerns regarding these practices which requires an analysis of whether patients should have access to these procedures and treatments in the first place.

This is not to say that patient access is not important, but rather that timely patient access can never be fully guaranteed and therefore should not form the limits for conscientious objections. For example, physicians in remote communities with genuine, non-discriminatory conscientious objections would not be able to object to providing any services within their scope and competence since no other means of access are readily available to these patients. This would effectively force physicians in remote communities to take positive actions far beyond referrals, to provide actual services against their consciences in a way that unfairly limits the fundamental freedoms of physicians working in underserviced areas. In an earlier paper, McLeod explicitly argues that in cases of conscientious objections, when timely referral is not possible, performance of the service in question is required.[193]

As previously discussed, when fundamental freedoms of conscience and religion are ranked below equality of access, those with non-majoritarian religious or conscientious beliefs about a good life, or a good death, are treated unjustly. Rawlsian political liberalism suggests that justice to patients and physicians alike is best served by tolerating the maximal spectrum of beliefs about the good and refraining from making positive demands on those whose beliefs do not align with the majority. While Kantymir and McLeod's model for limited accommodation of

[193] Carolyn McLeod, "Referral in the Wake of Conscientious Objection to Abortion," *Hypatia* 23, no. 4 (October 12, 2008): 42, https://doi.org/10.1111/j.1527-2001.2008.tb01432.x.

conscientious objections provides an excellent account of justification requirements for conscientious objections and the importance of panel review, social feedback and moral coevolution around medical practices, the genuineness plus model does not give sufficient weight to liberty of conscience and it limits conscientious objections in a way that is punitive to physicians. Thus, I propose a fourth line of argument that suggests two deviations from the model proposed by Kantymir and McLeod: (1) I argue that equality of access should not form the limit of conscientious objections; and (2) I argue that protecting patients from undue interference from physicians personal moral worldviews requires policies which attempt to prevent fundamental moral conflicts from occurring in the context of a physician-patient in the first place.

3.4 A New Model for a Limited Right to Conscientious Objections

Up to this point, I have shown that the Complete Ban, Maximal Accommodation and Limited Accommodation lines of argument all engage concepts of liberty, equality and the role of a liberal, pluralist, secular and democratic state in very different ways. Threaded throughout all three lines of argument is the notion that a liberal, democratic state has a responsibility to protect its citizens from undue interference. One difference between all three positions relates to positive and negative rights to non-inference. Those who seek to protect freedom of conscience for physicians make a negative claim, such that physicians' consciences are protected by inaction or non-participation. In order to protect patients' rights physicians may be forced to take positive action against their consciences to maintain access for patients. In this way physicians are seen as having a positive obligation to act. While I agree that unlimited accommodation of conscientious objections has the potential to create serious problems with access to public healthcare, I take issue with preferentially protecting equality of access to public healthcare over

freedom of conscience, particularly when it is done in the name of achieving liberty in a political democracy. In light of these objections, I propose a new model focusing on accommodating a limited right to conscientious objection provided that the objection be publicly registered and available to all members of the public. This new model treats conscientious objections as a right, which is limited in such a way as to restrict unreasonable discriminatory or baseless claims and unreasonably numerous claims to the extent that the physician is breaching the social contract for their specialty. This model requires physicians to register all conscientious objections and their justifications with the CPSO. Rather than examining every conscience claim, the regulatory body would only require justification from physicians whose claims are specifically flagged. It also requires physicians to ensure that these conscientious objections are made available to any member of the public who may come under their care.

The purpose of the registry with the CPSO is to allow the regulatory body to monitor which physicians are making conscientious objections and to what procedures and treatment. This will allow the regulatory body to collect valuable data on (1) trends that suggest which procedures are highly controversial, (2) mapping geographically where services are lacking for patients due to conscientious objections, (3) evidence-based conscience claims and their frequency province-wide, and (4) physicians who have conscience claims that require further investigation. In this way, this model expands upon Genuis and Lipp's argument that evidence-based conscience claims may lead to changes in medical standards: by collecting data and mapping the frequency of conscience claims trends in evidence-based objections it would become much clearer to the regulatory body and may expedite valuable patient-centred changes to standards of care. Additionally, for religion-based objections a true picture of the impact on patient access could be mapped. This would allow the regulatory body to clearly see which

services are contentious for physicians and which geographic areas are underserviced as a result of conscientious objections. In cases of highly controversial services, direct patient access without a referral requirement may be preferable. This registry model is less cumbersome and more feasible than the genuineness plus model, which requires a panel review of each and every conscientious objection. For this model, a panel review would only occur if a physician was flagged for further investigation. Physicians with conscientious objections that appear to be discriminatory or baseless or physicians with unreasonably numerous objections would be required to justify their objections before a diverse panel for review. Like Kantymir and McLeod, I agree that an appeal process should be in place in order to address the potential for implicit biases in the panel.

This model treats conscience as a fundamental freedom and a protected right, which still takes the impact of conscientious objections on patient access seriously. Currently, unless a patient makes a complaint to the CPSO, there are no checks on physicians with conscientious objections, even in the case of objection to referral. Without a registry which allows the CPSO to collect data on conscientious objections, patient access is blocked by conscientious objections that occur in the context of private physician-patient relationships. The CPSO registry adds a dimension of accountability with respect to conscience claims.

Accountability to the public is also an important feature of this model. The public notification requirement addresses the shortcomings of religious maximal accommodation arguments which do not do enough to protect patient autonomy. By notifying patients of conscientious objections prior to developing a physician-patient relationship, patients are empowered and are able to make informed decisions about their choice of healthcare provider. Furthermore, by adjusting the system to allow patients direct access to highly controversial

services, patients who might be at a power disadvantage, because of the differential between physician and patient, are protected from encountering moral judgement from dissenting physicians during the provision of healthcare.

Because this model ranks conscience above equality of access, conscience claims that restrict patient access could occur. This is most likely to occur in remote or rural communities where the number of physicians is limited. This is a legitimate problem; however, as I have argued previously, no other model is able to address this problem without mandating provision of services outright. Since the regulatory body does not require physicians to provide healthcare services that they conscientiously object to, any conscientious objection will require patients to travel to access those services. In this case, patients would know this well in advance, rather than discovering the conscientious objection in the midst of a health crisis.

While equitable access is clearly important in a public healthcare system, equal access is nearly impossible to achieve and will almost always be a point of contention given that ideas around equality will always defer to matters of opinion or intuitive judgments.[194] All citizens, regardless of their personal worldviews have a vested interest in protecting basic liberties like conscience freedoms. Further, since medicine is not solely a scientific or statistical practice, it is unavoidable that physicians make culturally and historically-situated ethical decisions that do not defer to any universally-held ethical "truths." The liberal state has a duty to step outside comprehensive, all-or-nothing approaches and an obligation not to mediate extreme moral positions with respect to particular healthcare services. Instead, the liberal state must consider the principles of justice and equality of respect and concern for all persons, including physicians

[194] Rawls, *Political Liberalism*, 229.

whose ontological beliefs do not adhere strictly to rationalist ideas about the sanctity of life. Macintyre points out that in states with shared, traditional values a "physician could assume that the patients' attitudes towards life and death would be roughly the same as his own, and vice versa. Hence the patient in putting him or herself into the hands of his or her physician could feel that he or she was not relinquishing his or her moral autonomy."[195] However, this is not the case in the Canadian healthcare system, where there are many contentious procedures and the population is diverse, with a plurality of worldviews.

It seems that medical issues around sanctity of life such as abortions, birth control, and medically assisted death cause the deepest, most controversial moral disputes. Citizens are likely to hold fundamentally opposed and very deeply held beliefs around these kinds of issues given the wide variety of comprehensive personal doctrines held by citizens in pluralist nations. Likewise, those with strong secular views about the importance of autonomous choice around end-of-life care hold comprehensive views about what constitutes a good life or a good death. Neither view can make testable claims to moral superiority and only principles of justice can reasonably determine how to handle fundamental moral conflicts. Making positive demands upon all physicians to provide referrals to patients for services that they find morally reprehensible is unjust to those physicians with strong, religious convictions, because freedom of conscience is a fundamental matter of justice. A liberal democracy is neutral toward claims of moral superiority and is concerned only with providing equal respect and concern to all citizens, even those that hold eccentric, and, to a point, intolerant views. The question for liberal law-makers is not whether particular religious or secular moralities are correct, but rather whether the

[195] Macintyre, "How Virtues Become Vices," 108.

policy or law governing their ability to act or not act in a certain way leads to justice for all citizens.

Since MAID represents a fundamental policy shift around end-of-life care, and since it is a service that disturbs the consciences of many physicians, patient access to MAID is best preserved by removing the referral requirement altogether, rather than by forcing physicians to refer. Using Rawlsian political liberalism to determine the priorities of a neutral, liberal democracy, I propose a *fourth* line of argument that aims to step outside comprehensive religious or secular conceptions of the good by focussing exclusively on neutral liberal priorities, namely, liberty and equality. Rather than attempting to balance extreme positions on a controversial matter such as physicians' liberties and patients' rights to equality around the issue of MAID, stepping out-side comprehensive doctrines requires that we assign no inherent value to either position around an issue and consider justice only in terms of overlapping consensus between all competing worldviews.

In the Canadian context, freedom of conscience is equally important to both physicians and patients and thus deserves careful consideration. In order to establish reasonable limits on conscientious objections, I follow Rawls' ranking system which places freedom of conscience above equality of access. Thus, conscientious objections to participation or complicity in healthcare services around sanctity of life or treatments that are tied to individual conceptions of the good, such as MAID, abortion, contraception, etc., should be accommodated.

In order to prevent access issues for patients I recommend that these types of services operate outside the traditional gate-keeper system such that patients achieve direct access to assenting physicians without a referral. Other provinces in Canada, such as Alberta, have implemented policies that protect physicians' consciences and preserve patient access to MAID

through centralized referral services. Even though these solutions may be less desirable, they preserve patient access to MAID in a way that protects the consciences of physicians. Access to public healthcare is a very important feature of Canadian society but fundamental liberties like freedom of conscience cannot be balanced against equality of access. Liberal democracies should prioritize the fundamental liberties of *all* citizens equally, including those citizens with minority, eccentric or even intolerant views, while equality of access ranks secondarily to these fundamental liberties.

I propose a model that promotes a permissive but limited *right* to conscientious objections because it requires physicians to publicly declare and justify their objections. Rather than treating conscientious objections as privileges or exceptions, this model permits physicians, as healthcare professionals in a self-regulating profession, to be free to conscientiously object to healthcare services using their autonomous best judgement. For conscientious objections that do not fit into the direct access pathway, I build upon Kantymir and McLeod's model for a review panel to provide a sketch of how conscientious objections in medicine might be handled. While it is beyond the scope of this project to concretely outline a plan for how this would be operationalized, there are concrete regulations that can easily be put into practice that will safe guard both patient access and physicians' right to liberty: namely that conscientious objections should be publicly declared, visible to all prospective patients, and submitted to a registry monitored by the regulatory body and an external panel. The purpose of public declaration and a registry with the regulatory body is two-fold: (1) by publicly declaring conscientious objections, prospective patients are made aware of a physician's conscientious beliefs prior coming under their care which may prevent fundamental moral conflicts in the physician-patient relationship from happening in the first place; and (2) on-going review of the registry by the regulatory body

and an external panel is designed to ensure that discriminatory or baseless objections are not accommodated. Additionally, physicians with unreasonably long lists of conscientious objections, such that the services they provide are severely limited and no longer reflect the standards of practice for their chosen specialty, should be investigated for abuse of conscience rights. Since patient access can never be measurably guaranteed, and since equality of access ranks below freedom of conscience as a fundamental liberty, the model that I propose here allows physicians to conscientiously object, even if patient access is compromised.

Following this model, concerns about unreasonable intolerance or the projection of physicians' private worldviews onto their patients might be better handled in a number of ways: for example, physicians could be required to list and justify their objections publicly so that patients are able to determine for themselves whether or not a physician shares their beliefs prior to a face-to-face meeting. Pellegrino suggests that physicians should publish a leaflet outlining their conscientious objections and that this leaflet should be made known and available to all patients.[196] David Bleich also argues for legislation of a "notice requirement" such that physicians are legally bound to publicly post their conscientious objections to pre-emptively prevent moral conflicts from occurring.[197] Additionally, the CMA has suggested a similar idea whereby an online central service could provide information about local doctors and list all of their conscientious objections publicly so that patients could choose their physician accordingly. These measures would allow physicians to abstain from services that offend their consciences while protecting patients from surprising and upsetting moral conflicts in the provision of care.

---

[196] Pellegrino, "The Physician's Conscience, Conscience Clauses, and Religious Belief," 243.
[197] David Bleich, "The Physician as a Conscientious Objector Conference on Religious Values and Legal Dilemmas in Bioethics," *Fordham Urban Law Review* 30 (2003 2002): 265.

It must be noted that public expression of conscientious objections could have potential consequences for physicians; for example, it may mean that their patient base is considerably smaller if patients do not identify with the physician's conscientious objections and choose to see another doctor. However, the aim of mandating public expression of conscientious objections rather than allowing them to function implicitly or in secret, is to ensure that objections no longer exert unwanted coercive power over patients. By articulating one's ethical stance on a treatment and by providing a rationale for this stance to a review panel, physicians will become more attuned to their own moral principles. Many other scholars agree that a properly informed conscience requires this kind of reflection. Without social interaction and discussion with people holding different conscientious values, epistemic responsibility, evaluation and re-evaluation of one's beliefs is next to impossible.[198]

This model for conscientious objection, however cumbersome, holds significant merit. I admit that there is potential for these kinds of lists to become unreasonably long and so there must still exist limits on the accommodation of publicly declared conscientious objections. This is why tracking all conscientious objections through a central registry is essential. Physicians with conscientious objections could be required also participate in periodic review processes designed to investigate the rationale for their objections. The point of investigating the rationale is to uncover conscientious objections that are either: (1) baseless or grounded in ignorance; (2) overtly discriminatory in a way that tramples the fundamental liberties of patients or (3) unreasonably and unjustifiably numerous such that the physician is no longer meeting their

[198] Sulmasy, "What Is Conscience and Why Is Respect for It so Important?," 145; Haidt, "The New Synthesis in Moral Psychology," 999; "CMA, 'Code of Ethics,'" 1, accessed October 12, 2018, https://www.cma.ca/Assets/assets-library/document/en/advocacy/policy-research/CMA_Policy_Code_of_ethics_of_the_Canadian_Medical_Association_Update_2004_PD04-06-e.pdf.

chosen specialty's social contract with society. In order to achieve this, physicians under review might be required to submit a document that outlines the rationale for each objection. The review panel would need to be a diverse group to prevent implicit biases as much as possible, and there would also need to be an appeal procedure in place. By this model, the accommodation of a physician's conscientious objections ensures adequate standards of care are being met and that the right to conscience accommodations is not being abused.

While it may appear silly or superficial at first, a public register of conscientious objections might help create a broader diversity of practitioners within public institutions. Another possible benefit to this model is that it could create a map of underserviced areas and possibly illuminate trends in medicine which suggest that certain treatments require more investigation or alternative means of access if many physicians object to them. Unreasonable proliferation or abuse of conscience freedoms can only come to light if conscientious objections are publicly declared and analyzed whereas unrestricted and undeclared conscientious objections certainly run the risk of abuse and proliferation in ways that are harmful.

Conclusion

This project does not provide concrete policy solutions, but it is my hope that this work draws attention to the critical importance of protecting fundamental liberties in liberal political democracies. It is important not to confuse liberalism as a political system with particular comprehensive "liberal" ideals about the good because conflating the two opens the door to hypocrisy: one cannot make claims to liberalism while undermining of liberal principles of justice. Coercive policies, such as those which mandate effective referrals for MAID, place positive demands on physicians within a liberal democracy, thus directly limiting basic,

constitutional freedoms of conscience. Mutual respect can arise from shared values about justice and open discussion that makes room for competing religious, moral, and secular worldviews in a liberal democracy. Without transparency and public dialogue, motives and intentions behind conscientious objections become obscured by claims to rights and can lead to intractable and moral disputes. In pluralist, liberal states, it is essential that we remain sensitive to interpretations of what "liberalism" is so that we do not fall into the habit of deferring to majoritarian ideas of the good to justify restrictions on fundamental freedoms.

Using Rawlsian political liberalism as a framework to analyze scholarly and legal literature around conscientious objections to mandatory effective referrals for MAID, I have outlined the ways in which each line of argument treats the concepts of liberty of conscience and equality of access of the healthcare. Following Rawls, conscience freedoms as fundamental liberties, which are critical to justice in a liberal political state, deserve special consideration and must draw on public reason; all citizens, patients and physicians alike, have a special interest in protecting liberty of conscience. Equality of access to healthcare, while extremely important, cannot be guaranteed in the same way as fundamental liberties. Since equality of access to healthcare is dependent on a multitude of economic, social and geographic factors, physiological suitability for various services, and intuitive judgments about satisfaction with care or expectations for care, equitable access is neither measurable nor achievable. As such, it should not form the limits of conscience freedoms in the practice of medicine.

I have argued that banning all conscientious objections from the practice of medicine relies on assumptions about what constitutes the good in a way that unjustly restricts the conscience freedoms of physicians with non-majoritarian worldviews, thus rendering the argument indefensible in a liberal democracy at best and illiberal at worst. I have also noted that

concerns about proliferation of conscientious objections and subversion of patient's autonomous healthcare goals are legitimate in a pluralist, liberal democracy; for this reason, unlimited expression of physicians' consciences in the provision of public health care is also indefensible in a liberal state. I have argued that legal and scholarly arguments for limited rights to conscientious objections typically give too much weight to equitable patient access while making positive demands on physicians to provide services or referrals to which they conscientiously object. The differentiation between how both religious and moral objections, as well as evidence-based conscientious objections, are justified provides insight into how conscientious objections might best be handled. The model proposed by Kantymir and McLeod suggests that we ought to analyze conscientious objections for genuineness, while also monitoring for potential biases in discriminatory belief or a lack of reasonableness. Critically, they argue that these objections should only be approved if patient access is maintained. It is on this point that my model deviates from Kantymir and McLeod.

I have proposed a variation of Kantymir and McLeod's model which reflects the liberal state's objective to protect fundamental liberties above equality of access while considering the importance of public dialogue and transparency for patients. I propose that physicians with conscientious objections should be required to publicly declare their objections so that they are available for scrutiny by prospective patients, rather than keeping them private until after a patient comes under their care. The main rationale for this public declaration is that it prevents patients from unwanted moral advice from physicians who may hold fundamentally different views about what it means to live well. This removes the potential for surprising moral conflicts or religious subversion in the provision of healthcare. Additionally, I proposed that physicians should submit their conscientious objections to the regulatory body for a central registry. Each

year, certain physicians with conscientious objections could be selected for external review where they would be required to justify their objections to a diverse panel. Rather than treating objections as exceptions or privileges requiring approval, I argue that objections should be treated permissively unless they are found to be baseless, overtly discriminatory or unreasonably numerous. Thus, on-going panel reviews of justifications are designed not only to limit unreasonable conscientious objections, but also to uncover problems with current medical standards due to evidence-based objections or highlight trends which highlight that various services or areas have restricted access due to physicians' consciences. With respect to MAID, and any other healthcare service that relates to sanctity of life, physicians should not hold gate-keeper positions that could limit patients from autonomously electing for these services. Since services like abortions, MAID and contraception are heavily linked to individual conceptions of the good, self-referral to assenting physicians is the best way to maintain patient access in pluralist, liberal democracies.

It is my position that by focussing on shared values about freedom of conscience and religion in a liberal, political state, particularly in the provision of healthcare services that engage conscientious beliefs about sanctity of life, will result in the best outcomes for both patients and physicians. By removing physicians as gate-keepers to these kinds of services, a centralized or self-referral service allows patients to quickly gain access to assenting physicians while also preventing the violation of physicians' consciences. Productive dialogue arises from mutual respect and tolerance. There will always be unreasonable or intolerant views within a pluralist society; however, this does not justify a complete ban on conscientious objections in medicine. Physicians who have moral aversions to participating in the death of a patient should not be forced to comply with patient wishes or with regulatory policies that mandate referrals. Patient

autonomy can be maximized in other ways and should not be achieved by restricting the fundamental conscience freedoms of physicians. As Rawls writes:

> It should be noted, that even when the freedom of the intolerant is limited to safeguard a just constitution, this is not done in the name of maximizing liberty. The liberties of some are not suppressed to make possible a greater liberty for others.[199]
>
> What is essential is that when persons with different convictions make conflicting demands upon the basic structure as a matter of political principle, they are to judge these claims by the principles of justice.[200]

Principles of justice require the protection of physicians' and patients' freedom of conscience and their ability to make autonomous choices. Preventing physician-patient moral conflict is the best way to achieve this in a liberal democracy. That said, respecting conscience freedoms should not give physicians a free license to express their private views in the provision of healthcare. Requiring the public declaration of physicians' conscientious objections is one way to neutralize potential moral conflicts and prevent slippage into unprofessional, hurtful or shame-inducing conversations between physicians.

An additional question which I have not considered in this project is how an external panel might handle abuse of conscience freedoms in medicine. If a physician is found to be making discriminatory, baseless or unreasonably many conscience claims, their objections should not be permitted and may lead to further investigation with respect to professional malpractice; this part of my proposed model requires further clarity. Additionally, the process of handling legitimate, evidence-based conscience claims also requires further thought.

---

[199] Rawls, *A Theory of Justice*, 220.
[200] Rawls, 221.

Overall, by examining the issue from the frame of political liberalism, this project aims to avoid dichotomous conflict between extreme and fundamentally opposed positions around mandatory effective referrals for MAID. Rather than attempting to compromise, balance or find a midpoint between extreme positions, political liberalism "stands on one side of an important line that distinguishes it from all competitors in the group."[201] I have attempted to step outside particular conceptions of the good, including those which are religious, moral, secular or political in nature, and instead view the issue of conscientious objections to effective referrals for MAID from a perspective that values fundamental liberties and principles of justice.

[201] Dworkin, "Liberalism," 65.

Bibliography

An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying), SC 2016, c.3: online: <https://www.parl.ca/Content/Bills/421/Government/C-14/C-14_4/C-14_4.PDF>

Auton (Guardian ad litem of) v. British Columbia (Attorney General), 2004 SCC 78, online: CanLII <http://canlii.ca/t/1j5fs>

Baylis, Francoise. "A Relational View of Conscience and Physician Conscientious Action." *International Journal of Feminist Approaches to Bioethics* 8, no. 1 (2015): 18–36.

Bleich, David. "The Physician as a Conscientious Objector Conference on Religious Values and Legal Dilemmas in Bioethics." *Fordham Urban Law Review* 30 (2003 2002): 245–66.

Bouchard, Thomas. "Moral Analysis of Conscientious Objection in Medicine," January 27, 2016. https://canadiancatholicphysicians.com/wp-content/uploads/2015/02/Moral-analysis-of-consciencious-objection-in-medicine-final.pdf.

Broad, C. D. "Conscience and Conscientious Action." *Philosophy* 15, no. 58 (1940): 115–30.

Callahan, Sidney Cornelia. "In Good Conscience Reason and Emotion in Moral Decision Making," 1991.

Cantor, Julie D. "Conscientious Objection Gone Awry — Restoring Selfless Professionalism in Medicine." *New England Journal of Medicine* 360, no. 15 (April 9, 2009): 1484–85. https://doi.org/10.1056/NEJMp0902019.

Card, Robert F. "Conscientious Objection and Emergency Contraception." *The American Journal of Bioethics* 7, no. 6 (June 1, 2007): 8–14. https://doi.org/10.1080/15265160701347239.

Chaoulli v. Quebec, 2005 SCC 35, online: CanLII <http://canlii.ca/t/1kxrh>

Charo, R. Alta. "The Celestial Fire of Conscience — Refusing to Deliver Medical Care." *New England Journal of Medicine* 352, no. 24 (June 16, 2005): 2471–73. https://doi.org/10.1056/NEJMp058112.

Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario, 2019 ONCA 393, online: CanLII < http://canlii.ca/t/j08wq>

"CMA, 'Code of Ethics.'" Accessed October 12, 2018. https://www.cma.ca/Assets/assets-library/document/en/advocacy/policy-research/CMA_Policy_Code_of_ethics_of_the_Canadian_Medical_Association_Update_2004_PD04-06-e.pdf.

CMDS. “Letter to the CPSO,” August 5, 2014. http://www.cmdscanada.org/my_folders/Position_Papers/Letter_to_CPSO_August_5_2014.pdf.

College of Physicians and Surgeons of Ontario. “Advice to the Profession: Professional Obligations and Human Rights.” Accessed November 2, 2019. https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Professional-Obligations-and-Human-Rights/Advice-to-the-Profession-Professional-Obligations.

———. “Medical Assistance in Dying,” December 2018. https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Medical-Assistance-in-Dying.

———. “Professional Obligations and Human Rights,” March 2015. https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Professional-Obligations-and-Human-Rights.

Daniels, Norman, ed. *Reading Rawls: Critical Studies on Rawls’ A Theory of Justice*. New York: Basic Books Inc., Publishers, 1975.

Di Camillo, John A. “Understanding Cooperation with Evil.” *Ethics and Medics* 38, no. 7 (July 2013): 1–4.

Downie, Jocelyn, and Francoise Baylis. “A Test for Freedom of Conscience under the Canadian Charter of Rights and Freedoms: Regulating and Litigating Conscientious Refusals in Health Care.” *McGill Journal of Law and Health* 11 (2017): S1–30.

Dworkin, Gerald. *The Theory and Practice of Autonomy*. Cambridge: Cambridge University Press, 1988.

Dworkin, Ronald. “Liberalism.” In *Liberalism and Its Critics*, edited by Michael Sandel, 60–79. New York: New York University Press, 1984.

Emerson, Claudia I., and Abdallah S. Daar. “Defining Conscience and Acting Conscientiously.” *The American Journal of Bioethics* 7, no. 12 (December 17, 2007): 19–21. https://doi.org/10.1080/15265160701709974.

Epstein, Elizabeth Gingell, and Ann Baile Hamric. “Moral Distress, Moral Residue, and the Crescendo Effect.” *The Journal of Clinical Ethics* 20, no. 4 (2009): 330–42.

Fiala, Christian, and Joyce H. Arthur. “‘Dishonourable Disobedience’ – Why Refusal to Treat in Reproductive Healthcare Is Not Conscientious Objection.” *Woman - Psychosomatic Gynaecology and Obstetrics* 1 (December 1, 2014): 12–23. https://doi.org/10.1016/j.woman.2014.03.001.

Fiala, Christian, Kristina Gemzell Danielsson, Oskari Heikinheimo, Jens A. Gudmundsson, and Joyce Arthur. "Yes We Can! Successful Examples of Disallowing 'Conscientious Objection' in Reproductive Health Care." *The European Journal of Contraception and Reproductive Health Care* 21, no. 3 (2016): 201–6.

Fitzgerald, Chloë. "A Neglected Aspect of Conscience: Awareness of Implicit Attitudes." *Bioethics* 28, no. 1 (January 1, 2014): 24–32. https://doi.org/10.1111/bioe.12058.

Flora v. General Manager, Ontario Health Insurance Plan, 2008 ONCA 538, online: CanLII <http://canlii.ca/t/1z90d>

Fries, James F., C. Everett Koop, Carson E. Beadle, Paul P. Cooper, Mary Jane England, Roger F. Greaves, Jacque J. Sokolov, and Daniel Wright. "Reducing Health Care Costs by Reducing the Need and Demand for Medical Services." *New England Journal of Medicine* 329, no. 5 (July 29, 1993): 321–25. https://doi.org/10.1056/NEJM199307293290506.

Genuis, Stephen J, and Shelagh K Genuis. "Resisting Cookbook Medicine." *BMJ : British Medical Journal* 329, no. 7458 (July 17, 2004): 179.

Genuis, Stephen J., and Chris Lipp. "Ethical Diversity and the Role of Conscience in Clinical Medicine." Research article. International Journal of Family Medicine, 2013. https://doi.org/10.1155/2013/587541.

Giubilini, Alberto. "Objection to Conscience: An Argument Against Conscience Exemptions in Healthcare." *Bioethics* 31, no. 5 (June 1, 2017): 400–408. https://doi.org/10.1111/bioe.12333.

Haidt, Jonathan. "The New Synthesis in Moral Psychology." *Science* 316, no. 5827 (2007): 998–1002.

Hirschl, Ran. "Negative Rights vs. Positive Entitlements: A Comparative Study of Judicial Interpretations of Rights in an Emerging Neo-Liberal Economic Order." *Human Rights Quarterly* 22 (2000): 1060–98.

Horwitz, Paul. "The Sources and Limits of Freedom of Religion in a Liberal Democracy: Section 2(a) and Beyond." *University of Toronto Faculty of Law Review* 54 (1996): 1–64.

Hughes, Jonathan A. "Conscientious Objection, Professional Duty and Compromise: A Response to Savulescu and Schuklenk." *Bioethics* 32, no. 2 (2018): 126–131.

Kälvemark, Sofia, Anna T Höglund, Mats G Hansson, Peter Westerholm, and Bengt Arnetz. "Living with Conflicts-Ethical Dilemmas and Moral Distress in the Health Care System." *Social Science & Medicine* 58, no. 6 (March 1, 2004): 1075–84. https://doi.org/10.1016/S0277-9536(03)00279-X.

Kantymir, Lori, and Carolyn McLeod. "Justification for Conscience Exemptions in Health Care." *Bioethics* 28, no. 1 (January 1, 2014): 16–23. https://doi.org/10.1111/bioe.12055.

Macintyre, Alasdair. "How Virtues Become Vices: Values, Medicine and Social Context." In *Evaluation and Explanation in the Biomedical Sciences: Proceedings of the First Trans-Disciplinary Symposium on Philosophy and Medicine Held at Galveston, May 9–11, 1974*, edited by H. Tristram Engelhardt and Stuart F. Spicker, 97–111. Philosophy and Medicine. Dordrecht: Springer Netherlands, 1975. https://doi.org/10.1007/978-94-010-1769-5_7.

Maclure, Jocelyn, and Isabelle Dumont. "Selling Conscience Short: A Response to Schuklenk and Smalling on Conscientious Objections by Medical Professionals." *Journal of Medical Ethics*, September 28, 2016, medethics-2016-103903. https://doi.org/10.1136/medethics-2016-103903.

Maclure, Jocelyn, and Charles Taylor. *Secularism and Freedom of Conscience*. Harvard University Press, 2011.

McLeod, Carolyn. "Referral in the Wake of Conscientious Objection to Abortion." *Hypatia* 23, no. 4 (October 12, 2008): 30–47. https://doi.org/10.1111/j.1527-2001.2008.tb01432.x.

Meyers, Christopher, and Robert D. Woods. "Conscientious Objection? Yes, but Make Sure It Is Genuine." *The American Journal of Bioethics* 7, no. 6 (2007): 19–20.

National Catholic Bioethics Center. "Transfer of Care vs. Referral: A Crucial Moral Distinction," May 2015. https://www.ncbcenter.org/resources/news/transfer-care-vs-referral-crucial-moral-distinction/.

Pellegrino, Edmund D. "The Physician's Conscience, Conscience Clauses, and Religious Belief: A Catholic Perspective Conference on Religious Values and Legal Dilemmas in Bioethics." *Fordham Urban Law Review* 30 (2003 2002): 221–44.

Polizogopoulos, Albertos. "Factum of the Intervener CMDS vs. CPSO," March 31, 2017. https://www.jccf.ca/wp-content/uploads/2017/04/Factum-of-the-Intervener.pdf.

———. "Submissions from the Christian Medical and Dental Society and the Canadian Federation of Catholic Physicians' Societies to the College of Physicians and Surgeons of Ontario," 2015. http://albertosp.com/wp-content/uploads/2015/02/Submissions-of-the-CMDS-and-the-CFCPS.pdf.

———. "Submissions from the Christian Medical and Dental Society and the Canadian Federation of Catholic Physicians' Societies to the College of Physicians and Surgeons of Ontario 'Schedule A,'" 2014. http://albertosp.com/wp-content/uploads/2015/02/Submissions-of-the-CMDS-and-the-CFCPS.pdf.

Rawls, John. *A Theory of Justice*. Cambridge: The Belknap Press of Harvard University Press, 1971.

———. *Political Liberalism*. New York: Columbia University Press, 1993.

Roach v. Canada (The Minister of State for Multiculturalism and Citizenship), 1994 CanLII 3453 (FCA), [1994] 2 FC 406, online: CanLII <http://canlii.ca/t/4nm5>

Rutledge Harding, Sheila, and John Patrick. "Euthanasia: Principles and Observations from a Christian Perspective," April 1995. http://www.cmdscanada.org/my_folders/Resources/Euthanasia1.pdf.

Savulescu, Julian, and Udo Schuklenk. "Doctors Have No Right to Refuse Medical Assistance in Dying, Abortion or Contraception." *Bioethics* 31, no. 3 (March 1, 2017): 162–70. https://doi.org/10.1111/bioe.12288.

Scanlon, T.M. "Rawls' Theory of Justice." In *Reading Rawls*, edited by Norman Daniels, 169–205. New York: Basic Books Inc., Publishers, 1975.

Schuklenk, Udo. "Conscientious Objection in Medicine: Accommodation versus Professionalism and the Public Good." *British Medical Bulletin* 126 (2018): 47–56. https://doi.org/10.1093/bmb/ldy007.

———. "Conscientious Objection in Medicine: Private Ideological Convictions Must Not Supercede Public Service Obligations." *Bioethics* 29, no. 5 (June 1, 2015): ii–iii. https://doi.org/10.1111/bioe.12167.

Schuklenk, Udo, and Ricardo Smalling. "Why Medical Professionals Have No Moral Claim to Conscientious Objection Accommodation in Liberal Democracies." *Journal of Medical Ethics* 43, no. 4 (April 1, 2017): 234–40. https://doi.org/10.1136/medethics-2016-103560.

Shanawani, Hasan. "The Challenges of Conscientious Objection in Health Care." *Journal of Religion and Health* 55, no. 2 (April 1, 2016): 384–93. https://doi.org/10.1007/s10943-016-0200-4.

Spota, Kate. "In Good Conscience: The Legal Trend to Include Prescription Contraceptives in Employer Insurance Plans and Catholic Charities Conscience Clause Objection Comment." *Catholic University Law Review* 52 (2003 2002): 1081–1114.

Statistics Canada. "Canadian Demographics at a Glance, Second Edition," June 19, 2014. https://www150.statcan.gc.ca/n1/pub/91-003-x/2014001/section03/33-eng.htm.

Strickland, Sophie LM. "Conscientious Objection in Medical Students: A Questionnaire Survey." *Journal of Medical Ethics* 38, no. 1 (2012): 22–25.

Sulmasy, Daniel P. “What Is Conscience and Why Is Respect for It so Important?” *Theoretical Medicine and Bioethics* 29, no. 3 (June 1, 2008): 135–49. https://doi.org/10.1007/s11017-008-9072-2.

Syndicat Northcrest v. Amselem 2004 SCC 47, online: CanLII <http://canlii.ca/t/1hddh>

The Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario, 2018 ONSC 579, online: CanLII <http://canlii.ca/t/hq4hn>

Weinstock, Daniel. “Conscientious Refusal and Health Professionals: Does Religion Make a Difference?” *Bioethics* 28, no. 1 (January 1, 2014): 8–15. https://doi.org/10.1111/bioe.12059.

West-Oram, Peter, and Alena Buyx. “Conscientious Objection in Healthcare Provision: A New Dimension.” *Bioethics* 30, no. 5 (2016): 336–43.

Williams, Alan. “Intergenerational Equity: An Exploration of the ‘Fair Innings’ Argument.” *Health Economics* 6, no. 2 (1997): 117–132.