Canadian Journal of Bioethics
Revue canadienne de bioéthique

Canadian Journal of Bioethics
Revue Canadienne de Bioéthique

Institutional Conscientious Objection to Medical Assistance in Dying in Canada: A Critical Analysis of the Personnel-Based Arguments

Nicholas J. Abernethy

Volume 6, Number 2, 2023

URI: https://id.erudit.org/iderudit/1101127ar
DOI: https://doi.org/10.7202/1101127ar

See table of contents

Publisher(s)

Programmes de bioéthique, École de santé publique de l'Université de Montréal

ISSN

2561-4665 (digital)

Explore this journal

Cite this article

Abernethy, N. J. (2023). Institutional Conscientious Objection to Medical Assistance in Dying in Canada: A Critical Analysis of the Personnel-Based Arguments. *Canadian Journal of Bioethics / Revue canadienne de bioéthique*, *6*(2), 43–52. https://doi.org/10.7202/1101127ar

Article abstract

Debate rages over whether Canadian provincial and territorial governments should allow healthcare institutions to conscientiously object to providing medical assistance in dying (MAiD). This issue is likely to end up in court soon through challenges from patients, clinicians, or advocacy groups such as Dying With Dignity Canada. When it does, one key question for the courts will be whether allowing institutional conscientious objection (ICO) to MAiD respects (i.e., shows due regard for) the consciences of the objecting healthcare institutions, understood as unitary entities. This question has been thoroughly explored elsewhere in the academic literature. However, another key question has been underexplored. Specifically, precedent set by the Supreme Court of Canada's decision in *Loyola High School v. Quebec (Attorney General)* suggests that the courts will consider whether allowing ICO to MAiD respects the consciences of the *personnel* within objecting healthcare institutions. My answer to this question is no, by which I mean that allowing ICO to MAiD shows undue disregard for some consciences and undue regard for others. To justify this answer, I analyze the arguments that hold that allowing ICO in healthcare respects the consciences of the personnel within objecting healthcare institutions. My conclusion is that none of these personnel-based arguments succeed in the case of ICO to MAiD. Some fail because they are wrong about the nature of conscience and complicity. Others fail because they contradict the arguments' proponents' positions on conscientious objection by individual healthcare providers. Still others fail because they are internally inconsistent.

Canadian Journal of Bioethics
Revue Canadienne de Bioéthique

NJ Abernethy. *Can J Bioeth / Rev Can Bioeth.* 2023;6(2):43-52

ARTICLE (ÉVALUÉ PAR LES PAIRS / PEER-REVIEWED)

Institutional Conscientious Objection to Medical Assistance in Dying in Canada: A Critical Analysis of the Personnel-Based Arguments

Nicholas J. Abernethy[a]

Résumé

Le débat fait rage sur la question de savoir si les gouvernements provinciaux et territoriaux du Canada doivent autoriser les établissements de santé à s'opposer en conscience à la fourniture d'une aide médicale à mourir (AMM). Il est probable que cette question se retrouvera bientôt devant les tribunaux à la suite de contestations de la part de patients, de cliniciens ou de groupes de défense des droits tels que Mourir dans la dignité Canada. Dans ce cas, l'une des questions clés pour les tribunaux sera de savoir si le fait d'autoriser l'objection de conscience institutionnelle (OCI) à l'AMM respecte (c'est-à-dire prend dûment en compte) les consciences des établissements de santé qui s'y opposent, considérés comme des entités unitaires. Toutefois, cette question a été étudiée en profondeur dans d'autres publications scientifiques. Une autre question clé n'a pas été suffisamment explorée. En particulier, le précédent établi par la décision de la Cour suprême du Canada dans l'affaire *Loyola High School c. Québec (Procureur général)* suggère que les tribunaux examineront si le fait d'autoriser l'OCI à l'AMM respecte les consciences du *personnel* des établissements de santé qui s'y opposent. Ma réponse à cette question est non, c'est-à-dire que le fait de permettre l'OCI à l'AMM témoigne d'un mépris excessif pour certaines consciences et d'une considération excessive pour d'autres. Pour justifier cette réponse, j'analyse les arguments qui soutiennent que l'autorisation d'OCI dans les soins de santé respecte les consciences du personnel des établissements de santé qui s'y opposent. Ma conclusion est qu'aucun de ces arguments fondés sur le personnel n'aboutit dans le cas de l'OCI à l'AMM au Canada. Certains échouent parce qu'ils se trompent sur la nature de la conscience et de la complicité. D'autres échouent parce qu'ils contredisent les positions des partisans des arguments sur l'objection de conscience des prestataires de soins de santé individuels. D'autres encore échouent parce qu'elles sont incohérentes sur le plan interne.

Mots-clés

objection de conscience institutionnelle, aide médicale à mourir, soins de santé financés par des fonds publics, liberté de conscience, personnel de santé

Abstract

Debate rages over whether Canadian provincial and territorial governments should allow healthcare institutions to conscientiously object to providing medical assistance in dying (MAiD). This issue is likely to end up in court soon through challenges from patients, clinicians, or advocacy groups such as Dying With Dignity Canada. When it does, one key question for the courts will be whether allowing institutional conscientious objection (ICO) to MAiD respects (i.e., shows due regard for) the consciences of the objecting healthcare institutions, understood as unitary entities. This question has been thoroughly explored elsewhere in the academic literature. However, another key question has been underexplored. Specifically, precedent set by the Supreme Court of Canada's decision in *Loyola High School v. Quebec (Attorney General)* suggests that the courts will consider whether allowing ICO to MAiD respects the consciences of the *personnel* within objecting healthcare institutions. My answer to this question is no, by which I mean that allowing ICO to MAiD shows undue disregard for some consciences and undue regard for others. To justify this answer, I analyze the arguments that hold that allowing ICO in healthcare respects the consciences of the personnel within objecting healthcare institutions. My conclusion is that none of these personnel-based arguments succeed in the case of ICO to MAiD. Some fail because they are wrong about the nature of conscience and complicity. Others fail because they contradict the arguments' proponents' positions on conscientious objection by individual healthcare providers. Still others fail because they are internally inconsistent.

Keywords

institutional conscientious objection, medical assistance in dying, publicly funded healthcare, freedom of conscience, healthcare personnel

Affiliations

[a] Department of Philosophy, Queen's University, Kingston, Ontario, Canada

Correspondance / Correspondence: Nicholas J. Abernethy, 19nja3@queensu.ca

INTRODUCTION

Since the 2016 legalization of medical assistance in dying (MAiD) in Canada, many publicly funded[1] healthcare institutions have been conscientiously objecting (i.e., conscientiously refusing)[2] to provide MAiD. For example, between June 2016 and the end of 2019, in Alberta alone 125 patients were transferred out of conscientiously objecting healthcare institutions in order to get MAiD (1). However, some provincial governments – namely, Nova Scotia (2) and Prince Edward Island (3) – prevent

[1] In this paper, I focus on *publicly funded* healthcare institutions (by which I mean healthcare institutions that receive any amount of government funding, in any form) because I agree with commentators like Wayne Sumner who argue that public funding is what gives governments the pro tanto right to tell healthcare institutions which services to provide (1). In short, the case for allowing ICO by fully privately funded healthcare institutions is too prima facie strong to spend much time on. Besides, such institutions are vanishingly rare in Canada (1).

[2] Throughout this paper, whenever I say "conscientious objection" (by institutions or people), I mean "conscientious refusal." I use the former phrase because it is more popular than the latter in the academic literature, although I acknowledge that the latter is more accurate.

ISSN 2561-4665

publicly funded healthcare institutions from conscientiously objecting to MAiD, and Quebec does the same but excludes palliative care hospices for the time being (4). There is an ongoing debate about this issue, i.e., whether governments should allow institutional conscientious objection (ICO) in healthcare. This debate's two main themes are 1) patient access to healthcare services and 2) the consciences *of* objecting healthcare institutions, understood as unitary entities. Regarding the first theme, supporters argue that preventing ICO indirectly decreases patient access to healthcare services in general by causing objecting healthcare institutions to close (5-7). By contrast, opponents argue that allowing ICO to a healthcare service directly decreases patient access to the healthcare service (1,8-14). Regarding the second theme, supporters of ICO argue that healthcare institutions are agents that have consciences and thus deserve to be allowed to engage in conscientious objection (15-18). By contrast, opponents of ICO argue that healthcare institutions lack consciences (19-26). I do not discuss these issues in this paper because they have been thoroughly explored in the academic literature.

Instead, I discuss an underexplored third theme: the individual consciences of the individual personnel within objecting healthcare institutions. Specifically, I seek to answer the following question: does allowing ICO to MAiD respect (i.e., show due regard for) the consciences of the personnel within objecting healthcare institutions? Unfortunately, there is no authoritative definition of what constitutes a healthcare institution's "personnel." Indeed, not all commentators even use this term. However, most who do use this term focus on leaders (e.g., administrators, trustees, and directors) and individual healthcare providers (e.g., physicians, pharmacists, and nurses), so I follow suit and thus do not discuss non-medical staff (e.g., hospital janitors). In particular, for reasons that will become apparent later, I focus on three types of personnel within anti-MAiD healthcare institutions: 1) anti-MAiD leaders who want their institution to conscientiously object to MAiD, 2) pro-MAiD[3] individual healthcare providers who want to provide MAiD to eligible requesters but who would be prevented from doing so if their institution conscientiously objects to MAiD, and 3) anti-MAiD individual healthcare providers who want their institution to conscientiously object to MAiD. One might object that small morally cohesive anti-MAiD healthcare institutions (e.g., a private practice group consisting of several anti-MAiD doctors) have no type 2 personnel. However, like some other commentators (27), I exclude these institutions from this paper's scope, for two reasons. First, these institutions are a minor part of the contemporary Canadian healthcare system, which is characterized by morally non-cohesive institutions like hospitals (25). Second, Elizabeth Sepper has already sufficiently analyzed when to allow conscientious objection by morally cohesive institutions (25).

The relationship between ICO and personnel's consciences has been underexplored both in general and especially in the context of MAiD in Canada. For example, the only journal article that specifically analyzes whether to allow ICO to MAiD in Canada devotes just one paragraph to this topic, and the author considers only the main anti-ICO personnel-based argument, ignoring the many pro-ICO personnel-based arguments (27). This matter merits much more attention for two reasons. First, personnel's consciences are morally important; our society values conscience (particularly in healthcare), so these consciences should be front and centre in our discussion about ICO to MAiD. Second, in addition to moral importance, personnel's consciences will likely soon be *legally* important. As I show in the next section, this is because the relationship between ICO to MAiD and the consciences of the personnel within objecting healthcare institutions is likely to be central to how the Canadian courts determine the constitutionality of allowing ICO to MAiD. However, before moving on to this discussion, I offer the following outline that summarizes the themes of this paper, so far:

Figure 1: Visual representation of this paper's relationship with ICO discourse

- ICO discourse's themes:
  - Patient access *(setting aside because sufficiently analyzed elsewhere)*
  - Institutions' consciences *(setting aside because sufficiently analyzed elsewhere)*
  - Personnel's consciences
    - Types of objecting institutions:
      - Morally cohesive *(setting aside because rare and sufficiently analyzed elsewhere)*
      - Morally incohesive
        - Types of personnel:
          - Anti-MAiD leaders
          - Pro-MAiD individual healthcare providers
          - Anti-MAiD individual healthcare providers
    - Importance:
      - Moral
      - Legal *(below)*

THE IMPORTANCE OF THE RELATIONSHIP BETWEEN ICO TO MAID AND PERSONNEL'S CONSCIENCES IN THE CANADIAN LEGAL CONTEXT

To begin with, ICO to MAiD is likely soon to be judicially scrutinized. The debate could end up in court in many ways, such as 1) a private interest standing case against a forced transfer, 2) an appeal board challenge to a denial of privileges for a MAiD provider, and 3) a public interest standing case (e.g., *Carter v. Canada*) against forced transfers. However, the most likely situation will be anti-ICO advocates convincing governments to require healthcare institutions (via legislation, directives, etc.)

[3] Throughout this paper, whenever I say "pro-MAiD," I mean supporting providing MAiD to eligible requesters. Furthermore, all hypothetical cases that I discuss are assumed to involve eligible requesters.

to provide MAiD. This way has a proven track record. For example, both public and private pressure (including media attention and the threat of a legal challenge) convinced the Nova Scotia Health Authority to disallow St. Martha's Hospital from conscientiously objecting to MAiD (28). Recently, this advocacy has been proliferating. For example, Dying With Dignity Canada is encouraging the public to tell the British Columbian government to require all publicly funded healthcare institutions to provide MAiD (29). If such efforts are successful, some objecting healthcare institutions would likely legally challenge the government's anti-ICO actions. This can be extrapolated from how the Delta Hospice Society (a formerly publicly-funded British Columbian palliative care organization) fought all the way to the Supreme Court of Canada in a failed attempt to avoid being required to provide MAiD (30). However, to be clear, this court case was ultimately about the Delta Hospice Society's membership bylaws, not about ICO per se (31).

If ICO to MAiD does end up in court through a challenge to a requirement to provide MAiD, objecting healthcare institutions would probably base their main legal arguments on section 2(a) of the *Canadian Charter of Rights and Freedoms*, which entitles everyone to "freedom of conscience and religion" (32). This can be inferred from how supporters of conscientious objection by religious physicians based their main legal arguments on section 2(a)[4] in the leading Canadian court case about conscientious objection by individual healthcare providers: *Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario* (33). For context, this case was about whether the College of Physicians and Surgeons of Ontario breached the *Charter* when it required objecting physicians to provide effective referrals (33).

What would section 2(a)-based arguments for allowing ICO to MAiD look like? There are two main arguments that an objecting healthcare institution could make. First, it could argue that it itself is entitled to protection under section 2(a). In other words, an objecting healthcare institution could argue that it – as a unitary entity – deserves freedom of conscience and/or religion. Second, the institution could argue that allowing ICO to MAiD respects the freedom of conscience and/or religion of its personnel. While an objecting healthcare institution would probably make both arguments, the courts would likely look first to the second. To see why, we must turn to the leading Canadian court case about the communal aspect of religious freedom: *Loyola High School v. Quebec (Attorney General)*.

In this case, the majority of a seven-judge panel of the Supreme Court of Canada concluded that the Quebec Minister of Education, Recreation and Sport was wrong to require that Loyola High School – a Catholic institution – teach about Catholicism from a neutral perspective (34). Of note, the key finding for the majority was that the Minister's requirement unnecessarily limited the religious freedom of Loyola's *personnel*. Unlike the three judges who concurred partially in the result, the four-judge majority explicitly avoided the question of whether Loyola – as a unitary entity – has section 2(a) rights. Furthermore, even the three judges who argued that Loyola *does* have section 2(a) rights reasoned that it has these rights by virtue of how protecting its section 2(a) rights protects the rights of its personnel (34). In short, all seven judges agreed that the personnel's section 2(a) rights underlie why Loyola should be allowed to teach about Catholicism from a Catholic perspective. Therefore, it is legally important to consider whether allowing ICO to MAiD respects the freedom of conscience and/or religion of the personnel within objecting healthcare institutions.

Given this importance, one may ask why this paper focuses on conscience rather than religion. There are two reasons. The first is that, unsurprisingly, commentators on institutional *conscientious* objection tend to focus on conscience, so, given that this paper analyzes existing arguments, I follow suit. The second reason is that conscience-related analysis applies to both secular and religious healthcare institutions, not only religious ones. While most objecting healthcare institutions are religious, some are secular. For example, secular healthcare institutions were responsible for 16 of the previously mentioned 125 ICO-to-MAiD-induced transfers in Alberta (1). These institutions would have no choice but to appeal to freedom of conscience, so analyzing ICO only in terms of religious freedom would exclude these institutions.

METHODOLOGY

Having explained *why* this paper seeks to answer whether allowing ICO to MAiD respects the consciences of the personnel within objecting healthcare institutions, I will now describe *how* this paper will do so. To begin with, I present the arguments that allowing ICO in healthcare *in general* (i.e., not only for MAiD) respects the consciences of the personnel within objecting healthcare institutions. I consider general ICO arguments rather than those specific to MAiD because few if any commentators frame their arguments as exclusive to MAiD. Next, I sort the pro-ICO personnel-based arguments into three groups, as defined below. Groups 1 and 2 hold that allowing ICO respects the consciences of 1) leaders who want to engage in ICO and 2) personnel who want ICO to be engaged in, respectively. Group 3 holds that allowing ICO respects personnel's consciences because institutional conscience is a manifestation of personal conscience. Group 1 and Group 3 are less popular than Group 2 (and thus less fleshed out in the academic literature), but I nonetheless consider them because I want to consider *all* relevant pro-ICO arguments. Drawing on the anti-ICO personnel-based arguments, I then show that none of these groups succeed in justifying the case for ICO to MAiD. Ultimately, I conclude that allowing ICO to MAiD does not respect the consciences of the personnel within objecting healthcare institutions. That is, allowing ICO to MAiD shows undue disregard for the consciences of pro-MAiD individual healthcare providers and undue regard for the consciences of anti-MAiD leaders and anti-MAiD individual healthcare providers. Therefore, the ICO discourse related to personnel does not justify allowing ICO to MAiD.

[4] The appellants also argued that the effective referral requirement infringed physicians' section 15(1) equality rights, but the courts dismissed this argument (33).

DISCUSSION

Group 1: Allowing ICO Respects the Consciences of Leaders Who Want to Engage in ICO

The first group of pro-ICO personnel-based arguments, which I call Group 1, holds that allowing ICO respects the consciences of the anti-MAiD leaders of objecting healthcare institutions. In the academic literature, two main arguments fit into this group. The first is from Nikolas T. Nikas, who supports allowing ICO by arguing that "[a]ny health-care institution… should also be protected from coercion and discrimination. As institutions, they reflect the conscience of their guiding boards…" (35, p.46). In other words, prohibiting ICO prevents boards from exercising their consciences by prohibiting the provision of particular services.[5] The second argument is made by William L. Allen and David B. Brushwood, who support allowing ICO (albeit in the case of privately owned pharmacies) by arguing that the employer's conscience takes priority over the employee's conscience (36).

Drawing on a committee opinion by the American College of Obstetricians and Gynecologists (ACOG) (37), my response to the Group 1 arguments is that a leader cannot conscientiously object to a subordinate providing a service. Someone's freedom of conscience concerns what they do, not what others do, as the ACOG clearly explains: "the logic of conscience, as a form of self-reflection on and judgment about whether one's own acts are obligatory or prohibited, means that it would be odd or absurd to say "I would have a guilty conscience if she did 'x.'"" (37, p.1204) In other words, one can conscientiously object to doing something, but one cannot *conscientiously* object to someone else doing something.

Repurposing Christopher Kaczor's argument that the leaders of healthcare institutions are complicit in facilitating the actions of their subordinates (38), I believe that Nikas, Allen, and Brushwood would probably respond to the above counterargument by rejecting its assumption that objecting leaders want to conscientiously object to their subordinates providing particular services. Specifically, the Group 1 proponents would probably argue that objecting leaders actually want to conscientiously object to *doing things that make them complicit in* their subordinates providing particular services. For example, one might argue that preventing ICO forces leaders to enable the provision of particular services by giving their subordinates functional support (e.g., the use of medical supplies and staff).

Although the above response might be applicable in cases like ICO to surgical abortion, it is not applicable in the case of MAiD. To show why, I turn to a Group 2 proponent and the main supporter of ICO to MAiD in Canada: Sean T. Murphy. He describes how – unlike for services such as surgical abortion – "it is possible for non-institutional practitioners to provide euthanasia or assisted suicide to patients in a facility without requiring facility resources or the assistance or direct participation of facility staff" (39, p.1). I would extend this observation by noting that it is also possible for *institutional* practitioners to provide MAiD in a facility without requiring facility resources or the assistance or direct participation of other facility staff. Thus, with or without ICO, leaders can avoid *directly* enabling the provision of MAiD. To be fair, without ICO, leaders cannot avoid *indirectly* enabling the provision of MAiD – e.g., by giving physicians privileges and hiring nurse practitioners – but I contend that this enablement is too indirect to engender meaningful complicity (i.e., enough involvement to entitle leaders to conscientiously object to doing these actions). This line between meaningful and non-meaningful complicity must be drawn because most actions are *somewhat* interconnected, so most people are *somewhat* complicit in most actions, but people are not entitled to conscientiously object to doing most actions. For example, an anti-MAiD miner is not entitled to conscientiously object to mining metals that they know will end up in a needle that will be used to provide MAiD because the enablement is too indirect.[6] Some may disagree with me here and argue that actions like giving physicians privileges and hiring nurse practitioners are in fact direct enough to engender meaningful complicity. However, even if this were true, it would not justify allowing ICO to MAiD. To show why, I offer the following argument.

If the actions were direct enough, this would entail that leaders have a pro tanto conscientious right to decide whether their subordinates provide MAiD, but this right would have to be weighed against their subordinates' pro tanto conscientious right to decide whether to provide MAiD. The Group 1 proponents give no reasons to favour leaders' consciences, and there are three reasons to favour subordinates' consciences. The first is that, as Eva and Hugh LaFollette argue, consciences that are disrespectful of other consciences deserve less protection, all else being equal (40). As Daniel P. Sulmasy explains, "[t]o have a conscience is to commit oneself, no matter what one's self-identifying moral commitments, to respect for the conscience of others" (16, p.145). So, the leaders' consciences deserve less protection if they are disrespectful of their subordinates' consciences by preventing them from being able to decide whether to provide MAiD. The second reason is that, as Spencer L. Durland implicitly argues, consciences that are more directly involved in a decision deserve more protection regarding the decision, all else being equal (24). As Elizabeth Sepper explains, moral-integrity-related interests tend to scale to the directness of involvement (21), and this matters because protecting moral integrity is the main reason to respect conscience (41). So, the leaders' consciences deserve less protection regarding whether the subordinates provide MAiD because the leaders are less directly involved in the decision (21). The third reason is that there are more subordinates than leaders at most (if not all) healthcare institutions, so taking the choice away from the many and giving it to the few is disrespectful of personnel's consciences, in aggregate. In conclusion, the Group 1 arguments fail to justify allowing ICO to MAiD.

[5] In fairness to Nikas, I cut his quotation off early; he adds "or faith traditions" (35, p.46). However, I do not discuss the consciences of faith traditions because these are not personnel within healthcare institutions, so their consciences – if traditions can be said to have them – are beyond the scope of this paper.
[6] For more on this topic, see Murphy's discussion of morally significant causal contribution to wrongdoing (39).

Group 2: Allowing ICO Respects the Consciences of Personnel Who Want ICO to be Engaged in

The second group of pro-ICO personnel-based arguments, which I call Group 2, holds that allowing ICO respects the consciences of anti-MAiD personnel in objecting healthcare institutions who want to exercise their consciences by working in a community that follows their values (i.e., core moral beliefs).[7] In the academic literature, we can find proponents of five main arguments that fit into this group.[8] First, Mark R. Wicclair supports allowing ICO (in some cases) by arguing that, for conscientious reasons, "it can be important to physicians, nurses, pharmacists, and other personnel to be able to practice and work in a community that shares a commitment to a core set of goals, values, and principles" (5, p.131). Second, Lynn D. Wardle supports allowing ICO by arguing that "to deny [conscience clause] protection to health care institutions contradicts the central purpose of conscience clauses, which is to protect the moral sensibilities and deeply-held beliefs of the individuals who make up the institution" (45, p.186). According to Wardle, healthcare institutions effectuate their personnel's collective wills and purposes. Third, building on Wardle, Michael J. DeBoer supports allowing ICO by arguing that "[i]nstitutions are created… to [pursue] a particular mission or purpose (such as carrying out the healing ministry of the church), and the values and moral perspectives of the individuals who associate through an organization are reflected in the organization's identity and conscience" (7, p.1275). Fourth, Murphy supports allowing ICO by arguing that "it makes no sense to hold that a person is entitled to exercise freedom of conscience individually, but loses that freedom the moment he joins with someone else in a collective enterprise, especially one meant to put into practice beliefs informing the exercise of that freedom" (39, p.4). Fifth, Steven H. Miles, Peter A. Singer, and Mark Siegler support allowing ICO by arguing that people have a conscientious right to "affiliate in distinct moral communities – voluntary associations of people who share a common view of the moral good," in this case, a common healthcare philosophy (46, p.49).

My response to the Group 2 arguments is that they are inconsistent with the positions of Group 2 proponents on some cases of *personal* conscientious objection (i.e., conscientious objection by individual healthcare providers).[9] To understand why, consider the following two cases. First, imagine an anti-MAiD healthcare institution with a pro-MAiD physician whose conscience tells them that they must provide MAiD. If they do so, this would be what I call personal conscientious *provision*. The Group 2 arguments entail that this institution should be allowed to engage in ICO by preventing this physician from conscientiously providing MAiD. Thus, the Group 2 arguments subordinate this physician's conscience to the consciences of however many of this institution's personnel want to work in a community where everyone follows anti-MAiD values. Now imagine the inverse case, that of a pro-MAiD healthcare institution with some pro-MAiD personnel who want to work in a community where everyone follows pro-MAiD values. At this institution, there is an anti-MAiD physician whose conscience tells them that they must not provide MAiD. Because the Group 2 proponents support protecting personal conscientious objection regardless of what other personnel want (7,45,47,48), the Group 2 proponents would support requiring the institution to allow personal conscientious objection in this case. Thus, the Group 2 proponents would prioritize the anti-MAiD physician's conscience over the consciences of however many of the institution's personnel want to work in a community where everyone follows pro-MAiD values. As the above two cases show, the Group 2 proponents want to have it both ways. In the case of personal conscientious *provision*, they prioritize the consciences of other personnel over the conscience of the physician in question, whereas, in the case of personal conscientious *objection*, they prioritize the conscience of the physician in question over the consciences of other personnel.[10] This priority reversal is arbitrary. Interestingly, some ICO supporters agree with me here. For example, Group 1 proponents Allen and Brushwood concede that personal conscientious provision matters as much as personal conscientious objection (36).

Repurposing an argument by Murphy et al., I believe that the Group 2 proponents would probably respond to the above counterargument by arguing that this priority reversal is non-arbitrary because personal conscientious objection matters a lot (and thus cannot be outweighed by the consciences of other personnel), whereas personal conscientious provision matters less (and thus *can* be outweighed by other personnel's consciences). Specifically, Murphy et al. give two main reasons[11] why the bar for preventing personal conscientious objection is much higher than the bar for preventing personal conscientious provision (50). First, they argue that personal conscientious provision requires more of society (e.g., social resources) than does personal conscientious objection. Second, Murphy (and Genuis) claim that preventing personal conscientious objection seriously harms the would-be objector, whereas preventing personal conscientious provision does not harm the would-be provider much, if at all (49).

Murphy et al.'s reasons are inapplicable in the case of ICO to MAiD. The first is inapplicable because personal conscientious provision of MAiD requires less of society than personal conscientious objection to MAiD, both in terms of reducing referral

[7] Interestingly, the Group 2 arguments have an analog in *Loyola*; the majority of the judges concluded that allowing Loyola High School to control how it teaches about Catholicism respects its personnel's religious freedom because they became members of the institution to collectively manifest and transmit their religious beliefs, and the other judges echoed this sentiment (34).

[8] Robert K. Vischer advances an argument somewhat similar to the Group 2 arguments (42), so one might ask why I do not include him in this group. My answer is that Vischer's approach to conscience is fundamentally different because he opposes government protection of conscientious objection by individual healthcare providers (43). Furthermore, this is why I do not discuss his approach elsewhere in this paper; Group 2 proponent Murphy has already shown that this position entails that Vischer's approach violates the consciences of the personnel within healthcare institutions (44).

[9] This counterargument is heavily inspired by the anti-ICO argument of Spencer L. Durland (24).

[10] The Group 2 proponents might try to circumvent this counterargument by arguing that anti-MAiD healthcare institutions should engage in ICO differently – specifically, by only accepting anti-MAiD personnel – which would admittedly avoid the problem of having to prevent personnel from providing MAiD. However, this circumvention attempt would fail because it falls victim to a similar counterargument, given that the Group 2 proponents oppose pro-MAiD healthcare institutions only accepting pro-MAiD personnel (45).

[11] In another article, Murphy and Genuis give more reasons, specifically, reasons regarding moral integrity and moral responsibility (49). However, Group 2 proponent Wicclair disproves such reasons (41). For more of the debate on positive and negative conscience claims, see Volume 21, Issue 8 of The American Journal of Bioethics as well as Volume 31, Number 2 of The Journal of Clinical Ethics.

costs (administrative and often transportive) and in terms of expediting MAiD and thus reducing end-of-life (societal) healthcare costs (51). The second reason is inapplicable because preventing personal conscientious provision of MAiD often seriously harms the physician. As Jennifer D. Dorman and Shelley Raffin Bouchal outline, "[a]ttributes of moral distress in the context of MAiD focus on knowing the right course of action but being unable to act, especially when conflict or suffering occurs" (52, p.320). Examples of moral distress associated with wanting to provide MAiD can be found in Stefanie Green's book, *This Is Assisted Dying: A Doctor's Story of Empowering Patients at the End of Life*, in which she discusses cases where she has been constrained from providing MAiD to patients who were suffering intolerably (53). Importantly, preventing personal conscientious provision of MAiD often morally injures the physician as much as preventing personal conscientious objection to MAiD. To show why, I again turn to Group 1 proponents Allen and Brushwood, who concede that many individual healthcare providers "feel a sense of obligation to enable a terminally ill patient to end her suffering humanely that is no less profoundly felt than the objector's sense that the same act is morally reprehensible" (36, p.16). Therefore, the Group 2 proponents must either give up on supporting allowing ICO to MAiD or give up on supporting protecting personal conscientious objection regardless of the wishes of other personnel.

Some may disagree with the above analysis, so I offer a further independent counterargument: the Group 2 arguments cherry-pick which personnel's consciences to consider. Specifically, these arguments ignore the consciences of however many of an anti-MAiD healthcare institution's personnel want to work in a community where those who are eligible to provide MAiD are allowed to choose whether to do so. After all, often not all personnel working in an anti-MAiD healthcare institution are anti-MAiD, and often not all personnel who are anti-MAiD want all other personnel to be anti-MAiD. In fact, sometimes *most* personnel within an anti-MAiD healthcare institution disagree with the institution's anti-MAiD values, in which case allowing ICO to MAiD is *definitely* disrespectful of personnel's consciences, in aggregate. For example, as Ben A. Rich explains in the context of ICO by Catholic hospitals, "because of the expansion of Catholic healthcare through acquisition of previously secular or community-operated hospitals, it is less likely than ever before that the typical hospital in a Catholic system is one in which all or even a majority of the healthcare professionals on the staff… are practicing Catholics" (8, p.218). Studies lend credence to this observation. For example, a 2011 study of obstetrician-gynecologists found that "[p]hysicians who identify as Roman Catholic are no more likely (when the data are controlled for other characteristics) to work in a Catholic hospital… compared with those who report no religious affiliation" (54, p.72.e4). Extending this observation beyond Catholic hospitals, Elizabeth Sepper explains that most modern healthcare institutions are morally diverse because they "do not represent associations based on moral convictions" (25, p.1545). Instead, they represent associations based on a wide range of factors – including pay, convenience, and working conditions – all of which factor into employees' and affiliates' decisions about the healthcare institutions in which they choose to work (25). In many cases, then, allowing ICO to MAiD arbitrarily privileges the consciences of a minority of the personnel within an objecting healthcare institution. In conclusion, the Group 2 arguments fail to justify allowing ICO to MAiD.

Group 3: Allowing ICO Respects the Consciences of Personnel Because Institutional Conscience is a Manifestation of Personal Conscience

The third and final group of pro-ICO personnel-based arguments, which I call Group 3, holds that allowing ICO respects the consciences of the personnel within objecting healthcare institutions because institutional conscience is an *action* (specifically, a manifestation of personal conscience), rather than something that institutions *have*. By analogy, one can conceptualize school spirit not as something that a school possesses but rather as a set of practices in which its students participate (sometimes willingly and sometimes unwillingly). In the academic literature, one main commentator fits into Group 3: Elliot Louis Bedford.[12] He defines institutional conscience as "a judgment of practical reason made by an individual on behalf of an institution, applying institutional norms to a particular situation" (56, p.265). By "norms," he means "normative criteria," which can be established by things like policies (56). Based on these definitions, Bedford argues that "doing" institutional conscience is a manifestation of personal conscience, in the same way that personal conscientious objection is a manifestation of personal conscience (56). For Bedford, the main difference is just that "doing" institutional conscience applies institutional norms to a situation (even if one disagrees with those norms), whereas personal conscientious objection applies one's own norms to a situation (56). Therefore, the obvious implication is that protecting institutional conscience – by which Bedford seems to mean allowing ICO – respects the personal consciences of the personnel within objecting healthcare institutions. For the sake of argument, the rest of this section grants Bedford's conception of institutional conscience, although I will make the case that it does not entail what he claims it does.

My response to the Group 3 arguments is that Bedford's conception of institutional conscience entails the existence of a type of institutional conscience that goes against allowing ICO by healthcare institutions. To see why, consider the following. Bedford argues that "the activity of institutional conscience is a pervasive, ineradicable element of all human institutions, not just Catholic hospitals" (56, p.258). This entails the existence of not only healthcare-institution-specific institutional conscience but also professional-organization-specific institutional conscience. For the sake of simplicity, when I refer to "healthcare institutions" I am excluding professional organizations, even though they are institutions relating to healthcare. By "professional organization," Bedford and I mean bodies like the Canadian Medical Association (CMA), the Canadian Nurses Association, and regulatory colleges for physicians and nurses. By "professional-organization-specific institutional conscience," I mean – using Bedford's language – a judgment of practical reason made by an individual, applying a professional organization's norms

[12] Grattan T. Brown also advances a Group 3 argument (55), but this argument is unclear, as noted by Bedford (56) – so I focus on Bedford's argument, which is clearer.

to a particular situation. What does this look like? For example, most Canadian physicians[13] are bound to follow the norms (specifically, "virtues, values, and principles") in the CMA Code of Ethics and Professionalism (68, p.1). Of note for the ICO discourse, these physicians must obey the fundamental commitment of respecting patient autonomy and the professional responsibility of acting according to one's conscience, by which the CMA means following one's moral/religious beliefs (68,69). With these norms in mind, consider again the case of an anti-MAiD healthcare institution with a physician who wants to conscientiously provide MAiD, and this time assume that they are a CMA member. These norms entail that they should provide MAiD (and thereby both follow their pro-MAiD moral beliefs and respect the eligible requester's autonomy), and there are no CMA norms that contradict this entailment.[14] Indeed, the CMA explicitly supports physicians who conscientiously provide MAiD when legal (50). Thus, in the case in question, "doing" healthcare-institution-specific institutional conscience (i.e., following the institution's anti-MAiD norms) would go against "doing" professional-organization-specific institutional conscience (i.e., following the CMA's pro-MAiD norms). Therefore, allowing ICO to MAiD prevents physicians from "doing" professional-organization-specific institutional conscience. This matters because, if we grant Bedford's claim that preventing physicians from "doing" institutional conscience violates personal conscience, then we arrive at the conclusion that allowing ICO to MAiD violates personal conscience.

Interestingly, Bedford basically concedes all the above analysis (except the very last part). In response to anti-ICO arguments from medical professionalism, he concedes that what I call professional-organization-specific institutional conscience is indeed a type of institutional conscience according to his framework (70). Granted, Bedford says this about the American Medical Association and the ACOG (56), but there are no reasons to treat the CMA differently. Furthermore, he concedes that professional-organization-specific institutional conscience often goes against healthcare-institution-specific institutional conscience: "arguments from professionalism presuppose the validity of the concept of institutional conscience. Hence, the debate is… a matter of *which* institutional conscience" (70, p.420). With all this in mind, it is clear that Bedford's response to the above counterargument would simply be that healthcare-institution-specific institutional conscience takes priority over professional-organization-specific institutional conscience.

However, Bedford gives no reasons for this prioritization, and there are good reasons to flip it in the previously discussed case of an anti-MAiD healthcare institution with a physician who is a CMA member and who wants to conscientiously provide MAiD. Recall that the question here is as follows: *which of the two previously discussed institutional consciences is a more protection-worthy manifestation of the physician's personal conscience?* To answer this question, we must determine which of the two associated sets of norms is more important for the physician's personal conscience, and I propose two ways to determine this (both of which yield the same result). The first way is prioritizing the set of norms that the physician wants to follow. In the case in question, the physician wants to provide MAiD, so they want to follow the CMA's pro-MAiD norms. Inspired by Stefan Sciaraffa's argument that identifying with a role yields moral reasons to obey its obligations (71), the second way is prioritizing the set of norms with which the physician more strongly identifies.[15] In the case in question, this is probably the CMA's norms because these are closer to the physician's pro-MAiD values, and because the CMA's norms guide a physician's actions throughout their whole career (and wherever they work), whereas a particular healthcare institution's norms guide their actions only when working at that institution. This latter point matters because many physicians work at multiple healthcare institutions during their careers, and some work at multiple healthcare institutions at once. From the above analysis, it follows that the CMA's norms are probably more important and thus CMA-specific institutional conscience is a more protection-worthy manifestation of the physician's conscience. Therefore, respecting their conscience requires empowering them to "do" CMA-specific institutional conscience, i.e., empowering them to conscientiously provide MAiD. Allowing ICO to MAiD disrespects the consciences of physicians (and other personnel), so the Group 3 arguments fail to justify allowing ICO to MAiD.

CONCLUSION

None of the three groups of pro-ICO personnel-based arguments show that allowing ICO to MAiD respects the consciences of the personnel within objecting healthcare institutions. In fact, as shown throughout this paper, the main impact that allowing ICO to MAiD has on personnel's consciences is a negative one: disrespect for the consciences of personnel who want to conscientiously provide MAiD to eligible requesters.

[13] For context, there are two main ways that Canadian physicians can be obligated to follow these norms. The first is by becoming one of the tens of thousands of CMA members. The second is by working in a province or territory whose college of physicians and surgeons (or territorial equivalent) requires physicians to follow the CMA Code of Ethics and Professionalism. The vast majority of these colleges (57-64) – and Yukon's Medical Council (65) – do so. Furthermore, the colleges that do not do so require physicians to follow similar norms, at least insofar as patient autonomy is concerned (66,67).

[14] Moreover, one could argue that this entailment is buttressed by other CMA norms, such as the fundamental commitment to benefit patients (68). However, this argument is beyond the scope of this paper as it gets into the separate discussion about whether MAiD benefits eligible requesters.

[15] One may object that this second way is the same as the first because people always want to follow the set of norms with which they more strongly identify. However, this objection is wrong because someone can strongly identify with a set of norms as a whole (call it set X) despite strongly disagreeing with one of its members (call it norm X_1), and they can weakly identify with another set as a whole (call it set Y) despite strongly agreeing with one of its members (call it norm Y_1). In cases that mainly concern norms X_1 and Y_1, they may want to follow set Y rather than set X, even though they more strongly identify with set X.

Reçu/Received: 28/02/2023
Publié/Published: 27/06/2023

Remerciements
L'auteur remercie Udo Schüklenk, Françoise Baylis, Brad Abernethy, Ian D. Wolfe et Guido Calderini pour leurs commentaires utiles sur les versions préliminaires.

Acknowledgements
The author thanks Udo Schüklenk, Françoise Baylis, Brad Abernethy, Ian D. Wolfe, and Guido Calderini for providing useful comments on drafts.

Conflits d'intérêts
Aucun à déclarer

Conflicts of Interest
None to declare

Édition/Editors: Renata Iskander & Aliya Affdal

Les éditeurs suivent les recommandations et les procédures décrites dans le Code of Conduct and Best Practice Guidelines for Journal Editors de COPE. Plus précisément, ils travaillent pour s'assurer des plus hautes normes éthiques de la publication, y compris l'identification et la gestion des conflits d'intérêts (pour les éditeurs et pour les auteurs), la juste évaluation des manuscrits et la publication de manuscrits qui répondent aux normes d'excellence de la revue.

The editors follow the recommendations and procedures outlined in the COPE Code of Conduct and Best Practice Guidelines for Journal Editors. Specifically, the editors will work to ensure the highest ethical standards of publication, including: the identification and management of conflicts of interest (for editors and for authors), the fair evaluation of manuscripts, and the publication of manuscripts that meet the journal's standards of excellence.

Évaluation/Peer-Review: Ian D. Wolfe & Guido Calderini

Les recommandations des évaluateurs externes sont prises en considération de façon sérieuse par les éditeurs et les auteurs dans la préparation des manuscrits pour publication. Toutefois, être nommé comme évaluateurs n'indique pas nécessairement l'approbation de ce manuscrit. Les éditeurs de la *Revue canadienne de bioéthique* assument la responsabilité entière de l'acceptation finale et de la publication d'un article.

Reviewer evaluations are given serious consideration by the editors and authors in the preparation of manuscripts for publication. Nonetheless, being named as a reviewer does not necessarily denote approval of a manuscript; the editors of *Canadian Journal of Bioethics* take full responsibility for final acceptance and publication of an article.

REFERENCES

1. Sumner LW. Conscientious refusal to provide medically assisted dying. University of Toronto Law Journal. 2021;71(1):1-31.
2. Nova Scotia Health Authority. Medical Assistance in Dying (MAID). 18 Jul 2022.
3. Health PEI. Medical Assistance in Dying. 11 Apr 2023.
4. Act Respecting End-of-Life Care. CQLR c S-32.0001; 2014.
5. Wicclair MR. Conscientious refusals by hospitals and emergency contraception. Cambridge Quarterly of Healthcare Ethics. 2011;20(1):130-38.
6. Bussey BW. The right of religious hospitals to refuse physician-assisted suicide. Supreme Court Law Review. 2018;85:189-223.
7. DeBoer MJ. Access without limits – revisiting barriers and boundaries after the affordable care act. Connecticut Law Review. 2012;44:1239-80.
8. Rich BA. Your morality, my mortality. Cambridge Quarterly of Healthcare Ethics. 2015;24(2):214-30.
9. Wolfe ID, Pope TM. Hospital mergers and conscience-based objections – growing threats to access and quality of care. New England Journal of Medicine. 2020;382:1388-89.
10. Fogel SB, Rivera LA. Saving Roe is not enough: when religion controls healthcare. Fordham Urban Law Journal. 2004;31(3):725-49.
11. Sloboda M. The high cost of merging with a religiously-controlled hospital. Berkeley Women's Law Journal. 2001;16:140-56.
12. Clark BR. When free exercise exemptions undermine religious liberty and the liberty of conscience: a case study of the Catholic hospital conflict. Oregon Law Review. 2003;82(3):625-94.
13. West-Oram P, Buyx A. Conscientious objection in healthcare provision: a new dimension. Bioethics. 2016;30(5):336-43.
14. Wilson RF. The limits of conscience: moral clashes over deeply divisive healthcare procedures. American Journal of Law & Medicine. 2008;34(1):41-63.
15. Pellegrino ED. The physician's conscience, conscience clauses, and religious belief: a Catholic perspective. Fordham Urban Law Journal. 2002;30(1):221-44.
16. Sulmasy DP. What is conscience and why is respect for it so important? Theoretical Medicine and Bioethics. 2008;29(3):135-49.
17. Wildes KW. Institutional identity, integrity, and conscience. Kennedy Institute of Ethics Journal. 1997;7(4):413-19.
18. Sulmasy DP. Conscience, tolerance, and pluralism in health care. Theoretical Medicine and Bioethics. 2019;40(6):507-21.
19. Fiala C, Arthur JH. "Dishonourable disobedience" – why refusal to treat in reproductive healthcare is not conscientious objection. Woman – Psychosomatic Gynaecology and Obstetrics. 2014;1:12-23.
20. Dickens BM. Conscientious objection and professionalism. Expert Review of Obstetrics & Gynecology. 2009;4(2):97-100.
21. Sepper E. Not only the doctor's dilemma: the complexity of conscience in medicine. Faulkner Law Review. 2013;4:385-410.

22. Dickens BM. Ethical misconduct by abuse of conscientious objection laws. Medicine and Law. 2006;25(3):513-22.
23. Allain ME. Catholic hospital conscientious objection in Canada and rural areas: an ethical analysis. Master of Science. Health and Rehabilitation Sciences. London, Ontario: Western University; 2011.
24. Durland SL. The case against institutional conscience. Notre Dame Law Review. 2011;86(4):1655-86.
25. Sepper E. Taking conscience seriously. Virginia Law Review. 2012;98(7):1501-75.
26. Dickens BM. Reproductive health services and the law and ethics of conscientious objection. Medicine and Law. 2001;20(2):283-93.
27. Kirby J. Should institutional conscientious objection to assisted dying be accommodated? Canadian Journal of Bioethics/Revue Canadienne de Bioéthique. 2021;4(1):15-20.
28. Lord R, Quon A. NSHA quietly changes medically assisted dying policy at Catholic hospital. Global News. 18 Sept 2019.
29. Dying With Dignity Canada. Forced transfers in British Columbia. 2022.
30. Larsen K. Supreme court dismisses Delta Hospice Society appeal over membership dispute. CBC News. 9 Apr 2021.
31. Little S. B.C.'s top court rejects latest attempt to block medical assistance in dying at Delta hospice. Global News. 15 Nov 2020.
32. Canadian Charter of Rights and Freedoms. Part 1 of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (UK), 1982, c 11.
33. Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario. 2019 ONCA 393.
34. Loyola High School v. Quebec (Attorney General). 2015 SCC 12, [2015] 1 S.C.R. 613.
35. Nikas NT. Law and public policy to protect health care conscience. National Catholic Bioethics Quarterly. 2004;4(1):41-52.
36. Allen WL, Brushwood DB. Pharmaceutically assisted death and the pharmacist's right of conscience. Journal of Pharmacy & Law. 1995;5(1):1-18.
37. American College of Obstetricians and Gynecologists. The limits of conscientious refusal in reproductive medicine. Obstetrics & Gynecology. 2007;110(5):1203-8.
38. Kaczor C. Conscientious objection and health care: a reply to Bernard Dickens. Christian Bioethics. 2012;18(1):59-71.
39. Murphy ST. Institutional freedom of conscience in relation to euthanasia and assisted suicide. Protection of Conscience Project. 14 May 2022.
40. LaFollette E, LaFollette H. Private conscience, public acts. Journal of Medical Ethics. 2007;33(5):249-54.
41. Wicclair MR. Negative and positive claims of conscience. Cambridge Quarterly of Healthcare Ethics. 2009;18(1):14-22.
42. Vischer RK. Conscience and the common good: an introduction. Journal of Catholic Legal Studies. 2010;49(2):293-306.
43. Vischer RK. Conscience in context: pharmacist rights and the eroding moral marketplace. Stanford Law & Policy Review. 2006;17(1):83-119.
44. Murphy ST. To market, to market. Protection of Conscience Project. 4 Apr 2006.
45. Wardle LD. Protecting the rights of conscience of health care providers. Journal of Legal Medicine. 1993;14(2):177-230.
46. Miles SH, Singer PA, Siegler M. Conflicts between patients' wishes to forgo treatment and the policies of health care facilities. New England Journal of Medicine. 1989;321:48-50.
47. Murphy ST. Conscientious objection: resisting ethical aggression in medicine. Protection of Conscience Project. 17 Apr 2009.
48. Murphy ST. Entrenching a 'duty to do wrong' in medicine: Canadian government funds project to suppress freedom of conscience and religion. Protection of Conscience Project. 16 Mar 2014.
49. Murphy ST, Genuis SJ. Freedom of conscience in health care: distinctions and limits. Journal of Bioethical Inquiry. 2013;10(3):347-354.
50. Murphy S, Coelho R, Violette PD, et al. The Declaration of Geneva: conscience, dignity and good medical practice. World Medical Journal. 2020;66(4):41-47.
51. Trachtenberg AJ, Manns B. Cost analysis of medical assistance in dying in Canada. Canadian Medical Association Journal. 2017;189(3):e101-5.
52. Dorman JD, Raffin Bouchal S. Moral distress and moral uncertainty in medical assistance in dying: a simultaneous evolutionary concept analysis. Nursing Forum. 2020;55(3):320-30.
53. Green S. This is Assisted Dying: A Doctor's Story of Empowering Patients at the End of Life. New York: Scribner; 2022.
54. Stulberg DB, Dude AM, Dahlquist I, et al. Obstetrician-gynecologists, religious institutions, and conflicts regarding patient-care policies. American Journal of Obstetrics and Gynecology. 2012;207(1):73.e1-73.e5.
55. Brown GT. Institutional conscience and Catholic health care. In: Koterski JW, editor. Life and Learning XVI: Proceedings of the Sixteenth University Faculty for Life Conference at Villanova University 2006. Washington, DC: University Faculty for Life; 2006. p. 413-22.
56. Bedford EL. The reality of institutional conscience. National Catholic Bioethics Quarterly. 2016;16(2):255-72.
57. College of Physicians and Surgeons of British Columbia. CMA Code of Ethics and Professionalism. 2018.
58. The College of Physicians & Surgeons of Manitoba. Code of Ethics. 2019.

59. College of Physicians and Surgeons of Nova Scotia. Standards & Guidelines. 2023.
60. College of Physicians & Surgeons of Alberta. Standards of Practice. 2022.
61. College of Physicians and Surgeons of Saskatchewan. The Code of Ethics. 2020.
62. The College of Physicians & Surgeons of Prince Edward Island. Policies and Guidelines. 2023.
63. College of Physicians and Surgeons of Newfoundland and Labrador. Policies & Guidance. 2020.
64. College of Physicians and Surgeons of New Brunswick. Code of Ethics. 1996 (rev. 2021).
65. Yukon Medical Council. Legislation and Standards. 2023.
66. The College of Physicians and Surgeons of Ontario. Professional Obligations and Human Rights. 2008 (rev. 2015).
67. Code of Ethics of Physicians. CQLR c M-9, r17.
68. Canadian Medical Association. CMA Code of Ethics and Professionalism. 2018.
69. Abortion Rights Coalition of Canada. Canadian policies and laws on “conscientious objection” in health care. Position Paper #95 – Appendix. Nov 2022.
70. Bedford EL. The concept of institutional conscience. National Catholic Bioethics Quarterly. 2012;12(3):409-20.
71. Sciaraffa S. Identification, meaning, and the normativity of social roles. European Journal of Philosophy. 2009;19(1):107-28.