2011

CATHOLIC HOSPITAL CONSCIENTIOUS OBJECTION IN CANADA AND RURAL AREAS: AN ETHICAL ANALYSIS

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CATHOLIC HOSPITAL CONSCIENTIOUS OBJECTION IN CANADA AND RURAL AREAS: AN ETHICAL ANALYSIS

(Spine title: Catholic hospital conscientious objection in Canada)

(Thesis format: Monograph)

by

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Graduate Program in Health & Rehabilitation Sciences

A thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Science

The School of Graduate and Postdoctoral Studies
The University of Western Ontario
London, Ontario, Canada

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entitled:

Catholic hospital conscientious objection in Canada and rural areas: An ethical analysis

is accepted in partial fulfillment of the
requirements for the degree of
Master of Science

Date

Chair of the Thesis Examination Board

Abstract

Conscientious objection within health care is defined as a refusal to comply with a medically sanctioned request based on personal moral, or religious moral reasons. Although conscientious objection is an important foundation in bioethics, most research has focused on the legitimacy of its use by individual health care professionals. The following ethical analysis examines the ethical implications of Catholic hospital conscientious objections to providing reproductive services to which they are morally opposed within the context of the Canadian health care system, and more specifically within rural areas. Conclusions of the analysis suggest that hospitals do not possess a conscience according to the dominant view of conscience in bioethics and that limitations on the objections of Catholic hospitals are warranted in a number of important circumstances, many of which include rural areas. This analysis will help further the limited body of knowledge concerning conscientious objections by Catholic hospitals in Canada and inform future health policy decisions.

Keywords

Conscientious objection, conscientious refusal, conscience, Catholic hospitals, Canada, rural health, reproductive health, normative/applied ethics, health care ethics, bioethics

Dedication

To my *family*, without whom this journey would never have been possible.

Acknowledgments

In undertaking this degree I have come to realize that while it takes a village to raise a child the same may very well be true of writing a thesis. For this reason I am thankful to so many people who have given so generously of their time and contributed in ways big and small throughout this ever evolving process.

In particular, I would like to thank Ken Kirkwood for his guidance and support in seeing this thesis through from its inception to its completion. Many thanks as well to Carolyn McLeod for her thoughtful insight into the conceptualization of various ideas and for sharing her expertise in the field.

I am grateful to Laurie Hardingham - and the clinical ethics department with St. Joseph's Health Care, London –for her superb mentorship as well as for allowing me the opportunity to integrate my knowledge within a clinical and organizational health care setting. Thank you as well to Marleen Van Laethem for her caring and kind-hearted support and feedback.

To my friends and colleagues (within and outside of school), thank you for continuing to be an important source of inspiration, collegiality, and support. It is comforting to have such friends with you in the trenches. To those outside of school, thank you for continuing to ground me during difficult times as well as for your love and endurance.

Finally, I would like to sincerely thank my family – including my parents, Gwyneth and Marc Allain, and my aunt, Elizabeth Thomey - for their unconditional love, patience, understanding, and support of my goals and ambitions throughout this process. Words cannot express what your encouragement and confidence in my abilities have and

continue to mean to me. Your wisdom and loving guidance are what gave me the strength to persevere and to overcome obstacles that truly felt insurmountable. To you I am permanently indebted and forever grateful.

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Chapter 1. Introduction

1.1 Problem Statement & Purpose

In the summer of 2007, the peaceful town of Midland, Ontario, Canada, population 16,000, was unwillingly thrust into the limelight when the reproductive health services on which they relied were threatened (Gandhi, 2007). Following a year of closed-door discussions, on June 15, 2007, trustees of the region's only two hospitals - Huronia General Hospital (secular) and Penetanguishene General Hospital (Roman Catholic) not five kilometers away - voted to merge (Gandhi, 2007). What was troubling to both health care professionals (HCPs) and community members regarding this merger, however, was they proposed to do so as a Catholic organization. This would result in the immediate loss of a number of reproductive services to the community as well as to the region. As news of the merger spread, so did public opposition. Finally, on August 2nd 2007, after resignations from four Huronia General Board members (including the Chair) and six physicians from the Huronia District Medical Advisory Council, as well as mounting protests from the community and surrounding regions, the proposed merger was reversed (Abortion Rights Coalition of Canada, 2007; Glynn, 2007a, 2007b; "Simcoe county hospital", 2007).

Although Midland was successful in preserving access to its full complement of reproductive services, the same cannot be said for others. A case in point was the removal of tubal ligations from the services provided by St. Elizabeth's Hospital in Humboldt, Saskatchewan in 2006. This procedure was found to be contrary to the Health Ethics Guide (Catholic Health Association of Canada [now Catholic Health Alliance of Canada]

[CHAC], 2000) and as such was discontinued in the rural community, at first completely and then after significant public pressure, for birth control purposes only (Yaworski, 2007).

As these cases suggest, while the provision of health care by Catholic hospitals, or mergers between secular and Catholic hospitals, may seem harmless at first, a closer examination reveals they can pose significant barriers to accessing certain reproductive health care services. This is because religious philosophy is allowed to justify refusals to provide services, therapies, and procedures that contradict their guiding religious values. Thus the scope of services offered by Catholic hospitals, as opposed to secular hospitals, is directed by the doctrine and principles of the Roman Catholic Church, and not always by medical guidelines or the needs of the community it serves.

Prohibited or immoral interventions include: Abortion; sterilization (e.g., vasectomies and tubal ligations) for birth control purposes; cryopreservation; artificial insemination by a donor; in vitro fertilization; surrogacy; and "means that deliberately and intentionally interfere with the procreative aspect in sexual intercourse" (CHAC, 2000, p.40, article 50). To varying degrees and circumstances, these means can include refusals to dispense condoms, hormonal contraception, and emergency contraception (EC) (CHAC, 2000). Interestingly, final decisions relating to services that are and are not provided are often left to the local Bishop (McGowan, 2005; Roche, 2010; D. MacDermott, personal communication, September 20, 2010; J. Roche, personal communication, September 17, 2010). Because the Health Ethics Guide (CHAC, 2000) is a 'guide' and not a compendium of directives, differences in opinion or interpretation by local Bishops can lead to variability in services offered amongst Catholic hospitals across the country.

Although a popular and important foundation in bioethics, research and discussion about conscientious objection has usually focused on the legitimacy of its use by individual health practitioners (Alta Charo, 2005; Blustein, 1993; Brock, 2008; Cantor & Baum, 2004; Card, 2007; Savulescu, 2006; Fenton & Lomasky, 2005; Wicclair, 2000). A review of the literature reveals a significant gap in the research addressing the legitimacy of religiously affiliated hospitals to conscientiously object to services that contradict their guiding religious beliefs (Dickens & Cook, 2000; Fogel & Rivera, 2003, 2004; Gallagher & Goodstein, 2002; Gallagher, 1997; Pellegrino, 2002; Ryan, 2006; Sulmasy, 2008; Wicclair, 2011; Wildes, 1997). Less research still, addresses the issue within Canada or in rural areas (Donovan, 1996; Sloboda, 2001). In order to address the gap, the purpose of this thesis is to examine the ethical implications of Catholic hospital conscientious objections to provide reproductive services to which they are morally opposed within the context of the Canadian health care system, and more specifically within rural areas.

In the following sections I further discuss the topic of conscientious objection, the history and current status of Catholic hospitals in Canada, and the unique nature of the rural Canadian context. I conclude by outlining the methods used as well as proposing the two focal questions for analysis.

1.2 Conscientious Objection

Conscientious objection within health care, also known as conscientious refusal, is defined as a refusal to comply with a medically sanctioned request based on personal moral, or religious moral reasons (Childress, 1979, 1985). In this respect, refusing to offer requested services is not due to a lack of expertise or of resources, but because

doing so would represent a fundamental moral conflict for the individual HCP or institution. For the purposes of this thesis I will use the terms conscientious objection and conscientious refusal interchangeably.

The place of conscientious refusals within health care remains an important topic of discussion within the discipline of bioethics, as well as within relevant academic (e.g., philosophy, theology, health law and policy) and professional-practice discourse (e.g., relevant policy recommendations, guidelines, statements, and opinion pieces specific to the practice of nursing, pharmacy, midwifery, medicine, etc). Indeed, the topic continues to generate debate not just in North America, but also in many other corners of the globe, as media outlets, legislators, religious leaders, bioethicists, various HCPs, and the general public weigh in on the morally appropriate limits to conscientious objections to health care services, within applicable national and international contexts (Alarcon, 2009; Card, 2011; Casas, 2009; Cook & Dickens, 1999; Kelly, Ellis & Rosenthal, 2011; Mishtal, 2009; Sacchini & Antico, 2000; Van Bogaert, 2002).

Fueled in part, perhaps, by the lightning speed in which medical advancements occur, procedures and interventions in their infancy a mere ten to twenty years ago are now common practice. This rapid evolution of medical options has caused some to question their role in delivering services to which they object (Curlin, Lawrence, Chin & Lantos, 2007). Presumably, as progress is made, the lines between what we can and what we should do, will only continue to blur, thus leading to increased rates of conscientious refusals. In addition, Benjamin (1995) suggests: 1) the intimate involvement of our personal convictions regarding the "nature and meaning of creating, sustaining, and ending life" (p.515); 2) the potential for radical value differences between HCPs,

patients, and families; and 3) the frequent need for "agreement and cooperation on a single course of action" (p.515), will only continue to contribute to the prevalence of appeals to conscience in bioethics.

There are a number of procedures, interventions, and services in health care to which individuals can object[1]. However, "the most common examples in the literature and in day-to-day medical practice continue to involve reproductive medicine: specifically, the provision of therapeutic abortion services and access to contraceptive devices and medication" (Blackmer, 2007, p.16). Most recently, debates have focused on the conscientious refusals of pharmacists to dispense emergency contraception (Alarcon, 2009; Cantor & Baum, 2004; Fenton & Lomasky, 2005; Davidson, Pettis, Joiner, Cook & Klugman, 2010; Kelly et al., 2011; Wicclair, 2006) and whether HCPs have an obligation to inform, treat, or refer patients for reproductive interventions to which they object (Blustein, 1993; Brock, 2008; Chervenak & McCullough, 2008; Dickens & Cook, 2000; May & Aulisio, 2009; McLeod, 2008; Savulescu, 2006).

Arguments can, and have been made, on all sides of the conscientious objection debate. Potential advantages of allowing HCPs to invoke conscience include permitting them to remain true to their morals and values, thus preserving their personal integrity, as well as supporting the exercise of independent judgment (Cantor & Baum, 2004;

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[1] Other areas of conscientious refusal include, but are not limited to: euthanasia, physician assisted suicide, experimentation on human embryos, the rejection of blood products by Jehovah's Witnesses, the prescription of human growth hormone (HGH) to short but otherwise normal children, and the removal or continuation of patients from or on artificial life support (Benjamin, 1995; Blackmer, 2007).

Wicclair, 2000). Allowing individuals to refuse participation in acts that violate their personal, ethical, moral, or religious convictions is also an essential element of a free and democratic society (Benjamin, 1995; Cantor & Baum, 2004; Pellegrino, 2002). On the other hand, "in the biomedical context, respect for conscience may be inconvenient, inefficient, or detrimental to medical outcomes" (Benjamin, 1995, p.515). It may also serve to impose the values and personal morals of the HCP, while neglecting those of the patient (Savulescu, 2006). In face of these arguments, the salient question becomes: how do we manage to be respectful of a HCP's (or hospital's) conscience, while also safeguarding the patient's reproductive health and entitlement to autonomy and self-determination?

Although the debate regarding the precise scope of legitimate conscientious objection continues, it is generally accepted that individual HCPs may refuse, within limits, to provide services and medications, as well as refuse to directly participate in procedures, to which they morally oppose. In Canada a number of different professional associations and regulatory colleges[2] have released relevant policy statements and guidelines on or

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[2] Of note, professional codes of ethics provided by national associations such as the Canadian Medical Association (CMA) (2004), the Canadian Nurses Association (CNA) (2008), and the National Association of Pharmacy Regulatory Authorities (NAPRA) (1999), are guidelines provided from within the profession relevant to its members. In contrast, practice standards outlined by professional colleges such as the College of Physicians and Surgeons of New Brunswick (CPSNB) (2002), and the College of Registered Nurses of British Columbia (CRNBC) (2010), outline the criteria for which professionals are held accountable to the public. That being said, each may be used to indicate those values of importance to professionals.

related to the topic (Novel Tech. Ethics, 2010). For instance, both the Canadian Medical Association (CMA) (1988, 2004) and the Canadian Nurses Association (CNA) (2008) agree that physicians and nurses should be permitted to follow their conscience, as long as it does not unduly burden patients or compromise their well-being. This position is also supported by a number of the provincial regulatory colleges (College of Nurses of Ontario [CNO], 2009; College of Physicians and Surgeons of Alberta [CPSA], 2010; College of Physicians and Surgeons of New Brunswick [CPSNB], 2002; College of Pharmacists of British Columbia [CPBC], 2010; Saskatchewan College of Pharmacists [SCP], 2000). For nurses who do wish to object, the CNA states that refusals cannot be "based on prejudice, fear, or convenience" (CNA, 2008, p.45). Although each organization's statements are slightly different, doctors, nurses, and pharmacists must generally inform either the person requesting the service, or management, of their reasons for objecting, and as much as possible should do so in advance of any request (CMA, 1988; CPSA, 2010; CPSNB, 2002; National Association of Pharmacy Regulatory Authorities [NAPRA], 1999; Nova Scotia College of Pharmacists [NSCP], 2007; SCP, 2000). This practice allows for alternate arrangements to be made so that a patient's choice for the procedure or medication is not significantly affected.

In contrast to the prolific debate regarding the conscientious objections of individual HCPs, little attention has been paid to the conscientious refusals of Catholic hospitals (Dickens & Cook, 2000; Fogel & Rivera, 2003, 2004; Gallagher & Goodstein, 2002; Gallagher, 1997; Pellegrino, 2002; Ryan, 2006; Sulmasy, 2008; Wicclair, 2011; Wildes, 1997). Fewer still have addressed the unique concerns of the rural environment or a Canadian focus (Donovan, 1996; Sloboda, 2001). While certain points of debate may be

similar, there are a number of issues that require special attention and analysis. These particularities will be addressed in the analysis – chapters two and three.

1.3 Catholic Health Care

The Catholic Church maintains a steadfast commitment to fulfilling the teachings of Jesus Christ in a manner that espouses his compassion and healing presence (CHAC, 2000; McGowan, 2005). Faithful to its mission of administering care to the poor, the vulnerable, the sick, and the suffering, the Catholic Church remains "...the single largest provider of health care in the world, truly faithful to the mission given by Christ to teach and to heal" (McGowan, 2005). Globally, the Church is responsible for upwards of 111,000 Catholic health care institutions – this comprises approximately 6,000 hospitals; 17,000 clinics and primary care institutions; 12,000 homes for the aging and chronically ill; 800 leprosariums; and 25,300 centers of health care ministry (McGowan, 2005). Furthermore, 26.7% of the centers around the world providing treatment for people infected with HIV/AIDS are Catholic-based (Barragán, 2006).

The Catholic Church (recognized judicially as the Holy See[3]) also plays an influential role on the world diplomatic stage. The scope of its involvement includes participating in various international organizations, as well as maintaining formal diplomatic

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[3] The "Holy See" is the supreme and central government of the Roman Catholic Church. It is also recognized internationally as possessing a legal personality, allowing it to enter into treaties as the juridical equal of a State and to send and receive diplomatic representatives (U.S. Department of State, 2008). The Holy See is lead by the Pope who exercises ultimate legislative, executive, and judicial power as authorized to him through Canon law (Libreria Editrice Vaticana, 1983, Canon 331).

relationships with 177 countries. It is also a permanent observer[4] to the United Nations, the World Health Organization (WHO) (through the World Health Assembly), the World Food Program (WFP), the World Trade Organization (WTO), the International Labor Organization (ILO), and the United Nations Educational Scientific and Cultural Organization (UNESCO) among others (U.S. Department of State, 2008).

1.3.1 Catholic Health Care in Canada

Within Canada, the Roman Catholic Church's involvement in administering health care predates the country itself. In fact three Soeurs of the Augustines Hospitalières established the first hospital in North America in 1639 (Hôtel-Dieu) in Québec City, Québec (Humbert, 2004). Gradually, other orders of Roman Catholic Sisters followed suit and Catholic hospitals were opened across the country (Humbert, 2004). These hospitals include: St-Boniface Hospital, in St-Boniface, New Brunswick (1847) by the Grey Sisters; St. Michael's Hospital, in Toronto, Ontario (1892) by the Sisters of St. Joseph; Misericordia General Hospital, in Edmonton, Alberta (1900) by the Soeurs de

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[4] Observer status is a privilege granted by a number of Intergovernmental Organizations allowing for the participation of non-member States and international nongovernmental organizations (INGOs) in the organization's activities. While observers must generally apply for member status within a fixed number of years, the status of permanent observer is reserved for those who do not qualify for full membership or who do not wish to become full members but whose participation remains of mutual benefit (Carbon Sequestration Leadership Forum [CSLF], 2005). Permanent Observer status is often based on practice and for the United Nations dates from 1946 (United Nations, n.d.). Permanent observers generally have free access to meetings and documents, as well as the authority to make presentations and statements but lack the ability to vote on resolutions (CSLF, 2005; United Nations, n.d.).

Miséricorde; and St. Joseph's General Hospital, in Comox, British Columbia (1926) by the Sisters of St. Joseph, Toronto (Humbert, 2004).

While the number of Catholic hospitals in Canada has fluctuated throughout the years, the total number of Catholic health care facilities currently operating within the country is ambiguous. A comprehensive review of the literature, relevant databases, and personal communication (September 17, 2010) with the Executive Director of the Catholic Health Alliance of Canada (CHAC)[5], James Roche, revealed that a comprehensive and up to date list of Catholic health care facilities in Canada does not presently exist. In order to provide an overview of the number of Catholic hospitals currently operating in the country, an inventory of Catholic health care facilities was compiled.

The document was assembled through a systematic review of the Canadian Healthcare Association's, Guide to Canadian Healthcare Facilities (2011). Facilities marked as religious (*Rel.*)[6] were noted and wherever possible cross-referenced with

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[5] The Catholic Health Alliance of Canada [CHAC], formerly the Catholic Health Association of Canada, is a nationally based, voluntary alliance of Catholic health care providers in Canada. Its mission is to "strengthen and support the ministry of Catholic health care organizations and providers" (CHAC, n.d.b). Its mandate is 1) Advocacy: "to be the national voice of Catholic health care organizations" (CHAC, n.d.b), and 2) Governance: "to foster the distinctive mission and organizational culture of Catholic health care organizations" (CHAC, n.d.b). They also publish the Health Ethics Guide (CHAC, 2000).

[6] Health care facilities were defined as religious if they were "owned and controlled by a church or one of its branches, a religious order, or by a corporation, association, or society with religious objectives" (Canadian Healthcare Association, 2011, p.5).

organizational and provincial websites, as well as the online CHAC directory (n.d.a)[7]. Results of the inventory reveal that there are currently 136 Catholic health care facilities operating in nine Provinces across the country. Of these 136 facilities, 51 are listed as hospitals, 68 are long-term-care facilities, and 17 are a combination of treatment centres, hospices, retirement homes, outpatient centres, nursing stations, home care, and others (see Appendix A.).

1.3.2 Catholic Health Care Facility Sponsorship

To qualify as a Catholic health care facility, an institution must have a sponsor. Sponsors ensure facilities "remain true to Catholic values and identity" (McGowan, 2005, p.4). Examples of sponsors include: religious institutes such as the Ursuline Sisters, the Sisters of Providence, and the Grey Nuns; Dioceses such as the Archdiocese of Winnipeg and the Diocese of Victoria; and associations or corporations such as the Catholic Health Corporation of Ontario and the St. Joseph's Health Care Society (McGowan, 2005). Although sponsors can contribute financially through the administration of foundations and land ownership, the operating budgets of Catholic hospitals are allocated by provincial governments and administered through their respective funding systems (e.g.,

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[7] In reviewing the pages of the Guide to Canadian Healthcare Facilities (Canadian Healthcare Association, 2011) I came across a number of institutions that were mis-labeled (e.g., missing the 'rel' [religious] designation or having the 'rel' designation when the facility was no longer religiously affiliated). Although every effort was made to cross-reference any facility noted on the CHAC directory list but missed in the Guide to Canadian Healthcare Facilities (Canadian Healthcare Association, 2011) or suspected as being mis-labeled in the Guide to Canadian Healthcare Facilities (Canadian Healthcare Association, 2011), human error is such that a few institutions may have been missed.

through regional health authorities)(Canadian Institute for Health Information [CIHI], 2005; D. MacDermott, personal communication, September 20, 2010).

As the capacity of founding religious institutes to maintain the governance and sponsorship of their health care facilities dwindles, many new entities, in the form of lay organizations and societies, have been established to assume the role of sponsor (McGowan, 2005; Roche, 2010). In addition to their formal canonical status as public juridic persons (PJP)[8] of pontifical or diocesan right, these organizations have also adopted corporate status, permitting them reserved authority under both Civil and Canon Law (Roche, 2010). For founding institutes, the transfer of authority to a public juridic sponsor is generally viewed as a favourable option, as it assures the official continuation of the institution's Catholic ministry as well as their legacy (McGowan, 2005).

In Canada, an example of the PJP of pontifical right model is the Catholic Health Sponsors of Ontario, who operate civilly as the Catholic Health Corporation of Ontario (CHCO). Operating within a decentralized framework, each sponsored institution maintains its own Board of Trustees and chief executive officer (CEO). In order to retain oversight, directors of the CHCO sit as members of each institution's Board, deferring certain reserved rights - such as the approval or dismissal of the CEO and directors, as well as the spending or sale of major assets - to the board of the CHCO (Roche, 2010).

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[8] As defined by Canon 116, "public juridic persons are aggregates of persons or things which are established by the competent ecclesiastical authority so that, within the limits allotted to them, they might in the name of the church and in accordance with the provisions of law, fulfill the specific task entrusted to them in view of the public good" (McGowan, 2005, p.7).

As a PJP of pontifical right, the CHCO is directly accountable to the Vatican (to whom it reports annually) for ensuring its sponsored institutions maintain their Catholic identity, which includes the consistent application of the Health Ethics Guide (CHAC, 2000) approved by the Canadian Conference of Catholic Bishops (Roche, 2010; McGowan, 2005).

Conversely, Catholic Health of Alberta, who acts as a sponsor for all health care facilities who fall under Covenant Health Alberta, operates under the PJP of diocesan right model. Catholic Health of Alberta's members include all the Bishops of Alberta with the Archbishop of Edmonton as the permanent chairperson. Like the CHCO, Catholic Health of Alberta maintains reserved rights but is directly accountable to the Alberta bishops (as opposed to the Holy See) for the promotion of institution Catholicity (McGowan, 1999; J. Roche, personal communication, September 17th 2010).

As Catholic hospitals seek to provide health care in the twenty-first century, it will be interesting to observe how they cope with evolving pressures from society, science, and the potentially competing demands these may place on their religious beliefs.

1.4 The Rural Context

The rural health care setting is a unique and challenging environment. Yet despite the distinct nature of these communities, there is a significant lack of research surrounding those issues most pertinent to them (Kirby & LeBreton, 2002a; Nelson & Schmidek, 2008; Romanow, 2002; CIHI, 2006). This is compounded by the lack of a singular definition of what is meant by the term 'rural'. Interpretations of the term can for instance, be population dependent (less than 10 000 inhabitants), distance dependent (a

set number of kilometers away from an urban center), or dependent on social representation (culture and way of life) (Nelson & Schmidek, 2008; du Plessis, Beshiri, Bollman & Clemenson, 2001, 2002). This variability has led to a great deal of ambiguity regarding the meaning of 'rural', making it difficult to pinpoint a precise definition.

For the purpose of this thesis I will assume the 'rural and small town' definition of rural as outlined by Statistics Canada. According to this definition "rural refers to individuals in towns or municipalities outside the commuting zone of larger urban centres (with 10,000 or more population)" (du Plessis et al., 2001, p.6). I have chosen this definition for two significant reasons: first, because it is recommended by Statistics Canada as a starting benchmark for understanding Canada's rural population; and second because it is listed as an appropriate definition for describing issues with a community focus, including issues related to accessing health care services (du Plessis et al., 2001, 2002).

1.4.1 The Importance of Studying Rural Health Care Ethics

There are four primary reasons why the study of rural health ethics is of importance. The first concerns the significant number of people who continue to live in rural communities. According to our definition this represents approximately 22% of the population or 6.2 million Canadians (du Plessis et al., 2001, 2002). The second consideration concerns the often-distinct characteristics of rural communities. These include but are not limited to a higher concentration of low-income earners, higher poverty rates, increased rates of mental health issues, and increased involvement in risky sexual behaviour resulting in higher rates of teen pregnancy and sexually transmitted

infections (STIs) (CIHI, 2006; Dryburgh, 2000; Nelson & Schmidek, 2008; Romanow, 2002; Pong, 2007; Fairbairn & Gustafson, 2008; Kirby & LeBreton, 2002a). Third, there exist fewer health care providers and institutions per capita, than in urban areas, engendering shortages and longer wait times (Romanow, 2002; Kirby & LeBreton, 2002a; Fairbairn & Gustafson, 2008). Finally, ethical issues such as: 'safeguarding confidentiality', 'boundary conflicts due to overlapping relations', 'access to health care services', 'allocation of health care resources', 'reluctance to seek a diagnosis due to stigma', and 'community cultural value conflicts' can each become serious problems and are often neglected in discussions concerning general ethical issues (Nelson, 2004; Nelson & Schmidek, 2008). For these reasons, research that incorporates a rural lens or that comments on the rural context is important and needed.

1.5 Methods

Traditionally ethics and morality are studied in a philosophical context with a focus on normative as opposed to descriptive knowledge claims (Kagan, 1998). Therefore, in contrast to descriptive ethics (a subset of non-normative ethics) which uses empirical methods to investigate how people reason through and react to particular moral situations (Beauchamp & Childress, 2009), normative ethics "involves substantive proposals concerning how [one should] act, how [one should] live, or what kind of person [one should be]. In particular, it attempts to state and defend the most basic principles governing these matters" (Kagan, 1998, p. 2). Normative analysis thus seeks to describe what ought to be the case or what ethical norms should guide ethical conduct (Beauchamp & Childress, 2009; Kagan, 1998).

Although both normative and non-normative approaches to understanding morality are important and useful, one's guiding questions as well as one's purpose for asking these questions will differ depending on the approach assumed (Kagan, 1998). For example, if we wish to understand how moral norms guide professional practice in health care or how individuals go about confronting difficult moral dilemmas on a daily basis, a descriptive approach is best (Beauchamp & Childress, 2009). Curlin, Lawrence, Chin & Lantos (2007) effectively used this method when inquiring how physicians interpret their ethical rights and obligations when conflicts of conscience arise within clinical practice.

In contrast to descriptive approaches, normative approaches are best suited to situations where one seeks to "state and *defend* substantive moral claims" (Kagan, 1998, p. 8). Within the category of normative ethics, Beauchamp & Childress (2009) also add applied ethics. The focus of applied ethics is the application of normative moral principles, theories, and precedents to specific complex cases and contexts (Beauchamp & Childress, 2009; Kagan, 1998). This approach is useful in outlining injustices as well as drawing attention to inconsistencies between how people, organizations, and societies currently act and how they should act (ethically speaking) (e.g., simply because an action is legal does not mean it is ethical and vice versa). Because the purpose of my thesis is to analyze a relatively specific issue as well as to offer moral judgment and prescriptions related to it, my thesis can most accurately be described as normative and localized more specifically within the realm of applied ethics.

In assuming this approach I undertake a process of reasoned ethical analysis, informed by various normative ethical constructs such as those related to justice, beneficence, non-maleficence, and autonomy. In so doing, relevant arguments are

presented and the important task of determining which side presents the stronger case is outlined (Kagan, 1998). Through this process one constructs an ethical analysis that is expected to be both compelling and based on solid moral reasoning and justification.

1.6 Restatement of Purpose & Proposal of Research Questions

With 51 hospitals currently operating in eight provinces across the country (the Province of Newfoundland does not currently have Catholic hospitals only one long term care facility) (see Appendix A.), Catholic hospitals remain important players in the Canadian health care system. Despite their significant involvement in providing health care however, little attention has focused on the legitimacy of Catholic hospitals to conscientiously refuse to provide services that contradict their guiding religious beliefs. The purpose of this thesis is to examine the ethical implications of Catholic hospital conscientious objections to provide reproductive services to which they are morally opposed within the context of the Canadian health care system, and more specifically within rural areas. Moving forward the following two questions will assume the focus of the analysis.

1) Do hospitals possess a conscience according to the dominant view of conscience in bioethics?
2) Should Catholic hospitals be permitted to refuse to provide reproductive services to which they are morally opposed within the context of the Canadian health care system and in particular, within rural areas?

This analysis will help further the limited body of knowledge concerning the conscientious refusals of Catholic hospitals in Canada, spark dialogue and debate, and finally, to inform and influence future health policy decisions.

Chapter 2. Conscience: Do Hospitals Qualify?

2.1 Introduction

The importance of establishing a firm understanding of conscience lies in determining whether those who claim objections based on conscience use the term appropriately. Although there is a general consensus that individual human beings can claim to have a conscience (Benjamin, 1995), whether institutions and therefore hospitals can reasonably claim to possess a conscience, remains contested.

According to Cook and Dickens (1999), "Conscience is a right of individuals, but not of institutions such as hospitals and clinics" (p.85). They argue that, while corporations may benefit from a 'legal personality' in the context of various National and International laws, they are granted this status for purely pragmatic reasons (e.g., to allow organizations to sue and be sued, enter into contracts, and conduct business as a single entity) and therefore, unlike humans, do not possess a conscience. Given these limitations, hospitals they argue, are thereby precluded from enjoying the same entitlements (e.g., freedom of conscience) as 'natural persons' (humans) under international human rights legislation (Dickens & Cook, 2000). This position is also supported by Canadian Constitutional law, under which "corporations do not enjoy or exercise freedom of religion or conscience and, therefore, cannot claim an infringement of their own rights. Freedom of religion or conscience is a freedom that only individuals possess" (Wynn, Erdman, Foster & Trussell, 2007, p.258).

In contrast to these primarily legal points of view, authors such as Sulmasy (2008), De George (1982), and Gallagher and Goodstein (2002), argue that hospitals do in fact

have a legitimate claim to conscience, which is largely afforded to them via their established structures and processes. Although the possession of a conscience does not automatically engender a right or entitlement to make objections based upon it, it is the base standard, or first requirement for it. As such, the question of whether institutions, and thereby hospitals, possess a conscience is an important stepping stone in exploring the legitimacy or illegitimacy of a Catholic hospital's claim to conscientious refusal.

There are a number of ways in which to understand conscience. The prevailing view within bioethics, titled the "dominant view" by McLeod (forthcoming), is that conscience works to preserve or promote integrity, and does so by influencing agents to act in line with their moral values. The purpose of this chapter is to determine whether the dominant view of conscience allows us to say that hospitals have a conscience. Assuming the 'Dominant View' is correct, I will argue that hospitals, as institutions, cannot possess a conscience because they fail to fulfill a number of the necessary criteria for it.

To pursue my objective, the first section of the chapter begins with a brief introduction to the notion of conscience, followed by a description of the dominant view, and a proposal of the criteria necessary for an entity to qualify as possessing a conscience on this view. In the second section, using the developed criteria as a framework for analysis, I will discuss reasons why hospitals might satisfy the requirements for conscience as well as reasons why they might not. Ultimately, I will conclude the dominant view does not support the contention that hospitals have a conscience.

2.2 Conscience

2.2.1 A Brief Introduction to Conscience

Originating in the discipline of Christian moral theology (Benjamin, 1995; Hardt, 2008), the concept of conscience remains a fixture in contemporary academic and social discourse. Reference to it can be observed throughout various works, from the insightful teachings of Mahatma Gandhi (Rattan, 1991) to the Universal Declaration on Human Rights (United Nations, 1948, Articles 1 & 18). So engrained is the concept within the moral fabric of contemporary North-American and European societies that it has even been modeled into cartoon form, as portrayed by the lovable character Jiminy Cricket in Disney's 1940 rendition of Pinocchio.

The concept of conscience has also received growing attention in the field of medicine and bioethics, as conscience is relevant to the task of morally complex decision-making within our increasingly pluralistic society. Presumably, as science continues to push the boundaries of medicine, and the complexity of health care decisions grow, so too will the number of conflicts of conscience and conscientious refusals. Despite the established presence of conscience within society, however, scholars throughout history have often disagreed about its nature and have presented varied and, at times, contradictory descriptions of the concept (Benjamin, 1995; Lawrence & Curlin, 2007; McGee, 2007). The existence of such opposing understandings is brought to bear in the following passage by Bernard Wand (1961).

> It has been said of conscience that it is fallible (Broad), that it is infallible (Butler); that its ultimate basis is emotional (Mill), that its ultimate source is rational (Rashdall); that it is the voice of God (Hartman), or the voice of custom (Paulsen); that it is merely advisory (Nowell-Smith), that it is unconscious

> (Freud); that it is [a] faculty (Butler), that it is not (any contemporary moral philosopher); that it is disposition to have certain beliefs, emotions, and conations which, when operative issue in conscientious actions (Broad), and that it is conscientious action (Ryle) (p.771).

Although the debate continues, agreeing upon a definition of conscience is an essential step in establishing the fundamental requirements for it. In other words, we must garner a solid understanding of conscience before we can determine what would qualify an entity for it.

2.2.2 Conscience: The Dominant View

Despite the lack of consensus about how to understand conscience both within and across many disciplines (e.g., philosophy, theology), there is some consensus on the matter within bioethics. The relevant view of conscience, aptly named the dominant view by McLeod (forthcoming), proposes that conscience is best interpreted as a mode of reflective consciousness, wherein one's actions, or projected actions, are assessed for their consistency with one's moral values and standards. Conscience, as such, works to promote and maintain moral unity - understood as integrity - by compelling individuals to reliably act and conduct themselves in agreement with their moral values. The main advocates of this view are Martin Benjamin (1995), Jeffrey Blustein (1993), James Childress (1979, 1997), and Mark Wicclair (2000, 2006, 2007) (as cited in McLeod, forthcoming). (Hereafter, "conscience" will refer to the term as understood on the dominant view.)

2.2.2.1 Criteria For Conscience

In the following section I will describe the five criteria an entity would need to fulfill in order to qualify as possessing a conscience. To accomplish this objective, I first need

to develop the criteria, because a previously established list does not exist. Together these criteria should serve as a reliable template for analyzing an entity's claim to conscience. In addition, each of the criteria is individually necessary and together they are jointly sufficient for something to have a conscience.

i) The entity must be a reasonable candidate for moral agency.

ii) The entity must possess a set of values, which jointly contribute to the formation of its identity and self-concept.

iii) The entity must possess cognitive agency. By "cognitive agency," I mean the entity must be able to evaluate its actions, intentions, and desires regarding a situation based on its established set of values. Stated differently, the entity must be able to preserve or promote its inner moral unity by engaging in a relevant form of moral reasoning.

iv) The entity must have enough affective agency so that it can appropriately experience guilt and shame.

v) The entity must ultimately be subject to internal sanctioning, whereby feelings of shame and guilt are self imposed and internally mediated.

2.2.2.1.1 Criterion One – Candidacy for Moral Agency

The first requirement for conscience is that the entity in question must be a reasonable candidate for moral agency. To be a moral agent entails that one possesses the ability to identify, understand, and comply with relevant and applicable moral standards (Eshleman, 2009; Himma, 2008). We assign moral blame to agents who fail to uphold their moral obligations, because by virtue of their status as moral agents, they are

responsible for ensuring that their actions and inactions conform to those obligations. Because conscience is a moral quality, it encourages people to behave in accordance not with their mere preferences, but with their moral values (Blustein, 1993; Childress, 1979; Wicclair, 2000). To have a conscience is to possess at least some level of moral agency, because it is the role of conscience to help keep us, and our actions, accountable to our own moral standards, as well as to alert us when we are at risk of violating them. Therefore, to have a conscience is at the very least to be among the group that could conceivably qualify as moral agents.

This first criterion for conscience also encompasses the rest, in that the remaining criteria are all elements of moral agency. Being the sort of moral agent then who possesses these further qualities is sufficient for having a conscience.

2.2.2.1.2 Criterion Two – Value Framework

A second important requirement for conscience is that the entity in question possesses a set of values, which jointly contribute to the formation of its moral identity and moral self-concept. These commitments are especially important as they form the moral framework or 'master list' of moral values, rules, and standards to which conscience refers. According to the dominant view, an agent's integrity, or moral unity, depends upon their adherence to their espoused moral framework. Failure to uphold these moral commitments erodes their moral identity and causes emotional distress (McLeod, forthcoming). Heeding conscience preserves or promotes inner unity while transgressing the verdicts of conscience results in the imposition of negative sanctions and the

experience of moral fracture. (These last points are further discussed under criteria four and five.)

2.2.2.1.3 Criterion Three - Cognitive Agency

Thirdly, conscience includes a cognitive or evaluative component. This element is essential to the function of conscience; it permits the contextual application and interpretation of the agent's moral values, rules, and standards. In other words, having a conscience requires not only a set of values but also being able to examine these values and determine their weight, significance, and relevance to the situation in question. Therefore, while an individual may strongly value respect for human life in all its shapes and forms, when faced with a decision to withdraw life-sustaining treatment to a patient in a persistent vegetative state (PVS), he/she may freely reconcile with a decision to do so, knowing that it would eventuate in the patient's death, on the grounds that he/she also values respecting expressed patient wishes, and that continuing treatment would compromise the patient's basic human dignity by prolonging unnecessary pain and suffering. As this example shows, when evaluating a situation, individuals must often take into consideration multiple values (in our case three: respect for human life, for autonomy, and for human dignity) and in turn decide on a course of action based on their assessment of each value's relevance and importance given the circumstance(s). Conversely, to maintain self-harmony and unity, individuals must also evaluate their actions, anticipated actions, and intentions regarding a situation based upon their understanding of what these values require of them.

The evaluative component of conscience also signifies that while one's moral commitments play a crucial role in informing conscience, they themselves do not equal conscience (Childress, 1979). Childress (1979) makes this distinction, stating: "Although a person's appeal to his conscience usually involves an appeal to moral standards, conscience is not itself the standard. It is the mode of consciousness resulting from the application of standards to his conduct" (p.319). Conscience works to promote and maintain integrity by evaluating a situation based on whether it fits with one's moral values, and informing the individual whether he/she will feel guilt or shame as a result. In so doing, conscience operates both prospectively and retrospectively: promoting integrity by highlighting past wrongs and warning of future disharmony, should contemplated wrongs be committed (Benjamin, 1995; Childress, 1979, 1997).

2.2.2.1.4 Criterion Four - Affective Agency

The fourth requirement for conscience is affective or emotional. As Childress (1979) notes, conscience functions as an inner moral sanction, the ultimate and final arbiter, whose negative verdicts - imposed through feelings of guilt, shame and self-betrayal - are accompanied by the aching consciousness of a fundamental loss of integrity. Whereas a good conscience - often described by terms such as: 'clean', 'whole', 'quiet', and 'integrated' (Childress, 1979, 1997) - sits quietly on its own, pure as a lamb and uninterrupted in its thoughts, a bad conscience makes its presence distinctly known, rearing its ugly head with no apparent escape from the negative sanctions it wishes to impose. Proponents of the dominant view postulate that conscience mediates behaviour by threatening individuals with unpleasant emotions that they would much rather avoid. Because conscience works to promote positive behaviour through the threat of negative

sanctions, it is logical that an entity moved by conscience must first possess the capacity to experience the negative emotions (guilt and shame) with which it is threatened. An entity must therefore have enough affective agency to feel and experience the emotions of moral guilt and shame: the emotions that conscience uses to ensure agents remain accountable to their own moral standards.

2.2.2.1.5 Criterion Five - Internal Sanctioning

In addition to its affective component, conscience on the dominant view requires that the entity in question be subject to internal sanctioning. The judgments of conscience come from within and reflect one's own assessment of right and wrong as opposed to external judgments or sanctions imposed by others. As noted above, the threat that conscience poses is a loss of integrity: being kept in proper balance with oneself and not necessarily with others or with popular society. To prohibit an agent from following the dictates of her conscience would be to force her to commit a form of self-betrayal and submit to the negative sanctions of her conscience (Wicclair, 2000, 2006, 2007). In short, the capacity not only to feel guilt and shame, but also to actively 'punish' oneself with these feelings as a result of misguided thoughts or actions is a necessary part of possessing a conscience.

2.2.2.2 Support For the Dominant View

McLeod (forthcoming) gives a number of reasons for thinking that the dominant view is correct. Among the most compelling arguments is that the dramatic language often used by conscientious objectors reinforces the threatening nature of conscience, while underscoring its commitment to preserving inner moral unity. Examples of such appeals

include: "I must protect my sense of myself"; "I wouldn't be able to live with myself if I did [X]"; "I wouldn't be able to look myself in the mirror/sleep at night"; "I could no longer think of myself as a Jehovah's Witness [Catholic, Jew, moral person etc…] if I were to do or assist in [Y]" (Childress, 1997, 2006; Benjamin, 1995). Furthermore, as McLeod (forthcoming) notes, the dominant view coheres well with three other broadly popular aspects of conscience: namely that a conscience is uneasy when it is guilty – fitting with the dominant view's portrayal of conscience as causing distress in the face of moral discord (Childress, 1979, 2006); that its jurisdiction to impose sanctions is strictly personal (i.e., its verdicts are limited to our own actions or inactions and not the actions or inactions of others) - suggesting a concern for the self and protection of one's own integrity vs. a general concern for what is right (Benjamin, 1995; Blustein, 1993; Ryle, 1940); and that it respects the distinction between making a moral judgment (e.g., X is morally wrong) and making an appeal to conscience (e.g., X is morally wrong and there is an added wrongness for me to participate in X because it would compromise my integrity) (Blustein, 1993).

Thus, the dominant view has compelling aspects to it. To sum up the view itself: conscience is a mode of reflective consciousness which influences one to act, either prospectively or retrospectively, in accordance with one's moral values in order to promote and maintain individual moral integrity. Failing to abide by one's conscience causes distress in the form of guilt and shame (negative sanctions), and leads to fractures within the self. Using this definition, I established five criteria for having a conscience: 1) being a reasonable candidate for moral agency; 2) possessing a set of values which help

to define the self; 3) possessing cognitive agency; 4) possessing affective agency; and 5) being capable of internal sanctioning.

The dominant view is not immune to criticism (see McLeod, forthcoming). Nevertheless, it is dominant in bioethics, and more importantly, it is compelling in many ways. Thus, it is worth discerning whether the view would allow for institutional conscience. In the next section, I use the criteria I have developed as a framework for analyzing whether hospitals have a legitimate claim to conscience.

2.3 Assessing The Hospital's Claim To Conscience

While discussing in this section whether hospitals are reasonable candidates for having a conscience, I will examine reasons that various authors offer for why hospitals do possess a conscience. I will also ultimately argue that such a view about hospitals is incorrect.

2.3.1 Criterion One – Candidacy for Moral Agency

The literature on moral agency identifies two different kinds of agents: 1) individual agents and 2) collective agents. To quote from this literature:

> While the notion of moral responsibility, traditionally understood, grounds moral blameworthiness in the will of discrete individuals who freely cause harm, the notion of collective responsibility associates both causation and blameworthiness with groups and construes groups as moral agents in their own right (Smiley, 2011, p.2).

Conceptualized as such, groups are alleged, for all intents and purposes, to possess the ability to formulate intentions and to act as a unified entity with similar rights, privileges, and demands afforded to and imposed upon them as on individual moral agents (Smiley, 2011). To function as a collective agent is to act not as a mere aggregate of individuals,

but as a non-distributive entity that "transcends the contributions of particular group members" (Smiley, 2011, p. 4).

An ideal example of such an agent is that of the Borg, a fictional pseudo-race of 'cybernetic organisms' (beings with both biological and artificial parts) featured in the series Star Trek. Unaware of being made up of discrete individuals, the Borg form an integrated collective of drones who operate with a shared consciousness, or a 'hive mind', which allows them to think and act as one ("Borg", n.d.). Thus, it is impossible to refer to the encounters, actions, and deliberations of one drone without referring to those of the entire collective and vice versa.

As I have said, the Borg represents the 'ideal' (collective agent); in practice it is not necessary for a group to achieve such a pervasive level of integration in order to qualify as a collective agent. What is necessary, however, is that agents move away from thinking and acting only as discrete individuals and move towards defining their thoughts, actions, failures and accomplishments, intentions, and subsequent identity as one with the collective. Accordingly, proponents of collective responsibility advocate that groups, through their own established structures and processes, can bring about actions not possible of individuals alone (Cooper, 1968; French, 1998; May, 1987; as cited in Smiley, 2011). As Buchholz and Rosenthal (referring to Werhane 1985) suggest:

> In a collective action each individual action is mixed with others and transformed into an action or policy of the organization. Because of this process of transformation, the collective action of the corporation is quite different from the primary inputs of any of the individual contributors (Buchholz & Rosenthal, 2006, p.238).

Proponents also highlight that as a society, we are often quick to assign generalized blame to groups, corporations, and organizations, which presupposes that some level of

collective responsibility/agency exists (Cooper, 1968; Tollefsen, 2006; as cited in Smiley, 2011).

Those who favor a hospital's claim to conscience (Gallagher & Goodstein, 2002; Pellegrino, 2002; Sulmasy, 2008; Wildes, 1997) often speak of the organization as a collective moral agent, whose integrity reflects the actions and deliberations it undertakes. In this way, authors attempt, albeit in different ways, to characterize hospitals as legitimate moral agents who, in their own right, possess a collective conscience. While there is still debate regarding whether institutions, such as hospitals, often operate or truly qualify as collective agents (Smiley, 2011),[9] it is sufficient for the purposes of this paper that they find themselves among those that are plausible candidates for moral agency. Recall that the first criterion for conscience developed above was that the entity be a *candidate* for moral agency. We can therefore accept, at least for the time being, that hospitals satisfy this criterion, not because they count as individual moral agents, but because they could easily count as collective moral agents.

2.3.2 Criterion Two – Value Framework

Moving forward, in order to successfully fulfill the second criterion for conscience, an entity must possess an established set of values, which in turn contribute to the

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[9] Those who raise concerns about the legitimacy of collective responsibility highlight a number of controversies, two of which include: 1) whether groups/organizations can form intentions and act upon these intentions; 2) whether groups/organizations, as distinct from group/organization members, can be morally blameworthy (Smiley, 2011). For a more in depth look at the controversy and an overview of the current debate, see Smiley (2011).

formation of its identity and self-concept. To satisfy this condition, advocates of the idea that hospitals can have a conscience are often quick to draw similarities between hospital mission statements and their more personal counterpart, individual value frameworks (Pellegrino, 2002; Sulmasy, 2008; Wildes, 1997).

Mission statements are primarily defined as management tools that serve to internally motivate staff while concurrently establishing the direction, objectives, and ideology of an organization. At their fullest, they are formal documents that outline an institution's purpose, vision, and values, and are subsequently meant to guide decision-making and resource allocation (Bart, 2007; Bart & Hupfer, 2004; Forbes & Seena, 2006). Understood as such, mission statements, like personal value frameworks, can provide hospitals and those working within them, with an ontology, or paradigm of sorts, for understanding how the organization views the world and how health care should be delivered. In this way, as argued by Sulmasy (2008) and Wildes (1997), established guidelines provide a framework of values upon which individuals can draw and similar to personal value commitments, help to inform conscience and guide decision-making across the organization. Some say, that in addition to their role as general value frameworks, mission statements are both a source and an expression of the hospital's shared values, commitments, and culture (Bart, 2007), and thereby serve as a mechanism through which it can manifest a distinct moral identity (Pellegrino, 2002; Sulmasy, 2008; Wildes, 1997).

Integrated into the mission statements of Catholic hospitals are the established principles and teachings of the Roman Catholic Church (Bart, 2007; CHAC, 2000; O'Rourke, 2001). The values that inform these statements contribute to a moral identity

founded at least partly in the teachings of Jesus Christ. A religious institution's identity is often strongly linked to its mission (O'Rourke, 2001; Smith Iltis, 2001; Stempsey, 2001; Wildes, 1997),[10] which according to Pellegrino (2002) provides it with a strong claim to having a conscience.

The analogy between personal value frameworks and mission statements is quite strong. Nevertheless, there are two reasons to be suspicious of whether, despite having mission statements, some health care institutions satisfy the second criterion for conscience.

The first concern relates to the potentially vague nature of mission statements as explicit value frameworks. Because these statements are generally designed for high level, overarching guidance, they often sacrifice specificity in exchange for broader, more generalized themes of guidance. Teasing out more than a few specific values might not always be possible, thereby requiring professionals to simultaneously consult and apply their own, or alternate, values to a situation. This process is further complicated by the nature of mission statements as unranked decision guidelines, making not merely cognition (criterion three) but the addition of further values, such as those that help rank competing principles, necessary in cases of conflict.

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[10] Note this does not preclude secular hospitals from forging a strong identity relationship with their own mission statements. Nor does it mean that to have a strong identity a hospital's values must be religiously based. The link between mission statements, identity, and integrity simply seems to be more emphasized in the literature regarding the identity of Catholic hospitals.

Consider for example the established organizational values of St. Joseph's Health Care, London (London, Ontario, Canada): respect, excellence, and compassion (St. Joseph's Health Care, London, 2010); or those of St. Michael's Hospital (Toronto, Ontario, Canada): Human dignity, excellence, compassion, social responsibility, community of service, and pride of achievement (St. Michael's Hospital, 2011). As value statements they are certainly representative of what the organization wishes to achieve as a whole, but as tangible and applicable values, they are vague and still require a great deal of situational manipulation and interpretation. Although under Criterion two, we are concerned with the simple *existence* of an established set of values, the factor of ambiguity is important to note, as it will return to play a decisive role in the analysis of later criteria.

The second important point of contention lies in the potential for collective ownership of the institutional mission statement. As an administrative tool, common buy-in across various levels and sectors of the organization is essential for collective application (Wildes, 1997). If a mission statement is not completely representative of the culture, or is poorly developed – for example if it is developed too quickly or without sufficient staff consultation – its legitimacy and authority, as an overarching value framework and identity-conferring tool, will be weak. This point too will return in our discussion of the remaining criteria for conscience.

Despite these concerns, mission statements, if they are well developed, can work to establish a sufficiently recognizable set of institutional values, which in turn can contribute to the formation of the hospital's identity and self-concept. Thus, while having some reservations about whether some health care facilities satisfy the second criterion is

appropriate, hospitals whose mission statements genuinely define their identity can fulfill both parts (set of values, moral identity) of this criterion.

2.3.3 Criterion Three – Cognitive Agency

The next and third important element is the ability for an entity to engage in moral reasoning. This ability is what permits the contextual application and interpretation of one's value framework. Possessing a conscience is not only about adopting a set of values as one's own, but also about evaluating (either consciously, or subconsciously via intuition or perception) one's actions, or anticipated actions and desires regarding a situation, based upon these values.

A number of authors assume or argue that hospitals exercise cognitive agency. For example, Sulmasy (2008) claims that,

> The conscience of an institution is rooted in the fact that it professes a set of fundamental moral commitments... and is exercised in making the moral judgment that a decision that it has made or is considering would violate those...commitments (p.143).

The assumption here is that hospitals possess the cognitive agency necessary for having a conscience and that the individuals, who work for it, will judge whether or not the hospital has lived up to its values and moral expectations.

Hospitals have this ability, according to Gallagher and Goodstein (2002), because of what these commentators call "mission discernment": "...a core organizational process that allows health care institutions to actively reflect on their mission and core values and confront the ethical challenges posed by the contemporary health care context" (p.435). In this way, actors within the hospital, such as members of governing Boards,

committees, policy councils, and ethics teams, make decisions based on the hospital's moral values and commitments by reasoning together as a collective agent. According to advocates of institutional conscience, these groups and bodies, especially at the Board and governance levels, can engage in collective moral cognition and reasoning, thereby achieving a collective mental state representative of the hospital (Gallagher & Goodstein, 2002; Sulmasy, 2008).

But in many ways, it remains problematic to attribute cognitive agency – collective or otherwise – to hospitals or institutions. As Sulmasy (2008) and Gallagher and Goodstein (2002) would have us believe, hospitals do in fact possess the ability to apply their established organizational values to particular contexts. They do so in the manner of a collective agent, wherein employees from the boardroom to the bedside, work collectively, advancing and applying the values of the organization to everyday problems and situations. But are we really speaking of a truly collective conscience that can respond to situations in light of the organization's values, in a consistent and morally unified way, or are we more accurately referring to a number of agents, who individually, through the efforts of their own conscience, work to interpret and apply the established values of the hospital? In the following paragraphs I will argue that hospital employees do not function as a collective cognitive agent, but instead, as individual agents, who themselves engage in cognitive reasoning and reflection on behalf of the hospital in unique, introspective, and personally inspired ways. To do so, I will first examine the interpretation and application of hospital values at the level of the individual health care professional (HCP)/employee and second, at the Board level.

2.3.3.1 The Individual HCP or Employee Level

In a multicultural society, the content of people's consciences will vary considerably depending on their personal, professional, and social roles or values. Moreover, research suggests that among complex organizations, especially those divided along clear occupational lines, such as hospitals, various subcultures will emerge (Scott, Mannion, Davies, & Marshall, 2003). Although individuals within these co-existing subcultures are linked by a common thread - i.e., the delivery of health care services within an organization - Scott et al. (2003) indicate that each person's professional affiliation (whether they are administrators, doctors, nurses, therapists, clerks, porters, or cleaners), as well as their gender, ethnicity, social class, religion, and even sub-specialty, can create a distinctive sense of identity and purpose.

Health care is a value-laden enterprise. Accordingly, there are calls for professionals at all levels of the hospital to behave not as 'automatons', or 'technical clerks' (Wicclair, 2006), but as conscientious and knowledgeable stewards of their profession and affiliated organization. To ask less of these people would be to compromise their personal as well as their professional integrity. As hospitals grow in diversity and complexity, the mixing of personal, professional, and organizational values will invariably create differences in moral interpretation across the organization. While the values of the hospital may remain those of the organization as a whole, their centrality to the everyday workings of individual conscience will depend upon their positioning as 'deep moral commitments' – those values most central to one's core moral identity – as well as the significance individuals see them having to particular situations.

While governance Boards grapple with joint decision-making, we might, for the time being, consider their efforts as channeling those of a collective moral agent, whose deliberations reflect a shared collective conscience. As we expand from the core governance of the organization however, the same does not necessarily hold true. The capacity for Boards to reason together is largely predicated on their shared understanding of the established core values of the hospital and their expected commitment to keep them at the forefront of the decision-making process. Once we start moving away from the core of the organization, however, we gradually depart from the absolute centrality of these established values to the moral reasoning that informs conscience.

Just as a circular ripple of water emanating from a central point of impact gradually dissipates and looses force the further it travels from the core, so too might the established values of the hospital. Although we recognize the broader ripples as belonging to the initial point of impact within an otherwise calm lake, as the ripples grow in diameter, they become more removed from this point and are less influenced by it.

Similarly, as we expand from the core governance structure of the organization, it becomes less likely that the values of the hospital will maintain the same strength or force as they do at the Board level. It is more likely, as we move from governance to bedside, that individuals will include and incorporate personal and professional values (i.e., those values strongly influenced by subculture, previous life experience etc…) into their daily understanding and judgments of conscience. This trend will appear regardless of whether the hospital has a religious affiliation.

Consider the results of a recent study comparing the content and mission-related performance of Canadian hospitals (Bart, 2007):

> While the faith-based institutions in this study appear to excel in garnering significantly higher levels of emotional conviction to their missions, they fail to capture the same degree of advantage over their secular counterparts when it comes to keeping the mission 'front and centre' as a decision making tool (p.688).

In other words, while members of Catholic hospitals tended to express a greater emotional commitment to the hospital's mission, these hospitals struggled just as much as secular ones in having mission statements guide 'day-to-day decision-making' (Bart, 2007). While individuals working within the hospital, by virtue of agreeing to work there, will likely have adopted and integrated the values of the hospital into their own value systems to some degree, for many these values will not be *core values* – those most central to the deliberations of conscience - as opposed to *perimeter* or *peripheral* values, which are still important to the moral decision-making process but successively less so than values at the core (See Figure 1).

I use the terms perimeter and peripheral here to illustrate incremental differences between those values closer to our core and those further away. Furthermore, given the existence of multiple subcultures within

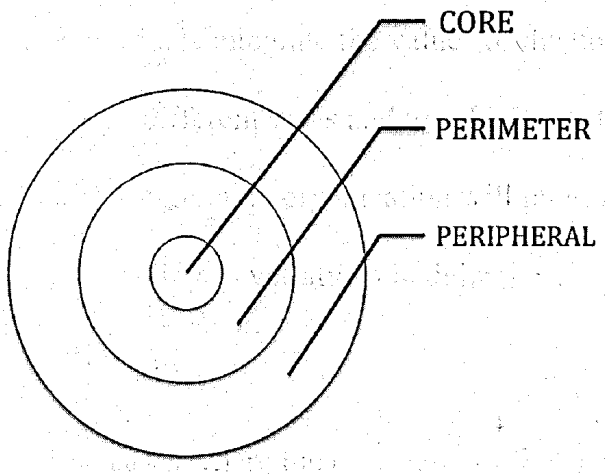

Figure 1. Relationship between core, perimeter & peripheral Values

organizations and the desperate need for health care providers across the country, even if one argued that to work at a hospital an employee's core values should align with those of the organization, it is unlikely the values of all staff would precisely mirror those of their employer. Moreover, even if one's core values did accurately align with those of the hospital, it is further unlikely, considering differences in individuals' perimeter and peripheral values, that each verdict of conscience across an organization would be the same.

To elaborate, in as much as organizational values may inspire an understanding of oneself as a hospital employee, each person will bring with them their own values and experiences, which, to varying degrees, must be balanced with those of the hospital. This is not to say organizational values are unimportant to the everyday deliberations of staff. Simply put, while we may work for an organization, and even agree with many of its values, at the end of the day, the values that will remain at the forefront of our decision-making process will be those most central to our *own* integrity and self-concept. Given the diversity of core values that exist, as individuals integrate the values of the hospital into their practice, they will inevitably do so in different ways and to different extents. It is therefore not surprising, that individuals throughout an organization will interpret and apply organizational values differently, thus leading to variations in deliberations and judgments of conscience across the hospital.

As I've said, however, there may also be cases where the core values of a hospital and of an employee align. Indeed an individual may have opted to join a particular organization because of its espoused values, or after having worked there for a period of time, find that their values have become those of the organization. Unfortunately though,

even the alignment of core values does not ensure that verdicts of conscience will be the same. To illustrate my point, consider once again the core values of St. Joseph's Health Care, London – Respect, Excellence, and Compassion (St. Joseph's Health Care, London, 2010) – viewed this time in the context of an ethical dilemma where two hypothetical staff are asked to administer increasing amounts of morphine to a dying patient. For the sake of argument, I will assume that the core values of both staff members align with those of the hospital, but that the staff members differ in their perimeter and peripheral values. Thus, both value respect, excellence, and compassion, but at the same time, one sees the administration of potentially lethal amounts of morphine as being permissible and the other does not. Looking more closely, the first staff member sees the high doses of morphine as respecting the patient's dignity by easing his pain and suffering. Although she understands it may hasten death by suppressing the respiratory system, the intention of administering the morphine is to ensure the patient's comfort. In administering the medication, the first staff member - informed by perimeter and peripheral values about beneficence (e.g., the reduction of pain and suffering) and the preservation of dignity during this difficult time - believes she is acting in the best interests of the patient and thus providing excellent and compassionate care. Conversely, our second staff member interprets the administration of these high doses of morphine as potentially compromising the sanctity of life and violating the principle of non-maleficence. In this case, despite the fact that the morphine will ease some of the patient's pain, it will also have the unacceptable effect of hastening his death. Therefore, for the second staff member, the proposed actions - informed by perimeter and peripheral standards about non-maleficence

and the sanctity of life - are not in line with the respectful and compassionate delivery of care.

In the previous example both staff members are convinced they are accurately promoting the core values of the hospital. However, as a result of their conscience, each is compelled to follow an opposite path. This scenario reinforces how the deliberations and verdicts of conscience can be unique, despite individuals possessing the same core values. Core values can also come to mean different things when informed by different perimeter and peripheral values. Once again we are reminded of the diversity of conscience within organizations, and this time how a person's perimeter and peripheral values can play into it.

In this way, although Sulmasy (2008) and Gallagher and Goodstein (2002) argue that the shared understanding of a hospital's governance Board permit it to reflect on situations in the manner of a collective agent, the truth is that these people represent only a small number of those operating within the organization. As we expand to encapsulate the efforts of the broader organizational community, we see that a greater proportion of people within it are not working as a collective reflective agent, but rather as individual agents working to preserve or promote inner unity, or unity between their values and those of the hospital in unique ways.

2.3.3.2 The Board Level

Having explored the interpretation and application of hospital values at the individual HCP/employee level, I now turn to the Board level. Here, I question whether it is enough to say that because Board members have a common understanding of the organization's

values, and together reach common decisions, that their deliberations afford them, and thereby the hospital, the one mindedness necessary for a collective conscience. In as much as Board members, adhering to the same core values, might arrive at a collective decision, the reasons why each individual agreed to the decision can be strikingly different. In other words, when we look more closely, our ripple analogy seems to fall apart; even at the Board level, the core of the organization, the epicenter of the ripple, things are not completely unified.

As an example, let us examine a Board deliberating about dishonesty. Let us also say that during this deliberation, the unequivocal answer from all members was that lying is wrong. Indeed the final answer to any question is important, but what might be even more telling when examining conscience is the deeper reasoning behind its verdicts.

Returning to our example, let us probe further into the reasons why Board members might decide that lying is wrong:

1) God says so,

2) It violates a categorical moral imperative,

3) Deception contradicts the values of the medical profession,

4) It produces undesirable consequences

Although the example is relatively simple, it makes a clear point. Each of these justifications produces the same result - dishonesty is wrong - but the justifications differ. The decision-makers arrive at a collective verdict, but not for the same reasons. The

reasoning that informs conscience differs from one person to the next. There is no collective cognitive agency.

By concentrating on the final answer to a question, we neglect important information that hides beneath the surface. When small, seemingly insignificant details about the question change, a previously established consensus could fall apart. This is especially true in health care, where the weighing and balancing of values is a frequent, exceedingly complex, and an ever-evolving process. Looking once again at our example, what answer might our Board members give if the parameters were slightly changed? That is, instead of simply asking whether lying was wrong, they were asked whether lying in order to save a patient's life was wrong. This time, we might see some disagreement. Although Board members with reasons 1) and 2) above might continue to disapprove of lying, in light of the changes to the question, Board members with reasons 3) and 4) might reconsider their verdict. Let us look more closely at each possibility:

1) Lying violates God's eighth commandment ("You shall not bear false witness against your neighbor" (The Holy See, n.d., A traditional catechetical formula, ¶ 8)). Therefore, this Board member may choose to abide by his original decision. Alternatively, he could permit lying in this context, because not doing so may cause him to indirectly violate the fifth commandment ("You shall not kill" (The Holy See, n.d., A traditional catechetical formula, ¶ 5)).

2) A categorical moral imperative is absolute and unconditional. This Board member will definitely continue to view lying as wrong.

3) Not lying would violate the Hippocratic oath – above all, do no harm. In this situation, this Board member will permit lying.

4) In this case, the death of the patient as a result of *not* lying will likely produce more undesirable consequences than those caused *by* lying. Thus, this Board member will likely allow lying.

The slight change in question will cause most Board members to ponder again the ethics of lying, and for members with reasons 3) and 4) (and possibly 1)), to alter their verdicts entirely. This exercise suggests that the consensus of a group does not necessarily come from a collective cognitive agent; the consensus can disguise differences in moral justification that come to the surface once the topic of discussion changes only slightly.

Because deliberations of conscience are subjective, there will presumably be differences (big and small) among agents as each of them applies different values to a situation or weighs different values differently. There may also be differences within individual agents themselves, as values are reassessed over time. Therefore, although it might be tempting initially to view the decisions of Boards as those of a collective cognitive agent, upon closer examination we see that this perception is false. Instead, individuals at all levels of an organization such as a hospital, engage in moral reflection in an individual fashion.

Thus, I contend that hospitals do not satisfy the third criterion for conscience. In addition, because each criterion is individually necessary for conscience, hospitals automatically fail on the larger scale. Assuming that my argument is correct, I could end the analysis here and reliably conclude that hospitals do not possess a conscience. But

since my argument might be flawed, I will move on to consider how hospitals fair with respect to the remaining two criteria.

2.3.4 Criterion Four – Affective Agency

In order for hospitals to have the affective agency needed for conscience, they must possess the capacity to experience shame and guilt. Unfortunately, according to Campbell (1957) (as cited in Haskar, 1998), the inner life that permits individual persons to experience pleasant or unpleasant emotions is precisely what robots, corporations, governments and other similar entities lack.

> [For] even if they instantiate rational systems or functional systems such that it makes sense to attribute actions … to them, they do not have an irreducible inner phenomenology. Thus a corporation or state is not joyous and does not suffer (in the phenomenological sense) except in the sense that is reducible to the suffering and joys of its members (Haskar, 1998, The inner life and the Kantian view section, ¶ 4).

From this perspective, hospitals cannot have the mental states required for affective agency. In "contrast to the healthcare professionals" that work within hospitals (Wicclair, 2011, p.130), hospitals themselves cannot experience feelings of physical or emotional distress, nor can they experience the effects of guilt or shame at the prospect of a fundamental loss to their 'moral integrity'.

While this perspective may indeed be correct, hospitals, like many organizations, are inherently driven by their membership. As such, although hospitals, as artificial entities of the law, may not possess emotions, it is worth considering whether hospitals as collective moral agents can. In other words, can the feelings of those within the organization amount to a collective or shared sense of guilt or shame sufficiently united

and reflective of the entire organization that we can say the organization feels guilt or shame?

Most authors currently writing in favour of the moral agency and conscience of hospitals do not explicitly touch on whether institutions can feel guilt or shame, though one might reasonably assume that if they had, they would have pointed to the possibility of a collective sense of guilt or shame within the institution. This possibility arises, for example, when people who are affiliated with a hospital feel guilt by association when the hospital makes bad decisions. Consider the case of hematologist Dr. Nancy Olivieri. In 1998, after publishing negative results on a drug she was testing, Dr. Olivieri was subject to public attempts to discredit her reputation by the drug company funding the clinical trial she was heading (Apotex), her employers (the Hospital for Sick Children & the University of Toronto), and various individuals within them. Despite threats of legal action and the lack of support from the Hospital and the University – both anticipating continued funding from Apotex – Dr. Olivieri felt she had an ethical obligation to inform her patients and the broader scientific community of the drug's harmful effects. Dr. Olivieri has since been vindicated, but in the years that followed the disclosure of her findings, she was nonetheless subjected to continued reprisals from the organizations involved (Olivieri, 2001; Thompson, Baird & Downie, 2001, 2005). In this case employees of the hospital could easily have felt guilt from being part of an organization that acted in such a defamatory and negligent way. There also could easily have been a collective sense of guilt within the organization.

I question, however, whether guilt by association is truly collective guilt, as opposed to individual guilt that reflects not a collective bad conscience, but individual bad

consciences. Consider that the magnitude of guilt felt by the individuals involved will presumably differ from one person to the next depending on: 1) their involvement; 2) their role within the organization; and 3) their personal value framework (including which of their values are core vs. perimeter or peripheral).

Looking back at the Olivieri case, while there may be a minimal base sense of guilt felt throughout the organization, individual experiences of this guilt will vary. For example, lay members may feel guilty for their association with the organization, but will feel less guilt than the administrators who had penned and authorized the defamatory allegations against Dr. Olivieri. Similarly, colleagues who stood by Dr. Olivieri throughout her ordeal will feel quite differently than those who abandoned her during her time of need. Individuals' personal values will also affect their level of guilt. Those who deeply value the hospital's role as a protector of the public's health may interpret the situation differently than those who deeply value its role in promoting clinical research.

Value differences will also influence the pervasiveness of guilt felt across an organization. Although in specific cases of gross and obvious misconduct by the organization – such as in the case of Dr. Olivieri – there will probably be at least a base level of collective guilt/shame felt across the organization, in other cases, this may not be true. Instead, we might see people at opposite ends of a spectrum on feeling guilt versus feeling proud of the organization. A case in point would be that of Sister Margaret McBride, a Catholic nun in the United States who was fired from the hospital's ethics committee where she worked and was subsequently excommunicated from the Roman Catholic Church after she authorized the abortion of an eleven-week-old fetus to save the mother's life (Kristof, 2010). In this case, some employees firmly supported the

institution's decision and felt guilty that such a procedure had been performed in their place of work. Conversely, others were appalled that such action would be taken against Sister McBride, because what she did conformed to the Church's doctrine of double effect. These staff felt guilty that their place of employment took such severe action against Sister McBride. As we see, organizations can be significantly divided, which prevents there from being collective guilt, at least across the organization.

Thus, although at times they may be similar, the emotions of those within an organization can vary considerably from one person to the next, which means that there is not the united manifestation of emotion that is necessary for collective affective agency. As we will soon see, these differences among individuals will also affect the possibility for collective sanctioning within the organization.

2.3.5 Criterion Five – Internal Sanctioning

As a final requirement for conscience, the entity in question must ultimately be subject to internal sanctioning, whereby feelings of shame and guilt are self imposed and internally mediated. Once again, while authors writing on the subject do not make explicit reference to the ability of such organizations to engage in forms of internal sanctioning, they do speak of hospitals as moral agents subject to moral punishment. Therefore, in as much as hospitals are moral agents responsible for their actions and inactions, so too are they worthy of praise, blame, and the imposition of sanctions (Gallagher & Goodstein, 2002; Sulmasy, 2008). These sanctions may come in various forms, and by virtue of a hospital's role within society, may be the result of impediments to the law, internal/external policy standards, political will, etcetera. It is improbable,

however, that hospitals would possess the ability to adequately sanction themselves internally in a manner that would be representative of conscience.

Hospitals, I argue, can only be sanctioned externally or rely on those who work within the organization to either sanction one another or submit to the sanctions of their own consciences. But to mirror individual conscience, it must be the hospital sanctioning itself. This is an important element of conscience as its fundamental role is that of an internal mediator whose verdicts are limited to the self and remain distinct from the judgments or sanctions imposed by others. Consequently, the pressure of negative public opinion, legal, or external policy sanctions could not count as legitimate sanctions of institutional conscience. To be sure, a conscience may internalize and later incorporate cues from the external environment into its assessment of individual moral blameworthiness. Its verdicts, however, will necessarily reflect the subjective experiences and values of the individual.

Moreover, penalties meted out after employee disciplinary hearings or the like do not obviously count as sanctions of conscience, because conscience can tell the employee who is punished that she is, in fact, blameless. Individuals can maintain a clear conscience, while being found to have violated established corporate policies or even the law. Well-known examples include those of Jack Kevorkian regarding his provision of assisted suicide in the United States ("Jack Kevorkian", n.d.); the experience of Dr. Henry Morgentaler regarding his administration of abortions in Canada during the 1970's and 1980's ("Abortion crusader", 2009); as well as the case of Robert Latimer, a Saskatchewan farmer convicted of second-degree murder in 1994 for what he maintains was the 'mercy killing' of his severely handicapped daughter, Tracy ("Compassionate

homicide", 2009; "Latimer still defends", 2011). In each of these cases the defendants maintained a clear and unaltered conscience and probably believed that they would have suffered a worse fate at the hands of their own conscience had they not acted as they did. In short, legal sanctions are not sanctions of conscience because they are externally imposed and do not reflect each person's internal deliberations.

While I have established that external sanctions and those imposed by others do not clearly count as sanctions of conscience, the question begs to be asked, what of the possibility of a collective sanctioning of conscience? Fortunately the question seems to have already been answered. If guilt, shame, or responsibility is not collective, then there can be no hope of collective sanctioning. And if there is no collective sanctioning, there can be no collective conscience. Building upon the discussions about the previous criteria, I argue there is a lack of compelling evidence that individuals within hospitals experience guilt or responsibility collectively. Moreover, the differences in how they will sanction themselves preclude the possibility of a collective conscience.

2.4 Conclusion

2.4.1 Summary of Findings

Having reviewed the elements necessary for conscience, it seems conclusive the dominant view does not support the contention that hospitals possess a conscience. Although they were moderately successful in fulfilling criteria one and two, hospitals cannot adequately fulfill criteria three, four, and five, and consequently fail to possess a conscience.

With respect to criterion one, we saw that hospitals could qualify as moral agents that are collective in nature. However, in light of the evidence presented about criteria three, four, and five, whether hospitals fully meet the criterion of moral agency is now in doubt. (Recall that criteria two to five all discuss capacities that are elements of moral agency.) At least some hospitals fulfilled criterion two: those that possess well-developed and fully-integrated mission statements could claim to have an established set of values which contribute to the formation of their identity. In criterion three, hospitals were assessed not to meet the necessary requirements, as they do not function as collective cognitive agents. Discussion about criterion four revealed that hospitals do not reliably exhibit the truly unified and collective sense of guilt and shame necessary for collective affective agency. Finally, with respect to criterion five, it was determined that hospitals do not possess the ability to impose upon themselves internal sanctions.

From these findings we see that at the very least, hospitals do not meet three of the five criteria for conscience. Given that candidates for conscience must fulfill *all* of the criteria, we can reliably say that hospitals do not possess a conscience, as conscience is understood according to the dominant view of conscience in bioethics.

2.4.2 Future Focus

Some readers might disagree with me about whether hospitals can possess a conscience, perhaps because they do not accept the dominant view. (They might accept instead a Catholic view of conscience.) All readers should agree, however, that possessing a conscience does not automatically engender a right or entitlement to make objections based upon it, or to have those objections respected in all circumstances. Thus,

even if one assumes that hospitals qualify as having a conscience, one still must question whether or to what degree they ought to receive conscience protection. Should Catholic hospitals be permitted to conscientiously refuse to provide services within the context of the Canadian health care system and in particular, within rural areas? This question will be the focus of my next chapter.

Chapter 3. Catholic Hospital Conscientious Objection

3.1 Introduction

It is a current practice in Canada that religiously affiliated hospitals may conscientiously refuse to provide services, therapies, and procedures that contradict their guiding religious values. They are generally permitted to do so on the grounds that failing to uphold their guiding religious beliefs would compromise their identity and integrity (Pellegrino, 2002; Sulmasy, 2008, Wildes, 1997). For Catholic hospitals, these beliefs are informed by the principles outlined in the Health Ethics Guide (Catholic Health Association of Canada (now Catholic Health Alliance of Canada) [CHAC], 2000), as well as the general teachings established by the Roman Catholic Church (e.g., Humanae Vitae (Paul IV, 1968), Donum Vitae (Congregation for the Doctrine of the Faith, 1987), Dignitas Personae (Congregation for the Doctrine of the Faith, 2008)).

Prohibited or immoral interventions include: Abortion; sterilization (e.g., vasectomies and tubal ligations) for birth control purposes; cryopreservation; artificial insemination by a donor; in vitro fertilization; surrogacy; and "means that deliberately and intentionally interfere with the procreative aspect in sexual intercourse" (CHAC, 2000, p.40, article 50). To varying degrees, these means can include refusals to dispense condoms[11],

[11] Distributing condoms is a standard practice in public health for reducing the transmission of HIV/AIDS and Sexually Transmitted Infections (STIs) (UNAIDS, United Nations Population Fund, World Health Organization, 2009).

hormonal contraception, and emergency contraception (EC)[12] (CHAC, 2000). Interestingly, final decisions relating to services that are and are not provided are often made by the local Bishop (McGowan, 2005). Differences in opinion or interpretation by local Bishops can lead to variability in services offered amongst Catholic hospitals across the country.

An important aspect of any free and democratic society is respect for conscience. In Chapter two, however, I argued against the view that such respect is warranted in the case of hospitals, as they do not have a conscience according to the dominant view. Hospitals, on this view, cannot conscientiously object in a legitimate manner. At the same time, even if hospitals could be considered to be entities that have a conscience, continuing to provide blanketed protection of their conscientious refusals may represent an infringement on the personal autonomy of individual Canadians, and in some cases, impose significant barriers to accessing standard reproductive services. Refusals may also unjustifiably compromise secular ethical principles, such as those of beneficence, nonmaleficence, and justice.

In contrast to the rich debate regarding the proper scope and limits of conscientious refusals by individual health care professionals (HCPs), there is relatively little discussion on the topic at the hospital level (Dickens & Cook, 2000; Fogel & Rivera, 2003, 2004; Gallagher & Goodsetin, 2002; Gallagher, 1997; Pellegrino, 2002; Ryan, 2006; Sulmasy,

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[12] EC is frequently administered as part of the standards of practice for treating sexual assault victims who present at emergency departments (WHO, 2003; ACOG Committee on Practice Bulletins-Gynecology, 2010).

2008; Wicclair, 2011; Wildes, 1997; Donovan, 1996; Sloboda, 2001). While certain points of debate may be similar, there are a number of issues that require special attention and analysis. The purpose of this chapter is to examine whether, and to what degree, Catholic hospitals should be permitted to conscientiously refuse to provide reproductive services that they morally oppose, within the context of the Canadian health care system and in particular, within rural areas. I argue that, in as much as their refusals do not disadvantage or impose significant burdens on individuals, the community, or other hospitals and HCPs in the service area, Catholic hospitals may legitimately receive some conscience protection. However, in cases where significant burdens, limitations, or injustices are imposed, or where reasonable and timely access to services is compromised, the protection of conscience is no longer ethically justified and limits on those protections are necessary.

I propose to fulfill my objective through a two-part analysis. First I will explore reasons for believing that Catholic hospitals should continue to enjoy conscience protection and second, I will explore reasons for believing that they should not. Through my analysis, I conclude that in a number of important circumstances, the reasons against protecting the conscientious refusals of Catholic hospitals outweigh those in favour, and that limitations on the conscientious objections of Catholic hospitals are warranted. I end by summarizing these key points and suggesting situations in which limitations should be imposed.

3.2 Reasons in Favour of Protecting The Conscientious Refusals of Catholic Hospitals

In the following paragraphs I will outline a number of reasons in favour of protecting the conscientious refusals of Catholic hospitals and provide additional insight into their importance.

One of the most compelling reasons for allowing Catholic hospitals continued freedom of conscience, and one highlighted by Wicclair (2011), is the possibility that not permitting them this freedom may cause their withdrawal from health care altogether. From their perspective, Catholic hospitals are promoting the greater good by protecting their own integrity (and from their point of view, that of the general public as well) by not allowing acts that they view to be immoral to occur. Permitting presumed immoral acts to occur under their jurisdiction would not only compromise their fundamental religious beliefs, but signify formal cooperation[13] in evil practices and full moral complicity in the illicit act (CHAC, 2000). Being party to these practices may also signify explicit approval of the objectionable services, sending conflicting messages to Catholics and the broader

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[13] According to the Health Ethics Guide (CHAC, 2000), the principle of cooperation "applies to situations where an action involves more than one person, and sometimes when the persons have different intentions. It is unethical to cooperate *formally* with an immoral act, i.e. directly to intend the evil act itself. But sometimes it may be an ethical duty to cooperate *materially* [also termed legitimate cooperation] with an immoral act, i.e. one does not intend the evil effects, but only the good effects, when only in this way can a greater harm be prevented" (p.13-14). For example, when done to save the mother's life, one may consider ending an ectopic pregnancy an act of legitimate cooperation. In this case, the intention is to preserve the mother's life, while the termination of the pregnancy is seen as an unfortunate and necessary requirement for doing so.

society regarding what is and is not, morally permissible. Instead of compromising their identity and integrity, Catholic hospitals may instead choose to close their doors entirely. Unfortunately, as Wicclair (2011) highlights, the most vulnerable would likely experience the most detrimental effects of this decision. "Moreover, in some communities, the closing of one health care facility [could] substantially reduce convenient access to health services for all residents" (Wicclair, 2011, p.132), thus placing a higher burden on an already over-extended health care system and leaving other hospitals to absorb the backlash. Given the potentially severe consequences of not allowing Catholic hospitals to conscientiously object, it is important to examine reasons for believing Catholic hospitals are important and why we may value their continued involvement in health care.

First, it is essential to acknowledge the significant contributions Catholic hospitals have made throughout the years to both the Canadian health care system, and to the health of countless individual Canadians (Humbert, 2004). By not allowing Catholic hospitals to continue operating within the Canadian health care system as *Catholic* hospitals not only are we devaluing their legacy and commitment, past and present, but we also fail to preserve and respect them into the future.

Second, with experience also comes a great deal of expertise. Like many religious enterprises, Catholic hospitals are especially committed to delivering health care that is not only inspired by the 'healing ministry' of Jesus Christ, but that also nurtures the physical, mental, and social well being of patients and staff, in a manner that treats everyone with dignity, compassion, and respect (CHAC, 2000; McGowan, 2005). Since the establishment of the first hospital in North America by the Soeurs of the Augestines

Hospitalières in 1639 (Hotel-Dieu, located in Quebec City, Quebec) (Humbert, 2004), Catholic hospitals have provided a number of necessary and beneficial health care services across the country. In so doing, they have amassed a wealth of knowledge pertaining to various aspects of hospital administration and health care delivery, while also leading the way in many areas of health care, including palliative care (Morrison, Maroney-Galin, Kralovec, Meier, 2005). Given their depth of expertise and their innovative approach to certain health care practices (e.g., palliative care), we can continue to learn a great deal from Catholic hospitals. If Catholic hospitals withdrew from health care this opportunity for cooperative learning and knowledge exchange could be lost.

In a 2011 article focusing on the objections of Catholic hospitals to dispense EC to rape victims in the United States, Mark Wicclair[14] highlights several additional reasons why we might consider continuing to allow Catholic hospitals to conscientiously object. First, "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" (Wicclair, 2011, p.131). Wicclair (2011) continues to explain that for some people, simply working in an organization that permits actions that violate their core values could compromise their moral integrity and lead to significant moral distress.

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[14] Note. In this same article Mark Wicclair (2011) goes on to argue that despite their claims of identity and integrity, Catholic hospitals have an obligation to "ensure that rape victims, no matter their age, who present at the ED [emergency department] have an opportunity to receive information about EC without delay and have timely and convenient access to it if they decide to take it" (p.136).

In order to avoid such distress, some people may choose to work in an environment where they would be able to avoid such situations. In a case where the alternative is for the HCP to move, or discontinue practicing all together (both of which would result in a loss to the community), one could argue that having Catholic hospitals serves a greater good.

Second, it can be "important to patients to receive care in a facility that is committed to their fundamental values" (Wicclair 2011, p.131). Thus for some, knowing one's values are reflected in those of the hospital where one receives treatment, can be reassuring and help alleviate stress. Third, "even when they are not hospital or nursing home patients, members of a faith community may have an interest in the existence of hospitals that exemplify its fundamental principles" (Wicclair, 2011, p.131). For Catholics, administering to the sick and suffering is an important aspect of their Christian mission and is an essential part of living out their faith in a modern society (CHAC, 2000; McGowan, 2005).

Fourth, Wicclair (2011) suggests that one could claim - with the notable exception of certain outliers such as the Nazi regime - that "the existence of hospitals dedicated to upholding perceived moral ideals is intrinsically valuable" (p.131), and that a society wherein such moral ideals can be freely promoted is a better society for it. Fifth, such hospitals could be interpreted as important to the maintenance and encouragement of religious diversity (Wicclair, 2011). In fact, as previously stated, the hallmark of a free and democratic society is its nurturing and support of diversity.

Finally, "it might be claimed that insofar as such hospitals have a *social* mission,

which is perhaps especially true of religiously affiliated facilities, they promote social justice and contribute to social welfare" (Wicclair, 2011, p.131). This may be particularly true in the American context (in which Wicclair writes), where Catholic hospitals often assume care for those who lack health insurance and those who do not have the resources to pay for services out of pocket (Catholics for a free choice [CFFC], 2005). His statement is also relevant to the Canadian context, as the preferential treatment of the poor and marginalized remains a central value of Catholic health care (CHAC, 2000; McGowan, 2005). Respect for social justice and welfare might have been what led the Soeurs of the Augestines Hospitalières to first recognize, centuries ago, the need for public health care (Humbert, 2004).

Given the many positive contributions Catholic hospitals have made and continue to make, as well as the potentially severe consequences of not allowing them to conscientiously object, any decision to limit or disallow their objections must be taken seriously. One must also soberly assess such a decision against what communities, as well as the broader health care system, stand to gain by limiting the ability of Catholic hospitals to conscientiously refuse and what they stand to lose through the imposition of those same limitations.

3.3 Reasons For Imposing Limits on The Conscientious Refusals of Catholic Hospitals

While there are certainly reasons to continue protecting the conscientious refusals of Catholic hospitals, there are also a number of important reasons for imposing restrictions on these same refusals. In short, just as HCPs are not permitted 'carte blanche' when conscientiously refusing, nor should Catholic hospitals. In the following section I will discuss reasons why we might limit the ability of Catholic hospitals in Canada to make

conscientious objections. I will explore five main points: the concept of health care as a socially-mediated and public enterprise, the potential imposition of beliefs on individuals and its effect on autonomy, the use of public funds, the imbalance of conscience, and the creation of barriers to access.

3.3.1 Health Care as a Socially-Mediated & Public Enterprise

The first reason for placing limits on the refusals of Catholic hospitals relates to the special status of health care as a highly valued and socially-mediated service and the reciprocal obligations that ensue when endeavouring to provide these services.

In contrast to the American health care system, the Canadian health care system is largely predicated on a more socialized distribution and delivery of care (Fisher, 2009; Romanow, 2002). Indeed, for many Canadians, the system's shared values of "equity, fairness, and solidarity" (Romanow, 2002, p.xvi), have come to define "their understanding of citizenship" (Romanow, 2002, p.xvi) and in many respects what it means to be Canadian. As outlined by the Honorable Roy Romanow (2002):

> Canadians consider equal and timely access to medically necessary health care services on the basis of need as a right of citizenship, not a privilege of status or wealth. Building from these values, Canadians have come to view their health care system as a national program, delivered locally but structured on intergovernmental collaboration and a mutual understanding of values. They want and expect their governments to work together to ensure that the policies and programs that define medicare remain true to these values (p. xvi).

This passage highlights the importance Canadians attribute to the equitable and timely access of health care services. It also reinforces that, although health care is not a legal or constitutional right, Canadians have come to understand it as such, or in the very least, view it as an important social service that should be protected.

By committing to provide health care as a publicly mediated service however, governments also assume the responsibility of ensuring the relevant health care needs of society are reasonably met. For in as much as a 'good' (in this case health care) has been shielded from certain pressures of the market, a level of competition and the ability for consumers to exercise direct purchasing power over the services they want and need have been removed[15]. In other words, because the publicly funded system in Canada is the only option, it must meet the needs of the population it serves in a timely manner, or risk being rendered unconstitutional (Kirby & LeBreton, 2002b). This was largely the issue in the case of *Chaoulli v. Quebec (Attorney General)* (2005). Although constitutional law does not generally recognize positive rights, such as a right to health care, it does protect certain negative rights (Kirby & LeBreton, 2002b) – such as the right to life, liberty, and security of the person as outlined in section 7 of the *Canadian Charter of Rights and Freedoms* (1982). It is in this respect that challenges to the availability of health care services, such as in the cases of *R. v. Morgentaler* (1988) and *Chaoulli v. Quebec (Attorney General)* (2005), could be raised. In both these cases, delays in treatment and availability were determined to give rise to situations where severe psychological and physical suffering could compromise the security of the person. As Supreme Court Justices McLachlin and Major, in the case of *Chaoulli v. Quebec (Attorney General)*

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[15] In saying this I do not pretend that Canadians are unable to have their wants and needs recognized by the health care system. Indeed voting in governmental elections, participating in opinion polls or governmental round tables (such as those held by the Romanow commission), and joining lobby groups/associations focused on specific health needs, are each ways of having one's voice heard. What I am saying, however, is that individuals are removed from *directly* determining market interests simply by their purchasing power.

(2005), write:

> The primary objective of the *Canada Health Act*, R.S.C. 1985, c. C-6, is "to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers" (s. 3). By imposing exclusivity and then failing to provide public health care of a reasonable standard within a reasonable time, the government creates circumstances that trigger the application of s. 7 of the *Charter* (¶ 105).

While each of these cases deals with particular situations and interpretations of Charter rights, taken as a whole they help to clarify what Canadians can reasonably expect from their health care system. That is, although there is no specific legal right to health care in Canada, by undertaking the role of providing socially-mediated health care services, that have the overall effect of a government monopoly, these same governments are responsible for ensuring, within reason, that the health care needs of Canadians are adequately met. For their part, Canadians can reasonably expect not to be unduly delayed or burdened in accessing these services. Furthermore, one could argue that because Canadians interpret health care to be a general right (even though technically it is not), there is an added element of responsibility on governments (and by extension providers) to ensure services properly reflect the public's needs.

In the same way governments have a responsibility to ensure health care services are congruent with the health needs of Canadians, hospitals, by extension, have similar obligations to both the governments who grant them this ability and to the society, whom they serve. In a 2006 article on the reciprocal obligations of pharmacists and pharmacy licensees, which similarly applies to hospitals, Mark Wicclair argues that those who have been granted a monopoly by relevant licensing authorities are afforded such licenses with the understanding that they will uphold relevant standards and practices, and promote

specific ends. In the case of pharmacies, and of hospitals, these ends relate to ensuring "the public health, safety, and welfare" (Wicclair, 2006, p.228). Therefore, in as much as licenses are granted with the expectation that certain relevant requirements to the public will be met (e.g., for Canadian hospitals, administering to the needs of the population they serve), in freely accepting such a license, licensees agree to meet them. This is what Wicclair (2006) terms the 'social contract obligation', as failing to meet the outlined terms is a failure to uphold one's commitments to the licensure as well as to society. In a similar respect, Wicclair (2006) notes that an obligation to promote the goals of the health care system can also follow from requirements of reciprocal justice. In this case, licensees who enjoy specific rights and privileges have a reciprocal obligation to ensure the terms of their license are met, otherwise "they do not merit the rights and privileges associated with [the] license" (Wicclair, 2006, p.229). Because Catholic hospitals have freely chosen to provide health care services as part of the public system, and have been granted the regulated (and largely monopolistic) authority to do so, they have a social contract and a reciprocal justice obligation to ensure that the requirements of the governments who 'license' them, and the needs of the population they serve are met. In cases where these obligations are not met, limitations may be warranted.[16]

In urban areas where reasonable access to reproductive services can be maintained by

[16] Although licenses can engender obligations in a private system, the obligations on licensees in a public health care system are arguably even greater as organizations have freely agreed to participate in providing a publicly mediated service that must reflect (within reason) the needs of the general service population. In these circumstances organizations such as hospitals have an even greater obligation to serve public interests because they are public enterprises.

local hospitals or facilities in close proximity, deferring a Catholic hospital's responsibility to provide reproductive services may be permissible. In these contexts, while Catholic hospitals continue to fulfill their obligations to governments and the community in other areas of health care, the public safety and welfare are met through the general availability of reproductive services elsewhere. Refusals by Catholic hospitals will not likely impose significant burdens on the community and may be justified. Furthermore, by maintaining a certain level of flexibility in situations where reproductive services are otherwise reasonably available, we are establishing an environment of mutual respect wherein Catholic hospitals are not unnecessarily made to provide services to which they morally oppose.

In rural areas however, where availability of reproductive services cannot be reasonably met within the vicinity, deferring the responsibility of Catholic hospitals to provide these services may no longer be justified. In these contexts, even though Catholic hospitals continue to provide a variety of services, their obligations to meet the needs of the community, combined with a lack of general availability to reproductive services that meet these needs, may require them (Catholic hospitals) to provide these services. Otherwise they may impose significant burdens on the community and fail to meet government responsibilities to promote the public health safety and welfare. They may also trigger claims under section 7 of *Canadian Charter of Rights and Freedoms* (1982).

3.3.2 The Imposition of Beliefs & the Effect on Autonomy

As the potential for the refusals of Catholic hospitals to impose their religious beliefs on patients who do not share these beliefs increases, so does the justification for imposing

limits on these same refusals.

A guiding principle in medical ethics is respect for autonomy. Consistent with this principle, individuals should be permitted to make decisions and to act on their own accord free from the constraints of others (Beauchamp & Childress, 2009). According to the American College of Obstetricians and Gynecologists' (ACOG) Committee on Ethics (2007),

> To respect a patient's autonomy is to respect her capacities and perspectives, including her right to hold certain views, make certain choices, and take certain actions based on personal values and beliefs. Respect for autonomy has particular importance in reproductive decision making, which involves private, personal, and often pivotal decisions about sexuality and childbearing (p.1205).

When conscientiously objecting Catholic hospitals impose their moral beliefs on patients who do not share these beliefs, respect for the patient's autonomy is undermined.

Canadians expect hospitals, within reason, to provide medically indicated and generalized services that reflect the community's health care needs. Reproductive services are among these services and are often highly valued. In a US national survey conducted by Belden, Russonello, and Stewart (2000) a majority of women polled believed that community hospitals should provide a broad range of reproductive services. More specifically, regardless of an institution's affiliation with the Roman Catholic Church, a majority of women wanted their hospital to offer: medically indicated abortions[17] (general 87%; Catholics 86%; strongly religious Catholics (SRCs) 82%), birth control pills (general 91%; Catholics 90%; SRCs 82%), sterilization procedures (general

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[17] Medically indicated abortions are defined as abortions provided when the woman's life or health is in danger (Belden, Russonello and Stewart, 2000).

85%; Catholics 77%; SRCs 67%), and morning-after pills for rape victims (general 78%; Catholics 76%; SRCs 68%) (Belden, Russonello & Stewart, 2000). In addition, 50% of women in general, 48% of Catholics, and 38% of SRCs, expressed support for a community hospital that performs elective abortions when the health of the woman is not at risk, over a hospital that does not provide this service (Belden, Russonello & Stewart, 2000). While equivalent statistics are not available in Canada, reports suggest that approximately: 74% of Catholics in Canada believe "the doctrine of the Catholic Church regarding things such as abortion [and] contraception…is dated and out of sync with the times" (CFFC, 2004, p.23); 68 % believe the "church should abandon its opposition to the use of contraception"(CFFC, 2004, p.11); and 72% and 46% respectively believe that abortion is 'not wrong at all' or 'wrong only sometimes' if a fetus has serious defects (72%) or if a family has a very low income (46%)(CFFC, 2004).

These statistics point not only to the general desire of individuals to access reproductive services, but to a considerable desire from Catholics to do the same. The findings also suggest that Catholics are not homogeneous in their views, and that many disagree with the official position of the Roman Catholic Church on reproductive issues. It would be misleading therefore to argue, even in cases where a hospital serves a pervasively Catholic population, that reproductive services are not desired or warranted. Furthermore, even if it were true that most Catholics in a community did not want their hospital to provide certain reproductive services, in a publicly mediated health care system, sacrificing the needs of the few simply for the religious beliefs of the many is not necessarily ethically justifiable. This is especially true when the sacrificed services are easily provided by most hospitals and do not require specialized expertise or machinery

or can be provided without significant financial costs. Such is the case for many reproductive services including EC, sterilizations, and even abortions (both medically indicated and elective)(Kaposy, 2010; Trussell, Wiebe, Shochet, Guilbert, 2001).

In health care systems where access to resources is limited, priorities must be established. Optimizing scarce resources often requires centralizing specialized services in urban centres (Romanow, 2002). Although it is unfortunate that those who live outside these centres must travel outside their communities to access certain treatments (e.g., radiation treatment) and diagnostic tools (e.g., Magnetic Resonance Imaging (MRI) machines), sustaining costly systems across a vast geography would be impractical and place unreasonable financial burdens on the entire system. In the case of Catholic hospitals however, decisions not to offer certain medically indicated reproductive services are not based on financial limitations or a lack of highly specialized tools and staff but instead on religious doctrine. Moreover, the values of the hospital may not align with the values of the patient seeking medical attention. In this respect, the degree to which refusals by Catholic hospitals constitute an imposition of their beliefs on those who do not share them warrants concern.

In urban areas other hospitals in the area will likely provide reproductive services that the Catholic hospital does not. Therefore an acceptable level of access to these services will most likely be maintained. The availability of services within the area means that individuals can go elsewhere without facing significant burdens or impositions on their autonomy. Access might be less convenient but is still available.

Some circumstances that bring people to the hospital however, might be so burdensome that something as simple as going elsewhere (even in an urban area) may be physically or emotionally unmanageable. When a victim has already experienced severe trauma, as in the case of sexual assault, refusing applicable reproductive services would only add to the stress of the situation. Providing EC for victims of sexual assault is a standard medical practice (WHO, 2003; ACOG Committee on Practice Bulletins-Gynecology, 2010). Not providing EC, for those who want it, only limits their autonomy and can further victimize already vulnerable individuals by increasing their risk for an unwanted pregnancy and possible abortion. It may also expose individuals to having their requests for EC made out to be immoral. In these situations Catholic hospitals may have an obligation to provide EC, or at the very least facilitate the procurement of EC through transportation assistance to a providing pharmacy or hospital. They should also have an obligation to fully inform victims about EC so that they can make a fully informed and autonomous decision about this option.

In rural areas, the conscientious refusals of Catholic hospitals will also have a significant impact on the ability for individuals within the community to equitably access services as well as to exercise autonomy over their reproductive health decisions. In this context, the conscientious refusals of Catholic hospitals comparative to availability of services become highly pervasive. Instead of one or two HCPs objecting it amounts to hundreds, as each HCP must abide by the hospital's conscientious refusal policies. When hospitals are the sole providers for an area, the choice of whether to go elsewhere is effectively removed from the patient, thus diminishing their autonomy as well as their

ability to access medically indicated services. The hospital is now acting as the moral compass of the community and as such, exercising a monopoly over a public service.

According to Alta Charo (2005) "claiming an unfettered right to personal autonomy while holding monopolistic control over a public good constitutes an abuse of the public trust" (p.2473). This is especially true if people expect to receive certain services and are subsequently denied, simply because hospital policy forbids it on religious grounds, or if people are not familiar with what is and is not provided within Catholic hospitals. For instance Belden, Russonello & Stewart (2000) found that nearly half (45%) of the women they polled believed that if admitted to a Catholic hospital, they would be provided with the medical services they needed, even if those services contradicted Catholic teachings. In addition, while most women were aware of Catholic restrictions on abortions, few knew that a broader range of reproductive services were also restricted. Only three percent recognized that sterilizations were not provided and six percent knew that there was no access to EC (Belden, Russonello & Stewart, 2000). In Canada, determining which services are and are not provided at particular hospitals is further complicated by the possibility for differences in interpretation of the Health Ethics Guide (CHAC, 2000) by various sponsors and Bishops.

Women and men in rural areas that have secular services also enjoy more reproductive autonomy than women in the community that has only a Catholic provider. This is a form of discrimination. Even if you were aware of a Catholic hospital's sole provider status when moving to a community you might not be able to live elsewhere, and if you were able to live elsewhere you would have to proactively anticipate which services you think you would want or need in the future. This can be highly

unpredictable. What an individual thinks they might do in a situation and what they actually choose to do in a situation can be very different (e.g., circumstances might lead an individual to have an abortion who never thought she herself would elect to have such a procedure).

The ability for hospitals to provide health care as a socially mediated good and then for them to withdraw certain relevant and highly valued services for religious reasons represents an abuse of power. In rural areas, this also represents an abuse of trust as Catholic beliefs may be forced on those who do not share similar convictions while simultaneously not including the opportunity to go elsewhere. In this environment the potential burdens imposed on an individual's autonomy are significant enough to warrant limitations on the conscientious refusals of Catholic hospitals.

3.3.3 The Use of Public Funds

The third reason to consider imposing limitations on the conscientious refusals of Catholic hospitals is that, like most hospitals in Canada, they are publicly funded. In fact, in 2004, 92% of funding for hospitals came from the public sector (mostly through provincial & federal taxes) (Canadian Institute for Health Information [CIHI], 2005). The remaining 8% came from various sources, such as private insurance (e.g., for extra costs associated with private rooms), ancillary fees (e.g., food services & parking), donations, and investments (CIHI, 2005).

Simply stated, when a service is purchased with the taxpayer's dollar it is no longer the sole interests of the institution that should be promoted, but rather the needs and values of the public it serves. When organizations enter the public domain, they should

play by public rules. In Canada, because hospitals are largely funded by the public purse, hospitals have a reciprocal obligation to meet the public's needs. Even when a hospital is administered by a Catholic organization, public funds are allotted.

Churches, temples, mosques, and other religious institutions that are privately governed, and who serve a specific subset of the population, do deserve to be reasonably shielded from laws that would require them to contradict their religious beliefs (e.g., forcing the Catholic Church to preside over same sex marriages). Those who seek the assistance of these institutions do so of their own free will and can decide not to frequent a particular place of worship should they disagree with its beliefs. Hospitals on the other hand are public pursuits and even when governed by religious organizations, they should be expected to step outside their religious insulation to serve public demands. Because Catholic hospitals are publicly funded, they cannot choose those whom they serve, nor will they only serve Catholics. (Even if it was allowable to only serve Catholics, as previously discussed, Catholics are not homogeneous in their beliefs regarding the permissibility of different reproductive services [CFFC, 2004].)

Differences between the physician funding framework and the way hospitals are funded may also be cause for imposing limits on the refusals of Catholic hospitals. In contrast to the majority of physicians in Canada who are reimbursed on a fee-for-service basis, hospitals are allocated standard operating budgets, which they are expected to distribute across their organization (CIHI, 2005). In most parts of the country, hospitals are funded through regional or local health authorities. The amount of funding a hospital receives is generally based on a combination of who is served (e.g., proportion of seniors in the area), the types of services provided (e.g., is the hospital a trauma centre vs. a

general hospital; number of hip replacements, open heart surgeries, transplants performed), how much the hospital spent in the past, and whether the hospital provides services related to the government's political platform (e.g., special funding may be allocated for priority programs) (CIHI, 2005). Once a hospital's funding is approved it is generally responsible for allocating it as it sees fit. In this respect, while physicians are not compensated for services they do not provide, hospitals will continue to receive similar, if not the same, level of funding had they chosen to provide certain basic reproductive services (e.g., EC, sterilizations, abortions). By refusing to provide these services, not only are Catholic hospitals decreasing overall access to them, they are reducing the financial flexibility of surrounding hospitals (since funds that could have been allocated to these hospitals must be shared with Catholic hospitals), while simultaneously increasing the burden on these hospitals and their HCPs to provide reproductive services more frequently.

Despite a Catholic hospital's receipt of public funds, and the potential for increased financial pressures on other hospitals, reasonable access to reproductive services within urban areas will likely be maintained. By continuing to provide services to which they do not object, Catholic hospitals are also helping to lower the demand for these services at other hospitals. Furthermore, any additional burdens as a result of the Catholic hospital's conscientious refusal will most likely become diluted amongst other hospitals in the area so that no one hospital or group of HCPs will be unreasonably burdened.

In rural areas where a Catholic hospital is an area's sole provider or where accessing another hospital would be excessively burdensome, limitations to a hospital's refusals may be necessary, unless reasonable and timely access to those services are made

available to the community through alternate providers. By operating with public funds and not providing basic reproductive services, Catholic hospitals once again exercise a monopoly over a publicly mediated service. In rural areas individuals might not be able to easily access another hospital, in which case the needs of the population are not adequately being met. Furthermore because there are fewer hospitals in rural areas (Romanow, 2002; Kirby & LeBreton, 2002a; Fairbairn & Gustafson, 2008), each hospital, assuming they are reasonably accessible, would be required to assume a proportionally higher level of burden in providing reproductive services, compared to their urban counterparts. In this respect both individuals and hospitals in rural areas are being disadvantaged and limits that minimize these disadvantages are necessary.

3.3.4 The Primacy of Conscience Imbalance

A fourth reason for imposing limits on the objections of Catholic hospitals is for what I call the 'primacy of conscience imbalance'.

If we accept that hospitals have a conscience, the question must be asked – is it appropriate for the conscience of a hospital to supersede an individual's? I argue that it is not. In fact, it contradicts the very idea of conscience as a personal mediator, responsible for one's own integrity and inner unity and not that of others. For this reason, when the conscience of a hospital is allowed to override an individual's, an unacceptable imbalance is created.

Health, as defined by the World Health Organization (WHO), is a state of "complete physical, mental and social well-being and not merely the absence of disease or infirmity"(1946, p.1). Since contradicting one's personal moral values can cause serious

psychological harm and emotional distress, not allowing professionals to heed their conscience could result in serious health consequences.

When hospitals conscientiously object, they do so on the basis of religious doctrine set out and passed down by sponsoring organizations. HCPs are therefore restricted in their ability to necessarily follow the dictates of their own conscience, as they are required to work within the ethical guidelines dictated and imposed by the sponsoring organization's religious beliefs. These guiding principles may not accurately represent the values of all those employed by the hospital. In order to preserve their conscience, some employees may break the rules or resign (Freedman, Landy & Steinauer, 2008; Yaworski, 2007) while others may be required to suffer the fragmenting of their conscience in silence, as not working is simply not an option they would consider.

Conscientious refusals by Catholic hospitals represent an imposition of beliefs from the top down simply because of the organization's religious beliefs and not because an intervention would contradict the values of medicine. Arguably the conscience of an individual bears a significantly higher moral weight because of the risk to personal health. Furthermore, as argued in Chapter two, hospitals do not possess affective agency and therefore do not have the ability to experience the same fragmenting of integrity as humans. Institutional objections based on hospital policy that constrict the moral views of those who must subsequently enforce them impede autonomy and jeopardize the potential well being of HCPs who have different values[18].

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[18] Of note these policies also limit the consciences of patients (e.g. the conscience of a woman telling her to obtain an abortion). Although this is an important topic, in order to limit scope, in this section I concentrate

While this imbalance is certainly true, it is also true that individuals do not have the right to work for a specific organization. For example, I may love books and be an excellent salesperson, but I cannot make a local Chapters, or the local public library, hire me on these personal criteria alone simply because I want to work there. Nor can I force them to continue employing me should I repeatedly contradict their policies. Therefore, in urban areas, there may be a strong case for arguing that employees who disagree with the Catholic approach to health care should practice in a hospital that more accurately reflects their values. Finding a position in another hospital, or transferring to such a position may not be easy, but given the high demand for qualified HCPs (Romanow, 2002; Kirby & LeBreton, 2002a), it will not likely be impossible. Individuals may also need to be willing to take a job that is not in the department they initially want or were in before as supporting diversity requires flexibility.

In rural areas however, or where the hospital is a region's sole provider, HCPs have less choice and flexibility in where they work. Given their specialized skills, and the HCP shortage – especially in rural, remote, and northern areas (Romanow, 2002; Kirby & LeBreton, 2002a; Fairbairn & Gustafson, 2008) if an individual is willing to work in their profession they should be enabled to do so. In such cases, the autonomy of the HCP as well as the hospital's duty of beneficence towards society bear an added weight against the 'conscience' of the hospital, as the HCP's choice of where to practice is more constrained, and losing the HCP would presumably negatively impact the community.

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solely on the ethical implications of the conscientious refusals of employees to their employer's conscientious refusals.

3.3.5 Barriers to Access

A fifth reason for imposing limits on the conscientious refusals of Catholic hospitals is when they affect equitable access to reproductive services. In these cases obstacles imposed can become so great that they surpass the status of a mere inconvenience and become veritable barriers.

Defining access to health care is contingent upon multiple variables. What might constitute reasonable access for one person may present considerable challenges for another. Traveling to a hospital 45 minutes away will not likely present considerable challenges for an individual with a car, whereas being forced to make the same trip when reliant on public transportation can be exceptionally difficult. At times inequalities can exist by virtue of their implications. When considering conscientious objections by Catholic hospitals, we must consider the "degree to which [refusals] create or reinforce an unfair distribution of the benefits of reproductive technology"(ACOG Committee on Ethics, 2007, p. 1206) or access to medically indicated reproductive services. In this respect, refusals that "unduly burden the most vulnerable of society violate the core commitment of justice in the distribution of health resources" (ACOG Committee on Ethics, 2007, p.1206) and may need to be limited.

Barriers to access can present themselves differently depending on the individual's needs and their ability to address those needs. While similar barriers can exist in urban areas, in rural communities a number of factors, including geographic distance and the lack of health care service options help to amplify the problem (Romanow, 2002; Kirby & LeBreton, 2002a; Fairbairn & Gustafson, 2008). In rural communities where a

Catholic hospital is the sole service provider, or where a merger would confer upon a hospital corporation sole provider status, barriers to access can become so great that essential services are effectively denied.

A case in point was the removal of tubal ligations from the services provided by St. Elizabeth's Hospital in Humboldt, Saskatchewan, in 2006. If we recall, this procedure was found to be contrary to the Health Ethics Guide (CHAC, 2000) and as such was discontinued in the rural community, at first completely and then for birth control purposes only (Yaworski, 2007). This decision limits autonomy and poses a risk to female reproductive health. The ACOG recommends that an appropriate time for tubal ligation is immediately following delivery (ACOG Committee on Practice Bulletins-Gynecology, 2003). Religious beliefs prohibiting sterilization for birth control purposes may subject a woman to an unnecessary procedure at a different facility. This increases the risk of infection, recovery time, cost to the health care system, personal inconveniences, and risk of additional pregnancies until the procedure can be completed (Fogel & Rivera, 2003).

Accessing health care services in a rural environment is challenging at best. When limitations imposed by Catholic hospitals are added, challenges can quickly become barriers in which fair and equal services are lost. Rural communities often have higher concentrations of low-income earners, higher poverty rates, increased rates of mental health issues, lower levels of education, and increased involvement in risky sexual behavior resulting in higher rates of teen pregnancy & STIs (CIHI, 2006; Dryburgh, 2000; Nelson & Schmidek, 2008; Romanow, 2002; Pong, 2007; Fairbairn & Gustafson, 2008; Kirby & LeBreton, 2002a). While the entire community will feel the restriction of

services by Catholic hospitals, those who are already vulnerable (e.g., women, the minimally educated, those of low socioeconomic status, and teenagers) will be particularly affected.

In the following paragraphs I will discuss potential barriers to accessing reproductive services in the rural environment and how they relate to the diagram shown. Each barrier is multi faceted and can present a wide array of challenges. For these reasons a detailed discussion of each barrier is warranted. In addition, as figure 2 depicts, while each barrier can exist independently, each is also influenced by the broader context (delineated here as 'systemic influences') and interrelated with one another.

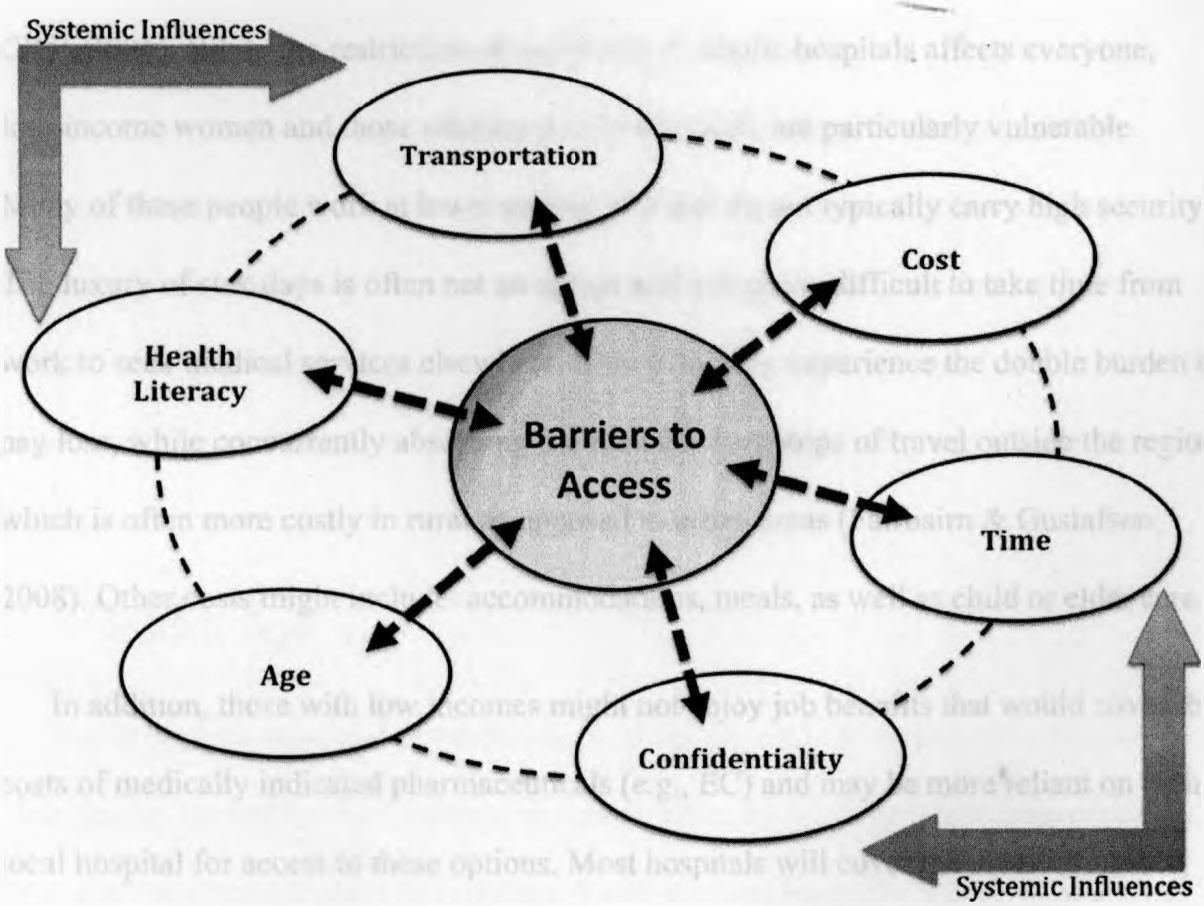

Figure 2. Barriers to access

3.3.5.1 Transportation

Access to public transportation is often limited in rural areas (Romanow, 2002; Kirby & LeBreton, 2002a; Fairbairn & Gustafson, 2008). Schedules may be sporadic and long walks and multiple transfers may be necessary. Roads can often be seasonally affected, impacting the ability for individuals to travel from one community to another and the speed in which their journey can be accomplished.

3.3.5.2 Cost

Rural areas are characterized by a higher demographic of low-income earners (Romanow, 2002; Kirby & LeBreton, 2002a; Fairbairn & Gustafson, 2008; Pong, 2007; CIHI, 2006). While the restriction of services by Catholic hospitals affects everyone, low-income women and those who are poorly educated, are particularly vulnerable. Many of these people work at lower paying jobs that do not typically carry high security. The luxury of sick days is often not an option and it remains difficult to take time from work to seek medical services elsewhere. If they do, they experience the double burden of pay loss, while concurrently absorbing the financial hardships of travel outside the region which is often more costly in rural as opposed to urban areas (Fairbairn & Gustafson, 2008). Other costs might include: accommodations, meals, as well as child or elder care.

In addition, those with low incomes might not enjoy job benefits that would cover the costs of medically indicated pharmaceuticals (e.g., EC) and may be more reliant on their local hospital for access to these options. Most hospitals will cover the costs of most medically indicated pharmaceuticals when patients are under their care (CIHI, 2006).

3.3.5.3 Time

The increased time required to access services outside one's community may impose delays on time sensitive interventions. For instance, EC must be administered within 72 hours or it becomes significantly less effective (WHO, 2004; ACOG Committee on Practice Bulletins-Gynecology, 2010). Because a hospital's catchment area may be large geographically, in rural areas one's local hospital can be thirty minutes away. If this hospital is Catholic, and will not provide the service, the next available hospital might be hours away, thus making the logistics more complicated.

3.3.5.4 Confidentiality

Safeguarding confidentiality in rural areas can be difficult and is identified in the literature as an important ethical issue (Nelson, 2004; Nelson & Schmidek, 2008). Boundary conflicts due to overlapping roles and close-knit ties within the community can remove elements of anonymity and compromise confidentiality (Nelson & Schmidek, 2008). In some cases leaving the region might also require informing or soliciting the help of others. For those who fear severe repercussions from family and friends, expanding the circle of trust can be traumatic.

3.3.5.5 Age

Youth have an increased dependence on others. In rural areas especially, they are often further limited in their ability to access services, by costs, access to transportation, time, and community values and stigmas. Youth are also generally highly visible in the community and along with seniors, represent a disproportionate number of rural inhabitants (Kirby & LeBreton, 2002a). These factors help make their actions and

activities more noticeable. For example, failing to show up for school will be documented and reported to parents or guardians. Furthermore, when seeking out abortion services, teenagers are more likely to use hospitals (Dryburgh, 2000).

3.3.5.6 Health Literacy

The World Health Organization (WHO) defines health literacy as the "cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good *health*" (WHO, 1998, p.10). Health literacy is therefore more than being able to read a pamphlet. It involves the capacity to access and use the information to make fully informed decisions about one's health (WHO, 1998, p.10; & Peerson & Saunders, 2009).

"Health literacy is itself dependent upon more general levels of literacy" (WHO, 1998, p.10). Those with lower levels of education, cognitive disabilities that affect reading and comprehension, and those whose first language is not predominate within the region, may face significant burdens navigating and understanding health options (McKeary & Newbold, 2010; Newbold & Willinsky, 2009; WHO, 1998). In Canada, education and other social variables are strongly associated with one's knowledge and use of reproductive options (Black et. al., 2009; Rotermann & McKay, 2009). As cited by Black et. al. (2009), "despite many contraceptive options, Canadian women [including rural women] continue to use a narrow range of contraceptive methods and to use contraception inconsistently" (p.627). In addition, a 2005 study on knowledge about EC in the U.S. revealed that only 67% of women respondents answered that they were aware of options to prevent pregnancy after sexual intercourse (Abbott, 2005). Moreover, of

those who knew about EC, nearly half were unclear about the correct time constraints (72 hrs). Many mistakenly believed it must be taken within 24 hours (Abbott, 2005). In situations where access to EC is not immediate, this false belief could lead individuals to put off attempting to travel elsewhere, believing it is too late.

Access to detailed information about Catholic hospitals can be hard to find. Easily accessible lists of where each hospital is located and what reproductive services each provides, do not exist. In many cases, patients are left to creatively investigate what their options are and where to go. Patients may alternatively discover first hand what is not provided. As previously stated, many women are not fully aware of what services Catholic Hospitals do not provide (Belden, Russonello & Stewart, 2000). Requesting services where they are morally prohibited may subject patients to moral criticism, potentially diminishing their autonomy as well as their emotional (and perhaps physical) well-being.

In rural areas accessing information on a home computer may be difficult as a number of homes are still reliant on dial-up internet or do not have access to broadband internet connections (McKeown, Noce & Czerny, 2007; Fairbairn & Gustafson, 2008). Navigating across multiple high resolution web pages may be time consuming and frustrating. Alternatively, accessing information in public may also present challenges. Depending on the location of resources (e.g., placement of computers and pamphlets) within a building, going to a public library or pharmacy to access relevant information can draw attention and reduce confidentiality (e.g., are computer screens easily visible to other library patrons; are pamphlets located directly next to the pharmacist or cashier).

3.3.5.7 Systemic Influences

No system operates in a vacuum. Each of the barriers described will be influenced by the broader context. These factors include, but are not limited to the economic status of the region, the number of health care providers and institutions per capita, cultural diversity, the influence of religious ideologies, various social determinants of health, and the present political climate – regionally, provincially, and nationally.

3.3.5.8 How Barriers Interrelate

The rural health care setting is a unique and challenging environment. As mentioned at the outset, while each barrier can exist independently, they are frequently interrelated. Together these individual barriers compound and contribute to each other, leading to a sum much larger than its constituent parts. This sum contributes to what I term, a total 'burden of access quotient'.

For example, a teenager living in a rural area faced with an unwanted pregnancy and served by a Catholic hospital, might experience a significant compounding of barriers in her attempts to terminate the pregnancy. Because of her age and dependence on others, our teenager, not wanting to inform others of her situation, will be forced to take public transportation and incur costs she cannot afford. Her absence from school will be noticed and relayed to parents, and the bus driver could easily be a family friend. Looking up resources online may not be easy because the family computer is located in the living room and teachers monitor school computers. Our teenager, expected to be home each day between four and five o'clock also has time constraints. Traveling by public transit may take too long and not present a viable option.

When a population who does not have the means is automatically precluded from equitable health care, it violates accessibility and justice standards. In rural areas there may be a two-tiered system when Catholic hospitals limit the availability of reproductive health care services, as these limitations can place potentially insurmountable burdens on those most vulnerable. This practice promotes unjust distributions of health care burdens. It also violates the public's interest in comprehensive and unbiased health care. Needless to say, in these circumstances, limits on the conscientious refusals of Catholic hospitals are warranted.

3.4 Conclusion

In a pluralist society, where health care is administered as a public good, institutions must practice a wide range of tolerance in order to ensure the needs of the population they serve are adequately met. For Catholic hospitals, this requires limiting their ability to conscientiously refuse to provide reproductive services to which they morally oppose, in circumstances where the needs of the population will not otherwise be met, or where their refusals would impose significant burdens on individuals, hospitals, or other HCPs in the area.

There are a number of good reasons to protect the conscientious refusals of Catholic hospitals. The promotion of religious diversity, the hospitals' integrity, and respect for their legacy and continued contributions to health care are each valid points. As much as their contributions are admirable however, their participation in the public system should not come at the cost of reasonably accessible health care. Furthermore, while loosing Catholic hospitals would represent a significant setback to the Canadian health care

system, if we are committed to the reproductive health and well being of individuals we must accept this possibility and implement contingency plans to address it, as opposed to simply allowing the threat of withdrawal to override the reproductive autonomy and interests of those who ultimately guide and fund the health care system (individual Canadians).

As established in the previous discussion, while the implications of conscientious refusals by Catholic hospitals may be tolerable in urban areas, in rural areas a strong case for imposing limits on their refusals emerges. Given the previous discussion, in order to safeguard the autonomy of individuals as well as promote principles of beneficence, non-maleficence, and justice, refusals by Catholic hospitals must be limited in situations where:

1) A Catholic hospital is an area's sole service provider,

2) Reasonable and timely access to reproductive services is not available elsewhere within the community or region,

3) Refusals would impose significant financial burdens on other hospitals in the area,

4) Refusals would impose significant burdens on an individual's autonomy,

5) An individual HCP who is willing to work in a rural, remote, northern, or underserviced area, would have their conscience overridden or negatively impacted (when providing medically indicated care or care they feel is in the best interests of the patient) by hospital religious policy, or

6) Refusals would present significant barriers to accessing equitable health care services or impose an unjust distribution of care on individuals or communities with the least means to overcome such refusals.

In these situations the interests of the public to accessing equitable health care services override the interests of the Catholic hospital to conscientiously object and concessions on behalf of the hospital must be made.

Although a detailed policy assessment is beyond the scope of this thesis, I encourage policy makers to be creative in incorporating these limitations into policy solutions and to keep in mind important systemic factors that might affect their decisions. In the discussion I offer a number of recommendations in order to provide insight and to act as a launching point for dialogue and debate.

Chapter 4: Discussion

4.1 Summary of Findings

The purpose of this thesis was to examine the ethical implications of Catholic hospital conscientious refusals to provide reproductive services that they morally oppose, within the context of the Canadian health care system and more specifically within rural areas. To achieve this goal two main questions were identified:

1) Do hospitals possess a conscience according to the dominant view of conscience in bioethics?
2) Should Catholic hospitals be permitted to refuse to provide reproductive services to which they are morally opposed within the context of the Canadian health care system and in particular, within rural areas?

Chapter two began with a brief introduction to the concept of conscience. This was followed by a description of the dominant view, and a proposal of the criteria necessary, for an entity to qualify as possessing a conscience on this view. Using the developed criteria as a framework for analysis, I discussed reasons why hospitals might satisfy the requirements of conscience as well as reasons why they do not. Ultimately, I concluded that the dominant view does not support the contention that hospitals possess a conscience, as they fail to meet at least three of the five criteria necessary for it, namely cognitive agency, affective agency, and internal sanctioning. For these reasons, upholding the same respect for conscience and conscientious refusal for hospitals as we would for individuals is not warranted, as they do not properly possess a conscience.

Because some could disagree with me whether hospitals possess a conscience – for instance they may not accept the dominant view – in chapter three I focused my attention on determining whether and to what degree Catholic hospitals ought to receive conscience protections. In that chapter I argued that, in as much as their refusals do no disadvantage or impose significant burdens on individuals, the community, or other hospitals and health care professionals (HCPs) in the service area, Catholic hospitals might legitimately receive some conscience protection. However, in cases where significant burdens, limitations, or injustices are imposed, or where reasonable and timely access to services is compromised, the protection of conscience is no longer ethically justified. Although there were valid reasons for protecting the conscientious refusals of Catholic hospitals, my analysis of both sides of the debate lead me to conclude that limitations are warranted in cases where:

1) A Catholic hospital is an area's sole service provider,

2) Reasonable and timely access to reproductive services is not available elsewhere within the community or region,

3) Refusals would impose significant financial burdens on other hospitals in the area,

4) Refusals would impose significant burdens on an individual's autonomy,

5) An individual HCP who is willing to work in a rural, remote, northern, or underserviced area, would have their conscience overridden or negatively impacted (when providing medically indicated care or care they feel is in the best interests of the patient) by hospital religious policy, or

6) Refusals would present significant barriers to accessing equitable health care services or impose an unjust distribution of care on individuals or communities with the least means to overcome such refusals.

In these situations the interests of the public to accessing equitable health care services override the interests of the Catholic hospital to conscientiously object and concessions on behalf of the hospital must be made.

4.2 Policy Recommendations

Although a detailed policy analysis and set of recommendations are beyond the scope of this thesis, there are a number of preliminary suggestions that may serve as a platform for more detailed policy proposals. In moving forward, I encourage policy makers to consider innovative policy solutions that respect the contributions of Catholic hospitals to health care, while upholding the interests of Canadians to access equitable health care services.

1) Unless Catholic hospitals agree to provide reasonable reproductive services, governments may consider not allowing Catholic hospitals to operate in environments where they would be an area's sole provider, or where reasonable and timely access to reproductive services is not available elsewhere within the region.

2) Where Catholic hospitals are operational, governments should ensure comprehensive reproductive services are provided through other means with reasonable hours of operation and access.[19]

3) To help preserve autonomy, all Catholic hospitals should be required to fully inform patients of relevant and medically indicated health care options, including those to which they morally oppose. Staff should also be required to deliver this information in an unbiased manner that focuses on the medical implications of the service, as opposed to their perceived moral implications.

4) In cases where patient distress is high, and going elsewhere for services would be physically or emotionally unmanageable, Catholic hospitals should have an obligation to provide the service or to facilitate transportation to a facility that can.

5) Disclosure statements regarding what reproductive services each Catholic hospital provides and does not provide, should be easily accessible and visible within the hospital, as well as posted on their website. Staff should also disclose relevant services to which the organization objects and provide the patient with information on how to access these services if they so choose.

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[19] Of note, in some circumstances, reliance on free standing clinics or health units may not provide adequate levels of access, as their capacity to supply services (e.g., tubal ligations and vasectomies), or their hours of operation (e.g., If a woman is sexually assaulted on a Friday night will the clinic be open? Will it be open on Saturday or Sunday?) may be limited. Furthermore, in rural areas, given the ethical issues surrounding confidentiality, a specialized freestanding clinic devoted to providing these services, may not be a particularly viable option.

6) Where refusals by Catholic hospitals would impose significant financial burdens on other hospitals in the area special funding may need to be allocated to these hospitals in order to help compensate for the extra burden imposed.

Although these policy proposals are not exhaustive, they provide an important starting point for future policy discussions and decisions.

4.3 Applications of Research

To assume that the cases of Midland, Ontario, and St. Elizabeth's in Humbolt, Saskatchewan, were one time isolated incidents would be erroneous. The experiences of Midland and Humbolt can be extrapolated to rural (and urban) areas across the Provinces, the Nation, and beyond Canada's borders.

In the United States, approximately 12.7% of hospitals are Catholic (Catholic Health Association of the United States, 2011). Catholic organizations also own 11 of the 40 largest health care systems in the country (Ascension Health, the third largest system in the U.S. counts 78 hospitals in 20 States as part of its organizational structure) (United States Conference of Catholic Bishops, n.d.) and control seven of the ten largest non-profit hospitals (Fogel & Rivera, 2004). In 1999, there were also 91 counties in the U.S. where a Catholic institution was the sole hospital provider (Fogel & Rivera, 2004) and as of 2011, a third of Catholic hospitals are located in rural areas (Catholic Health Association of the United States, 2011). In many cases, refusals by Catholic hospitals have removed access to a long list of reproductive service options (Fogel & Rivera, 2004; Sloboda, 2001). These decisions have effectively precluded entire segments of the population from services to which these hospitals oppose.

Outside North America, the issue of conscientious refusals by HCPs and to some extent hospitals, has sparked growing debate, especially in Latin America where the Catholic Church exercises a great deal of influence over public policy and health care decisions (Casas, 2009; Cook & Dickens, 2009; Cook, Olaya & Dickens, 2009). The topic is also relevant to developing countries, where the Roman Catholic Church funds a number of hospitals and health outreach programs, which in many cases are the only ones in the area (Catholics for Choice, 2008). In Africa for example, this includes funding programs targeted at preventing the transmission of HIV/AIDS (a major health crisis in the region) but does not include dispensing condoms or educating individuals on the merits of their use (Catholics for Choice, 2008). According to a joint position statement by UNAIDS, the United Nations Population Fund (UNFPA) and the World Health Organization (WHO) (2009) "the male latex condom is the single, most efficient, available technology to reduce the sexual transmission of HIV and other sexually transmitted infections"(p.1).

While each country assumes its own framework of health care administration the fact remains – the denial of reproductive services by Catholic hospitals can easily limit access as well as the autonomy of those most in need. For these reasons despite the present research having a Canadian focus, much of the analysis also has relevant international applications.

In presenting this analysis I trust that it will contribute to and help further the limited body of knowledge concerning conscientious refusals by Catholic hospitals in Canada, as well as to provide targeted insight into its potential impact on rural communities within the country. I also trust it will help to spark dialogue and debate regarding this important

topic, as well as to inform and influence future health policy decisions within Canada and abroad.

4.4 Future Research

The lack of Canadian research on conscientious refusals by Catholic hospitals provides for a broad spectrum of possibilities for future investigation. Having presented a reasoned, normative analysis on the current situation and proposed limits that ought to be imposed ethically, a beneficial future step would be to examine the issue empirically.

Canadian research is needed to explore how individuals within this country interpret and experience the refusals of Catholic hospitals as well as their familiarity with the topic. Studies that assume quantitative methods as well as those that assume qualitative methods would each help to address this need. Questions for future investigation may include:

- What do Canadians expect their hospital to provide by way of reproductive health options? Do they believe that these same expectations should apply to Catholic hospitals?
- Are Canadians aware of what Catholic hospitals will and will not provide, and to what extent?
- How are conscientious refusals by Catholic hospitals experienced by patients as well as HCPs in Canada?

- How is the experience of Catholic hospital conscientious objection different across health care professions, within rural as opposed to urban areas, and across different segments of the population?

Research is also needed to more precisely determine the scope of the issue as well as to identify areas of interest or 'hot spots' across the country. Specific approaches to research might include:

- Surveying Catholic hospitals across the country to determine exactly what reproductive services each provides, as well as how often services are not provided as a result of hospital refusal policy.
- This same survey may also ask hospitals to provide insight into the justifications behind their policies on different reproductive health services and interventions. These justifications can be analyzed in order to identify similarities and discrepancies between hospitals across Canada.

Of note, attempts at researching these two questions could be fraught with difficulty, as Catholic hospitals may be reluctant to draw attention to what reproductive services they have and have not chosen to provide, for fear of sparking controversy or alienation on both sides of the debate. In order to increase participation, researchers may want to consider removing identifiers from published research investigating the specific practices of each Catholic hospital.

Finally, as suggested earlier in this chapter, policy analyses and recommendations should be drafted in order to provide guidance to governments on how they might handle

conscientious refusals by Catholic hospitals as well as mergers between secular and Catholic hospitals.

4.5 Conclusion

The world in which Catholic hospitals operate has changed. Rapid advancements in technology have introduced health care options unthinkable twenty years ago. Some of these options contradict Catholic moral teachings about the beginning and end of life, as well as those related to sexuality and reproduction. While Catholic hospitals continue to make significant contributions to the Canadian health care system, their refusals to provide reproductive services to which they are morally opposed can compromise an individual's ability to access medically indicated services, as well as their autonomy.

In my analysis of the two guiding research questions I argued that: 1) hospitals could not legitimately claim to possess a conscience according to the dominant view of conscience in bioethics and therefore could not conscientiously object in a legitimate manner; and 2) that the refusals of Catholic hospitals warrant limitations in a number of important circumstances, many of which are applicable to rural areas. I trust that this analysis will succeed in furthering the limited body of knowledge concerning the conscientious refusals of Catholic hospitals in Canada, to spark dialogue and debate, and finally, to inform and influence future health policy decisions.

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APPENDIX A. Inventory of Catholic Health Care Facilities in Canada

HEADING DEFINITIONS & CODES

Ref. #: The reference number assigned to each health care facility

Facility (Site) Name: Name of the health care facility site

Corporate Organization Affiliation: Name of the health care organization to which the health care facility belongs (where applicable)

Sponsor: Name of the Catholic sponsor

City/Town: Name of the city or town where the site is located

Province: Name of the province where the site is located

BC = British Columbia
AB = Alberta
SK = Saskatchewan
MB = Manitoba
ON = Ontario
QC = Quebec
NB = New Brunswick
NS = Nova Scotia
NF = Newfoundland

Facility Type: Delineates the general type of facility

H = Acute Care (General or Special) Hospitals
L = Long Term Care Centre
S = Hospice
R = Retirement Home/Resource Centre
N = Nursing Station
O = Outpatient Health Services Centre
A = Home Care
T = Treatment
P = Public Health /Mental Health Units

Facility Sub-Type: Delineates the more specialized focus of the facility

Gen. = General
Resid. Care Fac. = Residential care facility
Rehab. = Rehabilitation

Hospice = Hospice
Ext. Care = Extended care
Nur. Home = Nursing home
Aux. Hosp. = Auxiliary hospital
Retirement Home = Retirement home
Spec. Care Home = Special care home
Psych. = Psychiatric
Pers. Care Home = Personal Care Home
Home for Aged = home for the aged
Home Care = Home care
Chron. = Chronic
Outpatient Centre = Outpatient centre
Community Health = Community health
Treatment Centre = Treatment centre

Status: Denotes whether the health care facility is 'public' or 'private'.

1 = Public

"A public hospital is defined as one which is not operated for profit, accepts all patients regardless of their ability to pay, and is recognized as a public hospital by the province in which it is located" (Canadian Healthcare Association, 2011, p.6).

2 = Private

"A private hospital is defined as one which ordinarily restricts its admissions to patients paying for the care provided, at rates determined by the management" (Canadian Healthcare Association, 2011, p.6). "A private long-term-care facility is defined as one which ordinarily restricts its admissions to clients (residents) paying for the care provided at rates determined by the management. However, there are privately operated special care facilities which do not restrict admissions. These may be facilities funded by a provinvial government, or private individuals who have formed a not-for-profit corporation and contract with government and associations to provide care" (Canadian Healthcare Association, 2011, p.6).

Year Established: Year the health care facility was established

Beds: Total number of beds located at the site – not including certain specialized beds such as those in operating theatres, observation and holding beds, beds located in emergency, day surgery beds, recovery beds, and birthing beds.

Total Admissions: "An inpatient admission is defined as the normal acceptance and reception of a person as an inpatient. Such reception involves the allocation of a regular facility bed, cot or bassinet" (Canadian Healthcare Association, 2011, p.14).

Staff: Total number of full time equivalent staff working at facility site or employed by the organization

Budget: "The approximate annual cost of running the healthcare facility, based on the latest figures available as provided by the facility or regional board" (Canadian Healthcare Association, 2011, p.14).

Address: mailing address for the health care facility site

Regional/Local Health Authority Affiliation: The regional or local health authority to which the health care facility site belongs (where applicable or listed).

Website: Health care facility or organizational website

Additional Comments: Additional information entered to give insight into the work of the facility or other relevant information about it – information entered at the discretion of the researcher.

Information Source(s): Source of information contributing to the information entered about the facility

GCHF = Guide to Healthcare Facilities in Canada (Canadian Healthcare Association, 2011)
CHACD = Catholic Health Alliance of Canada [CHAC] Directory (available online at: www.chac.ca/alliance/directory/membership-directory_e.php) (CHAC, n.d.a)
CHAO = Catholic Health Association of Ontario [CHAO] – members list (available online at: www.chaont.ca/aboutus/members.php) (CHAO, n.d)
CHCO = Catholic Health Corporation of Ontario [CHCO] – member institutions list (available online at: www.chco.ca/about/memberinstitutions.php) (CHCO, n.d.)
OW = Organizational Website (specified where applicable in table)

Ref. #	Facility (Site) Name	Corporate Organization Affiliation	Sponsor
040	Saint Boniface General Hospital	-	Catholic Health Corporation of Manitoba
041	Winnipegosis General Hospital Inc.	-	Catholic Health Corporation of Manitoba
042	Misericordia Health Centre (1)	Misericordia Health Centre	Misericordia Corporation - Archdiocese of Winnipeg
043	Saint Paul's Home	-	Sisters Servants of Mary Immaculate
044	Villa Youville Inc.	-	-
045	Doctor Gendreau Personal Care Home Inc.	-	-
046	Foyer Valade Inc.	-	Catholic Health Corporation of Manitoba
047	Holy Family Home Inc.	-	Sisters Servants of Mary Immaculate
048	Saint Amant Inc.	-	Catholic Health Corporation of Manitoba
049	Trache Centre	-	Catholic Health Corporation of Manitoba
050	Saint Joseph's Residence Inc.	-	Catholic Health Corporation of Manitoba
051	Winnipegosis-Mossey River Personal Care Home Inc.	-	Catholic Health Corporation of Manitoba
052	Misericordia Health Centre (2)	Misericordia Health Centre	Misericordia Corporation - Archdiocese of Winnipeg
053	Sara Riel Inc.	-	Catholic Health Corporation of Manitoba
054	Hopital de L'Enfant-Jesus RHSJ	-	Catholic Health International (Catholic Health Partners)
055	Hopital Stella-Maris-de-Kent	-	Catholic Health International (Catholic Health Partners)
056	Foyer Notre-Dame-de-Lourdes Inc.	-	Catholic Health International (Catholic Health Partners)
057	Mount Saint Joseph Nursing Home	-	Catholic Health International (Catholic Health Partners)
058	Foyer St. Joseph de St-Basile Inc	-	Catholic Health International (Catholic Health Partners)
059	Rocmaura Inc.	-	Catholic Health International (Catholic Health Partners)
060	Saint Patrick's Mercy Home	-	Sisters of Mercy
061	Saint Martha's Regional Hospital	-	Sisters of St. Martha
062	Saint Vincent's Nursing Home	-	Roman Catholic Archdiocese of Halifax
063	Villa St. Joseph-du-Lac	-	Catholic Health International (Catholic Health Partners)
064	Saint Joeseph's Home Care	Saint Joseph's Healthcare Hamilton	St. Joseph's Health System
065	Saint-Vincent Hospital	Bruyere Continuing Care	Catholic Health Corporation of Ontario
066	St. Mary's of the Lake Hospital	Providence Care	Catholic Health Corporation of Ontario
067	Providence Hospital	Providence Healthcare Toronto	Catholic Health Corporation of Ontario
068	Saint Joseph's Hospital	Saint Joseph's Care Group	Catholic Health Corporation of Ontario
069	Saint Joseph's Health Centre Guelph (1)	Saint Joseph's Health Centre - Guelph	St. Joseph's health System Hamilton
070	Parkwood Hospital	St. Joseph's Health Care London	St. Joseph's Health Care Society London
071	Hotel Dieu Hospital of Kingston	-	Religious Hospitallers of St. Joseph
072	Saint Mary's General Hospital	-	St. Joseph's Health System
073	Mattawa General Hospital	-	Catholic Health Corporation of Ontario
074	Pembroke Regional Hospital	-	Catholic Health Corporation of Ontario
075	Saint Joseph's Health Centre - Toronto	-	Catholic Health Corporation of Ontario
076	Chatham-Kent Health Alliance	Chatham-Kent Health Alliance	St. Joseph's Health Care Society London
077	Hotel Dieu Site	Hotel-Dieu Grace Hospital	Catholic Health International (Catholic Health Partners)
078	Saint Joseph's Healthcare - Charlton Campus	Saint Joseph's Healthcare Hamilton	St. Joseph's Health System
079	Saint Michael's Hospital	Saint Michael's Hospital	Catholic Health Corporation of Ontario

Ref. #	Facility (Site) Name	Corporate Organization Affiliation	Sponsor
080	Saint Joseph's General Hospital - Elliot Lake	St. Joseph's General Hospital - Elliot Lake	Catholic Health Corporation of Ontario
081	Saint Joseph's Hospital	St. Joseph's Health Care London	St. Joseph's Health Care Society London
082	The Southdown Institute	-	Emmanuel Convalescent Foundation
083	Waypoint Centre for Mental Health Care	-	Catholic Health Corporation of Ontario
084	Mental Health Services	Providence Care	Catholic Health Corporation of Ontario
085	Lakehead Psychiatric Hospital	Saint Joseph's Care Group	Catholic Health Corporation of Ontario
086	Saint Joeseph's Healthcare - West 5th Campus	Saint Joseph's Healthcare Hamilton	St. Joseph's Health System
087	Regional Mental Health Care - London	St. Joseph's Health Care London	St. Joseph's Health Care Society London
088	Regional Mental Health Care - St. Thomas	St. Joseph's Health Care London	St. Joseph's Health Care Society London
089	Hotel Dieu Shaver Health & Rehabilitation Centre	-	Catholic Health International (Catholic Health Partners)
090	Elisabeth Bruyere Hospital	Bruyere Continuing Care	Catholic Health Corporation of Ontario
091	Saint Joseph's Villa - Dundas	-	St. Joseph's Health System
092	St. Patrick's Home Ottawa	-	Catholic Health Corporation of Ontario
093	Marianhill Home For the Aged	-	Catholic Health Corporation of Ontario
094	St. Joseph's at Fleming	-	Fontbonne Society Perterborough
095	Elisabeth Bruyere Residence	Bruyere Continuing Care	Catholic Health Corporation of Ontario
096	Saint-Louis Residence	Bruyere Continuing Care	Catholic Health Corporation of Ontario
097	Providence Manor	Providence Care	Catholic Health Corporation of Ontario
098	Saint Joseph's Health Centre Guelph (2)	Saint Joseph's Health Centre - Guelph	St. Joseph's health System Hamilton
099	Saint Joseph's Continuing Care Centre Cornwall	-	Religious Hospitallers of St. Joseph
100	Carmel Heights Seniors' Residence	-	Carmelite Sisters of Mississauga
101	Mariann Home	-	Catholic Health Corporation of Ontario
102	Saint Joseph's Continuing Care Centre - Sudbury	-	Catholic Health Corporation of Ontario
103	Good Shepherd Centre	Good Shepherd Centres	Good Shepherd Society
104	Cardinal Ambrozic Houses of Providence	Providence Healthcare Toronto	Catholic Health Corporation of Ontario
105	Hogarth Riverview Manor	Saint Joseph's Care Group	Catholic Health Corporation of Ontario
106	St. Joseph's Heritage	Saint Joseph's Care Group	Catholic Health Corporation of Ontario
107	Saint Joseph's Lifecare Centre	Saint Joseph's Lifecare Centre	St. Joseph's Health System
108	Saint Joseph's Manor	St. Joseph's General Hospital - Elliot Lake	Catholic Health Corporation of Ontario
109	Mount Hope Centre for Long-Term Care	St. Joseph's Health Care London	St. Joseph's Health Care Society London
110	Diabetes Health Thunder Bay	Saint Joseph's Care Group	Catholic Health Corporation of Ontario
111	Saint Joesph's Healthcare - King Campus	Saint Joseph's Healthcare Hamilton	St. Joseph's Health System
112	Behavioural Sciences Centre	Saint Joseph's Care Group	Catholic Health Corporation of Ontario
113	St. Joseph's Health Centre	Saint Joseph's Care Group	Catholic Health Corporation of Ontario
114	Saint Joseph's Hospice Sarnia Lambton	-	St. Joseph's Health Care Society London
115	Good Shepher Centres - Emmanuel House	Good Shepherd Centres	Good Shepherd Society
116	Stedman Community Hospice	Saint Joseph's Lifecare Centre	St. Joseph's Health System
117	Balmoral Centre	Saint Joseph's Care Group	Catholic Health Corporation of Ontario
118	Sister Margaret Smith Centre	Saint Joseph's Care Group	Catholic Health Corporation of Ontario

Ref. #	Facility (Site) Name	Corporate Organization Affiliation	Sponsor
119	Saint Michael's Hospital Detoxification Centre	Saint Michael's Hospital	Catholic Health Corporation of Ontario
120	Oaks Centre Alcohol and Drug Treatment Centre	St. Joseph's General Hospital - Elliot Lake	Catholic Health Corporation of Ontario
121	Hopital Marie-Clarac	-	Sœurs de Charité de Sainte-Marie
122	Foyer de St-Celestin	-	Soeurs Grises de Montreal
123	Providence Notre-Dame de Lourdes Inc.	-	Sisters of Providence
124	Saint Anthony's Hospital	Catholic Health Ministry of Saskatchewan	Saskatchewan Catholic Health Corporation
125	Saint Joseph's Hospital Estevan	Catholic Health Ministry of Saskatchewan	Saskatchewan Catholic Health Corporation
126	Saint Joseph's Hospital - Gravelbourg	Catholic Health Ministry of Saskatchewan	Saskatchewan Catholic Health Corporation
127	Saint Peter's Hospital - Melville	Catholic Health Ministry of Saskatchewan	Saskatchewan Catholic Health Corporation
128	Saint Paul's Hospital (Grey Nuns) of Saskatoon	Catholic Health Ministry of Saskatchewan	Saskatchewan Catholic Health Corporation
129	Providence Place for Holistic Health Inc.	Catholic Health Ministry of Saskatchewan	Saskatchewan Catholic Health Corporation
130	Foyer St. Joseph Nursing Home Inc.	Catholic Health Ministry of Saskatchewan	Saskatchewan Catholic Health Corporation
131	Mont St. Joseph Home Inc.	-	Mont St. Joseph Foundation
132	Saint Joeph's Health Centre - Maklin	-	Sisters of St. Elizabeth, Humbolt
133	Santa Maria Senior Citizens' Home Inc.	-	(Archepiscopal Corporation of Regina)
134	Foyer d'Youville - Gravelbourg	Catholic Health Ministry of Saskatchewan	Saskatchewan Catholic Health Corporation
135	Saint Ann's Senior Citizens' Village Corp	Catholic Health Ministry of Saskatchewan	Saskatchewan Catholic Health Corporation
136	Saint Joseph's Home	Saint Joseph's Home	Ukrainian Sisters of St. Joseph of Saskatoon

Ref. #	City/Town	Province	Facility Type	Facility Sub-Type	Status	Year Established	Beds	Total Admissions	Staff	Budget
001	Banff	AB	H	Ext. Care	1	1930	46	-	94	$7,700,000
002	Castor	AB	H	Gen	1	1911	21	-	70	-
003	Vegreville	AB	H	Gen	1	1910	32	-	-	8,350,000
004	Bonnyville	AB	H	Gen.	1	1986	33	-	289	-
005	Camrose	AB	H	Gen.	1	1924	76	2757	236.2	23,597,787
006	Edmonton	AB	H	Gen.	1	1988	343	57615	1213	140,000,000
007	Edmonton	AB	H	Gen.	1	1969	298	15000	1234	138,000,000
008	Killam	AB	H	Gen.	1	1930	12	-	-	-
009	Edmonton	AB	L	Aux. Hosp.	1	1927	202	255	216	16,000,000
010	Bonnyville	AB	L	Nur. Home	1	1986	30	-	-	-
011	Castor	AB	L	Nur. Home	1	-	21	-	-	-
012	Edmonton	AB	L	Nur. Home	1	1895	502	-	1058	37,000,000
013	Killam	AB	L	Nur. Home	1	1963	45	-	-	-
014	Lethbridge	AB	L	Nur. Home	1	1929	202	302	300	9,500,000
015	Lethbridge	AB	L	Nur. Home	1	-	200	-	-	-
016	Mundare	AB	L	Nur. Home	1	1929	30	15	33	2,700,000
017	Saint Albert	AB	L	Nur. Home	2	1965	191	84	-	7,000,000
018	Trochu	AB	L	Nur. Home	1	-	28	-	-	-
019	Edmonton	AB	L	Nur. Home	1	2011	150	-	-	-
020	Calgary	AB	L	Nur. Home	1	1910	112	46	170	-
021	Trochu	AB	N	Nur. Home	1	1909	56	-	75	-
022	Saint Albert	AB	R	Retirement Home	2	-	41	33	45	2,400,000
023	Lethbridge	AB	R	Retirement Home	1	-	118	-	-	-
024	Vancouver	BC	H	Gen.	1	1946	140	-	-	-
025	Vancouver	BC	H	Gen.	1	1894	757	23074	3634	470,870,000
026	Comox	BC	H	Gen.	1	1913	237	5782	553.5	52,000,000
027	Vancouver	BC	H	Rehab.	1	1947	76	-	-	-
028	Vancouver	BC	L	Resid. Care Fac.	1	1990	76	23	53	4,700,000
029	Vancouver	BC	L	Resid. Care Fac.	1	1973	87	30	68	-
030	Victoria	BC	L	Resid. Care Fac.	1	1941	200	70	182	16,600,000
031	Vancouver	BC	L	Resid. Care Fac.	1	1947	142	-	-	-
032	Vancouver	BC	L	Resid. Care Fac.	1	1946	100	-	-	-
033	Vancouver	BC	L	Resid. Care Fac.	1	-	150	-	-	-
034	Vancouver	BC	L	Resid. Care Fac.	1	1991	221	-	-	-
035	Vancouver	BC	L	Resid. Care Fac.	1	1969	84	-	-	-
036	Victoria	BC	L	Resid. Care Fac.	1	-	14	-	-	-
037	Comox	BC	L	Resid. Care Fac.	1	1913	125	-	-	-
038	Vancouver	BC	S	Hospice	1	2005	12	-	-	-
039	Sainte Rose-du-Lac	MB	H	Gen	1	1939	26	1222	68	3,200,000

Ref. #	City/Town	Province	Facility Type	Facility Sub-Type	Status	Year Established	Beds	Total Admissions	Staff	Budget
040	Winnipeg	MB	H	Gen.	1	1871	485	23250	4000	250,000,000
041	Winnipegosis	MB	H	Gen.	1	1966	14	477	25.6	1,553,225
042	Winnipeg	MB	H	Gen.	1	1898	14	-	-	-
043	Dauphin	MB	L	Pers. Care Home	1	1928	70	17	70	4,325,000
044	Sainte Anne	MB	L	Pers. Care Home	1	1965	66	18	62	5,800,000
045	Sainte Rose-du-Lac	MB	L	Pers. Care Home	1	1975	65	19	60	3,765,135
046	Winnipeg	MB	L	Pers. Care Home	1	1976	154	34	147.8	-
047	Winnipeg	MB	L	Pers. Care Home	1	1957	276	80	265	175,000,000
048	Winnipeg	MB	L	Pers. Care Home	1	1959	211	9	1100	60,000,000
049	Winnipeg	MB	L	Pers. Care Home	1	1973	314	79	337.2	22,800,000
050	Winnipeg	MB	L	Pers. Care Home	1	1973	100	35	93.1	-
051	Winnipegosis	MB	L	Pers. Care Home	1	1981	20	6	15.2	-
052	Winnipeg	MB	L	Pers. Care Home	1	1898	288	-	-	60,000,000
053	Winnipeg	MB	Other	-	1	1974	-	-	-	-
054	Caraquet	NB	H	Gen.	1	1963	12	63	176	12,800,000
055	Sainte Anne de Kent	NB	H	Gen.	1	1966	20	321	120	6,800,000
056	Bathurst	NB	L	Nur. Home	1	1972	100	30	105	6,620,509
057	Miramichi	NB	L	Nur. Home	2	1949	133	130	120	7,000,000
058	Saint Basile	NB	L	Nur. Home	1	1976	126	38	127	6,711,769
059	Saint John	NB	L	Nur. Home	1	1972	150	40	180	-
060	Saint John's	NF	L	Nur. Home	1	1958	209	117	197.7	14,288,173
061	Antigonish	NS	H	Gen.	1	1906	82	-	-	-
062	Halifax	NS	L	Home for Aged	2	1966	149	65	232	10,806,067
063	Yarmouth	NS	L	Home for Aged	2	1960	74	36	93.3	5,216,180
064	Hamilton	ON	A	Home Care	1	1921	-	-	-	-
065	Ottawa	ON	H	Chron.	1	1924	336	-	-	-
066	Kingston	ON	H	Chron.	1	1946	144	792	507	-
067	Toronto	ON	H	Chron.	1	1857	347	1800	1700	71,700,000
068	Thunder Bay	ON	H	Chron.	1	1884	224	1526	1700	125,123,000
069	Guelph	ON	H	Chron.	1	1861	91	-	300	28,000,000
070	London	ON	H	Chron.	1	1925	530	-	-	-
071	Kingston	ON	H	Gen.	1	1845	42	979	643	69,000,000
072	Kitchener	ON	H	Gen.	1	1924	191	6693	936	-
073	Mattawa	ON	H	Gen.	1	1878	19	486	49.5	6,486,470
074	Pembroke	ON	H	Gen.	1	1878	178	6000	768	6,873,036
075	Toronto	ON	H	Gen.	1	1921	375	21287	2470	231,524,000
076	Chatham	ON	H	Gen.	1	1890	283	9905	930	127,000,000
077	Windsor	ON	H	Gen.	1	1888	305	11644	1785	170,000,000
078	Hamilton	ON	H	Gen.	1	1890	459	-	2304.9	-
079	Toronto	ON	H	Gen.	1	1892	572	575000	3999	-

Ref. #	City/Town	Province	Facility Type	Facility Sub-Type	Status	Year Established	Beds	Total Admissions	Staff	Budget
080	Elliot Lake	ON	H	Gen.	1	1959	57	2000	240	26,000,000
081	London	ON	H	Gen.	1	1888	168	10808	-	407,400,000
082	Aurora	ON	H	Psyc.	2	1966	48	-	-	-
083	Penetanguishene	ON	H	Psyc.	1	1904	312	1079	860	70,000,000
084	Kingston	ON	H	Psyc.	1	1854	198	266	499	-
085	Thunder Bay	ON	H	Psyc.	1	1944	46	98	-	46,854,400
086	Hamilton	ON	H	Psyc.	1	1876	165	-	585.6	-
087	London	ON	H	Psyc.	1	1870	454	73562	705	-
088	Saint Thomas	ON	H	Psyc.	1	1939	145	-	-	-
089	Saint Catherines	ON	H	Rehab.	1	1948	139	906	259	26,000,000
090	Ottawa	ON	H	Rehab.	1	1845	120	-	-	123,000,000
091	Dundas	ON	L	Home for Aged	1	1879	378	-	270	-
092	Ottawa	ON	L	Home for Aged	1	1895	202	-	106	11,000,000
093	Ottawa	ON	L	Home for Aged	1	1954	139	-	190	-
094	Peterborough	ON	L	Home for Aged	1	1959	159	-	118	-
095	Ottawa	ON	L	Home for Aged	1	-	71	-	-	-
096	Ottawa	ON	L	Home for Aged	1	1966	198	149	172	10,273,719
097	Kingston	ON	L	Home for Aged	2	1861	243	102	267	-
098	Guelph	ON	L	Home for Aged	1	-	235	-	-	-
099	Cornwall	ON	L	Nur. Home	1	1969	150	-	160	8,300,00
100	Mississauga	ON	L	Nur. Home	2	1952	48	44	13	-
101	Richmond Hill	ON	L	Nur. Home	1	1979	64	37	55	3,300,000
102	Sudbury	ON	L	Nur. Home	1	1884	128	-	81	7,485,000,000
103	Hamilton	ON	L	Nur. Home	1	1972	24	-	18	-
104	Toronto	ON	L	Nur. Home	1	1962	288	-	-	-
105	Thunder Bay	ON	L	Nur. Home	1	2004	96	96	94	4,400,000
106	Thunder Bay	ON	L	Nur. Home	1	1979	110	-	97	5,203,660
107	Brantford	ON	L	Nur. Home	1	2004	205	-	-	-
108	Elliot Lake	ON	L	Nur. Home	1	2002	64	-	-	-
109	London	ON	L	Nur. Home	1	1869	390	285	-	-
110	Thunder Bay	ON	O	Outpatient centre	1	-	-	-	-	-
111	Hamilton	ON	O	Outpatient centre	1	-	-	-	-	-
112	Thunder Bay	ON	O	Psyc.	1	-	-	-	-	-
113	Thunder Bay	ON	P	Community Health	1	1944	86	-	-	-
114	Sarnia	ON	S	Hospice	1	-	10	-	3	-
115	Hamilton	ON	S	Hospice	1	-	10	36	15.2	-
116	Brantford	ON	S	Hospice	1	2005	6	117	-	-
117	Thunder Bay	ON	T	Treatment Centre	1	-	22	-	-	-
118	Thunder Bay	ON	T	Treatment Centre	1	-	-	40	-	-

Ref. #	City/Town	Province	Facility Type	Facility Sub-Type	Status	Year Established	Beds	Total Admissions	Staff	Budget
119	Toronto	ON	T	Treatment Centre	1	1973	22	-	12.7	-
120	Elliot Lake	ON	T	Treatment Centre	1	-	52	-	-	-
121	Montreal-Nord	QC	H	Rehab.	2	1995	198	1856	303	26,400,000
122	Saint Celestin	QC	L	Resid. Care Fac.	1	1916	52	-	41	-
123	Montreal	QC	L	Resid. Care Fac.	2	1934	162	71	156.8	11,000,000
124	Esterhazy	SK	H	Gen.	1	1940	22	671	58	2,893,311
125	Estevan	SK	H	Gen.	1	1938	91	2460	191	16,000,000
126	Gravelbourg	SK	H	Gen.	1	1928	9	591	70	3,200,000
127	Melville	SK	H	Gen.	1	1942	30	1230	85	6,082,410
128	Saskatoon	SK	H	Gen.	1	1907	200	-	-	-
129	Moose Jaw	SK	L	Pers. Care Home	2	1995	174	-	196	11,126,064
130	Ponteix	SK	L	Pers. Care Home	2	1959	32	17	30	1,800,000
131	Prince Albert	SK	L	Pers. Care Home	1	1956	120	54	130	9,000,000
132	Macklin	SK	L	Pers. Care Home	2	1996	26	-	29	$1,253,050
133	Regina	SK	L	Spec. Care Home	1	1968	147	-	160	10,000,000
134	Gravelbourg	SK	L	Spec. Care Home	1	1961	50	-	-	-
135	Saskatoon	SK	L	Spec. Care Home	1	1953	79	-	74	$3,625,000
136	Saskatoon	SK	L	Spec. Care Home	1	1965	85	-	60	-

Ref. #	Address	Regional/Local Health Authority Affiliation	Website
001	505 Lynx St. P.O. Box 1050 T1L 1H7	Alberta Health Services	www.catholichealth.ca
002	5402 - 47 st. P.O. Box 329 T0C 0X0	Alberta Health Services	www.covenanthealth.ca
003	5241 - 43 st. P.O. Box 490, T9C 1R5	Alberta Health Services	www.covenanthealth.ca
004	5001 Lakeshore Dr. P.O. Box 1008 T9N 2J7	Alberta Health Services	www.covenanthealth.ca
005	406 - 53rd st. T4V 1Y5	Alberta Health Services	www.stmaryscamrose.com
006	1100 Youville Dr. W. T6L 5X8	Alberta Health Services	www.covenanthealth.ca
007	16940 - 87th ave. T5R 4H5	Alberta Health Services	www.covenanthealth.ca
008	5203 - 49 ave P.O. Box 40. T0B 2L0	Alberta Health Services	www.covenanthealth.ca
009	10707 - 29th ave N.W. T6J 6W1	Alberta Health Services	www.covenanthealth.ca
010	5001 Lakeshore Dr. P.O. Box 1008 T9N 2J7	Alberta Health Services	www.covenanthealth.ca
011	5402 - 47 st. P.O. Box 329 T0C 0X0	Alberta Health Services	www.covenanthealth.ca
012	11111 Jasper Ave. T5K 0L4	Alberta Health Services	www.covenanthealth.ca
013	5203 - 49 ave P.O. Box 40. T0B 2L0	Alberta Health Services	www.covenanthealth.ca
014	1400 - 9th ave S. T1J 4V5	Alberta Health Services	www.covenanthealth.ca
015	253 Southgate Blvs. T1K 2S1	Alberta Health Services	www.covenanthealth.ca
016	Polomark Dr. P.O. Box T0B 3H0	Alberta Health Services	www.covenanthealth.ca
017	9 St. Vital Ave. T8N 1k1	Alberta Health Services	www.covenanthealth.ca
018	451 de Chauney ave. P.O. Box 100, T0M 2C0	-	www.covenanthealth.ca
019	16515 - 88 ave. NW. TSR 0A4	Alberta Health Services	www.covenanthealth.ca
020	332 - 146 Ave. S.E. T2N 2A3	Alberta Health Services	www.flnh.net
021	451 de Chauney ave. P.O. Box 100, T0M 2C0	-	www.covenanthealth.ca
022	1 st. Vital ave. T8N 1k1	-	www.foyerlacombe.ca
023	950 14 st. S. T1J 2Y8	Alberta Health Services	www.covenanthealth.ca
024	3080 Prince Edward St. V5T 3N4	Vancouver Coastal Health Authority, Vancouver	www.providencehealthcare.org
025	1081 Burrard St. V6Z 1Y6	Vancouver Coastal Health Authority, Vancouver	www.providencehealthcare.org
026	2137 Comox Ave. V9M1P2	Vancouver Island Health Authority, Victoria	www.sjghcomox.ca
027	7801 Argyle St. V5p 3L6	Vancouver Coastal Health Authority, Vancouver	www.providencehealthcare.org
028	704 W. 69th Ave. V6P 2W3	-	www.columbusresidence.ca
029	3150 Rosemont Dr. V5S 2C9	Vancouver Coastal Health Authority, Vancouver	-
030	861 Fairfield Rd. V8V 5A9	Vancouver Island Health Authority, Victoria	www.mtstmary.victoria.bc.ca
031	7801 Argyle St. V5p 3L6	Vancouver Coastal Health Authority, Vancouver	www.providencehealthcare.org
032	3080 Prince Edward St. V5T 3N4	Vancouver Coastal Health Authority, Vancouver	www.providencehealthcare.org
033	4650 Oak St. V6H 4J4	Vancouver Coastal Health Authority, Vancouver	www.providencehealthcare.org
034	255 W. 62nd Ave. V5X 4V4	Vancouver Coastal Health Authority, Vancouver	www.providencehealthcare.org
035	4950 Heather St. V5Z 3L9	Vancouver Coastal Health Authority, Vancouver	www.providencehealthcare.org
036	2474 Arbutus Road V8N 1V8	Vancouver Island Health Authority, Victoria	www.sistersofsaintanne.org/bc/ministry.htm
037	2137 Comox Ave. V9M1P2	Vancouver Island Health Authority, Victoria	www.sjghcomox.ca
038	900 West 12th Ave. 9th Fl. V5Z 1N3	Vancouver Coastal Health Authority, Vancouver	www.providencehealthcare.org
039	P.O. Box 60, R0L 1S0	Parkland Regional Health Authority, Dauphin	-

Ref. #	Address	Regional/Local Health Authority Affiliation	Website
040	409 Trache ave. R2H 2A6	Winnipeg Regional Health Authority, Winnipeg	www.sbgh.mb.ca/home.html
041	230 Bridge St. P.O. Box 280, R0L 2G0	Parkland Regional Health Authority, Dauphin	http://www.margueriteyouville.ca/network_Winnipegosis.html
042	99 Cornish Ave. R3C 1A2	Winnipeg Regional Health Authority, Winnipeg	http://www.misericordia.mb.ca/index.html
043	703 Jackson St. R7N 2N2	Parkland Regional Health Authority, Dauphin	-
044	15 Charriere Rd. R5H 1C9	-	-
045	P.O. Box 420, R0L 1S0	Parkland Regional Health Authority, Dauphin	-
046	450, ch. River, R2M 5M4	Autorite de sante regionale de Winnipeg, Winnipeg	http://www.margueriteyouville.ca/network_FoyerValade.html
047	165 Aberdeen ave. R2W 1T9	Winnipeg Regional Health Authority, Winnipeg	www.holyfamilyhome.mb.ca
048	440 River rd. R2M 3Z9	-	http://www.stamant.mb.ca/
049	185 Despins St. R2H 2B3	Winnipeg Regional Health Authority, Winnipeg	http://www.margueriteyouville.ca/network_TacheCentre.html
050	1149 Leila Ave. R2P 1S6	Winnipeg Regional Health Authority, Winnipeg	http://www.margueriteyouville.ca/network_StJosephsRes.html
051	230 Bridge St. P.O. Box 280, R0L 2G0	Parkland Regional Health Authority, Dauphin	http://www.margueriteyouville.ca/network_Winnipegosis.html
052	99 Cornish Ave. R3C 1A2	Winnipeg Regional Health Authority, Winnipeg	http://www.misericordia.mb.ca/index.html
053	210 Kenny Street, R2H 2E4	Winnipeg Regional Health Authority, Winnipeg	www.sararielinc.com
054	1 boul. St-Pierre Ouest, E1W 1B6	Regie de la sante A, Bathurst	-
055	7714 Rte. 134, E4S 1H5	Regie de la sante A, Bathurst	www.beausejour-nb.ca/English/apropos/index.cfm?id=98
056	2055 prom. Vallee-lourdes, E2A 4P8	Regie de la sante A, Bathurst	www.fndl.org
057	51 Lobban Ave. E1N 2W8	-	www.mountsj.ca
058	475 rue Pincipale E7C 1J2	-	-
059	10 Parks /st, E2K 4P1	-	www.rocmaura.com
060	146 Elizabeth Ave. A1B 1S5	Eastern Health St. John's	www.spmhf.nl.ca
061	25 Bay St. B2G 2G5	Guysborough Antigonish Strait Health Authority #7, Antigonish	www.gasha.nshealth.ca
062	2080 Windsor St. B3K 5B2	-	www.svnh.ca
063	R.R. 1, P.O. Box 810, B5A 4A5	-	www.villasaintjoseph.com
064	698 King St. W., L8P 1C7	Hamilton Niagrara Haldimand Brant LHIN	www.stjosham.on.ca
065	60 Cambridge St. L1R 7A5	Champlain LHIN	www.bruyere.org
066	340 Union St. W. K7L 5A2	South East LHIN	www.providencecare.ca
067	3276 St. Clair Ave. E. M1L 1W1	Toronto Central LHIN	www.providence.on.ca
068	35 Algoma St. N. P.O. Box 3251 P7B 5G7	Norh West LHIN	www.sjcg.net
069	100 Westmount Rd. N1H 5H8	Waterloo Wellington LHIN	www.sjhh.guelph.on.ca
070	801 Commissioners Rd. E. N6C 5J1	South West LHIN	www.sjhc.london.on.ca
071	166 Brock St. K7L 5G2	South East LHIN	www.hoteldieu.com
072	911 Queen's Blvd. N2M 1B2	Waterloo Wellington LHIN	www.smgh.ca
073	215 Third St. P.O. Box P0H 1V0	North East LHIN	http://www.mattawahospital.ca/english/home/default.htm
074	705 MacKay St. K8A 1G8	Champlain LHIN	www.pemreghos.org
075	30 The Queensway, M6R 1B5	Toronto Central LHIN	www.stjoe.on.ca
076	80 Grand Ave. W., P.O. Box 2030, N7M 5L9	-	www.ckha.on.ca
077	1030 Ouellette Ave. N9A 1E1	Erie St. Clair LHIN	www.hdgh.org
078	50 Charlton Ave. E. L8N 4A6	Hamilton Niagrara Haldimand Brant LHIN	www.stjosham.on.ca
079	30 Bond St. M5B 1W8	Toronto Central LHIN	www.stmichaelshospital.com

Ref. #	Address	Regional/Local Health Authority Affiliation	Website
080	70 Spine Rd. P5A 1X2	North East LHIN	www.sjgh.ca
081	288 Grosvenor St. P.O. Box 5777, N6A 4V2	South West LHIN	www.sjhc.london.on.ca
082	1335 St. John's Sideroad E. L4G 0P8	-	www.southdown.on.ca
083	500 Church St. L9M 1G3	North Simcoe Muskoka LHIN	www.mhcp.on.ca
084	752 King St. W. K7L 4X3	South East LHIN	www.providencecare.ca
085	580 Algoma St. N. Box 2930, P7B 5G4	North East LHIN	www.sjcg.net
086	100 West 5th St. P.O. Box 585, L8N 3K7	Hamilton Niagrara Haldimand Brant LHIN	www.stjosham.on.ca
087	850 Highbury Ave. P.O. Box 5532, Stn. B, N6A 4H1	South West LHIN	www.sjhc.london.on.ca
088	467 Sunset Dr. N5P 3V9	South West LHIN	www.sjhc.london.on.ca
089	541 Glenridge Ave. L2T 4C2	Hamilton Niagrara Haldimand Brant LHIN	www.hoteldieushaver.org
090	43 Bruyere St. K1N 5C8	Champlain LHIN	www.bruyere.org
091	56 Grovernor's Rd. L9H 5G7	Hamilton Niagrara Haldimand Brant LHIN	www.sjv.on.ca
092	2865 Riverside Dr. K1V 8N5	Champlain LHIN	www.stpats.ca
093	600 Cecelia St. K8A 7Z3	Champlain LHIN	www.marianhill.ca
094	659 Breakey Dr. K9K 2R8	Central East LHIN	www.stjosephsatfleming.com
095	75 Bruyere St. K1N 5C8	Champlain LHIN	www.bruyere.org
096	879 Ch. Hiawatha Park, K1C 2Z6	Champlain LHIN	www.bruyere.org
097	275 Sydenham St. k7K 1G7	South East LHIN	www.providencecare.ca
098	100 Westmount Rd. N1H 5H8	Waterloo Wellington LHIN	www.sjhh.guelph.on.ca
099	14 York St. K6J 5T2	Champlain LHIN	www.stjosephscentre.ca
100	1720 Sherwood Forrest Circle, L5K 1R1	Missisauga Halton LHIN	http://sites.google.com/site/carmelheightsca/home
101	9915 Young St. L4C 1V1	Central LHIN	http://www.mariannhome.org/
102	1250 South Bay Rd. P3E 6L9	North East LHIN	www.sjsudbury.com
103	10 Delaware Ave. P.O. Box 1003, L8N 3R1	Hamilton Niagrara Haldimand Brant LHIN	www.goodshepherdcentres.ca
104	3276 St. Clair Ave. E. M1L 1W1	Toronto Central LHIN	www.providence.on.ca
105	300 Lillie St. N., P7C 4Y7	Norh West LHIN	www.sjcg.net
106	63 Carrie St. P7A 4J2	North East LHIN	www.sjcg.net
107	99 Wayne Gretzky Pkwy. N3S 6T6	Hamilton Niagrara Haldimand Brant LHIN	www.sjlc.ca
108	70 Spine Rd. P5A 1X2	North East LHIN	www.sjgh.ca
109	21 Grosvenor Street, N6A 1Y6	South West LHIN	www.sjhc.london.on.ca
110	285 A Memorial Ave. P7B 6H4	Norh West LHIN	www.sjcg.net
111	2757 King St. E. L8G 5E4	Hamilton Niagrara Haldimand Brant LHIN	www.stjosham.on.ca
112	300 Lillie St. N., P7C 4Y7	Norh West LHIN	www.sjcg.net
113	710 Victoria Ave. E. P7C 5P7	North East LHIN	www.sjcg.net
114	111 Water Rd. N. N7T 7G9	Erie St. Clair LHIN	www.stjosephshospice.ca
115	90 Stinson St. P.O. Box 1003, L8N 3R1	Hamilton Niagrara Haldimand Brant LHIN	www.goodshepherdcentres.ca/emmanuelhouse.htm
116	99 Wayne Gretzky Pkwy. N3S 6T6	Hamilton Niagrara Haldimand Brant LHIN	www.sjlc.ca
117	667 Sibley Dr. P7B 6Z8	Norh West LHIN	www.sjcg.net
118	301 Lillie Street North, P7C 0A6	North East LHIN	www.sjcg.net

Ref. #	Address	Regional/Local Health Authority Affiliation	Website
119	30 Bond St. M5B 1W8	Toronto Central LHIN	www.stmichaelshospital.com
120	9 Oakland Blvd. P5A 2T1	North East LHIN	www.sjgh.ca
121	3530 Boul. Gouin Est. H1H 1B7	-	www.hopitalmarie-clarac.qc.ca
122	475 rue Houde C.P. 90 J0C 1G0	Region 4 - Mauricie et Centre-du-Quebed	-
123	1870 boul. Pie IX H1V 2C6	-	-
124	216 Ancona St. P.O. Box 280 S0A 0X0	-	www.catholichealth.ca
125	1176 Nicholson Rd. P.O. Box 5000 S4A 0H3	Sun Country Health Region, Weyburn	www.catholichealth.ca ; stjosephsestevan.ca
126	216 Bettez St. Bag 50 S0H 1X0	Five Hills Health Region, Moose Jaw	www.stjosephshospitalgravelbourg.com
127	200 Heritage Dr. P.O. Box 1810 S0A 2P0	Sunrise Health Region, Yorkton	www.catholichealth.ca
128	1702 - 20th St. W. S7M 0Z9	Saskatoon Health Region, Saskatoon	www.catholichealth.ca
129	100 - 2nd ave. N.W. S6H 1B8	Five Hills Health Region, Moose Jaw	www.catholichealth.ca
130	P.O. Box 450 S0N 1Z0	Cypress Health Region, Swift Current	www.catholichealth.ca
131	777 - 28th st. E. S6V 8C2	Prince Albert Parkland Health Region, Prince Albert	http://montstjoseph.org/foundation/index.shtml
132	P.O. Box 190 S0L 2C0	-	-
133	4215 Regina Ave. S4S 0J5	Regina Qu'Appelle Health Region, Regina	-
134	216 Bettez St. Bag 50 S0H 1X0	Five Hills Health Region, Moose Jaw	www.stjosephshospitalgravelbourg.com
135	2910 Louise St. S7J 3L8	Saskatoon Health Region, Saskatoon	www.catholichealth.ca
136	33 Valens Dr. S7L 3S2	Saskatoon Health Region, Saskatoon	-

Ref. #	Additional Comments	Information Source(s)
001	Primary Care: acute care, continuing care, maternal/child care, outpatient clinics & palliative care; Births (108)	GCHF; CHACD; OW
002	Acute care; Emergency (24hrs); continuing care	GCHF; CHACD; OW
003	Continuing care; Medicine/Surgery; Obstetricts/Gynaecology.; Renal care & Dialysis; 24hr emergency care	GCHF; CHACD; OW
004	Emergency; Aacute & long-term care; Palliative care; Cancer treatments	GCHF; CHACD; OW
005	Acute care; Births (236); Surgery; Obstetrics; Urology; Ultrasound	GCHF; CHACD; OW
006	Acute care; Births (5047); Pharmacy; Ultrasound; 24hr emergency	GCHF; CHACD; OW
007	Acute care; Births (2618); Pharmacy; Ultrasound; 24hr emergency	GCHF; CHACD; OW
008	24hr emergency care	GCHF; CHACD; OW
009	Dialysis, Renal care; Elderly; Palliative care; Community day support program	GCHF; CHACD; OW
010	Located at the same site & affiliated with Bonnyville health centre (H) ; Long term care & palliative care	GCHF; CHACD; OW
011	Elderly, continuing care, palliative care	GCHF; CHACD; OW
012	Continuing care, palliative care; subacute care	GCHF; CHACD; OW
013	Long term care; palliative care	GCHF; CHACD; OW
014	Continuing care, palliative care; rehab (36)	GCHF; CHACD; OW
015	assited living	GCHF; CHACD; OW
016	elderly, Long term care	GCHF; CHACD; OW
017	elderly; Mentally handicapped; Ex-psych, continuing care, dementia, palliative care	GCHF; CHACD; OW
018	Elderly aux. care	GCHF; CHACD; OW
019	complex continuing care & complex mental health	OW
020	elderly, physically & mentally disabled ; special needs day services	GCHF; CHACD; OW
021	assited living, continuing care	GCHF; CHACD; OW
022	Retired Oblates of Mary Immaculate priests and brothers	GCHF; CHACD; OW
023	Retirement Home	GCHF; CHACD; OW
024	Acute care; ultrasound; mannography	GCHF; CHACD; OW
025	Births 1740; Emergency room visits: 77,136; numbers are an amalagamtion of all providence healthcare numbers	GCHF; CHACD; OW
026	Beds: Obstetrics & Gynaecology (9), Intensive care, Pedeatrics, Medicine/surgergy,Psychiatry; Births: 560	GCHF; CHACD; OW
027	-	GCHF; CHACD; OW
028	Elderly extended and intermediate care	GCHF; CHACD; OW
029	-	GCHF; CHACD
030	Long term care	GCHF; CHACD; OW
031	Located at the same site & affiliated with Holy Family Hospital (H)	GCHF; CHACD; OW
032	Located at the same site & affiliated with Mounth Saint Joseph Hospital (H)	GCHF; CHACD; OW
033	-	GCHF; CHACD; OW
034	Long term care	GCHF; CHACD; OW
035	Elderly, multilevel care, alzheimers care	GCHF; CHACD; OW
036	Not listed in the GCHF - long term care home for elderly and retired Religious Sisters	CHACD; OW
037	Located at the same site & affiliated with St. Joseph's General Hospital (H)	GCHF; CHACD; OW
038	Hospice & palliative care	GCHF; CHACD; OW
039	Medicine/Surgery; Paliative Care	GCHF; CHACD

Ref. #	Additional Comments	Information Source(s)
040	Cardiology;Geriatric rehab; Intensive care; Medicine;Neonatal intensive care; Obstetrics/Gynaecology; Surgery; 24hr emergency care	GCHF; CHACD; OW
041	Medicine/Surgergy; Pediatrics; 24hr emergency care	GCHF; CHACD; OW
042	24hr urgent care	GCHF; CHACD; OW
043	Elderly	GCHF; CHACD
044	Elderly, physically and mentally handicapped	GCHF; CHACD
045	Elderly	GCHF; CHACD
046	Elderly, physically and mentally handicapped	GCHF; CHACD; OW
047	Elderly	GCHF; CHACD; OW
048	Developmentally disabled	GCHF; CHACD; OW
049	Elderly and physically handicapped	GCHF; CHACD; OW
050	Elderly	GCHF; CHACD; OW
051	Elderly and physically handicapped	GCHF; CHACD; OW
052	-	GCHF; CHACD; OW
053	Mental Health	CHACD; OW
054	-	GCHF; CHACD
055	-	GCHF; CHACD; OW
056	Elderly	GCHF; CHACD; OW
057	Elderly and physically handicapped	GCHF; CHACD; OW
058	-	GCHF; CHACD
059	Elderly and physically& mentally handicapped	GCHF; CHACD; OW
060	Nusing & respite care	GCHF; CHACD; OW
061	Intensive care; Medicing/Surgery; Psychiatry; Births (483)	GCHF; CHACD; OW
062	Elderly	GCHF; OW
063	Elderly & disabled	GCHF; CHACD; OW
064	Home care services	GCHF; OW; CHAO
065	Chronic care	GCHF; CHACD; OW; CHAO
066	Continuing Care, palliative care, rehab	GCHF; CHACD; OW
067	Acute care	GCHF; OW; CHAO
068	Complex Chronic care; palliative care; Rehab	GCHF; CHACD; OW; CHAO
069	Complex continuing care; Rehab; Respite Care	GCHF; CHACD; OW
070	-	GCHF; CHACD; OW
071	Psychiatric and ambulatory care patients	GCHF; CHACD; OW
072	Intensive care; Medicine/Surgery; Ultrasound; X-ray; 24hr emergency	GCHF; OW
073	Chronic care; Medicine/Surgery; pediatrics; 24hr emergency care	GCHF; CHACD; OW; CHCO
074	Intensive care.; Maternity; Pediatrics; Psychiatrics; Surgery; Rehab; Medicine; Births (403)	GCHF; CHACD; OW; CHAO
075	24hr emergency care	GCHF; CHACD; OW; CHAO
076	Acute; Chronic Care; Mental Health; Rehab; Women's and Children's Health	GCHF; CHACD; OW
077	Intensive care; medicine/Surgery; Mental Health; Cariology; 24hr emergency care & trauma centre	GCHF; CHACD; OW
078	Continuing care; medicine; Neonatal intensive care; Obstetrics/Gynaecology; Surgery; Births (3513)	GCHF; OW; CHAO
079	-	GCHF; CHACD; OW; CHAO

Ref. #	Additional Comments	Information Source(s)
080	Intensive care; Chronic care; Med.Surg; Births 84	GCHF; CHACD; OW; CHCO
081	-	GCHF; CHACD; OW
082	Specializes in addressing issues of addiction and mental health - limited to clergy and the religious (each individual sponsored by a religious community or diocese)	GCHF; OW
083	Psychiatric care	GCHF; CHACD; OW; CHAO
084	Psychiatric, forenzic and mental health	GCHF; CHACD; OW
085	Dementia; Geriatrics; Rehab; Mental health and addictions	GCHF; CHACD; OW; CHAO
086	Formerly Hamilton psychiatric Hospital	GCHF; OW; CHAO
087	Mental Health; Formerly known as the London Psychiatric Hospital	GCHF; CHACD; OW
088	Mental Health; Formerly known as St. Thomas Psychiatric Hospital	GCHF; CHACD; OW
089	Complex Chronic care; rehabilitation	GCHF; OW; CHAO
090	Rhabilitation; palliative care	GCHF; CHACD; OW; CHAO
091	Elderly	GCHF; OW; CHAO
092	Elderly	GCHF; CHACD; OW; CHAO
093	Long term care	GCHF; CHACD; OW; CHAO
094	Elderly; physically and developmentally handicapped	GCHF; CHACD; OW; CHAO
095	Elderly	GCHF; CHACD; OW; CHAO
096	Elderly	GCHF; CHACD; OW; CHAO
097	Elserly and physically and developmentally handicapped	GCHF; CHACD; OW
098	Elderly, physically & mentally handicapped	GCHF; CHACD; OW
099	Elderly	GCHF; OW
100	Elderly	GCHF; OW
101	Elderly, mentaly handicaped	GCHF; OW; CHAO
102	Elderly, Long term care	GCHF; CHACD; OW; CHAO
103	Elderly, physically & mentally handicapped, EX-psychiatric & emotionally disturbed	GCHF; OW
104	Elderly, physically & cognitively impaired	GCHF; OW; CHAO
105	Elderly, Long term care	GCHF; CHACD; OW; CHAO
106	Elderly, physically & mentally handicapped	GCHF; CHACD; OW; CHAO
107	Long term care	GCHF; CHACD; OW; CHCO
108	nursing care	GCHF; CHACD; OW; CHCO
109	Long term care	GCHF; CHACD; OW
110	Diabetes health and management	GCHF; CHACD; OW; CHAO
111	Formerly St. Joseph's Community Health Centre	GCHF; OW; CHAO
112	Counselling	GCHF; CHACD; OW; CHAO
113	Mental Heatlh & addictions	GCHF; CHACD; OW; CHAO
114	palliative care & terminally ill	GCHF; OW
115	Terminally ill; palliative care	GCHF; OW
116	Hospice & palliative care	GCHF; CHACD; OW; CHCO
117	Withdrawl management programs; Detox	GCHF; CHACD; OW; CHAO
118	Additions and mental health: eating disorders; 10 youth beds & 30 adult beds	GCHF; CHACD; OW; CHAO

Ref. #	Additional Comments	Information Source(s)
119	Detoxification programs	GCHF; CHACD; OW; CHAO
120	Alcohol and drug treatment; drug withdrawl treatment	GCHF; OW
121	-	GCHF; CHACD; OW
122	Elderly	GCHF
123	Elderly	GCHF; CHACD
124	Acute care hospital; 24hr emergency	GCHF; CHACD; OW
125	Intensive care; Long term care; Medicine/surgery/pediatrics; Obstetrics/Gynaecology; Births (320); 24hr emergency care	GCHF; CHACD; OW
126	Acute care; 24 hr emergency care	GCHF; CHACD; OW
127	Acute care; Births (6); 24hr emergency care	GCHF; CHACD; OW
128	Intensive care; Surgery; Medicine; Palliative care; Rehab	GCHF; CHACD; OW
129	Long term care; Geriatric Rehabilitation; Day services	GCHF; CHACD; OW
130	Long term care	GCHF; CHACD; OW
131	Long term care; Alzheimer's; palliative care	GCHF; CHACD; OW
132	Elderly, physically & mentally handicapped, Long term care, palliative care	GCHF; CHACD
133	Elderly; Long term care	GCHF; CHACD
134	Long term care ; Same site as Saint Joseph's hospital - Graavelbourg	GCHF; CHACD; OW
135	Nursing Care	GCHF; CHACD; OW
136	Nursing Care	GCHF; CHACD