bioethics

Bioethics ISSN 0269-9702 (print); 1467-8519 (online)
Volume 28 Number 1 2014 pp 33–46

doi:10.1111/bioe.12057

WELCOME TO THE WILD, WILD NORTH: CONSCIENTIOUS OBJECTION POLICIES GOVERNING CANADA'S MEDICAL, NURSING, PHARMACY, AND DENTAL PROFESSIONS

JACQUELYN SHAW AND JOCELYN DOWNIE

Keywords
conscience,
conscientious objection,
moral conflict,
conscientious refusal,
religious belief,
moral values,
conflict of interest

ABSTRACT

In Canada, as in many developed countries, healthcare conscientious objection is growing in visibility, if not in incidence. Yet the country's health professional policies on conscientious objection are in disarray. The article reports the results of a comprehensive review of policies relevant to conscientious objection for four Canadian health professions: medicine, nursing, pharmacy and dentistry. Where relevant policies exist in many Canadian provinces, there is much controversy and potential for confusion, due to policy inconsistencies and terminological vagueness. Meanwhile, in Canada's three most northerly territories with significant Aboriginal populations, whose already precarious health is influenced by funding and practitioner shortages, there are major policy gaps applicable to conscientious objection. In many parts of the country, as a result of health professionals' conscientious refusals, access to some legal health services – including but not limited to reproductive health services such as abortion – has been seriously impeded. Although policy reform on conscientious conflicts may be difficult, and may generate strenuous opposition from some professional groups, for the sake of both patients and providers, such policy change must become an urgent priority.

INTRODUCTION

In Canada, patients have been refused care by health professionals because of their weight, substance abuse,[1] sexual orientation, vaccination refusal,[2] or requests for reproductive services (e.g. abortion, emergency contraception or sterilization[3]). These refusals have been, at least in part, on the grounds of conscience. Internationally, the range of reasons for conscientious refusal appears similarly broad, with reports that: in the US, an Oklahoma physician denied emergency contraception to a rape victim for religious reasons,[4] and a California

[1] M. Siegel. 24 April 2012. Orthopedic Surgeon Recommends Refusing Knee Replacement Surgery for Smokers. *Tobacco Analysis Blogspot*. Available at: http://tobaccoanalysis.blogspot.ca/2012/04/orthopedic-surgeon-recommends-refusing.html. [Accessed 6 Jul 2013].

[2] E. Mountney. 2012. Doctor Refused to Treat Girl without Vaccinations: mother. *Toronto Sun* 30 July. Available at: http://www.torontosun.com/2012/07/30/doctor-refused-to-treat-girl-without-vaccinations-mother. [Accessed 6 Jul 2013].

[3] In 2006, a Catholic-run Saskatchewan hospital ended contraceptive sterilization, triggering a human rights complaint; Canadian Broadcasting Corporation News. 2007. Woman Given Settlement after Being Denied Tubal Ligation. *Canadian Broadcasting Corporation News*, 13 September. Available at: http://www.cbc.ca/news/canada/saskatchewan/story/2007/09/13/tubal-ligation.html. [Accessed 6 Jul 2013].

[4] A.-R. Strasser. 2012. Oklahoma Doctor Refuses to Provide Rape Victim with Emergency Contraception. *Truthout*, 1 June. Available at: http://truth-out.org/news/item/9528-oklahoma-doctor-refuses-to-provide-rape-victim-with-emergency-contraception. [Accessed 6 Jul 2013]. Approximately 12% of surveyed US physicians may refuse rape victims emergency contraception, with male physicians refusing more frequently; R. Kesharvaz, R.C. Merchant & J. McCreal. Emergency Contraception Provision: A Survey of Emergency Department Provisions. *Academic Emergency Medicine* 2002; 9(1): 69, 71.

Address for correspondence: Professor Jocelyn Downie, Schulich School of Law, Dalhousie University Halifax, Nova Scotia, Canada. Tel. 902-494-3495. Email: Jocelyn.downie@dal.ca
Conflict of interest statement: No conflicts declared

clinic denied artificial insemination to a lesbian patient;[5] in Britain, surgeons have debated denying smokers joint replacement surgery;[6] and in Germany, a Jewish surgeon, noting his patient's swastika tattoo, refused to operate.[7] Not only are licensed practitioners refusing care,[8] but some medical students conscientiously refuse to learn, for instance, to treat patients of the opposite sex or those intoxicated with alcohol or recreational drugs.[9]

It is certainly desirable that practitioners possess some latitude in applying their powerful skills and knowledge. However, due to conscientious refusals to provide treatment or services, patient access to some health services – e.g. abortion – is seriously curtailed, potentially threatening patient health and wellbeing.[10] We therefore need effective professional policies that permit acts grounded in conscience, but which also place reasonable limits on the exercise of conscience. Unfortunately, as this article shows, at least for some professions, Canada is severely impoverished in this regard.

This article maps the current state of Canada's health policy arena with respect to conscientious objection in health care. In Part I, we report the results of a comprehensive review of policies relevant to conscientious objection by physicians, registered nurses, pharmacists, and dentists in all Canadian provinces and territories.[11] We expose the potential for practitioner confusion generated by existing policies and make comparisons across the four surveyed professions, demonstrating significant variability. We conclude that greater predictability and consistency for practitioners and patients is needed, regarding what protection conscience can expect. In Part II, we describe several recent conflicts over objection policies, which illustrate the considerable controversy regarding what healthcare conscientious objection policies are and should be. In Part III, we explore what would constitute a legitimate policy-making process for addressing the deficiencies in the policy landscape identified in Part I against the challenges identified in Part II.

Before proceeding to the results of the policy review, some discussion of terminology is necessary. 'Conscientious objection', for the purposes of this article, may involve a health practitioner's belief that a procedure requested by a patient, or by a practitioner's employer or co-workers, is morally wrong, leading the practitioner to voice resistance, or to take other actions consistent with that belief. It may also involve a moral belief regarding care provision to particular patients (e.g. to those who are gay or lesbian). It may refer to an act of resistance (e.g. refusing abortion referrals), or to a verbal act expressing one's belief (e.g. a waiting room sign, stating that killing a fetus conflicts with the physician's beliefs about the sanctity of life and that the physician's policy is to refuse abortion referral). A verbal objection may also precede a physical act. Typically, healthcare conscientious actions are negative, involving 'conscientious refusals' of requested procedures. However, objection may also involve positive activity,[12] such as providing care: 1) in excess of that requested by a patient or substitute decision-maker (e.g. giving artificial hydration and nutrition to a patient with an advance directive refusing life-prolonging interventions); 2) in excess of that required by institutional policy (e.g. anaesthetizing whole brain-dead organ donors);[13] or 3) not covered by the health insurance

[5] S.D. James. 2008. Doctors Deny Lesbian Artificial Insemination. *ABC News* 28 May. Available at: http://abcnews.go.com/TheLaw/story?id=4941377&page=1 [Accessed 6 Jul 2013]; Community Editor. 2007. Settlement Reached in Case of Lesbian Denied Infertility Treatment by Christian Fundamentalist Doctors. *Proud Parenting*, 30 September. Available at: http://www.proudparenting.com/node/766 [Accessed 6 Jul 2013].

[6] D. Newling. 2007. Smokers Told to Quit or Surgery Will be Refused. *Mail Online*, 4 June. Available at: http://www.dailymail.co.uk/news/article-459574/Smokers-told-quit-surgery-refused.html [Accessed 6 Jul 2013].

[7] N. Stafford. Surgeon Who Refused to Operate on Man with Swastika Tattoo Should Not be Disciplined, says German Medical Association. *BMJ* 2010; 341: 7279.

[8] The few empirical studies show physician conscientious refusal rates varying by procedure, region and practitioner characteristics. Male, very religious, foreign-born or foreign–trained physicians conscientiously refuse fertility-related procedures more often. See F.A. Curlin et al. Religion, Conscience and Controversial Clinical Practices. *N E JM* 2007; 356(6); R.E. Lawrence et al. Obstetrician-Gynecologist Physicians' Beliefs about Emergency Contraception: A National Survey. *Contraception* 2010; 82. Some 11% –28.7% of physicians refuse abortion referral. See R.E. Lawrence & F.A. Curlin. Physicians' Beliefs about Conscience in Medicine: A National Survey. *Acad Med* 2009; 84(9); R.A. Rosenblatt, R. Mattis & L.G. Hart. Abortion Attitudes in Rural Idaho: Physicians' Attitudes and Practices. *Am J Pub Health* 1995; 85(10): 1423–1425. Contraceptive refusal measured 1.1% (all methods). See R.E. Lawrence et al. Obstetrician-Gynecologists' Views on Contraception and Natural Family Planning: A National Survey. *Am J Obstet Gynecol* 2011; 204(2).

[9] Some 45.2% of U.K. medical students believe physicians should have a right to refuse any procedure; S. Strickland. Conscientious Objection in Medical Students: A Questionnaire Survey. *J Med Ethics* 2012; 38: 22–25.

[10] For example, in 2012, an Irish woman died of septicemia, after being refused induction for several days, when her 17-week old fetus began to miscarry. K. Kissane. 2012. Death of Woman Denied Abortion puts Global Pressure on Ireland for Law Reform. *Sydney Morning Herald*, 15 November. Available at: http://www.smh.com.au/world/death-of-woman-denied-abortion-puts-global-pressure-on-ireland-for-law-reform-20121115-29d3d.html. [Accessed 6 Jul 2013].

[11] We obtained policies by searching the websites of the provincial/territorial regulatory/ advocacy bodies of medicine, nursing, pharmacy and dentistry. Over 100 policies were screened in this survey, whose results will be published online at: Let Conscience Be Their Guide, University of Western Ontario, Canada, Available at: http://conscience.uwo.ca/ [Accessed 6 Jul 2013].

[12] L.H. Harris. Recognizing Conscience in Abortion Provision. *NEJM* 2012; 367(11): 981–983.

[13] During the 1990s, Canadian anaesthetists were sometimes requested to assist in organ harvesting despite the fact that pain sensation is considered inconsistent with whole-brain death; A.W. Gelb & K.M.

scheme (e.g. physicians providing free care to undocumented migrants despite legal restrictions).[14]

It should also be noted here that, while practitioner refusals based on practitioner convenience, irrational fear, prejudice or reluctance to treat patients perceived to be making unhealthy lifestyle choices may not seem to be *conscientiously* motivated, conscience claims have sometimes been cited as reasons for such refusals, and many of the policies we reviewed would address such refusals. In addition, refusals based on seemingly unhealthy lifestyles may be thought by some practitioners to be motivated by their secular conscientious beliefs regarding health professional aims and gatekeeper roles. For these reasons, the discussion will include these less traditional types of refusals as well.

PART I – CONCERNS

A. Confusion

Considerable potential for practitioner confusion exists based on the bewildering array of policies existing in many provinces and territories.

The sheer diversity of bodies issuing policies must be a source of considerable uncertainty for practitioners attempting to determine their obligations. For instance, there often exist, simultaneously for any given profession, policies issued by national advocacy bodies, by national regulatory authorities, by provincial/territorial regulatory bodies (some of which are merged with provincial/territorial advocacy bodies).[15] This large body of policies is further augmented by the fact that, in a few cases, there are also additional policies issued by provincial/territorial advocacy bodies, even where a provincial regulatory body policy already exists, and by national bodies governing certain specialties within professions (e.g. obstetricians and gynecologists). Confusion seems not only possible, but likely.

Differences exist among some of the issuers of – and entities governed by – these policies, in that some of these organizations are composed of individuals,[16] while others comprise and govern not individual professionals but the provincial/territorial regulatory authorities that in turn govern individual professionals.[17] Some national policies may apply by means of provincial adoption, in part or in full,[18] although the adoption status may require some investigation to discover. Other policies may apply only if a province/ territory voluntarily becomes a member of a national regulatory authority.[19] In other cases, a national policy may be adopted by various provinces, but may disappear from national policy lists without withdrawal notice even while the same organization actively refers practitioners to that policy.[20] Significantly, there is no indication in any policy regarding priority, i.e. which policy takes precedence over any other, or what a practitioner should do in the event of an inconsistency or conflict among multiple applicable policies. In some jurisdictions, notably the northerly territories of the Yukon, Northwest Territories and Nunavut, policies do not exist for most of the surveyed professions.[21] Overall, the impression left following a review of the available policies is of a morass of somewhat inconsistent, partially or completely overlapping and potentially conflicting policies, whose interpretation and degree of priority is unclear. The following specific examples illustrate this impression.

Robertson. Anaesthetic Management of the Brain Dead for Organ Donation. *Can J Anaesth* 1990; 37(7): 806–812.

[14] Spanish medical societies encourage physician conscientious noncompliance with a law denying free healthcare to undocumented migrants, R. Trivino. Conscientious Objection and Undocumented Migrants in Spain. Bioethics Forum blog, *Hastings Cent Rep* 2012; 42(6). Available at: http://www.thehastingscenter.org/Bioethicsforum/Post.aspx?id=5999&blogid=140. [Accessed 6 Jul 2013].

[15] For instance, the Nurses Association of New Brunswick is 'the regulatory body and professional association for nurses in New Brunswick' available at http://www.nanb.nb.ca/ [Accessed 6 Jul 2013]. The Association of Registered Nurses of Prince Edward Island, is also 'the professional organization and regulatory body for registered nurses in Prince Edward Island' available at http://www.arnpei.ca/ [Accessed 6 Jul 2013].

[16] E.g. regulatory bodies such as the College of Physicians and Surgeons of Nova Scotia.

[17] E.g. national regulatory authorities such as the National Association of Pharmacy Regulatory Authorities, or NAPRA which is composed of individual provincial (and other) regulatory authorities.

[18] E.g. the Canadian Medical Association, or CMA Code.

[19] As in the case of NAPRA policies.

[20] E.g. NAPRA. Model Statement Regarding Pharmacists' Refusal to Provide Products or Services for Moral or Religious Reasons. 1999. Available at http://napra.ca/Content_Files/Files/Model-Statement-Regarding-Pharmacists.pdf [Accessed 6 Jul 2013]. This statement is no longer included on the NAPRA policy list and does not show up via a search of the website. Yet NAPRA, elsewhere on its website than the policy section, actively encourages reference to this policy, even providing a link to it, on its webpage: NAPRA. (Undated). Emergency Contraception. Available AT: http://napra.ca/pages/Practice_Resources/%20drug_information_%20resources.aspx?id=2141 [Accessed 6 Jul 2013]. Thus the Statement's status as an active or withdrawn policy is left unclear. The NAPRA policy has been adopted by pharmacy regulatory bodies in New Brunswick, Prince Edward Island and Manitoba.

[21] One Yukon physician service withdrawal policy exists. See Yukon Medical Council. 2002. Withdrawal of Physician Services Directive. Available at: http://www.yukonmedicalcouncil.ca/pdfs/withdrawal_of_physician_services.pdf. [Accessed 6 Jul 2013]. There are also nursing policies for the Yukon, Northwest Territories and Nunavut, each of which requires compliance with the (entire) CNA Code of Ethics. See Yukon Registered Nurses Association. 2008. Standards for Registered Nursing Practice in the Yukon. Available at: http://www.yrna.ca/assets/%20Standards2008-1.pdf. [Accessed 6 Jul 2013]. Also Registered Nurses' Association of the Northwest Territories and Nunavut. 2006. Standards for Nursing Practice for RNs: 4. Available at: http://www.rnantnu.ca/%20Portals/0/Documents/%20Standards_Nrsing_Prac_2006.pdf>. [Accessed 6 Jul 2013].

Specifically, at the national level, what are frequently thought of as authoritative national policies are often documents issued by national advocacy bodies, such as the Canadian Medical Association (CMA) for physicians and the Canadian Nursing Association (CNA) for registered nurses.[22] The CMA and CNA both have ethics policies applicable to conscientious objection. However, while appearing to have national application and to be authoritative, these do not have the same force for all practitioners across the country. These documents have force in a province or territory only where a provincial or territorial regulatory body has expressly adopted them and this has seemingly not been done everywhere.[23]

With regard to national bodies not made up of individuals, the Canadian Dental Association (CDA) was recently converted from a body of individual dentists to one of provincial/territorial dental regulatory authorities, withdrawing the CDA's national code.[24] A new regulatory federation, the Canadian Dental Regulatory Authorities Federation (CDRAF) has not issued any national guiding documents on any topic to govern individual dentists.[25] CDRAF's voluntary membership excludes all three northern territories, so dentists there will not be governed by any future CDRAF policies.

For pharmacists, the situation has in the past been complicated by the fact that membership in the National Association of Pharmacy Regulatory Authorities (NAPRA) is voluntary rather than automatic; not all provinces and territories have always been NAPRA members.[26] Before 2008–9, Ontario, Québec and two of Canada's northern territories, the Yukon, and Nunavut, were not members;[27] all provinces and territories are now members,[28] but websites for the Yukon, Northwest Territories and Nunavut do not state whether they have adopted NAPRA's policies. Thus it is not clear whether pharmacists in the three northern territories are governed by a national policy.

At the provincial/territorial level, relevant policies may be issued not only by the provincial regulatory body, but also by the provincial advocacy body,[29] where these are separate bodies. Thus, depending on the province or territory, a practitioner may be subject to potentially inconsistent conscientious objection policies,[30]

[22] A Canadian Pharmacists' Association (CPhA) also exists but no policies were accessible from it.

[23] E.g. the entire CMA code is adopted by the College of Physicians and Surgeons of Newfoundland & Labrador. 2010. By-Law 5. Available at: http://www.cpsnl.ca/default.asp?com=Bylaws%20&m=292&y=&id=5. [Accessed 6 Jul 2013]. In contrast, the College of Physicians and Surgeons of Prince Edward Island's policy on relationship termination sets out the ethical framework as adopting specifically ss. 1,5, 17–19 of the CMA code, notably excluding from this framework ss. 11 (requiring conflict of interest disclosure), 12 (requiring informing the patient if the physician's personal values affect recommendations) and 15 (requiring a physician to recognize his/her limitations as when indicated recommend or seek additional opinions). In the nursing profession, numerous provincial Colleges expressly adopt the entire CNA Code of Ethics, e.g. The College and Association of Registered Nurses of Alberta. 2005. Nursing Practice Standards: s. 3. Available at: http://www.nurses.ab.ca/Carna-Admin/Uploads/new_nps_with_ethics.pdf. [Accessed 6 Jul 2013]. In contrast, Manitoba recently updated its standards to require compliance with the (entire) CNA Code of Ethics. See the College of Registered Nurses of Manitoba. 2013. Standards of Practice for Registered Nurses in Manitoba. Available at: http://cms.tng-secure.com/file_%20download.%20php?fFile_id=140. [Accessed 6 Jul 2013]. However, the Manitoba College's website, available at: http://www.crnm.mb.ca/publications-standardscodedocs.php [Accessed 6 Jul 2013], states that it has only adopted part I of the CNA Code (which contains sections dealing with conscience conflict), but has not adopted part II of the Code 'Ethical Endeavours,' which gives more detailed guidance on ethical issues, including conscience conflicts.

[24] E-mail, 1 August 2012, Natalia de Savigny, CDA Communications Coordinator, to author.

[25] A new CDA policy, under discussion, will guide provincial/ territorial regulatory bodies, not individual dentists.

[26] It is not just provinces/ territories who are members: the Canadian Armed Forces are also regulatory authority members. See NAPRA. 2010. Annual Report 2009–2010. Available at: http://napra.ca/Content_Files/Files/Annual_Report_20092010_Final.pdf [Accessed 6 Jul 2013].

[27] NAPRA. 2007. Annual Report 2006–7. Available at: http://napra.ca/Content_Files/Files/Final-AnnualReport06-07.pdf [Accessed 6 Jul 2013]; and NAPRA. 2009. Annual Report 2008–9. Available at: http://napra.ca/Content_Files/Files/Annual_Report_20082009_Final.pdf [Accessed 6 Jul 2013].

[28] Nunavut joined in Jan 2011. See: NAPRA. 2011. NAPRA Welcomes New Member- Nunavut Dept of Health and Social Services. Available at: napra.ca/. . ./NR_NAPRA_Welcomes_Nunavut_January252011_English_. . . [Accessed 6 Jul 2013]. Also see: NAPRA Structure. 2009. Available at: http://www.napra.org/pages/About/NAPRA_Structure.aspx [Accessed 6 Jul 2013].

[29] E.g. in British Columbia there are two policies relevant to conscience conflicts. College of Physicians and Surgeons of British Columbia. 2010. Ending the Patient-Physician Relationship. Available at: https://www.cpsbc.ca/files/u6/Ending-the-Patient-Physician-Relationship.pdf. [Accessed 6 Jul 2013]. There is also: British Columbia Medical Association.1996. Code of Ethics. Available at: https://www.bcma.org/about-bcma/code-ethics. [Accessed 6 Jul 2013].

[30] E.g. Manitoba's standards for both community and hospital pharmacists (which both employ most of the wording of the NAPRA 'Model Statement on Refusal'), require a pharmacist's conscientious objection to be verbalized to the pharmacy *manager*, not the patient. See Manitoba Pharmaceutical Association. Standards of Practice – Community 2006. Pharmacist's Responsibilities in the Refusal to provide Products or Services for Moral or Religious Reasons. Available at: http://mpha.in1touch.org/uploaded/38/web/SofP+Community.pdf [Accessed 6 Jul 2013]. Also see: Manitoba Pharmaceutical Association. 2004. Hospital Standards of practice – Responsibilities in the Refusal to Provide Products or Services for Moral or Religious Reasons. http://mpha.in1touch.org/uploaded/38/web/documents/Standards-of-Practice-Hospital-09.pdf [Accessed 6 Jul 2013]. Yet Manitoba Draft Regulations would allow and encourage pharmacists (including those opposed to emergency contraception) to 'enter into a dialogue' with patients seeking Schedule III drugs, such as the emergency contraceptive levonogestrol ('Plan B'), and to advise such patients regarding 'risks' and 'alternatives'. Manitoba Pharmaceutical Association. 2012. Draft Regulations. Available at: http://www.msp.mb.ca/files/draft_practice_directions.pdf [Accessed 6 Jul 2013]. To a pharmacist morally opposed to Plan B, this may be interpreted as permitting a verbal objection on emergency contraception directly to the patient (e.g. provision of

or alternatively, more of a policy vacuum.[31]

A further source of potential confusion derives from the fact that many policies leave key terminology undefined, permitting interpretative differences regarding obligations. For example, what constitutes a 'legitimate reason' for a physician to terminate care is usually undefined.[32] 'Reasonable notice' also remains vague in termination policies, but may be clearly quantified in the same body's service withdrawal or practice-leaving policies.[33] Although many policies require practitioners to provide 'urgent' or 'emergency' care despite objections, little interpretative guidance exists.[34] For example, is exposure to unwanted pregnancy an 'urgent' situation? One need only look at the debate in the *Canadian Medical Association Journal* about the meaning of the CMA Policy on Induced Abortion and Code of Ethics (discussed *infra*) to see the depth of confusion that exists in this arena.

B. Variability

A range of professional policies is relevant to conscientious objection, including policy statements on moral objection, moral conflict, conflict of interest, ethical distress, relationship termination, discrimination, service withdrawal, and disruptive behaviour. All four professions reviewed clearly anticipate conscience conflicts, yet there are significant differences in how each addresses such conflicts.

Overall, we found a greater diversity in physician policy types: ethics codes, by-laws and stand-alone policies on moral conflict or conflict of interest, establishing or terminating patient relationships, discrimination, professional misconduct, service withdrawal, disruptive behaviour, and specific procedures. In contrast, other professions usually have a main ethical code or practice guideline set, with components addressing moral conflict, referral, or discrimination.

In pharmacy and nursing, objection is generally permitted, subject to certain conditions (e.g. advance notification) and limitations (e.g. non-obstruction of access)[35] beyond which, objection is subordinated to patient needs. In nursing, compassion, ethics, and safety are values explicitly associated with this subordination, while pharmacy policies emphasize assurance of a functional drug provision system that minimizes patient suffering and inconvenience. Medical policies more frequently permit termination of the physician-patient relationship, with some jurisdictions closely linking termination with conscience conflicts.[36]

Overall, physician policies tend to be vague as to whether referral is required in a conflict. For example, non-directive language is often used, merely 'encouraging,' 'preferring' or 'expecting' physicians to 'consider' or 'offer' to 'help' a patient 'find a new physician' (who, in turn, may or may not actually be able to provide the procedure), and such help is required only 'if possible,' 'reasonable,' or 'in the patient's medical interests.'[37] In physician policies, referral tends to be discussed only in connection with termination of the physician-patient relationship.[38] Thus, where physician referral might

unsolicited advice regarding moral 'risk' and alternatives). Following such dialogue, the draft regulation would also permit the pharmacist to refuse to sell the drug to the patient, again allowing a pharmacist conscientious objection to be made to the patient directly, rather than to the pharmacy manager, as the NAPRA policy on moral refusal requires.

[31] For instance, in the Yukon, Northwest Territories and Nunavut, no policies having relevance to conscientious objection were found for physicians, except for in the Yukon, which possesses a policy on 'Withdrawal of Physician Services' that could potentially be applied to a collective withdrawal of services to patients.

[32] See, e.g. The College of Physicians and Surgeons of Saskatchewan. Undated. Code of Ethics for Saskatchewan Physicians. Available at: http://www.quadrant.net/cpss/communication/brochures/ethics.html [Accessed 6 Jul 2013].

[33] E.g. Alberta 'Standards of Practice' require: 'advance written notice of intention to terminate care [with] a timeline that is commensurate with the continuing care needs of the patient.' Yet in contrast, in a case of imminent practice closure 'A physician must provide a minimum of ninety (90) days' notice [to patients] of the medical practice closure or move . . .'. College of Physicians and Surgeons of Alberta. 2010. Standards of Practice. http://www.cpsa.ab.ca/Libraries/Res_Standards_of_Practice/CPSA_Standards_of_Practice_Consolidated_Version.pdf [Accessed 6 Jul 2013].

[34] Two exceptions were found, as two policies defined dental 'emergency;' the Manitoba Dental Association Code of Ethics By-law 2003 Amendment No. 6.03 Art. 9; and the *Alberta Dental* Association and *College* Code of Ethics 2007 s.A9.

[35] College of Pharmacists of British Columbia. 2009. Professional Practice Policy-35. Pharmacists Refusal to Provide a Product or Service for Moral or Religious Reasons. Available at: http://library.bcpharmacists.org/A-About_Us/A-2_Governance/5003-PGP-PPP35.pdf [Accessed 6 Jul 2013].

[36] E.g. in the context of a moral conflict, Ontario physicians are merely 'encouraged to consider referring', but if they 'cannot and must end the relationship,' they are expected to 'be as helpful as possible' in finding a new doctor, providing emergency care if alternative care is impossible, though not indefinitely. In NS, it is 'expected that physicians will, to the best of their ability, provide a referral.'

[37] Eg. Under the College of Physicians and Surgeons of Ontario's (CPSO) policy statement 5-08, physicians are merely '*encouraged* to *consider* referring', or alternatively, under CPSO policy statement 3-08, they are *expected* to 'be as *helpful as possible*' to patients in finding a new physician; the College des Medicins du Quebec *Code of Ethics of Physicians* s.24 requires physicians simply to *offer* to *help* a patient find a new physician, while under s.23, if refusing treatment for reasons such as morality, they need only refer 'if *in the patient's medical interest*;' under New Brunswick's *Guideline on Moral Objection*, '*preferred* practice' involves referral to a non-objector; both Prince Edward Island's and Nova Scotia's guidelines on ending a patient relationship require the physician only to 'be as *helpful as you can be*' in locating a new provider; and under the College of Physician and Surgeons of British Columbia's *Guidelines on a Ending a Patient Relationship*, s.3, it is only '*where possible and reasonable*,' that the physician must aid the patient in finding a new physician. Emphasis added.

[38] Judging by the fact that these clauses discuss interim care by the physician 'until the new physician takes over' (or until reasonable notice has elapsed, if no new physician is found).

seem a logical first step in a conscience conflict, and termination a last resort for all concerned, in fact, referral may only be discussed (and in a somewhat non-directive fashion) where a physician plans to terminate the relationship. However, to date, no information exists indicating whether termination is a common physician response in conscientious conflict circumstances governed by such policies. Of course, any physician who terminates a relationship without referral in a conscientious conflict could potentially face legal liability for 'patient abandonment'. Yet pursuing this avenue of recourse will require financial resources unlikely to be available to the average Canadian patient, and may be unsuccessful, suggesting it is less likely to influence physician conduct than policies may be.

In contrast, nursing[39] and pharmacy policies generally discuss referral and the specific details thereof,[40] while termination of the patient-practitioner relationship is seldom mentioned.[41] Overall, in pharmacy and nursing, greater policy support seems to exist for a conscientiously objecting pharmacist or nurse to avoid most objectionable care through referral, after which the relationship is expected to continue for future, non-objectionable care. It is unclear why patient termination is so infrequently mentioned in nursing and pharmacy policies, relative to physician policies.[42]

Trust is frequently cited in physician policies as a reason for conscience conflict to trigger termination.[43] However, despite mentioning 'trust', policies rarely discuss practitioner fiduciary duties and societal trust. Only two physician policies even hint at fiduciary duty[44] or societal trust in relation to conscience or conflict of interest.[45] In pharmacy, one British Columbia policy described the pharmacist-patient relationship as a 'covenant' (a solemn, formal promise or agreement) whereby pharmacists have moral obligations corresponding to the societal trust invested in them.[46] An Alberta policy mentions the 'higher standard'[47] (an expression evocative of talk of fiduciaries) expected of pharmacists as professionals. It is unclear why so little policy emphasis is placed on fiduciary duty and societal trust, especially where, given the clearly fiduciary nature of the physician-patient relationship, this might be expected in physician policies applicable to conscientious conflicts.

In general, physician policies supporting conscientious objection seem less clear, more convoluted and more confusing than those of pharmacy, nursing, and dentistry. Physician policies also sometimes contain confusing, internally contradictory clauses.[48] Overall, the impression given is that much less directive power exists over physicians' conscientious actions, compared with those of pharmacists and nurses.

Variability is also found in relation to service withdrawal or continuity of care policies that might be well suited to limit problems associated with practitioner conscientious objection, although they typically apply to 'job actions' (e.g. strikes). These policies exist in medicine where, in several provinces or territories, they apply

[39] Where termination was mentioned in one policy, the suggestion was that the objecting nurse consider employment elsewhere, rather than that the patient seek alternative care. College of Nurses of Ontario (CNO). Practice Guideline – Ethics. http://www.cno.org/Global/docs/prac/41034_Ethics.pdf [Accessed 6 Jul 2013].

[40] E.g. whether and how referral is to be arranged, any referral limitations, and alternatives if referral fails.

[41] Policies allowing a practitioner to terminate a patient relationship exist for Ontario and Alberta pharmacists, British Columbia nurses, and Quebec, Ontario, Manitoba, Alberta, and British Columbia dentists.

[42] It is possible that these differences may relate to the different employment status of nurses and pharmacists – i.e. as employees with less freedom to terminate a patient relationship – compared with physicians – as independent contractors who can more freely decide the terms of their relationship. In ten provinces/territories, physician policies permit patient relationship termination: Newfoundland/Labrador, Nova Scotia, New Brunswick, Prince Edward Island, Quebec, Ontario, Manitoba, Saskatchewan, Alberta and British Columbia. Of these, the policies of Nova Scotia, Quebec, Ontario and Manitoba are closely associated with conscience conflict.

[43] E.g. in Nova Scotia and Ontario, this can occur with 'breakdown of trust and respect between the physician and the patient.'

[44] In two cases considered in 1992, the Supreme Court of Canada discussed the applicability of fiduciary principles to doctor-patient relationships. In the earlier ruling, *McInerney v McDonald*, discussing the confidentiality of patients' health information, the Court unanimously held that the physician-patient relationship can be fiduciary, although not necessarily in all circumstances. A unanimous Court stated: 'In characterizing the physician-patient relationship as "fiduciary", I would not wish it to be thought that a fixed set of rules and principles apply in all circumstances or to all obligations arising out of the doctor-patient relationship . . . A relationship may properly be described as "fiduciary" for some purposes, but not for others.' *McInerney v McDonald*, [1992] S.C.J. No. 57 at para 20. However, the Court did not clarify when it will *not* be fiduciary. Subsequently, in *Norberg v Wynrib*, which addressed physician sexual misconduct with a vulnerable, young patient, all of the justices at least mentioned the potential applicability of fiduciary principles to the case. *Norberg v Wynrib*, [1992] 92 DLR (4th) 449.

[45] The College of Physicians and Surgeons of British Columbia. 2010. Standard: Conflict of Interest. Available at: https://www.cpsbc.ca/files/u6/Conflict-of-Interest.pdf [Accessed 6 Jul 2013]. The College of Physicians and Surgeons on Nova Scotia. 2007. Conflict of Interest Guidelines. Available at: http://cpsns.ns.ca/DesktopModules/Bring2mind/DMX/Download.aspx?Command=Core_Download&EntryId=8&PortalId=0&TabId=180 [Accessed 6 Jul 2013].

[46] College of Pharmacists of British Columbia. Undated. Code of Ethics (Detailed). http://www.bcpharmacists.org/legislation_standards/standards_of_practice/code_of_ethics_detailed).php [Accessed 6 Jul 2013]. Value 1.1.

[47] College of Pharmacists of Alberta. 2010. Code of Ethics. Available at: https://pharmacists.ab.ca/nPharmacistResources/CodeofEthics.aspx [Accessed 6 Jul 2013].

[48] E.g. in Québec's physician Code of Ethics, s.24, a physician whose personal convictions prevent treatment 'must' offer to help find another provider. Yet under s.23, this directive wording is weakened to 'may,' if the same physician refuses examination or treatment, based on listed grounds (including a patient's pregnancy, illness, or morality), whereupon the physician may refer if it is 'in the patient's medical interests'.

to disputes or service withdrawals,[49] which might be interpreted as including collective conscientious withdrawals of some services. Such policies also feature frequently in pharmacy,[50] although not in nursing or dentistry. Typical service withdrawal policies require advance notification, planned alternative and emergency services, staggered practitioner withdrawal, monitoring of alternatives, and penalties for policy violation.[51] In contrast, physician policies applicable to moral conflict do not stipulate any such measures, but leave much of the response to physician discretion. Yet conscience conflicts can damage continuity of care similarly to a strike.

There is also much variability in the ways that the policies of the professions dealt with information provision. Provincial medical,[52] dental[53] and pharmacist[54] policies often require truthfulness, or at least scientific accuracy, and forbid deception or withholding of salient information from patients. However, only some physician policies require disclosing when a conscience conflict influences recommendations,[55] and only some require that information actually be comprehensible to the patient.[56] In contrast, many dental policies require providing a 'fair' or 'accurate' opinion, usually falling within views 'accepted' by the profession.[57] For some reason, few provincial nursing policies state or imply a requirement for truthfulness, information-sharing, or non-deception with patients.[58]

It is common that some costs or penalties are associated with obeying one's conscience. The possibility of unspecified penalties for conscientious objection is mentioned in the Canadian Nurses Association (CNA) code,[59] while Ontario Nursing Association policy also mentions penalties for 'insubordination' and 'abandonment', urging nurses to avoid penalties by performing objectionable care on request, but grieving later for future accommodation.[60] One policy suggests that

[49] E.g. the College of Physicians and Surgeons of British Columbia mandatory Professional Standard. 2012. Withdrawal of Physician Services. Available at: https://www.cpsbc.ca/files/u6/Withdrawal-of-Physician-Services.pdf. [Accessed 6 Jul 2013]. This standard involves a 'dispute which is undertaken by an individual physician or a group of physicians,' in contrast to the Yukon's Directive, which involves 'any withdrawal of services' by physicians. Yukon Medical Council. 2002. Withdrawal of Physician Services Directive. Available at: http://www.yukonmedicalcouncil.ca/pdfs/withdrawal_of_physician_services.pdf. [Accessed 6 Jul 2013].

[50] E.g. the Nova Scotia pharmacist college requires in part: 'Registrants plan for continuity of care to their patients in the event of conscientious objection, contract disputes, labour action, pharmacy relocation or closure, natural disasters or other situations where continuity of care may be interrupted'. Nova Scotia College of Pharmacists. Undated. Code of Ethics. Available at: http://www.nspharmacists.ca/ethics/documents/NSCPCodeofEthics_000.pdf [Accessed 6 Jul 2013].

[51] See for example, the College of Physicians and Surgeons of British Columbia. 2012. Professional Standard: Withdrawal of Physician Services. Available at: https://www.cpsbc.ca/files/u6/Withdrawal-of-Physician-Services.pdf. [Accessed 6 Jul 2013].

[52] Seven provincial physician policies require truthful and or accurate information provision (i.e. New Brunswick, Quebec, Ontario, Manitoba, Saskatchewan, Alberta and British Columbia). E.g. in New Brunswick's 'Moral factors' policy, physicians must not 'withhold information about the existence of as procedure' due to a moral/religious conflict; in Quebec's ethical Code the physician s.29 must ensure the patient 'receives explanations pertinent to his understanding' although only regarding treatments etc. the physician actually *plans to carry out*, but under s.20(4) the physician 'must not withhold information of a confidential nature to the prejudice of a patient'; under Ontario's Human Rights policy #5-08 at 3, physicians must 'provide information about all clinical options that may be available or appropriate . . . [and] 'must not withhold information about the existence of a procedure or treatment because providing that procedure or giving advice about it conflicts with their religious or moral beliefs'; in Alberta's 'Code of Ethics' under 'Accountability,' physicians must 'communicate with integrity' and under 'Respect for others,' physicians are to 'interact with patients . . . with . . . honesty'.

[53] All seven of the available provincial dental policies (Nova Scotia, Quebec, Ontario, Manitoba, Saskatchewan, Alberta, British Columbia) require accurate and/or truthful information.

[54] Eight provincial pharmacy policies (Newfoundland/Labrador, Nova Scotia, New Brunswick, Ontario, Manitoba, Saskatchewan, Alberta, British Columbia) require truthful or accurate information. E.g. in Ontario and Manitoba, 'truthful' information and/ or 'honesty' is required; in Alberta and Saskatchewan), there may be an implied requirement for truthful information. In Alberta, pharmacists must 'consider appropriate information' for each patient, while in Saskatchewan they must 'respect patient's right to receive pharmacy products . . . based on objective and accurate information'.

[55] Seven provincial physician policies (New Brunswick, Quebec, Ontario, Manitoba, Saskatchewan, Alberta and British Columbia).

[56] E.g. in New Brunswick and Saskatchewan, physicians must: '[m]ake every reasonable effort to communicate with . . . patients in such a way that information exchanged is understood.' Similarly, in Nova Scotia, Newfoundland/ Labrador, and British Columbia, pharmacists must provide 'understandable information,' or disclose information 'in an understandable . . . way'.

[57] E.g. under the Manitoba Dental Association. 2002. Code of Ethics By-law No. 6.02: Principle 5: 'Dentists must be truthful and forthright in all professional matters,' and under Art. A6, must provide 'full and accurate comment and opinion concerning their oral health.'

[58] However, at the national level, the CNA Code of Ethics requires honesty, at F3: 'Nurses do not engage in any form of lying . . .' and at G2: 'Nurses are honest and practice integrity in all of their professional interactions. See Canadian Nurses Association. 2008. Code of Ethics for Registered Nurses. Available at: http://www2.cna-aiic.ca/CNA/documents/pdf/publications/Code_of_Ethics_2008_e.pdf. [Accessed 6 Jul 2013]. Several provincial policies do also require truthfulness. E.g. nurses must disclose 'all information that a reasonable person would want to know in decision-making', noting that 'deceiving the patient is coercive'; Canadian Nurses Association. 2004. Everyday Ethics: Putting the Code into Practice. In Ontario, '[t]ruthfulness [means] providing enough information to ensure the client is informed. Omissions are as untruthful as false information.' See College of Nurses of Ontario (CNO). Undated. Practice Guideline – Ethics. Available at: http://www.cno.org/Global/docs/prac/41034_Ethics.pdf: [Accessed 6 Jul 2013]. In Newfoundland, nurses are urged to 'share [medical or ethical knowledge] with clients' and in Alberta, nurses are to 'advocate to . . . promote client rights to . . . access to information.'

[59] The CNA Code of Ethics for Registered Nurses states at 46: '. . . declaring a conflict of conscience may not protect [nurses] against formal or informal penalty.'

[60] The Ontario Nurses Association (ONA). 2006. Position Statement: Objection to Work Assignment for Religious Reasons. Available

an objecting nurse might ultimately need to seek employment elsewhere.[61] For self-employed nurses, objection could result in immediate job loss, if it damaged client trust. Thus objections may generate costs to a nurse. In contrast, in pharmacy, no mention of penalties occurs in conjunction with conscientious objection, but objecting pharmacists often must 'be prepared to explain the basis of their objection'.[62] This requirement may be intended as a minor obstacle, to ensure that an objection is genuine, or for other reasons. Yet the effort required appears minimal. Among other costs, if prearranged care temporarily sends customers to another pharmacy, a loss of revenue will result, a cost exacerbated if the patient seeks all future care from the alternative pharmacy. Thus there may be conscientious objection 'costs' to the pharmacy and to objecting pharmacists. For physicians, penalties such as 'professional misconduct' are mentioned somewhere by most policies[63] applicable to conscientious conflict, but are not always closely associated. As discussed *infra*, the professional misconduct penalty in Ontario's termination policy became a lightning-rod in 2008. The penalty was to be applied if a physician refused to set aside personal values in facilitating referral, but after the Ontario Medical Association (OMA) intervened, the requirement was weakened.[64]

As noted earlier, objecting may impose a financial cost or 'penalty' on practitioners. Since most Canadian physicians are paid on a 'fee-for-service' basis, rather than receiving a fixed salary as Canadian nurses and pharmacists do, physician refusals and permanent relationship termination will exact a financial cost. However, if the prevalence of physician termination policies[65] reflects actual practice, the financial costs of relationship termination do not appear to be a major deterrent.

Finally, variability exists among the few accessible dental policies. Some resemble physician policies in their support for dentist treatment refusal[66] and relationship termination,[67] while others resemble nursing or pharmacy, in requiring referral[68] or in subordinating practitioner objections to patient needs.[69] Permissible grounds for dentist objection appear to be more related to professional clinical ethics – for example, what constitutes 'appropriate' dental treatment or an 'improvement' in oral functioning, under dental community standards – rather than involving personal religious or moral grounds. The impression gained from the policy review is that the dental profession has not yet been faced with conscientious objection as frequently as medicine, nursing, or pharmacy. This may change, altering the policy landscape, given future growth in requests for unusual oral modifications. However, overall, no strong patterns emerged from dental policies, partly since fewer policies were accessible for analysis than for the other professions.

One final locus of variability concerns the rarity of conscience-related policies in Canada's three northern territories, as contrasted with the provinces.[70] This lacuna is unfortunate, due to the greater health vulnerability of those living in these territories. Canada's

at: http://www.ona.org/documents/File/pdf/Religious_objection.pdf. [Accessed 6 Jul 2013]. Also CNO Practice Guideline. 2009. Refusing Assignments and Discontinuing Nursing Services. Available at: http://www.cno.org/Global/docs/prac/41070_refusing.pdf> [Accessed 6 Jul 2013].

[61] College of Nurses of Ontario. Practice Guideline- Ethics. Available at: http://www.cno.org/Global/docs/prac/41034_Ethics.pdf [Accessed 6 Jul 2013].

[62] E.g. College of Pharmacists of British Columbia. 2009. Professional Practice Policy-35 (PPP-35): Pharmacists Refusal to Provide a Product or Service for Moral or Religious Reasons. Available at: http://library.bcpharmacists.org/A-About_Us/A-2_Governance/5003-PGP-PPP.pdf. [Accessed 6 Jul 2013].

[63] In nine provinces: in one province (New Brunswick) in relation to discrimination, inadequate termination notice and failure to inform of moral conflict; in another in a disruptive physician policy (Ontario), in three (Alberta, Manitoba, Newfoundland/Labrador) related to the provincial code violations; in three (Prince Edward Island, Nova Scotia, Ontario) in termination policies and in another three (Prince Edward Island, Nova Scotia, the Yukon) in service withdrawal policies.

[64] Originally, the policy was to impose professional misconduct penalties for physicians' failure to set aside personal views by providing referral; P. Tuns. 2008. Ontario Medical Group Reconsiders Plan to Curb Conscience Rights. *The Interim*, October. Available at: http://www.theinterim.com/2008/oct/02ontmedical.html. [Accessed 6 Jul 2013]. However, complaints led to the weaker, current policy statement: College of Physicians and Surgeons of Ontario. 2008. Policy statement #3-08: Ending the Patient Relationship. Available at: http://www.cpso.on.ca/uploadedFiles/policies/policies/policyitems/ending_rel.pdf [Accessed 6 Jul 2013]. This now allows several responses to a moral conflict, without penalty, instead of strictly requiring referral: 'Discontinuing required services constitutes professional misconduct unless: the patient requests the discontinuation; alternative services are arranged, or the patient is given a reasonable opportunity to arrange alternative services.'

[65] In the physician policies of ten provinces: Newfoundland/Labrador, Nova Scotia, New Brunswick, Prince Edward Island, Quebec, Ontario, Manitoba, Saskatchewan, and British Columbia.

[66] E.g. Quebec dentists must only perform treatment 'necessary' from a dental perspective and can refuse other requests.

[67] E.g. Ontario dentists can terminate for office routine disruption, payment non-compliance or 'demonstrating a lack of confidence' in a dentist's abilities; Royal College of Dental Surgeons of Ontario policy 'Handling the difficult problem of dismissing a patient.'

[68] Overall, six of the seven available dental policies (Nova Scotia, Ontario, Manitoba, Saskatchewan, Alberta, British Columbia) allow relationship termination with referral (for any reason relating to training, experience or competence, thus not specific to conscience but conscience could be included). Another province (Quebec) allows treatment cessation in a conflict of interest seemingly without requiring without referral, although elsewhere in the same policy, the dentist must 'recognize the right' of the patient to consult a colleague or other professional (upon the patient's request).

[69] E.g. Ontario dentists must respect a patient's right to choose based on the patient's values. Patients may receive 'compromised or unconventional treatment' with full dentist disclosure.

[70] As noted elsewhere, there exist aYukon physician service withdrawal policy, and nursing policies for the Yukon, Northwest Territories and Nunavut.

North is sparsely populated, under-funded and understaffed with health practitioners, so conscientious refusal may doom a patient to no safe, timely alternative access, especially when travel is more difficult or dangerous. Our survey found virtually no territorial conscience policies for physicians, nurses, or pharmacists in the Yukon, the Northwest Territories or Nunavut. The dental profession in some northern territories (e.g. the Yukon)[71] is not self-regulated, meaning that territorial legislation[72] – not professional policies – regulates dental conduct. In addition, while some national professional policies, e.g. of the CMA and CNA or NAPRA, may apply by adoption, it is not clear whether the national policies have been expressly adopted in all of these northern territories.[73]

C. Summary

In sum, the policy review uncovered confusion about, and differences among, the conscience-related policies of the various professions and jurisdictions. Potential implications of the confusion and variability include: regional disparities in patients' healthcare options and outcomes; increased care costs, some being borne by patients as they access alternative providers and others borne by Canada's healthcare system; interprofessional friction, particularly as interprofessional collaborative care alters traditional hierarchies and professional roles; and broadly, both patient and provider uncertainty regarding the services to be expected in a conflict. The policy environment with respect to conscientious objection across Canada is, to some extent, one of 'feast or famine': a confusing array of national and provincial policies applying in some regions, with significant policy gaps in others. Multiple, inconsistent, or conflicting policies appear likely to confuse practitioners and produce misunderstandings regarding obligations. A more consistent, comprehensive, and clear approach is needed to define the scope of permissible conscientious objection. Given the more restricted healthcare options and the potential to exacerbate existing northern health vulnerabilities, strong, clear policies controlling objection are needed, precisely where such policies are rare. These 'policy deserts' urgently warrant attention.

[71] Telephone communication between Fiona Charbonneau, Registrar, Yukon Community Services Consumer Services, (governing Yukon physicians, pharmacists and dentists) and the author, 2 August 2012.

[72] The relevant legislation contains no mention of conscience issues.

[73] Nunavut is still not a NAPRA member; the Yukon, Northwest Territories and Nunavut are not CDRAF members. See Canadian Dental Regulatory Authorities Federation. Undated. About CDRAF. Available at: http://www.cdraf.org/english/about/members.html. [Accessed 6 Jul 2013].

PART II – CONTROVERSY

Given the confusing and variable elements present in Canadian policies on conscientious objection, one might reasonably call for policy reform. However, one should enter the reform process with open eyes: given the controversial nature of conscientious objection, reform will not come easily. This, however, is not a reason to avoid it. Rather it is a reason to design a reform process appropriate to a controversial issue and alert to previous attempts to navigate the waters made choppy by the controversy. Therefore, before moving into a discussion of a reform process, we briefly describe some of the recent controversy regarding conscientious objection in relation to both policy-interpretation and policy-making.

A. The CMA Code of Ethics and Policy on Induced Abortion

In 2006, Professors Jocelyn Downie and Sanda Rodgers published an editorial in the *Canadian Medical Association Journal*, discussing whether a physician who objects to abortion on conscientious grounds must nevertheless provide a patient requesting abortion with a referral to an alternative physician or clinic that performs abortions. Downie and Rodgers argued that a physician's failure to provide such a referral would violate the CMA's Policy on Induced Abortion (1988) and also the CMA Code of Ethics (2004). Their position triggered many heated responses. Opponents argued strenuously that neither the CMA Code nor the Policy on Induced Abortion obliges physicians to refer patients for abortion and that these two documents provide a 'right of conscientious objection'[74] to participating in abortion, other than by supplying emergency care. Downie and Rodgers responded. Later, Jeff Blackmer, Executive Director of the CMA Office of Ethics, weighed in, arguing that Downie's and Rodgers' interpretation of the Code and Policy was incorrect. He concluded that, at most, a conscientiously objecting physician must 'indicate alternative sources where [the patient] might obtain a referral,'[75] and then only if the patient has specifically requested referral. Finally, purportedly because of the volume of responses, the *CMAJ* closed the topic to further correspondence.[76] Later, the Co-Chairs of the Parliamentary Pro-Life

[74] J.E. Buckingham. Access to Abortion *CMAJ* 2007; 176(4): 492: 'The 1988 CMA Policy on Induced Abortion specifically allows for such a right of conscientious objection [to abortion participation].'

[75] J. Blackmer. Clarification of the CMA's Position Concerning Induced Abortion. *CMAJ* 2007; 176(9): 1310.

[76] J. Downie. 2009. On Being a Legal Academic in a Politically Charged Context. In Of What Difference? Reflections on the Judgment and Abortion in Canada Today. Toronto, Canada. National Abortion Federation. Available at: http://prochoice.org/pubs_research/publications/downloads/canada/ofwhatdifference.pdf: [Accessed 6 Jul 2013].

Caucus wrote to Downie and Rodgers' respective deans and asked 'that you take the necessary steps to ensure that your Faculty members – who have tremendous power to influence the minds of our future lawyers and doctors – not allow their own personal biases to impair their ability to accurately represent the law.'[77] Something is clearly a controversial topic when it can trigger closure of discussion of a topic of great public policy significance by a professional journal and a blatant attempt by members of the federal Parliament to restrict the academic freedom of two professors.

B. Regulatory body policies

In 2008, Ontario's provincial medical regulatory body (the College of Physicians and Surgeons of Ontario, 'CPSO') created, allegedly without input from medical practitioners,[78] a strongly worded draft policy to restrict physician conscientious objection. Specifically, the CPSO draft policy stated that practitioners should be prepared to 'set aside their personal beliefs' in providing care. It also threatened to apply professional misconduct penalties if physicians conscientiously object to referring patients for certain procedures (e.g. abortion).[79] The CPSO draft policy subsequently received over 1300 mostly negative responses,[80] and the provincial advocacy body (the Ontario Medical Association, OMA) weighed in, criticizing the CPSO draft.[81] This resulted in a weakened final stance on the use of professional misconduct penalties to restrain physician conscientious objection. Where, under the original CPSO draft policy, a misconduct penalty could be imposed for failure to refer for conscience reasons, under the current CPSO policy, the penalty is possible if an objecting physician has both, in terminating a patient relationship, failed to arrange alternative care (i.e. referral) and failed to provide adequate notice to the patient to arrange such care.[82] However, the CPSO held firm in requiring objecting physicians not to withhold relevant information.

Pharmacy has also been the site of controversy. For example, over the past decade, various policies on emergency contraception have been issued by the Manitoba Pharmaceutical Association ('MPhA'), some diametrically opposed to each other. In April 2005, the Canadian Pharmacists Association ('CPhA') issued guidelines[83] recommending that pharmacists collect and store the personal information of women requesting the emergency contraceptive levonorgestral ('Plan B').[84] Shortly thereafter, a strongly worded May 2005 MPhA 'Registrar's Notice'[85] appeared, stating that, when faced with youth seeking 'Plan B', Manitoba pharmacists are legally required to question these patients, warning them of potential notification of police, parents, or child welfare authorities regarding child sexual abuse.

A subsequent February 2006 policy document 'Notice to Pharmacists: Emergency Contraception "Controversy" ' was then issued by the MPhA as a whole,[86] following MPhA collaboration with the Manitoba Ombudsman,[87] and communication with the Manitoba

[77] J. Downie. 2009. On Being a Legal Academic in a Politically Charged Context. In Of What Difference? Reflections on the Judgment and Abortion in Canada Today. Toronto, Canada. National Abortion Federation. Available at: http://prochoice.org/pubs_research/publications/downloads/canada/ofwhatdifference.pdf: [Accessed 6 Jul 2013].

[78] P. Tuns. 2008. Ontario Medical Group Reconsiders Plan to Curb Conscience Rights. *The Interim*, October. Available at: http://www.theinterim.com/2008/oct/02ontmedical.html. [Accessed 6 Jul 2013].

[79] CPSO's draft policy stated: 'Physicians should be aware that decisions to restrict medical services offered, to accept individuals as patients or to end physician-patient relationships that are based on moral or religious belief may contravene the [Ontario human rights] code, and/or constitute professional misconduct;' Margaret Somerville. 2008. Denying Doctors Free Conscience Unconscionable. *Calgary Herald*, 18 September. Available at: http://www.canada.com/calgaryherald/news/story.html?id=3794616b-c515-4a87-84a2-6773c0f2c6cb. [Accessed 6 Jul 2013].

[80] P. Tuns. 2008. Ontario Medical Group Reconsiders Plan to Curb Conscience Rights. *The Interim*, October. Available at: http://www.theinterim.com/2008/oct/02ontmedical.html. [Accessed 6 Jul 2013].

[81] 'It should never be professional misconduct for an Ontarian physician to act in accordance with his or her religious or moral beliefs.' L. Singh. 2008. New-Look Inquisitions Want to Call Doctors in for a Little Chat. *MercatorNet*, 1 October. Although CPSO accepted OMA's input by not requiring referral, it rejected information withholding, CPSO president Preston Zuliani stating: 'Let the patient make their own decision without the doctor having to make a referral, but [s/he is] not to withhold any important information;' T. Baklinski. 2008. Ontario Medical Association Wades into Battle over Doctor's Rights of Conscience. *LifeSiteNews*, 15 September.

[82] 'Discontinuing required services constitutes professional misconduct unless: . . . alternative services are arranged [by the physician], or the patient is given a reasonable opportunity to arrange alternative services;' CPSO. 2008. Ending the Physician-Patient Relationship. Manitoba and Alberta were inspired to amend their policies to follow CPSO's original draft, though with little apparent success.

[83] No CPhA guidelines were accessible to the researchers. The particular CPhA guideline in question was reportedly changed after a controversial article criticizing them was published in the *Canadian Medical Association Journal*, as described *infra*. See J.P. Kassirer et al. Editorial autonomy of *CMAJ*. *CMAJ* 2006; 174(7): 945 at 946.

[84] L. Eggertson & B. Sibbald. Privacy Issues Raised Over Plan B: Women Asked for Names, Address, Sexual History. *CMAJ* 2005; 173(12): 1435 at 1435.

[85] MPhA Registrar's Notice. May 2005. The Duty of Pharmacists to Report Issues in the Course of Counseling and Providing Emergency Contraception Care for Minors. Available at: http://mpha.in1touch.org/uploaded/38/web/documents/CFS.pdf. [Accessed 6 Jul 2013].

[86] MPhA Notice to Pharmacy Managers: Emergency Contraception 'Controversy.' 2 February 2006. Available at: www.napra.ca/Content_Files/. . ./NoticetoPharmacyManagersFeb206.pdf [Accessed 6 Jul 2013] and MPhA Manitoba Commentary for the Provision of Emergency Contraception (Plan B). 2 February 2006. Available at: mpha.in1touch.org/uploaded/38/web/. . ./Ombuscommentary_1_.pdf [Accessed 6 Jul 2013].

[87] The Manitoba Ombudsman's purpose involves primarily 'complaint investigation and resolution of disputes,' but it also systematically

Privacy Commissioner,[88] stating that the pharmacist behaviour urged by the Registrar's Notice was legally impermissible and promising to issue a revised emergency contraceptive policy. Just over a week later, an updated 2006 MPhA emergency contraceptive policy was issued,[89] requiring that objecting pharmacists post signs notifying patients of objections, and requiring referral of patients to non-objecting practitioners.

Nor was this the only controversy linked with these CPhA emergency contraception guidelines. An interrelated issue involved allegations that the CMA (through its publishing arm, CMA Holdings, or 'CMAH') had attempted to suppress a story eventually published (in modified form) in the *Canadian Medical Association Journal ('CMAJ')*, which criticized the effects of these same CPhA guidelines.[90] Several months after the Plan B story was published, the two most senior *CMAJ* editorial staff were fired during another period of controversy over reported modifications to a different *CMAJ* article.[91] Subsequently, an investigative committee concluded that the CMA had, through the attempts to reject the Plan B article, interfered with the editorial independence and threatened the reputation of this highly respected medical journal, leading to the description of *CMAJ*'s editorial autonomy as largely 'illusory'.[92]

Following the 2008 transfer of the emergency contraceptive drug Plan B to Schedule III status (i.e. drugs able to be purchased over the counter from a pharmacy, without a prescription or pharmacist's advice),[93] a set of MPhA draft regulations was created in 2012, urging pharmacists (including those objecting to emergency contraception) to engage patients in a dialogue over the purchase of Schedule II or III drugs, the former being drugs available without a physician prescription, but at the pharmacist's discretion. Via the dialogue, pharmacists would be required to obtain information (including personal information) from the patient, suggest alternatives, or refer the individual to alternative health practitioners. Following such dialogue, the pharmacist would be permitted to refuse to sell a Schedule II or III drug to that patient, including but not limited to Plan B.

This history of policy interpretation and policy-making controversy involving both provincial and national regulatory bodies gives a good indication of the challenges that may lie ahead for any future policy reform attempts related to conscience. Reformers will need to be particularly careful to draft clear policies, leaving no room for interpretive debate. They will also need to carefully ground their policies in law and ethics – explicitly balancing the competing rights, freedoms, and interests at stake. Finally, they will need to be prepared to resist pressure and weather backlash from those who object to the policies – keeping squarely at the front of their minds, their obligation to act in the public interest.

PART III – THE POLICY-MAKING PROCESS

As argued previously, policy reform is necessary (given the confusion and variability) but will be difficult (given the controversial nature of the issue). Unfortunately, at this point, it is premature to argue for a particular substantive result in terms of the policy reform. This is because the reform process should include steps that it is not possible for us to take within the confines of the ivory tower. However, we can (and will) here outline the elements of a process of moving towards policy reform that we believe would be appropriate for this context. When arguing about the deficiencies in the process of legislative reform in relation to a federal private member's bill, Bill C-537, An Act to Amend the *Criminal Code* (Protection of Rights in the Health Care Profession), one of us (JD) has argued elsewhere, that a legitimate legislative reform process combines the approaches of scholars Jennifer Llewellyn and Jennifer Nedelsky and attempts to enlarge decision-maker perspectives through considering contextual and social justice factors and through meaningful participation by, and dialogue with, those groups directly and indirectly benefitted or harmed by a particular decision. Such an approach can, and we would argue should, be taken with respect to the development and reform of conscientious objection policies.

reviews administrative fairness in the 'application of laws, policies, procedures and practices of governing bodies.' See: Manitoba Ombudsman. History and Purpose of the Ombudsman's Office. Available at: http://www.ombudsman.mb.ca/about.htm. [Accessed 6 Jul 2013].

[88] L. Eggertson. Manitoba Pharmacists' Association Clarifies Plan B Regulations. *CMAJ* 2006; 174(8): 1078.

[89] MPhA Practice Guideline 'Emergency Contraception (EC) Care *(Post Coital Contraception)*. 2006. Available at: http://www.napra.org/Content_Files/Files/Manitoba/current%20web%20site/ECPUpdated Guideline2006-b.pdf [Accessed 6 Jul 2013].

[90] An investigative committee requested by the former CMAJ editor-in-chief reported that CMAH had argued the story did not meet its publication standards. The committee noted: 'The interference of CMA/CMAH with the Plan B story was a clear and overt infringement of editorial independence. It is a blatant example of editorial interference – the first time that the current editors have ever been asked to pull a story.' It also concluded: 'Despite claims by the CMA, the CMAJ's editorial independence is largely illusory' and 'In our view, any [future] attempt by the CMA to impose its influence on the editors would be catastrophic for the CMAJ's reputation as well as damaging to the reputation of the CMA.' J.P. Kassirer et al. Editorial Autonomy of CMAJ. *CMAJ* 2006; 174(7): 945, 946, 949.

[91] Ibid: 946.

[92] Ibid: 945–950; the partially suppressed Eggertson and Sibbald article is cited *supra* at note 84.

[93] L. Eggertson. Plan B Comes Out from Behind the Counter. *CMAJ* 2008; 178(13): 1645–1646. See also Canadian Women's Health Network. 2005. Improving Access to Emergency Contraception. Available at: http://www.whp-apsf.ca/pdf/ECbackgrounderEN.pdf [Accessed 6 Jul 2013].

Under Llewellyn's approach, various contextual factors require consideration.[94] For our purposes, first consider the contextual factor of the relative power of the parties. Conscience-related rules commenced with the English Court of Chancery centuries ago.[95] Later, conscientious objection came to greater prominence as civil disobedience against a powerful establishment by less privileged religious minorities (e.g. pacifist Quakers and Mennonites).[96] As in the early Chancery court, where conscience protection implied reciprocal duties,[97] early military objectors paid a price for refusing to perform required military service, being arrested, interrogated, jailed, publicly shamed as 'cowards,' assigned non-conflictual but demanding 'alternative service' in mining, forestry, agriculture or medical care or, in some cases, executed.[98] Today, the power dynamic in healthcare objection is almost completely reversed. Conscientious objectors in health care are among society's most powerful and privileged elite, holding a legal monopoly over health care, and thus are able to hold patients effectively to ransom in relation to accessing healthcare procedures. Under self-regulation, any negative repercussions of objection now mainly redound to patients, rather than to objecting practitioners, for whom penalties may rarely be pursued. There is also nothing resembling early requirements for alternative service provision, although such requirements seem warranted, given the added burdens that may be imposed upon non-objector providers within the system, increasing patient loads and potentially case complexity through delay. To account for such contextual factors, any future policy-making dialogue cannot simply be a conversation among objector and non-objector healthcare providers, but must include those at risk of conscientious refusals, i.e. patients and the Canadian public more broadly.

Another contextual factor requiring consideration is the fact that reciprocal social obligations are incurred by physicians, by virtue of their government-granted monopoly over provision of a wide range of healthcare services,[99] freedom to self-regulate, clinical independence, and also heavy tax-payer subsidization of medical education for those physicians who are trained in Canada.[100] The privileges medicine enjoys appear not dissimilar to those enjoyed by Canada's legal profession. That is, their professional autonomy, independence, and monopoly appear to flow not from 'private practice freely playing in the competitive marketplace; on the contrary, [they result from] a state created and facilitated privilege and advantage . . . [which these professionals] have proactively encouraged'[101] against other occupations' encroachment. Within this monopoly, when some physicians conscientiously refuse to perform certain procedures, additional costs and burdens are placed on co-workers and the healthcare system overall, requiring other healthcare professionals to provide care beyond their normal patient loads and creating cost-inflating treatment delays. Even in the absence of a formal social contract, when practitioner autonomy to conscientiously object systematically erodes patient access to care, the ancient, equitable concepts of 'unjust enrichment' and *quantum meruit*[102] may apply. Where social obligations to the public are not met,

[94] J.J. Llewellyn. 2012. Restorative Justice: Thinking Relationally about Justice. In *Being Relational: Reflections on Relational Theory and Health Law*. J. Downie and J.J. Llewellyn, eds. Vancouver, BC: UBC Press: 89–108.

[95] B. Dickens. Unethical Protection of Conscience: Defending the Powerful Against the Weak. *Am Med Assoc J Ethics* 2009; 11.

[96] Ibid.

[97] Ibid.

[98] Canadian War Museum. Undated. Conscientious Objectors. Available at: http://www.warmuseum.ca/cwm/exhibitions/guerre/objectors-e.aspx. [Accessed 6 Jul 2013].

[99] Various authors discuss physicians' social obligation to provide access to medical care as a reciprocal obligation that flows from the government grant of privileges to the medical profession: '. . . society has granted medicine autonomy in practice, a monopoly over the use of its knowledge base, the privilege of self-regulation . . . in return, physicians are expected to put the patient's interest above their own, assure competence through self-regulation, demonstrate morality and integrity, address issues of societal concern and be devoted to the public good'; R.L. Cruess & S.R. Cruess. Expectations and Obligations: Professionalism and Medicine's Contract with Society. *Perspectives in Biology and Medicine* 2008; 51(4). Other professions in Canada, such as lawyers, owe similar obligations to the public to provide access to legal services, which is rationalized based on similar government granting of the same professional privileges: a monopoly over legal services, autonomy and self-regulatory independence. Based on Locke's social contract theory, Richard Devlin argues of lawyers: 'in exchange for their monopoly, autonomy and independence there is a corresponding obligation on the legal profession to ensure there is equal access to law for all . . .' He notes too that, like most Canadian physicians, the majority of Canadian lawyers have received public investment, subsidizing their training, which further supports their obligation to provide public access to the services within their a monopoly. R. Devlin. 2002. Breach of Contract? The New Economy, Access to Justice and the Ethical Responsibilities of the Legal Profession. *Dal. L.J.*; 25: 335, cited in *Lawyers' Ethics and Professional Regulation*, 2nd edn. A. Woolley, R. Devlin, B. Cotter, and J.M. Law, eds. Canada: Lexinexis 642–643.

[100] Physicians trained outside Canada will not have received the same educational subsidization by Canadian tax-payers. However, foreign-trained physicians appear to be a declining minority in Canada: as of 2009, Canadian Institute for Health Information figures showed that foreign-trained physicians comprised fewer than one quarter of Canada's practising physicians, showing an 11% decrease during the past four decades. See: Canada Relying Less on Foreign-Trained Doctors. 2009. *Canada Immigration News*, August.

[101] Devlin, *op. cit.* note 99.

[102] *Quantum meruit* means 'as much as he has deserved, the reasonable value of serices, damages awarded in an amount considered reasonable to compensate a person who has rendered services in a quasi-contractual relationship. *Quantum meruit* is still used today as an equitable remedy to provide restitution for unjust enrichment. It is often pleaded as an alternative claim in a breach of contract case, so the plaintiff can recover *even if the contract is unenforceable*' (emphasis added). Bryan A. Garner, ed. 2009. *Black's Law Dictionary*. 9th edn. St Paul: West Group: 1361–1362.

state-created privileges physicians presently enjoy could presumably be withdrawn, or partially granted to other professions.[103] It is with this context in mind that conscientious objection should be considered.

Further applying Llewellyn's scholarship regarding legitimate process, social justice factors must also be considered in future conscientious objection policy-making processes. In particular, the tendency of conscientious objection to disproportionately affect women – and to have especially negative effects on young, poor, marginalized or otherwise vulnerable women,[104] who may lack the resources or education to bypass practitioner conscientious refusals of information or care – urgently warrant consideration. While conscientious objection issues are not strictly limited to female reproductive health issues (e.g. access to *in vitro* fertilization, abortion, sterilization, contraception or emergency contraception), issues surrounding the control of female fertility form a dominant thread, particularly in the most heated and intractable discussions of practitioner conscientious objection.

This greater impact on women should be fully considered, requiring that future policy-making processes involve attendance and meaningful opportunity for comment by a representative range of women of different ages, race or ethnicity, educational, religious, and class backgrounds, and by NGOs concerned with women's health, welfare, and equality. In addition to considering the parties most directly harmed by an activity, Llewellyn suggests we also factor in less direct 'ripple effects' extending from an activity, such as health policy-making, into the broader community. Taking this perspective, not only must women be heard, but potentially also their children and others, e.g. resource groups dealing with single parenthood, poverty, legal aid, or mental health, which may also experience a downstream impact from practitioner decisions to withhold information, services, or referrals.

On Jennifer Nedelsky's view on legitimate process,[105] decision-makers must meaningfully factor in others' perspectives, thereby 'enlarging their perspective' beyond their own subjective intuitions. In this process, responding to others' views and objections – especially to rejected views – is important. Here it is important to keep in mind that there is not one conscientious perspective that should inform the dialogue, but several. Some practitioners may feel their consciences will be harmed by requirements to provide information or refer. Yet other practitioners feel equally conscientiously motivated to provide services such as abortion,[106] by which patients can express their autonomy and achieve optimal health. The latter practitioners may equally feel harmed by having to compensate for colleagues' conscience-related service delays or obstruction, potentially creating unmanageable patient caseloads and/or rendering care more difficult, risky, or costly. Moreover, as noted by the lone female Supreme Court of Canada Justice in its leading case on abortion, *R. v Morgentaler*,[107] women patients may have equally fervent, well-considered, conscience-based reasons for requesting particular procedures. For instance, a woman may desire not to bring a child into the world if fathered by a rapist, or by an unfit, abusive partner, who may then in practice be linked to the mother and child in perpetuity, through child support payments, custody-seeking, and visitation rights.[108] The patient requesting a procedure, such as termination, is likely to be better placed than a professional with little direct involvement in the patient's daily life to know what physical, psychological, socio-economic, spiritual, or other harms may result – to her, her family and community – from a conscientious refusal. Therefore, women's voices must also, according to Nedelsky's relational account of policy-making, be a significant part of the policy-making conversation.

Ultimately, what is required for conscientious objection policy reform is a meaningful dialogical process. To be meaningful, the process must engage all affected

[103] E.g. in South Africa, Dickens notes the expansion of midwives' scope of practice to include abortion provision, effectively encroaching on what had previously been a physician monopoly over the provision of medical services.

[104] This disproportionate female impact derives from the frequent association of practitioner conscientious objection with female fertility-control procedures, such as abortion, sterilization, contraception or emergency contraception. More vulnerable women, having fewer resources at their disposal, may be more severely affected. See: M. Campbell. Conscientious Objection and the Council of Europe. *Med Law Rev* 2011; 11: 284–287.

[105] J. Nedelsky. The Reciprocal Relation of Judgement and Autonomy: Walking in Another's Shoes. In *Being Relational: Reflections on Relational Theory and Health Law*. J. Downie and J.J. Llewellyn, eds. Vancouver, BC: UBC Press: 35–62.

[106] L.H. Harris. Recognizing Conscience in Abortion Provision. *NEJM* 2012; 367(11).

[107] In *Morgentaler*, Justice Bertha Wilson stated: '. . . I believe that the decision whether or not to terminate a pregnancy is essentially a moral decision, a matter of conscience . . . The question is: *whose conscience*? Is *the conscience of the woman* to be paramount or the conscience of the state? I believe . . . that in a free and democratic society it must be the conscience of the individual [i.e. the pregnant woman];' and: 'Accordingly, for the state to take sides on the issue of abortion, as it does in the impugned legislation by making it a criminal offence for the pregnant woman to exercise one of her options, is not only to endorse but also *to enforce . . . one conscientiously-held view at the expense of another*. It is *to deny freedom of conscience to some*, to treat them as means to an end, to deprive them . . . of their 'essential humanity.' *R. v Morgentaler*, [1988] S.C.J. No. 1 para 249, 253 [Accessed 6 Jul 2013]. (Emphasis added).

[108] In the US, 32,000 children are conceived and 10,000 born through rape each year. Rapists can demand parental visitation rights, thereby requiring women to face them again in court. Canadian Broadcasting Corporation. 2012. Child Custody for Rapists. *The Current*, 5 December. Available at: http://www.cbc.ca/thecurrent/episode/. [Accessed 6 Jul 2013].

parties, not just the objecting healthcare providers and/or their regulators. It must include objector and non-objector providers, a representative range of women and organizations representing women's interests, and organizations dealing with downstream effects of conscientious refusals to provide information or services. To be meaningful, it must include consideration of the relative power of the parties, the reciprocal social obligations of physicians incurred by virtue of their monopoly, self-regulation, clinical independence, and subsidization of education as well as the disproportionate impact of conscientious refusals to provide information and services on women (especially vulnerable women).

CONCLUSION

To create a functional healthcare system respecting the needs and values of both practitioners and patients, Canada is overdue for a discussion of conscientious objection policy. The current level of confusion and variability across professions and jurisdictions requires remediation, but the current level of controversy suggests that a remedy will not come easily. A properly inclusive process will result in legitimate policy reform. Such a process will require dialogue among those affected, factoring in social context, social justice, and ripple effects of individual actions across the wider community. Policymakers must meaningfully engage with various groups, to expand the range of influential perspectives beyond their own personal, subjective intuitions and beyond those groups historically at the table, thus considering context and social justice factors relevant to those both directly and indirectly affected. We recognize that such a process will not be easy to implement. However, change is clearly needed. Our hope is that the change will be brought about through a legitimate process such that the controversy of the past can be replaced with constructive dialogue that results in a clear and consistent policy landscape that finds the best balance as between the multitude of competing claims with respect to conscience and health service needs.

Acknowledgements

We gratefully acknowledge the support of Canadian Institutes for Health Research (CIHR) Grant # MOP-102516 in conducting this research. We also thank Professor Carolyn McLeod, University of Western Ontario, Canada, and members of Dalhousie University's Novel Tech Ethics for helpful comments and suggestions during manuscript preparation.

Jacquelyn Shaw is a Research Associate at Novel Tech Ethics. She holds a Master of Laws from Dalhousie University, Halifax, Nova Scotia, and a Master of Science from the University of Toronto, Toronto, Ontario, Canada.

Jocelyn Downie is a Professor in the Faculties of Law and Medicine at Dalhousie University. She is a Fellow of the Royal Society of Canada and the Canadian Academy of Health Sciences.