

ABORTION AND CONSCIENTIOUS OBJECTION: THE NEW BATTLEGROUND

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This paper examines the vexed issue of conscientious objection and abortion. It begins by outlining the increasing claims to conscientious objection invoked by physicians in reproductive health services. After an examination of developments overseas, the paper turns to the acrimonious debate in Victoria concerning the conscience clause and the 'obligation to refer' contained in the Abortion Law Reform Act 2008 (Vic) ('ALRA'). This paper questions the interpretation by the Catholic Church that the clause breaches its right to freedom of conscience and freedom of religion. We argue that the unregulated use of conscientious objection impedes women's rights to access safe lawful medical procedures. As such, we contend that a physician's withdrawal from patient care on the basis of conscience must be limited to certain circumstances. The paper then examines international and national guidelines, international treaties and recommendations of treaty monitoring bodies, laws in other jurisdictions, and trends in case law. The purpose of this examination is to show that the conscientious objection clause and the 'obligation to refer' in ALRA is consistent with international practice and laws in other jurisdictions. Finally, the paper turns to the problematic interpretation of conscience and moral responsibility in the context of abortion. We believe that narrow interpretations of conscience must be challenged, in order to incorporate patients' rights to include the choice of abortion and other lawful treatments according to their conscience. We conclude that the conscientious objection provisions in ALRA have achieved the right balance and that there is no justifiable legal reason upon which opponents can challenge the law.

I INTRODUCTION

This paper examines the issue of abortion and the increasing use of conscientious objection by physicians and others opposed to abortion. Our main focus is on the conscience clause and the 'obligation to refer' contained in s 8(1)(b) of the *Abortion Law Reform Act 2008* (Vic) ('ALRA'). The conscience clause engendered an acrimonious public debate that saw the Catholic Church threaten to close

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Catholic hospitals in Victoria should the law pass.¹ The Catholic Church and other religious groups argued that the clause breached their freedom of religion and freedom of conscience under international law and under the Victorian *Charter of Human Rights and Responsibilities Act 2006* ('the Charter'). We argue that this interpretation is flawed and that the unregulated use of conscientious objection denies women their fundamental right to lawful medical care. Hence, the law is required to undertake a balancing act to ensure that one right is not able to undermine the exercise of other rights.

We begin with an overview of the increasing use of conscientious objection in the United States, Europe, Latin America and South Africa. Our examination is not an exhaustive one. It is restricted to countries where, like Australia, Christianity is the dominant religion, and is able to exert influence on contentious political and moral issues. The purpose of this overview is to demonstrate an increasing trend by opponents of abortion to rely on claims of conscientious objection as a response to the liberalisation of abortion law. We then turn to the Victorian debate concerning the conscience clause in *ALRA*. In this section, we will also examine the interaction between *ALRA* and the *Charter*. It was often claimed by opponents of *ALRA* that the conscience clause in s 8 of the Act undermined physicians' freedom of conscience under the *Charter*.² This argument is disingenuous and ignores the role played by religious groups concerning how s 48, 'the savings provision', came to be included in the *Charter* and its subsequent impact on *ALRA*.

We explore freedom of conscience under international and national guidelines, recommendations by international treaty monitoring bodies and the implementation of conscience clauses in foreign jurisdictions. We undertake this examination in order to demonstrate that the provisions in *ALRA* are not a radical departure from current practice or developments in other jurisdictions. Indeed, we argue that freedom of conscience and religion under international law is not absolute, and that the conscience clause and the 'obligation to refer' in *ALRA* are consistent with international practice. We then turn to the problematic issue of the interpretation of conscience and moral responsibility, arguing that narrow interpretations that undermine women's decision-making and autonomy must be challenged. The concept of conscience must be broadened to incorporate patients' rights and their choices according to their conscience.

1 Barney Zwart, 'Archbishop in Abortion Law Threat', *The Age* (online), 23 September 2008 <<http://www.theage.com.au/national/archbishop-in-abortion-law-threat-20080922-4lsl.html>>.

2 See, eg, Eamonn Mathieson on behalf of Doctors in Conscience, *Submission to the Scrutiny and Regulations Committee regarding Victoria's Charter of Human Rights and Responsibilities 2006* (2008) <<http://www.doctorsconscience.org/>>.

II THE RISE AND RISE OF CONSCIENTIOUS OBJECTION: DEVELOPMENTS IN THE US, EUROPE, LATIN AMERICA AND SOUTH AFRICA

A United States

According to Zampas and Gher, there has been a ‘striking expansion of international and regional human rights standards and jurisprudence that support women’s human right to abortion’.³ This trend appears to be occurring in all parts of the world, in both developed and developing nations, including countries where the dominant faith is Catholicism, such as Portugal,⁴ Spain⁵ and Columbia.⁶ However, this progressive liberalisation of abortion laws has not remained unchallenged. While legal challenges to liberal abortion laws have largely failed, there has been an increase in claims of conscientious objection to the provision of reproductive healthcare.⁷ Indeed, Cook, Olaya and Dickens argue that conservative and religious ‘strategy has become directed to resistance through invocation of human rights to religious conscience’.⁸ In the United States, every state has laws on conscientious objection or ‘refusal laws’ in relation to abortion.⁹ These laws were first enacted as a legislative response to *Roe v Wade*,¹⁰ which legalised abortion during the first trimester. The US Supreme Court ruled that a state law banning abortion, except where the mother’s life was at risk, was unconstitutional. The Court held that such laws ‘violate[d] the Due Process Clause of the Fourteenth Amendment, which protects against state action the right to privacy, including a woman’s qualified right to terminate her pregnancy’.¹¹ Within weeks of the decision, Senator Frank Church introduced the Church Amendment that permitted health providers who received public funding the right to refuse to

3 Christina Zampas and Jaime M Gher, ‘Abortion as a Human Right — International and Regional Standards’ (2008) 8 *Human Rights Law Review* 249, 249.

4 Peter Wise, ‘Portugal Votes to Liberalise Abortion Law’, *Financial Times* (online), 12 February 2007 <<http://www.ft.com/cms/s/0/dc858f20-b9f7-11db-89c8-0000779e2340.html#axzz1tlvPzDUG>>.

5 ‘Spain OKs New Abortion Laws, Angers Church’, *NBC News* (online) 24 February 2010 <http://www.msnbc.msn.com/id/35565952/ns/world_news-europe/t/spain-oks-new-abortion-law-angers-church/>.

6 Emilia Ordolis, ‘Lessons from Colombia: Abortion, Equality, and Constitutional Choices’ (2008) 20 *Canadian Journal of Women and the Law* 263.

7 Rebecca J Cook, Mónica Arango Olaya and Bernard M Dickens, ‘Healthcare Responsibilities and Conscientious Objection’ (2009) 104 *International Journal of Gynecology and Obstetrics* 249.

8 Ibid.

9 R Alta Charo, ‘Health Care Provider Refusals to Treat, Prescribe, Refer or Inform: Professionalism and Conscience’ (2007) 1(1) *Advance* 119, 120–1.

10 410 US 113 (1973); see also Georgia Chudoba, ‘Conscience in America: The Slippery Slope of Mixing Morality with Medicine’ (2007) 36 *Southwestern University Law Review* 85; Kristin M Roshelli, ‘Religiously Based Discrimination: Striking a Balance between a Health Care Provider’s Right to Religious Freedom and a Woman’s Ability to Access Fertility Treatment without Facing Discrimination’ (2009) 83 *St John’s Law Review* 977, 987.

11 *Roe v Wade*, 410 US 113 (1973).

perform procedures that would be contrary to their religious belief.¹² In 1974, the Church Amendment was ‘expanded to include protection for religious or moral objection to *any* health service’ which received public funding.¹³

Initially, conscience clauses focused on physicians’ obligations and were mainly concerned with participation in abortion and sterilisation procedures.¹⁴ However, in more recent years, the meaning of ‘participation’ has expanded to include providing referrals to other providers, counselling or aftercare medical assistance. Indeed, many states in the US have expanded the legislation to cover not only abortion but also ‘other reproductive services, such as traditional contraception, emergency contraception, and IVF or other fertility services’.¹⁵ In parallel with the broadening of the definition of ‘participation’, there has been a growth in medical professionals claiming conscientious objection to the provision of reproductive health services. For example, US states such as Arkansas, Georgia, Mississippi, and South Dakota have all enacted laws that allow a pharmacist to refuse to fill prescriptions for contraceptives based on their moral or religious beliefs.¹⁶ Effectively, this means that not only is a woman’s access to abortion obstructed by conscience claims, but their efforts to obtain contraception can also be obstructed.¹⁷

B Europe

The issue of abortion and conscientious objection in Europe is more complex than in the US. The vast majority of European countries allow abortion without restriction up to 12 weeks gestation.¹⁸ After 12 weeks, abortion is permitted in cases where it is required to preserve the mother’s health or life, or where serious abnormalities of the foetus have been found.¹⁹ According to research undertaken in 2005, 69 per cent of World Health Organisation Member States in Europe allowed abortion on request; 79 per cent allowed for abortion for economic and social reasons; 88 per cent for foetal impairment; 87 per cent for rape and incest;

¹² Jody Feder, ‘The History and Effect of Abortion Conscience Clause Laws’ (Report for Congress, Congressional Research Service, 14 January 2005) 2 <<http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/RS2142801142005.pdf>>.

¹³ Leslie C Griffin, ‘Conscience and Emergency Contraception’ (2006) 6 *Houston Journal of Health Law and Policy* 299, 302–3 (emphasis in original); see also Chudoba, above n 10, 87.

¹⁴ Griffin, above n 13, 302.

¹⁵ Charo, above n 9, 121.

¹⁶ Ibid 122.

¹⁷ Jed Miller, ‘The Unconscionability of Conscience Clauses: Pharmacists’ Consciences and Women’s Access to Contraception’ (2006) 16 *Health Matrix: Journal of Law–Medicine* 237, 238; see also Claire A Smearman, ‘Drawing the Line: The Legal, Ethical and Public Policy Implications of Refusal Clauses for Pharmacists’ (2006) 48 *Arizona Law Review* 469; Martha S Swartz, ‘“Conscience Clauses” or “Unconscionable Clauses”: Personal Beliefs versus Professional Responsibilities’ (2006) 6 *Yale Journal of Health Policy, Law and Ethics* 269.

¹⁸ Center for Reproductive Rights, *The World’s Abortion Laws 2012* <<http://worldabortionlaws.com/map/>>.

¹⁹ International Planned Parenthood Federation European Network (‘IPPF’), *Abortion Legislation in Europe* (8th ed, January 2007) <http://www.ippfen.org/NR/rdonlyres/2EB28750-BA71-43F8-AE2A-8B55A275F86C/0/Abortion_legislation_Europe_Jan2007.pdf>.

90 per cent to preserve mental health; 90 per cent to preserve physical health; and 96 per cent to save a woman's life.²⁰ A minority of countries such as Poland have very restrictive abortion laws,²¹ while Malta and Ireland are the only two European countries where abortion remains illegal; with the exception of saving the life of the mother.²² Since the initial research undertaken in 2005, further liberalisation has occurred in a number of European countries. For example, in 2007, Portugal, which had one of the strictest abortion laws in Europe, voted in a referendum to 'allow women to have an abortion at an authorised health clinic during the first 10 weeks of pregnancy'.²³ This change in Portugal was followed by Spain in 2010. Spain eased restrictions on abortion, allowing terminations up to 14 weeks without restriction, and gave 16 and 17 year olds the right to have an abortion without parental consent.²⁴

As is the case with abortion laws, laws on conscientious objection vary across European countries. The Council of Europe recently adopted a resolution titled *The Right to Conscientious Objection in Lawful Medical Care Resolution 1763 (2010)*. The resolution requires member states to recognise the right to conscientious objection, while at the same time ensuring that patients can request lawful medical procedures in a timely manner.²⁵ The only European country to object to *Resolution 1763* was Sweden. In Sweden, patients' rights are paramount. Conscientious objection to abortion is not recognised under Swedish Law. The Swedish Parliament, in response to *Resolution 1763*, stated:

[that it] stands firm that Sweden should support efforts which makes abortions free, safe and legal for all women. Sweden is one of few countries who are central in the international work focusing on sexual and reproductive health and rights. The Swedish policy on Sexual and Reproductive Health and Rights remains stable. The standing committee notices that the issue of abortion is not covered by the EU treaty. The standing committee remain negative to the content of *Resolution 1763* (2010) and consider the [Swedish] delegation to take more action to accomplish a change of this resolution.²⁶

No other country in Europe has such a restrictive approach to conscientious objection although it is given a far more limited interpretation and application than that found in the US. For example, in 2001, two French pharmacists claimed that their freedom of religion had been breached 'as a result of their conviction

20 Gunta Lazdane, 'Abortion in Europe: Ten Years After Cairo' (2005) 59 *Entre Nous: The European Magazine for Sexual and Reproductive Health* 4, 4; see also IPPF, above n 19.

21 IPPF, above n 19, 48–9.

22 Health on Track, *Abortion Law Remains in Place in Malta and Ireland* (21 December 2010) <<http://healthontrack.info/abortion-law-remains-malta-ireland/>>.

23 Wise, above n 4.

24 'Spain OKs New Abortion Laws, Angers Church', above n 5.

25 Mark Campbell, 'Conscientious Objection and the Council of Europe: The Right to Conscientious Objection in Lawful Medical Care' (2011) 19 *Medical Law Review* 467, 467, 469.

26 Society for the Protection of Unborn Children, *Swedish Parliament Votes to Campaign against Conscientious Objection to Abortion* (11 May 2011) <<http://www.spuc.org.uk/news/releases/2011/may11/>>.

by French authorities for refusing to dispense oral contraception to three female customers.²⁷ The two pharmacists appealed to the European Court of Human Rights arguing their rights under art 9(1) of the *European Convention for the Protection of Human Rights and Fundamental Freedoms* had been breached. The Court found that the ‘pharmacists’ refusal to sell contraceptives did not fall within the scope of the right to manifest a religion and belief.²⁸ The Court stated that the pharmacists ‘could not give priority to their personal beliefs over their professional obligations’, where contraceptives are legal and can only be gained through prescription at a pharmacy.²⁹

Another means by which the Catholic Church has recently sought to influence European countries regarding the protection of conscientious objection is through the use of concordats with individual countries.³⁰ The Catholic Church has signed many concordats with individual countries which contain provisions on conscientious objection.³¹ Traditionally, the conscientious objection clauses in concordats have concerned military service, but in 2003, the Vatican commenced talks with Slovakia to sign a concordat that extended protection of conscientious objection to abortion, artificial or assisted fertilisation, experiments involving human embryos and human sex cells, euthanasia, sterilisation and contraception.³² This attempt to expand conscientious objection via a concordat was challenged by the EU which convened a panel of experts to examine the proposed agreement. The EU Network of Independent Experts on Fundamental Rights (‘EUNFR’) stated that the draft treaty may lead to the Slovak Republic violating its obligations under the *International Covenant on Civil and Political Rights*, the *International Covenant on Economic, Social and Cultural Rights*, and the *Convention on the Elimination of All Forms of Discrimination against Women*.³³ While recognising that ‘certain religious organisations’ should have the right not to perform operations or procedures that ‘conflict with the ethos or belief on which they are founded’, they nonetheless stated that:

it is important that the exercise of this right does not conflict with the rights of others, including the right of all women to receive certain medical services or counselling without any discrimination. Approximately 70% of the population in the Republic of Slovakia is catholic. There is a risk that the recognition of a right to exercise objection of conscience in the

²⁷ Adriana Lamačková, ‘Conscientious Objection in Reproductive Health Care: Analysis of *Pichon and Sajous v France*’ (2008) 15 *European Journal of Health Law* 7, 7–8.

²⁸ Ibid 8.

²⁹ Ibid.

³⁰ Catholics for Choice, *In Good Conscience: Conscience Clauses and Reproductive Rights in Europe — Who Decides?* (2010) <<http://www.catholicsforchoice.org/documents/InGoodConscience--Europe.pdf>>.

³¹ EU Network of Independent Experts on Fundamental Rights, *The Right to Conscientious Objection and the Conclusion by EU Member States of Concordats with the Holy See* (14 December 2005) <http://ec.europa.eu/justice/fundamental-rights/files/cfr_cdfopinion4_2005_en.pdf>; see also Concordat Watch for a list of countries that have concordats with the Vatican <http://www.concordatwatch.eu/websitem.php?org_id=844>.

³² EU Network of Independent Experts on Fundamental Rights, above n 31, 28.

³³ Ibid 32.

field of reproductive healthcare will make it in practice impossible or very difficult for women to receive advice or treatment in this field, especially in rural areas.³⁴

The consequence of the EUNFR Report and the public opposition that it generated caused a split in the governing coalition and eventually the fall of the Slovakian Government.³⁵ However, the election of a centre-right party in June 2010 could see the issue re-emerge as the elected government has indicated that they have ‘no problem fulfilling the international commitments between Slovakia and the Vatican’.³⁶

C Latin America and South Africa

Claims regarding conscientious objection are also increasing in developing countries. According to Casas, women’s increasing claims to improved access to sexual and reproductive health services in some Latin American countries has been accompanied by a corresponding rise in physicians claiming conscientious objection.³⁷ She argues that ‘access to accurate information and care is increasingly under siege from providers who claim that rendering such care is counter to their religious or personal beliefs’.³⁸ Casas cites Peru and Argentina, where access to reproductive health and rights are now guaranteed; Mexico City and Colombia, where induced abortion is now allowed; and Chile, which introduced emergency contraception as part of its health policy in 2004, as reasons for the rise in claims of conscientious objection in those countries.³⁹ In Mexico City, since the legalisation of first trimester abortion in 2007, opponents have launched a campaign calling upon hospital staff to utilise conscientious objection laws and conservative politicians have attempted to introduce amendments to enshrine stronger protection for objector’s rights.⁴⁰

In Chile, Casas states that conscientious objection was not an issue in family planning until ‘2004 when emergency contraception was included in the treatment protocol for rape victims’ free of cost.⁴¹ This resulted in pharmacists refusing to stock the drug, local mayors refusing to have the drug given to rape victims in their jurisdictions, and the Catholic Archbishop of Santiago urging

34 Ibid 30–1.

35 National Secular Society, *Vatican Concordat Row Causes Government to Fall in Slovakia* (10 February 2006) <<http://www.secularism.org.uk/vaticanconcordatrowcausesgovernm.html>>; see also Catholics for a Free Choice, *The Church and State: Slovak Government Falls over Concordat with Vatican* (22 June 2006) The Free Library by Farlex <<http://www.thefreelibrary.com/The+church+and+state%3A+Slovak+government+falls+over+concordat+with+the...-a0145680887>>.

36 Vatíkanske Zmuvy A Výhrada Svedomia, 2010: *Pact with Vatican on Objection of Conscience Still Pending* <<http://vatikanskezmuvy.wordpress.com/english-2/>>.

37 Lidia Casas, ‘Invoking Conscientious Objection in Reproductive Health Care: Evolving Issues in Peru, Mexico and Chile’ (2009) 17(34) *Reproductive Health Matters* 78.

38 Ibid 78.

39 Ibid 79–80.

40 Ibid 81.

41 Ibid 82.

Catholics to defy the law.⁴² In 2008, the Constitutional Court of Chile banned the free distribution of emergency contraception through the public system.⁴³ Consequently, the then President, Michelle Bachelet, issued an executive order to secure free access to emergency contraception for rape victims. This action was subsequently annulled by the Court.⁴⁴ In July 2009, the Bachelet Government introduced a Bill into the Lower House to allow the free distribution of emergency contraception in the public system. This was passed by a vote of 73 to 34 with two abstentions.⁴⁵ However, the Bill never went to the Upper House due to the election of a conservative government that opposed the Bill.⁴⁶ Claims of conscientious objection to abortion have also increased in South Africa after the restrictive *Abortion and Sterilization Act* of 1975 was replaced by the liberal *Choice on Termination of Pregnancy Act* in 1996.⁴⁷ The 1996 Act made abortion on demand legal, in the first 12 weeks of pregnancy, and conditional thereafter.⁴⁸ Despite this liberalisation of abortion law, Van Bogaert argues that women in South Africa still resort to unsafe practices.⁴⁹ He concludes that this practice is the result of a number of reasons: ignorance of the law, unavailability of services, particularly in rural areas, lack of education, taboo and stigmatisation, and ‘appeal[s] to conscientious objection by health care providers in state-run facilities’.⁵⁰

The next section turns to the debate concerning conscientious objection to abortion during the abortion law reform process in Victoria in 2008.

⁴² Ibid.

⁴³ Angela Castellanos, *Chile: The Struggle Over Emergency Contraception* (19 October 2009) RH Reality Check <<http://www.rhrealitycheck.org/blog/2009/10/19/chile-the-struggle-over-emergency-contraception>>.

⁴⁴ Ibid.

⁴⁵ Ibid.

⁴⁶ Ibid.

⁴⁷ Charles Ngwena, ‘Conscientious Objection and Legal Abortion in South Africa: Delineating the Parameters’ (2003) 28(1) *Journal for Juridical Science* 1.

⁴⁸ *Choice on Termination of Pregnancy Act 1996* (South Africa). Abortion can still be performed from the 13th week to the 20th week provided that the medical practitioner, in consultation with the pregnant woman, is of the opinion that continuing the pregnancy would pose a risk of injury to the woman’s physical or mental health; or there exists a substantial risk that the foetus would suffer from severe physical or mental abnormality; or the pregnancy resulted from rape or incest; or the continued pregnancy would significantly affect the social or economic circumstances of the woman: s 2(1)(b). After 20 weeks if a medical practitioner in consultation with another practitioner or midwife, is of the opinion that the continued pregnancy would endanger the woman’s life; would result in a severe malfunction of the foetus; or would pose a risk of injury to the foetus; the termination of the pregnancy may be carried out: s 2(1)(c). This Act was amended by the *Choice of Termination of Pregnancy Amendment Act 2004* which made abortion more accessible by allowing registered nurses and midwives to perform abortions up to 12 weeks: s 6.

⁴⁹ Louis-Jacques Van Bogaert, ‘The Limits of Conscientious Objection to Abortion in the Developing World’ (2002) 2 *Developing World Bioethics* 131, 141.

⁵⁰ Ibid 141–2.

III CONSCIENTIOUS OBJECTION AND THE ABORTION LAW REFORM ACT 2008 (VIC)

Laws covering freedom of conscience or the right to claim conscientious objection are found in all Australian states. Generally, they provide that no person is under a duty, whether by contract, statutory or other legal requirement, to perform a termination to which they have a conscientious objection.⁵¹ Such clauses only apply to individuals. The sole exception is Western Australia, where the conscience clause is extended to cover hospitals, health institutes or any other institution or service.⁵² Conscience clauses do not apply in emergency situations where a termination is necessary to save a life or prevent injury to the pregnant woman.⁵³

The issue of abortion, freedom of religion and conscientious objection had historically not featured prominently in public debates about abortion in Australia. That changed with the introduction of the Abortion Law Reform Bill 2008 into the Victorian Parliament on 19 August 2008. After a long and acrimonious debate, the Abortion Law Reform Bill became law on 22 October 2008: The *Abortion Law Reform Act 2008 (Vic)*. *ALRA* fully decriminalised abortion up to 24 weeks. After 24 weeks, a termination can proceed provided that the medical practitioner ‘reasonably believes that abortion is appropriate in all the circumstances’ and, that the medical practitioner has consulted one other medical practitioner who also ‘reasonably believes that the abortion is appropriate in all the circumstances’.⁵⁴

More controversially, *ALRA* contains provisions relating to health practitioners who hold a conscientious objection to abortion. *ALRA* requires that a practitioner must inform the woman of their objection to abortion, and must refer the woman to another practitioner who does not have a conscientious objection to abortion. However, in the event of an emergency, a medical practitioner is under a duty to perform an abortion to save a woman’s life and cannot rely on conscientious objection to refuse medical treatment.

The conscience clause engendered much debate and opposition from particular sectors of the community. The Victorian Catholic Archbishop, Denis Hart, threatened to close maternity wards in Catholic hospitals.⁵⁵ Another agitated

⁵¹ See *Criminal Law Consolidation Act 1935* (SA) s 82A(5); *Criminal Code Act 1924* (Tas) s 164(7); *Health Act 1911* (WA) s 334(2); *Health Act 1993* (ACT) s 84; *Medical Services Act* (NT) s 11(6).

⁵² *Health Act 1911* (WA) s 334(2).

⁵³ See *Criminal Law Consolidation Act 1935* (SA) s 82A(6); *Criminal Code Act 1924* (Tas) s 164(8). None of the other state Acts have a clause that states that conscientious objection does not apply in an emergency situation but guidelines such as the *Code of Ethics for Nurses in Australia* (1993) state that nurses are morally entitled to refuse to participate in procedures that they object to, provided it is a non-emergency situation: see Royal College of Nursing Australia, *Conscientious Objection: Position Statement* <http://www.rcna.org.au/WCM/Images/RCNA_website/Files%20for%20upload%20and%20link/policy/documentation/position/Conscientious_objection-under_review_25Nov04.pdf>. The Australian Medical Association ‘Code of Ethics’ provides for conscientious objection but states that in emergency situations practitioners must set aside their objections and perform the procedure, see Victorian Law Reform Commission (‘VLRC’), *Law of Abortion*, Final Report No 15 (2008) 113 [8.19].

⁵⁴ *Abortion Law Reform Act 2008* (Vic) s 5(1).

⁵⁵ Zwartz, above n 1.

commentator attacked civil libertarians for not supporting physicians' freedom of conscience.⁵⁶ A third asserted that the conscience provisions were totalitarian and doctors of conscience should engage in civil disobedience.⁵⁷ A fourth opined that the conscience provisions in *ALRA* and the fact that the right to freedom of conscience in the Victorian *Charter* 'failed' to protect religious freedoms may also have contributed to religious opposition to a proposed federal charter of human rights in 2010.⁵⁸

The above arguments are flawed for two reasons. First, they do not acknowledge that freedom of conscience and religion under international law are not absolute. Second, they do not acknowledge the role of religious lobbying that saw the inclusion of s 48 of the *Charter* which specifically excluded abortion or laws relating to abortion from coverage by the *Charter*.

The conscience clause that elicited such a hostile response from the Catholic Church as well as some other religious groups is found in s 8 of *ALRA*. It provides that:

- (1) If a woman requests a registered health practitioner to advise on a proposed abortion, or to perform, direct, authorise or supervise an abortion for that woman, and the practitioner has a conscientious objection to abortion, the practitioner must —
 - (a) inform the woman that the practitioner has a conscientious objection to abortion; and
 - (b) refer the woman to another registered health practitioner in the same regulated health profession who the practitioner knows does not have a conscientious objection to abortion.
- ...
- (3) Despite any conscientious objection to abortion, a registered medical practitioner is under a duty to perform an abortion in an emergency where the abortion is necessary to preserve the life of the pregnant woman.
- (4) Despite any conscientious objection to abortion, a registered nurse is under a duty to assist a registered medical practitioner in performing an abortion in an emergency where the abortion is necessary to preserve the life of the pregnant woman.

Section 1(b), the requirement to 'refer' a woman to another registered health practitioner, proved to be the most controversial part of s 8.

⁵⁶ Greg Craven, 'Denying People Right to Conscience Akin to Fascism', *The Age* (online), 28 September 2008 <<http://www.theage.com.au/news/opinion/denying-people-right-to-conscience-akin-to-fascism/2008/09/25/1222217428407.html?page=fullpage#contentSwap1>>.

⁵⁷ Frank Brennan, *Totalitarian Abortion Law Requires Conscientious Disobedience* (24 September 2008) Eureka Street <<http://www.eurekastreet.com.au/article.aspx?aeid=9155>>.

⁵⁸ Patrick Parkinson, 'Christian Concerns about an Australian Charter of Rights' (2010) 15 *Australian Journal of Human Rights* 83, 104

During the second reading speech, Maxine Morand, Minister for Women's Affairs, explained the practical effect and rationale for s 8 as follows:

These requirements ensure that, as recommended by the commission [VLRC], an effective referral is made. It is expected that practitioners will, in general, already be aware of practitioners in their regulated profession who do not have a conscientious objection to abortion. However, if they do not have this information, it will be a simple matter for them to consult their peers before referral, as would commonly be the case in relation to other kinds of referral ...

The purpose of requiring the health practitioner to refer the woman to another comparable registered health practitioner promotes the woman's right to make decisions about her own health care, and to receive the highest attainable standard of health care. Requiring a medical practitioner to conduct an abortion in an emergency, and a registered nurse to assist with the procedure protects the woman's life, and promotes her right to medical care and treatment. Clause 8 has been carefully crafted in order to strike an appropriate balance between the rights of registered health practitioners to conduct themselves in accordance with their religion or beliefs, and to freedom of expression, and the right of women to receive the medical care of their choice.⁵⁹

This view was not accepted by Archbishop Hart, who stated that catholic hospitals may have no option but to close their maternity and emergency departments if the Bill was passed.⁶⁰ The Archbishop attacked the requirement to refer, stating that catholic hospitals would not provide such referrals.⁶¹ He argued that it was 'an unprecedeted attack on the freedom to hold and exercise fundamental religious beliefs.'⁶² The Archbishop argued that the law

[made] a mockery of the *Victorian Charter of Human Rights* and the *Equal Opportunity Act* in that it requires health professionals with a conscientious objection to abortion to refer patients seeking an abortion to other health professionals who do not have such objections.⁶³

However, Archbishop Hart was incorrect in his interpretation of the *Charter*. There were two errors in the Archbishop's claims:

The first is that only human beings, not hospitals or related entities, have human rights. The other is found in the charter: human rights are 'subject under law only to such reasonable limits as can be demonstrably justified in a free and democratic society based on human dignity, equality and freedom'. The lives of women must weigh in that balance.⁶⁴

⁵⁹ Victoria, *Parliamentary Debates*, Legislative Assembly, 19 August 2008, 2953–4 (Maxine Morand).

⁶⁰ Zwartz, above n 1.

⁶¹ Ibid.

⁶² Ibid.

⁶³ Ibid.

⁶⁴ Anne O'Rourke 'Playing Politics with Lives', *The Age* (Melbourne), 24 September 2008, 15.

Section 7 of the *Charter* requires that in the event of a conflict between rights, lawmakers can place limits on rights, taking into account: ‘the nature of the right; the importance of the purpose of the limitation’; ‘the nature and the extent of the limitation’; and, ‘any less restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve.’ This reflects the position under international human rights instruments. For example, art 18(1) of the *International Covenant on Civil and Political Rights* (*ICCPR*) states that ‘[e]veryone shall have the right to freedom of thought, conscience and religion.’ However, art 18(3) allows ‘such limitations as are prescribed by law and are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others.’ Therefore, rights to freedom of conscience are not absolute and are sometimes limited to ensure the protection of other people’s human rights. One area where rights of conscience are limited is in sexual and reproductive healthcare. As highlighted by Lamačková:

Given that women are the primary users of these [reproductive health] services, conscientious objection primarily interferes with women’s access to health care, and in turn jeopardizes their effective enjoyment of rights and freedoms connected to sexual and reproductive health.⁶⁵

As a result, there is a conflict between ‘the right to manifest one’s religion or belief’, and ‘respect for women’s rights and health needs’, which requires some ‘restrictions on the exercise of conscientious objection in the reproductive health care context.’⁶⁶

In Victoria, opponents also took issue with the fact that the then Bill proposed that ‘doctors and nurses, regardless of their conscientious objections, be required to perform an abortion “in an emergency where the abortion is necessary to preserve the life of the pregnant woman”’.⁶⁷ Doctors of Conscience also condemned this requirement, stating that in their view, it amounted to ‘compulsory participation in abortion through referral and in some instances, direct assistance’.⁶⁸ The latter refers to the emergency clause in s 8(4). However, Mathieson from Doctors in Conscience challenged this requirement stating that an ‘emergency abortion’ was a clinical fiction.⁶⁹ He claimed that:

The management of complicated and life-threatening obstetric cases does not necessitate the direct and active killing of the unborn. The indirect and unintended loss of life of an unborn child in early pregnancy resulting from the management of serious maternal health risk is not an abortion per se. And attempting to deliver a live birth late in pregnancy is always the safer option in emergency or high risk situations. Suicidal risk for a

⁶⁵ Lamačková, above n 27, 8.

⁶⁶ Ibid.

⁶⁷ Brennan, above n 57.

⁶⁸ Doctors in Conscience, *Conscience Laws and Healthcare* (2009) Catholic Lawyers <http://www.catholiclawyers.com.au/index.php?option=com_docman&task=doc_details&gid=19&Itemid=>>.

⁶⁹ Eamonn Mathieson, ‘Proposed Abortion Laws Threaten Doctor’s Rights’, *ABC Opinion and Analysis* (online), 2 October 2008 <<http://www.abc.net.au/news/stories/2008/10/02/2379845.htm>>.

pregnant woman is a psychiatric emergency, not a surgical or abortion emergency.⁷⁰

This comment ignores the fact that there are a number of medical conditions that may occur during pregnancy that are potentially fatal. These include: preeclampsia and eclampsia — which can affect the kidney, liver and brain of the pregnant woman, and, according to the National Health Law Program, accounts for 17 per cent of maternal deaths in the US;⁷¹ premature rupture of membranes ('PROM') — this can lead to maternal sepsis which if left untreated or undiagnosed can also be fatal;⁷² and ectopic pregnancy — another potentially life-threatening condition for pregnant women.⁷³ There are also unforeseen medical circumstances such as finding that one has cancer requiring chemotherapy which may necessitate an abortion. In light of these life-threatening medical conditions, it is simply incorrect to label an 'emergency abortion' a 'clinical fiction'.

Doctors in Conscience also ignore what is known as the 'principle of double effect'. Although abortion in Catholic hospitals is never permissible, the principle of double effect essentially allows doctors to perform an operation on a pregnant woman when there is a danger to her health 'even if the surgery puts the fetus at risk, so long as the intention is not to terminate the pregnancy.'⁷⁴ The National Health Law Program explains the principle as follows:

When an action that is good has two effects — the intended good effect and an unintended evil effect, the action may be morally acceptable if: 1) the action is good in its intention, 2) it is not reasonably possible to achieve the good effect without the evil consequence, 3) the evil consequence is not the means to a good end, and 4) the good effect is equal or greater than the evil effect.⁷⁵

Dickens argues that the 'ethical principle of double effect, which justifies acts to save life or seriously endangered health', along with the 'duty to save life and health ... imposed by legal principles and professional medical ethics ... creates a fair balance between the competing rights of healthcare providers', and women in need of emergency procedures.⁷⁶ He further contends that refusing to perform an

⁷⁰ Ibid.

⁷¹ National Health Law Program ('NHeLP'), *Health Care Refusals: Undermining Quality Care for Women* (2010) Heathlaw, 48 <http://www.healthlaw.org/images/stories/Health_Care_Refusals_Undermining_Quality_Care_for_Women.pdf>.

⁷² Ibid 47.

⁷³ Ibid 56.

⁷⁴ Ibid 52.

⁷⁵ Ibid 51–2; see also Raanan Gillon, 'The Principle of Double Effect and Medical Ethics' (1986) 292 *British Medical Journal* 193; during the parliamentary debate in Victoria one of the authors spoke to a number of doctors working in Catholic hospitals and was told that doctors do perform emergency abortions if a woman's life is in danger but it is not discussed openly within the hospitals. The doctors interviewed wished to remain anonymous.

⁷⁶ Bernard M Dickens, 'Conscientious Objection: A Shield or a Sword?' in Sheila AM McLean (ed), *First Do No Harm: Law, Ethics and Healthcare* (Ashgate, 2006) 337, 349–50.

abortion when a women's life is at risk on the grounds of conscientious objection is an abuse of conscience amounting to ethical misconduct.⁷⁷

IV SECTION 48 OF THE CHARTER OF HUMAN RIGHTS AND RESPONSIBILITIES ACT 2006 (VIC)

Another contentious issue and one that was initially unforeseen was the role of s 48 of the *Charter* and in particular, its interaction with the Abortion Law Reform Bill. Doctors in Conscience, a group of Victorian doctors that formed to oppose the Bill, and the Catholic Church were concerned that s 48 was being used by the then Labor Government to deny their right to conscience under the *Charter*.

Section 48 of the *Charter* contains a clause relating to abortion which states:

48 Savings provision

Nothing in this Charter affects any law applicable to abortion or child destruction ...

Doctors in Conscience sought legal advice on the operation of s 48 and, specifically, whether the Government could rely on the section to forego a statement of compatibility⁷⁸ in relation to the Bill's impact on the rights guaranteed under the *Charter*.⁷⁹ According to legal advice obtained by Doctors in Conscience, the purpose of the savings clause was to preserve the status quo and to ensure that the *Charter* itself did not effect any change in abortion law.⁸⁰ In reference to s 48 and referring to the Second Reading Speech, the legal advice quoted the following passages:

'Neither the charter nor this amendment defines when life begins. Whether or not any of the charter rights and obligations is relevant to a person before their birth will depend on the right that is being claimed and the

- 77 Bernard Dickens, 'Ethical Misconduct by Abuse of Conscientious Objection Laws' (2006) 25 *Medicine and Law* 513; Bernard Dickens, 'The Ethical Responsibilities of Conscience' (2009) 43 *IPPF Medical Bulletin* 3.
- 78 This refers to s 28 of the *Charter of Human Rights and Responsibilities Act 2006* (Vic), which states:
28 Statements of compatibility
 - (1) A member of Parliament who proposes to introduce a Bill into a House of Parliament must cause a statement of compatibility to be prepared in respect of the Bill.
 - (2) A member of Parliament who introduces a Bill into a House of Parliament, or another member acting on his or her behalf, must cause the statement of compatibility prepared under subsection (1) to be laid before the House of Parliament into which the Bill is introduced before giving his or her second reading speech.
 - (3) A statement of compatibility must state-
 - (a) Whether, in the member's opinion, the Bill is compatible with human rights and if so, how it is compatible; and
 - (b) If, in the member's opinion, any part is incompatible with human rights, the nature and extent of the incompatibility.
- 79 Neil J Young and P G Willis, *In the Matter of the Abortion Law Reform Bill 2008* (3 October 2008) Doctors in Conscience, 28 <<http://www.doctorsconscience.org/pdfs/Opinion.pdf>>.
- 80 Victoria, *Parliamentary Debates*, Legislative Council, 19 July 2006, 2555 (John Lenders), cited in ibid.

circumstances in which it is claimed. Nothing in the charter affects any law applicable to abortion or child destruction.

The right to life is a key civil and political right and is protected by the bill. ... as the provision is not intended to affect abortion laws, a clause is included to put beyond doubt that nothing in the charter affects the law in relation to abortion or the related offence of child destruction. The government is mindful of the range of strong community views on this issue and has never intended the charter, which is aimed at enshrining the generally accepted core civil and political rights, to be used as a vehicle to attempt to change the law in relation to abortion.⁸¹

The conclusion drawn by the legal advice in reference to the second reading speech, was that the ‘objective of s 48 ... was to ensure that the law of abortion would not be changed by the *Charter* itself but only by specific legislation.’⁸² When the Abortion Law Reform Bill was introduced into the Parliament, the Minister stated that s 48 precluded ‘the necessity for a statement of compatibility of the Bill with the human rights set out in the *Charter*.’⁸³ However, the legal advice disagreed with the Minister’s assessment of s 48. The advice, by Young and Willis, argued that as the Abortion Law Reform Bill was subjecting health practitioners to ‘newly defined rights, authorities or obligations in connection with their involvement, or potential involvement, in abortion advice or procedures concerning abortion’, a proper construction of s 48 ‘[did] not preclude the need for a statement’ of compatibility.⁸⁴ Essentially, opponents of the Bill wanted the Government to issue a statement of compatibility ‘to measure the Bill against the *Charter* to consider whether the Bill’ was in fact ‘incompatible with medical practitioners’ freedom of conscience guaranteed under the *Charter*.⁸⁵

Archibishop Hart also argued forcefully against the Abortion Law Reform Bill claiming that it breached medical practitioners’ freedom of conscience and would place them ‘in a position where they would be acting contrary to the law if they acted in accordance with their deeply held moral convictions.’⁸⁶ Brennan further claimed that s 48 of the *Charter* ‘was included to accommodate the concerns of

81 Young and Willis, above n 79, 28.

82 Ibid.

83 Ibid.

84 Ibid 29.

85 Ibid 30.

86 Brennan, above n 57; Professor George Williams chaired the Victorian Human Rights Consultation Committee that led to the enactment of the *Charter of Human Rights and Responsibilities Act 2006* (Vic). In relation to s 48, Williams says:

[Section] 48 now operates as a saving provision in stating that ‘nothing in this Charter affects any law applicable to abortion or child destruction’. This avoids a direct restriction on as fundamental a right as that to life. It also ensures that when other rights in the *Victorian Charter of Rights*, such as privacy, might impact upon the abortion debate, they are incapable of doing so. The provision meant that the *Victorian Charter of Rights* could be enacted in a way that maintains the status quo in the law as it relates to abortion.

See George Williams, ‘The Victorian *Charter of Human Rights and Responsibilities*: Origins and Scope’ (2006) 30 *Melbourne University Law Review* 880, 896.

Professor Williams and his colleagues that the Charter not purport to resolve the question of when life begins for the purposes of defining the right to life.⁸⁷

However, the concerns of Doctors in Conscience about the interaction between s 48 and their rights under the *Charter*, and Hart and Brennan's criticisms, gloss over the Catholic Church's role in the inclusion of s 48 in the *Charter*. Likewise, Archbishop Hart and other Catholic commentators also ignored the role of the Church in reference to s 48 and were being somewhat insincere when asserting that their own rights of conscience under the *Charter* were being undermined by the Bill.

Section 48 was originally included in the *Charter* due to the lobbying efforts of religious groups including the Catholic Church.⁸⁸ In response to concerns raised by Archbishop Hart that the new law made a mockery of the *Charter*, the then Victorian Attorney-General, Rob Hulls, stated unambiguously that:

It has to be remembered that abortion was specifically precluded from the charter, that was actually at a request with the Catholic Church, so the charter of human rights and responsibilities specifically precludes any laws in relation to abortion, so I don't think there will be any problem with the charter of human rights, in fact, I'm quite sure about that.⁸⁹

The Catholic Church was concerned that women could use the *Charter* to enforce their reproductive rights as had happened under the *Canadian Charter of Rights and Freedoms*,⁹⁰ and sought to ensure that the *Charter* could not be utilised for that purpose. Ironically, this attempt by the Catholic Church to remove abortion from the ambit of the *Charter* resulted in its own rights being undermined. The reason for this was that as the conscientious objection clause and the 'obligation

⁸⁷ Brennan, above n 57.

⁸⁸ Rachel Ball, 'Victoria's Abortion Law Reform Act' (2008) 33 *Alternative Law Journal* 237.

⁸⁹ ABC Local Radio, 'Catholics Rail against Abortion Bill', *The World Today*, 23 September 2008 (Rob Hulls) <<http://www.abc.net.au/worldtoday/content/2008/s2372242.htm>>.

⁹⁰ See *R v Morgentaler* [1988] 1 SCR 30. In this case Dr Morgentaler brought a case before the Canadian Supreme Court claiming that the abortion provisions in the *Criminal Code of Canada* were unconstitutional as they violated a woman's right to liberty and security of the person under the Canadian Charter. The Court agreed. Since that decision abortion law is now unenforceable in Canada. The *Morgentaler* decision is viewed as having the same significance in Canada as *Roe v Wade* did in the US. The decision was printed as a book with commentary; see Shelagh Day and Stan Persky (eds), *The Supreme Court of Canada Decision on Abortion* (New Star Books, 1988). A later decision, *Tremblay v Daigle* [1989] 2 SCR 530, held that a foetus has no legal status as a person in Canada.

to refer' was contained in a Bill or proposed 'law', 'applicable to abortion', s 48 operated in such a way to render any *Charter* rights inapplicable.⁹¹

Furthermore, had the government issued a statement of compatibility, it would not have changed the outcome in relation to the right to freedom of conscience, since under the *Charter*, as well as international human rights treaties such as the *ICCPR*, 'human rights law allows for limitations on the right to manifest religion and belief' to ensure that others' rights to health, or liberty and security of the person are not undermined.⁹²

V CONSCIENTIOUS OBJECTION AND THE OBLIGATION TO REFER: A RADICAL DEPARTURE FROM CURRENT PRACTICE?

A International and National Guidelines and Directives

The fracas over s 8, and in particular, the 'obligation to refer', could be interpreted as a radical departure from current practice. This is not the case. An examination of international and national guidelines demonstrates that s 8(1)(b), the obligation to refer a woman to a non-objecting doctor, is consistent with international practice. For example, the International Federation of Gynecology and Obstetrics ('FIGO'), *Ethical Guidelines on Conscientious Objections*, states that first and foremost, the 'primary commitment of obstetrician-gynecologists ... is to serve women's reproductive health and well-being'.⁹³ In the event that a practitioner is unable to deliver a medical service, due to conscientious objection, they still bear ethical responsibilities to the patient.⁹⁴ FIGO states that practitioners' conscientious objection must be respected, and that in turn, objecting practitioners must also respect patients' choices.⁹⁵ This means that patients are entitled to be referred

91 Legal advice provided to members of the Legislative Council by Julian Burnside QC also questions the Doctors in Conscience and the Catholic Church's claim that s 8 of *ALRA* infringes on the freedom of conscience and religion contained in the Victorian *Charter*. Burnside advises that their argument is misconceived. First, that s 48 of the *Charter* 'provides that no law affecting abortion shall be subject to the *Charter*'s provisions. It removes the entire subject matter of abortion from the *Charter*'s ambit'. Burnside also comments on the fact the 's 48 was included in the *Charter* at the behest of the Catholic Church which objected to the prospect that abortion should become a matter upon which the judiciary would deliberate.' According to Burnside, the Church 'preferred to have abortion remain as a subject for parliament, a forum in relation to which it would have greater influence'. Secondly, Burnside makes the point that, even if the *Charter* were applicable 'it is not clear that a court would find that a Catholic medical practitioner's freedom of conscience is infringed by Clause 8 of the *Charter*'. Burnside explains that 'there is an important distinction between undertaking an abortion against conscience and referring a patient to another practitioner in the knowledge that the other practitioner does not have the same conscientious objection'. Letter to Members of the Legislative Council from Julian Burnside, 8 October 2008, on file with the authors.

92 Ball, above n 88, 238.

93 FIGO Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health, *Ethical Issues in Obstetrics and Gynecology* (2009), 25 <<http://www.igo.org/files/igo-corp/Ethical%20Issues%20-20English.pdf>>.

94 Ibid 25–6.

95 Ibid 27.

in ‘good faith’ to practitioners who do not object.⁹⁶ However, in an emergency situation, FIGO guidelines maintain that medical ‘practitioners must provide the medically indicated care of their patients’ choice, regardless of the practitioners’ personal objections’.⁹⁷

The World Medical Association’s *Declaration on Therapeutic Abortion* affirms the principle of referral, maintaining that: ‘If the physician’s convictions do not allow him or her to advise or perform an abortion, he or she may withdraw, while ensuring the continuity of medical care by a qualified colleague.’⁹⁸

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (‘RANZCOG’) *Code of Practical Ethics* contains an identical guideline which states that ‘[n]o doctor shall be compelled to act contrary to their moral conviction or religious belief, except as required by law.’⁹⁹ Where the practitioner’s personal value system conflicts with the patient’s desired treatment, the practitioner ‘must make an appropriate referral and with the patient’s consent, communicate relevant information to a new practitioner.’¹⁰⁰ The ethical obligation to refer is also found in the *NSW Health Policy Directive Pregnancy Framework for Terminations in New South Wales Public Health Organisations*. This Directive states under 4.2 that:

In circumstances where staff have a conscientious objection to participate in terminations of pregnancy or administer any abortifacient agents, there is an obligation to transfer the care of the patient to another medical specialist (or health professional) on site or at another AHS facility.¹⁰¹

B International Treaties and Treaty Monitoring Bodies

According to Hernández, in the international sphere, since the late 1960s, there have been ‘myriad international resolutions, declarations and statements by international groups’ and treaty bodies ‘that have acknowledged that matters of family planning and reproductive freedom as issues of individual rights’.¹⁰²

A number of international treaty committees have issued general recommendations relating to women’s rights to comprehensive reproductive health services. These

⁹⁶ Ibid.

⁹⁷ Ibid.

⁹⁸ World Medical Association, *Declaration on Therapeutic Abortion* (October 2006) <<http://www.wma.net/en/30publications/10policies/a1/index.html>>.

⁹⁹ Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *The RANZCOG Code of Ethical Practice* (May 2006), 3 <<http://www.ranzcog.edu.au/about/pdfs/codeofethics.pdf>>.

¹⁰⁰ Ibid 6.

¹⁰¹ NSW Health, *Pregnancy — Framework for Terminations in New South Wales Public Health Organisations* (25 May 2005) 5 <http://www.health.nsw.gov.au/policies/pd/2005/pdf/PD2005_587.pdf>.

¹⁰² Berta E Hernández, ‘To Bear Or Not To Bear: Reproductive Freedom as an International Human Right’ (1991) 17 *Brooklyn Journal of International Law* 309, 310. See also Rebecca J Cook, ‘International Protection of Women’s Reproductive Rights’ (1991) 24 *New York University Journal of International Law and Politics* 645.

are: the Committee on the Convention on the Elimination of Discrimination against Women ('CEDAW'), the Committee on the Rights of the Child ('CRC'); the Human Rights Committee ('HRC') in relation to rights under the *ICCPR*, the Committee on the International Covenant on Economic, Social and Cultural Rights ('ICESCR'), and the Committee on the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment ('CAT').¹⁰³ Only two committees, CEDAW and HRC, have expressly addressed the issue of conscientious objection, while the others have made recommendations on access to abortion generally.

The CEDAW committee in relation to the 'obligation to refer' stated in their general recommendations 1999, art 12, that:

It is discriminatory for a State party to refuse to legally provide for the performance of certain reproductive health services for women. For instance, if health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers.¹⁰⁴

The CEDAW Committee has also consistently criticised countries that have restrictive abortion laws. It has 'often framed restrictive abortion laws as a violation of the rights to life and health', and 'recommended that the state party [Burkina Faso] provide social security coverage for abortion'.¹⁰⁵

The HRC has discussed restrictive abortion laws, as well as unsafe and illegal abortion as a violation of the right to life under art 6 of the *ICCPR*.¹⁰⁶ The justification for this is that the HRC 'has made the link between illegal and unsafe abortions and high rates of maternal mortality'.¹⁰⁷ In restricting women's access to abortion, women seek clandestine abortions that put their lives at risk.¹⁰⁸ Concerned about the use of medical practitioners' use of conscientious objection in Poland, the Committee requested further information clarifying the position in Poland.¹⁰⁹

In 2002, the Center for Reproductive Law and Policy, DEMUS (a Peruvian feminist organisation) and CLADEM (the Latin American and Caribbean committee for the defence of women's rights) submitted a petition to the HRC challenging Peruvian public health officials' refusal to perform a therapeutic

¹⁰³ Center for Reproductive Rights, 'Bringing Rights to Bear: Abortion and Human Rights' (2008) (Briefing Paper, 2008) <http://reproductiverights.org/sites/crr.civicactions.net/files/documents/BRB_abortion_hr_revised_3.09_WEB.PDF>.

¹⁰⁴ The Committee on the Elimination of Discrimination against Women, 'Article 12(1): Women and Health' (General Recommendation No 24, 1999) [11] <<http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom12>>.

¹⁰⁵ Center for Reproductive Rights, above n 103, 4.

¹⁰⁶ Ibid 8.

¹⁰⁷ Ibid.

¹⁰⁸ Ibid.

¹⁰⁹ Ibid 9.

abortion on a 17 year old, KL, who was carrying an anencephalic foetus.¹¹⁰ KL was informed by a gynaecologist and obstetrician of the abnormality and that it could pose a risk to her life if the pregnancy continued.¹¹¹ She decided to have a termination. Despite the assessment of a social worker and a psychiatrist that KL was suffering depression, distress and emotional instability, the director of the hospital refused to authorise an abortion. She gave birth to a daughter, who survived for four days. During this time KL had to breastfeed her daughter. After the daughter's death she fell into a deep depression.¹¹²

The petition filed on behalf of KL alleged that the refusal to terminate the pregnancy was a violation of KL's rights under arts 2, 3, 6, 7, 17, 24 and 26 of the *ICCPR*.¹¹³ After reviewing the petition, the HRC found that Peru had violated arts 2, 7, 17 & 24 of the *ICCPR*. The HRC held that Peru was required to furnish KL with an effective remedy including compensation, and had an obligation to take steps to ensure that similar violations did not occur in the future.¹¹⁴

The other committees have not directly addressed conscientious objection, abortion or the obligation to refer, however they have made comments on reproductive health. For example, the Committee on ICESCR in its *General Comment 14 (2000)*, interprets the right to the highest attainable standard of health as requiring state parties to implement measures to improve access to 'sexual and reproductive health services, including access to family planning'.¹¹⁵ The Committee has also commented on 'high rates of maternal mortality and illegal, unsafe, and clandestine abortions', and has urged states to decriminalise abortion.¹¹⁶ In 2004, the CAT Committee expressed grave concern about Chile's practice of coercing 'women who sought life-saving treatment after illegal abortions to provide information on who performed the abortion'.¹¹⁷ The Committee urged Chile to 'eliminate the practice of extracting confessions for prosecutorial purposes' and review old convictions.¹¹⁸ In 2006, Peru came under the CAT Committee's scrutiny for its extremely restrictive practices, even in cases of rape, which led to unnecessary deaths due to women resorting to illegal abortions.¹¹⁹ The Committee recommended that Peru amend its laws to provide

¹¹⁰ Human Rights Committee, *Views: Communication No 1153/2003*, 85th sess, UN DOC CCPR/C/85/D/1153/2003 (22 November 2003) ('KL v Peru'). The claims in the petition in relation to the *ICCPR* were: State Party fails to comply with its obligations to guarantee the exercise of a right (art 2); applicant suffered discrimination (art 3); serious impact on health and safety, applicant had two options after refusal; to seek an unsafe clandestine abortion, or to continue a dangerous and traumatic pregnancy which put her life at risk (art 6); forced to continue with the pregnancy amounts to cruel and inhuman treatment (art 7); State Party interfered arbitrarily in KL's private life (art 17); as an adolescent she did not receive the rights guaranteed to her (art 24); and the public officials' refusal left KL in an unprotected state incompatible with the right to equal protection of the law (art 26).

¹¹¹ Ibid 4.

¹¹² Ibid 5.

¹¹³ Ibid 2.

¹¹⁴ Ibid 11.

¹¹⁵ Center for Reproductive Rights, above n 103, 10.

¹¹⁶ Ibid 11.

¹¹⁷ Ibid 14

¹¹⁸ Ibid.

¹¹⁹ Ibid 13–14.

better access to reproductive information and reproductive health services.¹²⁰ The CRC Committee has also commented on the link between illegal abortion and high maternal mortality rates and recommended that states consider reviewing abortion laws particularly in cases of rape and where a woman's life is at risk.

C Laws in Other Jurisdictions

An examination of laws in other countries also demonstrates that the conscientious objection clause and the obligation to refer found in *ALRA* are consistent with laws in comparable countries. For example, van Bogaert in his examination of conscientious objection laws highlights that in Britain, France, Italy and Norway:

doctors are not legally required to authorise or to perform abortions, but are obliged to be involved in pre-operative care and referral. In Denmark and the Netherlands, one can conscientiously object to being involved in pre-operative care, but there is nonetheless a legal obligation to refer the woman seeking an abortion to another colleague.¹²¹

Conscientious objection in New Zealand is protected by s 46 of the *Contraception, Sterilisation, and Abortion Act 1977* (NZ). That section states that no medical practitioner, nurse or other person is under an obligation to assist or perform an abortion or sterilisation, or fit or assist in the fitting, or supplying or administering contraception or giving advice on contraception if he or she objects to doing so on the grounds of conscience.¹²² However, medical practitioners who have an objection are under a legal obligation to refer the woman to a non-objecting medical practitioner.¹²³ Likewise, the United Kingdom National Health Services regulations 'require medical practitioners to make an effective referral in circumstances where they have a conscientious objection to certifying approval for lawful abortion'.¹²⁴

VI THE OBLIGATION TO REFER — AN UNJUSTIFIABLE RESTRICTION?

Opponents of the obligation to refer in Australia also criticised s 8(1)(b) on the grounds that it effectively required them to participate in an abortion by compelling them to refer a woman to another doctor that he or she knows does not have such an objection.¹²⁵ This concern was based upon the interpretation that the clause required the objecting doctor to undertake some research to find a

120 Ibid 6.

121 Louis-Jacques van Bogaert, 'The Limits of Conscientious Objection to Abortion in the Developing World' (2002) 2 *Developing World Bioethics* 131, 142.

122 *Contraception, Sterilisation, and Abortion Act 1977* (NZ) s 46(1)(a)–(b).

123 Abortion Services in New Zealand, 'What to Do' (20 May 2006) <<http://www.abortion.gen.nz/whattodo.html#4>>. See also VLRC, above n 53, 113.

124 VLRC, above n 53, 112.

125 Burnside, above n 91.

non-objecting doctor and facilitate a formal referral. According to Burnside, the intention of the obligation to refer is clear:

It is to provide a woman with the means to exercise an informed choice about what course of action she might best take in what are, in most cases, very fraught circumstances. ... the Clause may be complied with if a doctor with a conscientious objection simply refers his or her patient to a public hospital or to a recognised independent pregnancy service. It is not a requirement that the practitioner name another doctor with whom they know they have a conscientious disagreement. In this way, the doctor may act in accordance with their conscience while at the same time engaging in an uncomplicated effective referral.¹²⁶

This interpretation is supported by Larcombe who contends that ‘refer’ in s 8(1)(b) should be given its ordinary meaning which is simply to ‘send or direct’.¹²⁷ In this sense, suggesting that the woman consult her local community health centre or attend the Royal Women’s Hospital would satisfy the requirement to ‘refer’.¹²⁸ She further argues that should a more formal referral be required to satisfy s 8(1)(b), it is questionable ‘that objecting practitioners are being unjustifiably coerced or compelled to act against their conscience’.¹²⁹ This is particularly the case where such practitioners have the ability to minimise placing themselves in a position where they are obliged to make a referral. Larcombe suggests a number of simple steps that practitioners can implement to avoid being asked for information about an abortion or for a referral. These include: displaying signs in their surgeries stating they have a conscientious objection to abortion, providing written information to new patients, as well as notes on practice websites and informing local community health centres and hospital emergency departments.¹³⁰

VII CASE LAW AND CONSCIENTIOUS OBJECTION: DEVELOPING TRENDS

There is no case law in Australia on the issue of abortion and conscientious objection. However, there have been a small number of cases in other jurisdictions that are relevant to the analysis. These cases are from different regions of the globe but they are establishing a trend in terms of defining the limits of conscientious objection in relation to abortion.

The most comprehensive decision to date in terms of its detailed consideration of conscientious objection was handed down in 2008 by the Constitutional Court of

¹²⁶ Ibid.

¹²⁷ Wendy Larcombe, ‘Rights and Responsibilities of Conscientious Objectors under the *Abortion Law Reform Act 2008*’ (Paper presented at W(h)ither Human Rights, University of Sydney, 10–12 December 2012) 6.

¹²⁸ Ibid.

¹²⁹ Ibid.

¹³⁰ Ibid.

Colombia.¹³¹ This case has been described by Cook, Arango Olaya and Dickens, as having ‘considerable significance and instruction nationally [Colombia], regionally, and internationally’, as it is the first case to lay down a broad set of principles governing the use of conscientious objection by medical practitioners and institutions.¹³²

The case involved a 13 year old rape victim who requested an abortion through her mother. Five hospitals declined to assist on the ground of conscientious objection and further claimed that they were not legally required to assist unless there was ‘risk to life’; this was despite the fact that the girl had attempted to commit suicide. In finding against the hospitals, the Court held that:

- (a) The human right to respect for conscience is a right enjoyed by natural human beings, but not by institutions such as hospitals. The Court found that, by allowing their gynecologists’ conscientious objections to limit their services, hospitals were unlawfully asserting conscientious objections of their own.
- (b) Hospitals whose physicians object to undertaking procedures on grounds of conscience must have, on staff or by other means available, physicians to whom patients have convenient, timely access and who do not object.
- (c) Physicians who invoke rights of conscientious objections may do so on grounds only of their own religious convictions, which they must explain individually in writing.
- (d) Conscientious objection cannot be invoked with the effect of violating women’s fundamental rights to lawful healthcare. Women denied abortion services on grounds of conscience must be referred to physicians willing and able to provide a service. Individual objecting

131 Constitutional Court of Colombia Decision T-209/2008, quoted in Cook, Arango Olaya and Dickens, above n 7, 249.

132 Ibid 249. This is the second significant case on abortion in Colombia. There was an earlier Constitutional Court Decision C-355/2006 which declared a statute criminalising abortion under all circumstances as unconstitutional. According to Undurraga and Cook, the 2006 court decision was significant in its use of international and comparative law and how that law was used to facilitate women’s rights in Colombia. They argue that it ‘provided two examples in which migration transforms the meaning of ... borrowed legal doctrines, resulting in the improved recognition of women’s rights’. The first concerns the incorporation of international human rights treaties into Colombian constitutional law. The broad recognition of women’s rights under international law made it possible to strengthen their constitutional status in Colombia. In its decision the Colombian Court applied a number of international human rights instruments including the *ICCPR*, art 6, protecting the right to life; *CEDAW*, art 21.1 protecting women’s equality in accessing health care, as well as the *CEDAW* Committee’s General Recommendation on violence against women; and *ICESCR*, art 12, protecting the right to the highest attainable standard of health. The second reference to borrowed legal doctrines relates to the application of the proportionality principle, which following European precedents, considers both domestic and international law regarding the constitutionality of abortion regulation. See Verónica Undurraga and Rebecca J Cook, ‘Constitutional Incorporation of International and Comparative Human Rights Law: The Colombian Constitutional Court Decision C-355/2006’ in Susan H Williams (ed), *Constituting Equality: Gender Equality and Comparative Constitutional Law* (Cambridge University Press, 2009) 245–6. C-355/2006 does not address the issue of conscientious objection in detail but stated that only individual doctors, not institutions, could be conscientious objectors.

physicians have a duty of immediate referral, and institutions must maintain information of non-objecting physicians to whom patients can be promptly referred.

- (e) A claim of conscientious objection will be reviewed by a medical professional or another governmentally designated committee, to ensure that the objection is legitimately founded on well-based convictions such as the teachings of an acknowledged religion.
- (f) The governmental system responsible for healthcare security is obliged to ensure an adequate supply of abortion service providers.
- (g) The health authority liable to pay compensation is entitled to recover contributions from physicians who, in failing to refer patients to other practitioners who would undertake the procedure, violated her legal rights and rules on conscientious objection set under the authority of the Court.¹³³
- (h) The lower court judges who denied a remedy to enforce the applicant's legal right should be investigated under the rules of professional discipline for disregard of the Criminal Code, the Constitution, and the 2006 decision of the Constitutional Code.¹³⁴
- (i) The appropriate Ministry of Health and Office of Health Supervision should investigate the offending hospitals in light of the regulations established for legal termination of pregnancy, and impose sanctions where they were violated or disregarded.¹³⁵

The above ruling not only addresses the limits of medical practitioners claiming conscientious objection, but also puts hospital administrators and legal officers on notice that they cannot obstruct a woman's right to access lawful medical procedures. In terms of defining the limits of conscientious objection, the Court confined it to direct participation by individuals and 'not for more remote acts of administration or service'.¹³⁶ More significantly, the obligation to refer a patient to a non-objecting doctor was given legal force by the Columbian Court.

The leading British case on the scope or parameters of conscientious objection in relation to abortion is *Janaway v Salford Health Authority*.¹³⁷ This case set the precedent regarding the definition of 'participation' for the purpose of the conscientious objection provision in the *Abortion Act 1967* (UK) ('the UK Act').¹³⁸ In this case, Janaway was employed as a doctor's receptionist and secretary at the IrIam Health Centre. She was asked by a medical practitioner to type a

¹³³ Constitutional Court Decision C-355/2006.

¹³⁴ Ibid.

¹³⁵ Decision T-209 of 2008 has not been translated into English. The list establishing the parameters of conscientious objection is quoted in Cook, Arango Olaya and Dickens, above n 7, 250.

¹³⁶ Ibid 251.

¹³⁷ [1988] 3 All ER 1079 ('Janaway').

¹³⁸ General Medical Council, *Personal Beliefs and Medical Practice* (March 2008) <http://www.gmc-uk.org/guidance/ethical_guidance/personal_beliefs.asp>.

letter of referral for an appointment with a consultant regarding a termination of pregnancy. Janaway refused to type the letter on the grounds that she was a Roman Catholic who believed that abortion was morally wrong. The letter was instead hand-written by another doctor at the Centre. Janaway claimed that she was entitled to refuse to write the letter by virtue of the conscientious objection clause in s 4(1) of the UK Act.¹³⁹ Subsequently, she received a letter from the personnel officer stating that her refusal was an ‘unjustified refusal of a lawful and reasonable instruction’.¹⁴⁰ The employer sought an assurance from Janaway that in future she would obey lawful instructions. She replied that she would undertake her contractual duties as specified in her job description, except insofar as she was afforded protection by s 4(1) of the UK Act. As a result, Janaway’s employment was terminated. She appealed to the health authority’s appeal tribunal which ratified the initial dismissal decision. She then applied for judicial review which was dismissed at first instance by a single judge.¹⁴¹ The dismissal by the judge was then affirmed by the Court of Appeal.¹⁴² Finally, Janaway applied to the House of Lords.

The issue before the House of Lords concerned the true construction of the words ‘participate in any treatment authorised by this Act’.¹⁴³ Janaway submitted that the words meant ‘taking part in any arrangements preliminary to and intended to bring about medical or surgical measures aimed at terminating a pregnancy, including the typing of letters referring a patient to a consultant’.¹⁴⁴ The health authority, on the other hand, submitted that the meaning of the words was limited to ‘taking part in the actual procedure’.¹⁴⁵ The House of Lords agreed with the health authority stating that ‘on a proper construction the word “participate” in s 4(1) ... in its ordinary meaning referred to actually taking part in treatment administered in a hospital or other approved place’.¹⁴⁶

In a more recent case in Scotland, two midwifery sisters claimed that being forced to supervise staff taking part in abortions violated their right of conscientious objection under s 4(1) of the UK Act.¹⁴⁷ This case — as with *Janaway* — centered on the meaning of ‘participation’ within the context of conscientious objection in the UK Act. The two petitioners, Mary Teresa Doogan, 57, and Concepta Wood,

¹³⁹ *Abortion Act 1967* (UK) s 4(1) states that:

- (1) Subject to subsection (2) of this section, no person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorised by this Act to which he has a conscientious objection: Provided that in any legal proceedings the burden of proof of conscientious objection shall rest on the person claiming to rely on it.
- (2) Nothing in subsection (1) of this section shall affect any duty to participate in treatment which is necessary to save the life or to prevent grave injury to the physical or mental health of the pregnant woman.

¹⁴⁰ *Janaway* [1988] 3 All ER 1079, 1080.

¹⁴¹ See *Regina v Salford Health Authority, Ex Parte Janaway* [1988] 2 WLR 442, 443.

¹⁴² *Ibid* 442.

¹⁴³ *Janaway* [1988] 3 All ER 1079, 1081.

¹⁴⁴ *Ibid*.

¹⁴⁵ *Ibid*.

¹⁴⁶ *Ibid* 1082.

¹⁴⁷ *Petition of Mary Teresa Doogan and Concepta Wood for Judicial Review of a Decision of Greater Glasgow and Clyde Health Board* [2012] CSOH 32.

51, claimed conscientious objection on the ground of religious belief. Both women were Roman Catholic. The question before the Court was: whether the provisions entitle the petitioners ‘to refuse to delegate to, supervise or support staff on the labour ward who are directly involved with patients undergoing termination of pregnancy’.¹⁴⁸

The petitioners were employed in management and leadership roles which required delegation of direct patient care to midwives and the provision of management and support to midwives. Lady Smith referred to The Royal College of Nursing guidelines on ‘Abortion Care’, which state:

The *Abortion Act 1967* provides a right of conscientious objection in Section 4 which allows nurses to decline to participate in abortion. This right is limited only to the active participation in an abortion where there is no emergency with regard to the physical or mental health of the pregnant woman.¹⁴⁹

The Greater Clyde and Glasgow Health Board (‘the Board’) argued that s 4 of the UK Act did not confer a right to refuse to delegate, supervise and/or support staff involved in caring for patients having terminations. According to Lady Smith, the key words in the UK Act were ‘participate’ and ‘treatment’.¹⁵⁰ She explained that they had to be understood in the ordinary sense rather than interpreted in a technical sense.¹⁵¹ Referring to *Janaway*, Lady Smith said that ‘participation’ means or ‘connotes joining in or becoming involved in an activity’.¹⁵² In reference to the word ‘treatment’, she explained that ‘treatment’ included the use or administration of abortifacient drugs. That is, the ordinary meaning of the word ‘treatment’ is that which is ‘capable of bringing about ... its purpose, the termination of the pregnancy’.¹⁵³ Lady Smith drew a distinction between the Labour Ward Coordinator who has a supervisory and administrative role to that of the nurse or midwife who gives the woman the abortifacient. She said:

What constitutes interference with the manifestation of religious belief depends on all the circumstances of the case, including the extent to which the individual could reasonably expect to be at liberty to manifest those beliefs in practice. Here, the petitioners are being protected from having any direct involvement ... [t]hey are sufficiently removed from direct involvement ... Further, they knowingly accepted that these duties [delegation and supervision] were to be part of their job. They can be taken to have known that their professional body ... takes the view that the right of conscientious objection is limited and extends only to active participation.¹⁵⁴

¹⁴⁸ Ibid [27].

¹⁴⁹ Ibid [14].

¹⁵⁰ Ibid [43].

¹⁵¹ Ibid [44].

¹⁵² Ibid [44]–[46].

¹⁵³ Ibid [47].

¹⁵⁴ Ibid [80].

As a result, Lady Smith held that their s4(1) right of conscientious objection had not been violated.¹⁵⁵

There are also two pending cases before the European Court of Human Rights on the issue of conscientious objection and abortion. Both of these concern Poland.¹⁵⁶ In the first case, *Z v Poland*,¹⁵⁷ the applicant's daughter developed ulcerative colitis between the fourth and fifth week of pregnancy. As a result of the diagnosis, the daughter required a number of visits to the hospital. According to Z, her daughter received basic treatment such as intravenous and oral administration of steroids and antibiotics but did not undergo an endoscopy or colonoscopy which would have provided more information.¹⁵⁸ She was then diagnosed with an abscess and had three operations to remove it. During the daughter's stay at the hospital a full endoscopy was requested. The doctor refused stating that 'my conscience does not allow me', as it may endanger the life of the foetus.¹⁵⁹ The daughter's fiancée urged the doctor to perform the procedure to save the woman's life, irrespective of the consequences to the foetus. The doctor refused. The daughter lost the foetus on 5 September 2004 and then died on 29 September 2004 from septic shock caused by sepsis. Z has submitted a number of complaints to the Court, two of which relate to conscientious objection: First, that the State breached art 2 of the *European Charter of Human Rights*, by failing to adopt a legal framework that would have prevented the death of her daughter. The applicant specifically challenges the manner in which the law governing conscientious objection is regulated and overseen.¹⁶⁰ Secondly, the applicant alleges that under art 8 of the Charter, the doctors did not provide her and her daughter with reliable and timely information about her daughter's health. The applicant further complains about the conscientious objection law and her lack of access to the relevant medical records.¹⁶¹

The second case, *P and S v Poland*,¹⁶² is a more interesting case as it concerns the freedom of conscience of the woman seeking an abortion. P was raped when she was 14 years old by a boy her own age. She was not offered emergency contraception and as a result became pregnant. It was decided that as she was a minor, the pregnancy was the result of rape, and that she wished to pursue her education, she would seek to terminate the pregnancy.¹⁶³ The applicant's mother went to a hospital to inquire about a referral for termination. It was suggested to the applicants that they should meet with a Catholic priest. This offer was refused. The applicants then reported to the hospital for the termination. The applicants were told that an abortion could not proceed without the presence of

¹⁵⁵ Ibid [72].

¹⁵⁶ *Z v Poland* (European Court of Human Rights, Application No 46132/08, 19 June 2009); *P and S v Poland* (European Court of Human Rights, Application No 57375/08, 18 November 2008).

¹⁵⁷ *Z v Poland* (European Court of Human Rights, Application No 46132/08, 19 June 2009).

¹⁵⁸ Ibid 2.

¹⁵⁹ Ibid.

¹⁶⁰ Ibid 3.

¹⁶¹ Ibid.

¹⁶² *P and S v Poland* (European Court of Human Rights, Application No 57375/08, 18 November 2008).

¹⁶³ Ibid 1.

the head of the gynecological ward and they would have to wait until the head returned from holidays. The first applicant returned to the hospital alone and was taken to see a priest who attempted to convince her not to have an abortion. The second applicant then arrived at the hospital and was told by the doctor that she was a bad mother and that she would adopt the first applicant and the baby. This caused much distress to the first applicant who was present during the discussion between the second applicant and the doctor. The applicants were then told that no abortion would be undertaken at the hospital.

The applicants then travelled to a second hospital with a certificate issued by a prosecutor and a medical certificate issued by the national consultant in gynecology stating that the first applicant had a right to a lawful abortion.¹⁶⁴ However, just before the procedure, the deputy head of the ward stated that he had received a communication from the first hospital stating that the first applicant did not want an abortion. The first applicant was then required by law to wait a further three days. During this period, she was contacted by the Catholic priest who informed her that he was working on her case and people all around Poland were praying for her. She then received numerous text messages from anti-abortion activists; the priest attended the hospital with an activist to apply pressure on her to abandon the termination; the hospital contacted the first applicant's father for his consent; and a psychological report was prepared on the first applicant which was not given to the second applicant; all designed to frustrate the first applicants access to a termination.¹⁶⁵ The applicants tried to leave the hospital but were blocked by anti-abortion activists which resulted in the arrival of the police who subsequently took the applicants away for questioning. In the meantime, the first hospital had taken the matter to the family court which resulted in a restriction upon the second applicant's parental rights and the first applicant being placed in juvenile shelter where she was placed in a locked room and her cell phone confiscated. The matter then went before the Family and Custody Court where it was alleged that the second applicant was forcing the first into having an abortion. By this time, the media was also involved in the case. The second applicant then brought proceedings against the police which were later dismissed. The second applicant then filed a complaint with the Office of Patient's Rights of the Ministry of Health which resulted in a resolution and the first applicant undergoing an abortion. However, upon returning home, the applicants realised that information about the abortion had been put on the internet by the Catholic Information Agency.

On 18 November 2008, the applicants lodged a complaint with the European Court of Human Rights, alleging amongst other things: cruel and inhumane treatment; deprivation of liberty; unlawful removal of the first applicant from her mother; difficulties in obtaining access to legal abortion; breach of medical confidentiality; lack of medical assistance; and, under art 9 of the *European Charter of Human Rights*, they asserted:

¹⁶⁴ Ibid 3.

¹⁶⁵ Ibid.

a violation of the right of freedom of thought, conscience and religion. The State, in facilitating and encouraging Catholic priests to provide unwanted and manipulative counselling to the applicants in the setting of a public hospital, and [allowing them] to exert pressure on [the applicants] to make them change their minds [regarding] the termination amounted to a breach of the applicants' right to freedom of conscience. Further, the State's failure to regulate the practice of conscientious objection in the health care setting resulted in public hospitals relying on freedom of religion and refusing to perform lawful termination of pregnancies. It also resulted in an unlawful, unjustifiable and improper imposition of religious views on the applicants.¹⁶⁶

Both cases are yet to be determined, but they raise important issues. *Z v Poland* provides an example of the necessity to institute laws to abolish the exercise of conscientious objection in certain circumstances, as is found in s 8(3) of *ALRA*, and challenges the notion that such situations are a 'clinical fiction'. The second case problematises the notion of conscience. In cases of abortion, conscience or conscientious objection is assumed to derive from a religious basis as opposed to specific action. *P and S v Poland* turns this on its head by claiming freedom of conscience and religion against the exercise of religious conscience by medical practitioners and priests. The 'privileging of "freedom of conscience" based on religious belief is highly problematic' as it requires

the state to take sides on the issue of abortion, ... by making it a criminal offence for the pregnant woman to exercise one of her options, is not only to endorse but also enforce, on the pain of a further loss of liberty ... one conscientiously-held view at the expense of another.¹⁶⁷

This issue is further discussed below.

Although there are only three detailed cases on conscientious objection and abortion, these cases, when considered alongside comments by treaty monitoring bodies and developments in national laws, suggest that conscientious objection is not, and cannot, be an inalienable and unlimited right as opponents desire. To recognise it as such would essentially give the Catholic Church and religious medical practitioners, amongst others, effective control over women's bodies and women's freedom of conscience. In addition, it is clear from these developments that there is nothing radically new about s 8 of *ALRA*. As conservative or traditional views about women give way to placing greater value on women as autonomous beings and moral decision-makers, international bodies and domestic laws are recognising that women's rights to reproductive healthcare cannot be circumscribed by objecting medical practitioners. The law must engage in a balancing act, ensuring respect for conscience on the one hand, but that such objections do not frustrate or negate a woman's right to access abortion or other reproductive services on the other.

¹⁶⁶ Ibid 9.

¹⁶⁷ *R v Morgentaler* [1988] 1 SCR 30, 173 (Wilson J).

VIII WHOSE CONSCIENCE?

As stated above, the interpretation of conscience within the context of abortion is highly problematic. It is always assumed that it only refers to those with religious or moral beliefs that oppose abortion and related services. This interpretation needs to be challenged. Patients' rights include the choice of abortion and other lawful treatments according to their conscience. They are deprived of this choice if they unknowingly see a doctor who either refuses to offer abortions or presents information in a way that deprives the patient of choice. Mackenzie argues that conservative notions of conscience and morality or moral responsibility are 'premised on a set of assumptions which are fundamentally oppressive to women'.¹⁶⁸ She points out that 'moral responsibility in pregnancy gets construed very narrowly as just responsibility towards the foetus',¹⁶⁹ an interpretation 'that seems to commit women to maternity'.¹⁷⁰ The problem with this construction is that there are other important questions ignored, such as:

whether you are in a position to adequately care for [the foetus], both now when it is in the foetal stage and, more importantly, when it is an independent being; how and whether [the foetus] can be integrated into your life and the lives of others, for example other children, whose lives will also be significantly affected by your decision; whether you feel yourself able, or prepared, to provide the physical and emotional care and nurture needed in order for both foetus and child to flourish. What emerges from these discussions of responsibility is that the assumption of moral responsibility in pregnancy cannot be construed just in terms of responsibility towards the foetus but has a wider focus — on the self, relations with significant others and a person's commitments and projects.¹⁷¹

Looking at conscience and morality from this broader perspective means that 'the choice of abortion is in many cases the morally responsible decision'¹⁷² that should not be overridden by the imposition of another's conscience.

Resolving the tension between a woman's right to access reproductive health care and claims of conscientious objection is important given recent survey results of medical students. For example, recent investigations into the attitudes of medical students and physicians in the UK illustrate the conflict between women's rights to reproductive health services and claims of conscience by medical professionals. A survey of English medical students found that nearly half believed doctors should be allowed to refuse to treat a patient if this conflicts with their personal, moral, or religious beliefs.¹⁷³ Abortion proved to be the most contentious issue.

¹⁶⁸ Catriona Mackenzie, 'Abortion and Embodiment' (1992) 70(2) *Australasian Journal of Philosophy* 136, 140.

¹⁶⁹ Ibid.

¹⁷⁰ Ibid.

¹⁷¹ Ibid 140–1.

¹⁷² Ibid 141.

¹⁷³ Sophie LM Strickland 'Conscientious Objection in Medical Students: A Questionnaire Survey' (2012) 38(2) *Journal of Medical Ethics* 22, 23.

Nearly a third of survey respondents stated they ‘would not perform an abortion for a congenitally malformed fetus after 24 weeks, a quarter would not perform abortion for failed contraception after 24 weeks’, while ‘a fifth would not perform abortion on a minor who was a victim of rape.’¹⁷⁴ Similarly, a survey of US physicians found that only a small majority agreed that physicians have a professional obligation to refer patients for all legal medical services for which the patients are candidates, even if the physician believed that such a referral is immoral.¹⁷⁵

Given that conscientious objection is most often asserted in the area of reproductive health services and that women are the primary users of those services, a more contentious issue concerns medical training and the commitments that one needs to undertake to become a doctor. According to Cantor:

Conscientious objection makes sense with conscription, but it is worrisome when professionals who freely choose their field parse care and withhold information that patients need. As the gatekeepers to medicine, physicians and other health providers have an obligation to choose specialties that are not moral minefields for them. Qualms about abortion, sterilization, and birth control? Do not practice women’s health.¹⁷⁶

Such sentiments were expressed as early as 1938 in *R v Bourne*, where Macnaghten J, discussing objections to performing an abortion based on religious grounds, stated that ‘a person who holds such an opinion ought not to be a doctor practising in that branch of medicine’.¹⁷⁷ To recognise conscientious objection as an absolute right, or to allow the scope of the right to be expanded, is to go down the path of ‘value-driven medicine’: such discriminatory medicine would undermine women’s access to health and reproductive services.¹⁷⁸

A second, but rarely discussed aspect of the issue, concerns protecting the conscience of medical practitioners who are pro-choice but work for a religiously affiliated hospital or health service. In 2010, a physician in the US wrote an anonymous article about the way her employer constrained her ability to provide information on reproductive health service.¹⁷⁹ In her article she questioned the narrow interpretation of conscience, stating:

Nationally, new ‘conscience rules’ protect people who believe abortions are wrong from having to provide information or medications they think

¹⁷⁴ Ibid 24.

¹⁷⁵ Michael P Coombs et al, ‘Conscientious Refusals to Refer: Findings from a National Physician Survey’ (2011) 37(7) *Journal of Medical Ethics* 397, 399.

¹⁷⁶ Julie D Cantor, ‘Conscientious Objection Gone Awry — Restoring Selfless Professionalism in Medicine’ (2009) 360(15) *The New England Journal of Medicine* 1484.

¹⁷⁷ *R v Bourne* [1938] 3 All ER 615, 618.

¹⁷⁸ Social, Health and Family Affairs Committee, Council of Europe, *Women’s Access to Lawful Medical Care: The Problem of Unregulated Use of Conscientious Objection* (Report, Doc No 12347, 20 July 2010) 5.

¹⁷⁹ Steph Sterling and Jessica L Waters, ‘Beyond Religious Refusals: The Case for Protecting Health Care Workers’ Provision of Abortion Care’ (2011) 34 *Harvard Journal of Law & Gender* 463, 464. See also Dr X, *A Doctor Tells Why She Performed Abortions — and Still Would* (June 2010) *Health Affairs* <<http://content.healthaffairs.org/content/29/6/1264.full>>.

would end a life. But there aren't any conscience rules in place to protect people who, if their home [medical] institution believes otherwise, provide medications or [abortion] procedures they believe would save a life — the mother's.¹⁸⁰

A recent example of this type of problem is provided by the case of Sister Margaret Mary McBride. Sister McBride was a nun and senior administrator at a Catholic hospital in Phoenix, Arizona. She also oversaw the hospital's ethics committee. The ethics committee was presented with a case where a 'pregnant mother of four suffering from pulmonary hypertension would die if she continued her pregnancy'.¹⁸¹ The ethics committee approved the abortion. As a result of that decision, Sister McBride, was excommunicated and reassigned from her position as vice-president of mission integration at the hospital.¹⁸² Bishop Thomas J Olmsted of Phoenix, who initiated the excommunication, stated that 'the direct killing of an unborn child is always immoral, no matter the circumstances, and it cannot be permitted in any institution that claims to be authentically Catholic'.¹⁸³ The woman's condition carried a near certain risk of death if the pregnancy continued.

This case, and the case of *P and S v Poland*, point to the absurdity of the unjust practice of privileging conscience based on religious beliefs over conscience based on secular or humanist reasoning. Indeed, as Sterling and Waters argue, it is time to ensure 'health care professionals who seek, also as a matter of conscience, to *affirmatively provide* reproductive health care for their patients have parallel legal protections'.¹⁸⁴

IX CONCLUSION

It is clear from the discussion in this paper that there is nothing radically new about the conscience clause in ALRA. As conservative or traditional views about women give way to greater value being placed on women as autonomous beings and moral decision-makers, international treaty bodies, foreign jurisdictions as well as domestic laws are recognising that women's rights to reproductive healthcare cannot be circumvented by objecting medical practitioners. The law must engage in a balancing act, ensuring respect for conscience, and that such objections do not frustrate or negate a woman's right to access abortion or other reproductive services. The 'obligation to refer' is the consequence or outcome of that balancing

¹⁸⁰ Sterling and Waters, above n 179, 464.

¹⁸¹ Ibid.

¹⁸² Ibid. See also 'Sister Margaret McBride Excommunicated for Support of Life-Saving Abortion', *The Huffington Post* (online), 1 June 2010 <http://www.huffingtonpost.com/2010/06/01/sister-margaret-mcbride-e_n_595802.html>; 'US Religious Sister Excommunicated for Role in Abortion Decision', *Cath News* (online), 20 May 2010 <<http://www.cathnews.com/article.aspx?aid=21436>>; Nicholas D Kristoff, 'Sister Margaret's Choice', *New York Times* (online), 26 May 2010 <<http://www.nytimes.com/2010/05/27/opinion/27kristof.html>>.

¹⁸³ 'US Religious Sister Excommunicated for Role in Abortion Decision', above n 182.

¹⁸⁴ Sterling and Waters, above n 179, 466.

exercise. Referral ensures that conscientious objection is protected by allowing objecting practitioners' to withdraw from certain medical procedures, while at the same time, not frustrating a woman's right to reproductive health services and equating rights of conscience with this right. We believe that *ALRA* has achieved an appropriate balance between the rights of freedom of conscience and the rights of women to access reproductive health services. Section 8 of *ALRA* clearly reflects and is consistent with the recommendations and ethical guidelines of international and national peak medical bodies, the recommendations of international treaty monitoring bodies and developing case law from several jurisdictions across the globe. On this basis, we argue that there is no justifiable ground upon which s 8 of *ALRA* can be challenged.