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Without hindrance or fear of reprisals: The attitudes and experiences of doctors with a conscientious objection to abortion in New South Wales and Victoria

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WITHOUT HINDRANCE OR FEAR OF REPRISALS: THE ATTITUDES AND EXPERIENCES OF DOCTORS WITH A CONSCIENTIOUS OBJECTION TO ABORTION IN NEW SOUTH WALES AND VICTORIA

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DECLARATION

To the best of the candidate's knowledge, this thesis contains no material previously published by another person, except where due acknowledgement has been made. This thesis is the candidate's own work and contains no material which has been accepted for the award of any other degree or diploma in any institution.

HUMAN ETHICS

The research presented and reported in this thesis was conducted in accordance with the National Health and Medical Research Council National Statement on Ethical Conduct in Human Research (2007, updated 2018).

The proposed research study received human research ethics approval from the University of Notre Dame Australia Human Research Ethics Committee (EC00418), Approval Number #0171775,

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ABSTRACT

This thesis explores the phenomena of conscience from the perspective of doctors with a conscientious objection to abortion. Its focus is a novel empirical study on the attitudes and experiences of 35 doctors who self-identify as having a conscientious objection to abortion and who practice in New South Wales and Victoria, Australia. Findings include the reasons for their objection and the types of actions they refuse to perform, whether and how the law has limited the free expression of their beliefs in the workplace, and what they would change to achieve a more reasonable accommodation of their conscientious objection in medicine.

Of central importance is the finding of insufficient education on conscience for doctors and medical students. Whilst this is of general importance to society, it is, a fortiori, important for Catholic educational and health institutions, as well as those educational and health institutions committed to an alternative ethos.

This thesis also explores the natural law's understanding of conscience, as enhanced by the teachings of the Catholic Church. It explains how a doctor who subscribes to this understanding of conscience can be harmed by performing or participating in the act of abortion when it goes against their conscience. It considers to what extent human rights law and Australian domestic law recognises and protects freedom of conscience for health professionals with regards to abortion, and how the right to life, the right to health, and the notion of public health have developed over time to become acceptable reasons to limit a doctor's freedom of conscience.

This thesis performs fundamental legal research which uses social science methods to assist lawyers and policy makers to understand the relationship between laws that permit access to abortion whilst at the same time respecting a doctor's freedom to disagree with the state about whether abortion is standard healthcare and to decline to perform or participate in it. Its empirical study fills a gap in the available research and builds upon research performed by others regarding the attitudes of obstetricians, gynaecologists and general practitioners to abortion and conscience protection, and the experiences of women trying to access abortion.

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I thank all the doctors who involved themselves in this study as participants. Your openness and courage in discussing your attitudes on how to manage conscientious objection to abortion in the workplace, and your honesty in discussing your experiences in navigating the contemporary health landscape as 'pro-life' doctors, including those instances where you did not follow your conscience, was most instructive and deeply appreciated by me.

Finally, to the 'Seat of Wisdom,' may I have produced a thesis worthy of the University that bears Her name.

TABLE OF CONTENTS

CHAPTER			PAGE NUMBER
1.	Introduction		13
2.	Research, Design and Methodology		24
	2.1	Introduction	24
	2.2	The Purpose of the Study	24
	2.3	The Research Question	25
	2.4	Research Paradigm	26
		2.4.1 Epistemology of Research Paradigm	27
		2.4.2 Ontology of Research Paradigm	28
		2.4.3 Methodology of Research Paradigm	29
	2.5	Study Design	33
		2.5.1 Data Collection Tool	34
		2.5.2 Ethical Considerations for Design	36
		2.5.3 Sampling	38
		2.5.4 Method of Data Collection	41
	2.6	Data Analysis	43
		2.6.1 Content Analysis	44
		2.6.2 Thematic Analysis	46
	2.7	Strengths and Limitations of the Study	48
		2.7.1 Credibility	49
		2.7.2 Generalizability	49
		2.7.3 Dependability	49
		2.7.4 Additional limitation of the study	50

CHAPTER **PAGE NUMBER**

3. Theoretical Analysis: Conscience *Qua* Conscientious Objection 52

3.1 Introduction 52
3.2 Synderesis: The Primary Precept and the Intellect 57
3.3 Synderesis: The Primary Precept and the Emotions 61
3.4 The Process of Conscience 68
3.5 Practical Conscience 75
3.6 Moral Complicity 80
3.7 Conclusion 85

4. Legal Analysis: Conscientious Objection to Abortion and the Australian Law 89

4.1 Introduction 89
4.2 Human Rights Perspectives On Conscientious Objection to Abortion 93
4.2.1 Freedom of Conscience 93
4.2.2 The Right to Life 98
4.2.3 The Right to Health 106
4.2.3 The Public Health Exception 109
4.3 Australian Law 112
4.3.1 Federal Law: Freedom of Religion 112
4.3.2 The Development of Australian Abortion Law 119
4.4 Broad Conscientious Objection Clauses: Western Australia and the ACT 123
4.5 Narrow Conscientious Objection Clauses: Victoria, Northern Territory, and Queensland 127
4.6 Middle Way Conscientious Objection Clauses: Tasmania, New South Wales, and South Australia 135
4.7 Conclusion 143

CHAPTER **PAGE NUMBER**

5. Literature Review of Empirical Studies 147
   - 5.1 Introduction 147
   - 5.2 The United States of America 149
     - 5.2.1 Legal Framework 149
     - 5.2.2 Empirical studies 154
       - 5.2.2.1 Curlin et al study 154
       - 5.2.2.2 Lawrence et al study 155
       - 5.2.2.3 Combs et al study 156
       - 5.2.2.4 Frank study 157
       - 5.2.2.5 Rasinski et al study 159
       - 5.2.2.6 Brauer study 160
   - 5.3 The United Kingdom 163
     - 5.3.1 Legal Framework 163
     - 5.3.2 Empirical Studies 168
       - 5.3.2.1 Gleeson study 168
       - 5.3.2.2 Strickland study 169
   - 5.4 Europe 171
     - 5.4.1 The Legal Framework 171
     - 5.4.2 Empirical Studies 181
       - 5.4.2.1 Nieminen et al study 181
       - 5.4.2.2 Nordstrum et al study 182
       - 5.4.2.3 Nordberg et al study 183
       - 5.4.2.4 Håkansson et al study 187

CHAPTER **PAGE NUMBER**

5.5 Australia 189

5.5.1 Empirical Studies

5.5.1.1 de Costa et al study 190

5.5.1.2 Dawson et al study 191

5.5.1.3 Doran and Hornibrook study 193

5.5.1.4 Keogh et al study 195

5.6 Discussion 197

5.7 Conclusion 198

6. Findings: Content Analysis 199

6.1 Introduction 199

6.2 Description of Respondents 200

6.3 Content Analysis – Attitudes 203

6.3.1 Attitude to Abortion 204

6.3.2 Attitude to Referral 204

6.3.3 Attitude to Contraception 205

6.4 Content Analysis – Experiences 207

6.4.1 Negative Comments 207

6.4.2 Fear of Reprisals 207

6.4.3 Complaints 207

6.4.4 Loss 208

6.5 Thematic Analysis – Attitudes 209

6.5.1 Basis of Conscientious Objection to Abortion 210

6.5.1.1 Science and Principle 213

6.5.1.2 Principle and Science 214

6.5.1.3 Science Alone 215

6.5.1.4 Religious Faith Alone 215

CHAPTER **PAGE NUMBER**

6.5.2 Scope of Conscientious Objection to Abortion 216
6.5.2.1 Objection to all Abortion
Including Hormonal Contraception 217
6.5.2.2 Objection to all Abortion
But not Contraception 217
6.5.2.3 Exceptions for Abortion 219
6.5.3 Basis of Conscientious Objection to Referral 220
6.5.3.1 Will Not Refer 221
6.5.3.2 Will Consider Referring for Abortion 223
6.5.4 Scope of Conscientious Objection to Referral 230
6.5.4.1 Will Not Provide Referral for 231
Or Information on Abortion
6.5.4.2 May Consider Providing Information 231
On Third Party Organisations
6.6.4.3 Will Refer 234

6.6. Thematic Analysis: Experiences: 240
6.6.1 Burdens 240
6.6.1.1 Negative Comments 241
6.6.1.2 Fear of Reprisals 243
6.6.1.3 Complaints 248
6.6.1.4 Loss 252
6.6.2 Accommodation of Conscientious Objection 255
6.6.2.1 Self-Accommodation 255
6.6.2.2 Supervisor/Employer 259
6.6.2.3 College/University 263
6.6.2.4 Patient 267

CHAPTER **PAGE NUMBER**

6.6.3 Recommendations 272

6.6.3.1 Mentoring and Support 272

6.6.3.2 Abortion Education 276

6.6.3.3 Law Reform 279

6.6.3.3.1 Full Legal Protection of Conscience 279

6.6.3.3.2 No Conscience Clauses 280

6.6.3.3.3 Repeal Section 8 281

6.6.3.3.4 Policy 282

6.7 Discussion 283

7. Recommendations and Conclusion 287

Bibliography 295

Appendices

Book list: 'Creating a Culture of Respect' 331

Ethic Documents

Data Collection Tool 333

Consent Form 335

Participant Information Sheet 336

Transcript of Interviews

Doctor 1 341

Doctor 2 351

Doctor 3 358

Doctor 4 368

Doctor 5 375

Doctor 6 383

Doctor 7 390

Doctor 8 398

Doctor 9 410

PAGE NUMBER

Doctor 10	418
Doctor 11	427
Doctor 12	437
Doctor 13	447
Doctor 14	453
Doctor 15	460
Doctor 16	471
Doctor 17	478
Doctor 18	482
Doctor 19	490
Doctor 20	497
Doctor 21	502
Doctor 22	511
Doctor 23	517
Doctor 24	523
Doctor 25	529
Doctor 26	536
Doctor 27	546
Doctor 28	551
Doctor 29	557
Doctor 30	562
Doctor 31	569
Doctor 32	577
Doctor 33	584
Doctor 34	590
Doctor 35	595

LIST OF CHARTS, TABLES AND FIGURES

		PAGE NUMBER
Chart 1	NSW Participants by Specialty and Religious Affiliation	201
Chart 2	Victorian Participants by Specialty and Religious Affiliation	202
Chart 3	Comparison of NSW and Victorian Participants by Years of Experience	202
Chart 4	Conscientious Objection to Key Attitudes Cross Referenced To Religious Affiliation	205
Chart 5	Conscientious Objection to Key Attitudes Based on State	206
Chart 6	Comparison of Burden by Experience Level	208
Figure 1	Theme 1- Basis of Conscientious Objection to Abortion	211
Figure 2	Theme 2 – Scope of Conscientious Objection to Abortion	216
Figure 3	Theme 3 – Basis of Conscientious Objection to Referral	221
Figure 4	Theme 4 – Scope of Conscientious Objection to Referral	230
Table 1	Summary of Circumstances where Doctor has Referred Patient for Abortion	234
Figure 5	Theme 5 – Burden Caused by status as a Conscientious Objector to Abortion To Abortion	240
Figure 6	Theme 6 – Accommodation of Conscientious Objection	255
Figure 7	Theme 7 – Recommendations	272

CHAPTER ONE

INTRODUCTION

> It should strike the reader as very odd that in all the recent debates about conscience, conscientious objection, institutional conscience, and the consciences of physicians, pharmacists and patients, so little attention has been paid to understanding exactly what conscience is and what its importance might be. When definitions are offered, they are typically vague and unhelpful.[1]

For the last 15 years conscience conflicts in healthcare have occupied a large part of the bioethics literature. Whilst everyone speaks of conscience as a deeply held moral belief, limited attention has been paid to exploring in more detail what conscience is and whether people are harmed by being forced to either act against it or prevented from acting in accord with it. This thesis explores the phenomena of conscience within the context of Australian abortion law and the impact it has had on the attitude and experiences of Australian doctors from New South Wales and Victoria with a conscientious objection to abortion.

As Kondrlik notes, conscience clauses to resolve conflict between doctors and patients first appeared in Britain in 1898 to protect parents who objected to the mandatory vaccination of their children against smallpox.[2] They re-appeared again when abortion started to be legalised in the late 1960's and early 1970's but this time they protected doctors from having to perform abortion on patients. [3] However, with the decriminalization of abortion around the world, some lawmakers have tried to dilute the protection afforded by conscience clauses in order to compel doctors and other health professionals to perform or participate in abortion.[4]

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[1] Daniel P Sulmasy, 'What is Conscience and Why Is Respect for It So Important?' (2008) 29 *Theoretical Medical Bioethics* 135, 135.

[2] See *Vaccination Act 1898* (UK). See also Kristen K Kondrlik, 'Conscientious Objection to Vaccination and the Failure to Solidify Professional Identity in Late Victorian Socio-Medical Journals (2020) 53(3) *Victorian Periodicals Review* 338, 343. As Kondrlik notes, the medical profession at that time was still struggling to establish itself as a profession and have its opinions and expertise accepted by both the government. In addition, there were still unresolved issues such as informed consent for children.

[3] See Thaddeus Mason Pope, 'Legal Briefing: Conscience Clauses and Conscientious Refusal' (2010) 1(2) *Journal of Clinical Ethics* 163, 164; Nadia N Sawicki, 'Disentangling Conscience Protections' (2018) 48(5) *Hastings Center Report* 14, 14.

[4] Ibid.

Not much is known about how and to what extent a doctor who believes that abortion is the unjustified killing of the unborn might be harmed by being compelled to act against this belief either directly or indirectly. Indeed, there seems to have been little interest in knowing more about this. Rather, the emphasis has been on the unexamined assumption that refusing to perform or participate in abortion causes unjustified harm to women seeking abortion, which in turn harms the medical profession and the community at large that supports access to abortion as an essential healthcare service for a modern, civilised society.

Arguably, the root of disinterest in harm to doctors from acting against conscience is the contemporary notion of tolerance, where 'strong opinions are nothing more than strong preferences for a particular version of reality, [with] each version [being] equally true' and as correct as one's own.[5] At its core is the belief that truth is merely subjective. Hence, subjective, epistemic modesty can persuade a person to concede that their view, even if strongly held, could be wrong. In this context, a person may justify performing an action they believe is wrong when directed to do so by the law, a workplace policy, or professional organisation.

However, a person who believes in objective truth and one version of reality can present a challenge because they may refuse to accept by words or actions that an opposing belief is correct or as correct as one's own. This in turn leads them to refuse to act out of accord with their beliefs about right and wrong. This refusal to yield is seen as a source of conflict by proponents of contemporary tolerance who represent the majority.[6] Crucially, the refusal to yield is seen not only as intolerant, but it is a cause of disharmony in the community,[7] and harm to the dignity of the person whose version of freedom is challenged.[8]

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[5] DA Carson, *The Intolerance of Tolerance* (Wm B Eerdmans Publishing Co, 2013) 3, 11.

[6] The subjective truth worldview also refuses to yield in that it insists everyone support subjective truth and multiple realities. This insistence is itself an absolutist belief and flows from the philosophy of relativism. See Chris Stefanick, *Absolute Relativism: the new dictatorship and what to do about it* (Catholic Answers Press, 2011). As Stefanick noted, the main criticism of relativism as a philosophy is that its main proposition is self-contradicting: that it is absolutely true for everyone, that nothing is absolutely true for everyone.

[7] United Nations Education, Scientific and Cultural Organization, *Declaration of Principles on Tolerance*, UN Doc SHS.96/WS/% (1995, adopted 16 November 1995) art 1.3.

[8] See D Beyleveld and R Brownsford, *Human Dignity in Bioethics and Biolaw* (Oxford University Press, 2004) 242. Freedom of choice is seen by many as being the cornerstone of human dignity.

We see the impact of the contemporary notion of tolerance in the notion of 'value-neutral medicine' which advocates for doctors to respect the autonomy of their patient by constraining themselves from expressing their religious and metaphysical views about a service they object to in case it harms the patient.[9] As Beckwith and Peppin note, when it comes to abortion, the pro-choice legal framework uses Locke and Rawls to elevate autonomy and free choice to basic goods along with other freedoms.[10] Accordingly, choosing abortion is good where it is the genuine expression of a woman's feelings about what she believes is best for her.

However, personal moral reflections and philosophical views on the nature of the human person can influence a doctor's practice of medicine. Arguably there is no such thing as 'value-neutral' medicine.[11] Further, the belief that being 'value-neutral'[12] is the only correct approach to medicine is itself an absolutist belief sought to be imposed on others.[13] As Pellegrino notes, whilst value neutrality may be a legitimate goal for government, it is not appropriate in medicine, because it 'elevates secularism to a social orthodoxy, thereby violating one of the major tenets of secularism itself - that no ideology would have preference over any other.'[14]

Despite abortion having served as the proxy for conscientious objection in healthcare, some suggest it should be excluded from the broader discussion on managing conscience conflicts because of its 'peculiarities,' which are not shared with other services.[15] Certainly abortion raises the question of when a human life begins, but it also raises the basic moral question of why it is wrong to take human life.[16] Arguably, euthanasia also demonstrates similar, foundational metaphysical disagreements about the moral worth of human life and when it may be ended by another person.[17]

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[9] See Edmund D Pellegrino, 'Commentary: Value Neutrality, Moral Integrity, and the Physician' (2000) 28 *Journal of Law, Medicine and Ethics* 78, 78.
[10] Francis J Beckwith and John F Peppin, 'Physician Value Neutrality: A Critique' (2000) 28 *Journal of Law, Medicine and Ethics* 67, 68.
[11] Ibid 71-72.
[12] It would be remiss not to note here, the problem with 'values language'. See, eg, Iain T Benson, 'Values Language: A Cuckoo's Egg or Useful Moral Framework' in David Daintree (ed) *Creative Subversion: The Liberal Arts and Human Educational Fulfilment* (Connor Court, 2018) 1-43.
[13] Beckwith and Peppin (n 10) 74.
[14] Edmund D Pellegrino, 'The Physician's Conscience, Conscience Clauses, and Religious Belief: A Catholic Perspective' (2002) 30(1) *Fordham Urban Law Journal* 221, 240.
[15] See, eg, Holly Fernandez Lynch, *Conflicts of Conscience in Healthcare* (MIT Press, 2008) 38-9. Cf Francis J Beckwith, *Defending Life: A Moral and Legal Case Against Abortion Choice* (Cambridge University Press, 2007) 43. Beckwith notes that all positions on abortion presuppose a metaphysical point of view.
[16] Peter Singer, *Rethinking Life & Death* (The Text Publishing Company, 1994) 105. According to Singer, this question is the key to unlocking the abortion debate.
[17] For some people, the fact that an adult suffering with a terminal illness consents to be killed by their doctor is not a reason to permit euthanasia or physician assisted suicide.

This thesis is best described as social-legal research, or fundamental research.[18] Interdisciplinary in nature, it is a theoretical and doctrinal analysis of the relationship between freedom of conscience and abortion laws which may limit a doctor's ability to conscientiously object to participating in abortion, and it performs empirical research to analyse the impact these types of laws have on doctors who are affected by them. As far as has been determined, this empirical study is the first of its kind. Accordingly, this thesis aims to make an original contribution to knowledge and be useful in crafting discussion and policy in this area.

During the time data was collected, several states and territories of Australia de-criminalised abortion and legislated to limit the protection of a doctor's conscientious objection to abortion. In 2016, New South Wales' attempt to decriminalise abortion failed,[19] but this was followed by successful decriminalisation in the Northern Territory, Queensland, New South Wales, and South Australia.[20] The findings from this thesis' empirical study were used by the writer in various submissions to law reform commissions and, in evidence before the New South Wales Legislative Council Standing Committee on Social Issues, regarding conscience clauses.[21]

Before describing the seven chapters in this thesis and setting out their key points and arguments, this thesis will provide a synopsis of the broader legal issues, both domestic and international, which provide context for this empirical study. It commences with an overview of abortion and conscience clauses in Australia and then concludes with the perspective of human rights law. This thesis has an emphasis on domestic legal issues in two states of Australia. This is so that it may generate domestic discussion and recommendations on the issue of whether and to what extent Australian law should respect the conscience of doctors.

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[18] See Reza Banakar and Max Travers, 'Introduction to Theory and Method in Social Legal Research' in Reza Banakar and Max Travers (eds) *Theory and Method in Social Legal Research* (Hart Publishing, 2005) xi.
[19] Abortion Law Reform (Miscellaneous Amendment) Bill 2016 (NSW).
[20] See *Termination of Pregnancy Law Reform Act 2018* (NT); *Termination of Pregnancy Act 2018* (Qld); *Abortion Law Reform Act 2019* (NSW); *Termination of Pregnancy Act 2021* (SA).
[21] See, eg, Evidence to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, 14 August 2019, 64 (Anna Walsh); Anna Walsh, Submission No 21, Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, Inquiry into the Reproductive Health Care Reform Bill 2019 (13 September 2019); Anna Walsh, Submission, South Australian Law Reform Institute, South Australian Abortion Law Reform Reference, 31 May 2019, 3 [1]-[26]; Anna Walsh, Michael Quinlan and Michael McAuley, Submission No 494, Queensland Law Reform Commission, Inquiry into Termination of Pregnancy Bill 2018, 5 September 2018 [19]-[28].

Whilst abortion has been decriminalized throughout Australia,[22] until 2008, legislation which regulated abortion as a health service always contained a clause which protected any person opposed to carrying out or assisting in abortion.[23] This changed for Victoria in 2008 when it deviated from this model. Adopting a modified 'abortion on request' framework, its legislation created statutory duties for doctors with a conscientious objection to abortion to disclose their objector status to patients and perform certain acts that, from the objecting doctor's perspective, could place a burden on the doctor's conscience.[24]

The Victorian legislation requires doctors with a conscientious objection to abortion to perform abortion in an emergency and refer women seeking abortion to a doctor they know does not have a conscientious objection to abortion.[25] Whilst little has been said about the emergency provision, much has been written about the duty to refer for the following three reasons; firstly, a referral is not needed to access abortion in Victoria; secondly, abortion providers are not prohibited from advertising their services; and thirdly, referral raises the complex ethical issue of moral complicity in wrongdoing.[26]

As Cornides notes, justification for infringing a doctor's freedom of conscience with respect to abortion requires three things: Firstly, the decriminalisation of abortion based on respect for a woman's bodily autonomy and to characterise it as time sensitive healthcare; Secondly, the characterisation of conscience as an emotion based on subjective certitude and therefore capable of being renounced in favour of the civil law if its expression causes harm to others; and Thirdly, the characterisation of a doctor's opposition to abortion, whilst sincerely held, as being intolerant, judgmental, and harmful to women who seek or have undergone abortion.[27]

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[22] *Termination of Pregnancy Act 2021* (SA); *Abortion Law Reform Act 2019* (NSW); *Termination of Pregnancy Act 2018* (Qld); *Termination of Pregnancy Reform Act 2017* (NT); *Reproductive Health (Access to Terminations) Act 2013* (Tas); *Abortion Law Reform Act 2008* (Vic); *Health Act 1911* (WA); *Health Act 1993* (ACT).
[23] See *Health Act 1911* (WA) s 334(2); *Health Act 1993* (ACT) s 84(1)(2); *Criminal Law Consolidation Act 1935* (SA) s 82A(6).
[24] *Abortion Law Reform Act 2008* (Vic) s 8.
[25] Ibid ss 8(3)(5).
[26] See, eg, Michael Quinlan, 'When the State Requires Doctors to Act against Their Conscience: The Religious Freedom Implications of the Referral and the Direction Obligations of Health Practitioners in Victoria and New South Wales' (2016) 4 *Brigham Young University Law Review* 1237, 1245.
[27] Jakob Cornides 'Human Rights Pitted Against Man' (2008) 12(1) *International Journal of Human Rights* 107, 113. When deemed to be healthcare, it is difficult to see abortion as something other than 'good.'

Arguably, Victoria's duty to refer, along with the other jurisdictions which have adopted it,[28] weakens an objecting doctor's position by forcing them to co-operate in abortion. In a sense, referral endorses the woman's decision to choose abortion.[29] However because the woman has other means of ascertaining where to obtain abortion, and the doctor does not necessarily have any special knowledge about abortion providers, it begs three questions: How does referral affect objecting doctors? How does refusal to refer affect women seeking abortion? Is placing the burden on objecting doctors the least restrictive solution?

Recourse to human rights law to resolve a conflict in rights and freedoms has some challenges. Whilst freedom of conscience is recognised in the International Covenant on Civil and Political Rights ('*ICCPR*') as a fundamental freedom all persons enjoy by virtue of their dignity as humans, it does not define dignity or conscience.[30] Further, it provides that a person's manifestation of their belief may be limited by the state where the state considers it necessary to preserve public security, public health, public morals or public order, or where its manifestation is held to infringe the rights and freedoms of others.[31]

[28] See *Abortion Law Reform Act 2019* (NSW) s 9; *Termination of Pregnancy Act 2018* (Qld) s 8(3); *Termination of Pregnancy Reform Act 2017* (NT) s 11(2)(b); *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 7(2).

[29] See, eg, Daniel Sulmasy, 'Conscience, Tolerance, and Pluralism in Health Care' (2019) 40 *Theoretical Medicine and Bioethics* 507, 514.

[30] See Marek Bielecki, 'Conscience Clauses and Conscientious Objection in Medical Practice Against the Legal Situation of Representatives of Other Professions' in Grzegorz Blicharz (ed) *Freedom of Conscience: A Comparative Law Perspective* (Prawo Publiczne, 2019) 93.

[31] *International Covenant on Political and Civil Rights*, opened for signature 16 December 1966, UNTS 999 (entered into force 23 March 1976) art 18(3) ('*ICCPR*'). See also *Universal Declaration of Human Rights*, 1948, (resolution 217 A), adopted 10 December 1948 ('*UDHR*') art 18. Also, critically, it must be domesticated to be effective. This has been sporadic. See *Kassam v Hazzard* [2021] NSWSC 1320.

In moral matters, the 'margin of appreciation' may operate (such as in Europe) so that state compliance with the domestic law is sufficient to discharge human rights obligations.[32] When it comes to abortion, the inability to agree on the nature of unborn human life has been considered sufficient in Europe to characterise abortion as falling within the margin of appreciation.[33] In addition, the United Nations Human Rights Committee recently affirmed that limiting the scope of a doctor's conscientious objection to abortion, or even prohibiting them from entering the medical profession, can be a proportionate response to a public health risk.[34]

Accordingly, solutions to manage conscientious objection to abortion may differ between states due to the domestic landscape. It is this thesis' position that where the aim of abortion law is greater access to abortion, it does not inevitably follow that conscientious objection to abortion must be limited. This is supported by the fact that whilst all Australian jurisdictions have permissive abortion laws, not all have adopted Victoria's strict approach to conscience.[35] However limited empirical research has been undertaken regarding the domestic impact of current abortion laws and their conscience clauses on those directly affected by them.[36]

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[32] See Philip Alston and Ryan Goodman, *International Human Rights: Texts and Materials* (Oxford University Press, 2013) 946-7. See also *Eweida v United Kingdom* (European Court of Human Rights, Application No. 48420/10, 15 January 2013). The ECtHR noted at [84]: 'According to its settled case-law, the Court leaves to those States party to the Convention a certain margin of appreciation in deciding whether and to what extent an interference is necessary. This margin of appreciation goes hand in hand with European supervision embracing both the law and the decisions applying it. The Court's task is to determine whether the measures taken at national level were justified in principle and proportionate.'

[33] See, e.g. *Open Door and Dublin Well Woman v Ireland ('Open Door')* (1992) EHRR 244, 68; *Vo v France* (2004) 40 EHHR 12 [82], [84], [85]. Cf Carolyn Evans, 'Individual and Group Religious Freedom in the European Court of Human Rights: Cracks in the Intellectual Architecture' (2010) 26(1) *Journal of Law and Religion* 321, 332, 342. Evans argues that the Court can choose to use the margin of appreciation in order to avoid discussion of these type of controversial issues.

[34] See United Nations, Human Rights Committee, *General Comment No. 36 Article 6 right to life*, UN Doc CCPR C/GC/36 (3 September 2019).

[35] See *Abortion Law Reform Act 2019* (NSW), s 9; *Health Act 1991* (ACT) s 84(1)(2); *Health Act 1911* (WA) s 334(2); *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 7(2); *Termination of Pregnancy Act 2021* (SA) s 11(4).

[36] See, eg, Louise Keogh et al, 'Conscientious Objection to Abortion, the Law and its Implementation in Victoria, Australia: Perspectives of Abortion Service Providers' (2019) *BMC Medical Ethics* doi 10.1186/s12910-0-19-0346-1:1-10. For further discussion, see chapter 5 of this thesis.

Those directly affected include women seeking abortion, health professionals with a conscientious objection to abortion, and health professionals who perform abortion. Globally, there is limited research on the nature of any harm that doctors with a conscientious objection to abortion may have suffered, whether it can be measured, and how it compares to any harm a pregnant woman feels when the objecting doctor will not provide a referral.[37] Such research is important to undertake if the lawmaker accepts that differing conceptions of conscience exist and ought to be respected by being accommodated as far as is reasonable.

This thesis is concerned with the phenomena of conscience from the perspective of doctors who have a conscientious objection to performing or participating, in abortion. It includes an interpretative, descriptive, qualitative study which seeks to, amongst other things, know more about 35 doctors' attitudes and experiences to changes to law and practice in their respective states and whether and how it has limited their free expression of conscience in the workplace, their experience being a doctor with a conscientious objection to abortion, and what they would change to achieve a more reasonable accommodation of their conscientious objection.

These are areas of enquiry well suited to empirical research.[38] However the findings from this study cannot by themselves create a new theory of conscience or a policy for conscientious objection in healthcare, though they might be useful in its formation. Rather, any solution arising from empirical research must be anchored to a pre-interpretative theory which is used to understand the perspective of the participants and may form the basis of policy. The writer used a specific theory to interpret the results of the study and faithfully explain how and in what circumstances the duties the law imposes on these doctors can cause them harm.

[37] See Eva M Nordberg, Helge Skibekk and Morten Magelssen, 'Conscientious Objection to Referrals for Abortion: Pragmatic Solution or Threat to Women's Rights?" (2014) 15 *BMC Medical Ethics* doi:10.1186/1472-6939-15-15: 1-9. Cf Dubravka IG Håkansson, Pernilla Ouis and Maria E Ragnar, 'Navigating the Minefield: Women's Experiences of Abortion in a Country with a Conscience Clause—The Case of Croatia' (2021) 22(1) *Journal of International Women's Studies* 166.

[38] See Lee Epstein and Andrew D Martin, *An Introduction to Empirical Legal Research* (Oxford University Press, 2014) 3. This is because empirical research measures things both numerically and non-numerically.

Chapter 2 is entitled ‘Research, Design and Methodology.’ This chapter identifies the purpose of the empirical study, states the research questions, and explains the research paradigm and conceptual framework of the study. It discusses the methodology of ‘focused discourse,’ which adopts a theoretical framework most suited to this study’s participants. It then describes the study design including the development of the data collection tool, sampling, the method used to collect data, and the ethical considerations the study raised, and explains how the data was analysed. Finally, it identifies the study’s strengths and limitations.

Chapter 3 is entitled ‘Theoretical Analysis: Conscience Qua Conscientious Objection.’ The methodology of the empirical study requires a detailed understanding of participants’ likely perspective on these issues in order to faithfully interpret data gained from their interviews. As most participants to the study identified as practising Catholics, this chapter provides an overview of the classical natural law theory of conscience with its specific way of understanding freedom, dignity, and complicity in wrongdoing, as enhanced by the Catholic Church’s systematic teachings on these and associated issues.

Chapter 4 is entitled ‘Legal Analysis: Conscientious Objection to Abortion.’ It is a doctrinal analysis of the law as it relates to conscientious objection. It discusses the human rights law approach to conscientious objection to abortion and how the development of the right to life, right to reproductive health and the notion of public health have provided infrastructure for limiting conscience protection of doctors in law. It then critically analyses Australian law relating to conscience, abortion, and conscientious objection to abortion, and identifies and discusses three distinct domestic approaches to the recognition of conscientious objection.

Chapter 5 is entitled ‘Literature Review: Empirical Studies.’ It identifies and comments upon common attitudes of doctors surveyed in selected countries to conscientious objection in healthcare generally and abortion in particular. It notes characteristics of the relevant legal framework for abortion, conscientious objection, and the way healthcare is delivered, any limitations in findings due to study design and methodology, and any issues from the studies which support the need for further research. Ultimately this chapter justifies why the questions this empirical study explores are important to law, medical education and bioethics.

Chapter 6 is entitled ‘Findings and Discussion.’ This chapter reports on and discusses the findings of the empirical study using graphs and schematics to visually describe and organize the results of the content analysis. Content analysis looked at seven areas capable of binary responses. The first three areas measured the participants’ attitudes to the core issues of whether they held an absolutist position against abortion, referral for abortion and contraception. The next four areas measured their experiences with negative comments, fear of reprisals, complaints, and loss as a result of being a conscientious objector to abortion.

The chapter then goes on to report on thematic analysis, which delved deeper into these attitudes and experiences and revealed seven key themes: the basis for their conscientious objection to abortion, the scope of their conscientious objection to abortion, the basis for their conscientious objection to referral, the scope of their conscientious objection to referral, the burden on them as a conscientious objector, their thoughts on the scope for accommodation of conscientious objection to abortion and other morally controversial services, and their recommendations for changes to the law.

Chapter 7 is entitled ‘Recommendations and Conclusion.’ It commences by discussing key findings of this empirical study that have not been the subject of any substantial discussion in the published bioethics literature. It notes interesting findings in the data, including ambiguity, that are considered by the writer to be worthy of further research. It also considers the feasibility of the recommendations put forward by the participants themselves for the protection of conscience of health professionals with regard to abortion in both Victoria and New South Wales in the context of the domestic provision of health services in Australia.

Finally, it summarises the aims of this thesis and demonstrates the extent to which the research questions have been answered by its theoretical and empirical components. Given New South Wales’ *Abortion Law Reform Act* is scheduled for review in 2023, and the increasing debates on legalising other morally controversial health services such as euthanasia and physician assisted suicide, this thesis is timely. Chapter 7 concludes by identifying what contribution this thesis can make to knowledge in the cross disciplinary areas of law, medical education and bioethics.

This thesis was undertaken during a tumultuous period of legal change in Australia regarding abortion and conscience protection. As at its completion date in mid-2022, all jurisdictions in Australia have decriminalised abortion, with several having also introduced legislation permitting euthanasia and/or physician assisted dying. The protection of conscience has never been more important yet despite an initial flurry of activity and interest in the bioethics world about knowing more about what doctors and health professionals think about conscientious objection, empirical research on those who seek the law's protection has been minimal.

The conscience clause is an opportunity for the lawmaker to demonstrate respect for a person's liberty to choose what to believe in by not compelling them to act against deeply held beliefs by threatening civil penalties or other punishments. The conscience clause should also allow for reflection on how the expression of an opposing moral belief causes harm to others and whether the harm is of sufficient concern to justify outlawing the manifestation of minority views. Arguably, the worldview which underpins pro-abortion discourse should not also claim the realm of conscience without further discussion about freedom.[39]

With the growing acceptance of other morally controversial services as legal healthcare in Australia, reflection on whether and how we should protect the conscience of health professionals who disagree with the state's characterisation of such services as healthcare and refuse to perform actions in line it, is both timely and urgent. Finally, whilst this thesis highlights the perspective of doctors with a conscientious objection to abortion, it encourages research into two other associated areas: how pregnant women seeking abortion are affected by conscience protection clauses, and the ethical education of the medical profession.

[39] This requires a return to the traditional understanding of tolerance. See Carson (n 5) 3. As Carson notes this is where people are not harmed by the existence of beliefs different to their own. As such, in the interests of 'fairness' they acknowledge the other person's right to hold and manifest a different belief. See also John Gray, *Two Faces of Liberalism* (New York, 2000). Such a conception of tolerance accords with *modus vivendi* liberalism.

CHAPTER TWO

RESEARCH DESIGN AND METHODOLOGY

> In the end, I am acutely aware of my own ignorance of the healthcare world and especially of the conversations that real conscientious objectors have with real patients. My suggestion for further research would start there.[1]

2.1 INTRODUCTION

This chapter is dedicated to describing the research, design, and methodology of this thesis' empirical study of 35 doctors with a conscientious objection to abortion. Specifically, this chapter identifies the purpose of the research, the research questions, and the research paradigm and conceptual framework within which the study operates. The study design section includes the development of the data collection tool, sampling, the method of data collection, and ethical considerations. The methods section explains how the data was analysed and the chapter concludes by identifying the study's strengths and limitations.

2.2 THE PURPOSE OF THE STUDY

This is a descriptive, interpretive study. Its purpose was to explore the attitudes and experiences of doctors who self-identify as having a conscientious objection to abortion and who practice in either New South Wales or Victoria. To achieve this, it used focused discourse methodology and qualitative research methods. Its secondary purpose is to discuss how its findings can be used in public discourse to develop public health law policy in this area of abortion, and potentially other areas of medicine involving morally controversial services that some doctors and other health professionals may have a conscientious objection to.

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[1] Christopher Cowley, 'Conscientious Objection in Healthcare and the Duty to Refer' (2017) 43(4) *Journal of Medical Ethics* 207, 212.

2.3 RESEARCH QUESTION

This study has a central research question followed by three sub-questions. The central research question is: 'What are the attitudes and experiences of doctors with a conscientious objection to abortion and who practice in New South Wales and Victoria'. The sub-questions are: 'What burden do these doctors believe that having a conscientious objection to abortion has had upon their professional lives?', 'Is there an association between the attitudes or experiences of these doctors based upon their religious affiliation?' and 'Is there an association between their attitudes and experiences based on which state they practice medicine?'

One may ask why the hypothesis 'that laws which limit the ability of doctors with a conscientious objection to abortion to refrain from participating in it causes harm to those doctors' is not being tested. To undertake that type of experimental research, the research question must be able to define 'conscientious objection', 'participate' and 'harm'. Given the absence of definitions of these terms in our laws, an exploratory study that investigates which actions these doctors will not participate in, and how they perceive they are harmed, is thought to be more useful for policy discussions.

Having defined the purpose of this study, this chapter now addresses the assumptions that underpin the writer's view of how we know things and what passes as acceptable knowledge in this area of research. Specifically, the next section will detail the study's ontological and epistemological perspectives, as well as its methodology under the overall heading of 'Research Paradigm.' These matters influence decisions about the study's design, the way it collects and analyses data and the way things are expressed, particularly any metaphysical assumptions. These matters contribute to the study's validity and credibility.

2.4 RESEARCH PARADIGMS

Research paradigms for this study must be discussed in relation to the phenomenon being researched. Here, the phenomenon is conscience. It is studied in the context of a particular action, abortion, from a particular perspective, doctors who have a conscientious objection to abortion and work in either of two jurisdictions of Australia. Both New South Wales and Victorian law declare abortion to be lawful when it is conducted in accordance with its legislation, with both states proscribing a normative response by doctors to legal requests for abortion.

Kuhn defines the research paradigm as the beliefs, theories, methods and language that a community of researchers has in common regarding the nature and conduct of research.[2] The epistemology of the paradigm is the macro framework. It represents the worldview or assumptions of the researcher about how we know things. The ontology of the paradigm is the micro framework for the study. It is the theory or theories that sit beneath the epistemology of the paradigm and influences how the researcher understands the nature of the social phenomenon being investigated.[3]

As Walter notes, the methodology of the research paradigm, which includes the methods, denotes the lens through which the research is designed and conducted, how the data is analysed and interpreted, and how the study will develop knowledge in its area.[4] It is important to note that a study's epistemology or ontology does not of itself dictate the methodology for a study. Rather, the choice of a study's methodology rests on whether it can answer the research question(s) and in doing so, achieve the purpose of the study. The study's methodology also allows the reader to assess the validity and reliability of the research.

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[2] Thomas Kuhn, *The Structure of Scientific Revolutions* (University of Chicago Press, 2nd ed, 1970) 16-17. Kuhn's understanding of this term has been criticized. See, eg, Charles Kivunja and Ahmed Bawa Kuyini, 'Understanding and Applying Research Paradigms in Educational Contexts (2017) 6(5) *International Journal of Higher Education* 26, 29; Nigel Wharburton, *Philosophy: the Classics* (Taylor & Francis Group, 2007) 274.
[3] Maggie Walter, *Social Research Methods* (Oxford University Press, 3rd ed, 2013) 16.
[4] Ibid 10.

2.4.1 EPISTEMOLOGY OF THE RESEARCH PARADIGM

Research paradigms in social science generally fall into three epistemological approaches: positivism, interpretivism and critical realism.[5] As Walliman notes, positivism is based upon realism, where the researcher believes the world exists and is knowable as it really is. It therefore favours experimental testing.[6] Interpretivism is based on a belief that different people see the world in different ways. It therefore focuses on exploring relationships and considering the consequences for action.[7] Critical realism accepts that there exists a natural order in social events but does not believe it can be detected by observing a pattern of events.[8]

As Kivunja and Kuyini note, research paradigms can be 'elusive to articulate and challenging to apply,'[9] and this is especially so with the phenomenon of conscience. This study is anchored to a discourse, to be discussed in chapter 3, which is predicated on objective truth about right and wrong. However, in this discourse, conscience is described as the 'perceptible and demanding presence of the voice of truth in the subject himself.'[10] So, whilst this discourse believes that acting against conscience causes negative sense experience and harm to the person, the person must firstly judge the particular action to be right or wrong.[11]

The quantitative studies reviewed in chapter 5 demonstrate that many doctors believe they can facilitate a service they morally object to with a clear conscience, but their process for determining this is unclear. This rendered some of the results of studies reviewed in that chapter to be confusing. A study that seeks to know what doctors believe about abortion, and how it influences their praxis and interacts with domestic law, must use 'meaning oriented' methodologies to understand the meanings participants assign to this phenomenon. This study falls, therefore, within the interpretive paradigm.

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[5] See, eg, Nicholas Walliman, *Social Science Research Methods* (Sage, 2nd ed, 2016) 12.
[6] Ibid 15-18.
[7] Ibid.
[8] Ibid.
[9] Kivunja and Kuyini (n 2) 26.
[10] Joseph Ratzinger, *On Conscience: Two Essays* (Ignatius Press, 2006) 25.
[11] If there is objective truth about moral norms, there must be sources of judgment outside the subjective assessment or conscience of the individual. See Steven D Smith, 'The Tenuous Case for Conscience' (2005) 10 *Roger Williams University Law Review* 325, 328 and chapters 3 and 4 for further discussion.

2.4.2 ONTOLOGY OF THE RESEARCH PARADIGM

The interpretive paradigm has its philosophical basis in phenomenology. As Creswell notes, the purpose of phenomenology is to 'reduce individual experiences with a phenomenon to a description of the universal essence.'[12] As a philosophy it does not start its enquiry with a belief in objective reality. Rather, it commences with individual human consciousness.[13] The researcher in a phenomenological study keeps their distance and suspends all judgments about what is real and in doing so, is required to 'bracket themselves' out of the study.[14]

Phenomenological research can challenge normative assumptions about phenomena by describing lived experiences of individuals.[15]Whilst this study would appear to share this end, it does not adopt phenomenological philosophy as its ontology. This is because the purpose of the study is not to use its findings to advance a new theory about conscience. Rather, it focuses upon persons who already share a conscientious objection to abortion and interprets their attitudes and experiences against a pre-interpretive discourse rooted in ontological realism.

As noted earlier, whilst this discourse believes in objective truth about moral norms, it provides an important clarification, which is that it is in the nature of conscience to believe itself to be true. It therefore provides for the possibility of an erring conscience.[16] The person with an erring conscience must still follow it, or at least not act against it, so long as their conscience is 'certain.'[17] They should still have the same negative sense experience or moral harm if forced to act against it. Ultimately, the discourse supports the need to respect conscience formed in this way, whether or not it is judged to be correct.

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[12] John W Creswell, *Qualitative Inquiry and Research Design: Choosing Amnong Five Approaches* (Sage, 2nd ed, 2007) 58.
[13] Ibid 58-9.
[14] Ibid 60.
[15] Ibid 62.
[16] Essentially, how a person's conscience operates, and the impact on them on being denied the ability to act in accord with it, is not dependent upon whether their belief is objectively true. See chapter 3 for further discussion.
[17] See, eg, Ratzinger (n 10) 16, 28, 34. This is a complex concept that involves the concept of invincible ignorance and the duty to take steps to know the truth. See chapter 3 for further discussion.

2.4.3 METHODOLOGY OF THE RESEARCH PARADIGM

As Bryman notes, qualitative research is committed to attempting as much as possible to 'see through the eyes of the people being studied.'[18] Inductive in nature, qualitative research seeks to know more about the meaning of phenomena through description. As such, it uses various techniques to describe, decode, and translate data from a select group of persons. Unlike quantitative research, it does not require large numbers of participants to form a statistical sample. To answer the research questions and achieve the purpose of this empirical study, in depth interviews were considered the best method of collecting data.[19]

As will be discussed in 2.5, data was analysed using standard content and thematic analysis, however the method was guided by focused discourse methodology. Focused discourse methodology is appropriate for a research area where an ideology and framework for a body of knowledge and its praxis has been developed but has been subjected to fragmentation and produced counter-discourses. In such cases, whilst the discourse and counter-discourses use similar terms and concepts, they may be invested with special meanings amongst their group members. [20]

This use of language, and a common understanding of terms and concepts, can determine group membership. As Little and Lipworth note, this creates a special unity where it is apparent that one group or community differs from another.[21] They argue that unconsciously, it can shape group members' beliefs and their behaviour. Importantly for this study, focused discourse recognizes that despite sharing a common understanding of words and concepts, group members may still exhibit opposing beliefs or practice. As such, homogeneity of all beliefs is not a requirement for group membership, with 'a loose agreement' deemed to be sufficient.[22]

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[18] Alan Bryman, *Social Research Methods* (Oxford University Press, 2nd ed, 2004) 502.
[19] See, eg, Miles Little and Wendy Lipworth, *Focused Discourse: An Exploratory Essay* (Centre for Values, Ethics and the Law in Medicine, 2007) 7.
[20] Ibid 7, 12. Examples in this study include conscience, health, harm, freedom, dignity, tolerance, and accommodation.
[21] Ibid 10.
[22] Ibid 16. This accords with and accommodates the notion that a conscience can be in error, as discussed above.

Little and Lipworth describe the five phases of focused discourse:[23]

1. The emergence and demarcation of the discourse, which may derive from other discourses or overlap or have complex relationships with other discourses
2. The formalization of the discourse through key documents and texts.
3. The expansion of the discourse into other discourses.
4. The fragmentation of discourse leading to the development of counter discourses, where the meaning of common words and concepts are altered, and new paradigms in different directions are developed.
5. The aftermath in which new discourses are developed to respond to problems emerging from the fragmentation.

The Catholic Church has a long tradition of bioethical reasoning. Its roots lie in the natural law that are then enhanced by the Church's systematic and interlinked teachings on truth, conscience, freedom, human dignity, sexual activity, abortion, and complicity in wrongdoing.[24] Centring on the sanctity of human life, Catholic bioethics makes a distinct contribution to the general discipline of bioethics,[25] has developed teachings which are binding on its members regarding abortion, and produced guidance for health professionals regarding conscientious objection to participating in it.[26]

The Catholic Church is one of the only religious faith traditions that formally opposes all direct abortion.[27] Here it is an exception-less norm,[28] and under its Canon Law, members are excommunicated for procuring it, and denied access to the Sacraments of the Church.[29] Arguably, its approach to conscience *qua* conscientious objection to abortion forms a distinct discourse with its own language and definitions of terms.[30] As will be seen, the majority of study participants identified as Catholic and expressed unified attitudes, and used similar language and/or expressed the same meaning.

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[23] Ibid.
[24] See John Paul II, *Evangelium Vitae* (Catholic Truth Society 25 March 1995) [52]-[63], [68]-[74], [89].
[25] Hazel J Markwell and Barry F Brown, 'Bioethics for Clinicians' (2001) 165(2) *Canadian Medical Association Journal* 189, 189. It has also been known over the years as medical morals, Catholic medical ethics, Catholic healthcare ethics, and now Catholic bioethics.
[26] See John Paul II, *Evangelium Vitae* (n 24) [52]-[63], [68]-[74].
[27] Pew Research Center, 'Religious Groups' Official Positions on Abortion' (Web Page, 16 January 2103) <https://www.pewforum.org/2013/01/16/religious-groups-official-positions-on-abortion/>.
[28] See John Paul II, *Evangelium Vitae* (n 24) [89]. This means that there are no circumstances that can ever make abortion (meaning a direct abortion) neutral or good.
[29] See Catholic Church, *Code of Canon Law* (Libreria Editrice Vaticana, 1983) 1398. This excommunication is immediate, known as *latae sententiae*.
[30] See, eg, Markwell and Brown (n 25).

This study, however, was not confined to Catholic doctors. Indeed, non-Catholic participants shared many key concepts of the focused discourse. Importantly, they also expressed points of difference which represent counter discourses. As noted above, focused discourse expects fragmentation of views to form counter discourses which do not diminish the primary discourse. Ultimately the areas of disagreement between participants highlighted the reality of the complexity of conscience, and this assisted with practical discussions on how to manage conscientious objection in healthcare.

Focused discourse methodology differs from other methodologies used for coding responses to interviews in that it must interpret participants' language and faithfully express what they mean so others can appreciate their views. It is a more in-depth way to explore and present what particular people think. As noted earlier, whilst there may be an expected level of homogeneity in how words and concepts are used by participants, Little and Lipworth note that focused discourse makes allowances for 'wild card' responses that do not fit the discourse.[31] This very neatly aligns with a key concept in the Catholic faith of the 'erring conscience.'

This methodology suited this study, as it was anticipated that participants would have a specific understanding of terms and concepts that might differ from doctors who do not have a conscientious objection to abortion. Examples of terms include 'therapeutic' and whether it can ever include abortion on demand, and 'harm' and whether this goes outside that measured in the usual clinical way, or whether it includes offence or inconvenience when a doctor has a moral objection to abortion. Examples of concepts include what it means to 'respect the patient's autonomy,' 'block access' to abortion or 'impose your beliefs' on a patient.

It is important to note that there are at least four different types of harm that could result from violation of a doctor's conscience. Firstly, there is the harm of how one is treated for refusing to act against conscience. Secondly, there is the harm of anguish for having acted against one's conscience. Thirdly, there is the harm of having acted against one's conscience irrespective of anguish, and fourthly there is the harm one can do to oneself to stave off one's anguish. The type of harm reported by the majority of participants to the study was of the first type as very few had violated their conscience with regard to abortion.[32]

[31] Little and Lipworth (n 19) 10, 16.
[32] I would like to thank Professor J Budziszewski for his helpful comments in the examination of this thesis which has led to clarifying these distinctions.

In addition to a specific understanding of the phenomena of conscience, and terms and concepts used in medicine and abortion discourse, there is also a need to explain what is meant by terms such as 'tolerance' given the varied ways in which it may be used in discourse and political philosophy. Carson notes that formerly, a person accepted that a different view existed and acknowledged the other person's right to have a different belief without attempting to suppress that belief. Today acceptance of different views tends to occur only when a person is prepared to adopt the other person's view as correct, or at least as correct as their own view.[33]

This thesis asks the reader to adopt a richer conception of tolerance by recognizing that there is another approach to conscience, and entertain the idea that a doctor who adopts it may suffer consequences that have not been fully recognized.[34] This richer conception of tolerance reflects the *modus vivendi* form of liberalism which assumes that disagreement is a permanent state of affairs and as such, solutions must be found that allow for co-operative non-agreement. This may be in the form of reasonable accommodation. Ultimately, this form of liberalism seeks 'co-existence and harmony' notwithstanding disagreements about certain beliefs.[35]

As Benson notes, where differences are irreconcilable there may need to be a 'tactical retreat or reduction in expectations.'[36] Conscience clauses that protect doctors from having to perform or participate in abortion in a community largely supportive of abortion as lawful healthcare, would be an example of a solution for a tolerant, diverse society. The *modus vivendi* form of liberalism can be contrasted with convergence liberalism that tolerates differences on the assumption that eventually there will a rational consensus.[37] Gray warns against the latter which he describes as a species of fundamentalism.[38]

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[33] DA Carson, *The Intolerance of Tolerance* (Wm B Eerdmans Publishing Co, 2013) 3.
[34] See Bernard Haring and Valentino Salvodi (transl. Edmund C Lane) *Tolerance: Towards an Ethic of Solidarity and Peace* (Alba House, 1995) 85. Haring and Salvodi note at 85 that, 'The hard work of being tolerant is a particular aspect of the difficulty which each one of us experiences in trying to do good.'
[35] John Gray, *Two Faces of Liberalism* (New York, 2000) 105.
[36] Iain T Benson, *Living Together with Disagreement: Pluralism, the Secular, and the Fair Treatment of Beliefs in Canada Today* (Connor Court Publishing, 2012) 21.
[37] Gray (n 35).
[38] Ibid 20-1. See also the views of William Galston on the different and competing conceptions of liberalism. William A Galston, *Liberal Purposes: Good, Virtues, and Diversity in the Liberal State* (Cambridge University Press, 1991).

2.5 STUDY DESIGN

This section covers four aspects of the study design of this empirical study: the development of the data collection tool, ethical considerations, the sampling, and the method of data collection. As little is known about this sub-category of doctors with a conscientious objection to abortion, a descriptive, interpretive study was felt to be an appropriate design choice for research into the attitudes and experiences of this unique group of doctors of whom we would like to know more. The method of data collection was one-on-one interviews between the participants and the writer.

According to Kumar, interview as a method of data collection in qualitative research is very common. In fact, it is the method of choice for the interpretive paradigm.[39] Interviews permitted the collection of in-depth information on how participants feel about a range of issues related to abortion and freedom of conscience in medicine and permitted the writer to clarify nuances or inconsistencies in stated beliefs and discuss sensitive experiences. The interview mode suited this research project, which comprised only a single researcher, working part time, under time constraints and with resource limitations.

However it required the writer to have the necessary skills to establish trust with each of the participants, in order to reassure them that their very personal beliefs, as well as their lived experiences, including any uncomfortable exchanges with colleagues, supervisors and patients, would be faithfully recorded and interpreted, so that their words were not twisted.[40] In addition, the success of interviews also depended upon the 'performance' of participants, specifically their level of engagement and their ability to articulate their attitudes and experiences in words.[41]

[39] Ranjit Kumar, *Research Methodology: A Step-by-Step Guide for Beginners* (Sage, 4th ed, 2014) 193.
[40] Rosaline S Barbour and John Schostak, Interviewing and Focus Groups in Bridget Somekh and Cathy Lewin, (eds) *Research Methods in the Social Science*s (Sage, 2005) 42.
[41] Ibid 41.

2.5.1 DATA COLLECTION TOOL

For this empirical study, it was important that the writer not be bound to a set of fixed questions, important though those were to framing all the interviews. The writer needed the flexibility to explore salient themes as they arose. Interviews with doctors were therefore semi-structured and resembled more of an informal, directed discussion. This ensured that issues the writer might not have anticipated were still explored. Given the sensitive nature of the enquiry, the semi-structured format also allowed the writer to develop a rapport with the participant and establish trust and empathy with them.[42]

Prior to conducting interviews, the writer drafted an interview guide as the data collection tool. The purpose of the interview guide was to act as an aide memoire for the writer during the interview in order to ensure that data was captured that could answer the research questions.[43] It also helped to streamline the process of directed discussion and prompted the writer to explore the same issues with each participant, subject to the participant's particular experience level. The final interview guide used in the interview process is reproduced in the appendices at page 333.

Ultimately, the interview guide contained ten questions flowing from the three research questions. Questions were drafted in an open-ended style to allow the participant to elaborate on their responses and allow the writer to probe further and take the discussion in different directions. Given the lack of consensus in doctors' attitudes to conscientious objection generally (as will be discussed in the empirical studies reviewed in chapter 5) no assumptions were made within the interview guide about a participant holding certain beliefs or behaving in ways consistent with those beliefs.

[42] Zakiya Q Al-Busaidi, 'Qualitative Research and its Uses in Healthcare' (2008) 8(1) *Sultan Qaboos University Medical Journal* 11, 14.
[43] Michael Quinn Patton, *Qualitative Evaluation Methods* (Sage Publications, 2002).

It was anticipated that some participants' positions on abortion might reflect a more nuanced or even inconsistent position compared to the discourse to be described in chapter 3 Alternatively, it was anticipated that whilst some participants might hold a strong belief about these matters, they might not have always applied those beliefs to their actions. The questions made provision for these responses, prompting the writer to ask the participant to clarify the context of the situation, and explore the impact of the participant's action or inaction against conscience on them.

An example of an open, compound question built into the interview guide is set out below. This extract focuses on the issue of referring a patient seeking abortion and as can be seen, it first seeks to clarify whether the participant has in fact referred a patient seeking abortion to another doctor and if so, the context of that referral:

> *Are there any circumstances where you have referred a patient seeking abortion on to another doctor?*
>
> - *What was the context in which this referral occurred?*
> - *What did the referral process involve?*
> - *Why did you make this referral?*
> - *How do you feel about having made this referral?*

At the time this data collection tool was drafted, the law in New South Wales had not yet been changed. However, a 2014 Department of Health policy made the 'mandatory referral' model an obligation on doctors working in government health facilities.[44] With the strong push to de-criminalise abortion law in Australia, which was completed in 2021 with South Australia's *Termination of Pregnancy Act,* this line of inquiry was drafted in anticipation of the law changing in New South Wales prior to the completion of this study so that responses would remain relevant. The law formally changed in 2019 with the *Abortion Law Reform Act.*

[44] Michael Quinlan, 'When the State Requires Doctors to Act against Their Conscience: The Religious Freedom Implications of the Referral and the Direction Obligations of Health Practitioners in Victoria and New South Wales' (2016) 4 *Brigham Young University Law Review* 1237, 1249-51. Quinlan highlights at 1251 that whilst this policy is not legislation, it was in effect a mandatory obligation on doctors, who could be the subject of a complaint to the relevant disciplinary body, and on government health facilities where its observance was a condition for funding. Hence, at the time participants were interviewed, the policy can be described as 'soft law.'

Nine months before interviews commenced, the interview guide was subjected to a pilot test on two doctors. This enabled the writer to critically evaluate whether the questions made sense to the participants, whether additional questions were needed, and whether the ordering of questions was appropriate.[45] It also assisted with working out how best to conduct the interview and establish trust with participants, what concerns participants might have to being involved with the study, and how to address any concerns about the power structure in the relationship with the writer.

2.5.2 ETHICAL CONSIDERATIONS FOR DESIGN

The Human Research Ethics Committee, the University of Notre Dame Australia approved this study. This section addresses how potential harm to participants was reduced or eliminated. These included social harm in the form of reputational damage and social stigma from being identified as a conscientious objector, psychological harm from discussing the issue of abortion and their experiences with acting against their conscience, and legal harm for participants for failing to discharge their duty to refer a patient seeking abortion to a doctor they know does not have a conscientious objection.

In regard to social harm, it was clear from the pilot study, and informal discussions with doctors prior to commencing the study that participants were very likely to be concerned about being identified in the wider community as having a conscientious objection to abortion. That concern was based on what they perceived to be a lack of protection in the law, and the risk of reputational damage and stigmatisation by colleagues and employers, as well as concerns of being subject to fake requests by patients for abortion referrals in order to report them to the Medical Board.

[45] Creswell (n 12) 133.

These concerns were considered to be legitimate concerns. As such, features were built into the study design to ensure confidentiality and minimise the ability to identify participants, or third-party actors in their interactions, through deductive reasoning. With regard to the participants, the study collected no direct identifiers, such as their name, e-mail, address, telephone number, place of employment, or indirect identifiers, such as sex, age, or postcode. In order to minimise the risk of re-identification, participants were given a pseudonym starting from 'Doctor # 1'.

When regard to patients, colleagues, or employers, the writer took care not to record direct or indirect identifiers of those persons other than what was necessary to make sense of their inclusion. This included their relationship to the participant and basic medical facts relevant to the interaction. The writer discussed minimum levels of description with both the participant and her supervisors. These features affect the study's generalisability, but were necessary to attract participants to the study, establish trust, and create the best conditions within which to obtain rich data.

In regard to potential psychological harm, this was thought possible if the participant had performed or referred for abortion in the past or experienced remorse by believing they had betrayed their beliefs about abortion out of a fear of reprisals from employers, or loss of social status with colleagues. To minimise any risk of distress in revealing such details as a result of participating in the study, the Participant Information Sheet provided a clear summary of the types of issues that were to be explored so participants could make an informed decision about participation. Written informed consent was also obtained.

The Participation Information Sheet and Consent Form are reproduced in the appendices at pages 336-40. The written Consent Form followed the verbal consent process, where the researcher explained the purpose of the study, the participant's role, and background, and referred to aspects of the Participant Information Sheet that was already provided to them. Participants were free to withdraw from the study up until the point when the data was being analysed. Research outcomes were made accessible to them by an agreement to email the chapter containing analysis of the results, after the thesis was submitted.

In regard to potential legal harm, this would only arise where a Victorian participant disclosed 'illegal' behaviour that was recorded in the thesis and could be used against the participant and reported to the Medical Board, exposing them to disciplinary action. As has been observed elsewhere, whilst there is a statutory duty in Victoria for doctors with a conscientious objection to abortion to refer women seeking lawful abortion to a doctor who does not have a conscientious objection, the scope and content of this duty is unclear and has not been judicially interpreted by the courts.

It is not for the writer to form a judgment as to whether or not a participant has or has not, divulged 'illegal' behaviour, nor is there any ethical obligation on the writer to act in any way on this information to the potential detriment of the participant. In any case, the limited collection of direct or indirect identifiers of participants and third parties would make it impossible to form a judgment that imposed a duty to report them. Therefore, at the time the application was made, the likelihood of a participant suffering legal harm as a result of their participation was considered by the Human Research Ethics Committee to be unlikely.

2.5.3 SAMPLING

The sampling in this study was determined by the aims of the study and the practicalities of having a single researcher. We do not know how many doctors in the two states targeted of New South Wales and Victoria have a conscientious objection to abortion. We do not know whether these doctors with a conscientious objection to abortion share homogenous views about abortion and conscience, mandatory referral, and the need for conscience protection in the law. Essentially, there is no reliable profile for the Australia doctor with a conscientious objection to abortion.

This study comprised a biased, non-random sample. In order to address the central research question, the study had two criteria for participation: that doctors self-identify as a doctor with a conscientious objection to abortion, and that they work in either New South Wales or Victoria at the time of the interview. Apart from those criteria, four variables were collected from the participants so as to ascertain patterns of association. The chosen variables were the doctor's area of specialisation, their geographical location, their years in practice, and their religious affiliation.

By way of background, surgical abortions are performed in both New South Wales and Victoria at private abortion clinics, with a limited number in public hospitals. Alternatively, medical abortions performed at home are available in both states, after a licensed health professional prescribes abortifacient drugs. Up until 2019, medical abortion could be arranged via telemedicine, with the drugs sent to the patient in the mail, so long as the woman was less than nine weeks pregnant and the patient lived within a certain distance from a hospital. No referral is required for either method of abortion.[46]

Therefore, doctors who might be asked to facilitate abortion include general practitioners asked to provide information on abortion including referrals to facilities that will perform abortion either medically or surgically, as well as private consultants specialising in obstetrics. Doctors working in the hospital system, especially in the emergency, paediatric, surgical, or obstetrics and gynaecology departments may also have exposure to patient requests for abortion. This group includes consultants, registrars training to become consultants, and residents and interns rotating to departments and undecided upon an area of specialisation.

Accordingly, given this context, the variables of specialisation, geographical location, and years in practice were collected on the suspicion they might impact upon the conscientious objector in so far as what they might be asked to do, and what challenges might exist for them in achieving an accommodation of their conscientious objection. Participants were categorised as general practitioners, hospital doctors or consultants with 5 years' experience, between 5-15 years' experience, or more than 15 years' experience, and working in either a metropolitan, regional, or rural area.

There was no requirement that participants to this study belong to these particular groups or that they have experience with disclosing or exercising their conscientious objection to abortion in the workplace. The opinion of doctors whose conscientious objection had not yet been tested in practice, were still considered to be relevant to this study. For those participants, the focus of discussion shifted to what drove their hypothetical concerns. Ultimately, fears and concerns about hypothetical situations were separated in the findings from instances of actual harm or burden.

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[46] Barbara Baird, Decriminalization and Women's Access to Abortion in Australia' (2017) 19(1) *Health and Human Rights* 197.

As will be discussed in chapter 5, previous overseas quantitative studies on doctors' attitudes to conscientious objection generally or to abortion specifically, consistently found that the religious affiliation of participants was associated with having a conscientious objection to a specific service such as abortion or another morally controversial service, as well as referral to a doctor who does not have a conscientious objection to the service. As a result of its reported relevance in those studies, information about the participant's religion was another indirect identifier collected.

Sample size is of less relevance to qualitative research compared to quantitative research.[47] This is because its purpose is not necessarily to count the frequency with which participants display a particular attitude or experience, but to explore the diversity of attitudes and experiences within this unique category of doctors. The researcher anticipated that 10 to 15 participants from each of the two states was an achievable target to achieve in terms of resources and the timeframe to complete this thesis. Most importantly, it was considered to be an appropriate number of participants for thematic saturation.

Participation in this study was voluntary. None of the participants were paid for their time. To locate potential participants, the researcher used a mixture of judgment sampling and the snowballing technique.[48] With the Catholic Church's clear moral prohibition against abortion, an assumption was made by the writer that doctors who identified as Catholic might be more likely to self-identify as having a conscientious objection to abortion, compared to doctors belonging to other religious traditions that might not have the same level of formal prohibition against abortion.

With a long background as a medical lawyer, the writer used her professional and personal connections to recruit several Catholic doctors to invite them to participate in the study. The writer's co-supervisor used his connections within the Church of Jesus Christ and Latter-Day Saints ('CJCLDS'), to likewise gauge interest in that community. This judgment sampling led to snowballing recruitment. The writer then gave a number of presentations on abortion and conscientious objection to groups including doctors in order to advertise the study in person.

[47] Creswell (n 12) 125-9.
[48] See, eg, Kumar (n 39) 244-5.

Finally, the writer approached leaders of relevant organizations to discuss the study with them, explain the likely uses it might have, and seek their assistance with advertising the study to potential participants through their networks.[49] Leaders were provided with the Participant Information Sheet and Consent Form and were asked to forward these documents to their membership base, or to discretely e-mail selected members asking them to consider participating in the study, and to contact the writer directly using the details provided in the Participant Information Sheet.

2.5.4 METHOD FOR DATA COLLECTION

The pilot test referred to in 2.5.1 above revealed that confidentiality was likely to be a significant concern with doctors, especially those in Victoria where referral to a non-objecting doctor was a statutory duty at the time of the study. Audio recording of interviews was seen as a likely deterrent for those who might otherwise be willing to participate. The writer tested two methods of manually recording responses; being longhand entries and computer note taking. The writer found that both methods were effective, with the writer preferring computer note taking.

As will be discussed in 2.7, the credibility of data in this type of study depends upon accuracy of recording responses. This is especially so where the researcher intends to use verbatim quotations to support interpretation. Accordingly, with the limitations of manual recording, additional measures needed to be taken to ensure the credibility of the data. It was decided that the writer give each participant a transcript of their interview within 24-48 hours of its completion, with the participant given time to review and amend the document before returning it to the writer in finalised form.

[49] These organizations included 'Solidarity', a Sydney based group with an affiliation in Melbourne that was formed in 2008 to educate and empower health professionals on conscientious objection; the Christian Medical and Dental Fellowship Association; Doctors for Conscience; Family Life International; the National Civic Council; and the Australian Catholic Medical Association.

The requirement that participants confirm and verify their responses as recorded by the writer in the transcript of their interview added inconvenience to the study but increased the data's credibility and reliability. It also provided an opportunity for more thoughtful responses from participants. During pilot testing of the interview guide, it was apparent participants had not given much thought to some issues. They appreciated the opportunity to reflect on and make changes to their responses, so they more properly reflected their considered opinion on any particular issue.

The pilot study also tested whether there was any difference in the quality of responses when the interview was conducted by the writer in person or by telephone**.** The writer perceived no issues with exploring issues or establishing rapport with the doctor during a telephone interview. Considering time pressures on participants, and their potential preference for an after-hours interview, together with time and resource limitations on the writer for travel to conduct interviews, the offer of a telephone interview was seen as a positive incentive to better engage participation by interested doctors.

Potential participants who responded directly to the writer's information about the study were sent an e-mail attaching the Participant Information Sheet and Consent Form. The Participant Information Sheet explained the aims of the study, the steps taken to ensure confidentiality, the types of questions to be explored in the interview, and any harm or inconvenience the participants might be exposed to in participating in the study. The Consent Form confirmed the participant could withdraw from the study up to the point of data analysis and required the participant's signature.

Doctors interested in knowing more about participating in the study were then invited to contact the writer by email to register their interest, ask any questions, and arrange a mutually convenient time and place to meet the writer for an in-person interview, or an interview via skype or the telephone. In person interviews took place at a location approved by the participant, such as at the School of Law, Sydney, the University of Notre Dame Australia, the doctor's place of work or their home, or a café in a location where the participant felt most comfortable having this kind of an open discussion.

On average, the duration of interviews with participants was around 90 minutes. The writer manually recorded responses on a lap top computer, capturing verbatim quotations. The typed summary of the interview was reviewed and verified by the participant. As noted, participants were permitted to reflect on and amend responses, if appropriate. The writer kept a diary during the interview process to note her impressions of potential trends in participants' responses. This progressive commentary on participants' responses assisted the writer with shaping discussions for the next interview.

The contact details of participants such as telephone numbers and email addresses were collected and sorted in an excel spreadsheet and cross referenced to their unique identifier as 'Doctor # X.' These details, together with the de-identified summaries of the interviews, were kept by the writer on a computer with password protection, backed up by an external hard drive. No identifiable data will be stored following the completion of this study and submission of this thesis. At the completion of the thesis process, all participants' contact details will be deleted from the writer's computer and hard drive.

2.6 DATA ANALYSIS

Data analysis involved a mixture of thematic analysis and content analysis, using recognised, standard protocols.[50] Both content analysis and thematic analysis aim to examine narrative materials, break the text into smaller units, and then subject those units to descriptive treatment.[51] Whilst these methods of data analysis may be described as simple, it does not necessarily follow that the findings are of low quality. In fact, identifying themes requires careful consideration and reflection, frequent review of the data, and openness to recognising different perspectives.[52]

[50] See, eg, Simeon J Yates, *Doing Social Science Research* (Sage, 2004) 204-10.
[51] Mojtaba Vaismoradi, Hannele Turunen and Terese Bondas, 'Content Analysis and Thematic Analysis: Implications for Conducting a Qualitative Descriptive Study' (2013) 15 *Nursing and Health Sciences* 398, 400.
[52] Ibid 403-4.

The writer chose not to use one of the computer packages available for qualitative analysis. Whilst such packages assist with managing large amounts of data and text, as Bryman notes, reliance on a computer program can detach the researcher from the data and lead to a more quantitative analysis, focusing on counting the number of times a theme is raised, rather than looking out for the diversity or nuance in responses.[53] The writer did, however, make use of Excel spreadsheets to organise data that could be described quantitatively, so as to identify any patters or associations.

In addition, the writer used computer graphics to help organise data into categories or themes based on characteristics that emerged with the analysis of each interview. This visual representation of the emerging categories and themes in the form of hierarchical and relational diagrams assisted the writer with decisions about whether to re-name or re-organise categories and themes, and to observe when a category or theme seemed significant enough to be upgraded to global status or whether it contained enough diversity to form become a new category or theme.

2.6.1 CONTENT ANALYSIS

According to Vasimoradi, Turunen and Bondas, content analysis is an appropriate form of analysis where there are no previous studies on the phenomenon. It is used to report common issues in data.[54] Therefore its analysis permits both a qualitative and quantitative approach. As it focuses on textual data, it can identify units of analysis or manifest content that does not require anything in the way of interpretation beyond surface analysis of the text.[55] In this way, content analysis allows for the frequency of responses to common issues to be identified, counted, and visually recorded in a table and presented as part of the findings of the study.

[53] Bryman (n 18) 202.
[54] Vaismoradi, Turunen and Bondas (n 51).
[55] Ibid 403.

In this study, the interview guide contained questions about attitudes to key issues. Some of these issues could be answered in a binary way (e.g., yes/no, agree/disagree, all/exceptions). Examples include whether the participant objected to all abortion or made exceptions, or whether the participant objected to providing the patient with a referral to obtain an abortion. As the relevance of these issues had been pre-determined from the literature review, these issues were re-named as categories. This process represented the **first step** in the content analysis.

The **second step** was to perform open coding of the textual data in order to open up the inquiry and ensure that additional categories that emerged from the data were not excluded merely because the writer had not pre-identified them in the interview guide.[56] The transcripts were read as a whole to become familiar with their content. Additional categories that could be responded to in a binary way were noted and then added to the list of categories. The **third step** was to review the list of categories and decide which were relevant to the purpose of the study and would be reported on.

The **fourth step** in content analysis was to list the final categories in an Excel spreadsheet, insert each participant's response to them, and then add the 5 variables collected during interview: their state (New South Wales or Victoria), their specialty (general practice, public hospital or private consultant), their religion (Catholic, Evangelical Christian, CJCLDS, Seventh Day Adventist or no religion), their geographical location (metropolitan, regional, rural), and their years in practice (less than 5 years, between five and fifteen years, and over fifteen years).

The **fifth step** was to perform cross sectional analysis. Whilst no causation can be implied from this data given the sample size,[57] the data was capable of a cross sectional analysis by comparing and contrasting participants' binary responses to the 5 variables in order to determine any patterns or associations. Essentially, a high frequency of the same response by participants on a particular issue was considered to be an association. In addition, the data was analysed for any patterns where participants shared more than one belief and shared other variables.

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[56] Ibid 402.
[57] Bryman (n 18) 42.

The **sixth step** in content analysis was to review the findings from the quantitative studies reviewed in chapter 5 and consider whether any statistically significant causal relationships reported on therein, such as the participant's religion, was apparent in an association or pattern identified in step five. In addition, as noted in 2.2 above, one of the research questions asked whether or not there was an association between participants' attitudes or experiences based on the state in which they practice. Accordingly, primary focus was placed on any associations or patterns in this area.

The **seventh and final step** was to decide how to present and interpret the relevant results from content analysis. As an Excel spreadsheet was used to record the data from content analysis, it was possible to convert the findings into graphs and charts in order to visually demonstrate the quantifiable data. A story line was then created for each table, graph, and chart to explain the findings. This visual representation of the data assisted the researcher with the next step in data analysis, which was thematic analysis, as it identified areas that required detailed conceptual analysis.

2.6.2 THEMATIC ANALYSIS

Thematic analysis is a more complex process than content analysis. This is because thematic analysis can consider both manifest and latent themes which are present through the entirety of the data. Importantly, a theme is not dependent upon how often it is mentioned in the data. Rather a theme arises where it is determined to be important to the research questions. It is purely qualitative analysis and analyses the data in detail, taking into account nuance and hidden meaning in text. It is also non-linear in that analysis requires the writer to continually re-visit the data.[58]

[58] Ibid 403.

It was important to explore any concepts behind manifest content found in the content analysis and to identify any latent content that was not found within the textual data.[59] In using axial coding, the results of open coding via content analysis were triangulated. This increased the validity of the findings. The writer searched for concepts hidden beneath the text. In line with focused discourse methodology, it required the writer to demonstrate her understanding of the beliefs held by the discourse of this community and interpret what participants were trying to convey beyond their words.

The **first step** in thematic analysis of this data was to examine the interviews one by one and identify significant statements. These statements were underlined, and each piece of text was given a provisional code name. During this step, the writer maintained a diary of her first impressions of each transcript and made descriptive notes about each of the coded pieces of text. As the process continued, the **second step** was to re-review the previous few interviews, compare the coded text, and note in the diary whether concepts were emerging that were relevant to the research questions.

The **third step** was for the writer to decide formally whether a concept was a theme that could be described and broken down into dimensions. Dimensions might include conditions for an attitude or belief, consequences of an action, or the actors involved in any significant conversations. The writer used standard computer applications to draw diagrams to organize themes, note their dimensions, and work out whether there was a relationship between themes that indicated a global theme, or whether it was a stand-alone theme with sub-themes flowing from it.

The **fourth step** was for the writer to step back and conceptualize the data. Final decisions were made about what themes to retain. These decisions were based upon whether the theme was relevant to the study, whether it helped answer the research questions, and whether it achieved the study's purpose. It was important for the writer to identify new knowledge from the responses that might not be explained by the discourse's understanding of the phenomenon but by domestic factors (such as the law) and be able to explain any 'wild card' responses that deviated from the discourse partially or entirely.

[59] Ibid.

The **fifth step** in the thematic analysis was to write up the findings from the thematic analysis by identifying the global themes, themes, and sub-themes, explain what each meant, and support their interpretation with appropriate verbatim quotations from selected transcripts. The transcripts from each interview appear as appendices to this thesis. The thematic analysis findings were then cross-referenced with the findings from the content analysis. This helped create a combined, triangulated analysis, which provides a thorough analysis of the phenomenon.

The findings of this study are set out in chapter 6. The findings from content analysis are presented first, using graphs to describe the participants' responses and demonstrates binary answers to three common attitudes and four common experiences that arose in interviews. The findings based on thematic analysis are then described. Thematic analysis identified seven distinct themes illustrated by key verbatim quotations from the interviews. The final section of this chapter focuses upon the strengths and limitations of the findings. It covers credibility, generalisability, and dependability.

2.7 STRENGTHS AND LIMITATIONS OF THIS STUDY

By its nature, qualitative research cannot rely upon standardised instruments such as those used in a scientific experimental study.[60] Additionally, the criteria of objectivity, reliability, and validity, which apply in quantitative research, are replaced in qualitative research with credibility, generalisability and dependability and the need for the researcher to use triangulation techniques to increase the confidence in the results of a qualitative study.[61] This section considers each of the accepted requirements of a qualitative study and identifies both its strengths and weaknesses in this study.

[60] Kumar (n 39) 218.
[61] YS Lincoln and EG Guba, *Naturalistic Inquiry* (Sage Publications, 1985) 314.

2.7.1 CREDIBILITY

When it comes to credibility, Lincoln and Guba note that the most important way of establishing credibility in qualitative research is to ensure that participants to the study verify the contents of any interview transcript.[62] As noted in 2.5.4 above, this was one of the steps in the data collection method. In addition, focused discourse methodology mandated triangulation by requiring open coding using the text of the interviews, followed by axial coding that searched for the meaning behind the words. These steps increase confidence in the credibility of this study's findings.

2.7.2 GENERALISABILITY

The ability to generalise the findings of this study to other contexts is a clear limitation of this study's design and reflects the sensitive nature of the research and concerns of participants of reprisals and the need for anonymity. Limited information was obtained from participants regarding both themselves and the settings in which experiences occurred. In addition, the sampling was small when compared to large scaled quantitative studies of doctors that have occurred overseas. Having said this, the smaller sample size permitted the collection of richer, more in-depth knowledge that would not have been possible in a large-scale quantitative survey questionnaire.

2.7.3 DEPENDABILITY

The dependability of the findings is a matter for the prudential judgment of the reader. As noted in chapter 5, the transferability of results of quantitative studies on hundreds of doctors is limited by matters such as the domestic legal framework regulating abortion and conscientious objection, together with matters such as the organisation of a country's health care system such as whether referrals from specific doctors are required in order to access abortion, and whether or not patients can choose their doctor or are assigned a doctor based on their geographical location.

[62] Kumar (n 39) 220.

The study was designed to be cross-sectional in order to answer the third research question, 'Is there an association between the attitudes or experiences of these doctors based upon the state in which they practice medicine?' As noted earlier, any patterns or association between variables cannot be used to denote a causal connection.[63] However, the finding of an association is still of interest and forms a solid basis for a recommendation that there be a further, larger scale study using quantitative methodology on doctors with a conscientious objection to abortion.

As has been noted elsewhere, the problem of how to properly balance the preservative freedom of doctors who have a conscientious objection to abortion with the patient's license to seek the assistance of the medical profession to affect a timely abortion, is complex where there are disputes about fundamental matters such as the value of freedom in society, the ethics of abortion, and the purpose of healthcare. This study addresses the perspective of its participants. Other issues should be researched to properly inform debate so as to produce public health law and educational changes that will benefit the common good.

2.7.4 ADDITIONAL LIMITATION OF THIS STUDY

When it comes to the exploration of harm that arises from a person violating his or her conscience, the data generated from interviews was restricted to the harm participants reported from their experiences. Most of the data from the interviews was useful in exploring and documenting the harm that occurs when a person refuses to act against conscience. As very few participants reported acting against their conscience, the ability to explore the harm that may arise from violating one's conscience was necessarily somewhat limited. A specific study made up of participants who have acted against conscience would provide another set of data to explore more fully these types of harm further.

Notwithstanding the above explanation, given the thesis is underpinned by a specific theory of conscience that perceives several types of harm that may flow from violating one's conscience, it is appropriate to acknowledge that the lack of data on all the types of harm that can arise in this situation is a limitation of this study.

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[63] Bryman (n 18) 42.

Having set out details of the research design and methodology, this thesis now sets out the theoretical basis for its focused discourse methodology. As discussed, the discourse to which this thesis is anchored to is a belief in objective truth about right and wrong. The theoretical basis of this discourse requires an explanation of key concepts including the three dimensions of conscience under the natural law theory with the enhancements made by the Catholic Church on conscience per se, abortion per se, and then conscientious objection by health professionals to abortion including the vexed issue of moral complicity in abortion.

CHAPTER THREE

THEORETICAL ANALYSIS: CONSCIENCE *QUA* CONSCIENTIOUS OBJECTION

> Whoever equates conscience with superficial conviction identifies conscience with a pseudo-rational certainty, a certainty that in fact has been woven from self-righteousness, conformity, and lethargy. Conscience is degraded to a mechanism for rationalization, while it should represent the transparency of the subject for the divine, and thus constitute the very dignity and greatness of man. The reduction of conscience to subjective certitude betokens at the same time a retreat from truth.[1]

3.1 INTRODUCTION

In the bioethics literature, a conscientious objection in healthcare is commonly defined as the 'deeply held moral or religious belief of a health professional.'[2] However over ten years ago, Sulmasy noted how odd it was that despite all the discourse on conscientious objection in healthcare, little time had been spent on discussing what conscience is.[3] Arguably, this observation remains pertinent today when one reviews both literature and laws that propose or impose duties and obligations on health professionals who conscientiously object to participating in a lawful health service.

This is not to suggest that there is a general absence of scholarly debate about conscience and conscientious action. Rather, in the published bioethics literature on conscientious objection in healthcare, there is rarely an acknowledgement of the complexity of conscience or of the contributions that can be made by philosophy and theology, particularly natural law theory, which provides guidance on the workings of conscience and degrees of moral complicity.[4] Instead politicisation of the status of the service in issue can overshadow discussions on how to manage conscientious objections.[5]

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[1] Joseph Cardinal Ratzinger *On Conscience: Two Essays* (Ignatius Press, 2006) 21-2.
[2] See, eg, Australian Medical Association, 'Conscientious Objection' (2019) <https://ama.com.au/system/tdf/documents/AMA%20Position%20Statement%20on%20Conscientious%20Objection%202019.pdf?file=1&type=node&id=50323>.
[3] Daniel P Sulmasy, 'What is Conscience and Why Is Respect for It So Important?' (2008) 29 *Theoretical Medical Bioethics* 135, 135.
[4] See, eg, John Cottingham, 'Conscience, Guilt and Shame' in Roger Crisp (ed) *The Oxford Handbook of the History of Ethics* (Oxford University Press, 2013) doi:10.1093/oxfordhb/9780199545971.013.0034: 1-16. At 2, Cottingham suggests that increasing secularism in philosophy leads to a mistrust of any frameworks about morality that are linked with religion and associates with the notion of 'sin.' Cf Xavier Symons, *Why Conscience Matters: A Defence of Conscientious Objection in Healthcare* (Routledge, 2022).
[5] Arguably, this has occurred with abortion and will be discussed further in chapter 4.

The relativist approach to conscience based on subjective certitude rejects the existence of objective moral truth or does not concern itself with knowing whether it exists.[6] Ultimately, it obeys other sources such as the general consensus of a profession or the law.[7] As noted in chapter 1, in the healthcare context, tolerance and epistemic modesty may persuade the doctor to accept the possibility that an opposing position is as equally true as theirs.[8] Notwithstanding their troubled conscience, the doctor with an objection may facilitate the patient's choice so as to avoid causing the patient harm by refusing to assist them.[9]

Crucially however, for those who believe there is objective moral truth, a very different concept of conscience and human dignity emerges with arguably different consequences to the person. Specifically, the natural law concept of conscience posits that humans are rational beings with a common nature oriented towards the pursuit of good and the avoidance of evil.[10] Our human reason, it is argued, allows us to know the moral law, which is etched into every heart, and commands us to obey its call.[11] As a result, a doctor acting against conscience experiences a type of harm *because they are acting against their reason*.

This chapter provides the pre-interpretative framework needed for analysis of findings from this thesis' empirical study of 35 doctors with a conscientious objection to abortion. Starting with the three dimensions of conscience, key assumptions and principles will be identified and explained as far as possible. However, this chapter will not critique distinctions, qualifications, or academic disputes on the aspects of natural law moral philosophy it touches upon. This is because it is considered to both be beyond the scope of this thesis, and unlikely to better assist the reader to understand the findings of the study.

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[6] See, eg, John Paul II, *Veritatis Splendor* (Vatican City, 6 August 1993) [32]; Ratzinger (n 1) 22.
[7] See, eg, Daniel Sulmasy, 'Conscience, Tolerance and Pluralism in Health Care' (2019) 40 Theoretical Medicine and Bioethics 507, 514.
[8] DA Carson, *The Intolerance of Tolerance* (Wm B Eerdmans Publishing Co, 2013) 11.
[9] See, eg, Julian Savulescu, 'Should Doctors Feel Able to Practise According to Their Personal Beliefs and Values? – NO' (2011) 195 (9) *Medical Journal of Australia* 497, 497.
[10] This is the primary precept of the natural law known as synderesis. See, eg, Robert J Smith, *Conscience and Catholicism: The Nature and Function of Conscience in Contemporary Roman Catholic Moral Theology* (University Press of America, 1998) 4. See also, Tom Angier, Iain T Benson and Mark D Retter (eds*) The Cambridge Handbook of Natural Law and Human Rights* (Cambridge University Press, 2022).
[11] See Pope Leo XIII, *Liberatas* [8] < http://www.vatican.va/content/leo-xiii/en/encyclicals/documents/hf_l-xiii_enc_20061888_libertas.html>; *Catechism of the Catholic Church* (St Paul's Publications, 2nd ed, 2009) [1954].

As noted in chapter 2, most of the participants to the study were Catholic and the Catholic Church has specific, interlinked teachings regarding conscience, abortion, and conscientious objection to abortion. Opposing all direct abortion as an exception-less norm, members are immediately excommunicated for procuring it, and are denied access to the Sacraments of the Church.[12] Members are under a 'grave and clear obligation to oppose [laws permitting abortion] by conscientious objection.'[13] As will be seen in chapter 6, all Catholic participants to the empirical study adopted the Church's approach to these issues.

Accordingly, the Catholic Church's position on conscience, abortion and conscientious objection to abortion formed the focused discourse on which data was analysed. Non-Catholic participants shared many of the same beliefs on conscience although there were some points of difference regarding moral complicity in abortion. As noted in chapter 2, the presence of diverse attitudes within a group does not discredit the primary discourse. Additionally, fragmentation of beliefs is presupposed by the Church's teaching on the erring and informed conscience which in turn supports an inclusive approach to respecting conscience.

This chapter provides an overview of the focused discourse for this thesis' empirical study. That discourse is best described as a classical natural law approach to conscience *qua* conscientious objection to abortion as understood by the teachings of the Catholic Church.[14] Ultimately, it aims to explain how in the context of abortion, doctors who adhere to this discourse may be harmed by being forced to act against conscience. It does not seek to persuade the reader that the discourse is correct, just that it exists and can provide an explanation for how and why some of these doctors who adhere to it may experience harm.

[12] See Catholic Church, *Code of Canon Law* (Libreria Editrice Vaticana, 1983) [1398]. The term direct abortion is defined as 'abortion willed either as an end or a means to an end.' This excommunication on members is immediate and known as *latae sententiae*.
[13] John Paul II, *Evangelium Vitae* (Catholic Truth Society, 25 March 1995) [73].
[14] See, eg, Erich Przywara, *A Newman Synthesis* (Sheed and Ward, 1930) 5-14.

It is worth noting here that as the focused discourse for this study is based on the systematic teachings from an organised religion, there is a legal cross over between the notion of conscience and religion.[15] However despite the religious aspect, there is no essential need for any doctor who adopts this discourse to be Catholic and/or believe in God. This is supported by the fact that the one participant to the study who identified as being of no religion, adopted the focused discourse of this study in its entirety.

A common metaphor for conscience is that of an inner voice calling us to obedience. Strohm describes conscience as a bridge between our inner convictions of right and wrong and our actions, with speech being its medium.[16] A fond literary example for children is the character of Jiminy Cricket in 'The Adventures of Pinocchio.'[17] However the natural law approach to conscience is far more complex. As Hoffman notes, sophisticated and systematic, 'conscience is an organ, not an oracle'[18] and has a cognitive dimension based on reason rather than on 'affection of the will or our feelings'.[19]

[15] This will be discussed further in chapter 4.
[16] Paul Strohm, Conscience, *A Very Short Introduction* (Oxford University Press, 2011) 77, 83.
[17] Carlo Collodi, *The Adventures of Pinocchio* (Penguin Classics, 2011).
[18] Ratzinger (n 1) 60.
[19] Tobias Hoffman, 'Conscience and Synderesis' in Brian Davies (ed) *The Oxford Handbook of Aquinas* (Oxford University Press, 2012) DOI: 10.1093/oxfordhb/9780195326093.013.0020:1-13, 9. The philosophy of 'feelings based evaluation' is called emotivism and has been said to be the theory that typifies approaches to ethics today. It is in stark contradiction and is fundamentally irreconcilable with traditions, like Catholicism, that base their moral teleological understandings on natural law with its focus on shared understandings of cosmos, human nature, human reason, metaphysics and education within that tradition; a tradition focused essentially upon virtues rather than values. See, Alasdair MacIntyre, *After Virtue: A Study in Moral Virtue* (Notre Dame University Press, 3rd ed, 2007); and George Grant, *Philosophy in the Mass Age* (Copp Clark, 1966).

Whilst there is no one theology of conscience promoted by the natural law theories, St Thomas Aquinas' views on the operation of conscience, particularly his explanation of the dimensions of conscience, are broadly representative of, and endorsed by, the Catholic intellectual tradition.[20] Aquinas' systematic approach to conscience builds upon Aristotle and others,[21] and has undergone further development,[22] but ultimately Aquinas' contribution to the natural law understanding of conscience is not confined to Catholic theology, and has had a significant impact on Western thinking generally.[23]

This section will describe, discuss, and apply key concepts from the three dimensions of conscience under the classical natural law theory of conscience to the issue of conscientious objection by doctors to abortion. It will also consider how the natural law's guidelines on moral complicity in wrongdoing may apply to a doctor who refers a woman seeking abortion to a doctor they know does not have a conscientious objection to abortion, and a doctor who provides information to a woman of a third-party organisation who then provides the woman with assistance to locate an abortion provider.

[20] Robert J Smith (n 10). Cf David Hume, 'Moral Distinctions Not Derived from Reason' in Russ Sahfer-Landau (ed), *Oxford Studies in Metaethics* (Oxford University Press, 2014*)* 151, 151. Whilst some may argue that Hume's moral theory represented a middle ground which insisted upon the fact/value dichotomy rather than subjectivism, Alasdair MacIntyre in *After Virtue* (Ibid) has noted that the most effective way to overcome the is/ought paralysis with respect to morality is to recover purpose. Natural Law, as George Grant points out so clearly in *Philosophy in the Mass Age* (Ibid), and as noted in the previous footnote comment, insists upon commitment to an understanding of the cosmos as teleologically framed. This thesis is not the place to resolve this centuries old debate except to point out that for theists the Universe is, indeed, a cosmos and not a chaos and that techne can only properly be evaluated in relation to telos and insistence on this framework is primarily maintained by those within the broad Natural law tradition.

[21] See Hayden Ramsay, 'Conscience: Aquinas – With a Hint of Aristotle' (2001) 40(2) *Sophia* 15; and Timothy C Potts, *Conscience in Medieval Philosophy* (Cambridge University Press, 1980). Potts notes contributions of Peter Lombard, Jerome, Philip the Chancellor, and Bonaventure.

[22] These include Germain Grisez, Bernard Haring and John Finnis.

[23] See Hoffman (n 19).

3.2 SYNDERESIS: THE PRIMARY PRECEPT AND THE INTELLECT

Aquinas defined conscience as an act of the intellect where a person decides what is right and what is wrong, with synderesis as its first dimension.[24] Also known as 'pre-conscience', Aquinas described synderesis as the 'law of our reason,' Kant as 'the inner court of justice', Jerome as the 'spark of conscience' that even Cain experienced, and Stepien as an immediate, intuitive knowledge that indicates to the conscience how one should act. [25] In summary, it relates to the 'cognitive perception of the principles of morality evident in the natural human drive to do good and avoid evil.'[26]

Importantly, synderesis presupposes objective truth about right and wrong and is considered infallible. It considers the principles of morality to be underived, and not subject to change to suit local custom or the times. This foundational natural law belief clashes with relativism and emotivism. We see this clash in debates regarding human rights. The cultural relativist and the emotivist argue that whilst there may be some common norms of behaviour, others are relative to a person's context or culture, and the fact that such diversity in beliefs exist, is proof, they say, that there are no universal beliefs of right and wrong, only a person's 'values.'[27]

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[24] Thomas Aquinas, *Summa Theologiae Volume 11 Man (Ia. 75-83)* (Cambridge University Press, 1966) 191 - 195.
[25] Thomas Aquinas, *Summa Theologiae Volume 28 Law and Political Theory (Ia2ae. 90-97)* (Cambridge University Press, 1966) 75-83. Aquinas also referred to it as the 'natural courtroom.' See also Andrea M Esser, 'The Inner Court of Justice Moral Knowledge and the Proper Object of Duty' in Andreas Trampota, Oliver Sensen, and Jens Timmermann (eds) *Kant's Tugendlehre* (De Gruyter, 2012) 269, 269 (The inclusion of Kant's definition of conscience is not to suggest that Kant was a Catholic); Potts (n 21) 6. This refers to the story of Cain in the Old Testament who in murdering his brother, Abel, committed the first murder in humankind; Katarzyna Stepien, 'Synderesis and the Natural Law' (2014) 3 *Studia Gilsoniana* 377, 378.
[26] Thomas Aquinas, *Summa Theologiae Volume 11 Man (Ia. 75-83* (n 24).
[27] See, eg, Philip Alston and Ryan Goodman, *International Human Rights: Texts and Materials* (Oxford University Press, 2013, 531-2.

There is significant philosophical and theological scholarship on synderesis, however Cottingham notes there has been little modern scholarship,[28] with Potts noting that most of its critique predates Descartes.[29] Whilst academic philosophical debate includes whether synderesis can ever be wrong, whether it involves free choice, and whether it is a disposition or a potentiality, as noted earlier, it is considered beyond the scope of this thesis to further critique these disputes, and unnecessary for the reader to know more about them in order to understand the findings of this thesis' empirical study.[30]

For Aquinas, synderesis involves a disposition of reason, by which basic deontic premises are known to us which can never be wrong.[31] However, whilst this theory of conscience posits that we all have synderesis and intuitively know the general moral principles, it is merely the starting point. It does not mean that there will be unity of judgment amongst all people about what one ought to do,[32] as each individual person must apply the general principles in the second and third dimensions of conscience to reach a judgment about a specific situation and how to act.

For the Abrahamic religions, God is the author of moral truth, and He is all good. Therefore, God's laws are the normative standard and authority for right and wrong.[33] As Pope St Paul VI noted: 'For man has in his heart a law inscribed by God… His conscience is man's most secret core and his sanctuary. There he is alone with God whose voice echoes in his depths.'[34] If we accept this premise, then conscience is more than a mere preference or opinion. It is a law '[we] do not impose on [ourselves]' but which 'holds us to obedience' unaffected by external control.[35]

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[28] Cottingham (n 4) 2.
[29] Potts (n 21) 2.
[30] The central point is that irreconcilable traditions require that consideration be given to methods of accommodation of diverse beliefs and that is where the importance of conscience protections becomes apposite.
[31] Aquinas, *Summa Theologiae Volume 11 Man (Ia. 75-83)* (n 24).
[32] This has implications for how to fashion a conscience clause and will be discussed later in the chapter.
[33] See John Henry Newman, 'Letter to the Duke of Norfolk' in *Certain Difficulties Felt by Anglicans in Catholic Teaching II* (Longmans Green, 1885) 248. Newman describes conscience as the Aboriginal Vicar of Christ.
[34] Paul VI, *Gaudium et Spes* Pastoral Constitution on the Church in the Modern World, 7 December 1965 [16]. http://www.vatican.va/archive/hist_councils/ii_vatican_council/documents/vat-ii_const_19651207_gaudium-et-spes_en.html. See also John Jago, 'Newman, Freedom of Conscience and Vatican II' (PhD Thesis, The University of Fribourg Switzerland, 1997) 213-36.
[35] Ibid.

Accordingly, it is not surprising that arguments about freedom of conscience are closely associated with monotheistic religion.[36] Pellegrino suggests this is because conscientious objectors often cite their religious faith as the source of their objection, and as such, they prefer to accept the consequences of disobeying man -made law than the consequences of disobeying God's law and acting in contradiction to what they believe to be good.[37] This is not to say that all conscientious objectors are 'religious,'[38] but if eternal consequences are real, then it may be rational for believers to obey God's law and suffer temporal penalties.

A famous example of this compulsion to follow conscience even unto death can be seen in St Thomas More. Essentially, More refused to take the Oath of Supremacy which made King Henry VIII head of the Church of England, and which allowed him to annul his marriage to Catherine of Aragon so he could marry Anne Boleyn. To defy the Oath was treason, punishable by death. Despite this, St Thomas resisted pressure from everywhere including from his daughter Margaret to 'say the words of the oath and in your heart think otherwise,' [39] and was beheaded in 1535, becoming a martyr and Saint.[40]

However, the natural law theories also teach that as all people have reason, belief in God is not required to know objective truth.[41] The Ancient Greeks, who did not believe in a monotheistic God, still believed there was a law above human law which had to be obeyed.[42] In Sophocles' *Antigone,* Antigone defies the edict of Creon and gives sacred burial to her brother Polyneices.[43] She feels compelled to follow her conscience, to follow what the gods commanded rather than the King's edict though it meant her death.

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[36] See, eg, Farr A Curlin, et al, 'Religion, Conscience, and Controversial Clinical Practices' (2007) 356(6) *New England Journal of Medicine* 593, 599. Here, there was an association between doctors who describe themselves as religious and those having a conscientious objection to abortion.
[37] Edmund D Pellegrino, 'The Physician's Conscience, Conscience Clauses, and Religious Belief: A Catholic Perspective' (2002) 30(1) *The Fordham Urban Law Journal* 221, 231.
[38] The definition of religion can be controversial. See, Iain T Benson, 'Getting Religion and Belief Wrong by Definition: A Response to Sullivan and Hurd' in Iain T Benson, Michael Quinlan, and A Keith Thompson, (eds), *Religious Freedom in Australia – A New Terra Nullius*? (Shepherd Street Press, 2019) 332, 333. Benson notes that atheism and agnosticism are also belief systems which 'often go unobserved or uncommented upon in contemporary law and religion scholarship, policy work and judicial analysis.'
[39] Robert Bolt, '*A Man for All Seasons: A Play in Two Acts'* (Vintage International, 1990) 81.
[40] Contemporary examples are that of Martin Luther King and Nelson Mandela with their imprisonment for the rejection of unjust laws validating racial discrimination.
[41] See M Cicero, 'Laws' in C Morris (ed) *Great Legal Philosophers* (University of Pennsylvania Press, 1959) 51. Cicero notes '…What is right and true is also eternal and does not begin or end with written statute...'
[42] See Cottingham (n 4) 3-4. Cottingham notes that whilst Ancient Greek philosophy regularly dealt with the concepts of guilt and remorse, it arguably lacked a developed idea of conscience.
[43] Sophocles, *Antigone* (University of Wisconsin Press, 2013).

As St Paul famously noted in Romans 2:14, 'For when Gentiles, who have not the law, do by nature those things that are of the law; these having not the law are a law to themselves.'[44]

There can be a tendency to assume that opposition to abortion is 'religious' and therefore not something to be considered when developing public policy and law.[45] However, as Chaput notes, natural law principles can be used as a bridge to build the common good.[46] Further, he notes:

> When Catholics oppose abortion, for example, they do so not because of some special Catholic religious doctrine or simply because the church says so. Rather, the church teaches abortion is wrong because it already is…It's a matter of natural law.[47]

The acceptance that reason is how we know right from wrong is endorsed in the criminal law. To be found guilty of a crime, the law requires that a person must have formed the intent to do the act with their free will for rational reasons.[48] Not knowing one has done the wrong thing can satisfy an insanity defence due to disease, disorder, or disturbance of the mind. In Australian law, and as Allnutt, Samuels and O'Driscoll note, insanity is made out if the person knows the act was wrong in the legal sense, but they were not capable of reasoning why it might be wrong from their subjective perspective.[49]

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[44] Edgar Swift and Angela M Kinney, *The Vulgate Bible: Douay-Rheims Translation* (Harvard University Press, 15th ed, 2010).
[45] Nicholas Tonti-Filippini, *About Bioethics Philosophical and Theological Approaches* (Connor Court, 2011) 135. Here, Tonti-Filippini describes a 'bigoted version of secularism' which seeks to exclude certain people from a seat at the table of reason.
[46] Charles J Chaput, *Render unto Caesar: serving the nation by living our Catholic beliefs in political life* (Doubleday, 2008) 95.
[47] Ibid 83.
[48] Stephen Allnutt, Anthony Samuels, and Colman O'Driscoll, 'The Insanity Defence: From Wild Beasts to M'Naghten' (2007) 15(4) *Australian Psychiatry* 292, 294.
[49] Ibid 296. See, eg, *R v Porter* (1936) 55 CLR 182. The criminal law distinguishes insanity from normal excitement, stupidity, obtuseness, lack of self-control and impulsiveness, where the person will still have culpability. Quite apart from insanity, diminished capacity is relevant in relation to seriousness or intent in many areas of the law where, for example, coercion or emergency act to ameliorate a person's actions. The concept of unconscionable conduct in equity reflects a normative acceptance of the existence of 'a good conscience'.

Aquinas' natural law approach to synderesis arguably has an analogue in the normative ethical theory of deontology, which emerged following the Reformation and Enlightenment. Kant's 'categorical imperative' known as the supreme principle of morality, provides that one ought never to conduct oneself except so that one can also will that one's maxim becomes a universal law. Unconditional and universal in force, the categorical imperative is said to represent the moral law knowable by all people through their reason, which leads us to be aware of our duty to be conscientious.[50]

Having considered the role of the intellect in the primary precept, this thesis now considers the role of emotions such as shame, guilt, and distress, and how they can be seen in natural law theories of conscience to serve a positive function in helping us know right from wrong. In this context, such emotions are not harmful. This can be contrasted with the relativist and the emotivist understanding of conscience. With a different understanding of conscience and freedom, feelings of guilt, shame and distress are harmful emotions imposed on the person via the external negative moral judgment of another person about the first person's choices.

3.3 SYNDERESIS: THE PRIMARY PRECEPT AND EMOTIONS

Theorists such as Hume argued that moral rules are not conclusions reached by our reason; rather they derive from our senses.[51] In more recent times, Haidt in defending his social intuitionist model, argued that moral reasoning does not cause our moral judgment about right and wrong; rather it is 'an ad hoc construction generated after a judgment has been reached,' which is influenced by social and cultural influences.[52] Ultimately, these theories sought to or are considered by some to have displaced the notion of rational, objective moral truth. Natural law theory on conscience, has a different view of the function of our emotions.

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[50] Henry E Allison, *Kant's Groundwork for the Metaphysics of Morals: A Commentary* (Oxford University Press, 2011) DOI:10.1093/acprof:oso/9780199691531.001.0001. Cf Cottingham (n 4) 6. Cottingham notes that Kant draws back from arguing that one must necessarily believe that God or a supreme being is the author of the moral law. Some dispute this. See Chaput (n 46) 9. Chaput observes that 'the Enlightenment's trust in the moral force of human reason cleansed of religion seems deader than Voltaire himself.' He argues that whether God exists is an important practical question because it influences a person's 'personal and public behavior: our actions, our choices and our decisions.'

[51] Hume (n 20) 158.

[52] Jonathan Haidt 'The Emotional Dog and its Rational Tail: A Social Intuitionist Approach to Moral Judgment' (2001) 108 (4) *Psychological Review* 814, 814.

In addition to our reason, natural law theories teach that our emotions assist us to know right from wrong. Conscience, 'accuses, excuses or torments us,'[53] by a stinging or gnawing away of the soul and our peace.[54] In the Judeo-Christian tradition, knowledge that we have done the wrong thing and need to seek forgiveness is accompanied by feelings of shame, which connect with the notions of sin and redemption. In Genesis, we are told that after disobeying God's prohibition against from eating fruit from the tree of knowledge of good and evil, Adam and Eve realised they were naked. As they felt fear and shame, they hid themselves from God.[55]

King David's *Miserere* in Psalm 50 of the Old Testament (Latin Vulgate) is famous for being the model for repentance in the Judeo-Christian faith traditions. After he realizes that having sexual intercourse with Bathsheba and then sending her husband, Uriah the Hittite, to war, were wrong, King David cries out:

> Have mercy on me, O God, according to thy great mercy. And according to the multitude of thy tender mercies blot out my iniquity. Wash me yet more from my iniquity, and cleanse me from my sin. For I know my iniquity, and my sin is always before me.[56]

St Augustine famously speaks of his shame in *Confessions* when describing his conscience speaking to him from within, berating him for his 10-year delay in converting to Christianity:

> The day came when I should be naked to myself and my conscience mutter within me: 'Where is my tongue? Indeed, you kept saying how that you would not cast off the burden of vanity for an uncertain truth. Behold, matters are now certain, and you are still burdened. And they are receiving wings on freer shoulders, others who have neither so worn themselves down in seeking nor spent ten years and more thinking about it'. Thus, I was inwardly gnawed and violently confused with horrible shame.'[57]

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[53] Smith (n 10) 10.
[54] Chad Ripperger, *Introduction to the Science of Mental Health* (Sensus Traditionis Press, 2013) 242. Ripperger observes that violation of the natural law leads to inward torture and loss of peace from which depression and confusion can occur which may lead to emotional and psychological illnesses.
[55] Swift and Kinney (n 44) Gen 3: 6-10.
[56] Ibid Psalm 50:3-5.
[57] Saint Augustine, *Confessions* (Penguin Books, 1961) 397-98.

A literary example of shame and knowledge of wrongdoing can be found in the character of Raskolnikov in Dostoevsky's *Crime and Punishment*, who decides to murder a pawn broker to free himself from poverty.[58] Ultimately, he kills two people and despite trying to justify the murders to himself (and experiencing illness as a result), he eventually recognises his wrongdoing, confesses, and seeks redemption. Notable quotations include, 'If he has a conscience, let him suffer if he acknowledges his fault. That'll be his punishment – over and above the labour camp.'[59]

However, the counter argument to this is that shame has no real purpose. Nietzsche, for example, derided the use of shame as a dangerous prescription of a religious neurosis.[60] In Australia, avoiding shame has been a key driver to decriminalising abortion, creating safe access zones around clinics, and obliging doctors to co-operate with abortion notwithstanding a conscientious objection.[61] The narrative is that if a woman feels shame after abortion, it does not come from within her. Rather, it is caused by, for example, 'a cruel society with prudish views about sexual morality, which she has then internalised.'[62]

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[58] Fyodor Dostoevsky, *Crime and Punishment* (Lerner Publishing Group, 2015).
[59] Ibid 234.
[60] See, eg, Peter Singer, *How Are We to Live?* (Oxford University Press, 2003) 18-19; Friedrich Nietzsche, *Beyond Good and Evil* (Oxford University Press, 1998) 45; Joel A Van Fossen, 'Nietzsche and Shame' (2019) 50(2) *Journal of Nietzsche Studies* 233. Van Fossen argues that shame is inherently superficial with no purpose. Cf Saint Augustine, *City of God* ((Random House, 1950) 442. See also Augustine's analysis of Lucretia's rape during the sacking of Rome and her subsequent suicide at 23-4. See also, Pope John Paul II in his reflections during 129 audiences between 1979 and 1984 that came to be known as the *Theology of the Body* teachings. See, eg, Christopher West, *The Theology of the Body Explained: A Commentary on John Paul II's "Gospel of the Body*" (Gracewing, 2003).
[61] See Anna Walsh, 'Freedom of Expression, Belief and Assembly: The Banning of Protests Outside of Abortion Clinics in Australia' (2018) 25(4) *Journal of Law and Medicine* 1119. Other drivers for this law are set out in Public Health Act 2010 (NSW) s 98B (a) 'the need to ensure the entitlement of people to access health services, including abortions, is respected' and (b) 'to ensure that people are able to enter and leave reproductive health clinics at which abortions are provided without interference, and in a manner that protects their safety and well-being and respects their privacy and dignity, including employees and others who need to access such clinics in the course of their duties and responsibilities.'
[62] See, eg, Clara Fischer, 'Abortion and Reproduction in Ireland: Shame, Nation Building and the Affective Politics of Place' (2019) 122 *Feminist Review* 32. See also Dubravka IG Håkansson, Pernilla Ouis and Maria E Ragnar, 'Navigating the Minefield: Women's Experiences of Abortion in a Country with a Conscience Clause—The Case of Croatia' (2021) 22(1) *Journal of International Women's Studies* 166. Cf Deborah Garratt, *Alarmist Gatekeeping Abortion* (Deborah Garratt, 2021).

Human dignity can be used to justify different positions on conscientious objection.[63] Whilst the definition of dignity can seem elusive,[64] clarification is found in normative premises which underpin each position and reflect whether the person believes that freedom is doing what is right or doing what we want. The natural law understanding of dignity rests on human nature, objective right and wrong, and an end for our existence,[65] whilst the modern liberal approach rests on dignity being the right to respect a person's autonomous choices, subject to any restraints or prohibitions imposed by the domestic lawmaker. [66]

Accordingly, if conscience is just a feeling or an emotion, then it is of no higher importance than any other right or freedom. Arguably, the public's understanding of conscience has been framed by the sustained efforts made by pro-abortion advocates to dominate abortion discourse, change social attitudes and the law. A powerful argument to dilute the strength of a doctor's conscientious objection is, as Garratt notes, the promotion of the unexamined preconception that 'every situation where a woman may consider an abortion is potentially life-limiting or hazardous.'[67]

This very thin concept of conscience as just a feeling or emotion influences the way in which one applies Mill's harm principle which tries to quantify and compare competing harms.[68] Against this background, the legalisation of abortion as standard healthcare can tip the balance in favour of being able to infringe a doctor's freedom of conscience. The choice is framed as being between a doctor feeling guilty for doing something they believe is wrong but which many believe is part of their job, and a patient feeling shamed by the doctor who fails to accept her conception of what is good and her experience of delay in accessing a lawful service.[69]

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[63] See, D Beyleveld and R Brownsford, *Human Dignity in Bioethics and Biolaw* (Oxford University Press, 2004) 242. Dignity is used to justify freedom to choose what health services a person undertakes.
[64] We see this particularly today with discussion on end-of-life healthcare ethics. See, eg, Ruth Horn and Angeliki Kerasidou, 'The Concept of Dignity and Its Use in End-of-Life Debates in England and France' (2016) 25(3) *Cambridge Quarterly Healthcare Ethics* 404, 404.
[65] See, eg, John Paul II*, Veritatis Splendor* (n 6) [32]; and Catholic Church, *Catechism of the Catholic Church* (n 11) [1730] – [1738].
[66] See Tom L Beauchamp and James F Childress, *Principles of Biomedical Ethics* (Oxford University Press, 7th ed, 2013) 101. The authors note that 'determining its [human dignity's] nature, scope or strength requires careful analysis.' See also, Therese Mary Lysaught, 'Respect or How Respect for Persons Became Respect for Autonomy' (2004) 29(6) *Journal of Medical Philosophy* 665, 674.
[67] Garratt (n 62) 17.
[68] JS Mill, *On Liberty* (Batcohe Books, 2001) 13.
[69] Or, as often, a doctor's beliefs conflicting with the autonomy of the patient. This does two things: first, falsely places the beliefs of the doctor to conscience/religion respect beneath the wishes of the patient by giving them no weight; and second, fails completely to recognise that two autonomy issues are at stake.

It is important to note here that concepts received from philosophy such as *synderesis* and *conscientia* have a place to bear in the evaluation of conscience that is not always picked up by the legal and ethical analysis of conscience itself. As described earlier, synderesis is the natural dispositional tendency of the moral intellect to know certain basic truths about right and wrong. We speak of a dispositional tendency to know these things rather than just knowing them, because we are not always thinking about them. C*onscientia* is the actualisation of such knowledge in the process of moral judgment. Remorse is the tormenting awareness of guilt which can occur from doing what our conscience judges to be wrong.

Synderesis cannot err, although a person can be deceived about what they know. *Conscientia* can err although the tradition requires that certain judgments of conscience must never be violated. Remorse can also err, because one may feel guilty about what was not wrong, or they may fail to feel guilty about what was wrong. This thesis now discusses the results of some empirical studies undertaken in the healthcare sector dealing with 'moral harm'. These studies, and this thesis, use terms taken from the bioethics literature, such as 'dignitary harm', 'anguish or torment', 'diluting the integrity of the doctor's belief' and 'being asked to hold and act in accordance with two contradictory beliefs'.

As has already been mentioned in chapter 2, with the framework of conscience used in this thesis, there are at least four types of harm that might be occasioned when a doctor violates his or her conscience: the harm of how one is treated for refusing to act against conscience, the harm of anguish for having acted against one's conscience, the harm of having acted against one's conscience irrespective of anguish, and the harm one can do to oneself to stave off one's anguish. Whilst none of the studies refers to the concept of 'conscience', they do appear to focus on the anguish of having acted against what one believes to be good healthcare. They do not acknowledge or explore the other types of harm.[70]

[70] I would like to thanks Professor J Budziszewski for his helpful comments in the examination of this thesis which has led to clarifying these distinctions.

As Sawicki observes, there is inadequate discussion in the bioethics literature about how to assess harm from conscience conflicts involving abortion.[71] She notes the preference has been to defer to a patient's self-assessment of harm but rely on external assessment by the profession of the severity of a doctor's harm. This is notwithstanding what she describes as the profession's lack of competence in 'evaluating moral culpability within the context of individual belief systems.'[72] Arguably, this undermines the dignity of the individual doctor or health professional and suggests all health professionals should react in the same way.

There is precedent in healthcare research for the measuring and recording of harm by health professionals occasioned in the workplace. Known variously as 'moral harm', 'moral distress' or 'moral injury', this phenomena has appeared in studies published in bioethics literature since around 1984,[73] although Dudzinski observes that its meaning is 'famously nebulous' with few studies addressing what makes moral harm moral.[74] Scenarios that have been the subject of studies include health professionals' feelings when pressured to do actions which contravene what they believe is good healthcare or their strong moral sentiments.

Studies mainly focus on nurses with some doctor and pharmacists.[75] Examples include resuscitating the elderly, administering pain relief, not being able to give adequate time to patient care, working under poor leadership, and general stress from the job.[76] Common feelings associated with this type of harm included anger, frustration, and suffering, with outcomes including weakened morale and deterioration in relationships.[77]

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[71] Nadia Sawicki, 'Who Judges Harm?' (2017) 27(3) *Journal of Clinical Ethics* 238, 239.
[72] Ibid. See also Håkansson, Ouis and Ragnar (n 62).
[73] See Andrew Ameton and Eileen M Jackson EM, 'Nuclear War and Nursing Ethics. What is the Nurse's Responsibility?' (1984) 4(1) *Mobius* 75. It is also known as 'moral distress' and 'moral injury'.
[74] See, Denise Marie Dudzinski, 'Navigating Moral Distress Using the Moral Distress Map' (2016) 42 *Journal of Medical Ethics* 321, 321. There is even disagreement as to whether the distress is personally experienced by the health professional or whether it is the patient who is harmed.
[75] See, e.g. Mahmoud Abbasi et al, 'Moral Distress in Physicians Practising in Hospitals Affiliated to Medical Science Universities' (2014) 16(1) *Iranian Red Crescent Medical Journal* 18791; Jacoba de Boer et al, 'Appropriateness of Care and Moral Distress Among Neonatal Intensive Care Unit Staff: repeated measurements' (2016) 21(3) *Nursing in Critical Care* 18; Jayne L Astbury and Cathal T Gallagher, 'Development and Validation of a Questionnaire to Measure Moral Distress in Community Pharmacists' (2017) 39(1) *Journal of Clinical Pharmacology* 156.
[76] See, eg, Anke J E de Veer et al, 'Determinants of Moral Distress in Daily Nursing Practice: A Cross Sectional Correlational Survey' (2013) 50 *International Journal of Nursing Studies* 100; Rowena L Escolar Chua and Jaclyn Charmaine J Magpantay, 'Moral Distress of Undergraduate Nursing Students in Community Health Nursing (2019) 26(7-8) *Nursing Ethics* 2340; Alisa Carse and Cynda Hylton Rushton, 'Harnessing the Promise of Moral Distress: A Call for Re-Orientation' (2017) 28(1) *Journal of Clinical Ethics* 15, 15.
[77] See, e.g. Edmund G Howe, 'Fourteen Important Concepts Regarding Moral Distress' (2017) 28(1) *Journal of Clinical Ethics* 3; Sneha Mantri et al, 'Identifying Moral Injury in Healthcare Professionals: The Moral Injury Symptom Scale-HP' (2020) *Journal of Religion and Health* doi: 10.1007/s10943-020-01065-w**:** 1-18.

As far as the writer is aware, harm arising from performing or facilitating abortion against conscience has not been studied save for one instance in Norway.[78] However the psychological impact on midwives of assisting at abortion has been the subject of several studies.[79] Generally speaking, the majority of participant midwives believe the abortions are morally justified, although in one quantitative study of 92 French midwives, a quarter of participants reported feeling an 'uneasiness' about the reasons for the abortion for personal, cultural and religious reasons.[80] The authors recommended more support, training, and education of midwives given the large number of abortions carried out in France each year.[81]

For some commentators, even if a doctor with a conscientious objection to abortion could quantify their harm, the issue is whether the harm is justified. Savulescu argues that conscientious objection by doctors is justified when it is an objection to harming people, but that 'harm and benefit are not in the eye of the beholder.'[82] In his opinion, harm, and benefit 'are grounded in robust, morally justified concepts of best interests and moral status.' Accordingly on this basis, *unjustified* conscientious objection by doctors that causes harm to patients should be ignored regardless of whether and to what extent the doctor is harmed.[83]

This concludes discussion on synderesis. Whilst synderesis is situated within a theological context[84] it also involves human reason which is said to allow us to regard reality, note our inclinations, and work out the natural law assisted by both the intellect and the emotions. However, synderesis on its own is insufficient to guide us to do the right thing in any particular situation. Therefore, there can be diversity of belief about what to do notwithstanding a common starting point about what is good. This chapter now deals with the second dimension of conscience known as the process of conscience.

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[78] Eva M Nordberg, Helge Skibekk and Morten Magelssen, 'Conscientious Objection to Referrals for Abortion: Pragmatic Solution or Threat to Women's Rights?' (2014) 15 *BMC Medical Ethics* doi:10.1186/1472-6939-15-15:1-9.

[79] See, eg, JM Whelton, 'Sharing the Dilemmas: Midwives' Role in Prenatal Diagnosis and Fetal Medicine' (1990) 5(1) *Profession Nurse* 514; C Bewley, 'The Midwife's Role in Pregnancy Termination' (1993) 8 *Nursing Standard* 25; E Cignacco, 'Between Professional Duty and Ethical Confusion: Midwives and Selective Termination of Pregnancy' (2002) 9 *Nursing Ethics* 179; M Garel et al, 'French Midwives' Practice of Termination of Pregnancy for Fetal Abnormality: At What Psychological and Ethical Cost?' (2007) 27 *Prenatal Diagnosis* 622.

[80] M Garel et al (n 79) 627.

[81] Ibid 628.

[82] Savulescu (n 9) 497.

[83] Ibid.

[84] In the Judeo-Christian traditions, it is intertwined with God's Eternal law includes God's plan of Divine Wisdom which directs all our actions so we can attain our end, which is the beatific vision. See, eg, John Paul II, *Veritatis Splendor* (n 6) [32]; and Catholic Church, *Catechism of the Catholic Church* (n 11) [1958].

3.4 THE PROCESS OF CONSCIENCE

The second dimension of conscience concerns the process of applying the principles of morality to given circumstances by what is called 'practical discernment.'[85] It requires more than synderesis. It requires formation. According to Aristotle, the virtuous person will do what is morally good because their intellect will choose what is best for itself, and the good person obeys their intellect.[86] This takes time, maybe even a lifetime. Good formation of a rightly ordered conscience is said to include our surroundings, the law, and our education, practice, and reflection.[87]

The Ancient Greeks observed that some people were *akratic*, and through a weakness of will, fail to do what is good and ultimately act against their better judgment.[88] Alternatively, a person's conscience can be poorly formed which leads to an erroneous conscience. It is important to note that while a person's conscience can be in error, this does not mean that synderesis is in error. As Ratzinger notes, if people lack formation on what is good, they may not be conditioned to recognise the inner promptings of truth.[89] Accordingly, they may do the wrong thing and not experience a sense of shame or moral distress.

That is why with synderesis, the experience of emotions does not exclusively dictate the knowledge of right and wrong. If the principles of morality under the natural law are objective, then whilst one is free to choose not to believe in them, they nonetheless continue to exist and operate despite one's beliefs or how one feels. Put another way, a person commits objective wrong, regardless of whether they know they did the wrong thing or whether they feel good about it and lack shame, guilt, or moral distress.[90] As the virtuous person is said to have a rightly formed conscience, they will experience balanced emotions.

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[85] Catholic Church, *Catechism of the Catholic Church* (n 11) [1780].
[86] Aristotle 'Nicomachean Ethics' in *The Ethical Life*: *Fundamental Readings in Ethics and Moral Problems*, Russ Shafer-Landau (ed) (Oxford University Press, 2010) 123, 127.
[87] Catholic Church, *Catechism of the Catholic Church* (n 11) [1784].
[88] See Sulmasy (n 1) 139. See also Catholic Church, *Catechism of the Catholic Church* (n 11) [1779] 'Every person needs to be sufficiently present to himself in order to hear and follow the voice of his conscience. This requirement of interiority is all the more necessary as life often distracts us from any reflection, self-examination or introspection.'
[89] Ratzinger (n 1) 38.
[90] Catholic Church, *Catechism of the Catholic Church* (n 11) [1790] – [1794]. See also Ripperger (n 54) 245. Ripperger posits that even where a person is bound to follow an erring conscience, they are acting contrary to the natural law and as such there may be negative effects. This is because regardless of whether the person is aware, nature knows they did the wrong thing and disorders may arise because objective wrong was committed.

Arguably, both the natural law and the modern liberal approach to conscience recognise there must be an ultimate authority that can restrain our choices.[91] Scalia argues that even a culture which advocates rejection of traditional authority figures can act 'more swiftly and absolutely than any inquisition ever did.'[92] Scalia's point is that the anti-authoritarian's attitude can be viewed as a distortion of the natural law's call to pursue the good and avoid evil because, he notes, '[w]e can remove God from our lives, but we cannot remove from our souls that tendency towards authority.'[93]

As will be discussed later, natural law theories oblige us to follow our conscience, but this is qualified by the requirement that conscience be properly formed. However how to properly form our conscience is the subject of dispute, including whether there is one religious faith tradition that is the 'teacher of the truth' with the ultimate moral authority to tell us how we ought to act. With the decline in the authority of religious faith traditions and the marginalisation of their voice through the active exclusion of their views in public debate on morality, the domestic lawmaker has arguably assumed this authority for many people.[94]

That a person's conscience can be judged to be fallible is unique to the natural law theory of conscience. Importantly for this thesis, in certain circumstances, the person is obliged to follow their conscience, even where it diverges from the truth.[95] The obvious question is who has authority to form a person's conscience and judge it. Given the variety of moral codes available today, coupled with a rejection that objective moral truth exists, it is unsurprising that the very idea that one tradition, religious or non-religious, can judge the correctness or merits of any person's conscience or system of morality is rejected in modern secular ethics. [96]

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[91] Therefore, the modern liberal approach to conscience is not as extreme as the new age esoteric philosophy of Thelema, and Aleister Crowley's famous mantra 'Do as thou wilt shall be the whole of the law'.
[92] Paul Scalia, 'The Author's Voice', *The Catholic Thing* (Web Page), 23 August 2020 <www.thecatholicthings.org>.
[93] Ibid.
[94] Tonti-Filippini (n 45) 13.
[95] This is illustrated by John Henry Newman's famous words: 'I shall drink to the Pope, if you please, still, to conscience first, and to the Pope afterwards.' See Newman (n 33). See also Alphonsus Liguori, *Moral Theology: Volume 1, Books 1-III, On Conscience, Law, Sin, and the Theological Virtues* (Mediatrix Press, 2017) 26. A distinction is made between consciences which are vincibly, as opposed to invincibly, in error. Only the invincibly erroneous conscience must be followed.
[96] See, Richard J Regan, *Private Conscience and Public Law- The American Experience* (Fordham University Press, 1972) 7.

However before considering how this approach to conscience dovetails with freedom, the question of 'Who is the teacher of the truth?' will be discussed. In the 16th century, this question loomed large in the Reformation. As Paul VI noted, the Magisterium of the Catholic Church has always held herself out as having 'valid authority to declare and confirm the principles of the moral order.'[97] It declares itself to be the 'teacher of the truth.' However, there are also other religious faith traditions which believe in the existence of objective moral truth but believe that they are the 'teacher of the truth.'

There are numerous misunderstandings about what the Catholic Church teaches about its role in forming conscience and being the 'teacher of the truth.' These include the assumption that Catholics 'check their brains in at the door' to blindly follow the current personal opinions of Church leaders on moral matters.[98] Archbishop Anthony Fisher notes that some people wrongly characterise the Church's Magisterium as:

> [A] voice external to the person and so set over against conscience, a voice that commands things to which the person's conscience are not naturally disposed. If the person cannot find a way around such commands, he or she must simply acquiesce to the lawgiver or disobey and take the consequences.[99]

Rather, in the context of objective moral truth, the Church teaches that having an external source pronounce on moral matters and form an individual's conscience assists the person achieve freedom, if one defines freedom not as doing what one wants but doing what is right. When we are doing what is right, we are in conformity with our human nature. Thus, adopting this definition of freedom, the external party, such as 'the teacher of the truth,' can pronounce on moral matters and be at the service of the individual's conscience because it is helping to shine light on the truths already etched into a person's heart.[100]

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[97] Paul VI, *Declaration on Religious Freedom Dignitatis Humane*, *On the Right of the Person and of Communities to Social and Civil Freedom in Matters Religious,* 7 September 1965 [14] <http://www.vatican.va/archive/hist_councils/ii_vatican_council/documents/vat-ii_decl_19651207_dignitatis-humanae_en.html>.

[98] This raises the issues of Papal Primacy, the development of doctrine, authoritative fallible teachings as opposed to private papal opinions, and finally the notion of 'ultramontanism.' All of these are beyond the scope of this thesis to discuss. But see, Joseph Cardinal Ratzinger, Congregation of the Doctrine of the Faith, *The Primacy of the Successor of Peter in the Mystery of the Church* https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19981031_primato-successore-pietro_en.html.

[99] Anthony Fisher, *Catholic Bioethics for a New Millennium* (Cambridge University Press, 2011) 41.

[100] See, eg, Catholic Church, *Catechism of the Catholic Church* (n 11) [1783].

Martin Luther, and the Reformation he in large part initiated, was a seismic historical event for conscience. It arguably commenced a shift towards the concept of conscience as subjective certitude and shaped how the Western world at least thinks about morality, religious liberty and therefore, freedom. Luther, an Augustinian Catholic priest, denied the Magisterium's authority as the external source for right and wrong. He famously declared at the Diet of Worms in 1521 that his conscience was captive only to God's word. His penalty was excommunication from the Catholic Church, but his reach was enormous.

Whilst Luther discarded the Magisterium as necessary in forming conscience, he retained the notion of God and the Scriptures. Philosophers during the Enlightenment period of the 17th century took two more important steps. They replaced God with reason and abandoned the notion of objective moral truth.[101] Various normative ethical theories for moral reasoning emerged, with a focus on liberty and competing processes on how to reason rightly.[102] Parts of these theories can be seen in legal frameworks which seek to manage conscientious objection to abortion, and which are referred to in chapter 4.

Ultimately, the Church teaches that each person has an obligation to seek the truth and take active steps to form his or her conscience.[103] This is the basis of the obligation to follow our conscience where it is clear, and to assume responsibility for our acts and omissions. However as noted earlier, the Church recognises the 'erring conscience.' It teaches that we will be judged by how we form and follow the particular judgments of our conscience.[104] Accordingly, whilst we will be considered culpable for wrongdoing if we follow a poorly formed conscience, it also makes provision for when we must follow the erring conscience.

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[101] See, Leonard M Hammer, *The International Right to Freedom of Conscience: Some Suggestions for its Development and Application* (Taylor & Francis Group, 2019) 9. See also John Paul II (n 6) [32]-[33]; Roger Trigg, 'Freedom of Conscience and Freedom of Religion' (2010) 99(396) *An Irish Quarterly Review* 407, 408.

[102] From deontological theories such as Kant's categorical imperative to Mills' utilitarian consequentialism. See, eg, Immanuel Kant, 'The Good Will and the Categorical Imperative' in *The Ethical Life*: *Fundamental Readings in Ethics and Moral Problems* in Russ Shafer-Landau (ed) (Oxford University Press, 2010) 87; John Stuart Mill, 'Hedonism' in *The Ethical Life*: *Fundamental Readings in Ethics and Moral Problems* Russ Shafer-Landau (ed) (Oxford University Press, 2010) 17, 17; Mill (n 68); John Locke, *A Letter Concerning Toleration* (Prometheus Books, 1990) 41. Locke still worked within a theological framework such as the notion that we are all created by God with free will and with human reason.

[103] Letter of His Holiness John Paul II to the Archbishop of Birmingham on the First Centenary of the Death of John Henry Newman, 18 June 1990 [4]. The Catholic Church takes the view that one must obey the certain judgment of one's conscience but that a person is culpable for bad acts committed in line with their conscience, but which is unformed through vincible ignorance. See Catholic Church (n 11) [1790] – [1791].

[104] Paul VI, *Gaudium et Spes* (n 34); Paul VI, *Dignitatis Humane* (n 97) [1]; and Catholic Church, *Catechism of the Catholic Church (*n 11) [1778].

An erring conscience reaches a wrong judgment from what is termed invincible ignorance or culpable error. For Aquinas, whether an erring conscience is binding upon a person is dependent upon the moral quality of the act in question. A person is only bound to follow an erring conscience when it relates to 'indifferent acts.'[105] Archbishop Fisher advises that we must 'follow the last and best judgment of our conscience even if, unbeknown to us, it is objectively in error.'[106] This assumes we have done our best to inform our conscience which may have consequences for how the protection of conscience might be approached in the law.

Archbishop Fisher goes on to note that the state plays a role here to avoid coercing people's consciences so that they can be 'persuaded rather than forced to live well.' This, he says, will involve tolerating differences in moral opinions.[107] By and large, doctors with a conscientious objection to abortion make a private act to seek protection from the law from harm. This is supported by the findings from this thesis' study where participants were not seeking to have their views about abortion imposed on public policy.[108] However as previously discussed, contemporary tolerance can be intolerant of certain moral positions.

The policy questions which are here include: Should all sincere conscientious objections from a doctor be accepted? If a conscience claim is based on a marginalised belief, should the doctor be permitted to act in accord with it?[109] Are the consequences on the person who is forced to act against an erring conscience different to those experienced by someone with an appropriately formed conscience forced to act against it? Should the overriding consideration in conscience claims be promoting the truth, ensuring a person's dignity, preventing harm to them or others, or achieving pluralistic accommodation?

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[105] Aquinas, *Summa Theologiae Volume 11 Man (Ia. 75-83)* (n 24). See also Liguori (n 95).
[106] Fisher, *Catholic Bioethics for a New Millennium* (n 99) 51.
[107] Ibid. One can add too that it is necessary to have the space for discussion on controversial issues without being 'cancelled' out of fear that such discussion will harm other people. This can lead to the neutering of conscience.
[108] See, eg, John Rawls, 'A Theory of Civil Disobedience' in Ronald Dworkin (ed), *The Philosophy of Law* (Oxford University Press, 1977) 94.
[109] See Cowley (n 39) 210. Cowley notes that common beliefs bind doctors to reject a sincere conscience claim based on an objection to provide healthcare to a patient solely because of their race, religion, sexuality, marital status. See also Mark K Wicclair, Conscientious Objection in Medicine (2000) 14(3) *Bioethics* 205, 215-6; Morten Magelssen, 'When Should Conscientious Objection Be Accepted?' (2012) 38 *Journal of Medical Ethics* 18, 19.

In the bioethics literature that defends conscience protection, a distinction is often made between 'preservative freedom,' where the person acts in order to preserve his or her moral integrity and character, and 'perfective freedom,' where persons seek to amplify his or her happiness by doing acts they believe to be good.[110] In a contest between these two types of freedoms, preservative freedom should dominate because it has the potential to harm the moral integrity of a person from being forced to act, or not to act, in accord with what they believe is true and good.[111]

According to Murphy and Genuis, forcing people to act against conscience is:

> [A]lways an assault on their personal dignity and essential humanity, even if they are objectively in error; it is always harmful to the individual, and it always has negative implications to society. It is a policy fundamentally opposed to civic friendship, which grounds and sustains political community and provides the strongest motive for justice. It is inconsistent with the best traditions and aspirations of liberal democracy, since it instils attitudes more suited to totalitarian regimes than to the demands of responsible freedom.[112]

Likewise, they argue that complicity in wrongdoing, where the person does not share the intention of the act, but has assisted in the circumstances of the act, may have similar negative consequences for the person and 'trigger an instinctive and profound sense of abhorrence, uncleanness, taint and shame, even when it is coerced.'[113]

Berlinger suggests that in healthcare, moral distress should be the focus of discussion on conscience rather than whether the situation involves preservative or perfective freedom.[114] She uses an example in Spain where doctors were prohibited from giving medical care to people who were undocumented immigrants due to austerity measures taken up by the government. Doctors were morally distressed and registered as conscientious objectors to signal their disagreement with the law and their intention to keep treating those people, using the same provisions that doctors who object to abortion use.

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[110] See, eg Sean Murphy and Stephen J Genuis, 'Freedom of Conscience in Health Care: Distinctions and Limits' (2013) 10 *Bioethical Inquiry* 347, 349.
[111] Ibid.
[112] Ibid 351.
[113] Ibid. See also John Paul II, *Evangelium Vitae* (n 13) [74].
[114] Nancy Berlinger, 'When Policy Produces Moral Distress: Reclaiming Conscience' (2016) 46(2) *Hastings Center Report* 32, 33. This of course avoids the central question of why something is right or wrong but falls into line with the Catholic teaching of an 'erring conscience.' Cf Savulescu (n 9).

Harris argues that the narrative about conscience and abortion implies that only those who refuse to perform abortion have a conscience.[115] This, she says, stigmatises abortion providers, 'reinforcing images of abortion providers as morally bankrupt,' and contributes to the shortage of abortion providers.[116] Further, she argues that failure to recognise that a doctor's conscience compels them to provide abortion, just as it might compel a doctor to refuse to perform one, makes conscience 'an empty concept.'[117] Indeed, many abortion providers defend their actions on the basis of exercising their freedom of conscience.[118]

Harris' argument is that doctors who are constrained from performing an abortion are harmed because they are prevented from doing what they believe is good. It is a starkly different conception of good from the natural law reasoning, but it is affirmed by utilitarian ethical theory which focuses on the ends of abortion, not the means, and sets aside the questions of whether abortion is the taking of human life and if it is, whether it is wrong.[119] Utilitarian theory provides guidance for the process of conscience, but unlike the natural law, the ultimate authority for what is good is the individual themselves, or the law, the state or the profession.

As MacIntyre observes, 'even where the differing philosophical positions are reduced to their base premises, there is no agreed mechanism to decide the moral superiority of competing claims about what is right.'[120] How then do we make sense of moral harm anchored to different conceptions of what is good? In such circumstances, Benson declares that compromise is not only impossible, but '…meaningless and, potentially, dangerous.'[121] If we accept that human beings are programmed to 'do the good and avoid evil', then this argues for a presumption in favour of accommodating sincerely held conscience claims.[122]

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[115] LH Harris, 'Recognizing Conscience in Abortion Provision' (2012) 367(11) *New England Journal of Medicine* 981.
[116] Ibid 982.
[117] Ibid 983. This re-opens the discussion about the role of conscience in determining what is right or wrong.
[118] See, eg, W Parker, *Life's Work: A Moral Argument for Choice* (Atria Books, 2017). See also, Steven J Ralston, 'The Conscience of an MFM' (2018) 218(6) *American Journal of Obstetrics and Gynecology* 596.
[119] Beauchamp and Childress (n 66) 354-5.
[120] MacIntrye (n 19) 8.
[121] Iain T Benson, 'An Examination of Certain "Pro-Choice" Abortion Arguments: Permanent Concerns about a "Temporary" Problem' (1988) 7 *Canadian Journal of Family Law* 146, 148, 150.
[122] See Iain T Benson, 'Should There be a Legal Presumption in Favour of Diversity? Some Preliminary Reflections' in Iain T Benson and Barry W Bussey (eds) *Religion, Liberty, and the Jurisdictional Limits of Law* (LexisNexis, 2017) 3.

3.5 PRACTICAL CONSCIENCE

The third aspect of conscience is practical conscience. This concerns decisions about what to do in any given situation. A morally permissible act is said to have three aspects: the object of the act, the end sought by the moral agent, and the circumstances in which the act occurs.[123] All aspects must be judged to be morally good or neutral. For abortion, assessing its moral permissibility hinges on clarity over the first question, which is whether abortion can ever be permissible. As noted earlier, for Catholics in good standing, the Church re-states the natural law that abortion is an exception-less norm.[124]

In canon 1398 of the Catholic Church 'any person who procures a completed abortion incurs a *latae sententiae* excommunication.'[125] At the time of the abortion, the person is automatically expelled from the Catholic Church with no right to the Sacraments, and they are no longer considered a Catholic. It is difficult to argue against the proposition that abortion intends to terminate human life.[126] The natural law perspective on abortion, embodied by the Church and supported by its other teachings, makes two further propositions: that a human being is created at conception and that human life is scared.[127]

Consequently, direct abortion is not permissible notwithstanding the good intention of the doctor to enhance the woman's health and wellbeing.[128] In this approach, the intent of the abortion provider is unambiguous – they seek to terminate human life. Whilst the circumstances in which an action takes place can increase or diminish the overall moral good or evil of the action and the person's culpability, the nature and moral quality of the act remain unchanged.[129] Accordingly, if abortion is inherently bad, the circumstances in which it is performed can never transform it into something good.

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[123] See Aquinas, *Summa Theologiae Volume 11 Man (Ia. 75-83)* (n 24); Catholic Church, *Catechism of the Catholic Church* (n 11) [1755]- [1756]; Daniel Sulmasy and Edmund Pellegrino, 'The Rule of Double Effect' (1999) 159 *Archives of Internal Medicine* 545. The authors explain the principle of double effect.
[124] Catholic Church, *Catechism of the Catholic Church* (n 11) [2271]-[2272].
[125] Catholic Church, *Code of Canon Law* (n 12) 1398.
[126] That is to not to say that there cannot be arguments as to whether there is a difference between human life and a human person.
[127] Congregation for the Doctrine of the Faith, *Dignitatis Personae: The Dignity of a Person*, *Instruction on Certain Bioethical Questions* (Libreria Vaticana, 2008) 10-11. The Church states, 'Indeed the reality of the human being for the entire span of life, both before and after birth, does not allow us to posit either a change in nature or gradation in moral value, since it possesses full anthropological and ethical status. The human embryo has, therefore from the very beginning, the dignity proper to a person.'
[128] Catholic Church, *Catechism of the Catholic Church* (n 11) [2271].
[129] Ibid [1754].

In contrast, abortion which intends the demise of the unborn child is morally permissible under utilitarian/consequentialist philosophy. As discussed, this theory is not concerned with the morality of the act as its focus is upon the consequences of it.[130] Since the ends justify the means, questions such as whether the unborn child is a human person are not relevant to the analysis of whether abortion is morally permissible. Instead, the focus of analysis is on the ends it achieves, such as preserving the woman's health, sexual freedom, avoiding the responsibility and sacrifice of raising a child and facilitating work outside the home.[131]

If a person places value on these ends, and one accepts that contraceptive drugs and devices have a failure rate and rape can cause conception, then they likely subscribe to the utilitarian/consequentialist approach to justify abortion. Control of reproduction is good for society. Therefore, making abortion lawful is sensible so long as one either dismisses the Kantian notion that rational human beings are an end in themselves or re-defines what a human being is. Alternatively, some abortion advocates concede that the unborn child is a human being but argue that abortion is morally justifiable as a form of self-defence.[132]

Justifying the abortion of an unborn human as self-defence requires an analysis of the reasons why abortion is being sought. This is because where a person's base premise is that both have a co-equal right to life, proportionality, necessity and reasonableness must be satisfied.[133] Where the unborn child poses a threat to the life of the woman, and abortion is being considered as a legitimate response, questions that arise include whether the threat really is imminent and significant, whether abortion is the only option to eliminate the threat, and whether there are likely to be long term consequences to her of undergoing abortion.

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[130] Beauchamp and Childress (n 66) 355. Arguably, whilst Mill and other utilitarians rejected the notion of objective moral truth, they were not subjectivists. Rather, they believed in inter-subjective moral answers.

[131] Sara E Davies 'Reproductive Health as. Human Right: A matter of access or provision?' in Michael A Grodin, Daniel Tarantola, George G Annas and Sofia Gruskin (eds), *Health and Human Rights in a Changing World* (Taylor and Francis Group, 2013) 389. See also Helga Kuhse and Peter Singer, *A Companion to Bioethics* (Wily-Blackwell, 2nd ed, 2018) 670, 7.

[132] See Judith Jarvis Thompson, 'A Defense of Abortion' (1971) 1(1) *Philosophy & Public Affairs* 47. See also, John Finnis, 'The Rights and Wrongs of Abortion: A Reply to Judith Johnson' (1973) 2(2*) Philosophy and Public Affairs* 117.

[133] Cf United Nations, Human Rights Committee, *General Comment No. 36 Article 6 right to life* UN Doc CCPR C/GC/36 (3 September 2019). At paragraph 12, the Human Rights Committee defines self-defence where there it is '…strictly necessary in view of the threat posed by the attacker; it must represent a method of last resort after other alternatives have been exhausted or deemed inappropriate and the amount of force applied cannot exceed the amount strictly needed for responding to the threat… the threat responded to must involve imminent death or serious injury.'

The equating of a threat to the woman's life with a threat to her health, including her mental health, emerged from the infamous case of *R v Bourne,* where the court was asked to determine whether an abortion on a teenage girl who conceived through rape met the legal exception that the abortion was for the purpose of saving her life. [134] The court held that the prospect of leaving the girl 'a mental wreck' qualified as a threat to her life. This was based on the defendant's opinion of the likely outcome. Interestingly, the court did not hear evidence about alternatives to abortion that could avoid harm to her.[135]

Whilst there has been wide scale acceptance in law that a threat to the woman's life equates to a threat to her health, to argue abortion as self-defence because the unborn child threatens the woman's autonomy requires a re-definition of the meaning of 'health' that encompasses the notion of 'wellbeing.' With no objective method of determining wellbeing, it is left to the woman to decide what will benefit her overall. She then requires a doctor who assents to her self-assessment that abortion is a good choice for her and is willing to use their professional skills to achieve this outcome.

For those who support the right to control reproduction but have trouble morally justifying abortion up to birth for any reason the woman believes benefits her wellbeing, they must alter the base premise that the unborn child does not have a co-equal right to life. [136] Accordingly, personhood arguments are often used to soften the utilitarian approach. If there is a difference between a human being and a human person, one can argue that it is not always *prima facie* morally impermissible to terminate human life.[137] This is the basis of laws that provide exceptions for abortion.

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[134] *R v Bourne* [1937] 1 KB 687.
[135] Ibid.
[136] See Beauchamp and Childress (n 66) 357-8. Some utilitarianism places a different emphasis upon when certain moral rules can be expended where they do not promote utility in a certain context. See also Lysaught (n 66) 674.
[137] Lysaught (n 66) 670.

As Khuse and Singer note, some proposed criteria for personhood include the existence of certain properties such as: 'self-consciousness, capacity for rational thought, being a subject of non-momentary interests, having a mental life that involves continuity of and connectedness via memory or simple consciousness.'[138] Alternatively, others have suggested that that the capacity for any of these properties is sufficient to define a person, or that it is possible to have degrees of personhood.[139] This lack of consensus on personhood within the philosophical community suggests that at this stage, the debate will continue on without resolution in sight.[140]

These personhood issues were raised in the seminal 1973 decision of the United States Supreme Court in *Roe v Wade* (recently overturned at the time of writing).[141] Justice Blackmun noted the following regarding when the state may enact laws to restrict abortion due to the fact that it has a duty to protect human life:

> We need not resolve the difficult question of when life begins. When those trained in the respective disciplines of medicine, philosophy, and theology are unable to arrive at any consensus, the judiciary, at this point in the development of man's knowledge, is not in a position to speculate as to the answer.[142]

The *legal* question was answered by Justice Blackmun based on the evidence before the Court. His Honour held that viability was the key and that the unborn child at the end of the second trimester 'has, at most, only potentiality of life.'[143] Twenty years later, the trimester system was replaced by the more specific notion of gestational weeks with 24 weeks being the time when an unborn child was considered 'viable' and thus when the state could lawfully infringe the woman's liberty so as to protect the life of the unborn child.[144] This provided the legal community with its own 'personhood' criteria that has been used in legislation for years. [145]

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[138] Kuhse and Singer (n 131) 620.
[139] Ibid.
[140] See, eg, Francis J Beckwith, 'Thomson's "Equal Reasonableness" Argument for Abortion Rights: A Critique' (2004) 49 *The American Journal of Jurisprudence (Notre Dame)* 185, 188. Therefore, whilst science can undoubtedly assist with measuring the criteria, there is no agreement as to what the criteria should be, who has the authority to decide this, nor to what extent the property must be present to satisfy personhood.
[141] *Roe v Wade,* 410 U.S. 113 (1973) ('*Roe*').
[142] *Roe* [160].
[143] Ibid.
[144] *Planned Parenthood of Southeastern Pa. v Casey* 550 U.S. 833 (1992) ('*Casey*').
[145] At the time of writing, *Roe* and *Casey* have been overruled in *Dobbs, v Jackson Women's Health Organization*, 597 U.S _ (2022) ('*Dobbs'*). This is an historical ruling, the effects of which are unclear at this time.

It is worth noting that where the term abortion is used in this thesis, it refers to what the Catholic Church calls 'direct' abortion as distinct from 'indirect' abortion, which may be morally permissible.[146] An example of indirect abortion, is foetal death due to an *unintentional but foreseeable* consequence of action taken to save the life of the mother such as removing a fallopian tube or cancerous womb containing an unborn child. The doctor does not intend their death but *passively permits* it to save her life.[147] A parallel exists with passive euthanasia and the removal of life support despite accelerating death.[148]

The absolutist belief that certain acts are by their nature always and at any time evil or morally impermissible is a high threshold. It can be an obstacle to unity amongst people who agree that the unborn child is a human person, or at least a human being with some degree of moral status, but they subscribe to other normative ethical theories where the intention of the doctors or the circumstances surrounding abortion can transform it into a good act. Accordingly, there can be fragmentation amongst people, including doctors who self-identify as being 'pro-life,' as to when and why abortion is morally wrong.

A central question explored in this thesis' empirical study was whether participants shared homogenous views on whether abortion is always wrong. Whilst there was general uniformity on this question, fragmentation was apparent regarding complicity in abortion, such as performing ancillary tasks associated with abortion. When it comes to complicity in evil actions, Archbishop Fisher notes that there is 'no more difficult question in moral theology' and 'perhaps this explains why so little has been written on it compared with the headline issues.'[149] This chapter now concludes with discussion on moral complicity.

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[146] Catholic Church, *Catechism of the Catholic Church* (n 11) [1755]. This distinction proved to be relevant to many participants in the qualitative study for this thesis, particularly those who identified as being of the Catholic faith.

[147] Ibid [2269]. It is accepted that there can be difficult distinctions between direct and indirect abortion. See, e.g., Gerald D Coleman, 'Direct and Indirect Abortion in the Roman Catholic Tradition: A Review of the Phoenix Case' (2013) 25 *HEC Forum* 127.

[148] See Dan W Brock, 'A Critique of Three Objections to Physician Assisted Suicide' (1999) 109(3) *Ethics* 519, 523.

[149] Fisher, *Catholic Bioethics for a New Millennium* (n 99) 70.

3.6 MORAL COMPLICITY

A complete set of principles regarding moral complicity can be found in the manual system of moral theology of the Catholic Church.[150] As Oderberg notes, this system of moral theology used in Catholic teaching is 'independently plausible despite its association with moral theology' and as such, could potentially be used as a 'judicially recognised ethic of cooperation.'[151] To be clear, the system is not specific to abortion, and it does not have a particular definition of wrongdoing. As such, it can be applied to any number of circumstances without the need to accept Catholic teaching on specific issues.[152]

For Catholic doctors, the encyclical *Evangelium Vitae* is a valuable reference regarding moral complicity in abortion. It teaches that forcing a person to co-operate in an immoral act, where a person does not share the intention of the act but has assisted in the circumstances of the act, may have negative consequences for the person.[153] There is no binding Magisterial teaching for Catholics about which co-operative actions are morally permissible. Hence, a person uses the system to form his or her private conscience. Arguably, the system should assist persons to be able to explain the basis of their sincerely held beliefs in a rational manner.[154]

Formal co-operation occurs where the person shares the intention of the person performing the principal act.[155] This would apply to health professionals who do not perform the abortion but share in the intention of the person performing the abortion, which is to terminate the life of the unborn child. Formal co-operation subdivides into direct/indirect actions, proximate/ remote actions, and active/passive actions.[156] Formal co-operation may include peripheral assistance. Regardless of the subtype of co-operation, if an action is morally impermissible, then where one shares in the intention of the principal agent, one shares in the guilt.

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[150] See Liguori (n 95). See also, Raphael Gallagher, 'The Manual System of Moral Theology since the Death of Alphonsus' (1985) 51(1) *Irish Theological Quarterly* 1.
[151] David S Oderberg, 'Further Clarity on Cooperation and Morality' (2017) 43 *Journal of Medical Ethics* 192, 193.
[152] Ibid. This system of moral complicity could be of great practical assistance to doctors and, as Oderberg notes, judicial recognition of this system of co-operation could also provide better support to the legal reasoning of courts faced with claims for conscience protection arising from cooperation.
[153] John Paul II, *Evangelium Vitae* (n 13) [52] – [63], [68] – [74].
[154] Oderberg (n 151). Oderberg argues that basing decisions on whether to allow conscientious objection based on 'mere sincerity' can lead to absurdities.
[155] Anthony Fisher, 'Co-operation in Evil: Understanding the Issues' in Helen Watt (ed) *Co-Operation, Complicity and Conscience* (The Linacre Centre, 2005) 27, 30-2.
[156] Ibid.

If a health professional shared in the intention of an abortion provider, then the following actions performed by the health professional are likely to be assessed as examples of formal co-operation in abortion that is also direct, proximate, and active: a doctor or nurse assisting an abortion provider at a surgical abortion by handing the abortion provider instruments, a doctor administering anaesthetic to the woman undergoing surgical abortion, a pharmacist dispensing a prescription for abortifacients so a woman can perform self-abortion, and a doctor referring a patient to an abortion provider in order for abortion to be performed.

Material co-operation is challenging and where much of the grey area appears in conscience claims. Like formal cooperation, the person provides peripheral assistance however with material co-operation, the person does not share the intention of the person performing the act. There are various reasons why the person co-operates with the principal agent including fear, coercion, or an inducement.[157] Material co-operation subdivides into direct/indirect, proximate/remote, active/passive.[158] Direct material co-operation is proximate participation in part of the act of abortion. It is morally impermissible regardless of the person's intention.[159]

Indirect material co-operation refers to supplying the means or conditions for something to occur. It can be proximate or remote.[160] In itself, the action may be morally permissible, but it is used to serve an immoral purpose. In some cases, the remoteness of the act to the principal act could be sufficient to make the action of the co-operating person morally permissible, but strict conditions must be met. There must be a proportionately grave reason which renders this level of cooperation licit. This requires an equivalency between the good that is sought to be achieved, and the unintentional evil that is caused by doing the good.[161]

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[157] Ibid. See also Oderberg (n 151).
[158] Fisher, 'Co-operation in Evil: Understanding the Issues' (n 155).
[159] Proximity can refer to where in the causal chain the person providing peripheral assistance stands in relation to the person performing the principal act. However, it is not restricted to spatio-temporal issues. Hence, an action may still be proximate even though distant in the spatio-temporal realm. See Oderberg (n 151) 194. The use of vaccines for Covid-19 that have been produced or tested on the cell lines of electively aborted babies has provoked a theological dispute in the Catholic Church about moral complicity. See 'Note on the Morality of using some Anti-Covid-19 Vaccines', Congregation for the Doctrine of the Faith, (Web Page, 21 December 2020) <https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20201221_nota-vaccini-anticovid_en.html>; Cf Bishop Athanasius Schneider, 'Covid Vaccines – "The Ends Cannot Justify the Means"' (11 December 2020) *Crisis Magazine* <https://www.crisismagazine.com/2020/covid-vaccines-the-ends-cannot-justify-the-means>.
[160] Oderberg (n 151).
[161] Ibid. Oderberg concedes that proportionality judgments tend to rely on reasoning that is non-consequentialist and as such, proportionality as a criterion for co-operation may be dismissed by some as being impossible to achieve or only possible to achieve by imposing a specific normative ethical theory.

When the principal act is abortion, then the type of co-operation a doctor renders for any peripheral assistance will turn heavily upon the facts. Arguably the laws of a particular country or region are relevant in terms of providing the circumstances in which abortion is delivered and accessed by women including who may perform abortion and where and how it is performed. Additionally, the steps the co-operating doctor took to minimise the risk of abortion occurring, and the probability that abortion will occur because of the doctor's indirect actions must all be considered.

Possible examples of actions which *may* involve material, indirect, remote co-operation in abortion include: filling out necessary paperwork to admit a patient into hospital for an abortion; inserting an intravenous line into a patient for the administration of drugs to induce abortion as well as drugs to assist in her recovery post abortion; a doctor referring a patient to an organisation which does not have a conscientious objection to abortion and which may facilitate abortion for the woman; and a doctor being consulted about options for a crisis pregnancy and failing to discuss options other than abortion with the patient.

Each one of these examples would require more detail in order for an assessment to be made. It may be that regardless of whether the health professional performs the action which co-operates in the abortion, it is highly likely that the abortion will occur anyway, and the consequences for the health professional in not performing the action could be loss of their job or disciplinary action that is likely to cause them and their family direct harm. It may also be that the health professional fears reprisals and as a result, has taken no reasonable steps to find out what information they may provide to patients to assist them to continue with pregnancy.

It is unsurprising that little has been written in bioethics discourse on moral complicity. This thesis speculates that as moral complicity is so fact specific and the subject of such intense debate, it is likely to result in a difference of opinion by those trained in this area of moral theology as well as those who work in the health professions and have had to make decisions on what to do. Accordingly, this section merely provides an outline of this complex area and raises some potential applications of theory to practice regarding doctors and health professionals co-operating with abortion.

An emerging trend in some states of Australia where doctors with a conscientious objection to abortion have a duty to refer patients to a non-objecting doctor, is to permit them to discharge that duty by referral to a specified third-party organisation(s) which provides 'all options' information to patients.[162] Under the Catholic system of moral complicity, it is arguable that this could break any causal chain for complicity in abortion. However, this conclusion may be dependent upon the content of information which the third-party organisation provides to the woman and any further referrals they may make.[163]

Pre-abortion counselling and 'all options' counselling is a highly contentious area with no clear definition of who may speak about abortion, what they may say about it, and what expertise the organisation has with assisting women to continue with pregnancy as opposed to ending it.[164] With the dominant discourse in Western countries supporting abortion as a human right,[165] research that links abortion with harm to women can fail to make any impact.[166] Alternatively where such research is published,[167] it is often criticised for having flawed methodology,[168] with its researchers 'swiftly discredited.'[169]

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[162] See *Reproductive Health (Termination of Pregnancy) Act 2013* (Tas) s 8(3); *Abortion Law Reform Act 2019* (NSW) s 9(4); *Termination of Pregnancy Act 2021* (SA) s 11(4).

[163] It would also need to consider the penalties faced by the doctor who fails to comply with this level of co-operation such as disciplinary action and de-registration. This may assist the person in discerning whether a proportionately grave reason exists which justifies their co-operation in what they believe is wrong.

[164] See Anna Walsh and Tiana Legge, 'Abortion Decriminalisation in New South Wales: an analysis of the Abortion Law Reform Act 2019 (NSW)' 2019 27(2) *Journal of Law and Medicine* 325, 328-331.

[165] See, eg, Garratt (n 62) 58; Ronli Sifris and Suzanne Belton, 'Australia: Abortion and Human Rights' (2017) 19(1) *Health and Human Rights Jou*rnal 209; Barbara Baird and Erica Miller, 'More than Stigma: Interrogating Counter Narratives of Abortion' (2019) 22(7-8) *Sexualities* 1110.

[166] See Fritz Baumgartner, 'Human Embryonic Stem Cell Research, Abortion and Publication Bias in the N*ew England Journal of Medicine'* (2019) 86(1) *Linacre Quarterly* 103, 108-9. Baumgartner reported that between 2000 and 2017, the *New England Journal of Medicine* demonstrated a consistent, aggressive editorial bias defending abortion providers, with over 50 pieces favourable to abortion published, but no publication of contrary opinions regarding negative risks associated with abortion.

[167] See, eg, Priscilla K Coleman, 'Abortion and Mental Health: quantitative synthesis and analysis of research published 1995–2009' (2011) 199(3) *British Journal of Psychiatry* 180. See also, David M Ferguson, L John Horwood, and Joseph M Boden, 'Does Abortion Reduce the Mental Health Risks of Unwanted or Unintended Pregnancy? A Re-Appraisal of the Evidence' (2013) 47(9) *Australian and New Zealand Journal of Psychiatry* 819.

[168] See Vignetta E Charles et al, 'Abortion and Long-term Mental Health Outcomes: A Systematic Review of the Evidence' (2008) 78(6) *Contraception* 436. The authors concluded that high quality studies found only minimal if any negative psychological sequelae from abortion, whereas those studies which found a link had flawed methodology. There is obviously an issue as to whether this criticism itself is flawed but this is beyond the scope of this thesis.

[169] See Garratt (n 62) 57-61.

As a result, and as Garratt observes, this can unconsciously lead to doctors self-censoring their advice to pregnant patients.[170] A lack of discussion by a doctor about the realities and risks of abortion, and its alternatives for fear of judging a pregnant woman (and causing offence) is worrying for it would seem to go against requirements for informed consent.[171] In addition, an argument can be made that the failure of a doctor to properly advise a pregnant woman about the option of continuing pregnancy with support could render the objecting doctor's inaction as proximate co-operation (as opposed to remote co-operation) in any abortion which ensues.[172]

Garratt refers to doctors who fail to speak up for fear of negative reprisals as 'walking the tightrope.'[173] She argues that they can place a woman on a pathway to abortion when they refer her to a third-party organisation which shares the dominant worldview on abortion being a human right.[174] This is because the doctor's silence may have a significant impact on women seeking information or support on continuing crisis pregnancies.[175] In this context the objecting doctor's conscience may compel them to take steps to ensure the woman has information on organisations which will support her in continuing with the pregnancy.[176]

Such steps might include giving the patient the name of a website address or contact information of an appropriate person or organisation. This must be weighed against any legal prohibition on the doctor from referring their patient to an unapproved organisation that supports women continuing pregnancy that may in turn result in civil penalties such as professional disciplinary proceedings for the doctor. Ultimately, without a consensus on what constitutes proximate material co-operation in abortion, it is the doctor's private conscience that determines what they will be done, assisted by his or her intellect, emotions and free will.

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[170] Ibid 98-9.

[171] This is particularly so where a doctor suspects that coercion is at play. Reproductive coercion, which includes coercing a pregnant woman into undergoing abortion is considered a crime in New South Wales. See, C*rimes Act 1900* (NSW) s 545B(1A)(a).

[172] This assessment involves several hypotheticals such as whether or not the woman was unaware of alternatives and if she would have availed herself of them, if so advised by the doctor.

[173] Garratt (n 62) 98-99

[174] See Baird and Miller (n 165) 1121. In this study, the authors reviewed the websites of Australian abortion clinics and pro-choice feminist commentary on abortion to see how they represented abortion. They noted a move away from stigma and foetocentric depictions of abortion to affirmation of personal autonomy for the woman who finds herself unwillingly pregnant. Ultimately the authors recommended researchers search for and amplify positive representations of abortion as a standard health procedure in addition to the individual experiences of women.

[175] Garratt (n 62) 98-99.

[176] There is an assumption here that the doctor has knowledge of such organisations and believes that the content and delivery of their information is accurate and delivered in a way which will not harm the woman. This is an issue that was explored in this thesis' empirical study.

3.7 CONCLUSION

The aim of this chapter was to address the theory of conscience most likely to accord with the participants to this thesis' empirical study, being 35 doctors with a conscientious objection to abortion who practice in New South Wales and Victoria. It forms the pre-interpretative framework of conscience from which the participants' responses were interpreted. As the majority of participants identified as members of the Catholic faith tradition, this chapter highlighted the Catholic Church's teachings on conscience and conscientious objection to abortion, which can be placed within the natural law.

The notion of conscience explored in this chapter is tied to the notions of truth, freedom, and right reason. Conscience has been called a person's only witness to their faithfulness with the law, with this witness taking place within their heart, where its workings cannot be seen by others. True law is said to be right reason, in conformity with our human nature, which is immutable and eternal. Our human reason calls us to do good and avoid evil. Accordingly, the judgement of the person's conscience has consequences for the person for as Newman noted, 'conscience has rights because it has duties.'[177]

As John Paul II notes 'in the practical judgment of conscience which imposes on the person the obligation to perform a given act, the link between freedom and truth is made manifest.'[178] As such, doing the right thing then, is the key to freedom. With practice, we become used to doing the right thing and we want to do the right thing. Thus, to be compelled to act against conscience is to act against one's reason. This disharmony is a source of harm discussed earlier in this chapter; specifically, the harm of having acted against our conscience irrespective of anguish. The harm is to our dignity as a human person and is rightly called 'dignitary harm.'

[177] Newman (n 33).
[178] John Paul II, *Veritatis Splendor* (n 6) [61].

Context is essential to understanding conscientious objection in healthcare. In medicine, attempts to find a 'common morality' with widely shared norms and a system of action guidance acceptable to a pluralistic society, resulted in the normative ethical theory of Principlism, with its four principles of respect for autonomy, beneficence, non-maleficence, and justice.[179] However as Tonti-Filippini observes, problems occur when principles lack precision or reflect political and social values.[180] Consequently, it can fail to provide a platform upon which to resolve conflicts.[181]

Twenty years ago, Pellegrino noted the loss of a 'common professional conscience' in medicine because of what he described as 'wildly divergent' positions within the profession about what is morally permissible.[182] The change in how we view the ends of medicine has a significant impact on the discussion on how we manage conscience conflicts in healthcare. Whilst it used to be concerned with curing disease and maintaining health, these ends of medicine now include enhancing the patient's quality of life and requiring the doctor to consider and adopt the patient's subjective views on happiness and wellbeing so as not to cause offence.

As these may conflict with a doctor's belief about what is good medicine, it is inevitable that conflict may arise where the patient requests a service that is lawful but which the doctor refuses to perform or co-operate in. Ultimately, as the doctor has a dual obligation to themselves and the patient, they must inform their conscience, know their personal beliefs, and identify when they may compromise, and when they must refuse to maintain their integrity and avoid harm to themselves. This requires more than professionalism. It requires an investment by doctors in their philosophical and ethical education, as well as personal courage.[183]

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[179] Beauchamp and Childress (n 66).
[180] Tonti-Filippini (n 45). See also the previous comment made about the problematic nature of values discourse generally as it has been identified as a language that entails 'that nothing is intrinsically good and no one is intrinsically worthy.' Edward Andrew quoted by Iain T Benson, 'Civic Virtues and the Politics of "Full Drift Ahead" (Occasional Paper, Centre for Independent Studies. Acton Lecture, 19 June 2017).
[181] See, Tom Koch, 'Bioethics as Ideology Conditional and Unconditional Values' (2006) 31 *Journal of Medicine and Philosophy* 251, 252.
[182] Pellegrino (n 37) 230.
[183] See Fabrice Jotterand, 'The Hippocratic Oath and Contemporary Medicine:
Dialectic between Past Ideals and Present Reality?' (2005) 30(1) *Journal of Medicine and Philosophy* 107, 118. Jotterand notes the loss of moral identity of the medical profession with its confused view of 'medical professionalism.' To this end, this thesis provides in its appendices, a recommended list of books for doctors and others to read entitled 'Conscience and Creating a Culture of Respect.'

When it comes to abortion, legal frameworks have elevated it to standard healthcare, with freedom to choose abortion symbolising the ultimate in human dignity. It clashes directly with the simple, ordered, and systematic way in which the natural law, enhanced by the Magisterium of the Church, considers the issue. However, opposition is not just a 'religious belief.' Whilst conscientious objections to abortion is loudly pronounced by the Catholic faith, its justifications are based on a series of metaphysical beliefs about the human person which make a valid philosophical argument which does not require a belief in God.

The Magisterium's teachings on conscience and the moral law have had a significant impact on Western thinking on ethics. They remain a primary source of knowledge. Despite differences of opinion regarding what abortion is and whether it is wrong, a conscientious objection by a doctor refusing to perform an abortion is accepted by many as being rational and able to be understood by public reason.[184] The battle ground today is not about compelling direct participation in abortion, but rather on indirect participation or co-operation in abortion and supposed harm to the community from doctors with absolutist 'pro-life' views.

The benefit of philosophical debate in this area should be obvious however as George notes, policies that compel doctors with a conscientious objection to abortion to refer to abortion providers use science to 'silence or marginalize' conscientious objectors and avoid further inquiry on this level.[185] Under the banner of science, he notes, these policies impose on doctors a conception about the ends of medicine, abortion, and conscience, whilst at the same arguing that conscientious objectors who refuse to perform abortion are imposing their views on patients and causing them harm.[186]

[184] This can be distinguished from a conscientious objection to refer for abortion, or to prescribe emergency contraception. See, eg, Robert F Card, 'Conscientious Objection and Emergency Contraception' (2007) 7(6) *American Journal of Bioethics* 8; Robert F Card, *A New Theory of Conscientious Objection in Medicine: Justification and Responsibility* (Taylor & Francis, 2020).
[185] Robert P George, 'Conscience and It Enemies' (2013) 18 *Catholic Social Science Review* 281, 281.
[186] Ibid 284.

This chapter has touched upon the notion of harm as a basis for resolving conscience conflicts between doctors and patients. This is a contentious area that has been taken up by the law in its attempts to mediate rights disputes and it will be the subject of further exploration in the next chapter. However arguably, the law's ability to provide a just response can be hampered where its own understanding of conscience is narrow and non-inclusive or where it adopts the state's underlying assumptions about why lawful abortion is healthcare and therefore good for society and carries those assumptions over uncritically to the issue of conscience protection.

As abortion ends a human life, it is 'a profound moral question'.[187] Arguably, the metaphysical foundations, often implicit, which form a person's beliefs connect with their understanding and experience of the notions of health and harm as well as freedom and conscience. In a legal system which purports to uphold freedom of conscience, people are free to disagree with the state about whether abortion is healthcare and something good. The central issue is whether barriers need to exist for doctors and health professionals who want to act in accordance with their beliefs about abortion because of its supposed impact on the community.

In laying out a theoretical framework for conscience based on a natural law perspective, as enhanced by teachings of the Catholic Church, this chapter has discussed the nature of conscience, its relationship between our intellect and our emotions, and the process of conscience and its practical application to the specific issue of doctors and conscientious objection to abortion. Its purpose was to prepare the reader for the findings of the empirical study attached to this thesis, in order to understand how these participants might be harmed by being compelled to act against their conscience.

This chapter's discussion on conscience and how it operates, as well as the systematic principles involved with moral complicity and its application to common scenarios in abortion, can potentially influence the formation of the civil law. It can do this by assisting with legal reasoning in court decisions, notwithstanding its roots in Catholicism. This thesis now moves on to an exploration of trends in human rights laws that impact freedom of conscience as well as a doctrinal analysis of the domestic laws impacting upon freedom of conscience and abortion, focusing particularly on conscience protection.

[187] *Dobbs* (n 145) 78-9.

CHAPTER FOUR

LEGAL ANALYSIS: CONSCIENTIOUS OBJECTION TO ABORTION

> What is at stake therefore is an essential right which, precisely as such, should be acknowledged and protected by civil law. In this sense, the opportunity to refuse to take part in the phases of consultation, preparation and execution of these acts against life should be guaranteed to physicians, health-care personnel, and directors of hospitals, clinics and convalescent facilities. Those who have recourse to conscientious objection must be protected not only from legal penalties but also from any negative effects on the legal, disciplinary, financial and professional plane.[1]

4.1 INTRODUCTION

This chapter provides an analysis of law pertaining to conscientious objection to abortion, with an emphasis on the domestic law of Australia. The analysis in this chapter provides the context for undertaking this thesis' empirical study which seeks to know more about doctors with a conscientious objection to abortion who practice within two Australian jurisdictions.

Freedom of conscience is a broad area of human rights law which also encompasses thought and religion.[2] As Taylor notes, this freedom is 'both symptomatic of a healthy democratic society and essential to the pluralism associated with a modern democratic society.'[3] There are many circumstances where individuals, religious organisations, and belief associations, find it difficult as a matter of conscience to comply with laws of general applicability.[4] Therefore, modern democracies tend to encourage tolerance of minority practices by informal accommodations or by enacting a formal system of exemptions.[5]

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[1] John Paul II, *Evangelium Vitae* (Catholic Truth Society, 25 March 1995) [74].
[2] See United Nations, *General Comment No. 22: The Right to Freedom of Thought, Conscience and Religion* CCPR/C/21/Rev.1/Add.4, G ('*General Comment No 22'*). See also Paul M Taylor, *A Commentary on the International Covenant on Civil and Political Rights* (Cambridge University Press, 2020) 499-537.
[3] Taylor (n 2) 501. See also *Kokkinakis v Greece* (European Court of Human Rights, Application. No 14307/88, 19 April 1993) [31].
[4] Religious objections can include eating certain food or taking alcohol; ascribing religious significance to certain days of the week or year where rituals are performed. Some religious communities or belief associations may refuse standard medical treatments. A well-known example is the Jehovah's Witness' refusal of blood transfusions.
[5] See William Galston, *The Practice of Liberal Pluralism* (Cambridge University Press, 2005) 2.

Exemptions from laws of general applicability can come in the form of general constitutional provisions, human rights instruments, and domestic anti-discrimination legislation. These can generally defend rights of conscience by implying that exemptions should be provided when conscientious objection has been raised.[6] They may also come in the form of legal exemptions for specific actions. However, respecting a person's conscience by allowing for exemptions to laws of general applicability can be subject to a proportionality test in which concerns about equality, discrimination, and harm to others are raised in reply.

There are many instances where domestic and specialist courts have had to determine conflicts. Well-known examples of conscientious objection include compulsory military service,[7] providing goods and services which celebrate homosexual orientation,[8] providing contraceptive drugs to employees through a company's health insurance plan,[9] removing religious clothing at work whilst employed by the state,[10] participating in or receiving health services or treatment,[11] and complying with public health orders to take a vaccine tested on the cell lines of electively aborted babies.[12]

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[6] See *International Covenant on Political and Civil Rights*, opened for signature 16 December 1966, UNTS 999 (entered into force 23 March 1976) art 18(3) ('*ICCPR*') art 18.

[7] See, eg, *Jeong et al v Korea*, CCPR/C/101/D/1642-1741/2007, 24 March 2011. Here the Human Rights Committee found that conviction of the authors for failure to undertake compulsory military service based on their religious objection against the use of arms to take the life of another person infringed art 18(1) of the *ICCPR*.

[8] See, eg, *Lee v McArthur &* Ors [2018] UKSC 49. Here, the UK Supreme Court held that a Christian bakery could not be forced to express a message on a cake with which they disagreed unless there was justification for doing this. At [69], the applicant's sexual orientation was held not to have been infringed, as the request would have been refused notwithstanding a customer's orientation, and his political beliefs did not provide justification for compelled speech which would have entailed imposing a civil liability for refusing to fulfil the order.

[9] See *Burwell v. Hobby Lobby Stores, Inc*. 573 U.S. 682 (2014). Here, the Supreme Court of the USA upheld a ruling that the US Department of Human Services could not mandate that a family business provide health insurance which funded contraceptive drugs and devices to employees where such drugs and devices offended against the deeply held religious convictions of the family business, and where such action violated a federal statute, being the Federal Religious Freedom Restoration Act 1993.

[10] See, eg, *Ebrahimian v France* App no 64846/11, Judgment, 26 November 2016 (ECtHR). Here, a Muslim social worker wanted to wear a veil to work. The ECtHR acknowledged her right to religious liberty was infringed but held that it was done to pursue the legitimate aim of protecting the rights and freedoms of others in a secular state that valued neutrality.

[11] See, eg, *Jehovah's Witnesses v the Russian Federation,* App no 302/02, 10 June 2010 (ECtHR). Here, the ECtHR found that members of the Jehovah's Witnesses faith in Moscow should be free to abstain from blood transfusion as a doctrine of their faith, notwithstanding that it raised questions of public health. Respect for human dignity and freedom, as well as self-determination and autonomy underpin the guarantees in the ECHR. As such, individuals must be free to pursue health options perceived by the state to be harmful or dangerous to them.

[12]See, eg, *Larter v Hazzard No 2* [2021] NSWSC 1451 (10 November 2021). Here, a paramedic was unsuccessful in challenging public health orders mandating he receive two doses of Covid-19 vaccines by a certain date or be prohibited from working as a paramedic. The applicant had a religious objection to taking the vaccines on the basis of being a Catholic opposed to receiving vaccines produced from cell lines from electively aborted babies. The Court held that under the *ICCPR,* public health can limit freedom of religion. Further, whilst the Court found the applicant's beliefs were genuine, it held that they departed from public statements of the Catholic Church and

Throughout history, religious minorities have sought exemptions from state laws which compelled them to act against what they believed were God's laws and were therefore intolerant and oppressive.[13] Prior to the rise in humanism, conscience was viewed through a theological lens.[14] Even after the Reformation, the search for truth was still conducted within the framework of the Christian Scriptures.[15] Accordingly, Hammer notes some of the difficulties in resolving conscience conflicts can be 'epistemological approaches that simply cannot escape from a pre-conceived understanding of religion and belief.'[16]

Today, there has been a rise of individuals with non-religious beliefs seeking exemptions or individuals who belong to an organised religion but whose objections are not considered by the courts to be linked closely enough to their religious belief. As Howe and Le Mire note, actions performed (or not performed) in accord with one's moral or philosophical convictions may fall into the category of 'secularised conscience.'[17] The notion of 'secularised conscience' raises the question of whether a non-religious belief is truly analogous to a religious belief and as a consequence, whether the law must respect and protect them in the same way.

Hammer asks:

> What role should beliefs that are not part of a religious system play in society and are they entitled to the same standing as a religious belief? What are the similarities and differences that the human rights system demands in providing protection to all forms of belief? Is it at all practical even to consider beliefs external to a formalised religious belief system given the difficulties in identifying such beliefs, the dangers associated with 'objective' external bodies assessing such beliefs, and the possibility that individuals might attempt to take advantage of the right?[18]

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hence his objection was considered to be a conscientious objection rather than a religious objection. Ultimately, the Court held it was reasonably open to the Minister for Health to make the public health orders.

[13] Leonard M Hammer, *The International Right to Freedom of Conscience: Some Suggestions for its Development and Application* (Taylor & Francis Group, 2019) 9-11. Hammer notes that throughout history and prior to the Enlightenment and the rise of individual moral reasoning, the enmeshing of religion with political systems meant that the authority of the state served to assert the dominant religion or prevent other religious beliefs from flourishing.

[14] Ibid 11.

[15] Ibid 12-13.

[16] Ibid 10. See also Joanne Howe and Suzanne Le Mire, 'Medical Referral for Abortion and Freedom of Conscience in Australian Law' (2019) 34(1) *Journal of Law and Religion* 85, 89-90.

[17] See Howe and Le Mire (n 16) 89-90.

[18] Hammer (n 13) 2.

Freedom of conscience must be considered in relation to the context of what is being objected to.[19] Chapter 3 described the natural law approach to abortion as well as counter perspectives. In legal disputes about conscientious objection to abortion, proportionality arguments revolve around notions of health and harm which may be subject to specific domestic definitions and cultural understandings. As such the domestic landscape, including the legal framework for abortion, community demand and the willingness of doctors to perform abortion, and the way in which abortion services are organised, resourced, and delivered are always important factors.

This chapter commences with identifying trends in human rights law, specifically decisions of United Nations' human rights law committees overseeing state compliance with human rights law in relation to the domestic regulation of abortion and the protection of conscience. It will identify and discuss the lens through which these committees view abortion and the fundamental rights and freedom of others and demonstrate why the most recent General Comment by the Human Rights Committee on the right to life confirms that states may limit conscientious objection by doctors to abortion in order avoid harm to women.[20]

Accordingly, given the domestic focus of this thesis' empirical study, this chapter's review of human rights law is selective in its scope. It focuses on how a state's conscience protection for health professionals regarding abortion have been challenged on the basis of other fundamental rights and freedoms of others, specifically the right to life, the right to health, and the notion of public health. The balance of this chapter is devoted to discussing the legal status of freedom of conscience protection in Australia generally, and then conscience clause protection for health professionals in respect of abortion in each jurisdiction specifically.

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[19] See Iain T Benson, 'Should There be a Legal Presumption in Favour of Diversity? Some Preliminary Reflections' in Iain T Benson and Barry W Bussey (eds) *Religion, Liberty, and the Jurisdictional Limits of Law* (LexisNexis, 2017) 13. This includes the specifics of the setting and beliefs involved before the abstract right is considered, otherwise it 'inappropriately places the onus where it does not belong.'

[20] See United Nations, Human Rights Committee, *General Comment No. 36 Article 6 right to life*, UN Doc CCPR C/GC/36 (3 September 2019) ('*General Comment No. 36'*).

Ultimately this chapter will demonstrate that Australian law has three distinct approaches to conscience protection for abortion. First, a broad approach where it protects doctors. Second, a narrow approach where it forces co-operation in abortion. Third, a 'middle way' approach which recognises the possible moral complicity of a doctor in abortion by referring a woman to a non-objecting doctor. The lack of national uniformity in approach in Australia, and the fact that the two most recent legislative reforms chose the 'middle way' approach suggests that Australian lawmakers may be open to trying to understand conscience in a broader way.

4.2 HUMAN RIGHTS PERSPECTIVES

4.2.1 FREEDOM OF CONSCIENCE

On one view, human rights are moral rights that are self-evident and attach to all people by virtue of them being human. They do more than conform to the will of the majority, or those with political power. They are said to impose a normative standard on all people regardless of culture and reflect our inherent dignity.[21] On one view, unlike legal rights, human rights are not 'given' to us by the state. They are not created by people, and they cannot be taken away.[22] Instead, the state protects these traditional rights and freedoms because as Cicero noted, 'what is right and true is also eternal and does not begin or end with written statutes.'[23]

The *ICCPR* recognises freedom of thought, conscience and religion as a fundamental human right enjoyed by all persons by virtue of their human dignity.[24] Specifically, art 18(1) provides that:

> Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance.

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[21] Mary Ann Glendon, *A World Made New* (Random House Trade, 2011) 221. See also Philip Alston and Ryan Goodman, *International Human Rights: Texts and Materials* (Oxford University Press, 2013) 687-9. The authors discuss the complexity of obliging sovereign states to respect human rights.

[22] This is of course a contested view. For example, Jeremy Bentham famously describing natural rights as 'nonsense on stilts.' See Philip Schofield, 'Jeremy Bentham's Nonsense on Stilts' (2003) 15(1) *Utilitas* 1, 2.

[23] M Cicero, 'Laws' in C Morris (ed) *Great Legal Philosophers* (University of Pennsylvania Press, 1959). Within natural law rights and natural law articulations there are critics of 'rights' as creations of a post Enlightenment humanism insufficiently based upon a richer recognition of human dignity in its theoretical ground. A variety of writers on this theme may be found in Tom Angier and Iain T Benson and Mark Retter (eds) *The Cambridge Handbook of Natural Law and Human Rights* (Cambridge University Press, 2022).

[24] *ICCPR* (n 6). See also, *Universal Declaration of Human Rights*, 1948, (resolution 217 A), adopted 10 December 1948 ('*UDHR*') art 18.

General Comment No. 22 from the Office of the High Commissioner for Human Rights, which comments on art 18 of the *ICCPR,* states that conscience is placed alongside freedom of thought and religion as a far reaching and profound fundamental human right which may not be derogated against, and which 'encompasses all matters, personal conviction, and the commitment to religious belief.'[25] Thought, conscience and religion include:

> [t]heistic, non-theistic and atheistic beliefs, as well as the right not to profess any religion or belief. The terms "belief" and "religion" are to be broadly construed. Article 18 is not limited in its application to traditional religions or to religions and beliefs with institutional characteristics or practices analogous to those of traditional religions.[26]

The use of the broader notion of conscience as opposed to the traditional notion of religion, with its attendant acceptance of the existence of God and of objective moral truth, is thought to effect greater freedom for all views. Promoting tolerance towards other views is in turn thought to be of great benefit in a pluralistic society.[27] However Haigh observes that conscience can be 'at best, just a silent partner to religion, and at worst, often ignored or unnoticed.'[28] He suggests that if conscience were recognised as an 'independent and robust freedom,' this could lead to a less contentious, less emotion driven freedom.[29]

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[25] *General Comment No 22* (n 2) [1]-[2].
[26] Ibid [2].
[27] See, eg, Nicholas Tonti-Fillipini, *About Bioethics Philosophical and Theological Approaches* (Connor Court, 2011) 126-128. Tonti-Fillipini observes that the term 'secular' has drifted from its original meaning of the governance of worldly affairs to 'a religious observance of an atheistic belief system or at the very least, an agnostic one, to the exclusion of any form of theism.' Accordingly, it is more appropriate to refer to pluralism. See also Roger Trigg, 'Freedom of Conscience and Freedom of Religion' (2010) 99(396) *An Irish Quarterly Review* 407, 408.
[28] Richard Haigh, 'Should Conscience be a Proxy for Religion in Some Cases?' in Iain T Benson and Barry W Bussey (eds), *Religion, Liberty, and the Jurisdictional Limits of Law* (LexisNexis, 2017) 203, 217.
[29] Ibid.

The controversy with religious freedom often arises because of the tendency to characterise religious views and practices which form the basis of an application for an exemption from laws of general applicability as being 'inferior and less deserving of protection than others.'[30] This characterisation may be fuelled by the fact that claimants need not prove the validity of the religious belief underlying their claim for religious freedom (which the courts lack the competency to assess).[31] However, the claimant is required to closely link the action with the belief. A remote connection with a precept of faith is generally not sufficient.[32]

A conscientious objection not based on a religious belief still has a connection with morality, but as Smith observes morality is never really defined.[33] Smith suggests three meta-ethical presuppositions for the source of morality. First, a natural law approach premised on the existence of objective moral truth and the need to demonstrate moral reasoning. Second, a relativist approach where the source of morality is whatever society says it is. Third, a subjectivist approach where the source of morality is the individual alone, with no need to refer to a common nature that imposes rules on everyone.[34]

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[30] Ibid.

[31] Cf *Bayatyan v Armenia* (European Court of Human Rights, Application No. 23459/03, 7 July 2011). This is based on article 9 of the European Convention on Human Rights which is similarly worded to art 18 of the *ICCPR*. See Council of Europe, *European Convention for the Protection of Human Rights and Fundamental Freedoms, as amended by Protocols Nos. 11 and 14*, opened for signature 4 November 1950, EST 5 (entered into force 3 September 1953) ('ECHR'). The ECtHR held that that the right to freedom of thought, conscience, and religion 'denotes views that attain a certain level of cogency, seriousness, cohesion and importance.' Cf The Supreme Court of the United States of America has held that the Court may not inquire into the truthfulness or falsity of a religious belief, only whether it is sincerely held by a person. See *United States v Ballard* 322 U.S. 78 (1944).

[32] *Eweida v United Kingdom* (European Court of Human Rights, Application No. 48420/10, 15 January 2013) [82]. See also *Skugar and Others v Russia* (European Court of Human Rights, Application No. 40010/04, 3 December 2009).

[33] Steven D Smith, 'The Tenuous Case for Conscience' (2005) 10 *Roger Williams University Law Review* 325, 328.

[34] Ibid 333.

Accordingly, a conscientious objection to an action which is derivative of an official teaching of a religion should qualify as a 'manifestation of a person's religion or belief.' As set out in chapter 3, when it comes to abortion Catholic doctors can rely on the Church's interlinked, official teachings on the nature of conscience and the need to form and follow it[35] and the moral impermissibility of performing or participating in direct abortion where there is an intent to cause foetal demise.[36] When it comes to co-operating in abortion, the person is required to apply the principles of moral complicity and follow their conscience, even if it is in error.[37]

Catholic doctors practising their faith could, it seems, qualify for freedom of conscience and freedom of religion. This may not be so for doctors of other religious faith traditions including other strands of Christianity where linkage to a religion as a group dimension is taken.[38] Their claims may more properly fall under freedom of conscience although this does not guarantee protection under the law. The *ICCPR* permits the state to limit a person's manifestation of their belief where it considers it necessary to preserve public security, public health, public morals, or public order or to protect the rights and freedoms of others.[39]

Regarding these limitations General Comment No. 22 provides that:

> Limitations may be applied only for those purposes for which they were prescribed and must be directly related and proportionate to the specific need on which they are predicated. Restrictions may not be imposed for discriminatory purposes or applied in a discriminatory manner.[40]

[35] Catholic Church, *Catechism of the Catholic Church* (St Paul's Publications, 2nd ed, 2009) [1786] – [1790].
[36] Ibid [270] – [2275]. See also Catholic Church, *Code of Canon Law* (Libreria Editrice Vaticana, 1983) [1398].
[37] Catholic Church, *Catechism of the Catholic Church* (n 35) [1790] – [1794].
[38] This is one legal method of approach but is not one recommended by this thesis. Idiosyncratic religious beliefs may still be considered religious beliefs and protect the dissenter.
[39] *ICCPR* (n 6) art 18(3).
[40] *General Comment No. 22* (n 2) [8].

The requirement for proportionality considers, amongst other things, how a person is harmed by being compelled to act against conscience. As will be seen in chapter 5, some studies found a correlation between doctors with a conscientious objection to abortion and those who identify as being 'religious,' but few have delved into the experience of objecting doctors.[41] Whilst it is not known whether an objection based on a religious belief increases the objector's level of anguish and distress, Smith suggests this could be so because the person's obligation to follow their conscience is an obligation which is independent of their preferences or the law.[42]

The anguish (described as 'moral distress') experienced by health professionals partaking in certain tasks was discussed in chapter 3. However as noted, the types of tasks focused on in those studies were not particularly controversial. There still needs to be discussion in the bioethics literature about the proper framing of a conscientious objection to abortion that goes beyond 'religious' objections. For example, a doctor's refusal to perform abortion based on a belief that it would be unsafe for the woman[43] could be a conscientious objection that also coincides with accepted 'professional ethics.'

With no hierarchy amongst rights and freedoms, the *ICCPR* permits states to elevate a doctor's freedom of conscience over a woman's legal right to access abortion and vice versa. The balance of this section focuses on decisions of the Human Rights Committee ('HRC') reviewing a state's compliance with the *ICCPR*. As will be seen, despite the variation in domestic laws and regulatory frameworks for abortion, the trend has been for the HRC to strike a balance between women's access to abortion and the doctor's right to conscientious objection to abortion by 're-framing' the right to life, the right to health and the notion of public health.

[41] See, eg, Farr A Curlin, et al, 'Religion, Conscience, and Controversial Clinical Practices' (2007) 356(6) *New England Journal of Medicine* 593.
[42] See, eg, Smith (n 33) 337. See also the discussion in chapter 3 on the types of harm from acting against conscience where the experience of anguish is not the sole determinant of harm as violation of conscience itself is a harm.
[43] Ibid 328.

4.2.2 THE RIGHT TO LIFE

The biggest challenge to a woman's lawful access to abortion overriding a doctor's conscientious objection to abortion is the moral taboo against intentionally killing another person. Art 3 of the *UDHR* provides that everyone has the right to life, liberty, and security of person'.[44] This is expanded upon in art 6(1) of the *ICCPR* which provides that '[e]very human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life'.[45] If the unborn child enjoys the right to life, it places obligations upon a state to protect that right.

Art 6(5) of the *ICCPR* also provides that 'sentence of death…shall not be carried out on a pregnant woman'. This lends support to the unborn child needing protection. Joseph argues that a proper review of the texts, historical context, and preparatory documents leads to the conclusion that the premise of the *UDHR* was that the unborn child 'is a member of the human family, with equal rights without distinction.'[46] Consistent with this, other documents such as the *Convention on the Rights of the Child,* explicitly recognises in its preamble, that the child 'before as well as after birth' requires special protection.[47]

Art 31 of the *Vienna Convention on the Law of Treaties* requires treaties to be interpreted in accordance with the ordinary meaning of treaty terms in their context and in light of their object and purpose.[48] Therefore it can be argued that the plain meaning of the child 'before and after birth' in, for example, the *Convention on the Rights of the Child*'s preamble, adds the necessary context and clarification to include the unborn child.[49] As such, Joseph concludes that as the international community accepted the premise that the unborn child had a right to life, it is not possible to derogate from it.[50]

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[44] *UDHR* (n 24); *ICCPR* (n 6).
[45] *ICCPR* (n 6).
[46] Rita Joseph, *Human Rights, and the Unborn Child* (Martinis Nihoff, 2009) 304.
[47] *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1577 UNTS 2 (entered into force 2 September 1990) preamble, para 6.
[48] *Vienna Convention on the Law of Treaties*, opened for signature 23 May 1969, 1155 UNTS 331 (entered into force 27 January 1990).
[49] Jacob Pichon, 'Does the Unborn Child Have a Right to Life" (2006) 7(4) *German Law Journal* 433, 441.
[50] Joseph (n 46).

This conclusion is disputed by others on the basis that the preamble is not enforceable, and as the text of the *Convention* fails to provide further guidance, the issue is open to discussion.[51] Disputers often point to the number of contracting states that had legalised abortion at the time of signing the *Convention*, the criticisms that states with restrictive abortion law have faced upon review by Treaty Monitoring Bodies or United Nations Committees, and the acceptance of lawful abortion as ancillary to the right to reproductive health discussed in international conferences.[52]

This dispute highlights different approaches to human rights law. Abortion advocates assert that human rights evolve and can abrogate old rights.[53] Arguably, this shifts the underpinnings of human rights law from natural law to a utilitarian/consequentialist philosophy, but raises the question of who may create these new rights and how this is done.[54] As Cornides muses, they could be a 'small and self-referential elite of enlightened technocrats that have somehow succeeded in occupying all available seats in all relevant committees and expert groups and now pretend to speak with universal authority.'[55]

Legally, there is no global consensus on the nature of the unborn human. As such, the scope and content of any human rights associated with the unborn are determined by a country's domestic law.[56] For Cornides, there can never be a human right to abortion on request. This is because it would require not only a common legal framework, but a common ethical ideology which in his opinion is impossible given that many of the world's leading religions are morally against it, with some countries also sharing that view.[57] However as noted in chapter 3, few religions absolutely condemn all abortion.

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[51] See, eg, Rebecca J Cook and Bernard M Dickens, 'Human Rights Dynamics of Abortion Law Reform' (2003) 25 *Human Rights Quarterly* 1, 24.
[52] See, eg, Beijing Declaration and the Platform for Action, Fourth World Conference on Women, Beijing, China, Sept. 4-15, 1995, UN Doc. A/CONF.177/20 (1995) para 106 (k).
[53] See, eg, Center for Reproductive Rights 'Bringing Rights to Bear', Briefing Paper, October 2008 <https://reproductiverights.org/document/bringing-rights-to-bear-abortion-and-human-rights>.
[54] Joseph (n 46) 329. Joseph argues that ideology must conform to human rights based in deontological duties and natural law principles, not the other way around.
[55] Jacob Cornides, 'Human Rights Pitted Against Man' (2008) 12(1) *International Journal of Human Rights* 107, 108-09, 112. Cornides argues at 112 that those who oppose conscientious objection to abortion overstate the religious aspect of the debate to paint objectors as 'obscurantist zealots with whom no reasonable exchange of arguments is possible…' and avoid the question of whether abortion is right or wrong.
[56] This is particularly the case in Europe where the European Court of Human Rights uses the margin of appreciation. See, eg, Alston and Goodman (n 21); Taylor (n 2) 163-5. For cases focused on the unborn child, see, eg, *Open Door and Dublin Well Woman v Ireland ('Open Door')* (1992) EHRR 244, 68; *Vo v France* (2004) 40 EHHR 12 [82], [84], [85].
[57] Cornides (n 55) 121.

The United Nations Human Rights Committee ('HRC') is empowered to monitor the substantial compliance of states with the *ICCPR,* provide 'General Comments' which clarify the nature of these rights, as well as make recommendations to states on how they can be realised.[58] Fine et al note that decisions and General Comments by these organs are necessary to 'advance an increasingly liberal international standard for abortion that has the potential to transform jurisprudence and impact domestic law and policy.'[59] This thesis will now consider the trends in key documents and decisions regarding abortion and human rights.

Since 1993, United Nations treaty monitoring bodies or committees that monitor whether a member state has complied with its duties under international human rights law, have been critical of restrictive abortion laws in states that recognise the right to life in the unborn. Such laws have been largely characterised by these human rights organs as a violation of the pregnant woman's right to life and to health.[60] As will be seen, recommendations have been consistent: member states must legalise abortion so that women do not harm themselves by seeking clandestine abortions.

The justification for this recommendation is that restrictive abortion laws violate the right to life and health of the woman because those who break them by undergoing illegal and unsafe abortions may suffer harm.[61] As Cornides notes, the counter argument is that the purpose of restrictive laws is not to cause women harm, but to reduce abortions.[62] The fact that women may undergo unlawful abortion is not in itself a reason to abrogate prohibitions against abortion. Whilst not stated explicitly, the object achieved in rejecting restrictive abortion laws is to reject the premise that the termination of unborn life is wrong because it is human life.

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[58] *ICCPR* (n 6) art 28.
[59] Johanna B Fine, Katherine Mayall and Lilian Sepulveda 'The Role of International Human Rights Norms in the Liberalization of Abortion Laws Globally (2017) 19(1) *Health and Human Rights Journal* 69, 70. See also Joseph (n 46) who agrees that the HRC has been increasingly advocating for states to provide legal abortion which she says shows the HRC has been compromised by ideology.
[60] Center for Reproductive Rights, *Bringing Rights to Bear,* Briefing Paper, October 2008.
[61] Cornides (n 55) 115.
[62] Ibid.

In 2007, the HRC reviewed the compliance of Madagascar. Its concern was that Madagascan laws on abortion did not make permit abortion when the life of the mother is in danger. It recommended that Madagascar reform its laws to ensure women could avoid both unwanted pregnancies as well as clandestine abortions which placed their lives at risk.[63] In 2008, the HRC recommended that Panama, which at that time restricted abortion to the first two months of pregnancy in the case of a rape that has been documented in court proceedings, amend its legislation in a similar fashion.[64] The same recommendation was made to Jamaica in 2011.[65]

In 2014, the HRC reviewed the laws of Ireland. At that time, the Irish *Constitution* recognized that the unborn child had the right to life and the state had the duty to protect and vindicate that right in it laws.[66] Despite this, the HRC criticised the very limited circumstances where women could lawfully obtain an abortion in Ireland owing to the *Constitution*, as interpreted by the Irish courts,[67] and advised Ireland to reconsider its legislation on abortion, and then amend its Constitution, so as to permit additional exceptions in the law for abortion due to rape, incest, serious risks to the health of the mother or the presence of a fatal foetal abnormality.

Arguably, these examples show a politically active HRC failing to show deference to the cultural and religious views of domestic states which have chosen to make valid laws that restrict abortion on the basis that it is a moral issue which involves the taking of human life.[68] In 2014, the Committee on the Rights of the Child went a step further in criticising the Holy See, a confessional state, for its disciplining of two of its members in Brazil. Here, a 9-year-old girl pregnant via rape/incest underwent an abortion. Consequently, the local Archbishop sanctioned both her mother and the doctor who performed the abortion.

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[63] Human Rights Committee, *Concluding Observations Madagascar*, HR Doc CCPR/C/MDG/CO/3 (11 May 2007) [14].
[64] Human Rights Committee, *Concluding Observations Panama*, HR Doc CCPR/C/PAM/CO/3 (17 April 2008) [9].
[65] Human Rights Committee, *Concluding Observations Jamaica*, HR Doc CCPR/C/JAM/CO/3 (17 November 2011) [14]. When reviewing the compliance of Jamaica, the HRC was concerned that the prohibition on abortion compelled pregnant women to seek clandestine abortions, and the same recommendations were made that Jamaica change its laws to allow abortion.
[66] Human Rights Committee, *Concluding Observations Ireland*, HR Doc CCPR/C/IRL/CO/4 (19 August 21014) [9]. Ireland's Constitution can only be amended by referendum.
[67] See *Attorney General v X* [1992] 1 IR 1.
[68] Alston and Goodman (n 21) 946-7.

As noted in chapter 3, canon 1398 of the Catholic Church provides that 'any person who procures a completed abortion incurs a *latae sententiae* excommunication.'[69] This means that when abortion occurs, the person is automatically expelled from the Catholic Church and has no right to the Sacraments as they are no longer considered to be a Catholic. In its Concluding Observations, the Committee requested the Vatican 'review its position on abortion which places obvious risks on the life and health of pregnant girls and amend Canon 1398 to identify circumstances where access to abortion may be permitted.'[70]

As the young girl accessed an abortion, the Committee's concern seems to have been the Catholic Church's internal process of sanctioning members for a clear breach of Church law. Membership in the Catholic Church is voluntary. People are free to leave the Church at any time.[71] Arguably, therefore, the Committee's focus was the Church's teaching on abortion, which they considered to be harmful and an obstacle to human rights. The human rights organ was not only demonstrating disagreement with the Church' teachings, but tried to effect change of its long held beliefs.

In 2015 the HRC reviewed the compliance of Macedonia and noted that the state had conducted a prolife campaign that they determined stigmatised those who had undergone abortion.[72] The possibility of there being benefits in a prolife campaign were not considered. Rather, the HRC concluded this might prompt some women to put their lives at risk by undergoing clandestine abortions that were unsafe. It recommended in its Concluding Observations that Macedonia avoid any further prolife campaigns, change its abortion laws, and ensure any and all procedural barriers that could cause women to seek illegal abortions, were removed.

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[69] Catholic Church, *Code of Canon Law* (n 36) [1398].
[70] Committee on the Rights of the Child, *Concluding Observation on the Second Periodic Report of the Holy See*, UN Doc CRC/C/VAT/CO/2 (25 February 2014) para 55.
[71] See, eg, Paul VI, *Declaration on Religious Freedom Dignitatis Humane*, *On the Right of the Person and of Communities to Social and Civil Freedom in Matters Religious,* 7 September 1965 [14] <http://www.vatican.va/archive/hist_councils/ii_vatican_council/documents/vat-ii_decl_19651207_dignitatis-humanae_en.html>.
[72] Human Rights Committee, *Concluding Observations Macedonia*, UN Doc CCPR/C/MKD/CO/3 (17 August 2015) [11].

In 2016, the HRC reviewed Poland. Its complaints about Poland focused on what it said was the significant incidence of clandestine abortions which put women's lives and health at risk, as well as the practical and procedural barriers for accessing legal abortion that obliged women to travel long distances or go overseas. In regards to conscientious objection, it noted abuses by doctors such as where a whole institution in one region of the country did not have any doctors willing to perform abortion, the lack of a reliable referral system mechanism to non-objecting doctors, and the general scarcity of doctors willing to perform abortion.[73]

The HRC recommended that Poland perform research on the number of women undergoing illegal abortions, and ensure that conscientious objection by doctors did not lead to clandestine abortions. So, whilst not going so far as to recommend that doctors perform abortion against conscience, it recommended, amongst other things, that Poland establish and regulate standardised guidelines in public health for the provision of lawful abortion throughout the country and enhance the effectiveness of any referral mechanisms to ensure access to legal abortion when a doctor exercises their conscientious objection.[74]

In 2019, the HRC issued General Comment No. 36 on the right to life.[75] This General Comment confirms that this right, which applies to all human beings without distinction, is not to be interpreted narrowly and that no derogation from it is possible.[76] However as the right to life has also been clarified to mean the right to not be arbitrarily deprived of life,[77] it goes on to provide that restrictions on abortion must not violate the woman's right to life, or her other rights under the *ICCPR*, including freedom from physical pain, mental pain or suffering, discrimination, or arbitrary interference with her privacy.[78]

[73] Human Rights Committee, *Concluding Observations Poland*, UN Doc CCPR/C/POL/CO/7 (23 November 2016) [23].
[74] Ibid [24].
[75] *General Comment No. 36* (n 20). This replaces General Comments No. 6 and No. 14.
[76] Ibid [6].
[77] Ibid [9].
[78] Ibid [8].

Whilst the HRC has not explicitly endorsed 'abortion on request,' it supports a reasonably permissive approach to it and recommends states provide access to abortion where the life or health of the mother is at risk or where continuing pregnancy would cause the mother substantial pain or suffering. In this latter regard, they give examples of pregnancy due to rape or incest, or where the pregnancy is 'not viable.' Clearly, it rejects the notion that the unborn child has a co-equal right to life with its mother and has largely adopted the equivalency of the unborn child's life with a broad understanding of the mother's health and wellbeing.

Difficulty occurs where this assumption of equivalency carries over as an unexamined premise when determining the reasonableness of a doctor's conscientious objection and when comparing the harm suffered by the doctor as compared to that suffered by the pregnant woman. As discussed in chapter 3, the weight of the dominant discourse advocating against conscientious objection accepts that a woman is harmed by conscientious objection, but it fails to register (or it ignores) that a doctor might feel anguish or torment at being compelled to act against conscience by taking what that doctor believes to be innocent human life.[79]

An example of hostility to conscientious objection follows:

> The courts in various jurisdictions have already, rightly so, conceded that it is a moot point trying to establish the truth or even plausibility of the views purportedly held by conscientious objectors… this concession opens the door to any number of more or less arbitrary and random conscientious objection claims… It is nigh impossible to predict which healthcare professional, in which part of the system will demand accommodation for which kinds of purported or real convictions. It is also evidently impossible to verify whether objecting healthcare professionals even hold the views they profess to hold. Such claims may merely be a convenient way out of the provision of inconvenient healthcare services. [80]

[79] See Nadia Sawicki, 'Who Judges Harm?' (2017) 27(3) *Journal of Clinical Ethics* 238, 239. See also the discussion in chapter 3 on the types of harm from acting against conscience where the experience of anguish is not the sole determinant of harm as violation of conscience is itself a harm.
[80] Udo Schuklenk and R Smalling, 'Why Medical Professionals Have No Moral Claim to Conscientious Objection Accommodation in Liberal Democracies' (2017) 43 *Journal of Medical Ethics* 234, 236.

The above quotation raises a number of important issues worthy of further research and discussion, but at the same time demonstrates the authors' irritation with the fact that in a pluralist society, not all doctors will think the same way. It is true that conscientious objection may impact efficiencies in the delivery of healthcare, but if diversity is valued it only serves to highlight the need to have in place a system which recognises services which might be legal, but which may also be morally controversial, and which manages conflict so that health professionals feel comfortable identifying themselves as objectors at an early stage.

Fear that continued pregnancy and birth will result in a woman losing her life is on a higher level than the fear that it will have a negative impact on her health or wellbeing. Whilst pregnancy is not a disease per se, there are known risks associated with being pregnant and with giving birth, and wellbeing is entirely subjective for each person. Accordingly, when the unborn child is not given the status of a human being, the circumstances where it can be said that abortion will benefit the woman's health or wellbeing, or when delay in accessing abortion will harm her health and wellbeing, would seem to be numerous.

Ultimately, without consistent definitions of health, wellbeing, and the status of the unborn child, it is difficult to analyse the reasonableness of the additional recommendations of the HRC. These included that states revise laws so that women do not resort to what are called 'unsafe' abortions, that they repeal criminal sanctions against women or health professionals, and that they remove 'barriers to access.' This subsection has revealed how important and decisive a state's baseline assumptions are on these issues. This thesis now considers the right to health and its relationship to abortion and conscientious objection.

4.2.3 THE RIGHT TO HEALTH

Article 25 of the *UDHR* provides that 'everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services.'[81] Art 12 of the *International Covenant on Economic, Social and Cultural Rights* ('*ICESCR*') provides more specificity and states that everyone has the right to the highest attainable standards of physical and mental health.'[82] But what does this mean in practice? Fredman asks, 'Is this a right to health or a right to healthcare? Is it a right to a particular standard of health or the highest attainable standard?'[83]

Arguably, the right to health is an abstract concept because its application is constrained by the definition of health and the difficultly in achieving a global standard due to the different realities of health.[84] These realities include the need for the state to develop and regulate the training of individuals for the health professions, the need for resources to develop infrastructure and acquire technology, the need to be able to organise the delivery of healthcare, as well as the community's cultural and religious beliefs. Accordingly, healthcare is often seen as part of the business of government and the political process.[85]

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[81] *UDHR* (n 24).
[82] *International Covenant on Economic, Social and Cultural Rights* opened for signature 16 December 1966 UNTS 3 (entered into force 3 January 1976) art 12. The *ICESCR* provides for progressive realization of the right to health due to resource limitations of Nation States.
[83] Sandra Fredman, *Comparative Human Rights Law* (2018, Oxford University Press) 231.
[84] See, eg, Thana Cristina de Campos 'Health as a Basic Human Need: Would This Be Enough?' (2012) *Journal of Law, Medicine and Ethics'* doi.org/10.111/j.1748-720X.2012.00662.x, 251; Harold Schmidt, Lawrence O Gostin, Ezekiel J Emanuel, 'Public Health, Universal Health Coverage, and Sustainable Development Goals: Can They Co-Exist?' (2014) 386 *Lancet* 928, 929.
[85] As opposed to creating justiciable human rights obligations. See Fredman (n 83).

When it comes to the notion of sexual and reproductive health being derivative of the right to health, the 1994 International Conference on Population and Development saw 176 countries recognise that a right to reproductive health exists, and then create objectives and action items for governments.[86] Reproductive health was said to imply that people have the right to a 'satisfying and safe sex life', with the freedom to reproduce and the capacity to decide if and when, and how often, they do so. It further stated that these are human rights already recognised in national laws, and international standards and consensus documents.[87]

Regarding the means used to achieve these freedoms, there was an emphasis on the government's positive obligations to enable and support a person's responsible decisions about their methods of choice for family planning, as well as other methods 'which are not against the law.'[88] Regarding abortion, the document stated that every attempt should be made to eliminate the need for abortion except that abortion should not be 'promoted as a method of family planning.' However, it noted that the role of abortion in a society was a question for the states to work out through their legislative process.[89]

There are several presuppositions built into these statements. First, they do not state definitively that abortion *per se* is morally wrong. Rather, they say that states should not promote abortion for family planning, and they are vague as to why that is so. Second, these statements imply that states may legislate its use for other reasons, but they are silent as to what reasons are acceptable. For instance, is it permissible to offer abortion if there has been a failure of contraceptive drugs and devices? Or where conception occurred due to rape or incest? Or there is the presence of disability in the unborn child?

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86 Report of the International Conference on Population and Development, Cairo 5-13 September 1994 UN Sales No. E.95.XIII.18 [7.2]- [7.3]. It is important to note that obligations are placed on the state and not on individual health professionals.
87 Ibid [7.3].
88 Ibid [7.5]. The document notes that the Holy See expressed reservations about this chapter on Reproductive Rights and Reproductive Health.
89 Ibid [8.25].

Finally, the report stated that unsafe abortion was a public health concern and recommended improving family planning services so as to reduce the need for abortion.[90] However it goes without saying that other than complete abstinence, all measures used by sexually active fertile people have an inherent failure rate, with abortion being the ultimate means of controlling reproduction. This foundational tension between whether or not the unborn child has the status of a human being just like its mother, and if so the consequences of permitting abortion as part of family planning, remained unresolved.

In 2000, the Committee issued General Comment No. 14 on 'The Right to the Highest Attainable Standard of Health.'[91] It confirmed that the right to health is a fundamental human right that includes the right to sexual and reproductive freedom, and the right to be free from interference. The Committee endorsed a broad definition of health that included 'the right to a system of health protection which provides equality of opportunity so people can enjoy the highest attainable level of health', as well as 'the right to correct the underlying determinants of health.'[92]

Taken together, the Committees' General Comments on the right to life and the right to health, provide the infrastructure for a state to limit the scope of any laws permitting conscientious objection to abortion, should it choose to do so. The broad characterisation of a right to health provides the infrastructure for limiting conscientious objection to abortion and other morally controversial services. This thesis will now consider public health as part of the balancing process which may limit freedom of conscience on proportionality grounds and look at how it has been used to reinforce the notion that access to abortion, and the silencing of those who oppose it, are essential to the community.

[90] Ibid.
[91] Committee on Economic, Social and Cultural Rights, *General Comments No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)* 22nd sess, UN Doc E/C.12/2000/4 (11 August 2000).
[92] Ibid [10]-[11].

4.2.4 THE PUBLIC HEALTH EXCEPTION

Where states agree to fund and deliver healthcare to the community, they accept responsibility for protecting public health. The power to control public health is derivative of the state's police powers to infringe an individual's rights based on necessity, or self-defence of the wider community.[93] Originally, public health policy was concerned with containing the spread of communicable diseases by compulsory vaccination and quarantine.[94] Whilst infringing the rights and freedoms of affected individuals, its purpose was to ensure the community was safe by reducing the risk of a disease spreading.

Generally, appropriate state intervention to reduce the threat of disease occurs where the burden on the affected individual is proportionate to the expected benefit to the community, and the intervention itself does not pose a health risk to the individual.[95] The type and magnitude of harm to the community is usually supported by epidemiological studies proving a causal connection between exposure and measurable poor health outcomes. However by broadening the traditional understanding of health and harm, contemporary public health initiatives can challenge the usual requirement that there be empirical evidence to support state intervention.

Contemporary public health focuses on enhancing social and economic determinants of health to achieve equality and social justice.[96] Public health initiatives can seek to rectify systemic areas of disadvantage through interventions that achieve distributive justice, or participatory parity.[97] Success in achieving outcomes can be hard to measure. In ensuring equal respect and treatment, initiatives operate upon definitions of health and harm that are arguably derived from a political notion of what is good. Hence, measurement of the risk to the public's health and what constitutes harm requires an acceptance of the state's understanding of what is good.

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[93] See, eg, *Jacobson v Massachusetts* 197 U.S. 11 (1905). This is an American case and is the seminal legal case for public health law. Here, the Supreme Court of the USA upheld the state's authority to use its police powers to enforce compulsory vaccination to protect public health.

[94] Other matters include public sanitation, environmental safety, early detection and screening for disease and medical intervention for disease.

[95] Lawrence O Gostin and Lindsay F Wiley, *Public Health Law. Power, Duty, Restraint* (University of California Press, 3rd ed, 2000) 9.

[96] Ibid.

[97] Ibid.

The protection of public health is a recognised limitation on a person freely manifesting their thought, conscience, or belief, where it is both prescribed by law and considered necessary.[98] Accordingly, if the state determines through a legislative process that decriminalising abortion is a public health issue because women attempt unsafe, illegal abortions, then the state could justify the need to decriminalise abortion and ensure access to it. At issue though is whether the state can pass on its burden to ensure sufficient access to lawful abortion to individual doctors with a conscientious objection to performing, participating in, or facilitating abortion.

Medicine's dependence on social institutions for its economic survival has arguably permitted the state to define health, healthcare, and harm.[99] Accordingly, the socio-political dimensions of healthcare can be used to re-frame conscientious objection from being about individual rights or beliefs, to that of access to healthcare. As Berlinger observes, where the good of society outweighs the good of the individual doctor, doctors who refuse to provide lawful treatment are seen as 'blocking access' even when an alternative doctor can be found to provide the service.[100] Conscientious objection can then be transformed into a public health concern.

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[98] *ICCPR* (n 6) art 18(3).

[99] Fabrice Jotterand, 'The Hippocratic Oath and Contemporary Medicine: dialectic between past ideals and present reality?' (2005) 30(1) *Journal of Medicine and Philosophy* 116. Here Jotterand describes the loss of common philosophy in medicine in the American context as being due to two factors: the loss of the profession's ability to maintain a moral identity, and the transformation of medicine into an industry dependant on the managed care Medicare/Medicaid system. These observations can arguably be extrapolated to the Australian context.

[100] Nancy Berlinger, 'Conscience Clauses, Health Care Providers, and Patients' in *From Birth to Death and Bench to Clinic: The Hastings Centre Bioethics Briefing Book for Journalists, Policymakers and Campaigns* (The Hastings Centre, 2008) 35. There is irony in her position given the purpose of human rights is to protect minorities from the tyranny of the majority.

In Australia, public health legislation has been deployed in Victoria, New South Wales, South Australia, and Western Australia to ban communication about abortion outside abortion clinics.[101] Known as 'safe access zones', they criminalise certain expressions of the pro-life worldview on the basis that it is causative of harm to women seeking abortion, including communication that is reasonably likely to cause anxiety and distress. As the stated aims of such laws are to protect women's dignity, as well as their security and privacy,[102] they reflect the contemporary and broad approach to public health of achieving 'perfective freedom.'

Parliamentary debate that accompanied the introduction of these laws highlighted anecdotal stories of the antics of prolife protesters and side walk counsellors which alleged harassment and even violence, as well as concerns about how the expression of the pro-life worldview was harmful to women contemplating abortion because they are vulnerable and such expressions seek to shame and stigmatise them.[103] Emphasis was placed upon the findings of an empirical study of one abortion clinic where participants reported anxiety and distress, and these findings were extrapolated to be representative of the conduct outside all clinics.[104]

An opportunity to review the validity of Victoria's *Public Health and Wellbeing Act 2008* was made via a High Court challenge alleging that the relevant sections infringed the implied right of political communication, however the appellant was unsuccessful.[105] Credible and reliable empirical research can certainly validate concerns about harm. However, where the true purpose of such laws is to minimise dignitary harm, what is really being tested is the community's appetite for the tolerance of minority views. As famously noted by Justice Jackson in *West Virginia Board of Education v Barnette*:

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[101] *Public Health and Wellbeing Act 2008* (Vic) s 185B(1)(a) and *Public Health Act 2010* (NSW) s 98; *Public Health Act 2016* (WA) s 202N; *Health Care Act 2008* (SA) s 48B. Other states have enacted similar bans through their abortion legislation. See *Health Act 1993* (ACT) s 85(a); *Termination of Pregnancy Reform Act 2017* (NT) s 14(4)(a); *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 9(1); *Termination of Pregnancy Act 2018* (Qld) s 15.

[102] See Anna Walsh, Freedom of Expression, Belief and Assembly: the banning of protests outside of abortion clinics in Australia' (2018) 25(4) *Journal of Law and Medicine* 1119, 1123-4.

[103] Ibid.

[104] Ibid.

[105] *Clubb v Edwards* [2019] HCA 11. The High Court considered abortion to be a health issue, and not a political issue for the purpose of the implied freedom of political communication.

> We can have intellectual individualism and the rich cultural diversities that we owe to exceptional minds only at the price of occasional eccentricity and abnormal attitudes. When they are so harmless to others or to the State as those we deal with here, the price is not too great. But freedom to differ is not limited to things that do not matter much. That would be a mere shadow of freedom. The test of its substance is the right to differ as to things that touch the heart of the existing order.[106]

This thesis is not suggesting there is no place for empirical research on harm. Rather, given the very controversial nature of abortion and the protection which surrounds the pro-abortion worldview, its base premises or the metaphysical beliefs which underscore it, are hard to unveil and examine so as to provide the context in which any empirical evidence can be considered (and vice versa). Having considered the trends in human rights law impacting on conscientious objection to abortion, this thesis now turns towards the domestic law of Australia, specifically the protections offered in the conscience clauses of abortion statues.

4.3 AUSTRALIAN LAW

4.3.1 FEDERAL LAW: FREEDOM OF RELIGION

As Thompson observes, freedom of religion is 'arguably the most fundamental legal right that is not yet protected in Australia.'[107] Despite ratifying the *ICCPR* in 1980, the federal government has not yet successfully used its external affairs power to enact domestic legislation on freedom of conscience that would bind the states and territories.[108] Accordingly, until such time, the states and territories may make laws regarding freedom of conscience subject to their Constitution, and the principle of legality.[109] Before considering the states, this thesis will describe the status of federal laws impacting on freedom of religion.

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[106] 319 U.S. 624 (1943) 641.

[107] A Keith Thompson, 'A Commonwealth Religious Discrimination Act for Australian?' (2017) 7(1) *Solidarity*, 1, 16. Thompson notes that 'the vision of freedom of conscience there expressed [in the ICCPR] was always a work in progress and is inadequate when compared with the legislative substance that is provided for other freedoms in stand-alone Acts that can run to 70 or more clauses.'

[108] See *Constitution of Australia Constitution Act 1901* (Cth) s51(xxxix) ('*Constitution*').

[109] See *Constitution* s 109; *Chow Hung Ching v The King* (1948) 77 CLR 449, 477-8 per Dixon J, and the following cases *Dietrich v The Queen* (1992) 177 CLR 292 (per Mason CJ and McHugh J) and *Kiao v West* (1985) 159 CLR 550 (per Gibbs CJ); *Attorney-General (South Australia) v Corporation of the City of Adelaide* (2013) 249 CLR 1, 34 (per French CJ).

Section 116 of the federal *Constitution* prohibits the Commonwealth from making laws that establish a religion, impose any religious observance, prohibit the free exercise of any religion, or require a religious test as a qualification for any office or public trust under the Commonwealth. The High Court has applied a broad definition of religion as being a belief in a supernatural being, thing or principle, and canons of conduct to give effect to that belief,[110] and has considered what it means to 'freely exercising one's religion' in only a few cases. One of those cases involved conscientious objection to compulsory military service.[111]

In *Krygger v Williams,* the Court held that:

> [t]o require a man to do a thing which has nothing at all to do with religion is not prohibiting him from a free exercise of religion. It may be that a law requiring a man to do an act which his religion forbids would be objectionable on moral grounds, but it does not come within the prohibition of section 116 and the justification for a refusal to obey a law of that kind must be found elsewhere.[112]

Federal Parliament later enacted legislation to protect conscientious objection to military service. Military service and engagement in war may expose a person to the killing of other people.[113] In 1993, legislation established a Conscientious Objection Tribunal to consider and exempt a person whose beliefs do not allow them to engage in combatant duties in war or warlike operations.[114] The word 'conscientious' is given a broad interpretation.[115] Since then, conscientious objection to military service has also been recognised by the HRC as a first order right in society, and an example of an absolutely protected right to hold a belief.[116]

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[110] *Church of the New Faith v Commissioner of Pay-Roll Tax* (Vic) (1983) 154 CLR 120, per Mason ACJ and Brennan J [17]. Importantly, the Justices noted that canons that offend against the ordinary laws lose any immunity, privilege or right conferred on the grounds of being a religion.
[111] *Krygger v Williams* (1912) 15 CLR 355.
[112] Ibid per Griffiths CJ at 369.
[113] Cf Steve Clarke, Conscientious Objection in Healthcare, Referral and the Military Analogy' (2017) 43 *Journal of Medical Ethics* 218, 291. Clarke makes the point at 219 that when considering conscientious objection to military service, it is important to know the nature of the conscientious objection. This is because it has an effect on what alternative services may be suggested to the objector as a reasonable accommodation. The same applies in the healthcare context.
[114] *Defence Act 1903* (Cth) ss 61(h), 61(1A), 61V(1).
[115] This overcame the problem of an objector belonging to a religion which does not officially hold pacifist views. See Hugh Smith, 'Conscience, Law and the State: Australian Approach to Conscientious Objection since 1901' 35(1) *Australian Journal of Politics and History* 13, 17.
[116] See Taylor (2) 507-511. As Taylor notes, whilst earlier cases such as *Yoon & Choi v Republic of Korea* focused on compulsory military service being an offence under art 18(3) of the *ICCPR*, the manifestation of a person's belief against the use of arms was in focus in the more recent case of *Jeong et al v Korea* (n 7) [7.3]. Here it was also considered an offence against art 18(1) of the *ICCPR*. Alternative service that is a real service to the community is often seen as an appropriate compromise to granting a person an exemption based on a genuine conscientious objection to compulsory military service.

The High Court's narrow construction of 'freely exercising one's belief'[117] has been criticised by commentators such as Parkinson who notes that secular states may not appreciate that a person's religious beliefs or convictions can impact upon everyday decisions, and that actions in life go beyond public acts of worship.[118] The danger, therefore, is that the content and scope of 'manifesting a religious belief' may become politicised, and permit the Commonwealth to legislate a narrow construction where free exercise of belief may cause 'ideological inconvenience.' There is a significant amount of academic discourse on this issue.[119]

Given that 'religious bigotry' can exist due to intolerance toward certain absolutist views, it raises the question as to whether doctors who oppose abortion feel comfortable characterising their objection as 'religious' or whether they choose to describe it another way. Indeed, this was one of the questions explored in this thesis' empirical study. As this thesis has stated several times, moral objections to abortion are based on a series of metaphysical beliefs about the human person. The fact that this reasoning may be enhanced by scripture, a religious faith tradition or theology, does not mean it is not also based on a sound philosophical argument.[120]

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[117] See also *Kruger v Commonwealth* (1997) 190 CLR 1. Here, Northern Territory laws that forcibly removed Indigenous Australians from their culture and heritage were found not to breach section 116; and *Adelaide Company of Jehovah's Witnesses Inc v Commonwealth* (1943) 67 CLR 116 per Latham CJ [10]. During wartime, the Adelaide branch of the Jehovah's Witnesses preached passivism and that the Government was an organ of Satan. The Court held that the Constitution enabled it to 'reconcile religious beliefs with ordered government' and permitted it to discontinue a Church and acquire its property where its activities were considered to be subversive.

[118] Patrick Parkinson, 'Christian Concerns about an Australian Charter of Rights' in *Freedom of Religion under Bill of Rights* in Paul Babie and Neville Rochow (eds), (University of Adelaide Press, 2012) 117, 121. Freedom of religion is viewed as not just the ability to hold a religious belief but to 'practice, manifest and teach' such beliefs. See *ICCPR* (n 6).

[119] See, eg, Alex Deagon, 'Defining the Interface of Freedom and Discrimination: Exercising Religion, Democracy and Same-Sex Marriage' (2017) 20 *International Trade and Business Law Review* 239; Neil Foster, 'Freedom of Religion and Balancing Clauses in Discrimination Legislation' (2016) 5(3) *Oxford Journal of Law and Religion* 385; Thompson (n 107).

[120] Francis J Beckwith, 'Religion, and the Metaphysics of Abortion: A Reply to Simmons' (2001) 43(1) *Journal of Church and State* 19, 25. The common Post Enlightenment shibboleth is that faith and reason oppose each other and that religion is unreasonable and irrational where arguably, its empirical field is simply different and some would argue it is wider. See John MacMurray, The Structure of Religious Experience (Faber & Faber, 1936). See also John Paul II, *Fides et Ratio* (Libreria Editrice Vaticana, 14 September 1998) [43]. Here, His Holiness likens faith and reason to 'two wings on which the human spirit rises to the contemplation of truth' as 'both the light of faith and the light of reason come from God... hence there can be no contradiction between them.'

Thompson notes the long resistance by the Australian federal government to enact human rights legislation including protection of religion and belief, with the Rudd government having rejected recommendations for improving human rights on the basis it would be divisive.[121] However following the passage of the *Marriage Amendment (Definition and Religious Freedoms) Act 2017*, where the right to marry is no longer determined by sex, the federal government promised a federal Religious Discrimination bill. After commissioning an expert panel and report, the government released drafts of three bills for community comment. [122]

The most recent bills were the Religious Discrimination Bill 2022, the Religious Discrimination (Consequential Amendments) Bill 2021 and the Human Rights Legislation Amendment Bill 2021. The Religious Discrimination bill aimed to prohibit discrimination because of a person's religious belief or activity and would have given effect to Australia's obligations under the *ICCPR* as well as other treaties.[123] However at the time of writing, the bills have lapsed due to an impasse in the Lower House arising from amendments that would have prohibited religious schools from expelling transgender children.[124]

Whilst it is unclear if and when debate will re-start, this thesis will consider the most recent iteration, the Religious Discrimination Bill 2022. Whilst the bill referred to 'religion or belief,' neither were defined nor was there any reference to conscience.[125] The bill focused on protecting a 'statement of belief' which was divided into statements based on religion and those on belief. A statement of a religious belief was defined as held by a person, made in good faith by written or spoken words by the person, where the person genuinely believed that the belief was in accordance with the doctrines, tenets, beliefs, or teachings of the religion.[126]

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[121] Thompson (n 107) 17. See also Human Rights and Equal Opportunity Commission, Commonwealth of Australia (1998) *Article 18, Freedom of Religion and Belief* [Recommendation 2.1-2.6].
[122] See Australian Government, Department of Prime Minister and Cabinet, 'Australian Government Response to the Religious Freedom Review' December 2018 <https://pmc.gov.au>.
[123] See Religious Discrimination Bill 2022, cl 64. The types of activities of public life affected include employment, education, access to premises and the provision of goods, services, and accommodation. If the bill had passed, the Australian Law Reform Commission would then have completed a review into religious exemptions within federal, state and territory anti-discrimination legislation to consider issues not covered by the federal and other laws to achieve national consistency.
[124] See Parliament of Australia, Religious Discrimination Bill 2022(Web Page) <https://www.aph.gov.au/Parliamentary_Business/Bills_Legislation/Bills_Search_Results/Result?bId=r6821>.
[125]As noted at 4.2.1, the equating of religious belief with conscience is standard in the human rights sphere. See, United Nations, Resolution adopted by the General Assembly, 'Elimination of All Forms of Intolerance and of Discrimination Based on Religion or Belief,' A/RES/63/181. This Resolution was affirmed by the United Nations in 1993 (Resolution 36/55) and again in 2007 (Resolution 48/128). Cf Haigh (n 28).
[126] Religious Discrimination Bill 2022, cl 5(1).

It would seem, then, that any uncertainty about what a particular religious faith tradition teaches about abortion and moral complicity in it, or any uncertainty by the person adhering to the religious faith tradition as to what their faith tradition does as a fact teach on it, would not have been a barrier to the person receiving protection under the law.[127] For the non-religious, their statement needed to be a belief held by them as a person who does not hold a religious belief, made in good faith by written or spoken words by the person, where the person genuinely believed that the belief was related to the fact of not having a religious belief.[128]

It is worth noting that the 2019 version of the bill contained express provisions on conscience protection for health professionals. A conscientious objection by a health practitioner was defined as a refusal to provide or participate in a service on the basis of a religious belief or activity where a person of the same religion as that objector would consider the refusal to be in accordance with the doctrines, tenants, beliefs or teachings of that religion.[129] Accordingly, the 2022 version of the bill would have made it easier for doctors of religious faith, or of the belief that abortion (or a particular request) is not healthcare, to be protected under federal law.

The 2022 bill made discrimination unlawful if it occurred because of a religious belief or activity that the person held or engaged in. Relevant for this thesis, cl 5 defined 'to engage in conduct' in line with one's religious belief to include both the doing of an act and omitting to do an act. Clause 17 also provided that if there were two or more reasons that the person engages in the conduct, then so long as one of the reasons was the person's religious belief or activity, then the conduct would be taken to have been undertaken as part of the person's religious belief regardless of whether that belief was the predominant reason for the conduct.

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[127] See discussion in chapter 3.6 of this thesis on moral complicity. See John Paul II, *Evangelium Vitae* (n 1) [89]. For Catholics, there are no circumstances that can ever make abortion (meaning a direct abortion) neutral or good. See also See Catholic Church, *Code of Canon Law* (36) [1398]. The precise actions that are considered to be illicit co-operation in abortion are undefined in the Code.

[128] Religious Discrimination Bill 2022, cl 5(2). Accordingly, a person who belongs to a religion, but holds a belief that they do not believe is expounded by their faith tradition, would have to fall under the alternative category.

[129] See Exposure Draft, Religious Discrimination Bill 2019, cl 5 <https://www.ag.gov.au>. In addition, clause 8(6) of the 2019 version of the bill provided that if a state or territory allows a health professional to conscientiously object to providing or participating in a particular kind of health service because of a religious belief or activity, then a conduct rule of that state or territory which suggests otherwise is to be considered unreasonable.

This raises an interesting issue referred to earlier in chapter 3 regarding the impact of the dominant narrative on abortion in our society on pro-life doctors. As Garratt noted, this narrative can be so strong that it can result in an 'unconscious self-censoring' by the doctor of their views about abortion.[130] This was something taken up in this thesis' empirical study, that is, the reason for the participant's conscientious objection to abortion. As will be seen in chapter 6, very few participants identified their religious faith alone as the reason why they held a conscientious objection to abortion.

Direct discrimination in clause 13 of the 2002 bill prohibited a person from treating another person less favourably than others are treated who do not share the second person's belief, and where the treatment was a result of the second person's belief. Indirect discrimination in clause 14(1) prohibited imposing an unreasonable condition, requirement, or practice on a person which disadvantaged those who engaged in a religious belief or activity. Clause 14(2) required consideration of the nature and extent of any disadvantage, the feasibility of overcoming or mitigating the disadvantage, and whether it was proportionate to the result sought.

When it came to employment, cl 39(2) provided an exception for employers whereby it was not unlawful for an employer to discriminate against another person on the ground of the other person's religious belief or activity if such discrimination was in connection with the other person's position as an employee, and because of their religious belief or activity they were unable to carry out the inherent requirements of their employment. Accordingly, if performing abortion or assisting patients to access abortion were an inherent requirement of the job, a doctor with a conscientious objection could not seek protection under the bill.

Whilst in cl 12(1) of the bill, a statement of belief would not constitute discrimination under the various federal and state anti-discrimination statutes, there were exceptions. Clause 12(2) provided that a statement of belief which was malicious, or one that a reasonable person would consider would threaten, intimidate, or vilify a person or group, or was one that a reasonable person would conclude counsels, promotes, encourages, or urges conduct which would constitute a serious offence, were not protected. Accordingly, the impact which a doctor's statement of belief about abortion might have on a pregnant patient would be relevant.[131]

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[130] Deborah Garratt, *Alarmist Gatekeeping Abortion* (Deborah Garratt, 2021).
[131] See discussion in chapter 3 regarding the relationship between shame, guilt, and stigma with abortion.

One cannot dismiss the wider impact of the safe access zone laws discussed at 4.2.4. In the laws of New South Wales and Victoria, any communication about abortion, within a certain geographical distance of an abortion clinic, which has the potential to cause anxiety or distress to a person entering or leaving a clinic, is considered to be a crime.[132] Penalties may include gaol time or significant fines or both.[133] Accordingly, it is at least possible that a pregnant woman unable to obtain advice and assistance from a doctor to access an abortion could allege that the doctor made an unlawful statement of belief as per clause 12(1) of the bill.

Finally, in terms of engaging in conduct because of their religion or belief, clause 26 of the bill made it unlawful for a person who provides goods or services to discriminate against another person on the ground of the other person's religious belief or activity by refusing to provide the other person with those goods or services, or on the terms or conditions which the person provides the other person with those goods or services, or makes those facilities available to the other person, or in the manner in which the person provides the other person with those goods or services.

Accordingly, if the basis of the pregnant woman's decision to request abortion was a 'non-religious belief' then it would also be a protected belief. This could produce a conflict between the pregnant woman seeking abortion and a doctor refusing to perform or participate in an abortion. As it is unclear what criteria would be used to ensure reasonable accommodation, given the history of attempts to pass federal religious freedom legislation, the fact that the bills have lapsed, and with a change in federal government, any further analysis is too uncertain to be helpful. As such, this thesis now looks to the situation in the states and territories.

[132] See *Public Health Act 2010* (NSW) s 98D; *Public Health and Wellbeing Act 2008* (Vic) s 185B.
[133] See *Public Health Act 2010* (NSW) s 98D(1); *Public Health and Wellbeing Act 2008* (Vic) s 185D.

4.3.2 THE DEVELOPMENT OF AUSTRALIAN ABORTION LAW

Australian law retains the 'born alive rule'. This rule provides that a person is not considered a legal person until they have been born alive and are outside the womb, whether or not they have an independent circulation.[134] Accordingly, the unborn child cannot be a legal person and as a result of this, it cannot be the victim of a crime. The rule harks back to times when stillbirth and miscarriage were common, and there was no technology to assist doctors to know if the child in the womb was alive.[135] Whilst this obstacle no longer exists, the born alive rule remains in force in all Australian jurisdictions.

As such, the law treats an injury or assault on a child in the womb as an injury to or assault on the mother.[136] However where the unborn child goes on to be born alive, then even if the child displays only minimal signs of life before dying, the criminal law recognises an offence against the child as a legal person.[137] In the civil law, a child born alive following an injury sustained in the womb can bring legal action for injuries that occurred at that time. Therefore, despite the law not considering the child in the womb to be capable of being legally harmed, a legal fiction is created to provide a just outcome for the child if they are born alive.[138]

Several attempts have been made to abrogate the born alive rule, however none have been successful.[139] If abrogated, coherence in the law would demand that if the unborn child is a legal person, then it has a co-equal right to life with the mother. Consequently, taking its life would only be justified in cases of self-defence.[140] Whilst frameworks for abortion on request could be justified as a principled exception, the state could not say it respected the sanctity of human life. Arguably therefore, the states and territories of Australia continue to withhold legal personhood from the unborn child and avoid having to balance competing interests.

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[134] See *Crimes Act 1900* (NSW) s 20; *Crimes Act 1900* (ACT) s 10; *Criminal Code 1899* (Qld) s 292; *Criminal Code Compilation Act 1913* (WA) s 269; *Criminal Code Act 1983* (NT) ss 1C scl (2)(a)-(c). See also *R v Hutty* [1953] VLR 338, 339; *Barrett v Coroner's Court* [2010] SASCFC 70.
[135] Kristen Savell, 'Is the Born Alive Rule Outdated and Indefensible?' (2006) 28 *Sydney Law Review* 631.
[136] See *R v King* (2003) 59 NSWLR 472.
[137] See *R v Iby* (2005) 63 NSWLR 278.
[138] See *Watt v Rama* [1972] VLR 353; *X&Y v Pal* (1991) 23 NSWLR 26; *Lynch v Lynch* (1991) 25 NSWLR 411.
[139] See Kristen, Savell, 'Life and Death before Birth: 4D Ultrasound and the Shifting Frontiers of the Abortion Debate' (2006) 15 *Journal of Law and Medicine* 103, 109. See also, Crimes Amendment (Zoe's Law) Bill 2013 No 2; Crimes Amendment (Zoe's Law) Bill 2017; Crimes Legislation (Offences against Pregnant Women) Bill 2020.
[140] See, eg, *General Comment No. 36* (n 20) [12]. This discusses the right to life and self-defence.

In Australia, the regulation of abortion is the responsibility of the states and territories. Prior to decriminalisation, an unlawfully performed abortion was a crime in all jurisdictions. The common law exception for an unlawful abortion was based on the English common law position where a doctor honestly and reasonably believed that continuation of the pregnancy posed a grave risk to the woman's life. As noted in chapter 3, the court in *R v Bourne* held that 'where continuation of pregnancy would make the woman 'a physical or mental wreck,'[141] this equated to a grave risk to life.

In Australia, the courts accepted that threats to the woman's physical or mental health were appropriate justifications for lawful abortion[142] with the Supreme Court of Queensland noting its concern in 1986 that this approach should not be seen as an endorsement of abortion on request.[143] Whilst not dictating the value doctors ought to give to the life of the unborn child when weighing the risks of continuing the pregnancy with the risks of abortion, the law relied on the ethics of doctors to guide their decision making so that outcomes accorded with good healthcare as judged by community standards.

Implicitly, the law assumed doctors had a common belief in the moral value of the unborn child, a similar definition of health, and the ethical training to exercise their legal discretion responsibly. However, without a common philosophy to ground medicine these assumptions seem to be unfounded. As previously noted, Pellegrino observed years ago that doctors hold 'wildly divergent' positions about what is morally permissible,[144] which raises questions about their ethics education. To paraphrase Lewis, without good ethics training, doctors may become 'men without chests' whilst we still 'expect of them virtue and enterprise.'[145]

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[141] See *R v Bourne* [1937] 1 KB 687.
[142] *R v Davidson* (1969) VR 667; *R v Wald* (1971) 3 DCR (NSW) 25; *R v Bayliss & Cullen* [1986] 9 Qld Lawyers Reps 8; *Central Queensland Hospital and Health Service v Q* [2017] 1 Qd R 87.
[143] See *R v Bayliss & Cullen* (n 142) 45. Maguire J noted, 'The spirit of *Bourne* …cannot be made the excuse for every inconvenient conception…There is no legal justification for abortion on demand.'
[144] Edmund Pellegrino, 'The Physician's Conscience, Conscience Clauses and Religious Belief: A Catholic Perspective' (2002) 30(1) *The Fordham Law Journal* 221, 230.
[145] C S Lewis, *The Abolition of Man* (Fount, 3rd ed, 1999) 16. One can add 'and conscientious behaviour.'

Later cases expanded the legal justification for lawful abortion to include concern by the doctor of actual or likely social or financial harm posed by pregnancy.[146] This signalled a shift in the normative position of the law regarding the moral value of the unborn child. However, this low threshold for justifying lawful abortion did not satisfy abortion providers with the assurance they felt they needed to defend themselves against a charge of unlawful abortion. Not wanting the burden of exercising discretion, they pushed for the law to permit abortion on request where its legality becomes a matter of meeting criteria set out in legislation.[147]

Some jurisdictions decriminalised abortion and legislated criteria to help doctors exercise their discretion based on the foetal characteristics of the unborn child, such as their gestational age and/or the presence or risk of significant disability.[148] Based upon normative beliefs about the sanctity and dignity that should be accorded to unborn human life,[149] this increased the circumstances where doctors could lawfully perform abortion, but did not provide the woman with a legal right to demand an abortion.[150] The doctor still had to agree that continuation of the pregnancy posed a greater risk to the woman's health than abortion.

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[146] See *R v Sood* [2006] NSWSC 1141 (31 October 2006) ('*Sood*'); *CES v Superclinics* (1995) 38 NSWLR 47, 70 per Kirby ACJ.

[147] See also Heather Douglas, Kirsten Black and Caroline De Costa, 'Manufacturing Mental Illness and Lawful Abortion: Doctors' Attitudes to Abortion Law and Practice in New South Wales and Queensland' (2013) 20 *Journal of Law and Medicine* 560, 575; Caroline De Costa, Heather Douglas and Kirsten Black 'Making it Legal: Abortion Providers' Knowledge and Use of Abortion Law in New South Wales and Queensland' (2013) 53(2) *Australian and New Zealand Journal of Obstetrics and Gynaecology* 184,188; Barbara Baird, Decriminalisation and Women's Access to Abortion in Australia' (2017) 19(1) *Health and Human Rights Journal* 197, 203.

[148] See *Health Act 1911* (WA) s 334 (7)(a); *Criminal Law Consolidation Act 1935* (SA) s 82A(1)((a)(ii).

[149] See, eg, Congregation for the Doctrine of the Faith, *Dignitatis Personae: Instruction on Certain Bioethical Questions* (St Paul's Publication, 2009) 11. The natural law position adopted by the Catholic Church, a large provider of medical care, is that unborn human life has full anthropological and ethical status. See also, Helen Pringle, 'Abortion and Disability: Reforming the Law in South Australia' (2006) 29(2) *University of New South Wales Law Journal Forum: Abortion and Disability* 207, 213. Pringle characterises abortion for foetal disability as 'eugenic.'

[150] According to Hohfeld's scheme, the woman in this situation has a privilege to request abortion and the doctor and others has a duty not to interfere with her privilege. See, eg, Brian Bix, *Jurisprudence: Theory and Context* (Sweet & Maxwell, 2012) 134-6.

In practice, preterm clinics offered abortion in the private sphere.[151] This provided relief to doctors who were employed in public hospitals in that they did not have to inform their employer of their conscientious objection, or even form a clear view on how they would respond to a request to perform abortion.[152] Police rarely investigated abortion clinics to ensure the law was being correctly applied, and this is evidenced by the very small number of prosecutions brought for unlawful abortion in Australia. Thus, the cases that were prosecuted usually involved clear violations for behaviour unlikely to meet with community standards.[153]

However, in 2008 Victoria permitted abortion on request up to 24 weeks gestation, and to birth where two doctors agree it is appropriate in all the circumstances. This model has been adopted by most other states. Currently, abortion has been decriminalised in every jurisdiction, and re-characterised as a standard health service when performed in accordance with specific requirements set out in the state or territory's relevant legislation.[154] Whilst small differences exist between jurisdictions, most permit abortion on request up to a specific gestational age, and to birth where two doctors agree it is appropriate in all the circumstances.[155]

A question which arises from this analysis of the development of abortion law in Australia is how the lawmaker, having committed itself to a normative position on the status of the unborn child, the lawfulness of abortion, and the impact of expressing an absolutist position on abortion in certain circumstances, ought to manage conscientious objection by doctors and other health professionals to abortion where the basis of the doctor's objection is centred on beliefs which may reject the moral norms underpinning the state's laws and reflect a minority worldview.

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[151] See, eg, Kate Gleeson, 'The Other Abortion Myth – the Failure of the Common Law' (2009) 6 *Bioethical Inquiry* 69, 73. Gleeson notes that pre-term clinics opened in Sydney in 1974 where abortions were performed for $8. See also Baird (n 147) 199.

[152] Baird (n 147) 201, 203-4. Baird notes that an ongoing issue despite decriminalisation of abortion in many states of Australia is the unwillingness of public hospitals to perform abortion for 'social reasons.'

[153] Gleeson (n 151) 72-3. See, eg, *R v Smart* (1981), unreported, NSW District Court; *Sood* (n 146).

[154] *Termination of Pregnancy Act 2021* (SA); *Abortion Law Reform Act 2019* (NSW); *Termination of Pregnancy Act 2018* (Qld); *Termination of Pregnancy Reform Act 2017* (NT); *Reproductive Health (Access to Terminations) Act 2013* (Tas); *Abortion Law Reform Act 2008* (Vic); *Health Act 1911* (WA); *Criminal Law Consolidation Act 1935* (SA); *Health Act 1993* (ACT),

[155] The upper gestational age limit for abortion on request is 16 weeks in Tasmania, see *Reproductive Health (Access to Terminations) Act 2013* (Tas) ss 4-5; 20 weeks in Western Australia, see *Health Act 1911* (WA) s 334(7); 22 weeks in Queensland and NSW, see *Abortion Law Reform Act 2019* (NSW) ss 5-6; and *Termination of Pregnancy Act 2018* (Qld) ss 5-6; 22 weeks and 6 days in South Australia, see *Termination of Pregnancy Act 2021* (SA) ss 5-6; and 24 weeks in Victoria, see, *Abortion Law Reform Act 2008* (Vic) ss 4-5.

4.4 BROAD CONSCIENTIOUS OBJECTION CLAUSES AUSTRALIAN CAPITAL TERRITORY AND WESTERN AUSTRALIA

In a truly free society, the state has no authority to control the thoughts people hold (as opposed to the thoughts they manifest) especially beliefs that are deeply held and form part of our identity. To genuinely acknowledge the autonomy of both doctors and patients to have views on abortion, the state must recognise that some doctors may hold a different view from the patient and the state about whether abortion, or any other morally controversial service, is good healthcare. It must also at least consider that compelling any person to act against a deeply held belief causes that person some degree of harm which does not benefit society.

The broad approach to conscientious objection encompasses the 'conscience absolutist' position which is that regardless of whether an act is active or passive, proximate or remote, if a person has discerned that the action is wrong, then compelling participation fractures a person's integrity, self-respect and causes psychological sequelae.[156] Like formal co-operation in wrongdoing, complicity in it still triggers an 'instinctive and profound sense of abhorrence, uncleanness, taint and shame, even when coerced.[157] Hence, this broad approach has the benefit of protecting doctors from moral complicity via indirect participation in abortion

Arguably Western Australia and the Australian Capital Territory accept this approach. After changes to their laws in the 1990's, they chose to include broad conscience clauses to protect health professionals who did not want to carry out or assist in abortion.[158] Whilst an exception applied for emergencies, there was no burden placed on the health professional to find someone to replace them, or to refer women to a non-objecting doctor. Arguably, Western Australia's broad approach to conscience protection dovetails with its acceptance in its legislation that there is more than one worldview about abortion.

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[156] See, eg, Sean Murphy and Stephen J Genuis, 'Freedom of Conscience in Health Care: Distinctions and Limits' (2013) 10 *Bioethical Inquiry* 347, 349; Richard J Regan, *Private Conscience and Public Law: The American Experience* (Fordham University Press, 1972) 7.
[157] Murphy and Genuis (n 156).
[158] Anna Walsh and Tiana Legge, 'Abortion Decriminalisation in New South Wales: An Analysis of the Abortion Law Reform Act 2019 (NSW)' (2019) 27(2) *Journal of Law and Medicine* 325; *Health Act 1911* (WA) s 334(2); *Health Act 1993* (ACT) s 84(1)(2); *Criminal Law Consolidation Act 1935* (SA) s 82A(6).

Section 334(2) of the *Health Act 1911* (WA) provides that:

> No person, hospital, health institution, other institution or service is under a duty, whether by contract or by statutory or other legal requirement, to participate in the performance of any abortion.

Uniquely, Western Australian law recognizes the potential conflict of interest that can arise when an abortion provider takes on the task of obtaining informed consent from a patient seeking advice about abortion. Accordingly, it prohibits the abortion provider from counselling the patient and obtaining informed consent from her. As such, another doctor who does not perform or assist in the abortion must offer counselling or advice being mindful of differing worldviews.[159] Arguably this approach identifies the potential harm that can arise where only one worldview is recognised in law and it therefore provides a remedy.

The Australian Capital Territory recently amended its conscience clause to identify the category of person to whom the protection applies and specified some of the actions that are protected for conscientious objectors. This included medical abortion which is achieved through the prescription of drugs which the woman takes at home to self-abort. Whilst it uses the term 'conscientious objection,' the legislation does not define conscience and importantly, the ACT does not impose a duty to refer. Section 84A(3) provides that:

> There is no breach of duty (by contract or by statutory or other legal requirement) or contravention of a territory law if an authorized person refuses to prescribe, supply or administer an abortifacient, or carry out or assist in carrying out a surgical abortion because of a conscientious objection.

However, it is possible that the conscience clauses in the WA and the ACT, whilst not explicitly requiring an objecting doctor to refer to a non-objecting doctor, could be narrowly interpreted by the courts to protect direct participation only and not indirect actions like referral. More discussion is required about what other actions conscientious objectors can refuse to perform. For example, can a doctor or nurse refuse to insert a cannula into a patient from which drugs will be administered to induce abortion? Can a pharmacist refuse to fill a script or sell drugs which induce abortion?[160]

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[159] See Walsh and Legge (n 158). See also *Health Act (1911)* WA s 334(5). Cf *Abortion Law Reform Act 2019* (NSW) s 7(1)(2).

[160] See, eg, *Pichon v Sajous v France* (European Court of Human Rights No 49853/99, 2 October 2001). In this case, two French pharmacists lost their appeal to the European Court of Human Rights to conscientiously object to administering contraceptive drugs. The Court held that they were able to practice their beliefs outside the

Whilst the specific actions covered by each jurisdiction's conscience clauses have not been tested in Australian courts, there have been decisions in other countries such as the United Kingdom worth noting. Two key decisions have focused on the actions by nursing and administrative staff in light of the conscience clause in the *Abortion Act 1967* (UK).[161] The situation in the United Kingdom will be discussed further in chapter 5 but for the purpose of this section, these decisions highlight what actions might engage the conscience clause in abortion legislation and how the clause might be interpreted.

The conscience protection clause in s 4(1) has been considered by both the Supreme Court of the United Kingdom and the House of Lords. Section 4(1) provides that 'no person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorized by this Act to which he has a conscientious objection.'[162] Importantly, both Courts held that s 4(2) limits the scope of this protection. This is because even objectors must perform abortion where it is 'treatment necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman.'

In *Greater Glasgow Health Board v Doogan and Anor*, two midwives alleged they were made to participate in abortion by having to delegate to, supervise, and/or support staff participating in abortion or caring for patients having abortion.[163] In deciding against them, the Supreme Court noted that freedom of conscience is not an unfettered right. The Court narrowly interpreted the meaning of 'participation' in abortion by distinguishing between 'direct' from 'indirect' participation. As such, health professionals with 'hands on' involvement could object to abortion. Ancillary actions such as administrative tasks were indirect and not protected.[164]

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professional sphere and the relevant consumer code only permitted an objection where the person was actively involved in the manufacture of the drugs, not the selling of them.

[161] *Abortion Act 1967* (UK) s 1(1)(a), (d). In the United Kingdom, abortion is permissible up to 24 weeks gestation where two doctors agree that criteria for abortion have been met. This includes that continuing the pregnancy involves a risk of injury to the physical or mental health of the woman or any existing children in her family, or the risk that if a child were born, they would suffer from such physical or mental abnormalities to be seriously handicapped.

[162] The United Kingdom has incorporated the human right to freedom of thought, conscience, and belief as set out in the European Convention on Human Rights into their domestic law via the *Human Rights Act 1998* (UK) at schedule 1. See Council of Europe (n 31).

[163] *Greater Glasgow Health Board v Doogan and Anor* [2014] UKSC 68 [37]-[38]. In places, this thesis reproduces and expands upon comments made in my Masters of Laws thesis. See Anna Walsh, 'The Legal Status of Prenatal Life in Australia' (Master of Laws thesis, The University of Sydney, 2016).

[164] Ibid.

This decision followed *Janaway v Salford Health Authority* where a receptionist refused to type a referral letter to a doctor that asked them to consult a patient regarding abortion.[165] The House of Lords held that 'participate' had its ordinary meaning of actually taking part in treatment administered in a hospital or other approved place. Accordingly, whilst these cases focused on specific administrative tasks, it seems possible that in the United Kingdom, the action of referring a patient to a non-objecting doctor may be characterised as 'indirect participation' in abortion and not something the law will protect the doctor from having to do.

All conscience clauses in the legislation of Australian jurisdictions contain an 'emergency' provision where an objecting doctor must nonetheless perform. However, the definition of emergency differs between jurisdictions. It ranges from saving the life of the woman,[166] to saving her life or preventing serious physical injury to her,[167] to saving her life, or preventing grave injury to her physical or mental health.[168] Consequently, the protection of freedom of conscience for health professionals in Western Australian and ACT is not an unfettered right which means there is the potential for its conscience clauses to be interpreted narrowly.

The next section considers the 'mandatory referral' approach to conscience protection. Essentially, this approach supports the protection of conscience on the basis that it maintains the moral integrity of the medical profession and the individual doctor.[169] However it requires the objecting doctor to refer their patient to a non-objecting doctor. This is characterised as a reasonable accommodation in a pluralist society.[170] This approach has sub-divided into a new approach that takes into account moral complicity where the duty to refer is discharged by referral to a third-party organisation which does not perform abortion.

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[165] [1989] AC 537 [1082].
[166] See *Abortion Law Reform Act 2008* (Vic) s 8(4).
[167] See *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 6(4).
[168] See *Criminal Law Consolidation Act SA* (1935) s 82A (6).
[169] See Tom Koch, 'Absent Virtues: The Poacher Becomes Gamekeeper' (2003) 31(3*) Journal of Medical Ethics* 337, 341. Koch argues that the personal accountability of the doctor is destroyed where they must adopt the lawmaker's view of what is right and true about abortion.
[170] See Mark Wicclair, 'Conscientious Objection in Medicine (2000) 14(3) *Bioethics* 205, 223. See also Christopher Cowley, 'Conscientious Objection in Healthcare and the Duty to Refer' (2017) 43(4) *Journal of Medical Ethics* 207, 212.

4.5 NARROW CONSCIENTIOUS OBJECTION CLAUSES: VICTORIA, NORTHERN TERRITORY, QUEENSLAND

As noted, in 2008, Victoria's *Abortion Law Reform Act* permitted abortion on request up to 24 weeks gestation for any reason the woman deems appropriate, and up to birth provided two doctors agree that it is appropriate in all the circumstances.[171] In addition, it imposed a statutory duty on conscientious objectors to not only perform abortion in an emergency, defined as 'where the abortion is necessary to preserve the life of the pregnant woman', but to refer women to 'another registered health practitioner in the same regulated health profession who the practitioner knows does not have a conscientious objection to abortion.'[172]

The Victorian legislation does not define the word 'refer.' The Explanatory Memorandum to the Act provides that the doctor is obliged to make enquiries or take other steps to inform themselves of the views of the doctor to whom the referral is made, so as not to refer the woman to another doctor who may share a conscientious objection to abortion.[173] So, to be effective, the objecting doctor would have to do more than inquire whether the second doctor supports a woman's right to choose abortion. Instead, it would seem that they must inquire whether the second doctor will assist the first doctor's patient to achieve an abortion.[174]

This is a distinction which has had very little attention given to it, but which has consequences.[175] It may be because there is a wide-spread assumption that doctors have a binary position on abortion. But is this true? Chapter 5 of this thesis will identify and analyse empirical studies that have investigated this issue. It will demonstrate that when presented with specific case scenarios, including the reason abortion is sought, doctors can fall along a spectrum. Arguably, these findings raise questions as to how the law expects the objecting doctor to discharge their duty to refer and what its impact is on their complicity in abortion.

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[171] *Abortion Law Reform Act 2008* (Vic) ss 4-5.
[172] Ibid s 8(1)(b), (3). Refer to earlier discussion where preserving the mother's life had been interpreted broadly in the common law. The requirement to refer is supported by key medical organizations since 2006. See, eg, International Federation of Gynecology and Obstetrics, Resolution on Conscientious Objection (2006) < https://www.figo.org/resolution-conscientious-objection-2006>.
[173] Explanatory Memorandum, Abortion Law Reform Bill 2008.
[174] This is because if an abortion cannot be guaranteed via the second doctor, the woman has wasted time in having to see a third doctor. If this interpretation is incorrect, then it raises the question of the proportionality of burden placed on the doctor with the conscientious objection, and that placed on the woman seeking abortion and questions the object of achieving timely access to abortion. See Walsh, 'The Legal Status of Prenatal Life in Australia' (n 163).
[175] But see Cowley (n 170).

As the aim of referral is to achieve timely access to abortion, then it seems reasonable that the objecting doctor would have to keep making efforts to find a doctor who does not have a conscientious objection to abortion in the patient's particular circumstances. The question this raises is whether this activity by the objecting doctor increases their moral complicity in abortion. In addition, can the objecting doctor discharge their duty to refer by providing the patent with details of the nearest abortion clinic? What if the objecting doctor has qualms about referring the patient to a clinic as opposed to a specialist gynaecologist who performs abortion?

The objecting doctor may find referral to an abortion clinic problematic because they do not know the doctor who will perform the abortion. The abortion provider's worldview may impact counselling, advice and information about abortion and other options such as keeping the baby. As the legislation requires objecting doctors to disclose his or her objector status immediately to the patient, there is a strong implication that objecting doctors cannot be trusted to continue a medical discussion about abortion and give accurate information, but that those doctors without a conscientious objection will be better able to advise the woman.[176]

At the time the Victorian bill was being debated, the Victorian branch of the Australian Medical Association advised its doctors to discharge their legal duty and avoid a conflict of interest by placing signs in their waiting rooms, or on their website, stating they are not available for advice or assistance with abortion.[177] This was thought to discourage women seeking abortion from consulting with an objecting doctor. However, this requires the doctor to have a binary or absolutist position on abortion and raises the issue of privacy and perhaps the possibility of recriminations from patients or discrimination from peers.[178]

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[176] Walsh and Legge (n 158). Cf One might compare this with the position in Western Australian law, and discussed earlier in this chapter, regarding the prohibition on doctors who perform an abortion on a patient also being the doctor who obtains the patient's informed consent for the abortion due to a perceived conflict of interest on the part of doctor performing the abortion.

[177] See Thomas D Harter, 'Toward Accommodating Physicians' Conscientious Objections: An Argument for Public Disclosure' (2015) 41 *Journal of Medical Ethics* 224, 225. Harter argues that mandatory disclosure of objector status is akin to disclosure of financial ties to the health industry.

[178] See, eg, 'Melbourne Doctors Speaks about Medical Board's Attack', Family Voice Australia (Web Page, 2 November 2002) <https://familyvoice.org.au/news/melbourne-doctor-speaks-about-medical-board-s-attack>. It also does not prevent patient requests nor is such action provided as an exception in the legislation.

Anticipatory disclosure via signage also does not assist doctors who work in facilities where they do not have an office upon which to display such a sign. Take for example junior doctors working in surgery, anaesthetics, gynaecology, or the emergency department. It would also prevent doctors with a conscientious objection to abortion from communicating about abortion with a patient who may have come to them seeking advice because they oppose abortion. For example, a long-time patient of a general practitioner with a crisis pregnancy may want to speak with a doctor who knows them, whom they trust, and whose worldview they respect.

The approach taken to conscientious objection in Victoria's Act is also known in the bioethics literature as 'mandatory referral.' It imposes a normative position on the highly complex ethical issue of complicity in wrongdoing. Moral theologians of the Roman Catholic Church have devoted significant time to developing a framework for complicity which includes formal and material co-operation, as well as direct, indirect, active, passive, proximate and remote co-operation.[179] Already discussed in chapter 3, complicity in an abortion is very dependent upon the facts of each individual case.

One does not have to be a practicing Catholic to subscribe to or support this moral framework for assessing complicity in wrongdoing. However, as noted earlier, whilst the Catholic Church has made Magisterial pronouncements about the moral evil of abortion and the principles upon which complicity is assessed,[180] it has not abstracted from those principles to proscribe certain indirect actions as being prohibited, based on specific circumstances. As stated before, there is very little in the way of research that has probed the minds of doctors with a conscientious objection to abortion regarding what actions they believe would make them morally complicit.

[179] See, eg, Anthony Fisher, 'Co-operation in Evil: Understanding the Issues' in Helen Watt (ed) *Co-operation, Complicity and Conscience* (The Linacre Centre, 2005) 27.
[180] See, eg, John Paul II, *Evangelium Vitae* (n 1) [52]-[63], [68]-[74].

Instead, there is an implicit assumption in Australian academic literature that a referral to a non-objecting doctor either does not harm the objecting doctor or if it does, it is proportionate to the good the law is seeking to achieve.[181] However, at the time of the debate, a pregnant woman in Victoria did not require a doctor's referral to access abortion, nor were doctors the holders of exclusive information on where to obtain abortion. Private clinics freely advertised their services in telephone directories and the internet, and some public hospitals also provided abortions to those who could not afford a private clinic.[182]

Since 2008, the internet has become accessible to many more people, early abortion can be performed at home via oral medication administered by accredited doctors, and the government has put in place a 24-hour dedicated telephone line operated by a registered nurse to provide women with information on abortion including where they can access abortion.[183] Despite this, the statutory duty on conscientious objectors to refer to a non-objecting doctor remains, although the impact of this duty on objecting doctors, the medical profession, women seeking abortion, and the community, is unclear.[184]

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[181] See, eg, Ronli Sifris, 'Tasmania's Reproductive Health (Access to Terminations) Act 2013: An Analysis of Conscientious Objection to Abortion and the "Obligation to Refer" (2015) 22 *Journal of Law and Medicine* 900, 913; Mark Davis, 'Conscientious Objection to Abortion – An Ethical and Professional Balancing Act' [2014] *Health Law Bulletin* 36, 38; Naomi Oreb,'Worth the Wait? A Critique of the Abortion Act 2008 (Vic)' (2009) 17 *Journal of Law and Medicine* 261, 268-9; Anna O'Rourke, Lachlan de Crespigny and Amanda Pyman, 'Abortion and Conscientious Objection: A New Battleground' (2012) 38(3) *Monash University Law Review* 87, 104-7; Danuta Mendelson, 'Decriminalization of Abortion Performed by Qualified Medical Health Practitioners Under Abortion Law Reform Act 2008 (Vic)' (2012) 19 *Journal of Law and Medicine* 651, 666.

[182] See Victoria State Government, 'Abortion in Victoria' *Better Health Channel* (Webpage, August 2019) <https://www.betterhealth.vic.gov.au/health/healthyliving/abortion-in-victoria>; Barbara Baird (n 147) 201-2; Michael Quinlan, 'When the State Requires Doctors to Act Against Their Conscience: The Religious Freedom Implications of Health Practitioners in Victoria and New South Wales' (2016) 4 *Brigham Young University Law Review* 1237, 1245.

[183] See, eg, Kathryn J LaRoche, LL Wynn and Angel M Foster, "We've got Rights and Yet We Don't Have Access": Exploring Patient Experiences Accessing Medication Abortion in Australia' (2020) 101 *Contraception* 256, 259.

[184] Chapter 5 will identify and discuss the findings from empirical research undertaken in Australia that touches upon these issues.

Accordingly in Victoria in 2008, compelling a doctor with a conscientious objection to abortion to refer a woman to another doctor who does not share those objections, was not about ensuring she had timely access to abortion.[185] This is because the doctor with the conscientious objection did not have special knowledge that the patient could not independently acquire themselves using the telephone or internet. Importantly, referral does not ensure timely abortion. As Minerva has noted, timely abortion requires enough abortion providers willing to meet community demand, including providing access in rural or remote locations.[186]

It is true, however, that a statutory duty to refer takes the burden off the patient of finding the details of an abortion provider, especially if their internet access is patchy or unreliable. There is good reason to ask why only the objecting doctor is seen as the bearer of the burden of service. However, the problem remains that by referring the patient to a doctor who does not have a conscientious objection to abortion, the objecting doctor involves themselves, however remotely, in achieving abortion. The standard response, however, is that this gesture of referral benefits women and the community at large by prohibiting intolerant and harmful behaviour generated by those doctors who persist in holding absolutist moral beliefs.[187]

When the Victorian bill was debated, the Archbishop of Melbourne threatened to close 15 Catholic hospitals in Victoria if it passed and, identified, the 'insidious irony that this coercion of conscience [was] being carried out in the name of choice.'[188] Within Parliamentary debates it was recognised that referral might infringe doctors' freedom of conscience, but ultimately re-characterising abortion as standard healthcare consistent with human dignity and freedom, reducing stigma and shame and establishing the contemporary concept of tolerance via mandatory referral, seemed to be higher objectives.[189]

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[185] Cf This needs to be differentiated from the argument that there is a relationship between the number of doctors with a conscientious objection to carrying out abortion and the waiting times for abortion on request. See Marco Bo, Carla Maria Zotti and Lorena Charrier, 'The *No Correlation* Argument: Can the Morality of Conscientious Objection be Empirically Supported? The Italian Case' (2017) 18(64) *BMC Medical Ethics* doi: 10.1186/s12910-017-0221-x.

[186] Francesca Minerva, 'Conscientious Objection in Italy' (2015) 41(2) *Journal of Medical Ethics* 170, 173.

[187] Walsh and Legge (n 158). The assumption that women are harmed by a doctor refusing to refer them needs to be explored further with empirical evidence. See Louise Keogh et al, 'Conscientious Objection to Abortion, the Law and its Implications in Victoria, Australia: Perspectives of Abortion Service Providers' (2019) *BMC Medical Ethics* doi 10.1186/s12910-0-190346-1:1-10.

[188] Barry Zwartz, 'Archbishop in Abortion Law Threat', *The Sydney Morning Herald*, 24 September 2008 <https://www.smh.com.au/national/archbishop-in-abortion-law-threat-20080923-4m04.html>.

[189] See, eg, Victoria, *Parliamentary Debates*, Legislative Assembly, 9 September 2008, 3374 and 3379. See also Francis J Beckwith and John F Peppin, 'Physician Neutrality: A Critique' (2000) 28 *Journal of Law, Medicine and Ethics* 67, 68. As discussed in chapter one, Beckwith and Peppin argue that prohibition of the absolutist

Victoria's *Charter of Human Rights and Responsibility Act 2006* provides that freedom of conscience is a fundamental human right, subject to reasonable limits. These limits are set out in section 7 where human rights are limited where it can be:

> demonstrably justified in a free and democratic society based on human dignity limit, equality and freedom, and taking into account all relevant factors including—
> (a) the nature of the right; and
> (b) the importance of the purpose of the limitation; and
> (c) the nature and extent of the limitation; and
> (d) the relationship between the limitation and its purpose; and
> (e) any less restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve.

Notwithstanding this, as section 48 of the Charter provides that nothing in the Charter is to affect abortion law, there was no requirement for the legislation to ensure that doctors with a conscientious objection to abortion were not burdened by the statutory duties to participate in abortion, or alternatively, that any burden was outweighed by the harm they may cause to public health or the rights and freedoms of others. In addition, the Victorian Act does not require the state to have considered less restricted measures to achieve its end.[190] Arguably, these provisions are narrower compared with freedom of conscience under art 18 of the *ICCPR*.

Mark Hobart, a suburban general practitioner, is an example of a doctor with a conscientious objection to abortion who was burdened by this law.[191] In 2013, he refused to refer a patient who was 19 weeks' pregnant to another doctor for a social sex selection abortion. Despite the woman being able to obtain the abortion a few days later, Hobart was subject to a disciplinary inquiry by the Victorian Medical Board for breaching s 8 of Victoria's *Abortion Law Reform Act 2008* which requires doctors with a conscientious objection to abortion to refer patients to a doctor they know does not also have a conscientious objection.

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position against abortion, with deference to the will of the state, is meant to be an example of 'value neutral medicine.' See also Walsh, 'The Legal Status of Prenatal Human Life' (n 163).

[190] The same exception for abortion and human rights applies in the two other jurisdictions that have enacted human rights legislation. See *Human Rights Act 2004* (ACT) s 9(2). Here, the Act provides that the right to life only applies to a person once they are born; *Human Rights Act 2019* (Qld) s 106. Here, the Act does not apply to law relating to abortion or the killing of an unborn child.

[191] Mark Hobart is currently suspended from practising as a medical practitioner. See, AHPRA and National Boards (Web Page) <https://www.ahpra.gov.au/Registration/Registers-of-Practitioners.aspx>.

It is worth noting that Hobart's patient did not make a complaint. Rather, Hobart's reaction to his patient's request came to the attention of the Medical Board who commenced an inquiry on its own motion. Ultimately, Hobart retained his registration for this complaint but only after much anguish and stress.[192] His case is all the more interesting given that the issue of social sex selection abortion has been raised in recent abortion law reform in New South Wales and South Australia. In 2019, New South Wales included a parliamentary condemnation of this practice in its legislation and in 2021, South Australia prohibited it.[193]

Minerva sums up the complexity of complicity where she states that:

> the 'moderate view' [mandatory referral] could theoretically work in a situation in which (1) degrees of complicity in relation to circumstances could be assessed once and for all; and (2) the physician would consider it moral to be an accomplice at least up to a certain degree. However, there is no formula to calculate degrees of complicity in different circumstances once and for all, because circumstances change continuously, depending on the number of physicians in a certain area and on the availability of each physician to inform, refer, or perform. Moreover, to some physicians, especially to Roman Catholic ones, even a minimum degree of complicity would represent a serious violation of their moral integrity. However, the efficiency of the health system and the well-being of the patients would be put at risk if healthcare practitioners were simply allowed to object to some forms of cooperation in what they view as wrongdoing.[194]

Writing in 2017, Baird made the point that prior to decriminalisation, public hospitals in Victoria performed around 20% of all abortions.[195] However since changes to the law, whilst clarity about the law has increased amongst abortion providers and the community, it may not have reduced the stigma attached to abortion or encouraged doctors to take up abortion. She notes that the only private clinic in Victoria offering abortions beyond 20 weeks' gestation for social as opposed to medical reasons, ceased operation in 2012. This was apparently due to the increased resources required to perform this type of abortion.[196]

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[192] Miranda Devine, 'Doctor Risks His Career After Refusing Abortion Referral' *The Daily Telegraph*, 5 October 2013 < https://www.heraldsun.com.au/news/opinion/doctor-risks-his-career-after-refusing-abortion-referral/news-story/a37067e66ed4f8d9a07ec9cb6fd28cf5>.
[193] *Abortion Law Reform Act 2019* (NSW) s 16(1); *Termination of Pregnancy Act 2021* (SA) s 12.
[194] Francesca Minerva, 'Conscientious Objection, Complicity in Wrongdoing, and a Not-So-Moderate Approach' (2017) 26 *Cambridge Quarterly of Healthcare Ethics* 109, 118.
[195] Baird (n 147) 201.
[196] Ibid 202.

Notwithstanding these points, in 2017 and 2018 the Northern Territory and Queensland adopted the Victorian approach and enacted a statutory duty on doctors with a conscientious objection to abortion to disclose their objector status and refer their patient to a non-objecting doctor. They must also perform abortion in an emergency notwithstanding their conscientious objection.[197] It is worth noting that prior to these changes, abortion in the Northern Territory was performed in two public hospitals at no cost, with concerns centred on the significant travel which patients needed to undertake to procure abortion in these hospitals.[198]

This raises an important query for further research: what is the appropriate balance where there is a demand for abortion in rural or remote areas and no local doctor willing to perform abortion and where patients must seek services outside their area at some inconvenience to them. It remains to be seen whether in Australia an 'emergency' could be broadly construed to include a risk to a woman's health from a delay in accessing abortion. The basis for this argument could be that delay causes her to be pregnant longer than she wishes to be and that this causes harm to her by infringing her right to self-determination.

In this circumstance, proof of harm could be the inability to obtain a timely abortion. Accordingly, it could be argued that in this scenario, a doctor with a conscientious objection to abortion must *directly* participate by performing the abortion themselves or being licensed to prescribe relevant drugs for medical abortion at home. This issue was raised by participants in this thesis' empirical study who identified as practising in rural and remote areas. Their attitude to what is an appropriate solution will be seen in the findings in chapter 6. This chapter now discusses the last approach to conscience protection – the 'middle way' approach.

[197] *Termination of Pregnancy Law Reform Act 2018* (NT); *Termination of Pregnancy Act 2018* (Qld); *Termination of Pregnancy Act 2021* (SA).
[198] See Baird (n 147) 204.

4.6. 'MIDDLE-WAY' CONSCIENTIOUS OBJECTION CLAUSES: TASMANIA, NEW SOUTH WALES, SOUTH AUSTRALIA

Notwithstanding the absence of a legal obligation to consider proportionality, it seems arguable that a just society should be curious about the impact of its law on conscientious objectors. It is instructive that it took five years after Victoria changed its law before the next state, Tasmania, came to decriminalise abortion. In so doing, it fashioned a less onerous duty on objecting doctors.[199] Rather than a duty to refer, it created a 'middle way' option where the doctor must 'provide the woman with a list of prescribed health services from which she can seek advice, information, or counselling on the full range of pregnancy options.'[200]

The option of giving a patient information about a third-party organisation which does not itself perform abortion raises the question of whether some doctors with a conscientious objection would consider this to be a reasonable compromise on the basis that it represents a break in the causal chain of moral co-operation in abortion. Certainly, the Tasmanian duty is not a formal medical referral. However what factors might an objecting doctor consider relevant in determining whether to accept this compromise? Can any concerns be accommodated in order to achieve a solution? If so, at what cost?

Some moral theologians may argue that there is a difference in the grade of complicity between referring a patient to a non-objecting doctor and providing a patient with information about a third party 'all options' organisation. Potentially, a factor an objecting doctor might be concerned with is whether they can supplement the list of organisations the state requires them to refer to, if they genuinely believe the woman's best interests are served by referral to, for example, a crisis pregnancy centre that focuses on assisting women who want to continue pregnancy. This is a controversial area.[201]

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[199] *Reproductive Health (Access to Terminations) Act* 2013 (Tas).
[200] Ibid s 7(2). See also Reproductive Health (Access to Terminations) Regulations 2014 (Tas) s4(1).
[201] See Walsh and Legge (n 158) 328-31.

Section 7(4) of the Tasmanian Act provides that nothing prevents an objecting doctor from 'continuing to provide treatment, advice, or counselling, in respect of matters 'other than a termination or advice regarding the full range of pregnancy options.' Arguably, a plain reading of this phrase suggests that objecting doctors may not discuss counselling or support options outside of those set out in the regulations which are currently: Family Planning Tasmania, Hobart Women's Health Centre (and its associated telephone line), The Link Youth Health Service and Pulse Youth Health Service.[202]

There are many privately funded 'crisis pregnancy' centres operating around Australia, usually staffed by volunteers.[203] There is no consensus on what qualifications a person need in order to counsel a woman about abortion. There can be complex psycho-social issues that impact on a woman's capacity to freely consent which can increase the risk of psychological sequelae.[204] The recent recognition of reproductive coercion as a crime in New South Wales, which includes a woman being forced to undergo abortion by a domestic partner, gives support to this observation, and suggests the need for further research and discussion [205]

Arguably, if the state adopted a neutral, freedom of choice position, then it would not only permit and support a woman's decision to choose abortion, but it would turn its mind to how to support the woman who does not want to choose abortion, so she can continue the pregnancy and give birth despite not having the means to choose this option.[206] It is possible that some doctors with a conscientious objection to abortion might accept this type of conscience clause on the proviso that they are not prohibited from referring patients to additional services not stipulated by the state. This was an area of enquiry taken up in this thesis' empirical study.

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[202] Reproductive Health (Access to Terminations) Regulations 2014 s 4(1). See also Walsh and Legge (n 158) 335-6.
[203] See Pregnancy Help Australia (Web Page, 2022) <https://pregnancyhelpaustralia.org.au>.
[204] See, eg, Royal Australian and New Zealand College of Psychiatrists ('RANZCP'), *Discussion Paper – Termination of Pregnancy* March 2011 <https://www.ranzcp.org/files/resources/reports/termination_of_pregnancy-pdf.aspx>. The RANZCP noted that whilst there are conflicting findings in studies about whether there is a link between abortion and mental health sequelae, it believes that 'adverse psychological outcomes are common enough to justify the availability of expert counselling and support services for every woman undergoing a termination of pregnancy if required.'
[205] *Crimes Act 1900* (NSW) s 545B (1A)(b). See also Marie Stopes Australia, *Hidden Forces: Shining a Light on Reproductive Coercion White Paper* (Marie Stopes Australia, 2019) 7 <https://www.mariestopes.org.au/wp-content/uploads/Hidden-Forces_MSA-RC-White-Paper_FINAL_WEB.pdf>.
[206] See Francis J Beckwith, 'Thomson's "Equal Reasonableness" Argument for Abortion Rights: A Critique' (2004) 49 *American Journal of Jurisprudence (Notre Dame)* 185.

In 2016, a private member's bill to decriminalise abortion in New South Wales was introduced into the Legislative Council. It proposed the blanket decriminalisation of abortion with no plan to place any statutory regulation on its practice, such as gestational age or other thresholds. Accordingly, it would have permitted abortion up until birth if the woman freely consented and could find a doctor who was agreeable to performing this abortion. For many people, this was too radical, excited considerable opposition, and the bill failed to pass. Regarding conscientious objection, it required objecting doctors to do the following:

> refer the person to another health practitioner, in the same profession, whom the health practitioner knows or reasonably believes does not have a conscientious objection to abortion or to a local Women's Health NSW Centre to enable the person to have full information about the options in relation to pregnancy.[207]

Adopting the requirements of both Victoria and Tasmania, the bill also sought to amend the *Health Practitioner Regulation Act 2009* (NSW) so that a doctor's failure to refer constituted a finding of unsatisfactory professional conduct. The bill was unsuccessful, but another Private Member's bill was robustly debated and passed in October 2019, and adopted a similar conscientious objection clause, with the arguably less onerous 'middle-way' duty to provide information.[208] Accordingly, in New South Wales, doctors have a statutory duty to refer, and the legislation provides directives on how this duty is to be discharged.

Initially, the New South Wales bill was introduced by an Independent Member of Parliament without the benefit of public consultation. However, between debates in the Legislative Assembly and Legislative Council, the Standing Committee on Social Issues organised a three-day stakeholder inquiry and invited the public to make submissions.[209] Regarding the conscience protection clause, the bill initially proposed that the objecting doctor refer or transfer the care of the woman to a non-objecting doctor who could provide the abortion and did not have a conscientious objection to it.

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[207] Abortion Law Reform (Miscellaneous Amendment) Bill 2016 (NSW).
[208] *Abortion Law Reform Act 2019* (NSW) s 9.
[209] See Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Reproductive Health Care Reform Bill 2019 [Provisions] Report* 55, August 2019 ('Standing Committee Report').

In both Houses, the conscience rights of health practitioners were the subject of debate. Proposed amendments included allowing doctors to refuse to assist in or otherwise co-operate in abortion, and not requiring a referral where the woman is under 22 weeks' gestation and the doctor reasonably believes it would not be difficult for her to find another doctor without a conscientious objection.[210] Objections to these were underpinned by the narrative that refusal to refer was both harmful to the women and not in accord with professional guidelines. An example includes the following from the member for Port Stephens, Ms. Kate Washington

> It is enormously important that health professionals do what their own governing body, the Australian Medical Association [AMA], says they ought to do. The policy of the AMA on conscientious objection states: 'A doctor with a conscientious objection should: inform the patient of their objection, preferably in advance or as soon as practicable; inform the patient that they have a right to see another doctor and ensure the patient has sufficient information to enable them to exercise that right; take whatever steps are necessary to ensure the patient's access to care is not impeded.'[211]

This statement does not explain how a patient's access to care is impeded. This is because a referral is not required to access abortion in New South Wales, women can independently locate abortion services on the internet, and the doctor may have no special knowledge about who will perform the abortion for the reasons requested.[212] Clearly, a lot turns on what 'impede' means. The legislation does not define the term. The Macquarie dictionary defines 'impede' as 'to restrain.'[213] Arguably, whether the conclusion that refusal to refer impedes access is just and fair is something worthy of further research and discussion.

A further argument to compel referral was concern for women in rural and remote areas. Member for Port Macquarie, Mrs. Leslie Williams, stated that failure to refer could result in delays and late-term abortions which would add 'confusion and a lack of clarity to what has otherwise been signed-off on by representative medical bodies.'[214] This may raise the need to educate the public that referral cannot guarantee timely abortion. This is because the referring doctor has no control over the abortion provider's waiting list, or the lack of qualified doctors who live in, or are willing to service, the woman's geographical location.

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[210] Standing Committee Report (n 209) 42-43.
[211] New South Wales, *Parliamentary Debates*, 8 August 2019, 19 (Kate Washington).
[212] New South Wales, *Parliamentary Debates*, 8 August 2019, 60-61 (Joe McGirr); Walsh and Legge (n 158, 333-5.
[213] Macquarie Dictionary (Macquarie Dictionary Publishers, 2020) <https:www/macquariedictionary.com.au>.
[214] New South Wales, *Parliamentary Debates*, 8 August 2019, 23 (Mrs Leslie Williams); Walsh and Legge (n 158) 335.

The consequences of an objecting doctor being forced to refer were discussed during the stakeholder inquiry. The evidence from the President of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists was that objecting doctors should transfer care or provide information to the patient so that she is able to access the care that she seeks.[215] The writer recommended that objecting doctors be consulted about a duty that directly affects them, and that referral to a third party 'all options' organisation might be more acceptable so long as the doctor is free to supplement that information with services the doctor believes are appropriate for the patient including those which support continuation of pregnancy.[216]

Ultimately, the conscientious objection clause was amended so that the way the duty to refer is discharged by a doctor includes providing information to the patient that has been approved by the Secretary of the Ministry of Health.[217] A downloadable fact sheet contains the telephone number and website address for NSW Pregnancy Options Helpline, a third party 'all options' service which can refer the woman on to an abortion provider and provide counselling to continue the pregnancy. Operating 24 hours a day, 7 days a week, this government run service saves the objecting doctor from being compelled to take additional action.[218]

In New South Wales, there is no explicit prohibition on objecting doctors providing additional information to patients about advice and assistance on 'all options.' It is an open question whether professional guidelines will step in and prohibit the objecting doctor from referring the patient to agencies whose sole aim is to assist the woman to continue pregnancy and choose not to undergo abortion. This is an important distinction given that a contravention of s 9 of the Act can lead to notification under the *Health Practitioner Regulation National Law* (NSW) or a complaint under the *Health Care Complaints Act 1993* (NSW).

[215] Evidence to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, 15 August 2019, 29 (Dr Vijay Roach).
[216] Evidence to Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, 14 August 2019, 64 (Anna Walsh); Walsh and Legge (n 158) 335.
[217] *Abortion Law Reform Act 2019* (NSW) s 9(3)(a), (4).
[218] For general practitioners or specialists with a conscientious objection, the fact sheet from New South Wales Health could be printed and kept in the reception area with other health brochures. This would prevent them from having to physically hand it to the patient and might increase their comfort whilst achieving the same end.

The statutory duty to provide information applies to registered health professionals asked to perform or advise on abortion such as doctors, nurses, pharmacists, and psychologists. However, health workers, such as radiographers who are asked to perform ultrasounds whilst an abortion is in progress, or medical students who have a conscientious objection to assisting in or facilitating an abortion, are not protected. Given the *Anti-Discrimination Act 1977* (NSW) does not recognize conscience as a protected attribute, they may need to seek informal accommodation from their employer and try to create an industry standard.[219]

South Australia was the last jurisdiction to decriminalise abortion and also adopted the Tasmanian/ New South Wales narrow, 'middle way' approach to conscience protection.[220] It is worth noting that prior to its passage, South Australia's conscientious objection clause acted as a shield to protect doctors who refused to perform or participate in abortion but placed an evidentiary onus on the objecting doctor to establish that they had a conscientious objection.[221] The focus and onus of proof was on the objector's sincerity, as opposed to the reasonableness of the objection.[222] However there is no case law to assist with how to prove one's sincerity.[223]

[219] This would presumably be remedied by passage of the Religious Discrimination Bill 2022 and the Australian Law Reform Commission's review of state and territory anti-discrimination legislation, as discussed earlier at 4.3.1; Walsh and Legge (n 158) 336.
[220] *Termination of Pregnancy Act 2021* (SA) s 11(4). The doctor's duty to refer is discharged where the objecting doctor gives the person information approved by the Minister which consists of details for a SA Government service that provides information about a range of health services and resources, including information about medical practitioners who do not have a conscientious objection to the performance of termination.
[221] *Criminal Law Consolidation Act 1935* (SA) s 82A(6) (now repealed).
[222] Cf Robert F Card, 'In Defence of Medical Tribunals and the Reasonability Standard for Conscientious Objection in Medicine' (2016) 42(2) *Journal of Medical Ethics* 73.
[223] Case law exists in the U.S.A regarding sincerity of belief for conscientious objection to military service as well as health related services where the focus of any enquiry is on whether the nature of the belief is religious as opposed to whether the belief is valid (for example, concerns which are financial), as well as whether it is sincere. See, eg, *United States v Seeger*, 380 U.S. 163 (1965); *Burwell v. Hobby Lobby Stores, Inc*. (n 9).

Minerva has noted a problem with abuse of conscience clauses in Italy, which has a very high percentage of conscientious objectors to abortion.[224] Historically in Australia, Cannold notes that between 1988 and 1990, South Australian nurses refused on the basis of their conscience, to provide services for second trimester abortions requested by women for 'social reasons'. This led to pregnant women travelling to Sydney or Melbourne for an abortion.[225] Since that time, there has not been a problem of supply and demand for abortion in Australia, but the incident raises some important questions.

With the decriminalisation of abortion, hospitals could theoretically perform social abortions, as opposed to limiting them to complex, late term abortions approved by an ethics committee. This might increase the number of doctors or healthcare professionals who will formally declare they have a conscientious objection. This is avoided where private clinics perform the bulk of abortions with staff who have freely chosen to do this work. It also raises questions about institutional conscientious objection by religious faith-based health facilities whose ethos may be against the idea of abortion as healthcare.[226]

Quite apart from abortion, legislation to permit physician assisted suicide and euthanasia ('EPAS') has been enacted in Victoria, Western Australia, Tasmania, Queensland and New South Wales.[227] Whilst each recognise freedom of conscience, there has been progressive limitation of its scope, with the most recent iteration in Queensland creating unique statutory duties on certain health facilities which do not provide information on EPAS because their ethos is against EPAS, to nonetheless allow another person reasonable access to their patient at their health facility to provide that EPAS information to the patient.[228]

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[224] Francesca Minerva (n 186) 170. Minerva claims there is a very significant and increasing percentage of conscientious objectors among gynaecologists, obstetricians, anaesthetists, and ancillary personnel.
[225] Leslie Cannold, 'Consequences for Patients of Health Care Professionals' Conscientious Actions: The Ban on Abortion in South Australia' (1994) 20 *Journal of Medical Ethics* 80. 85.
Ibid 81-2.
[226] This is addressed in the Religious Discrimination Bill 2022, cl 8.
[227] *Voluntary Assisted Dying Act 2017* (Vic); *Voluntary Assisted Dying Act 2019* (WA); *End of Life Choices (Voluntary Assisted Dying) Act 2021* (TAS); *Voluntary Assisted Dying Act 2021* (Qld); *Voluntary Assisted Dying Act 2022* (NSW).
[228] *Voluntary Assisted Dying Act 2021* (Qld) s 90. It is speculated that if the law obliges a facility to allow EPAS advice to be given to a patient on site because the patient is too ill to go off-site to receive it, then it stands to reason that it might also require the facility to permit the death to likewise occur on site. See 'Media Statement from CHA Chair on Passing of Assisted Dying Laws in QLD' Catholic Health Australia (Web Page, 16 September 2021) <https://www.cha.org.au/home/media-statement-from-cha-chair-john-watkins-am-on-the-passing-of-voluntary-assisted-dying-laws-in-quuensland/>.

Outside of facilities, Victoria's EPAS legislation allows individual doctors to refuse to provide information, participate in assessments, prescribe drugs, and be present at the death.[229] Western Australia's EPAS legislation covers similar actions except providing information.[230] Therefore there may be an expectation that doctors with a conscientious objector to EPAS refer patients to non-objecting doctors. Tasmania's EPAS legislation permits the doctor to refuse a request to assist with the EPAS process and whilst not requiring them to explain why, the legislation requires them to notify the relevant Commission that they have refused the request.[231]

Finally, Queensland's EPAS legislation is explicit in requiring doctors with a conscientious objection to refer on, but they may do so via the 'middle way' option to a third party 'navigator service' who will make the referral.[232] The 'navigator service' is a corollary to the 'all options' pregnancy support services discussed earlier in this chapter and referred to in abortion legislation in Western Australia, Tasmania, New South Wales and South Australia. This solution places the burden on the state, as the party responsible for legalising the service, to ensure supply and demand is met rather than placing the burden on individual doctors.

The 'middle-way' approach to achieving reasonable accommodation of conscientious objection to abortion takes more seriously the notion of moral complicity via a referral to a provider of the service in question or a non-objecting doctor. This is a positive advancement. However, as this chapter has demonstrated, there are still a number of issues associated with these referrals to third party organisations that are dependent upon matters that still need further exploration and discussion. Those matters get to the core of the conflict between worldviews about truth and freedom and were explored further in the empirical study.

[229] *Voluntary Assisted Dying Act 2017* (Vic) s 7.
[230] *Voluntary Assisted Dying Act 2019* (WA) s 9.
[231] *End of Life Choices (Voluntary Assisted Dying) Act 2021* (TAS) ss 20(3), 21.
[232] *Voluntary Assisted Dying Act 2021* (Qld) s 84 (1)(2).

4.7 Conclusion

Until recently, the long tradition of Western medicine highlighted the doctor's personal integrity as a key aspect of quality medical care.[233] This belief has been called the cornerstone of the argument for recognising conscientious objection by doctors. However contemporary medicine lacks a 'common philosophy' and a 'common conscience.'[234] As Krauss notes, it lost its 'guild power' in the second half of the 20th century and with it, the ability to influence the state on the morality of certain services. He notes that this role has largely been taken over by experts from the disciplines of bioethics and bio-politics.[235]

Conscience conflicts about morally controversial services often take place within polarising political debates which focus on the legality and social acceptance of the service and rarely delve into the metaphysical positions which justify the service in issue as being 'good' or therapeutic in more holistic sense. It is not surprising then that conscientious objection to abortion tends to be dismissed as merely 'religious reasoning', which is unjustly assumed to lack logic and be incomprehensible to non-members. In this context, patient autonomy becomes the default position to 'resolve' disputes between doctors and patients about controversial services.[236] This is not resolution at all.

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[233] Ludwig Edelstein, *The Hippocratic Oath: Text, Translation, and Interpretation* (Johns Hopkins Press, 1943).
[234] See, eg, Edmund Pellegrino, 'The Physician's Conscience, Conscience Clauses, and Religious Belief: A Catholic Perspective' (2002) 30(1) *Fordham Urban Law Journal* 221, 230. See also Tom Koch (n 169) 341. Koch argues that the personal accountability of the doctor is destroyed where they must adopt the lawmaker's view of what is right and true about abortion.
[235] Elliott Kraus, *Death of the Guilds* (Yale University Press, 1996) 49. Kraus also notes that modern medicine has lost the ability to influence the state regarding medical education/accreditation and workplace standards.
[236] See Tom L Beauchamp and James F Childress, *Principles of Biomedical Ethics* (Oxford University Press, 7th ed, 2013) 101. The authors state that respect for autonomy forms part of the common morality of medical principles but concede that its scope and content still require further analysis given its meaning is often the subject of dispute. Cf Nicholas Tonti-Filippini (n 27) 19-20.

Those who deny the place of conscientious objection in medicine have a very specific view of conscience. They argue that where the state has declared a service to be lawful healthcare to be performed by doctors, it has the right and duty to organise services and provide sufficient doctors to meet community demand for the service.[237] Medicine is a voluntary profession, they say, and if the doctor employed by the state cannot put their patient's needs before their own, then the doctor ought to leave the profession or choose specialties that do not cause conflicts with their conscience.[238]

This approach has a utilitarian understanding of beneficence and shifts the focus from the good the doctor thinks should be done for their individual patient, to the good the state thinks the doctor should do for society.[239] Accordingly, the state's characterisation of a medical practice as being lawful and the profession's acceptance of lawful treatment as the standard of care, can make the doctor's personal judgment of what is morally permissible and consistent with the ends of medicine irrelevant, and weaken their claim for conscientious objection being grounded in professional integrity or professional standards.

This position has been adopted by countries such as Sweden, Iceland, and Finland, which do not recognise conscientious objection by doctors to abortion where the abortion is sought within the public health system.[240] These systems mandate the training of all obstetricians and gynaecologists in abortion. Accordingly, these states effectively block conscientious objectors from entering the profession,[241] with conflict restricted to doctors who have trained abroad and who seek to work in obstetrics and gynaecology, or those who have changed their views after achieving specialisation.[242]

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[237] See, eg, Francesca Minerva (n 186) 71; Julian Savulescu, 'Should Doctors Feel Able to Practise According to their Personal Beliefs and Values? – NO' (2011) 195(9) Medical Journal of Australia 497, 497; Julie Cantor, 'Conscientious Objection Gone Awry – Restoring Selfless Professionalism in Medicine' (2009) *New England Journal of Medicine* 360:15, 1484, 1485.
[238] See, eg, Julian Savulescu, (n 237) Udo Schuklenk and Richard Smalling (n 80).
[239] Nancy Berlinger (n 99) 35. See also Nicholas Tonti-Filippini (n 27) 20.
[240] Christian Fiala et al, 'Yes We Can! Successful Examples of Disallowing 'Conscientious Objection' in Reproductive Care' (2016) 21(3) *European Journal of Contraception and Reproductive Health Care* 201, 201.
[241] Ibid 204.
[242] Ibid 205.

Whilst this is undoubtedly a solution to limit conflict, it may contravene the proportionality test in human rights law, which permits infringement of a person's rights to the extent required to permit the other person to exercise their rights (amongst other reasons).[243] If only a small part of a doctor's work involves requests for abortion or such requests can be accommodated, then it arguably imposes a punishment on those with a different worldview by denying them entry into, or continuing employment within, a particular field of medical practice, and advocates the social engineering of an entire profession.

As Murphy notes, with this approach, doctors must be capable of holding contradictory beliefs.[244] For example, whilst being personally opposed to abortion, they must be content to perform it, or refer to a willing provider, on the basis that their professional conscience is different to their personal conscience, with the former capable of overriding the latter. Alternatively, doctors would have to be 'value-neutral' and never insert their beliefs about right and wrong into their patient interactions. Clinical decisions would be made by doctors who blindly or obediently follow whatever the lawmaker decides is healthcare.[245] This approach desecrates a person's moral agency.

True tolerance for pluralism requires a transparent analysis of the rights in conflict, the intention of the law in question, and evidence about the impact it has upon relevant parties in relation to the contexts discussed above. Reasonable accommodation attempts to preserve both parties' rights, so as to protect diversity, and ensure harmony. For conscientious objectors, it is important to recognise the reality that we live in a democracy. Whilst human rights law exists, in part, to protect people with minority views from the tyranny of the masses, reasonable accommodation may involve a compromise on the part of one or the other affected parties and this is where further discussion and enquiry is needed.

[243] *ICCPR* (n 6) art 18(3).
[244] Murphy and Genuis (n 156).
[245] Francis J Beckwith and John F Peppin, 'Physician Value Neutrality: A Critique' (2000) 28 *Journal of Law, Medicine and Ethics* 67, 75.

Regarding doctors, this thesis takes the position that they should be permitted to disagree with the state, and with their patients, on the issue of their participation and co-operation in abortion and regulate their involvement in it. Health professionals should be permitted to have open dialogue about the ethical issues without fear, and have the space, support, and education to form a principled position over time so as to integrate their personal beliefs about the ends of medicine into the public practice of their profession. They must also learn more about how their position affects patients and the community.

Without the benefit of federal legislation on freedom of thought, conscience, and religion as infrastructure, Australia has approached the protection of conscience in what Oderberg would describe as an 'incremental approach', that is service by service.[246] This has resulted in Australian lawmakers being able to take a diverse approach to conscience protection without being confined by, and having the benefit of, well thought out and fully debated general principles and guidelines, as well as data from all key stakeholders from which to consider the issue. As such, the politics of the service has often clouded the discussion.

At the end of the day, this analysis has shown that the state can enact a permissive abortion framework without limiting conscientious objection by doctors and health professionals. Much depends upon the state's willingness to know more about how a conscientious objection to abortion harms women, how compelling a doctor to act against conscience harms them, and whether there are alternative solutions to resolving any conflict that has not yet been considered. This in turn depends upon people being willing to conduct sound research which not only provides credible data but addresses underlying ideological premises.

Having completed its legal analysis of conscientious objection to abortion, looking firstly at trends in human rights law and then at the domestic legislation in Australia, this thesis now reviews the social science literature on quantitative and qualitative studies that have sought to know more about doctors' attitudes to conscientious objection, with a particular emphasis on abortion. It will establish a gap in studies about the perspectives of 'pro-life' doctors who are directly affected by policies on managing conscientious objection. This literature review is the last chapter before this thesis reports on the findings from its empirical study.

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[246] David S Oderberg, 'Freedom of Conscience in UK Health Care: Time for a Change?' in Grzegorz Blicharz (ed) *Freedom of Conscience: A Comparative Law Perspective* ((Prawo Publiczne, 2019) 329.

CHAPTER FIVE

LITERATURE REVIEW: EMPIRICAL RESEARCH

> In a world ablaze with headlines about cloning, over-the-counter abortifacients, resource shortages in hospitals, withdrawal of feeding from the unconscious and any number of other problems, the subject of co-operation in evil might appear obscure, even self-indulgent. Yet it is precisely in this area that so many moral dilemmas arise for people.[1]

5.1 INTRODUCTION

The mandatory referral model used in the abortion laws of Victoria and New South Wales sets a precedent for how conscientious objection to other morally controversial services should be managed. Accordingly, exploring the effect of this legal framework on objecting doctors is potentially relevant in relation to other such areas. To date, however, there is limited knowledge about how women seeking abortion, or doctors who conscientiously object to it, are impacted by the mandatory referral framework.[2] Instead, research has primarily focussed on the views of all doctors to conscientious objection in specific situations.

Over the last 15 years, several quantitative studies have been conducted which explored the beliefs of doctors and medical students to conscientious objection. Involving thousands of participants, the common finding was that doctors did not want to be compelled to perform a medical service that offended their conscience but were supportive of the solution that the objecting doctor refer the patient to a non-objecting doctor (the 'mandatory referral' model). However, only one study sought to know the views of doctors who have a conscientious objection to referral.[3]

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[1] Anthony Fisher, *Catholic Bioethics for a New Millennium* (Cambridge University Press, 2011) 69.

[2] But see Louise Keogh et al, 'Conscientious Objection to Abortion, the Law and its Implementation in Victoria, Australia: Perspectives of Abortion Service Providers' (2019) *BMC Medical Ethics* doi 10.1186/s12910-0-19-0346-1:1-10; FM Doran and J Hornibrook, 'Barriers Around Access to Abortion Experienced by Rural Women in New South Wales, Australia' (2016) 16 *Rural and Remote Health* 3538; Eva M Nordberg, Helge Skibekk and Morten Magelssen, 'Conscientious Objection to Referrals for Abortion: Pragmatic Solution or Threat to Women's Rights?' (2014) 15 *BMC Medical Ethics* doi:10.1186/1472-6939-15-15:1-9; Dubravka IG Håkansson, Pernilla Ouis and Maria E Ragnar, 'Navigating the Minefield: Women's Experiences of Abortion in a Country with a Conscience Clause—The Case of Croatia' (2021) 22(1) *Journal of International Women's Studies* 166

[3] Nordberg, Skibekk and Magelssen (n 2).

Whilst 'mandatory referral' is promoted by key medical groups as the normative solution to conscientious objection to abortion, the studies showed that when participants were given details about a morally controversial service they opposed, support for conscientious objection increased and mandatory referral was not as clearly supported. Accordingly, it is perhaps unsurprising that some authors did not support mandatory referral,[4] whilst others cautioned against extrapolating their findings to other countries and instead recommended that further studies be undertaken.[5]

This chapter conducts a literature review of empirical studies on the issue of conscientious objection by doctors to abortion. Largely descriptive, it identifies key studies and comments upon the common attitudes captured from the doctors surveyed. Whilst there are many studies that have sought to measure doctors' attitudes to abortion per se, far fewer have focussed specifically on the issue of conscientious objection and mandatory referral to a non-objecting doctor. This chapter reviews studies performed in the United States of America, the United Kingdom, Europe, and Australia.[6]

The aim of this chapter is to provide background to the empirical study which is the focus of this thesis. It will note the relevant legal framework for abortion and conscientious objection in the relevant country, identify any limitations in findings due to study design and methodology, and discuss any questions raised from the studies that support further research. Ultimately this chapter seeks to confirm that the questions this thesis explores in its empirical study fill the gap left by previous studies and are relevant questions for the formation of sound law and policy.

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[4] See, eg, Farr A Curlin, et al, 'Religion, Conscience, and Controversial Clinical Practices' (2007) 356(6) *New England Journal of Medicine* 593, 599; Michael P Combs et al, 'Conscientious Referrals to Refer: Findings from a National Survey' (2011) 37 *Journal of Medical Ethics* 397, 400. Authors of these studies recommended further studies be undertaken before deciding on a policy.

[5] See, eg, Nordberg et al (n 2) 1; Petteri Nieminen, et al, 'Opinions on Conscientious Objection to Induced Abortion Among Finnish Medical and Nursing Students and Professionals' (2015) 16 *BMC Medical Ethics* DOI 10.1186/s12910-015-0012-1: 1-9, 5; Michael P Combs et al, (n 4).

[6] Due to word limitations, this thesis restricted itself to the four countries indicated and notes that there are published studies on doctors' attitudes to conscientious objection to abortion in Africa, Canada, Italy, South America, and Asia.

5.2 THE UNITED STATES OF AMERICA ('USA')

5.2.1 THE LEGAL FRAMEWORK

In the USA, abortion is a 'unique, intensely divisive controversy.'[7] The decision of *Roe v Wade*[8] in 1973 led to the first conscience protection laws in the world.[9] In *Roe,* Justice Blackmun noted that when it comes to when human life begins 'those trained in the respective disciplines of medicine, philosophy, and theology are unable to arrive at any consensus.[10] Notwithstanding this, a woman's constitutional right to privacy was held to limit state intervention to protect the unborn child before the third trimester because the unborn child to that point in time had 'at most, only potentiality of life.'[11]

By confining legal personhood to when a child is born alive,[12] the lawmaker had significant flexibility to make laws that prohibit, restrict, permit, or tolerate abortion based upon criteria that is both extrinsic and intrinsic to the unborn child and which reflects community norms. In this way, and as Cornides notes, changes in abortion law are more likely to reflect politics than genuine advances in science or philosophy.[13] However some commentators continued to ask the question that if the unborn child is not a human being, then what is it? If it were not alive, then why would you be terminating its life? [14]

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[7] See *Planned Parenthood of Southeastern Pa. v Casey* 550 U.S. 833, 836 (1992) ('*Casey*'). In places, this thesis reproduces and expands upon comments made in my Masters of Laws thesis. See Anna Walsh, 'The Legal Status of Prenatal Life in Australia' (Master of Laws thesis, The University of Sydney, 2016).

[8] *Roe v Wade*, 410 U.S. 113 (1973) ('*Roe*'). This decision created a negative right for women to access abortion in the first trimester on the basis of a constitutional right to privacy and in the second trimester if her life or health were at risk. It did not grant universal access to abortion.

[9] See Thaddeus Mason Pope, 'Legal Briefing: Conscience Clauses and Conscientious Refusal' (2010) 1(2) *Journal of Clinical Ethics* 163, 164.

[10] *Roe* (n 8) 160.

[11] Ibid.

[12] Kristen Savell, 'Life and Death Before Birth: 4D Ultrasound and Shifting Frontiers of the Abortion Debate' (2006) 15 *Journal of Law and Medicine* 103, 107-110. The born alive rule is an old English law that was created at a time when medicine lacked the technology to determine if the child in the womb was alive. Arguably, it is retained today in order to permit abortion to be a lawful medical procedure as opposed to the intentional killing of a person.

[13] Jacob Cornides, 'Human Rights Pitted Against Man' (2008) 12(1) *International Journal of Human Rights* 107, 113.

[14] See, eg, Justin Dyer, 'Reckoning with Roe v Wade' (2011) *The Public Discourse* <https://www.thepublicdisourse.com/2011/01/2426/>.

Twenty years after *Roe*, the majority of the Supreme Court in *Planned Parenthood of Southeastern Pa. v Casey* held that *Roe* was so important to the social fabric of American society, that overruling it would cause 'serious inequity to people who had made choices, defined their views of themselves and their places in society, and organised their lives in reliance on the availability of abortion should contraception fail.'[15] Whilst in *Casey* the Court replaced the notion of trimesters with foetal viability, it maintained its approach to unborn human life based on the 'gradualist' approach. [16]

However, the *Casey* Court held that a state may take measures to ensure that the pregnant woman makes an informed decision to undergo abortion, and that in achieving this, efforts to persuade her to choose childbirth, so long as these efforts are not an undue burden on her right to privacy, are legitimate.[17] This resulted in challenges to a number of state laws.[18] Recent decisions have been controversial. Laws setting out the type of facility which may offer abortion, and requiring doctors who perform abortion to be able to admit their patients into a nearby hospital if needed, were struck down by the courts for being unduly burdensome.[19]

In June 2022, the Court decided the case of *Dobbs v Jackson Women's Health Organization* which overruled *Roe* and *Casey*.[20] This case concerned a Mississippi statute banning abortion after 15 weeks' gestation. Whilst the statute reflected Mississippi's interest in protecting the life of the unborn, it conflicted with a woman's constitutional right to abortion. The Court was afforded the opportunity to re-visit *Roe* and *Casey* and the majority held these cases were wrongly decided and had the effect of 'short circuiting the democratic process by closing it to the large number of American who disagreed with *Roe.*'[21]

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[15] *Casey* (n 7) 836.
[16] Ibid. But see Leo Han, Maria Rodrigues and Aaron B Caughey, 'Blurred Lines: Disentangling the concept of Fetal Viability from Abortion Law' (2018) 28(4) *Women's Health Issues* 287; I Glenn Cohen and Sadath Sayeed, 'Fetal Pain, Abortion, Viability and the Constitution' (2011) 39(2) *Journal of Law, Medicine and Ethics* 235.
[17] *Casey* (n 7).
[18] See Guttmacher Institute, 'State policies in brief: Targeted regulation of abortion providers' March 2016 < http://www.guttmacher.org/statecenter/spibs/spib_TRAP.pdf.> See especially *Whole Women's Health v Hellerstedt*, 579 US 562 (2016); *June Medical Services, LLC v Russo,* 591 U.S. 1101 (2020).
[19] See especially Kate Greasley, 'Taking Abortion Rights Seriously: *Whole Woman's Health v Hellerstedt*' (2017) 80 *Modern Law Review* 325.
[20] 597 U.S. _ (2022) ('*Dobbs*'). For the earlier decision, See *Jackson Women's Health Organization v Dobbs* 379 F. Supp. 3d 549 (S.D. Miss. 2019).
[21] *Dobbs* (n 20) 43–45.

The majority of the Court in *Dobbs* noted that abortion is a 'profound moral question' and that without a Constitutional right to abortion, which they held had never been part of the nation's history and tradition, the power to regulate abortion should be returned to the states, and therefore to the people and their elected representatives.[22] The majority also held that where a state law went on appeal to the Supreme Court on the basis of its constitutionality, then even where it concerned 'matters of great social significance and moral substance' it would be decided on a rational basis review.[23]

The effect this decision may have on the attitudes of people generally, and doctors and health professionals specifically, about abortion and conscientious objection to it, is unknown at the time of writing. However, it is possible that the Court's affirmation that abortion is a profound moral question may give confidence to those health professionals with a conscientious objection to abortion who have felt a lack of respect and recognition from peak bodies regarding the legitimacy of their position. The balance of this section will provide some background to conscience clause development in the USA.

The complexity of abortion law and regulation in the USA is an interesting feature that raises a question about what factors impact upon an American doctor's position on abortion. For example, it is at least possible that a doctor who supports in theory 'a woman's right to choose,' or an abortion request in a particular circumstance, may have misgivings about the quality of care the woman may receive at an abortion clinic due to what the doctor perceives to be a problem with the regulation of the practice of abortion in their state. This variable is not something that has been studied.

[22] Ibid 8-39, 78-9.
[23] Ibid 77.

After *Roe*, the Church amendment was passed by Congress. This prohibited, amongst other things, public authorities from imposing certain requirements on individuals and entities who refused to perform or assist in abortion or sterilisations where it was contrary to their religious beliefs or moral convictions.[24] This amendment is derivative of the free exercise clause in the *American Constitution* which limits the government's power so citizens can adopt any religious belief they want, and protects actions made in accordance with that sincerely held belief.[25] This is supplemented by the *Religious Freedom Restoration Act* 1993 ('RFRA').

This RFRA prohibits the government from substantially burdening a person's exercise of religion save for two circumstances: where the burden to the person furthers a compelling governmental interest and is the least restrictive means of furthering that compelling governmental interest. There is significant case law and controversy about its application and impact on other people.[26] Most recently, the Catholic Benefits Association obtained a permanent injunction against a state mandate that its doctors refer patients for, and perform, gender-transition surgery notwithstanding a doctor's conscientious objection to this surgery.[27]

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[24] 42 *U.S.C.* 300a-7. See also *Taylor v St Vincent's Hospital* 523 F.2d 75 (9th Cir. 1975).), aff'd, 523 F. 2d 75 (1965). This case involved an attempt to obtain an injunction against a Catholic hospital for refusing to perform sterilisation on the basis of their religious objections even though they were receiving federal funds. The Supreme Court upheld this protection, preferring freedom of religion for denominational hospitals over a woman's right to privacy.

[25] See Augusto Zimmerman, *Christian Foundations of the Common Law Volume 2: The United States* (Connor Court Publishing, 2018) 142. Cf David S Oderberg, 'Further Clarity on Cooperation and Morality' (2017) 43 *Journal of Medical Ethics* 192, 192. Oderberg argues that using a mere sincerity test will lead to absurdity and that the Catholic moral system of complicity could be applied in legal reasoning to justify and support what is reasonable, as opposed to what is merely sincere.

[26] See, eg, Lucien J Dhooge, The Religious Freedom Restoration Act at 25: A Quantitative Analysis of the Interpretative Case Law' (2018) 27(1) *William and Mary Bill of Rights Journal* 159; Louise Melling, 'The Religious Freedom Restoration Act is Discriminatory. Let's Fix It' *Ethics, Religion News Service*, 18 May 2016 <https://religionnews.com/2016/05/18/the-religious-freedom-restoration-act-is-discriminatory-lets-fix-it/> ; Brian Hutler, 'Against the Political Use of Religious Exemptions' (2019) 47(3) *Philosophy and Public Affairs* 319.

[27] *Catholic Benefits Association et al v Alex M Azar II, Secretary of the United States Health and Human Services, et al*, Case No. 3:16-cv-00432, United States District Court, District of North Dakota, Eastern Division <https://www.hhs.gov/sites/default/files/document-124-memorandum-opinion-and-order.pdf>.

It is worth noting that the Church Amendment also protects the consciences of doctors and health professionals who want to perform abortion and do not share in an institution's religious or philosophical objections. In this way, institutions with an ethos against abortion such as Catholic hospitals may not discriminate against those health professionals who, when not working for them, perform abortion in public hospitals or private clinics, under threat of a penalty. As Wilson notes, the Church amendment protects the consciences of all by a proper non-discrimination clause.[28]

Generally speaking, conscience clauses in the United States fall into two categories; they can fully protect the doctor who refuses to be involved in the service or compel the doctor to co-operate in providing a service indirectly notwithstanding a conscientious objection. Maintained by a patchwork of federal and state laws, Pope notes that in the United States, '[c]onscientious objection laws provide *some* protection to *some* providers who conscientiously object to *some* procedures under *some* circumstances,' with the precise grounds for refusal often being unclear.[29]

In 2007, the American College of Obstetricians and Gynaecologists published its policy on conscientious objection and recommended that objectors refer women to non-objecting doctors to perform abortion where emergency referral is not possible or where it might negatively affect a patient.[30] At that time, there was no empirical research on the attitudes of doctors to conscientious objection either generally or to abortion specifically. However, since then six quantitative studies have been published, with four focussing on abortion, and these are reviewed in the next sub sections.

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[28] See, Robin Fretwell Wilson, 'When Governments Insulate Dissenters from Social Change: What Hobby Lobby and Abortion Conscience Clauses Teach about Specific Exemptions' (2014) 48 *UC Davies Law Review* 703, 779. This might be contrasted with 24 hour conduct clauses that apply to some teachers involved in Catholic education in others parts of the world.

[29] See Pope (n 9) 164. See also See, Adam Sonfield, 'Learning from Experience: Where Religious Liberty Meets Reproductive Rights', 5 January 2016 < https://www.guttmacher.org/gpr/2016/learning-experience-where-religious-liberty-meets-reproductive-rights.>; Nadia N Sawicki, 'Disentangling Conscience Protection' (2018) 48(5) *Hastings Center Report* 14. Sawicki notes at 18 that most conscience clauses protect adverse action taken by the government and private parties.

[30] American College of Obstetricians and Gynecologists, Committee Opinion No. 385 'The Limits of Conscientious Refusal in Reproductive Medicine' (November 2007) (reaffirmed 2016) https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2007/11/the-limits-of-conscientious-refusal-in-reproductive-medicine. This issue remains controversial and is not surprising that research on doctors' attitudes to conscientious objection starts to occur at around the time that this policy was created.

5.2.2 EMPIRICAL STUDIES

5.2.2.1 CURLIN ET AL STUDY

In their 2007 national study of 1,144 doctors, the authors asked participants for their opinion on their ethical rights and obligations when patients requested a legal procedure to which the doctor had a moral or religious objection.[31] In addition, the authors explored three morally controversial services: administering terminal sedation to dying patients, performing abortion for failed contraception, and prescribing oral contraception for adolescents without parental approval. Participants were asked whether the objecting doctor should be obliged to refer to a non-objecting doctor.[32]

In general, 71% of participants to this study reported that they believed that objecting doctors should refer the patient to a non-objecting doctor.[33] However, when the focus switched to the specific scenarios, a significant number of participants who reported an objection to abortion and contraception were less likely to support an obligation to refer.[34] Religious affiliation was a strong indicator of both support for conscientious objection and refusal to refer, with Catholics and Protestants less likely to support mandatory referral, although their reasons for opposing referral were not explored.[35]

Once the number of doctors who identify as having a conscientious objection to lawful medical services is known, the next level of enquiry should be into how that objection plays out in practice and whether there are any obstacles that prevent one's behaviour falling in line with one's beliefs. As the authors duly noted, this study did not measure whether the opinions reported by participants equated with their behaviour in real life. As such, they recommended that future research measure how doctors respond to ethical conflicts in actual patient encounters by obtaining responses to vignettes, using patient reports or by direct observation.[36]

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[31] Farr A Curlin et al, 'Religion, Conscience, and Controversial Clinical Practices' (2007) 356(6) *New England Journal of Medicine* 593.
[32] Ibid 595.
[33] Ibid.
[34] Ibid 597. The authors found that in the contexts described above, 52% were against abortion and 42% against contraception.
[35] Ibid.
[36] Ibid.

The authors speculated that the lack of consensus within the profession about the obligation to refer reflected the ambivalence in the bioethical literature.[37] As a result, despite the majority support for referral, the authors did not recommend mandatory referral. Rather, they recommended an interactive model of accommodation, where neither the doctor nor the patient is compelled to violate their convictions.[38] The authors acknowledged that this interactive model could result in a patient seeking a morally controversial service from a doctor having to be burdened with the need to consult with another doctor.[39]

5.2.2.2 LAWRENCE ET AL STUDY

In their 2009 national survey of 446 doctors, the authors posed two questions; first, whether a doctor has an obligation to provide a legal medical procedure to a patient where the doctor objects due to religious or moral reasons, and second, whether the doctor who will not provide the procedure has an obligation to refer the patient to someone who will.[40] Participants were also asked about whether they had an objection to three patient requests: physician assisted suicide, abortion due to failed contraception, and abortion due to the unborn child having Down syndrome.[41]

Overall, 77% of participants did not believe doctors must do what they personally believe is wrong. This response found the most support amongst participants who objected to the three scenarios described above.[42] However 82% of participants believed that doctors with a religious or moral objection should refer patients to a doctor willing to perform the service. A substantial minority disagreed with this position, with religious intensity being a strong predictor of opposition to an obligation to refer. As such, the authors concluded that this was an obstacle to finding a unified solution.[43]

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[37] Ibid 599.
[38] Ibid.
[39] Ibid 598. This raises the issue of the state's responsibility to bear the burden of ensuring supply and demand of controversial services that it has deemed to be lawful.
[40] Ryan E Lawrence and Farr A Curlin, 'Physicians' Beliefs About Conscience in Medicine: A National Survey (2009) 84(9) *Academic Medicine* 1276.
[41] Ibid 1279.
[42] Ibid.
[43] Ibid 1279-80.

Curiously, 36% of participants expressed a 'middle view' wherein they simultaneously believed that doctors ought not do what they think is wrong, yet they believed doctors sometimes have a professional obligation to provide medical services even if they personally believe it would be morally wrong to do so.[44] Whilst not explored further, the authors posited several explanations for this result, including that these 'middle view' participants might have difficulty imagining a scenario where their conscience is ever in conflict with a lawful medical service.[45]

5.2.2.3 COMBS ET AL STUDY

In this 2011 national survey of 1,032 doctors, the authors found that 43% of participants, a significant minority, did not believe doctors with a conscientious objection to referral ought to be forced to refer.[46] Like the previous two studies, the authors found that religion was a relevant predictor of attitudes, with participants who supported an obligation to refer being more likely to believe that 'no religion is uniquely and comprehensively true', to identify as being socio-politically liberal, and to identify respect for patient autonomy as 'the primary bioethical principle in their practice.' [47]

Like Curlin et al, the authors in this study noted that disagreements amongst practicing doctors regarding how to manage conscience conflicts was reflected in the disagreements exhibited in the bioethics literature.[48] The simple majority amongst the doctors surveyed in this study that opposed mandatory referral suggested to them that there was no unified ethical standard for conscientious objection within the profession. Ultimately, the authors predicted that the mandatory referral model for abortion would meet resistance from a significant portion of the medical profession.[49]

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[44] Ibid 1282.
[45] Ibid.
[46] Michael P Combs et al, 'Conscientious Referrals to Refer: Findings from a National Survey' (2011) 37 *Journal of Medical Ethics* 397, 400.
[47] Ibid 399.
[48] Ibid.
[49] Ibid 400.

With respect to alternative solutions to mandatory referral, the authors noted the problems associated with placing the onus on the doctor to resolve conflicts by choosing specialties where they are unlikely to require a violation of their conscience. These problems include the rapid change within specialties that can make it difficult to determine one's conscientious objection at the start of a career, as well as the injustice of prohibiting a gifted clinician from entering a specialty where their conscientious objection may impact only a small area of practice.[50]

In addition, the authors noted that the practice of anticipatory disclosure by a doctor to their patient of their objection can also raise problems where the way in which healthcare is organised in some countries or regions does not allow for patients to choose their own doctor (known as 'doctor shopping'). In such cases, conflict should be anticipated.[51] Ultimately, the authors suggested removing mandatory referral requirements for morally controversial services and, like Curlin et al, leaving it to institutions to mediate any conscience conflicts between patients and doctors. [52]

5.2.2.4 FRANK STUDY

Frank's 2011 national study involving 154 family doctors provides a unique perspective given these doctors are regularly exposed to patient requests for morally controversial services.[53] Focussing on 14 morally controversial procedures including abortion, end of life care and transgender medicine, the right to refuse to perform the service was dependent upon the service in question, with refusal rates varying from 12.3% to 57.8%. With regards to mandatory referral, 90.2% of participants supported the general concept.[54] This was the highest acceptance for the controversial approach of all studies considered in this chapter.

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[50] Ibid.
[51] Ibid.
[52] Ibid. The authors note that the institution would need to create its own protocol and policies on who to manage conflicts.
[53] Jennifer E Frank, 'Conscientious Refusal in Family Medicine Residency Training' (2011) 43(5) *Family Medicine* 330.
[54] Ibid 332.

However, there was one important exception to this result. This exception highlights the observation made by Lawrence et al earlier about the 'middle view' participants. When presented with this much broader menu of morally controversial services to choose from, 79.2% of participants reported an objection to performing or referring for social sex selection abortion.[55] Given the basis for justifying their exceptions was not explored in the study, it is difficult to know how participants reconciled general support for mandatory referral or abortion on demand for any reason with specific exceptions such as this.

These results suggest a curious point; that many doctors formed a view about conscientious objection and referral without considering all the possibilities that might arise and that could affect them. Frank observed that the profession was still defining its response to conscientious objection, but as previous studies have confirmed the prevalence of conscientious objection in certain areas, the issue is no longer just a philosophical dispute. She suggested that the next step for research was to explore how doctors' beliefs translate into behaviours and if so, how they impact upon patient care.[56]

Frank's study goes some way towards considering this by testing whether participants' beliefs matched their practice in the context of a doctor disclosing their conscientious objection to their supervisor. Despite 86.4% of participants believing that doctors have a moral obligation to inform supervisors of their objection, only 13% of those who reported an objection to at least one of the 14 services considered in the study, disclosed this to their supervisor. The reasons or barriers for not disclosing were not pursued in this study and suggests another fruitful area for further research.[57]

[55] Ibid.
[56] Ibid.
[57] Ibid 333.

5.2.2.5 RASINSKI ET AL STUDY

This large scale 2011 national study was the first American study to target the views of doctors within the sub speciality of obstetrics and gynaecology.[58] Involving 1,154 participants, it used thirty-two vignettes which varied factors such as sex of the doctor and the type and source of the doctor's objection. It then tested participants' attitudes to the policy of the American College of Obstetricians and Gynaecologists, where doctors with a conscientious objection to abortion must refer patients to non-objecting doctors and provide patients with notice of their objection prior to the consultation. [59]

A substantial minority of participants in this study disagreed with the proposition that a doctor who refused to perform an abortion must refer the patient on to a doctor who is willing to perform abortion.[60] As with previous studies, the intensity of the doctor's religious beliefs was a predictor of the belief that a doctor should not have to refer.[61] As has been noted in other studies, the authors noted this study's inability to measure whether participants' views mirrored their behaviour in real life. This further supports the call for further research into how theory influences praxis.

Interestingly, 70% of participants disapproved of a doctor disclosing the reason for their objection to the patient.[62] This compares unfavourably with the Curlin et al study, where 63% supported disclosure of reasons.[63] Here, the authors speculated that the reasons for participants' disapproval of disclosure could be their concern that it might influence a patient's decision to undergo abortion.[64] The authors supported further research into doctors' attitudes to disclosing the basis of their conscientious objection and when in the relationship doctors believe such disclosure should occur.[65]

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[58] Kenneth A Rasinski, et al, 'Obstetricians – Gynecologists' Opinion about Conscientious Refusal of a Request for Abortion: Results from a National Vignette Experiment' (2011) 37 *Journal of Medical Ethics* 711.
[59] Ibid 712.
[60] Ibid 713.
[61] Ibid.
[62] Ibid.
[63] Curlin et al (n 31) 587. It should be noted that the 63% refers to the general question of support for disclosure of reasons for objection, but when applied to the three scenarios of terminal sedation for pain relief, abortion for failed contraception, and prescription of oral contraceptives to an adolescent without parental approval, there was variation in support at 62%, 55% and 58% respectively. The reasons for these differences were not explored.
[64] Rasinski et al (n 58) 713-4.
[65] Ibid 714.

5.2.2.6 BRAUER STUDY

Finally, this 2016 study surveyed 896 primary care doctors and sought to clarify and build upon the results of previous studies reported in this chapter.[66] The authors purposefully designed their study so that participants did not have to respond to scenarios involving abortion. Instead, they described an un-named clinical intervention lacking in 'intra-professional debate and uncertainty but less public controversy' and contrasted this with narcotic pain relief.[67] This was done in order to see whether taking the focus off abortion would influence participants' attitudes.

Using vignettes, the authors explored support for the following propositions: whether doctors are more likely to support an objection based on professional or personal reasons; whether objectors should disclose to the patient the basis of their objection; whether objectors should provide treatment they object to or refer the patient to a non-objecting doctor who would also provide the treatment; whether doctors should inform the patient that the treatment objected to is legal and can be provided by another doctor but refuse to make the referral; and whether they may fail to provide this information and refuse to refer.[68]

In distinguishing personal and professional objections, the authors referenced three positions in the literature: advocating the exclusion of doctors who refuse to perform lawful services on personal grounds,[69] supporting only professional objections,[70] and permitting objections with mandatory referral.[71] However the authors failed to explain why a personal objection could not

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[66] Simon G Brauer, John D Yoon and Farr A Curlin, 'US Primary Care Physicians' Opinions About Conscientious Refusal: A National Vignette Experiment' (2016) 42 *Journal of Medical Ethics* 80.
[67] Ibid 81.
[68] Ibid 80.
[69] See Julie Cantor, 'Conscientious Objection Gone Awry – Restoring Selfless Professionalism in Medicine (2009) *New England Journal of Medicine* 360:15, 1484; Julian Savulescu, 'Should Doctors Feel Able to Practise According to their Personal Beliefs and Values? – NO' (2011) 195(9) *Medical Journal of Australia* 497.
[70] See, eg, Mark K Wicclair, 'Conscientious Objection in Medicine' (2000) 14(3) *Bioethics* 205, 2015-6; MS Swartz 'Conscience Clauses or Unconscionable Clauses': Personal Beliefs versus Professional Responsibilities' (2006) 6 *Yale Journal of Health Policy, Law and Ethics* 269.
[71] See, eg, DW Brock, 'Conscientious Refusal by Physicians and Pharmacists: Who is Obligated to do What, and Why?' (2008) 29 *Theoretical Medical Bioethics* 187; FA Chervenak and LB McCullough, 'The Ethics of Direct and Indirect Referral for Termination of Pregnancy' (2008) 199 *American Journal of Obstetrics and Gynecology* 232.e1.

also be a professional objection suggesting some unconscious bias on their part about the mutual exclusion of the two objections.[72]

Ultimately, as these terms were not defined in the survey, the authors could not rule out that participants may not have been able to differentiate between them.[73] As it turned out, 85% of participants supported doctors not having to violate their standards to provide a service they objected to, with there being no difference as to whether the objection was described as personal or professional.[74] With regard to providing information, there was higher support for the doctor who told patients the service was legal but refused to refer, than those who remained silent and refused to refer.[75]

On this question of providing information to the patient, the survey did not ask participants what level of obligation the objecting doctor should be under, such as whether they only needed to provide generic information or whether they had to make an 'effective referral.'[76] However with regard to referral, 57% of participants supported the objecting doctor referring the patient to a doctor who would provide the service.[77] Whilst this finding is consistent with other studies, it also means that a significant minority of participants did not agree with referral being an appropriate compromise.

As to whether an objecting doctor should disclose the basis of their objection to the patient, which is an issue that has drawn divided responses in previous research, the authors of this study found that participants had no particular preference as to what to do.[78] Finally, in line with other studies, those participants who were determined to be of 'high religiosity', that is where their religion was the most important part of their life, were more likely than others to refuse to perform actions they objected to, and to refuse to support referral as an appropriate compromise.[79]

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[72] Brauer, Yoon and Curlin (n 66) 80. This is particularly so as the authors later defined a personal objection as a 'religious' objection. This suggests the authors believe religious objections cannot align with professional objections or that non-religious beliefs form a valid basis for medical refusals.
[73] Ibid 84.
[74] Ibid 82.
[75] Ibid.
[76] Ibid 83. The term 'effective referral' is not used by the authors in this study, but essentially it refers to the doctor providing sufficient details to the patient so they can achieve the requested service in their particular situation. It therefore goes beyond giving general information such as directing the patient to a website.
[77] Ibid 83.
[78] Ibid 82-3.
[79] Ibid.

The United States has generated the largest amount of quantitative data on doctors' attitudes to conscientious objection in healthcare. This is possibly due to their broad constitutional protection of religion and greater demand for accommodation. Most doctors surveyed did not believe they should have to perform actions that violate their conscience, with a significant minority extending that refusal to having to refer patients on to a non-objecting doctor. However, the attitudes towards mandatory referral changed when the service, and/or the circumstances in which it was requested was one the participant objected to.

It is worth noting that these studies focused on doctors' attitudes rather than their experiences, and largely represented the views of those who did not have a conscientious objection to any of the scenarios presented. On the whole, American studies support further review of the issues including the feasibility of potential solutions. Whilst it is unclear what role further education will have upon doctors' attitudes and practices, a one size fits all solution for conscientious objection in healthcare in the United States seems unlikely to find majority support within the medical profession.

The next subsection considers data on conscientious objection to abortion in the United Kingdom. Whilst there are a number of published studies measuring the attitudes of doctors to abortion in the United Kingdom, these were largely conducted more than 15 years ago and unsurprisingly do not focus on conscientious objection to abortion.[80] There are, however, two published studies that focus on medical students' attitudes to abortion and their willingness to co-operate in it. These reveal a surprising trend that suggests future challenges to the profession in meeting the community demand for abortion.

[80] Studies not included in this review include C Francome, 'Attitudes of General Practitioners in Northern Ireland Towards Abortion and Family Planning (1997) 29 *Family Planning Perspectives* 234; C Francome and E Freeman, 'British Practitioners' Attitude Towards Abortion.' (2000) 32 *Family Planning Perspectives* 32 (2004) 189. These studies were excluded because they were conducted more than 15 years ago where issues such as mandatory referral were not commonly discussed. In addition, the more recent study by Mark Murphy et al, 'Termination of Pregnancy: Attitudes and Clinical Experiences of Irish GPs and GPs in Training' (2012) 18 *European Journal of General Practice* 136 was excluded on the basis that the authors did not discuss participants' attitudes to conscientious objection.

5.3 THE UNITED KINGDOM

5.3.1 THE LEGAL FRAMEWORK

In England, Wales and Scotland, abortion remains a crime under section 58 of the *Offences against the Persons Act 1861* (UK) unless the abortion meets the criteria set out in the *Abortion Act 1967* (UK). Section 58 of the *Offences against the Persons Act 1861* (UK) provides the following:

> Every woman, being with child, who, with intent to procure her own miscarriage, shall unlawfully administer to herself any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, and whosoever, with intent to procure the miscarriage of any woman, whether she be or be not with child, shall unlawfully administer to her or cause to be taken by her any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, shall be guilty of felony, and being convicted thereof shall be liable to be kept in penal servitude for life.

The application of this section and the test for a lawful abortion was decided in the seminal 1937 case of *R v Bourne,*[81] (referred to in chapter 3). This case involved an eminent gynaecologist charged under this section with performing an unlawful abortion on a 14-year-old girl who was allegedly raped by soldiers. Mr. Bourne formed the view that continuing the pregnancy would seriously damage the girl's health and he did not pretend that he performed abortion to save her life. The Attorney General's position was that the operation was lawful, but only if done to save her life and not otherwise.

The judge directed the jury that abortion was lawful to preserve the mother's life but went on to state that '[i]f the doctor is of the opinion that there are grounds and on adequate knowledge that the continuance would probably make the woman a physical or mental wreck, the act is lawful.' By defining the exception in this way, it is perhaps unsurprising that the jury returned a 'not guilty' verdict. However, there was no psychiatric evidence adduced as to the girl's mental state, alternatives to abortion, or concern that abortion might worsen her health.[82]

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[81] *R v Bourne* [1937] 1 KB 687.

[82] The notion that undergoing abortion might worsen some women's mental health is a more recent area of research. Whilst controversial, it has found some support but also has many critics. See, eg, David M Ferguson, L John Horwood, and Joseph M Boden, 'Does Abortion Reduce the Mental Health Risks of Unwanted and Unintended Pregnancy? A Re-Appraisal of the Evidence' (2013) 47(9) *Australian and New Zealand Journal of*

Some thirty years after this decision, Parliament enacted the *Abortion Act 1967* (UK). Pursuant to s 1 of the *Abortion Act*, abortion performed by a doctor, is lawful where two doctors are of the opinion, formed in good faith, of any of the following four circumstances:

1. That the pregnancy has not exceeded its twenty-fourth week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family;[83] or
2. That the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman; or
3. That the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated; or
4. That there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

This legal framework is not 'abortion on demand' because the pregnant woman must satisfy certain criteria. However, the requirement for two doctors to be satisfied that there are sufficient concerns for the woman's maternal or family health to justify an abortion is subjective. Implicitly, the Act accepts that there may be differing views on abortion within the profession. Accordingly, it is the doctor who determines whether a crime has been committed and the legislation anticipates that the doctor may reject the woman's self-assessment that abortion is a proportionate response to her circumstances.[84]

Psychiatry 819. Cf E Charles Vignetta et al, 'Abortion and Long-Term Mental Health Outcomes: A Systematic Review of the Evidence' (2008) 78(6) *Contraception* 436.

[83] Prior to 1991, the upper gestational age for abortion was 28 weeks. This was later lowered to 24 weeks because of new scientific knowledge regarding the viability of the foetus.[83] However more recent attempts to further lower the gestational age limit for abortion have not succeeded. See Savell, (n 12) 107-110.

[84] Arguably, at the end of the day, determining whether or not continuing pregnancy is a greater harm to the pregnant woman than undergoing abortion rests on an individual doctor's understanding of health and harm and will reflect their worldview.

In the United Kingdom, abortion is available for free from the National Health Service, ('NHS') and from private providers such as Marie Stopes United Kingdom, the British Pregnancy Advisory Service, and the National Unplanned Pregnancy Advisory Service.[85] Women do not need not obtain a formal referral letter from a doctor to access services.[86] Regarding conscientious objection to abortion, the United Kingdom has incorporated the human right to freedom of thought, conscience and belief as set out in the *European Convention on Human Rights*[87] into their domestic law.

Schedule 1 of the *Human Rights Act 1998* (UK) provides that:

> 1. Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief and freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance.
> 2. Freedom to manifest one's religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others.

Pursuant to s 4 of the *Abortion Act*, health professionals with a conscientious objection to abortion are exempt from performing or participating in abortion, except where abortion is deemed necessary to save the life or health of the woman.[88] There is no case law which interprets this phrase under this Act.[89] In terms of 'participation' (discussed in chapter 4) the Supreme Court ruled in *Greater Glasgow Health Board v Doogan and Anor* whether two midwives on a labour ward were made to participate in abortion by delegating to, supervising, and/or supporting other staff participating in abortion or caring for patients having abortion.[90]

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[85] See <https://www.nhs.uk>.
[86] She may 'self-refer' by presenting to an abortion clinic and having two abortion providers sign the relevant paperwork.
[87] See Council of Europe, *European Convention for the Protection of Human Rights and Fundamental Freedoms, as amended by Protocols Nos. 11 and 14*, opened for signature 4 November 1950, EST 5 (entered into force 3 September 1953) ('*ECHR*').
[88] See also David S Oderberg, 'Freedom of Conscience in UK Health Care: Time for a Change?' in Grzegorz Blicharz (ed) *Freedom of Conscience: A Comparative Law Perspective* ((Prawo Publiczne, 2019) 315, 316-17. Oderberg notes that anyone working for the National Health Service must comply with regulations which require objectors ensure prompt referral to a provider of primary medical services who do have a conscientious objection; Walsh (n 7).
[89] However note the court's broad definition of life or health of the pregnant woman in *R v Bourne* (n 81).
[90] *Greater Glasgow Health Board v Doogan and Anor* [2014] UKSC 68 ('*Doogan*').

Earlier in 2013, the Court of Appeal held that conscientious objection extended to the whole process of abortion and the right to object is recognised because 'the process of abortion is felt by many people to be morally repugnant.'[91] On appeal, the Supreme Court overruled the Court of Appeal and held that the right to conscientious objection was not unfettered, given exceptions exist such as to save the mother's life or prevent grave injury to her health. Accordingly, participation was narrowly construed and held to be restricted to performing the tasks involved in the course of treatment, in a 'hands on' capacity.[92]

Also discussed in chapter 4, *Doogan* followed *Janaway v Salford Health Authority*[93] where the House of Lords held that the term 'participate' was to have its ordinary meaning, of actually taking part in treatment administered in a hospital or other approved place.[94] Whilst objecting doctors are not under a statutory duty to refer women, the General Medical Council's ('GMC') guidance note provides that 'if it is not practical for the patient to arrange to see another doctor, the objecting doctor must make sure that arrangements are made for another suitably qualified colleague to take over their role.'[95] Failure to comply can result in disciplinary proceedings.

Oderberg argues that courts in the United Kingdom have approached conscientious objection in healthcare, especially the issue of co-operation in abortion, without adequate philosophical inquiry. He notes:

> For without a worked-out jurisprudence of cooperation, based on philosophical principles and tempered by the common sense of the common law, with overarching statutory backing, conscientious objections will find it hard to have any legitimate objection satisfactorily met. Moreover, as contentious as it may be, abortion is but one among many activities within healthcare where objections will undoubtedly arise. What about euthanasia? Transgender surgery? Extreme cosmetic surgery? Apotemnophilia (the persistent desire for the amputation of a healthy limb)? Surely the approach of 'one conscience clause at a time' would be a highly undesirable way to proceed.[96]

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[91] [2013] CSIH 36.
[92] *Doogan* (n 90) [37]-[38].
[93] [1989] AC 537.
[94] Ibid 1082. This case involved a receptionist typing a referral letter to a doctor to consult a patient regarding abortion was not participating in abortion. This narrow, legal understanding of participation in abortion fails to acknowledge the more complicated perspective of moral theology which concentrates on moral complicity or co-operation in wrongdoing. This was discussed in chapter 3. See also Walsh (n 7).
[95] See, General Medical Council, United Kingdom <https://www.gmk-uk.org.> The GMC is a statutory body created by the *Medical Act 1983* (UK) that is responsible for providing medical education, registration and revalidation of doctors and giving guidance to doctors on matters of professional conduct, performance, and ethics.
[96] Oderberg, 'Further Clarity on Cooperation and Morality' (n 25) 199.

Following the decision in *Doogan*, Baroness O'Loan introduced the Conscientious Objection (Medical Activities) Bill 14 into the House of Lords. Having passed the second reading stage in 2018, the bill is currently subject to a Committee review. The object of the bill aims to clarify the extent to which a medical practitioner (broadly defined) with a conscientious objection may 'refrain from participating in certain medical activities and for connected purposes.' In cl 2, the phrase 'participation in an activity' is given an open definition which includes supervision, delegation, planning or supporting of staff in respect of that activity.

Ultimately, as Oderberg notes, 'the UK ranks freedom of conscience fairly low.'[97] There are two published studies that focus on medical students and their attitudes to abortion and their willingness to co-operate with it. Obviously, when considering the attitudes of medical students, there is a limitation on what conclusions might be drawn about the impact their responses may have on the profession and the community in terms of supply and demand. This is because they have not yet entered into practice and their attitudes may change as they gain clinical experience. However downward trends in support for abortion are worth noting.

These studies raise questions about the amount and quality of the ethical education students receive in medical school and what they learn, if anything, about freedom of conscience. As Parker notes, junior doctors are vulnerable and can be morally exploited.[98] They are subject to the pressure of the medical hierarchy where they are at the bottom, they require supervision, and are subject to direction. Arguably, speaking up to a superior in order to refuse to perform certain activities and seek an accommodation takes courage, knowledge, and an ability to clearly articulate the basis of the objection and what activities they will and will not do.

[97] Oderberg 'Freedom of Conscience in UK Health Care: Time for a Change?' (n 88) 329.
[98] Joshua Parker, 'Junior Doctors and Moral Exploitation' (2019) 45 *Journal of Medical Ethics* 571, 572.

5.3.2 EMPIRICAL STUDIES

5.3.2.1 GLEESON STUDY

In Gleeson et al's 2008 survey of 300 first and second-year medical students at the University of Birmingham, 29% of participants identified as moderately or strongly pro-life, 64% as moderately or strongly pro-choice, and 7% were undecided.[99] Gleeson et al broke down the issue of abortion into various scenarios. The six scenarios were: where a mother's life is at risk; where the mother's health is at risk; where the child is conceived in rape; where the foetus will have serious disability; where the foetus is at risk of serious disability; and where the child is unwanted.[100]

When presented with these six abortion scenarios, 83% of the student participants who identified as being moderately or strongly pro-life reported that they would offer counselling to the pregnant woman, 43% would authorise the abortion, and, somewhat remarkably, 23% said they would perform abortion.[101] Interestingly, only 50% of all participants would authorise abortion on an unwanted pregnancy, with only 36% willing to abort the unwanted child.[102] This result demonstrates nuanced attitudes to abortion, which defies the binary 'pro-life' or 'pro-choice' divide.

Overall, student participants were more willing to be involved in abortion when the mother's life was at risk, than in less serious situations. Additionally, the stage of the pregnancy was also a factor in participants' willingness to be involved.[103] However as most abortions in the United Kingdom occur for unwanted pregnancy, the authors concluded that if participants' views followed them into practice, most doctors would be unwilling to perform abortions which would create supply and demand issues.[104] This trend in the United Kingdom is repeated in the next study.

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[99] R Gleeson et al, 'Medical Students' Attitudes towards Abortion: A UK Study' (2008) 34 *Journal of Medical Ethics* 783, 785.
[100] Ibid 785.
[101] Ibid 786.
[102] Ibid.
[103] Ibid. Abortion at an earlier gestation was more acceptable to participants than late term abortion.
[104] Ibid.

5.3.2.2 STRICKLAND STUDY

In Strickland's 2012 study of 733 medical students in the United Kingdom, she asked participants a number of questions including whether doctors should be allowed to refuse medical procedures on cultural, moral or religious grounds. It also assessed their beliefs about services including abortion, examining patients of the opposite sex, and treating patients intoxicated with alcohol or recreational drugs.[105] Overall 45%, of student participants believed that doctors should be allowed to refuse any service, with Muslim students reporting the most support for this belief at 76%.[106]

When identifying the basis of their objection, Muslim students recorded the highest rate of religious objection at 28.4%. However overall, the most common basis for an objection was described as 'non-religious' at 44.1%. This was followed by religious objections at 19.7% and 36.2% as a mixture of both.[107] When it came to abortion, almost a third of participants objected to abortion for a congenitally malformed foetus after 24 weeks, a quarter objected to abortion for failed contraception before 24 weeks, and a fifth objected to abortion on a rape victim who was a minor.[108]

Like in Gleeson's study, Strickland's study noted that if participants' views followed them into practice, it might make it impossible to accommodate conscientious objection in medicine due to the number of doctors who might make a claim for protection and upset access to abortion.[109] However interestingly, not all participants who reported an objection to performing a service would necessarily exercise a conscientious objection in practice.[110] Strickland noted the need for further research into why a doctor would perform a procedure if they felt it was morally wrong, as well as normative questions about the limits on conscience and who decides this.[111]

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[105] Sophie Strickland, 'Conscientious Objection in Medical Students: A Questionnaire Survey' (2012) 38(1) *Journal of Medical Ethics* 22.
[106] Ibid.
[107] Ibid 23.
[108] Ibid 24.
[109] Ibid.
[110] See also Frank (n 53) 333. Frank made a similar finding in her study of family doctors.
[111] Strickland (n 105) 24-5.

The decision of the English Supreme Court in *Doogan* regarding the interpretation of conscience protections contained within abortion legislation suggests how combining a conscience clause within permissive abortion legislation can lead to unexamined presumptions about abortion carrying over into freedom of conscience. Additionally, the Court's distinction between direct and indirect participation in abortion has a clear focus on a normative assessment of actions which can be recognised as a legitimate conscientious objection rather than focussing on the impact that action has or will have on the individual person.

The General Medical Council ('GMC') draws a tight rein on medical students.[112] In their 2006 Committee position regarding core education outcomes, they noted that whilst medical students have a right to freedom of conscience, they cannot 'compromise the fundamental purpose of the medical course: to train doctors who have the core knowledge, skills, attitudes and behaviour that are necessary at graduation.'[113] As such their view is that even though a conscientious objection is unlikely to harm patients, doctors must be trained to perform services they object to as it could affect future patients. [114]

The GMC also noted that this applies after graduation, when new doctors must complete a two-year foundation programme that requires them to experience emergency medicine with a diverse group of diverse and acutely ill patients. The results of these two studies are more than 10 years old and there is no evidence that access to abortion has been affected by these students' attitudes. This raises questions about whether participants underwent change when they commenced practice, whether they avoided areas of concern, or whether they were able to achieve a reasonable accommodation of their conscientious objection.

[112] General Medical Council, United Kingdom <https://www.gmk-uk.org.> The GMC is a statutory body created by the *Medical Act 1983* (UK) that is responsible for providing medical education, registration and revalidation of doctors and giving guidance to doctors on matters of professional conduct, performance, and ethics.
[113] Ibid [10].
[114] Ibid [11]. Specifically, they noted that refusing to examine half one's patients because of the patient's gender could not be accommodated and would in fact 'run counter to the most basic principles of ethical medical care. They did not mention refusal to perform or participate in abortion or other controversial procedures.

5.4 EUROPE

5.4.1 THE LEGAL FRAMEWORK

Given Europe comprises many sovereign states with their own domestic laws on the regulation of abortion, this subsection will commence with the legal instruments which regulate freedom of conscience generally, as well as non-binding Resolutions of the Council of Europe on conscientious objection to abortion. It will then describe selected cases in countries whose empirical studies are critiqued in section 5.4.2. The *European Convention for the Protection of Human Rights and Fundamental Freedoms* ('ECHR') affirms freedom of conscience as a fundamental human right in art 9 in similar terms to that of the *UDHR* and *ICCPR*.[115]

There are a number of decisions of the European Court of Human Rights which provide guidelines for the interpretation and application of art 9. As has been mentioned in chapter 1, when considering the ECHR, the European Court of Human Rights ('ECtHR'):

> leaves to the States party to the Convention a certain margin of appreciation in deciding whether and to what extent an interference is necessary. This margin of appreciation goes hand in hand with European supervision embracing both the law and the decisions applying it. The Court's task is to determine whether the measures taken at national level were justified in principle and proportionate.[116]

As a result, the domestic legislation of a particular member state, and the way in which it regulates, organises, and delivers abortion, and the way it regulates the various health professions, can be crucial in determining the outcome of a dispute.

A very useful case for general principles is *Eweida v United Kingdom.*[117] Here, a Christian employee of British Airways was prohibited by her employer from openly wearing a necklace with a discrete cross on it whilst at work pursuant to the company's policy that mandatory religious clothing had to be concealed by the company uniform. She refused to remove the cross and was offered another position that would not have made her subject to the company's

[115] *ECHR* (n 87) art 9.
[116] *Eweida v United Kingdom* (European Court of Human Rights, Application No. 48420/10, 15 January 2013). [84].
[117] Ibid.

uniform policy. She refused and was placed on leave without pay for several months. The company subsequently changed its policy but refused to pay the applicant for lost earnings.

The ECtHR noted at paragraph 81 that:

> the right to freedom of thought, conscience and religion denotes views that attain a certain level of cogency, seriousness, cohesion and importance. Provided this is satisfied, the State's duty of neutrality and impartiality is incompatible with any power on the State's part to assess the legitimacy of religious beliefs or the ways in which those beliefs are expressed.

Further at paragraph 82, the Court noted that:

> Even where the belief in question attains the required level of cogency and importance, it cannot be said that every act which is in some way inspired, motivated or influenced by it constitutes a "manifestation" of the belief. Thus, for example, acts or omissions which do not directly express the belief concerned or which are only remotely connected to a precept of faith fall outside the protection of Article 9(1). In order to count as a "manifestation" within the meaning of Article 9, the act in question must be intimately linked to the religion or belief. An example would be an act of worship or devotion which forms part of the practice of a religion or belief in a generally recognised form. However, the manifestation of religion or belief is not limited to such acts; the existence of a sufficiently close and direct nexus between the act and the underlying belief must be determined on the facts of each case. In particular, there is no requirement on the applicant to establish that he or she acted in fulfilment of a duty mandated by the religion in question.

The Court held that freedom of religion was important because 'a healthy democratic society needs to tolerate and sustain pluralism and diversity.'[118] This is because of 'the value to an individual who has made religion a central tenet of his or her life to be able to communicate that belief to others.' The Court determined that the wearing of a cross was a genuine manifestation of the applicant's beliefs. Whilst the company's policy to project a corporate image was a legitimate aim, too much emphasis had been placed on it without the benefit of adequate domestic protection of freedom of religion. A fair balance had not been struck.[119]

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[118] Ibid [94]

[119] Ibid [94]-[95]. There was no real impact on others' interests and no evidence that the applicant's or others' religious clothing had ever negatively impacted upon the brand of image of British Airways. The infringement on the applicant's freedom to manifest her religion was not necessary in a democratic society.

Whilst the *European Convention for the Protection of Human Rights and Fundamental Freedoms* affirms freedom of conscience as a fundamental human right,[120] the ECtHR has not recognised a specific right to conscientious objection in healthcare.[121] However in 2015, the Council of Europe's Parliamentary Assembly formally adopted Resolution 1763 (2010) on the right to conscientious objection in lawful medical care.[122] Whilst non-binding, it affirmed the place of conscientious objection in medicine and invited member states to develop appropriate domestic regulation. [123]

It is worth noting that the original draft resolution had a different focus. Considering the issue through a rights based lens, it asserted that conscientious objection was unregulated in many member states and was being abused by doctors particularly in regards to abortion, leading to a disproportionate, negative impact on women, particularly those on low incomes or living in rural areas.[124] Using selected cases from various countries to highlight how exercising conscientious objection has led to obstruction or denial of service, the report made a number of recommendations.

These included that member states produce comprehensive guidelines to define, regulate, and monitor conscientious objection including an effective complaints mechanism, that conscientious objection be restricted to individuals and not institutions, that it should only apply to direct participation, and that doctors be compelled to provide information to patients on services they object to and provide the service in question in an emergency or where referral to another provider is not possible, particularly where there is no 'equivalent practitioner within reasonable distance'.[125]

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[120] *ECHR* (n 87) art 9.
[121] Cf *Bayatyan v Armenia* (European Court of Human Rights, Application No. 23459/03, 7 July 2011). The ECtHR affirmed that conscientious objection to military service is derivative of art 9 of the ECHR.
[122] Council of Europe, 'The Right to Conscientious Objection to Lawful Medical Practice' *Parliamentary Assembly* (Resolution 1763, 7 October 2010) < https://assembly.coe.int>.
[123] See Mark Campbell, 'Commentary: Conscientious Objection and the Council of Europe' (2011) 19 *Medical Law Review* 467, 467.
[124] Christine McCafferty, 'Report: Women's Access to Lawful Medical Care: The Problem of Unregulated Use of Conscientious Objection' Social, Health and Family Affairs Committee, Doc 12347, 20 July 2010) <https://assembly.coe.int/Dcuments/WorkingDocs/Doc10/EDOC12347.pdf>.
[125] Ibid [55]-[58].

Containing a number of controversial, normative statements, the draft resolution underwent significant amendment, with the successful Resolution being far less proscriptive. Paragraph 1 of Resolution 1763 (2010) states:

> No person, hospital or institution shall be coerced, held liable or discriminated against in any manner because of a refusal to perform, accommodate, assist or submit to an abortion, the performance of a human miscarriage, or euthanasia or any act which could cause the death of a human foetus or embryo, for any reason.

After noting that member states were obliged to do things like ensure access to lawful medical care, protect the right to health and balance this against the need to respect a health professional's freedom of conscience, the resolution provided that whilst doctors exercising conscientious objection may impact on access to abortion within a state, states needed to:

> 4.1. Guarantee the right to conscientious objection in relation to participation in the medical procedure in question;
> 4.2. Ensure that patients are informed of any conscientious objection in a timely manner and referred to another health-care provider; and
> 4.3. Ensure that patients receive appropriate treatment, in particular in cases of emergency.[126]

The resolution recognised that lawful healthcare can still be morally controversial. It then went one step further and placed the burden of regulating the supply of services on the state rather than the individual. However, as the Council only made recommendations in principle, and because the ECtHR recognises a wide state margin of appreciation, in practice it seemed unlikely that challenges by those wanting to limit state policies which take doctors' consciences into account would succeed.[127] This seemed particularly so as the ECtHR respects the state's religious and cultural beliefs that form the basis of their domestic solution.[128]

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[126] Council of Europe, 'The Right to Conscientious Objection to Lawful Medical Practice' (n 122).
[127] An example is conflict between abortion law and the right to life. The ECtHR has held that the lack of consensus on the nature of the unborn marks this as a matter falling within the margin. See, eg, *Open Door and Dublin Well Woman v Ireland* (1992) EHHR 244, 68; *Vo v France* (2004) 40 EHHR 12 [82], [84], [85]. There is, as yet no human right to abortion.
[128] Cf Carolyn Evans, 'Individual and Group Religious Freedom in the European Court of Human Rights: Cracks in the Intellectual Architecture' (2010) 26(1) *Journal of Law and Religion* 321, 332, 342. Evans argues that the margin of appreciation can sometimes be used by the Court to avoid discussion of controversial topics.

However, in 2021, Parliament passed Resolution 2020/2215 (INI) on the Sexual and Reproductive Health and Rights in the European Union, in the frame of Women's Health ('SRHR')[129] It noted that whilst abortion laws are subject to domestic legislation, they can create barriers to access where there are not enough health professionals willing and able to perform abortion, and where care to women is denied based on 'personal' beliefs. Paragraphs 36-38 of the Resolution deal with conscience clauses for health professionals, with the tone being markedly different to Resolution 1763 (2010) and similar to its earlier draft.

Paragraph 36 recognises that whilst individual medical practitioners may invoke a conscience clause for 'personal reasons,' such a clause may not interfere with a patient's right to 'full access to healthcare and services.' Further at paragraph 37 it expressed regret that on occasions, conscience clauses had led to the denial of abortion care on grounds of religion or conscience which had put women's lives at risk as well as their rights. Finally, at paragraph 38, the Resolution noted that conscience protection had also hindered women's access to prenatal screening and that this violated the right to information.

Ultimately, in paragraph 38, the Resolution called on member states to 'implement effective regulatory and enforcement measures that ensure that the 'conscience' clause does not put women's timely access to SRHR care at risk.' Again, with no clear directive on how member states will achieve timely access, this latest Resolution demonstrates how the protection of a doctor's conscience can fare poorly when the emphasis is placed on abortion as a legal, standard, time sensitive healthcare which if delayed, has the potential to not just infringe a woman's rights to access it but to seriously threaten her life or health.

Where emphasis is placed upon the individual health professionals' right to manifest his or her religion or belief through conscientious objection there is, arguably, an unspoken assumption that they are challenging and judging the beliefs of others and in so doing, cause harm to others. There can be a lack of emphasis (and lack of evidence) on the impact that discriminatory policies or laws have on health professionals with a conscientious objection to abortion in the form psychological sequelae due to stress, coercion or bullying in the workplace, and ultimately loss of job (or even loss of career).

[129] European Parliament, 'Sexual and Reproductive Health and Rights in the EU in the Frame of Women's Health' (Resolution 2020/2215 (INI)) 21 June 2020 < https://www.europarl.europa.eu/doceo/document/TA-9-2021-0314_EN.pdf>.

Prior to these Resolutions, the issue of conscientious objection in healthcare had arisen in only a few cases before the ECtHR. The most quoted is *Pichon and Sajous* involving two French pharmacists who allegedly violated art 9 of the ECHR after being convicted of refusing to dispense the oral contraceptive pill to three customers in 1995 because of their religious beliefs.[130] The ECtHR ruled that priority could not be given to their personal beliefs over their professional obligations because contraceptives were legal and could only be dispensed at a pharmacy.

The Court noted that the Bordeaux police court drew a distinction between the supply of contraceptives and performing abortion, with the latter being recognized under the Public Health Code as an action which health professionals were not obliged to participate in. In contrast, the Consumer Code did not exempt a pharmacist from selling contraceptives on moral grounds if they were not actively involved with its manufacture. With the conviction upheld in the Court of Appeal and the Court of Cassation, the ECtHR found no contravention of the pharmacists' freedom of conscience.

Relevantly, the Court reiterated that manifesting one's religious beliefs took several forms such as worship, teaching, practice, and observance, but that 'practice' did not denote every each and every act or form of behaviour motivated by a religion or a belief. Here, the pharmacy was the only one in the area, and the women all held valid prescriptions from their doctor. In the Court's view, the pharmacists were still able to manifest their beliefs when not acting within the profession. Interestingly, there was no discussion on how dispensing contraceptives harmed the pharmacists themselves.

It is unclear whether this case would have been decided differently if the drugs involved were to affect an abortion, or if the persons involved were doctors and the action was to administer drugs to a patient to affect a medical abortion or to refer the patient to a non-objecting doctor. As the Consumer Code contained a normative perspective on moral complicity that only extended to pharmacists actively manufacturing contraceptive drugs, the decision is unsurprising, and it remains to be seen if that normative analysis of moral complicity will be extrapolated to other scenarios.

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[130] *Pichon v Sajous v France* (European Court of Human Rights No. 49853/99, 2 October 2001). See Walsh (n 7).

Since Resolution 1763(2010), the ECtHR has decided several high-profile cases involving complaints against Poland's restrictive abortion laws and the failure of doctors to complete documentation and facilitate the transfer of patients for lawful abortion. However conscientious objection was discussed only incidentally. In *R and R v Poland, P and S v Poland* and *Tysiac v Poland*, the ECtHR was not proscriptive and merely made the point that states must organise healthcare services so that an effective exercise of a doctor's freedom of conscience does not prevent patients from obtaining access to legal services.[131]

Whilst not a decision of the ECtHR, the 2018 decision of the Supreme Court of Norway is worth noting because of how it contrasts with the final cases mentioned in this subsection from Sweden. In *Sauherad Municipality v A Norge Kristelige*, a Polish Catholic family physician negotiated an oral agreement with the municipality's regular general practitioner scheme to not insert IUDs due to her Catholic faith.[132] Whilst this work was redistributed amongst other doctors, she was later terminated from her job on the grounds that her refusal conflicted with the municipality's duty to offer general medical services under regulatory requirements.

The Supreme Court noted that whilst s 15 of Norway's *Termination of Pregnancy Act 1975* required that organisations exempt employees with a conscientious objection to carrying out or assisting in abortions (but not from giving care before or after abortion), it was silent on insertion of IUDs.[133] After the applicant was hired, the Ministry of Health and Care Services issued a circular letter in 2011 to clarify that general physicians and regular general practitioners could not exercise a conscientious objection to prescribing contraceptives for family planning and referring patients for abortion and assisted fertilisation.[134]

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[131] *R and R v Poland* (European Court of Human Rights, Application No. 27617/04, 28 November 2011); *P and S v Poland* (European Court of Human Rights, Application No. 57375/08, 18 November 2008); *Tysiac v Poland* (European Court of Human Rights, Application No. 5410/03, 20 March 2007).
[132] *Sauherad Municipality v A Norge Kristelige* (2018) Case No. 2018/199, HR-2018-1958-A [28], [31].
[133] Ibid [36].
[134] Ibid [39]. This was later strengthened by the introduction of the Regular General Practitioner Regulations 2012 and their further amendment in 2015 but they did not have retrospective application.

On the possible justification for the prohibition on conscientious objection for insertion of IUDs, the Court noted the Municipality's submissions about the possibility of a reasonable accommodation by having another doctor in the practice attend to the patent's request:

> Refusal by way of referring the woman to another GP for reasons of conscience may affect the trust between the RGP and the patient. It can also not be ruled out that a referral may affect the women's psychological wellbeing and that she will later be reluctant to tell her RGP about conditions that she believes may be caused by the UID or the contraceptive. This in itself may have the effect that the patient does not get necessary health care. Reservations may in other words be contrary to the requirement of professional responsibility and diligent care under section 4 subsection 1 of the Health Personnel Act. Reservations may damage the access to the first-line service and diminish women's rights to reproductive health.[135]

The Court held that A's conscientious objection to inserting IUDs was a religious belief common to Catholic doctors that was infringed by a prescribed rule of law for a legitimate aim.[136] However, the requirement that the infringement be necessary in a democratic society was not made out. Whilst recognising the seriousness of the Ministry's concerns, the Court noted that this position placed an effective ban on all conscientious objection where the patient's needs trumped the doctor's conscientious objection even where the patient's needs could be attended to by staff in the same centre.

The Court noted that in Comment No. 24 on the *Convention for the Elimination of Discrimination against Women* there was no expectation of a blanket ban on conscientious objection by health professionals who refused to provide certain reproductive services. Instead, the Committee noted that, 'measures should be introduced to ensure that women are referred to alternative health providers.'[137] Whilst banning conscientious objection from the health professions is a method of ensuring patients have access to timely service, it must still be balanced against the right to freedom of thought, conscience, and religion.[138]

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[135] Ibid [84].
[136] Ibid [21].
[137] Ibid [90]-[91].
[138] Ibid [91]-[92].

Finally in 2020, the ECtHR decided the cases of *Grimmark v Sweden* and *Steen v Sweden,*[139] involving two midwives who both refused to participate in abortion and were denied employment in state run health facilities. The ECtHR held that their refusal was a manifestation of their religious beliefs which was protected under art 9 of the ECHR, however the Swedish authority's decision to not employ them as midwives was an appropriate limitation to the midwives' freedom of conscience because it was a limitation prescribed by law pursuing a legitimate aim considered to be a necessary limitation in a democratic society.[140]

Crucially, Swedish law provided that all employees are under a duty of care to perform all work duties given to them. Sweden's healthcare system provides for abortion.[141] Accordingly, the Court held that protecting the health of women seeking abortion was a legitimate aim of government. In relation to the limitation of the midwives' freedom of conscience being necessary for a democratic society, the Court held that there was an inherent obligation on the authorities to organise their healthcare system so that conscientious objection by health professionals within the system did not prevent abortion being provided.[142]

It is worth noting that the midwives were aware in undertaking employment in their new role that they had a duty to fulfil all work duties inherent in their job position. They had accepted this when signing their work contract and also had the option of returning to their previous jobs where abortion would not arise.[143] Accordingly, the Court held that as per the reasoning in *Eweida v United Kingdom*[144](although unlike its outcome), the correct balance had been achieved. As such, the complaint was found to be 'manifestly ill-founded', and the application was dismissed.[145]

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[139] *Grimmark v Sweden* (European Court of Human Rights, Application No. 43725/17, 11 March 2020). *Steen v Sweden* (European Court of Human Rights, Application No. 62309/17, 11 March 2020).
[140] *Grimmark v Sweden* (n 139) [25]-[26]; *Steen v Sweden* (n 139) [8].
[141] Cf *Regner v Czeck Republic* (European Court of Human Rights, Application No. 35289/11, 19 September 2017). Here, the ECtHR held that there is no right under the ECHR for a person to be promoted or to occupy a post in the civil service.
[142] *Grimmark v Sweden* (n 139) [26]; *Steen v Sweden* (n 139) [20]-[21].
[143] *Grimmark v Sweden* (n 139) [26]. *Steen v Sweden* (n 139) [8]. Each of the applicants had been employed as nurses and had undertaken further study to become midwives and thus were seeking new positions.
[144] *Eweida v United Kingdom* (n 116).
[145] *Grimmarck v Sweden* (n 139) [28].

Arguably, these decisions from Sweden complement the earlier decision of the ECtHR in *Pichon and Sajous* and follow the Court's trend in the Polish cases referenced above, in terms of the Court emphasising the domestic law and the way in which the state organises and delivers abortion services to the community. Where abortion has been so integrated into society and where midwives are expected to participate in abortion as part of their employment with the state, it will be challenging to try and persuade a court or tribunal to look beyond the positive law to determine whether the state has failed to strike the proper balance.[146]

However, the decision in *Sauherad Municipality v A Norge Kristelige* is a reminder that courts will not always consider placing the burden of ensuring timely access to abortion on individual doctors with a conscientious objection notwithstanding a prescribed law which is held to be pursuing a legitimate end. Alternative means of ensuring a patient's reproductive health needs are fulfilled do exist. Allowing other doctors to step in and provide the service is one such way that as yet, has not been shown to cause disadvantage to the patient. It highlights though the need for research in these areas to know more about the impact of this potential solution.

There are limited published studies in Europe focusing on doctors or medical students' attitudes to conscientious objection to abortion. This subsection considers two quantitative studies from Finland and Sweden involving hundreds of medical students, as well as one qualitative study from Norway on seven doctors with a conscientious objection to abortion, and one qualitative study from Croatia on the experiences of seven women who sought abortion and encountered a doctor with a conscientious objection.[147] These last two studies represent a broadening of the scope of research into this complex area of law and bioethics.

[146] The existence of anti-discrimination laws which cover the attributes of thought, religion and conscience may assist to re-establish the importance of freedom of conscience for a flourishing society.
[147] The Italian study by S De Zordo 'Obstetricians-Gynecologists' Attitudes Towards Abortion and Conscientious Objection in Italy' (2012) *International Journal of Obstetrics and Gynecology* S321 has not been included given only the abstract has been published.

5.4.2 EMPIRICAL STUDIES

5.4.2.1 NIEMINEN ET AL STUDY

Nieminen et al's survey of 548 first and final year medical and nursing students in Finland focussed upon whether or not conscientious objection should be permitted, as well as how to manage it.[148] At the time of the study, conscientious objection was not permitted in Finnish law, with abortion permitted up to 12 weeks' gestation where the pregnant woman provided reasons why continuation of the pregnancy placed a significant burden on her.[149] After 12 weeks, proof of a serious condition of either the mother or the unborn child was required before a doctor gave a referral to a hospital.[150]

Most medical students were supportive of working with colleagues with a conscientious objection to abortion, yet almost half did not believe any conviction justified conscientious objection to abortion.[151] The majority of participants believed that having a conscientious objection would cause conflict in work communities,[152] and they considered that students with a conscientious objection to abortion should still learn to perform abortion in case of an emergency. Only a minority of participants were satisfied that abortion could be learned through observation only.[153]

As only a small proportion of participants had a conscientious objection,[154] the value of the study lies in understanding how students who are not objectors to abortion think about these issues. The authors noted some inconsistency in responses and concluded that there was a real need to discuss the issue of conscientious objection in a practical way, rather than to consider it as a yes/no dichotomy. Further, they called for further discussion so that politicians, professionals, and the public could understand the complexity of the issue and its potential impact on patient care.[155]

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[148] Nieminen et al (n 5) 2.
[149] Ibid 1-2, 5. The authors note at the time of the study there was support for conscience protections to be introduced into law. The *Non-Discrimination Act* 2014 protects religion, belief, and opinion.
[150] Ibid 2. This referral was to an obstetrician/gynaecologist.
[151] Ibid 4.
[152] Ibid.
[153] Ibid 5.
[154] Ibid 4. Only 3.5% of nursing students and 14.1% of medical students expressed a 'personal volition to conscientious objection.'
[155] Ibid 8.

5.4.2.2 NORDSTRAND ET AL STUDY

Nordstrand et al's study of 531 medical students in fifth and sixth year in Norway included questions on abortion and the obligation to refer.[156] The authors noted that in Norway, the law permits abortion for any reason up to 12 weeks' gestation, with abortion performed in public hospitals, funded by the state.[157] Whilst the law recognised conscientious objection for hospital employees, general practitioners had to refer the patient to a non-objecting doctor.[158] In this study, 15-19% reported a conscientious objection to abortion, with less than 5% of those participants having an objection to referring a patient for abortion.[159]

Despite this, 10% of participants believed general practitioners should be able to refuse to refer for abortion, with 32% of those 10% reporting that religion was important to them. Overall, a substantial minority of participants to the study, 38%, supported a doctor's right to conscientious objection, with up to 55% of participants reporting they would tolerate conscientious refusals in different contexts.[160] The authors noted that medical ethics was a minor subject in medical schools in Norway and as such, it may not have included instruction about conscientious objection.[161]

It is unclear whether the authors were suggesting that further education in medical ethics would cause the number of students supporting conscientious objection to abortion to fall or reduce the internal inconsistency in responses. But whose ethics will be studied? The question is an important one because it may be equally relevant to practising doctors, given the finding of internal inconsistency in responses from studies in the United States. Arguably, the exploration of this issue is better suited to qualitative methodology so that factors that impact on attitudes can be probed in depth.

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[156] S J Nordstrand et al, 'Medical Students' Attitudes towards Conscientious Objection: A Survey' (2014) 40 *Journal of Medical Ethics* 609.
[157] Ibid.
[158] See *Law on Abortion 1975* (Norway) s 14; Abortion Regulations 2001 (Norway) s 15.
[159] Nordstrand et al (n 156).
[160] Ibid 610.
[161] Ibid 612.

5.4.2.3 NORDBERG, SKIBEKK AND MAGELSSEN STUDY

This 2012-3 study of seven Norwegian general practitioners was novel in that it explored the perspective of doctors with a conscientious objection to referral for abortion using qualitative methodology.[162] As noted earlier, Norway permits abortion on demand up to 12 weeks' gestation, with committee approval of abortion available between 13 and 18 weeks, and abortion after 18 weeks in exceptional circumstances. Abortion is performed in hospitals and paid for by the state, whilst general practitioners act as gatekeepers by providing a referral for patients.

Importantly, in Norway people cannot choose their doctors. Patients are assigned a doctor by their municipality, with the opportunity to change doctors arising only every two years.[163] Whilst Norwegian law recognises conscientious objection to performing or participating in abortion, it does not extend this objection to referrals by general practitioners for abortion, and the law is silent as to the process of referral.[164] While there has been discussion about abrogating this obligation and permitting self-referral, it had not occurred at the time of the study.

Participants were recruited via judgment sampling by using the authors' professional connections and the Norwegian Christian Medical Association. All participants identified as Christian, with two Catholics, and five Protestants. Participants were interviewed and content analysis was used to extract five themes: carrying out conscientious objection in practice, justification for conscientious objection, challenges when relating to colleagues, ambivalence and consistency, and the effects of having a conscientious objection on the doctor/patient relationship.[165]

[162] Nordberg, Skibekk and Magelssen (n 2).
[163] Ibid 3.
[164] Ibid 4.
[165] Ibid 3.

Two methods for managing a referral request were identified. The first involved avoiding consultations with women seeking abortion. Commonly, the doctor's secretary ensured that patients seeking a referral for abortion were booked into a non-objecting doctor. Where patients slipped through the cracks, most participants told their patients they could not comply with the request, but they refrained from providing specific reasons why in order to avoid the patient feeling judged.[166] Only one participant used anticipatory disclosure of his objection to his community.[167]

The second involved consulting with the patient, taking a history, performing an examination, and providing information, but not giving a referral. Most participants disclosed their refusal to refer at the conclusion of the consultation. None of the adherents to this method felt their patients were burdened because they provided the contact details of a non-objecting colleague so the patient could obtain the referral.[168] Known as a 'horizontal referral', it is one step removed from sending the patient to an abortion provider but is arguably part of the causal chain of obtaining abortion.

This type of referral is akin to where a doctor provides information to a patient of a third party who does not perform abortion, but who provides 'all options' counselling on pregnancy, including providing the contact details of where to obtain abortion in circumstances where a formal referral for abortion is not required. In both cases, the woman will be able to access abortion. However, with a horizontal referral, the woman is arguably more inconvenienced as she must have another consultation, rather than simply make a telephone call to obtain information.[169]

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[166] Ibid.

[167] Ibid. Some of these participants reported that they would have liked to counsel patients requesting abortion but felt their conscientious objection to abortion would prevent them from displaying the neutrality they felt was necessary to perform the role of counselling a patient.

[168] Ibid 6. One participant noted that the only potential burden on the patient was the experience of hearing that others have different views on her choice. The obvious point to be made here is that this is the participant's perception of whether the patient was burdened and could, therefore, be inaccurate.

[169] See *Abortion Law Reform Act 2019* (NSW) s 9. In New South Wales, Australia, doctors can discharge their duty to refer to a provider they know does not have a conscientious objection by providing the patient with the telephone number of a 24-hour pregnancy hotline operated by the state.

For most of the general practitioners in this study, horizontal referral was defended on the basis that it was a 'practically feasible' and a 'morally acceptable compromise.'[170] All participants who performed horizontal referral easily found colleagues willing to take over the patient relationship.[171] Two participants worked in regions where the local gynaecological department permitted patient self-referral. As an alternative to writing a referral endorsing abortion, they suggested simply stating in a note that the patient was pregnant so the patient could take this to the hospital.[172]

A few important observations made by the authors included that far from being absolutists, many of the seven participants displayed ambivalence towards abortion in situations they considered to be justified. These included conception from rape or incest. In such cases, they had made the decision to refer the patient for an abortion.[173] This is a common theme in the studies described so far and suggests a lack of homogeneity amongst 'pro-lifers'. The authors observed that some of the participants' practices to deal with referral would likely fail a normative analysis of moral complicity.[174]

For those participants who reflected on the moral culpability of referring patients for abortion, none of them had a definitive position in theory or practice. Instead, they made do with creating arbitrary lines for their conduct that were subject to change.[175] The authors noted that whilst all participants were Christian, the Protestant participants did not obtain guidance from their churches on how to deal with abortion and referral.[176] Of the two Catholic participants, only one believed the Church's official stance on co-operation in abortion was 'crucial in guiding and shaping the line of action chosen.'[177]

[170] Nordberg, Skibekk and Magelssen (n 2) 8.
[171] Ibid 5.
[172] Ibid 4.
[173] Ibid 5.
[174] Ibid 7. The authors did not attempt a normative analysis of these inconsistencies. For further details on moral complicity, see chapter 3.
[175] Ibid.
[176] Ibid.
[177] Ibid. As discussed in chapter 3, the Catholic Church has a clear position on the morality of abortion including a system of guidance on moral complicity.

Several participants were simply unable to refer for abortion and stated that if referrals were demanded of them, they would not be able to continue their work as general practitioners.[178] Two participants who had referred patients for abortion reported experiencing a 'bad conscience' and feelings of guilt.[179] Two participants initially lacked the courage to refuse, but ultimately realised they could not handle making referrals.[180] In all, the study raises important further questions for research including the need to explore internal inconsistencies in the attitudes and practices of pro-life doctors.

This study had several limitations. The most obvious was its very small sample size of seven participants. Whilst the authors noted that this allowed for richer descriptions from doctors, in addition to not telling the full story about the experiences of conscientious objectors, the study did not address how patients felt about being refused a referral.[181] To this end, the authors noted that studies of patient experiences raised methodological problems regarding their credibility and reliability if data was restricted to stories reported in the media and/or complaints to health complaint bodies that had managed to become public.

Understanding the experiences of patients who have encountered doctors who have exercised a conscientious objection to abortion is an important perspective to take into account when considering how conflict occurs and how it ought to be resolved. It can assist with educating both doctors and the public including those doctors who refuse to co-operate in abortion. Accordingly, the final study for this section discusses a recent Croatian study which focused upon the impact which laws protecting a doctor's freedom of conscience to refuse to perform or participate in abortion had upon seven women seeking lawful abortions.

[178] Ibid 4.
[179] Ibid. The study did not elaborate on the impact of a 'bad conscience.'
[180] Ibid.
[181] Ibid 8.

5.4.2.4 HÅKANSSON ET AL STUDY

This qualitative study focused on seven women who had an unwanted pregnancy and sought abortion in Croatia. It involved in-depth, semi structured interviews to explore their experiences of abortion in a predominantly Catholic country. Whilst abortion was legalised in 1978 under communist rule, it was restricted under conservative rule in 2003.[182] At the time of the study, Croatian law recognised a doctor's conscientious objection to abortion. However, objecting doctors are still required to refer patients to doctors who do not have a conscientious objection, and they must perform abortion in an emergency.[183]

Thematic and content analysis revealed the key overarching theme of 'navigating the minefield—women's experiences of abortion in a country with a conscience clause.' This then sub-divided into three further categories, namely, 'experiencing abortion—to endure a vulnerable situation,' 'the conscientious objection in practice—causing obstacles and stigma,' and 'views on abortion—socio-cultural and religious influence'.[184] Out of the seven women, six went on to have an abortion, with participants interviewed two and a half years after their abortion.[185]

The authors found that feelings of guilt were a recurring theme for participants who felt powerless and vulnerable, and felt judged by family and friends for being irresponsible.[186] All women wanted to achieve abortion discretely in the public as opposed to the private system. Participants reported feeling shame after consulting doctors whom they said made comments that implied they had a conscientious objection to abortion. Overall, the participants believed the law's conscientious objection clause was responsible for access to abortion being 'left to chance.'[187]

[182] Håkansson, Ouis and Ragnar (n 2) 166.
[183] Ibid 167.
[184] Ibid 166.
[185] Ibid 170.
[186] Ibid.
[187] Ibid 171-172.

Finally, the participants felt that in a conservative Catholic country, there was poor access to abortion, a lack of information on locating doctors willing to perform abortion, and a judgmental attitude from healthcare practitioners.[188] When speaking of the stigma participants reported experiencing, the authors speculated as to whether or not this was something also experienced by doctors who claimed a conscientious objection to abortion not out of any moral conviction about abortion being wrong, but out of 'fear of being judged or discriminated against by their colleagues.'[189]

The authors acknowledged that the attitudes and experiences of doctors in Croatia claiming a conscientious objection to abortion was an area worthy of further research, as were the attitudes and experiences of doctors willing to perform an abortion in the context of Croatian law and culture. Ultimately, the authors concluded that legal protection for conscientious objection to abortion 'legitimised moralisation and caused women to feel emotional and social stigma,' but they offered no recommendations on how to manage conscience conflicts beyond 'regulation to ensure access.'[190]

It is certainly true that protection of a doctor's conscience regarding participation in abortion is all about the morality of abortion. However, it is not well understood what harm is caused by it, and whether limiting conscience protection is the correct or only response. This study indirectly emphasised the need to know more about why some doctors refuse to perform abortion, and how those who claim a conscientious objection to performing or participating in abortion go about exercising their objection with their patients. This chapter now concludes by considering four empirical studies from Australia.

[188] Ibid 173.
[189] Ibid 175.
[190] Ibid 176.

5.5 EMPIRICAL STUDIES FROM AUSTRALIA

The situation in Australia regarding freedom of conscience and conscientious objection to abortion was examined in detail in chapter 4. Essentially, the states and territories have decriminalised abortion. Three jurisdictions have enacted a statutory duty for doctors with a conscientious objection to abortion to refer patients to a non-objecting doctor. Three jurisdictions have enacted a similar statutory duty to refer but with the caveat that it may be discharged by referring to a third-party organisation. Two jurisdictions have enacted broad conscience protection in their abortion laws, though these have not been tested in the courts.

Unlike some countries, a woman in Australia does not require a formal referral from a doctor in order to access abortion. Patients may 'doctor shop' and abortion providers may freely advertise their services. It is unclear how many Australian doctors have a conscientious objection to abortion. There is no publicly available list of doctors licensed to prescribe the drugs for medical abortion, or those who perform surgical abortion. It is unclear whether recent law reform to decriminalise abortion has increased the number of doctors willing to perform, participate or co-operate with it.

There is one national quantitative study on the attitudes of obstetricians and gynaecologists to abortion that explored whether doctors who objected to abortion made 'in principle' exceptions, and if so whether they were willing to refer patients to non-objecting doctors for abortion. There is also one qualitative study on the attitudes of general practitioners in New South Wales to prescribing drugs for medical 'at home' abortions, and the perceived barriers to increasing the number of doctors willing to undergo the training in order to be able to provide this service to their patients.

In regard to the impact a doctor's conscientious objection to abortion can have on patients, there is one qualitative study from the perspective of Victorian abortion providers with second-hand reporting on patient experiences, and one qualitative study on barriers to women accessing abortion in rural New South Wales. These studies provide important data which further research may build upon, including this thesis' empirical study. To date, there are no published studies on the attitudes and experiences of Australian doctors with a conscientious objection to abortion, and how they are affected by having to co-operate with abortion.

5.5.1 DE COSTA, RUSSELL AND CARRETTE STUDY

This 2009 online quantitative survey by de Costa, Russell and Carrette focussed on the opinions and current practices of 740 fellows and specialist trainees from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.[191] It found that 86.4% of participants were not opposed to abortion, and of the 14.6% of participants who identified as being 'totally opposed' to abortion, 44.4% made exceptions such as for serious maternal health concerns or severe foetal disability.[192] Of those who made exceptions, 16% would refer patients to colleagues for abortion.

Of the 86.4% of participants not opposed to abortion, performing abortion formed part of the regular practice of more than 73.3%.[193] Only fifteen out of 740 participants reported that they would perform abortion but for the fact they worked in small communities and did not want additional work, together with wanting to avoid the stigma of being 'the abortion doctor.'[194] A further seventeen out of 740 participants said they would perform abortion but for limited hospital access.[195] These findings suggest a general willingness amongst participants to perform abortion.

Whilst this study did not deal with attitudes to conscientious objection per se, it provided an interesting snap shot of the views of about half of the fellows and trainees in obstetrics and gynaecology in Australia.[196] Importantly, the authors noted there was a wide spectrum of views on abortion that were not able to be captured by their on line questionnaire.[197] The authors quoted comments from participants such as 'I think your questions are too simplistic as there are many shades to this issue', and '[so] me of the questions are too black and white – this subject has grey areas too.'[198]

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[191] Caroline M De Costa, Darren B Russell and Michael Carrette, 'Views and Practices of Induced Abortion Among Australian Fellows and Specialist Trainees of the Royal Australian and New Zealand College of Obstetricians and Gynecologists' (2010) 193(1) *Medical Journal of Australia* 13.
[192] Ibid 14.
[193] Ibid.
[194] Ibid.
[195] Ibid.
[196] Ibid.
[197] Ibid 16.
[198] Ibid 15.

5.5.2 DAWSON ET AL STUDY

Dawson et al's study of general practitioners from New South Wales explored the reasons why doctors had been slow to provide medical abortion since the federal government's approval of the key drugs mifepristone and misoprostol in 2012.[199] A descriptive-interpretative qualitative study, the authors undertook 28 semi-structured interviews with a diverse range of doctors. The authors formulated three key themes for exploration being scope of practice, the demand for medical abortion, its care and referral, and workforce needs.

Medical abortion involves a doctor prescribing a regime of drugs for a woman to take at home over a 24-hour period in order to cause an early abortion. It is an option where the unborn child is less than 13-weeks' gestation. In Australia, due to self-administration by the woman at home and inherent safety concerns with this method of abortion, doctors who prescribe these drugs must be on call for the period of time that the woman is aborting at home. In addition, the doctor must be able to admit a patient to a tertiary hospital in the case of a known, serious, life-threatening complication such as haemorrhage.[200]

Some participants reported medical abortion as being beyond the scope of their practice and something which ought to be provided for in abortion clinics.[201] A few participants had religious and moral objections to it[202] and some participants expressed concern about stigma and how their colleagues and others might perceive their practice if they were known to be facilitating medical abortion.[203] Those who did facilitate medical abortions reported feeling isolated and had encountered challenges when trying to admit patients to hospital where they experienced complications or needed surgery.[204]

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[199] Angela Dawson et al, 'Medical Termination of Pregnancy in General Practice in Australia: A Descriptive-Interpretive Qualitative Study' (2017) 14(39) *Reproductive Health* 1.
[200] Ibid 2.
[201] Ibid 3-4.
[202] Ibid 6.
[203] Ibid 4-5.
[204] Ibid 9-10.

Whilst a referral is not required in New South Wales to access abortion, general practitioners may still be approached by patients for advice regarding an unwanted pregnancy and options such as abortion. Under s 9 of the *Abortion Law Reform Act 2019*, doctors with a conscientious objection must disclose their status to their patient and refer them on to a non-objecting doctor. They also have the option of using the 'middle-way' approach of referring to a third-party organization which provides 'all-options' counselling and advice on the telephone or via a website (currently Pregnancy Choices Helpline).[205]

With medical abortion, the general practitioner is arguably less directly participating in it. Interestingly, study participants who refused to facilitate medical abortion did not describe themselves as having a conscientious objection. However, it is fair to ask whether the act of prescribing drugs to cause abortion at home, with the possibility of serious complications, might have triggered clinical concerns from doctors about safety. This would not necessarily mean that the doctor has a conscientious objection to abortion per se, but it may mean they have a conscientious objection to being involved with this method of abortion.

Ultimately the authors noted the need to increase the number of general practitioners willing to facilitate medical abortion and recommended more support to general practitioners wanting to provide medical abortion, with clear pathways for the public sector regarding how doctors should admit patients to hospital for treatment following complications from medical abortion.[206] However they offered no commentary on the need for continued ethical education and training of doctors to understand what conscientious objection to abortion is, and their legal duties and protections.

This highlights the focus of this thesis' empirical study, which sought to know more about why doctors might be unwilling to facilitate medical abortion, and their thoughts on how to balance freedom of conscience with the general concern for equitable patient access to this lawful service, especially in more rural settings. This chapter now concludes with a description of two studies on possible abuses of conscientious objection by pro-life doctors, as seen from the perspective of women seeking abortions and abortion providers to whom they related their experiences.

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[205] NSW Health, *Pregnancy Options* (Web Page, 24 June 2021) https://www.health.nsw.gov.au/women/pregnancyoptions/Pages/for-health-professionals.aspx.
[206] Dawson et al (n 199) 12.

5.5.3 DORAN AND HORNIBROOK STUDY

Doran and Hornibrook's 2015 qualitative study focused on the experiences of 13 women living in rural New South Wales accessing abortion within the last 15 years.[207] The aims of the study were reported to be to identify factors associated with accessing abortion and to make suggestions on how rural women could be better supported in seeking access to an abortion service. Given abortion was regulated under the *Crimes Act 1900* (NSW) at the time of the study, it did not focus on conscientious objection per se but it did explore what participants understood about how to access abortion.

Five participants reported that they self-referred to an abortion clinic after performing an internet search because they knew they did not need a referral and they were confident in finding the information on the internet. In addition, the authors noted that one participant was conscious that there was an 'uncertain legal climate' and another participant wanted to avoid seeing her doctor because she was concerned she would be judged by them. It is unclear from the study whether this particular participant who was keen to avoid judgment from their doctor nonetheless wanted to consult with a doctor to discuss any issues before self-referring.

Three participants contacted a government run women's service for information and then self-referred to a clinic. Of the five who sought advice from their general practitioner, one reported a positive experience, one required two ultrasounds before the doctor provided a referral in circumstances where the participant was unaware that she could self-refer, and one was provided with a pamphlet and advised to get a blood test but was not given information about self-referral to a clinic. Lastly, one participant reported seeing five doctors before one was willing to refer her for an abortion, but again the doctor did not discuss self-referral with her.

[207] Doran and Hornibrook (n 2).

It is not known whether doctors who were reported by participants to have failed to disclose to them the option of self-referral to an abortion clinic, would have behaved differently if the current statutory duty to refer to a non-objecting doctor or provide information to a third-party government referral organisation was in force. That some participants were unaware of the ability to self-refer is notable. It raises the issue of whose responsibility it is to educate the community about this. At the time of the study, with abortion regulated under the *Crimes Act*, it is perhaps understandable why this was left to the doctor.

However, with New South Wales permitting abortion up to 22 weeks' gestation for any reason the woman believes is appropriate,[208] the state may have a role in educating the community about this lawful service. This would absolve the doctor with a conscientious objection to abortion from having to provide information on how to access it and any moral complicity they judge to accompany this level of co-operation. It would also make the public aware that whilst legal, abortion remains a morally controversial service and a doctor's conscientious objection to it may extend to the provision of any and all information about it.

This would place some burden on pregnant women seeking abortion to make independent enquiries instead of making a doctor's appointment and expecting the doctor to provide the information. It might require the community to have good internet access and basic computer skills. Alternatively, printed information might need to be readily available at community centres or similar places. Interlinked with these observations is the question of what benefit, if any, a woman seeking abortion might place on being able to talk with her general practitioner about abortion and have them assent to their decision to undergo abortion.

It is not known from any published studies whether the way in which a doctor with a conscientious objection to abortion expresses their opposition to assisting their patient achieve abortion can impact whether a woman seeking abortion feels judged or stigmatised. This goes to the broader issue raised in chapter 1 regarding the contemporary notion of tolerance for different worldviews, and whether certain worldviews which judge particular actions to be morally wrong are causative of disharmony in the community and harm to individuals. All of these issues are worthy of further empirical research.

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[208] *Abortion Law Reform Act 2019* (NSW) s 5.

5.5.4 KEOGH ET AL STUDY

Keogh et al's 2015 qualitative study of 19 'experts in abortion provision' in Victoria is novel in that it focused on the perspectives of these experts on the impact of the conscientious objection clause in s 8 of the *Abortion Law Reform Act 2008* (Vic) from their experience and as related to them by patients who had been refused a referral by a doctor with a conscientious objection to abortion.[209] Experts were defined as those who had direct involvement in providing abortion, counselling women in accessing abortion, or were involved in policy or advocacy related to abortion provision.[210]

Interestingly, most participants saw the conscience protection clause as being for the benefit of women seeking abortion rather than the protection of doctors' freedom of conscience.[211] However participants were divided as to whether the duty to refer needed to be enshrined in the law.[212]All participants recounted stories from patients where patients reported that doctors with a conscientious objection, particularly in rural areas, commonly refused to refer to a non-objecting doctor,[213] or 'manufactured delays' so that patients went beyond 24 weeks gestation.[214]

The authors made two bold claims based on the experiences of these 19 participants. First, that exercising conscientious objection is causing problems with accessing abortion in Victoria worse by 'delaying or blocking access' to existing services. Second, that it contributes to the actual lack of abortion providers in Victoria.[215] In regard to the first claim, the authors describe the negative, silent impact of doctors' refusals to refer which they allege causes an increase in guilt and discomfort for the woman, a delay in accessing abortion, and in rare cases, inability to access abortion.[216]

[209] Keogh et al (n 2) 3.
[210] Ibid.
[211] Ibid 4.
[212] Ibid.
[213] Ibid
[214] Ibid.
[215] Ibid 7.
[216] Ibid 7.

As discussed in chapter 3, the cause of guilt and shame in connection to abortion is a controversial area of research. There is much critique about the methodology of studies which purport to show the link between a woman who has undergone abortion and feelings of shame, guilt and distress, and the role that the presence of persons with a 'pro-life' worldview have upon the causation of any shame, guilt, and distress. In addition, the conclusions from the data collected from studies can depend heavily upon the underlying worldview the researcher has about freedom, dignity, and harm.

In regard to the second claim, they say the ability of religious faith based medical institutions to opt out of providing abortion contributes to the lack of abortion providers because all doctors are bound to the views of the institution, regardless of their own view about performing abortion. However, this seems to contradict the results of de Costa, Russell and Carrette's study in 2009, at least as far as specialist obstetrician and gynaecologists are concerned. Most of them freely performed abortions, with only a small number suggesting the existence of obstacles prevented them from doing this.

This study is novel and provides interesting information alleging abuse by doctors with a conscientious objection to abortion of the mandatory referral provision in section 8 of the *Abortion Law Reform Act 2008* (Vic). However, a major limitation of the study is that the information of this alleged abuse did not come directly from affected women but was 'hearsay' evidence filtered through individual abortion experts. In addition, the authors made assumptions about why there are shortages in doctors willing to perform abortion, and they failed to acknowledge the need to know more about the attitudes and experiences of objecting doctors before making their recommendations.

Whilst the authors spoke of tightening the duty to refer, they did not provide any specific details and concluded that doctors with a conscientious objection needed to be educated. Whilst they did not specify what this would achieve, they seem to assume that doctors with a conscientious objection will be moved from their conviction against facilitating abortion by the second-hand recounting of the experiences of patients seeking abortion. This thesis hopes to enhance this discussion by highlighting the complexity of conscience and the impact that the duty to refer has on objecting doctors.

5.6 DISCUSSION

On one view, all of these studies show strong support within the profession that doctors should not be forced to do something they believe is morally wrong, but at the same time they show support for mandatory referral as an appropriate normative response to the dilemma of patients seeking services to which the doctor has a deep-seated moral objection to. The emphasis in the bioethics literature on mandatory referral for abortion, and the liberal legal framework for abortion within countries that were the subject of research, may be contributing factors to the phenomenon of the 'middle view participants.'

These 'middle view' participants support mandatory referral as an appropriate compromise but only until it touches upon a patient request that stirs the doctor's conscience. Research on this set of doctors' perspectives would be useful in order to know whether or not they perceive internal inconsistency in their position, and whether ethics education might cause them to think more broadly and adopt a position other than mandatory referral or strengthen their resolve to treat conscientious objection and mandatory referral as a 'service by service' or even 'act by act' proposition.

The common finding from many of the studies was the association between participants who reported adherence to a religious faith tradition and support for conscientious objection. However, there was a division within this group of doctors regarding the normative aspects of referring the patient to a doctor who would provide the service in issue. It is unclear from the studies why some doctors felt comfortable providing a referral to a service they believed was immoral or whether they believed they had no other choice, and what their thoughts were on policy development in this area.

The experiences of patients when confronted with a doctor who discloses a conscientious objection to abortion or another morally controversial service and refuses to refer is another important area for further research. Like the experiences of doctors with a conscientious objection, research in this area has been limited in Australia and elsewhere. Assumptions made in the bioethics literature about the likely harm which conscience protection has on women seeking abortion should be explored. It would be greatly beneficial to know more about both the positive and the negative aspects to these doctor/patient interactions.

5.7 CONCLUSION

This chapter identified and analysed key empirical studies from the United States of America, the United Kingdom, Europe, and Australia on the attitudes of doctors and medical students, as well as the experiences of women seeking abortion, to conscientious objection to abortion. Of most importance to this thesis, the studies confirmed how complex the issue is. It extends beyond a binary analysis that asks only whether doctors are for or against conscientious objection and whether justice demands that conscientious objectors assent to and facilitate access to services they morally object to, in order to avoid harm to the patient.

The nature of the service in issue can make a difference to a doctor's attitude to managing conflict between themselves and the patient. So too can the legal status of the service with the point being made in several studies that abortion is often seen as a 'settled' issue because in most countries, it is a lawful medical procedure. However, since the abortion laws of most countries engage doctors in the abortion process, especially when the pregnancy is advanced, it is clear that the judgment of medical professionals may be decisive regarding access to abortion.

This is of course unless the question of who bears the onus for delivery is more clearly addressed. Doctors must rely on their conscience and training to protect themselves and public morals and the state must not use doctors to effectuate forms of medicine about which reasonable people may well disagree. Apart from Nordberg's study of Norwegian general practitioners with a conscientious objection to abortion who are under a statutory duty to refer to a doctor who will provide abortion, there is little in the way of published literature regarding these doctors' perspectives and their experiences with handling requests for abortion.

Given these doctors are directly impacted by law or policy that mandates referral to a non-objecting doctor, research that understands and reports their perspective (as opposed to doctors who do not have a conscientious objection to abortion) is relevant and needed, as is the parallel question of how the state should carry the onus of providing services where individual doctors refuse to cooperate with lawful but controversial services. As discussed above, this sort of issue is only going to increase in future with the complexity of matters which may involve doctors.

CHAPTER SIX

FINDINGS & DISCUSSION

> Consulting with a GP is not about taking part in a transaction. We are not ATM machines. We are not a script dispensary service, or a referral dispensary service. We are supposed to act in the patient's best interest. I am also a human being, I have a conscience, and I don't want to transgress any moral laws in being a GP. I want to be a good doctor.
>
> Doctor # 3 [GP, NSW, Metropolitan, Catholic, 5-15 years]

6.1 INTRODUCTION

This chapter reports on the findings of the interpretative, descriptive study that explores the central question of 'What are the attitudes and experiences of doctors with a conscientious objection to abortion, and who practice in New South Wales and Victoria?' It also reports on the sub-questions: 'What burden do these doctors believe that having a conscientious objection to abortion has had upon their professional lives?' and 'Is there an association between the attitudes and experiences of these doctors based upon their religious affiliation or the state in which they practice medicine?' and discusses the findings.

As described in chapter 2, the writer conducted in-depth interviews with thirty-five doctors from New South Wales and Victoria between February and October 2018. As discussed in chapter 2, the study reports on data using both qualitative and quantitative approaches, although it uses qualitative methodology to analyse the data. The first half of this chapter focuses on the findings from content analysis of the data. Content analysis focused on common attitudes of participants to key issues identified in the literature, and by them as a focused discourse community.

The chapter then moves to the findings from thematic analysis of the data. Thematic analysis delves deeper into the attitudes reported in the content analysis, explores participants' experiences in practice, and seeks to understand any diversity in responses. Extensive verbatim quotations from interviews are used to support the writer's interpretation of responses by documenting the participants' words. The transcripts of the interviews, checked for accuracy by participants in line with the methodology set out in chapter 2, appear as an appendix to this thesis.

6.2 DESCRIPTION OF PARTICIPANTS

As noted in chapter 2, both judgment and snowball sampling were used to recruit participants to the study. Thematic saturation was considered by the writer to have been reached after interviews with thirty-five doctors in person, over the telephone, or via Skype. Tables 1, 2 and 3 demonstrate the make-up of participants, divided by state. As discussed in chapter 2, this study did not target a specific group of doctors, such as those practicing in certain areas of medicine. Rather, the starting point was a doctor's self-identification as having a conscientious objector to abortion.

Out of the 35 participants, 19 reported being from New South Wales and 16 from Victoria. General practitioners made up the largest group of participants in both states. Nine general practitioner participants were from New South Wales, and 8 were from Victoria. This was followed by doctors working in hospitals with 6 participants being hospital doctors from New South Wales and 6 in Victoria. Finally, 6 participants were consultants working as specialists in private practice with visiting privileges to hospitals, with 4 from New South Wales and 2 from Victoria.

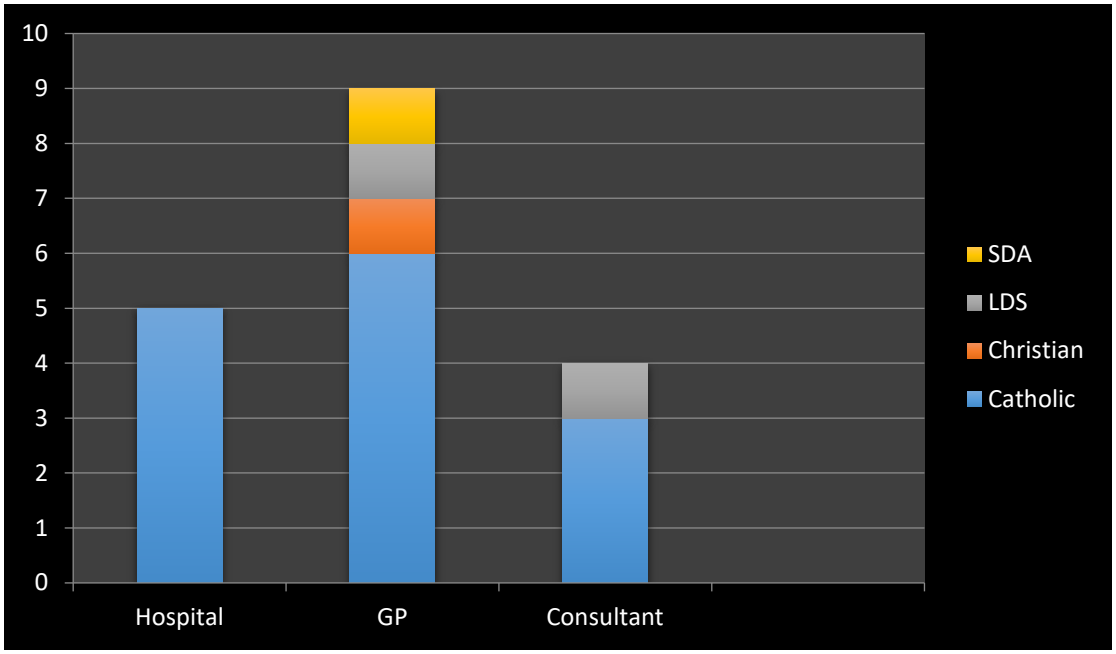
In terms of their experience level, three groups emerged. The largest group of doctors amongst participants was those with over 15 years' experience as a doctor, with 15 doctors across both states. The next most populated experience level was those with between 5- and 15-years' experience, with 12 participants. Finally, 8 participants reported less than 5 years' experience. Whilst not a specific research question, the relevance of the participants' years of experience to their attitudes and experiences was something the writer took into account when analysing responses.

Participants chose between metropolitan, regional, or rural as their geographical location. The descriptor 'metropolitan' covered tertiary hospitals as well as city, inner city, and suburban locations. Participants outside these parameters were asked to self-describe as either regional or rural. No participant identified as 'remote.' The majority of participants identified as metropolitan, with 16 in New South Wales, and 14 in Victoria. The balance of New South Wales participants comprised 1 regional and 2 rural physicians, and Victoria had 2 rural doctors.

For New South Wales, 1 participant self-described themselves as being of 'no religion.' Of the remaining 18 participants, 14 identified as Catholic, 2 as CJCLDS, 1 as Christian,[217] and 1 as Seventh Day Adventist. In Victoria, 11 participants identified themselves as Catholic, 4 as Christians, and 1 as Seventh Day Adventist. Whilst the participants were heavily skewed towards a Christian tradition, the researcher did not assume that these doctors shared homogenous beliefs about fundamental issues such as the ethics of abortion and referral for abortion.

This is because in this area of conscientious objection to abortion, the relevance of a doctor's religious affiliation may not be as important as what it is that they believe. It is possible that a doctor may identify with a religious tradition, yet not follow all its beliefs, or may not know them, or may understand them incorrectly. Therefore, any association between religion and attitudes has a superficial explanatory power only. Exploration of the basis of a conscientious objection needs to be undertaken and requires the doctor to articulate that basis beyond reference to their religion.

Chart 1: New South Wales Participants by Specialty and Religious Affiliation



[217] This is a reference is to 'non-specified' Christianity. Some participants identified themselves as Christian, others as belonging to the Seventh Day Adventist tradition, or the Catholic tradition. Whilst all are examples of different Christian groups, as the religion of the participant was a relevant issue in this study, it was considered beneficial to retain these distinctions.

Chart 2: Victorian Participants by Specialty and Religious Affiliation

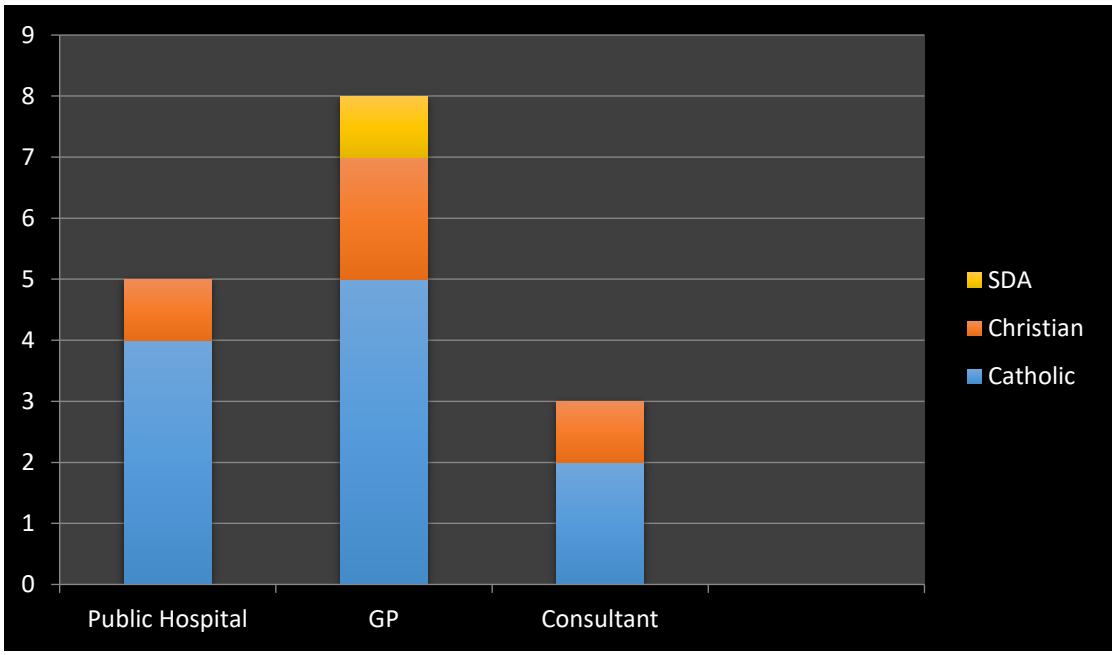
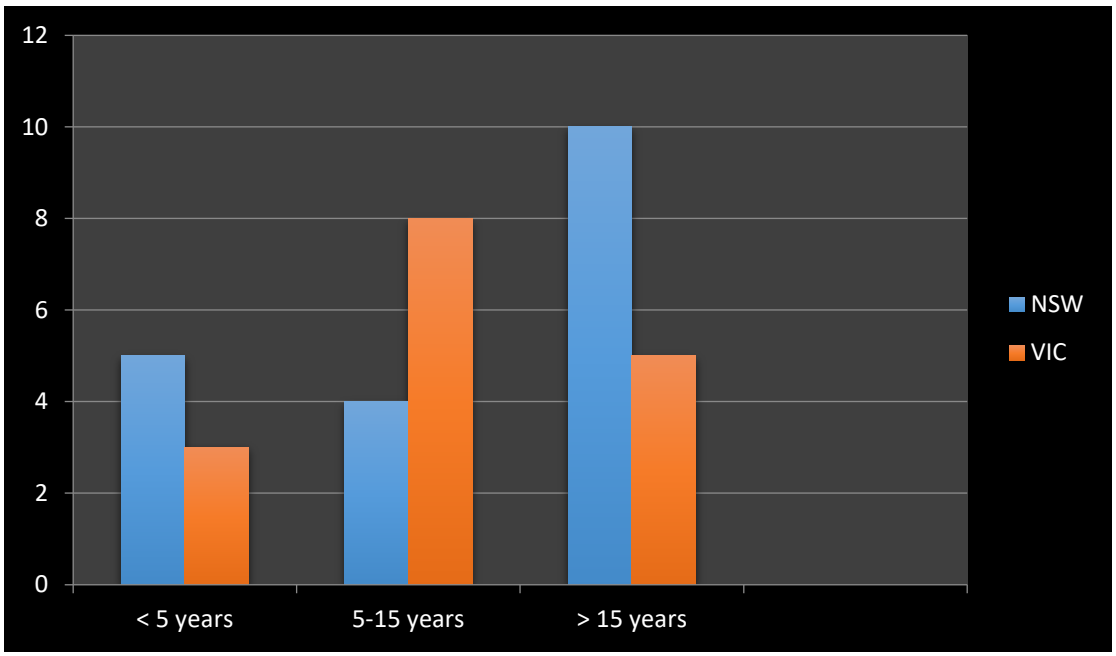


Chart 3: Comparison of New South Wales and Victorian Participants by Years of Experience



6.3 CONTENT ANALYSIS: ATTITUDES

Initial coding of the interviews was performed using content analysis directed towards key attitudes and experiences that were arguably capable of being categorised as binary. This analysis helped establish whether there were areas of homogeneity amongst participants. This type of analysis did not explore why the participant held the particular belief or the context in which the experience occurred. This was reserved for axial coding with thematic analysis, which is discussed later at 6.4. With both types of analyses, the results of this study were triangulated to increase its validity.

Identifying a binary yes/no response did not mean simply searching the text of interviews for 'yes' or 'no' responses. This is because as questions were open ended, this was generally not possible. Rather, it required the writer to consider the question the participant answered, read the text carefully, and consider whether based on the text, a conclusion could be drawn that the participant objected or did not object to the action or issue under discussion. Examples of textual responses were 'I don't have a problem with referring a patient for abortion' and 'I will never refer.'

Content analysis identified 3 core attitudes that returned binary responses. As a result, they could be counted and charted. These attitudes were re-named as 'categories' and included 'attitude to abortion,' attitude to referral,' and 'attitude to contraception.' An Excel spreadsheet was created to set out every participant's position on these three issues and compared them to the five variables collected from participants, being his or her state, specialty, geographical location, years in practice, and religion. This spreadsheet enabled the writer to search for patterns or associations.

Apart from their attitudes to key issues, certain key experiences of participants were capable of being categorised and then counted. These experiences, or categories, had a supra label of 'burden' and were then broken down into 'negative comments,' 'fear of reprisals,' 'complaints,' and 'loss.' Each transcript of interview was analysed for whether the participant did or did not mention having had experienced this type of burden, loss, or harm. These responses were then added to the Excel spreadsheet in order to search for patterns or associations.

6.3.1 ATTITUDE TO ABORTION

In this study, participants were asked to self-assess whether they had a conscientious objection to abortion. For this particular category, abortion referred to medical and surgical abortion. Hormonal contraception which can arguably be categorised as a potential abortifacient, and abortifacient barrier methods such as IUDs, were not included. Thirty-three participants objected to medical and surgical abortion for any reason. Two New South Wales participants made exceptions; a general practitioner of the Adventist faith with between 5-and -15 years' experience, and a consultant belonging to the CJCLDS with greater than 15 years' experience.

6.3.2 ATTITUDE TO REFERRAL

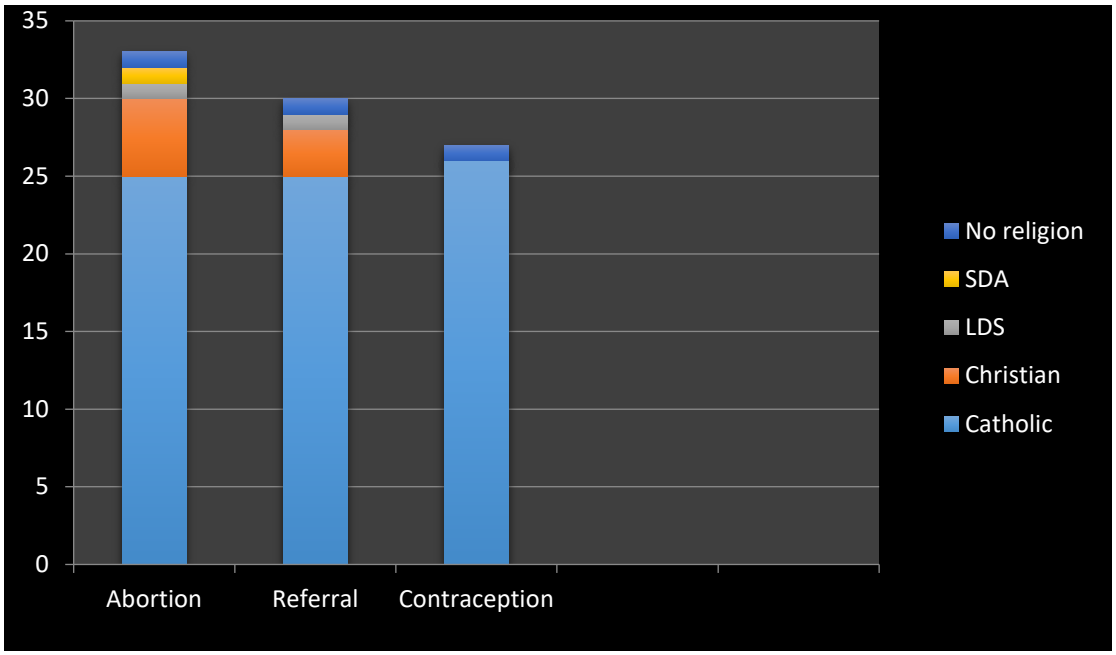
As discussed in chapter 4, there has been a degree of ambiguity about the doctor's duty under Victorian law to refer patients to a doctor who does not have a conscientious objection to abortion. The writer did not define the term 'referral.' Some participants described preparation of a note on letterhead, with their provider number, addressed to a doctor or facility, asking they assume patient care and effect an abortion, or inform them of all options, as well as providing information on where to obtain an abortion, such as the name and contact details of a doctor or facility.

Notwithstanding the ambiguity about what a referral means, 30 participants expressed an objection to referral. The five participants that did not have an objection included both Adventist general practitioners who had between 5-and-15 years' experience each, a CJCLDS general practitioner from metropolitan New South Wales with greater than 15 years' experience, a Christian general practitioner from metropolitan Victoria with greater than 15 years' experience, and a Christian consultant from Metropolitan Victoria with greater than 15 years' experience.

6.3.3 Attitude to Contraception

Whilst participants appeared to agree that some barrier contraceptive devices are abortifacient in their action, there was a difference of opinion regarding the action of hormonal contraception. A conscientious objection to abortion was more often associated with a conscientious objection to hormonal contraception, which in turn was associated with the participants' religion. All 25 Catholic participants from both states, in addition to the 'no religion' participant, declared a conscientious objection to hormonal contraception. The remaining 10 participants did not object to this.

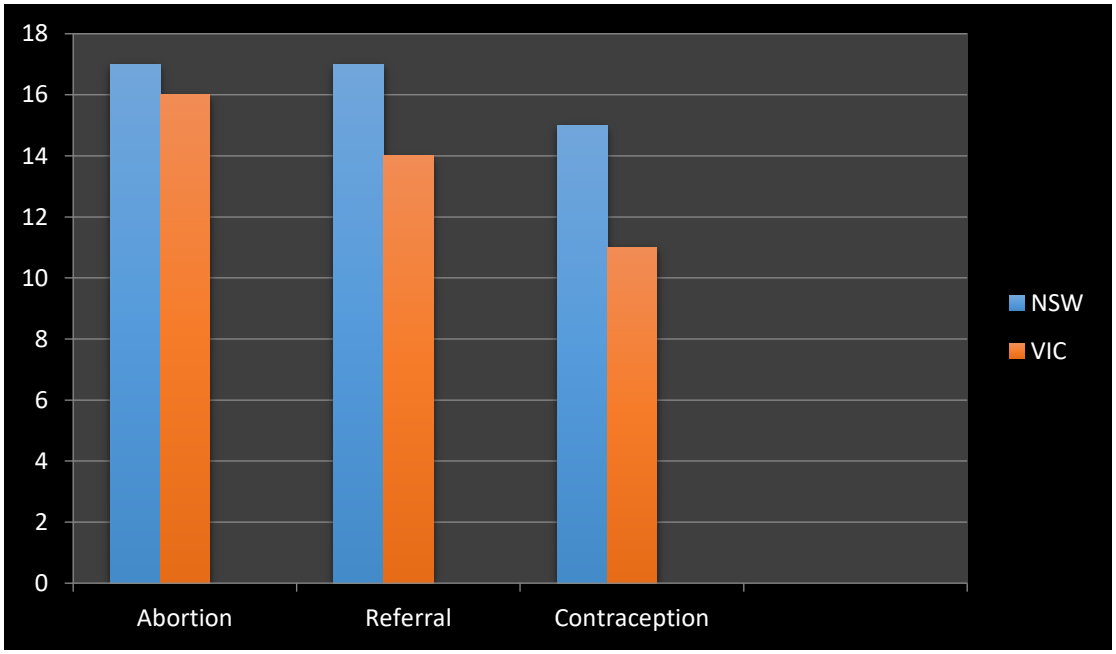
Chart 4: Conscientious Objection to Key Attitudes Cross Referenced to Religious Affiliation



In regard to whether there was any association between these attitudes and the state the participant practised in, it is important to note that there was an uneven mix of participants between the two states, with New South Wales having an additional three participants. However even taking this into account, it would not seem that the state the participant worked in made a difference to their position on these matters. If anything, the only association to be found was that participants who identified as being of the Catholic faith unanimously expressed a conscientious objection to all three issues.

The Excel spreadsheet showing binary responses to the three issues cross-referenced to the five variables collected from participants appear as an appendix to this thesis. As noted earlier, the responses and their association with religion is merely a starting point for discussion. The association cannot be used to conclude, for example, that because a participant indicated no personal objection to referral, that they agreed with a state sanctioned policy that all doctors must perform mandatory referral for abortion. Also, the way in which participants' experiences have shaped beliefs is not explained here.

Chart 5: Conscientious Objection to Key Attitudes Based on State



Given this study is anchored to a discourse that represents a natural law perspective as enhanced by the teachings of the Catholic Church, it is perhaps unsurprising that Catholic participants exhibited a block response to the attitudes explored above. However, whether this is co-incidental required in-depth analysis of the interviews. Of perhaps greater interest is the diversity of responses amongst the non-Catholic participants who, even with participants of the same religious tradition, did not always share beliefs or justifications for their beliefs on these issues.

6.4 Content Analysis: Experiences

6.4.1 Negative Comments

Seventeen participants reported specific statements which they recalled were made by educators, colleagues, or superiors, and which they believed denigrated persons, religious beliefs, or religious institutions that are opposed to abortion. Either directed at them personally, or outwardly to no one in particular, all the participants with less than 5 years' experience reported this experience, with the addition of some participants of other levels of experience. The writer could find no other association between this experience and the state the participant practiced in, his or her religion, geographical location, or specialty.

6.4.2 Fear of Reprisals

Eighteen participants reported a fear of reprisals from disclosing their status as a conscientious objector to abortion to his or her patients, colleagues, or superiors, or declining to participate in abortion through a referral, or declining to participate in peripheral actions that prepare the patient for abortion such as inserting intravenous lines to deliver abortifacient drugs or assisting in the operating theatre. Unsurprisingly, there was less fear of reprisals amongst the more experienced practitioners, but there was no association between this fear and the state the participant practiced in, or the other four variables collected.

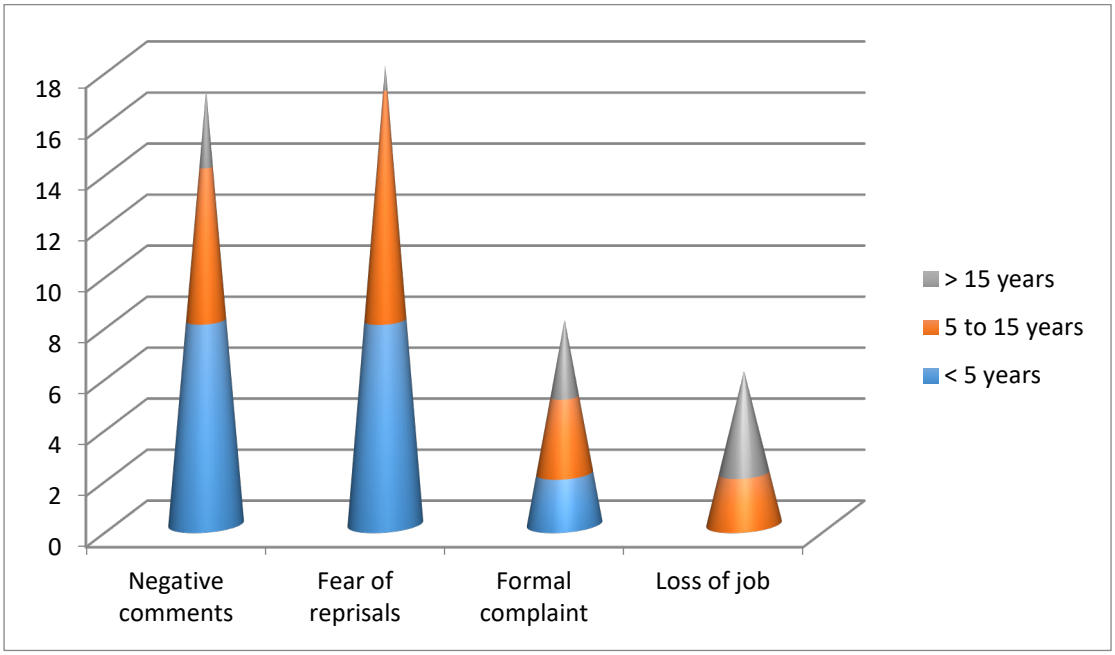
6.4.3 Complaint

Eight participants had complaints made against them, either to the Medical Board or his or her employer, as a result of their conscientious objection to abortion. This included their refusal to refer a patient for abortion, participate indirectly with abortion by inserting intravenous lines to deliver abortifacient drugs, or prescribe hormonal contraception. Hormonal contraception was included because the basis of those participants' objection was that hormonal contraception can act as an abortifacient, as well as being harmful to the patient. All participants who were the subject of a complaint belonged to the Catholic faith.

6.4.4 Loss

Six participants had a job offer withdrawn, were told that they would not be considered for a position, or had the position terminated due to their disclosure that they had a conscientious objection to abortion, including the prescription of hormonal contraception, or their refusal to provide those services. Again, all participants affected by this experience identified as being of the Catholic religious faith. The writer could find no specific association between this reported experience and the state the participant practiced in, but there was an association between this experience and years in practice.

Chart 6: Comparison of Burden by Experience Level



As noted above, content analysis focuses upon what is commonly raised in the text of interviews. It provided a useful backdrop for the second stage of data analysis. As content analysis is not designed to perform a deep analysis into the latent meaning of the textual responses, why participants have a particular attitude, or the context in which experiences have occurred, this detail must be explored though a different type of analysis. The balance of this chapter is taken up with the results of thematic analysis of the data. Significant quoting from interviews was considered necessary to faithfully convey participants' perspectives.

6.5 THEMATIC ANALYSIS:

The next step in data analysis was thematic analysis using focused discourse methodology, as described in chapter 2. This method allowed exploration of both attitudes and experiences by focusing upon the latent meanings behind textual responses. In addition, given the size of the study, the writer was able to cross reference a participant's attitude or experience in one area and compare it to another. In this way, the writer was better able to understand where the participant concurred or deviated from the discourse and consider explanations for the deviation.

Thematic analysis started with the pre-identification of likely themes taken from the literature review and highlighted in the interview guide. Each theme branched into a number of sub-themes. The creation of a sub-theme was not dependent upon the frequency with which it occurred in the interviews. Thematic analysis revealed seven themes: 'Basis for Objection to Abortion,' Scope of Objection to Abortion,' 'Basis of Objection to Referral,' 'Scope of Objection to Referral,' 'Burdens on An Objector,' 'Accommodation of Conscientious Objection,' and 'Recommendations.'

In the next sections of this chapter, each theme will be described, and its sub-themes visually represented by a diagram. The interpretation of the sub-theme will follow, using conceptual analysis and focused discourse methodology, with the writer's interpretation of responses supported by selected verbatim quotations from the interviews. Where considered relevant, the frequency with which a sub-theme occurred will be noted. As noted earlier, this section presents the findings of thematic analysis. Discussion of the overall findings is reserved for subsection 6.7, with further commentary in chapter 7.

6.5.1 BASIS OF CONSCIENTIOUS OBJECTION TO ABORTION

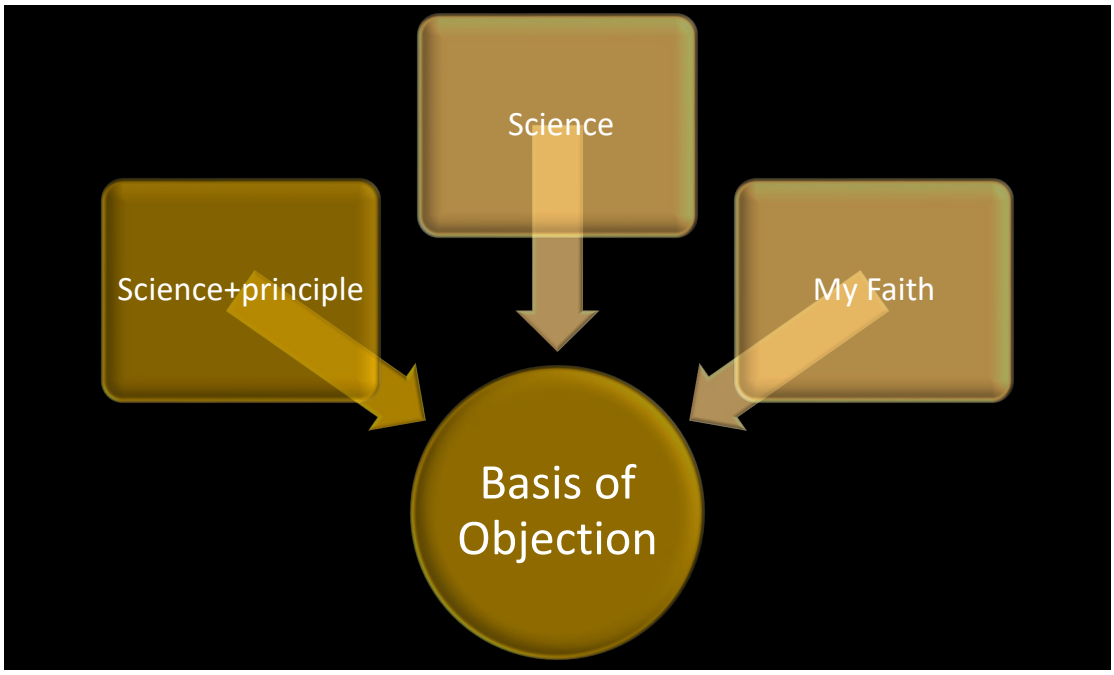
Conscientious objection to abortion can often be considered a religious objection. This can carry the unkind implication that the objection is devoid of reason. Whilst it is certainly true that a religious objection can sometimes be considered unintelligible to those who do not share the underlying belief system of the objector, conscientious objection to performing abortion differs from a purely religious objection to medical treatment in that its rationale does not require acceptance of sacred texts etc. This can be contrasted with a Jehovah's Witness' refusal to undergo blood transfusions based upon their interpretation of bible passages.[218]

As discussed at length in chapter 3, the natural law approach to abortion comfortably relies on human reason, which arguably has the explanatory power to support a doctor's conscientious objection to it. The argument encompasses the following: First, human life is a fundamental good. Second, life begins at conception. Third, killing a person is wrong. Fourth, the act of abortion is morally wrong. The challenge today lies more in relation to a doctor or health professional asserting a conscientious objection to participating or co-operating in abortion and seeking protection from the law from being forced to transgress that belief.

As noted, the study did not define 'conscientious objection to abortion' and therefore relied upon participants' self-identification with that descriptor. Participants did not have to subscribe to the focused discourse to participate in the study. As such, clarifying the basis of their conscientious objection to abortion was an opportunity to compare their reasoning to the discourse's and highlight any diverse responses. The reader should note that these responses were not necessarily what the participants would disclose to those enquiring why they have a conscientious objection.

[218] See Office of the Public Advocate, 'Jehovah's Witnesses and Blood Transfusions' <http://docs2.health.vic.gov.au/docs/doc/7EC20AD6B48DF5B2CA2578C3000333EA/$FILE/PG07_vahs_Witnesses_and_Blood_Transfusions_09[1].pdf> viewed 22 December 2018.

Figure 1: Theme 1 - Basis of Conscientious Objection to Abortion



Science + Principle

Thirty-one participants articulated a two-fold basis for their objection. This involved a scientific reference to when human life begins, together with a principle of some kind about the value of human life. There was limited diversity in how participants expressed the science. However, there was significant diversity in how they expressed the principle. Seventeen participants described the principle using various phrases such as 'the sanctity of human life,' 'human dignity,' 'the Hippocratic oath,' or 'human rights.' Fourteen specifically mentioned 'God' or 'my faith.'

Before breaking down the responses, and as was noted earlier, many participants noted in their responses that whilst their religious faith might be one of the bases for their conscientious objection, it was not necessarily something they would disclose to patients. The reason for them not disclosing their faith as one of bases of their conscientious the objections was largely based on their anticipatory concern that patients and others might react negatively to a doctor mentioning religious faith with regard to abortion. To avoid being dismissed, there was a preference for participants to express secular, science-based arguments. Examples follow.

> I didn't feel I had to bring up God at all. I almost refrain from doing this, as it's quite easy to defend my position on a secular level without adhering to a spirituality or God. The way people think today, they respond less to faith and more to rational and scientific arguments. The environment is toxic and has got more so with time, so it is probably unwise to start a discussion from a faith-based perspective, as it would immediately turn others off, I can't see the need to do this. Eventually, yes, I am happy to comment on my faith if asked. I feel a little bit deflated that I have to make this science/religion divide. Any comment you make on faith is labelled as being fuelled by religious prejudice. They consider themselves superior by relying on secular arguments.
>
> Doctor # 7 [Consultant, NSW, Metropolitan, Catholic, > 15 years]

> I think in today's postmodern age, raising religious beliefs is a red rag to a bull. People think that you believe what you like privately, but you don't raise it publicly. If you refer to personal reasons, tolerant people will respect that and it is less antagonistic to the person and less confronting, than referring to religion. In a certain sense it would be more honest of me to say that the reason is my religion, but it's more of a practical thing.
>
> Doctor # 5 [GP, NSW, Metropolitan, Catholic, > 15 years]

Other participants that disclosed the religious faith-based portion of their objection to patients left this disclosure to the conclusion of their consultation with the patient.

> I keep the disclosure about my faith to the end because it's about them and not about me, but I have bible verses up on the wall and I don't think anyone would not know that I am a Christian, but I think they would still come and see me to talk about it. I tell people I am a Christian so they will understand why I object to giving a referral.
>
> Doctor # 16 [GP, NSW, Metropolitan, Christian, > 15 years]

With regard to expressing the scientific basis of their objection, 28 of the 31 participants explicitly or implicitly stated that human life begins at conception. A selection of verbatim quotations from the interviews that best exemplify these 28 participants with a 'science plus principle' approach to abortion, are set out below. The reader will note the ordering of the principles. Most participants emphasised the science over the principle, whilst only a minority emphasised principle, specifically a reference to faith or God before resorting to a science-based objection.

6.5.1.1 SCIENCE & PRINCIPLE

It's a scientific fact that life begins at the moment of conception and ends at the point of death. As a doctor, if a person asks me to be involved with the killing of a human being, I must refuse. I choose to respect the life of all my patients, irrespective of their age or disability, as every person has innate dignity and human rights.

Doctors # 8 [GP, NSW, Metropolitan, Catholic, > 15 years]

My objection is two-fold. Firstly, I have a physiological objection. My test for the bounds of practice in medicine is that I must either be preventing pathology or treating it. I don't engage in any act directed against normal physiology and therefore termination of pregnancy is beyond the scope of acceptable practice. Secondly, I have a human rights objection based on the fact from conception, there is a human life present and act that interferes with that constitutes murder.

Doctor # 11 [Hospital physician, NSW, Regional, No religion, 5-15 years]

There is a scientific understanding that a human becomes a human individual when they are conceived, because that is when they have their own unique DNA and biologically are a separate organism from their parent. The value judgment is at what point life should be protected. The idea that human life at any given stage ought to be protected comes from values/beliefs/philosophy/religion. There is no science that says you cannot murder somebody. Science tells you when a human is a human, but your values tell you whether you shouldn't take a life or murder someone or be a part of doing that."

Doctor # 14 [GP, VIC, Metropolitan, Christian, 5-15 years]

It's a life and embryology support this. I do not want to be involved with ending a life…

Doctor # 16 [GP, NSW, Metropolitan, Christian, > 15 years]

My faith plays a part in my objection, but it is more scientific for me. The religious influence is the belief that life is sacred and has a spiritual element.

Doctors # 28 [Hospital physician, VIC, Metropolitan, Catholic, < 5 years]

It is the taking of an innocent human life. There is harm to the mother also in that process, harm to her near associates, and harm to the society in general. It's a multi-layered harm. Science backs up the notion that life begins at conception and my faith aligns with the science.

Doctor # 35 [GP, VIC, Metropolitan, Catholic, > 15 years]

6.5.1.2 PRINCIPLE & SCIENCE

> My belief is that all life is valuable and needs to be held with the same respect regardless of where that life is, or how intelligent it is, or how useful it is in productive sense. This belief is totally supported by my faith. I think science and faith go together. I cannot explain the laws of science without explaining God and vice versa. They complement each other and I don't think you can separate them.
>
> Doctor # 18 [Hospital physician, VIC, Metropolitan, Christian, 5-15 years]

> The basis of my objection is a mixture of both my faith and my understanding of the science, but it is probably more faith based. The origin of my values is my faith. The science is straight-forward…
>
> Doctor # 26 [Hospital physician, NSW, Metropolitan, Catholic, < 5 years]

> Number one; because it is the teaching of the Catholic Church, and number two: because I object to murder.
>
> Doctor # 30 [GP, NSW, Metropolitan, Catholic, > 15 years]

For the remaining three participants, their understanding of the science differed in that they believed it confirmed a later time than conception for when human life begins, such as viability, or they felt that the science around when human life begins is too vague to confirm that it begins at conception. A natural assumption flowing from these beliefs is that these doctors would not be troubled by early gestation abortion. This is something that will be cross-referenced later below. Their verbatim responses regarding why they object to abortion is set out below:

> For me, the basis of my objection is the sanctity of life. God has the ability to create and destroy. How do I have a right to destroy an unborn child who had no choice in being made? God has given us the ability to procreate, not destroy. Even though medical doctors understand scientific evidence, I also believe divine revelation trumps scientific evidence. There should be no conflict and I don't see this as a huge dichotomy…I draw the line where the baby is likely to become viable, so 4-6 weeks, when there is a heartbeat. Prior to that it is not a human life form…When the sperm hits the egg, it does not create a viable human life.
>
> Doctor # 9 [GP, NSW, Metropolitan, SDA, 5-15 years]

> I think God provides life and determines death and I don't think it's up to us to take that into our own hands…My objection is predominantly based on my faith, and I believe that at conception a new life is there, however I don't feel it is as valuable until it is viable outside the mother.
>
> Doctor # 25 [GP, VIC, Metropolitan/Rural, Catholic, > 15 years]

> I'm a little bit vague as to when it starts, either conception or later, but I don't want to be involved with it. I don't think science has the full answer. It's much more in terms of philosophical questions as to when life begins and has value.
>
> Doctor # 33 [Consultant, VIC, Metropolitan, Christian, > 15 years]

6.5.1.3 SCIENCE ALONE

Two participants referred to science alone, with one simply stating, 'life begins at conception.' The other provided a more fulsome response, which is set out below. In it, the participant makes clear that whilst their conscientious objection to abortion aligns with their religious faith, their religious faith is subservient to, and can be overridden by, the science. However, whilst science can argue for when human life begins, it is unclear how this scientific truth alone can be the basis for a moral belief about whether abortion is right or wrong and form the basis of a conscientious objection.

> Human life begins at conception, and we have a medical duty to attend to its wellbeing. I am a Catholic, however my objection is not based on an encyclical of the Church. I believe that the Church's teachings, which have been around for 2000 years are consistent with science.
>
> Doctor # 10 [GP, NSW, Rural, Catholic, > 15 years]

6.5.1.4 RELIGIOUS FAITH ALONE

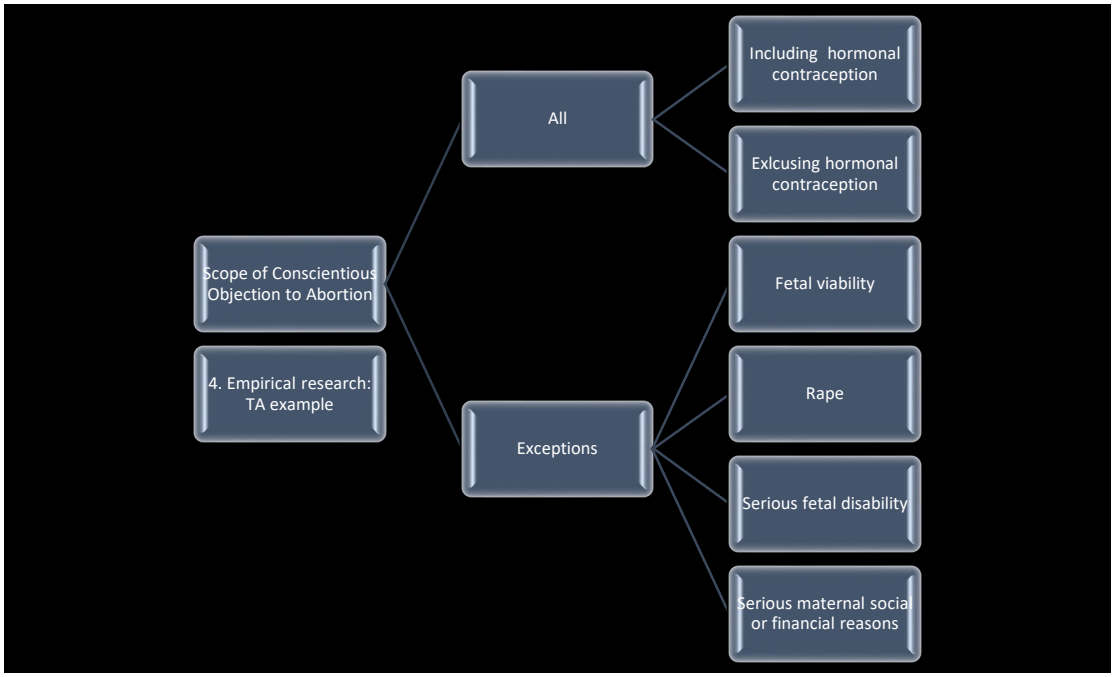
This response of doctor # 10 can be compared to one of the two participants who referenced only their religious faith as the basis of their objection. Here, doctor # 4 bypasses the science and speaks only of what guides them to make an ethical decision.

> The basis of my conscientious objection to abortion is my religious convictions. I have never really seen any evidence that can argue for abortion being an ethical thing to do. I have never really been convinced otherwise.
>
> Doctor # 4 [Hospital physician, NSW, Metropolitan, Catholic, < 5 years]

6.5.2 Scope of Conscientious Objection to Abortion

Having articulated why they have a conscientious objection to abortion, the next theme identified was the scope of the doctor's conscientious objection to abortion. Specifically, the writer wanted to check for internal correspondence between belief and praxis. Therefore, whilst participants' attitudes to abortion were already considered in the content analysis, it was helpful to see whether their convictions about abortion, based on the underlying beliefs identified by them, were taken to their logical consequences, or whether they made exceptions.

Figure 2: Theme 2 - Scope of Conscientious Objection to Abortion



As noted earlier, the writer broadened conscientious objection to abortion to include hormonal contraception. In content analysis, this broadly defined objection was raised with significant frequency by some participants and featured significantly amongst general practitioners as a far more common request than a referral for abortion. Therefore, these participants' experiences with achieving accommodation of their broadly defined conscientious objection to abortion, is an additional challenge when considering alternatives to imposing a normative solution in law or policy.

6.5.2.1 Objection to All Abortion Including Hormonal Contraception

The Catholic Church's prohibition on abortion and contraception is well known. For all Catholic participants, conscientious objection to hormonal contraception was a natural extension of their objection to abortion. Lest the objection be dismissed as merely an unintelligible 'Catholic thing,' the participant of 'no religion' also had a conscientious objection to it. The following quotation from doctor # 24 explains the medical and ethical reasoning behind their objection. Importantly, doctor # 24 makes the key, distinguishing point, because it's possible, I have a real objection to it.'

> I think many doctors have not really understood the way the pill works, and some of them doubt if it is truly abortifacient. It works to prevent ovulation and creates a barrier to stop sperm travelling to the uterus. But if there is breakthrough ovulation, and the sperm gets through and there is implantation, then it works as an abortifacient. Some people doubt whether this ever actually happens and reconcile their ethics this way, but because it's possible, I have a real objection to it.
>
> Doctor # 24 [GP, VIC, Rural, Catholic, 5-15 years]

6.5.2.2 Objection to All Abortion but not Contraception

These participants belonged to the Christian, Adventist, and CJCLDS faith traditions. They had a conscientious objection to medical/surgical abortion, with some specifically extending their objection to intrauterine devices on the basis that they have an express abortifacient action. Most specifically noted they had no objection to hormonal contraception. Whilst respectful of Catholic doctors with a conscientious objection to it, some participants characterised their understanding of that objection as solely a religious observance peculiar to the Catholic faith tradition.

> I don't generally have an objection with oral contraception. I am not Catholic and don't have a moral objection to it, but I understand others do and I respect that.
>
> Doctor # 14 [GP, VIC, Metropolitan, Christian, 5-15 years]

> With prescribing contraception, I understand that objection to this is often a Catholic thing and based on God wanting us to fill the earth. I have been raised to believe that God wants you to be responsible. My understanding is that the oral contraceptive pill is not an abortifacient. I believe this because I see so many people get pregnant on it. If you have been taking it for a week, it won't work at affecting the lining of the uterus. I don't like inserting the copper IUDs, as you can use it as emergency contraception.
>
> Doctor # 15 [GP, VIC, Rural, SDA, 5-15 years]

However, doctor # 18 understood and engaged with the scientific belief central to doctor #24's conscientious objection to hormonal contraception. It is worth comparing doctor #18's response with that of doctor # 24, as it demonstrates a difference in how they ethically reasoned to a moral conclusion about whether prescribing hormonal contraception is right and wrong.

> Some contraceptives don't suppress ovulation at all and just have an abortive effect (such as intrauterine devices). A lot of people don't know about this. So many of my friends who hold the same views as me, are mortified that their GPs put them on a particular contraceptive not knowing that it is going to cause abortion. I know some doctors don't prescribe contraception at all, and I respect that, but I have worked through this and believe that the purpose of taking an oral contraceptive is to prevent conception. Maybe one in a hundred thousand woman will experience breakthrough ovulation and conceive. As the womb is made a hostile environment through the action of the pill, the embryo will not implant, and an abortion will take place. Other contraceptives like the intrauterine device create a hostile environment and the women who use this should know that they may be conceiving and aborting. I am at peace with prescribing oral contraception to patients.
>
> Doctor # 18 [Hospital physician, VIC, Metropolitan, Christian, 5-15 years]

Both doctors # 18 and 24 were of the belief that life begins at conception and acknowledged that the pill has the possibility of acting as an abortifacient. However, for doctor # 18, the intention of the person taking the pill overrides unintended consequences. This ethical analysis is opposed to the Thomistic framework used by doctor # 24, where the overall goodness of an action considers the object of the act itself, the intention of the moral agent in performing it, and the circumstances in which it is performed.[219] All three criteria must be considered 'good' for the overall act to be deemed 'good'.

[219] Thomas Aquinas, *Summa Theologiae Volume 18 Principles of Morality (Ia2ae. 18-21)* (Cambridge University Press, 1966) 3-45.

6.5.2.3 EXCEPTION FOR SOME ABORTION

Content analysis identified two participants who made exceptions for abortion, doctors # 9, and 20. This section will focus on their responses. Doctor # 9 named their religious faith as one of the bases for objection but did not believe human life begins at conception. It is perhaps unsurprising, therefore, that they would make exceptions for abortion. Doctor # 20 was different and whilst believing in the sanctity of human life, made exceptions for abortion in accordance with their faith tradition. Accordingly, their reasons for justifying exceptions to abortion were very different.

> When it comes to abortion, I can't say I would never do it… My view is more nuanced…. Under 10 weeks, it comes down to why the abortion is sought. …. There can be medical reasons why abortion is legitimate such as chromosomal abnormalities, where the foetus is unable to survive or it has a syndrome that is incompatible with life, something like Edward's Syndrome. …I have no desire to pass judgment on people who do abort a Down Syndrome baby…Legitimate reasons for an abortion could be stretched to social reasons, but this is a grey area for me… I would also consider that rape could possibly be a legitimate reason for abortion although this is not a black and white decision…. I support abortion for maternal medical reasons.
>
> Doctor # 9 [GP, NSW, Metropolitan, SDA, 5-15 years]

Doctor # 20 differed from doctor # 9 in that they appeared to implicitly believe that life begins at conception, stating 'I believe in the sanctity of life based on embryonic development." However, this belief did not cause them to conclude that abortion is always morally wrong. Instead, doctor # 20 demonstrated submission of the mind and will to the teachings of their CJCLDS faith tradition, which made three explicit exceptions for abortion. The verbatim quotation explaining these exceptions and the doctor's unquestioning acceptance of them, is set out below:

> The church believes that abortion is acceptable in only three circumstances, where the pregnancy occurs following rape, where a child cannot be delivered in a live state, and where the mother's life is at risk. I cannot explain why the church permits abortion for rape, but I think it has to do with the fact that conception following rape can be very hard for the woman and it is left as her personal choice. … The Church does not permit abortion for fiscal or social reasons.
>
> Doctor # 20 [NSW, Consultant, Metropolitan, LDS, > 15 years]

6.5.3 Basis of Conscientious Objection to Referral for Abortion

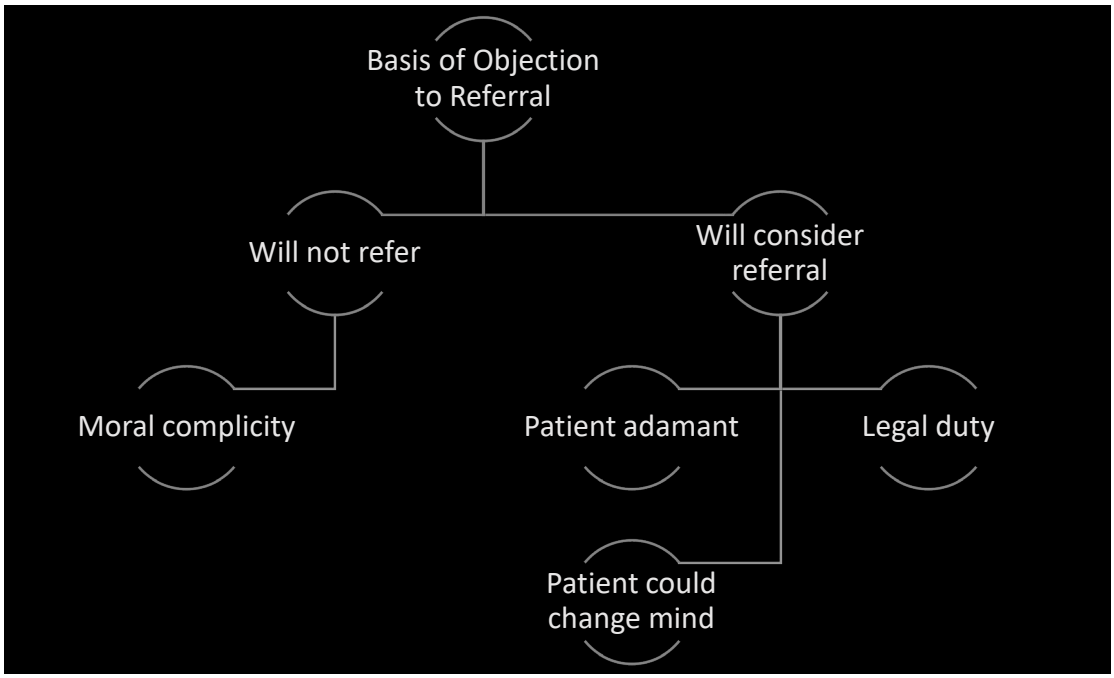
At the heart of this thesis on conscience is the requirement of doctors with a conscientious objection to abortion, and who believe that it is the taking of innocent human life, to make an 'effective referral' of a patient to someone who will ensure abortion is performed. As discussed in chapter 4, the requirement for a referral and the set-up of health care systems may differ between countries. Here in Australia, a referral is not required to access abortion in either New South Wales or Victoria. This balance of themes addressed in this study involves the concept of referral and conscience.

As discussed in chapter 3, the focused discourse provides principles for how to discern when participation or co-operation in wrongdoing leads to moral complicity in it. Fact driven, it involves an analysis of whether the referring doctor has engaged in 'formal co-operation in immoral action' or 'mediate material co-operation in immoral action.' The Catholic Church has applied these principles to abortion and formally states that as abortion is gravely immoral, Catholic doctors are prohibited from performing abortion or engaging in 'peripheral actions' associated with abortion where they meet certain criteria.

Formal co-operation requires the doctor in question to share the same intention of the person performing abortion, that is, to terminate the unborn child. However as discussed in chapter 3, mediate material co-operation in abortion is a far more complex analysis and includes consideration of how remote the doctor's action is to effecting abortion, its proximity to abortion, whether the doctor's action is necessary for abortion to occur, and whether the referring doctor does not intend, but foresees how their action will have the consequence of effecting abortion.

The counter-discourse imposes through laws and policies, a normative model for conscientious objection to abortion where because referral is considered indirect participation, it is not assumed to be an action that ought to negatively impact a doctor's conscience or if it does, it is not something worthy of protection. However as discussed in chapter 3, the actions comprising a referral are unclear. In this theme, the researcher did not focus on what the participant understood referral to be, but rather focused upon understanding why they objected to, or did not object to, the concept of 'referral'.

Figure 3: Theme 3 - Basis of Conscientious Objection to Referral



6.5.3.1 WILL NOT REFER

In the content analysis, thirty participants expressed in the text of their interviews that they had a conscientious objection to referral. In thematic analysis, the researcher looks behind the text to identify the basis of their objection. Most Catholic participants and the 'no religion' participant used the language of the discourse when articulating the basis of their conscientious objection to referral such as 'moral complicity', and 'mediate moral co-operation'. Whilst the non-Catholics did not use the formal language endorsed by the discourse, they expressed the same sentiment.

As this issue is not well explored in the literature, the writer has set out below a large number of verbatim quotations. The writer believes that each of the quotes clearly and succinctly articulates why referral troubled the participants' conscience. In each of these quotes, the participant uses unique wording. Some emphasise the act of abortion and how they want nothing to with the unborn child's death, others do not mention the termination of human life and focus on the harm abortion causes to the woman, and still others focus on the concept of referral being part of the causal chain.

I would not refer a patient seeking abortion to another doctor. I base this on the analogy of someone seeking a service that involved killing someone. I would feel complicit.

Doctor # 1 [NSW, Hospital, Metropolitan, Catholic, < 5 years]

It is not OK to make an effective referral. It makes you part of the causal chain.

Doctor # 3 [NSW, GP, Metropolitan, Catholic, 5-15 years]

I will not refer. Referral may not be carrying the gun, but it is giving someone a bullet. Referral is the bullet.

Doctor # 7 [NSW, Consultant, Metropolitan, Catholic, > 15 years]

I don't refer patients for abortion. I would not refer a patient for a service I have a moral objection to, or a concern that the service or procedure is harmful to them.

Doctor # 8 [NSW, GP, Metropolitan, Catholic, > 15 years]

If the law required me to refer to a doctor who did not have a conscientious objection, I just would not do it. Referral is being complicit. You are facilitating and enabling it. You are actively facilitating the death of that child. I cannot imagine a penalty I would not subscribe to, such as jail or de-registration.

Doctor # 10 [NSW, GP, Rural, Catholic, > 15 years]

I don't refer for abortion. It is not just providing information. It is a specific request to continue the care of the patient. You are putting yourself on the side of the patient asking someone else to consider that treatment. It is material co-operation in that bad act. I would not do it.

Doctor # 11 [Hospital physician, NSW, Rural, no religion, 5-15 years]

I have not referred anyone who is seeking a TOP to an abortion clinic or "pro-choice" health professional and would not do so. I wouldn't work in those contexts…As people can self-refer for abortion, I have come to the position that I don't have to disclose my beliefs. No referral is required…Everyone knows you can go and arrange it yourself. In Melbourne, in an area where people are self-sufficient (eg with a smartphone and access to Google), they find their own way to a clinic. I think that when this law came in in 2008, we hadn't quite got to the point where people could look up things very easily on-line. Now everyone is so native with their devices, you can look up whatever you want whenever you want, you don't need help from a health professional.

Doctor # 14 [GP, VIC, Metropolitan, Christian, 5-15 years]

> A referral is inviting another specialist to join you as a team in the care of this patient. You are entering into a contract and agreeing with the request you are referring the patent on for…I would never give a formal referral. I would prefer to lose my job. Losing my job would have massive consequences for me and my family, but writing a formal referral would make me feel that I am sinning before my God…
>
> Doctor # 18 [Hospital physician, VIC, Metropolitan, Christian, 5-15 years]

> A woman's choice is a different argument to the doctor materially co-operating with abortion.
>
> Doctor # 21 [Consultant, NSW, Metropolitan, Catholic, > 15 years]

> For me, you are either involved or you are not involved. Referral for abortion is involvement with abortion.
>
> Doctor # 27 [Consultant, NSW, Metropolitan, Catholic, > 15 years]

6.5.3.2 WILL CONSIDER REFERRING FOR ABORTION

As noted in the content analysis, five participants expressed a willingness to refer patients for abortion notwithstanding having a conscientious objection to abortion. This section takes an in-depth look at the responses of those five participants in order to try and understand his or her reasoning and how and why they diverge from the focused discourse. These were doctors # 9, 13, 15, 25 and 33. The verbatim quotations selected for each of these participants' attempts to include the context or conditions under which he or she will refer, some of which will be isolated and considered in greater detail.

Looking firstly at doctor # 9, whilst they believed in the sanctity of human life and that 'God has given us the ability to procreate, not destroy,' he or she did not believe that the unborn child under 4 to 6 weeks of age was a human life form and were sympathetic to abortion in a variety of scenarios. Despite there being no statutory duty to refer at the time of the interview, doctor # 9 referenced their 'legal duty,' taught to them as part of their general practitioner training, as having affected his or her attitude to mandatory referral.

> During special training as a GP, we were told that if we had a conscientious objection to abortion, we had an obligation to refer patients on to another doctor who would help. It was framed from the perspective that it is bad practice and unprofessional not to refer…

> If not for this obligation to refer, I would be more inclined to not give details of abortion providers…If a patient does not want to change their view about wanting an abortion, and it was sought for non-medical reasons, I don't have any protection and I must refer them to someone who will help…
>
> I would struggle if the patient asked me to refer them for abortion where it was a scenario I morally disagreed with. I would feel slight regret. I don't really want to be involved."
>
> Doctor # 9 [GP, NSW, Metropolitan, SDA5-15 years]

Doctor # 9 made it clear, however, that a free discussion with his or her patient about why the patient sought abortion and providing the patient with other options and the space to think about these, was an important part of the context in which the doctor felt comfortable in referring. This included counselling the patient. The participant noted that he or she took a risk in having this type of discussion, given the potential for a patient to feel judged or be offended. However, he or she recalled how on one occasion, the participant assisted a patient to think differently about their options.

> I persuaded one person to think about it differently. After counselling them they ended up deciding against abortion. I didn't push it. I did present the options and I explored conflict and the reasons why they sought abortion and gave them time. It was, actually, a lovely experience.
>
> …I think it would be ridiculous and bad medicine if doctors were prevented from speaking further with a patient about abortion because of a conscientious objection. It goes against logic because we know that many women regret the decision to abort. If provided with better information, and accompanied by empathetic discussion, they may have decided differently. To ban discussion is medically ridiculous. …
>
> It is very uncomfortable to have that discussion with a patient. You don't know if the patient will stand up and yell and call you a dickhead. It has not happened to me yet. My core values drive me to say this person deserves care despite me disagreeing with their moral position.
>
> Doctor # 9 [GP, NSW, Metropolitan, SDA, 5-15 years]

Apart from believing they had a legal and professional duty to refer, the participant discussed the necessity of providing a referral so a patient can access abortion. On the one hand, the participant did not believe that the burden ought to fall to him or her, and that information was freely available to all people on where to access abortion. Whilst this accords with the views of other participants who will not refer, doctor # 9 went on to state that there are people who do not know where to go. It was unclear whether the fact that such people may exist was justification for this participant to refer.

> The idea that the patient is left in no man's land if one does not refer them, I feel is naïve. It does not rest on me to provide information and to find a provider for them. There is easy information available on the Internet and other sources. However, there are people who don't know where to go. A lot of people may assume that all GPs agree with abortion. I would imagine that the vast majority of people believe abortion is legal in New South Wales.
>
> Doctor # 9 [GP, NSW, Metropolitan, SDA, 5-15 years]

For doctor # 13, also a general practitioner from New South Wales, he or she had earlier stated that they believed we do not have a right to terminate prenatal life. However, the participant expressed an understanding as to why in some situations, such as rape or where women feel it is inappropriate to continue, abortion is sought. The participant's position on referral, set out below, reflected his or her current practice. This was heavily influenced by the participant's actual experiences in dealing with patients who had requested abortion or other services the participant had a moral objection to.

> I don't have a problem with referring for abortion. I had one patient request a referral after I went through my spiel. She stood her ground and said, "thank you for what you have said, but I really want you to refer me to Marie Stopes so I can get an abortion.' She was adamant and had a friend with her at the time. Nothing deterred her. So, I did the referral. I felt OK about it. I felt I had explained everything to her. I felt that if I ultimately did not give her a referral, she would have gotten it done anyway. I hoped that after giving her the referral, and before she went to the abortion clinic, she might think about what I said and change her mind at the last minute. It does happen.
>
> Doctor # 13 [NSW, GP, Metropolitan, LDS, > 15 years]

At first blush, the reader might conclude that this response supports the counter-discourse, but that would miss the participant's pivotal reference to their 'spiel.' This refers to his or her ability to freely talk to the patient about the participant's views on abortion. Like doctor # 9, the freedom to talk to patients appears to be why the participant felt comfortable with referral. This raises an important issue about at what point during the consultation the doctor must refer the patient, why conscientious objection might preclude the doctor from having this frank discussion, and whether practising in this way might put the doctor at risk of complaint or disciplinary action.

> For patients who want an abortion, I always state my view and say something like: I don't believe in abortion, but I respect you as a human being and your right to decide what you want to do with this pregnancy and your body… You should have some counselling. This is not something that should be done in an off-handed fashion… I have come across post abortion grief in some women, maybe not straight away, but down the track. We don't know what the future holds. People's views change with age and experience… Have you looked into other alternatives? Have you thought about adoption? There are many couples that have not had the opportunity to have children because of infertility. Wouldn't it be better to have the child and give it to someone who will love them?
>
> Doctor # 13, NSW, GP, Metropolitan, LDS, > 15 years]

For doctor # 15, a Victorian general practitioner with between 5- and 15-years' experience, his or her position on referral evolved over time. The quotation below is long and continuous, no doubt reflecting the participant's struggle with arriving at a comfortable position. Clearly, multiple factors influenced their position. It is worth nothing that they had limited intellectual tools available to them to educate their conscience. Like doctors # 9 and 13, the context in which doctor # 15 provides referral includes an assumption that the doctor is free to have a discussion with the patient.

> I started off university thinking I would never make a referral for abortion. I thought it would make me complicit in it. However, having talked about it with a doctor, who was a Baptist, I do provide women with information on where they can get a termination if after much counselling, they still insist that this is the only option they feel they can proceed with. I have become aware that in other areas of medicine, referrals are often facilitating a request for a second opinion to which patients are entitled and it does not necessarily mean I agree with it or that a given procedure will happen. I don't know if the doctor I spoke to had any training in philosophy behind these concepts, but I certainly haven't. I get my theology from the reading of the Bible, but I think you can philosophize until the cows come home and you won't have everyone agreeing with it.

> It is more about how I feel convicted about it based on my prayerful study of the Biblical principles, combined with insights gained from discussing the topic with other Christian medical professionals who have a conscientious stance in regard to this. If you cannot provide a service, letting people know where else to go is their right and prerogative. I don't necessarily like it, but it doesn't necessarily make you complicit in it. Looking at the bigger picture, the devil came and ruined this world and God put in a plan to remedy that. In the meantime, God has given his law and he knows people can choose either his law or the devil's way. People have free will. It is not our job to tell people what to do. This is between their conscience and the creator. It's tricky. Maybe I have compromised to make it work. It's quite a grey area. I think it's hard when you feel like you are the only one. The fear factor about being hauled in front of AHPRA is real, but I don't want to compromise my faith over that.
>
> Doctor # 15 [GP, VIC, Rural, SDA, 5-15 years]

As noted earlier, doctor # 25 was of the belief that a non-viable unborn child has less value than one outside the womb. Whilst the participant declared he or she would never perform an abortion, the participant was comfortable with referrals, having provided a number of referrals for abortion over the years, including an occasion where he or she referred a patient for abortion of a 'viable foetus.' Yet again like the other participants, the referral was given in the context of a free discussion with the patient, with the participant having disclosed their objection and given the patient the space to re-consider their options.

Importantly, as an experienced practitioner, doctor # 25 practiced at a time when doctors transitioned from giving contraceptive advice to facilitating abortion, and where the participant had more time to spend time with each patient. Patients accepted that they just had to wait to see the doctor. With the entry of bulk billing into general practitioner practices, the participant conceded this caused a small change in what he or she said to patients requesting abortion because of the need to move on to the next patient and there was an emphasis on the patient's convenience.

> I have referred a number of patients for abortion… If they have not thought deeply about the whole thing and I have come to the conclusion that I am not going to change their mind, then if I don't write a referral, they will just go somewhere else and get one. This makes it more straightforward for me to refer them and for them to come back later and see me so we can make sure they are using good contraception. It just makes it more complicated for them if I don't write a referral.
>
> Doctor # 25 [GP, VIC, Metropolitan, Christian, > 15 years]

However, despite providing this justification for why the participant was willing to write a referral, doctor # 25 recalled an exception. In this instant, the patient met doctor # 25's requirements of having thought about it, and being resolute in their decision, but the patient sought referral for abortion for a reason doctor # 25 did not agree with. This led to doctor # 25 refusing to give the patient a formal referral note (or 'second signature' as it was known at the time). Instead, doctor # 25 provided the patient with the address of an abortion facility, even though the patient would have been able to find this herself. This meant the patient had to find another doctor to complete the form.

> I remember another client who was in a stable relationship and wanted an abortion so she could go on a trip. I told her people often regretted the decisions they made, and some people experienced ill effects afterwards, but her mind was made up. I didn't think this was a good reason to get an abortion and I couldn't bring myself to give her a referral, so I just gave her the address of the clinic that meant she still had to find a doctor to sign the form.
>
> Doctor # 25 [GP, VIC, Metropolitan, Christian, > 15 years]

The reader will note that earlier, doctor # 25 justified their decision to refer by stating: '…if I don't write a referral, they will just go somewhere else and get one.' Why then did this justification not inform their action on this occasion? Arguably, this example highlights the position of a person who adopts 'situational ethics' to abortion, which does not deliver consistent conclusions. For this doctor, facilitating an abortion for social reasons that do not reflect something resembling a concern for health did not sit well with his or her conscience, which the participant obeyed despite inconveniencing the patient.

The participant made the following comment that is important to this discussion. It demonstrates tolerance for freedom of individual conscience about abortion rather than support for a group think mentality amongst doctors, that abortion for any reason judged by the woman to be in her best interests is standard healthcare and that everyone can refer with a clear conscience. This doctor, who has a conscientious objection to abortion yet feels able to refer most of the time, does not support a law or policy that requires mandatory referral for all abortion requests.

> Even though I don't have a big problem with referring, I know other doctors that do. I think if people have indicated that it is their position not to refer, they should not be required to refer to someone who will.
>
> Doctor # 25 [GP, VIC, Metropolitan, Christian, > 15 years]

Finally, doctor # 33, a consultant from Victoria, also provided referrals for abortion in some instances. This participant's background included having undergone a gradual conversion from being a doctor who had a self-described 'vague view about abortion' and had personally performed 'a couple of dozen' abortions in the past, to refusing to perform abortion and screening for foetal disabilities, which often leads to abortion. The context in which the participant provided a referral was again important and involved referrals to private doctors known to them.

> The fact is most people shy away from termination of pregnancy, and it only attracts a few doctors. Abortion is unpalatable for most of my colleagues…Years ago I would send patients to the doctor who did abortions in the hospital. I thought he would take responsibility for the decision that patient had already made. In retrospect, I don't feel very good about that. However, if someone were unsure about abortion, I would not send her to that doctor, but to someone else...I don't have a particular problem with referring people on to someone else to make the decision to do abortion, or to refer them to a private doctor so they can get a Medicare rebate rather than going to a clinic where they have to pay up front.
>
> Some people are ethically tight on this, and black and white, but that's not me. In my view, the patient takes responsibility for their own decision, but I understand other people may take a different view and won't refer and that is their right to decline to do this. I've thought a lot about mandatory referral laws in Victoria. It's social engineering. They are trying to change the attitudes and ethics in society, to impose a progressive agenda. It's a bit leftist, and certainly anti-Christian.
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> Doctor # 33 [Consultant, VIC, Metropolitan, Christian, > 15 years]

Interestingly, doctor # 33 expressed a conscientious objection to euthanasia and indicated they would not refer a patient for this service. Asked to articulate why he or she would not refer for euthanasia but would for abortion, doctor # 33 responded as follows:

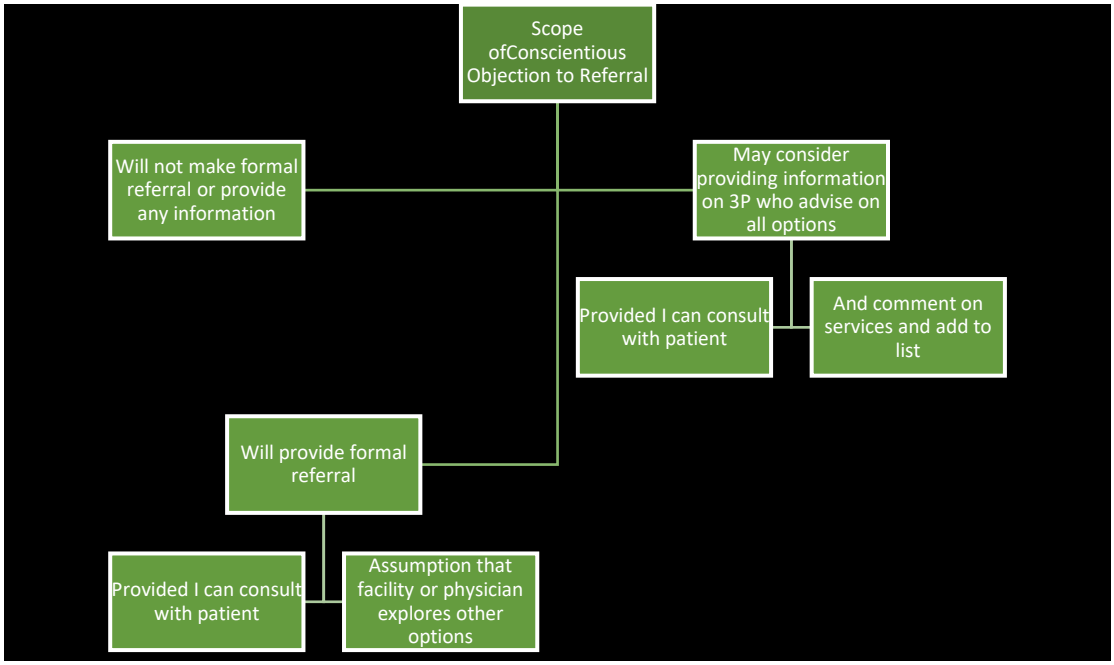
> I have a conscientious objection to euthanasia. I would not refer a patient seeking this to a willing provider. It's an instinctual reaction, and I have not really thought through why I object to referral for this but not for abortion. I think it has to do with the maturity of intrauterine life. If a woman has a miscarriage at six weeks, she will usually flush it down the toilet. But if it occurs at 18 weeks, she will bring the foetus in a jar to the hospital. It indicates a change in attitude according to the maturity of nascent life and I think carrying that through to mature adulthood, you could argue that the full potential of the person has been released and the person has a different degree of value.

6.5.4 Scope of Conscientious Objection to Referral

Whilst the content analysis revealed that 30 out of 35 participants would not refer for abortion, and theme three, 'basis for conscientious objection to abortion', discussed participants' exposed reasons for their position on referral, theme four, 'scope of conscientious objection to abortion,' explores how participants apply that belief to refer or not refer in their everyday clinical practice and how they justify it when navigating this conflict with patients. Some participants spoke hypothetically whilst others responded from a position of having had experiences with patients.

Thematic analysis revealed three themes. Apart from those participants who would not refer or provide information that facilitates abortion and those who will, some in the former group were open to discussing a 'third way' such as providing the patient with a government authored brochure containing information on all options for crisis pregnancy. However, for these participants entertaining the third way contained cautions and caveats, especially the requirement to be free to discuss abortion with patients and check out and add services to any brochure.

Figure 4: Theme 4 - Scope of Conscientious Objection to Referral



6.5.4. 1 Will Not Provide Referral or Information on Abortion

Participants in this category were staunchly against providing any assistance to patients to facilitate abortion. Some of them specifically addressed and rejected the concept of a 'third way.' To the writer, their responses reflected a significant amount of reflection about not just what they will or will not do, but why. A selection of verbatim quotations follows:

> I would not refer for an abortion. Abortion is a moral act causing irreparable harm to the woman. It's lethal, and there are other places people can go to get this done. If you direct them to a location that is where the line is. I would not give them any direction, not to a place or a person… Referral to a third party that provides information about abortion, but also provides information about continuing with pregnancy, would still offend my conscience. It still provides information for people on how to get an abortion, and I would feel a part of that, I would feel like an accessory. Like I morally assent to it. I would not do that.
>
> Doctor # 2 [NSW, Hospital, Regional, Catholic, < 5 years]

> If the law compelled me to refer a woman to a willing provider, I would not change what I do. With pregnancy counselling, some women connect, others don't. …I will not send a patient to a hospital with a diagnosis of a foetal anomaly for termination and say that I don't agree with it but am trying to comply with the law. I will not co-operate with termination in any shape or form. Once I put my name to a letter I am co-operating. If I wrote a letter like that, I would think 'what's the point'? I would prefer to go to jail.' I did not work as hard for that child as I should have …I will never do anything about the process. It's not part of my medical training and it will go towards materially co-operating in a termination.
>
> Doctor # 21 [Consultant, NSW, Metropolitan, Catholic, > 15 years]

6.5.4.2 May Consider Providing Information on Third-Party Organisations

It is important for the reader to note that the primary position of these participants was that they did not support referral for abortion. Their consideration of the third way was in the hypothetical context of being compelled by law to adopt a government-authored brochure listing all options for crisis pregnancy. As will be seen, enthusiasm was on a scale, with many not keen to embrace it unless faced with a penalty for non-compliance. This issue was not raised with all participants, and only where the conversation naturally led to its consideration.

I am not comfortable with giving a patient a pamphlet that has the names of doctors who will do abortion. I would however tell people that the information is readily available on the Internet. A brochure that sets out the contact details of a third party that provides information and referral could be considered the internet.

Doctor # 1 [Hospital physician, NSW, Metropolitan, Catholic, < 5 years]

If a patient asks for a referral for abortion, I say that I am aware that there are some doctors who will help you, but that I know certain doctors in my practice will also not refer for abortion, and I suggest they talk to the receptionist about that. I don't lead the patient to the door of the doctor who will assist them.

…If a law came in mandating referral but permitting referral to a third-party organization that offered all choices, then being honest, I think I would probably be risk averse and take the view that giving information about the third-party organization would not be akin to guaranteeing any particular outcome. However, in providing the patient with a pamphlet containing the contact details for the third-party organization, I would annotate it and give them additional numbers such as 'Sarah's Place' or Church support groups, and I would schedule a follow up to see what their decision was. I would feel bound to do this as a good doctor who cares about their patient. When you refer patients to specialists, the patient will always come back and tell you if the specialist was awful and you feel bad because you were the one who referred them. Annotating a pamphlet and directing them to additional places they can go, is simply an extension of this. The way I see it, I did not cut off an option. Rather, I extended their options.

Doctor # 3 [GP, NSW, Metropolitan, Catholic, 5-15 years]

…the government has this information for you regarding different options. I would verbally add to that pamphlet, other services not on it, and I would write on it as well. I would stress that and say I can help you as much as I can with the other options.

Doctor # 5 [GP, NSW, Metropolitan, Catholic, > 15 years]

If the law required me to refer patients to specific third -party organizations that dealt with information and referrals for abortion, I would tell patients I was giving them non-directional counselling, as required by the government, and then I would make a personal judgment about the organizations on the list…I know that the government provides clinical guidelines for primary health professionals to follow, which are adapted to your local services. Their resources direct people to Marie Stopes. This is inappropriate, as Marie Stopes has a fiscal interest in providing the service. They don't provide information about adoption, so it is biased. I would tell the patient that the organization was biased and would then tell them where to find people who lean the other way, that is, people who are prolife.

Doctor # 6 [GP, NSW, Rural, Catholic, > 15 years]

If the state forced me to give specific information to woman about a third-party organization that spoke of abortion options and may refer, then this is less of a problem, but I would still struggle with that. This is because I cannot verify that they can give the salient objective information to the patient. It depends what is on the pamphlet. If it was a group that was wishy-washy and you could add to that pamphlet, I might add additional details in. I think the state should have input from doctors about what information goes in those pamphlets, what services or organizations are detailed. There should be transparency. Sometimes living with civil penalties is the only option. You can't have freedom of conscience but then have a secondary clause that contradicts that statement.

Doctor # 7 [Consultant, NSW, Metropolitan, Catholic, > 15 years]

If we were required to give patients a brochure that listed where they could get abortion, I would want it also to list crisis pregnancy centres. Before I gave the brochure out, I would ring those centres first to see what information they give.

Doctor # 16 [GP, NSW, Metropolitan, Christian, > 15 years]

I would be OK with a government brochure that set out information on where to obtain an abortion if it also contained balanced information about crisis pregnancy services. I would want to check the service out in the brochure, talk to the woman and support her, and give her information about any additional services, such as those that provide accommodation for teenage pregnancies, and support them through schooling. If I were a GP, I would probably make my own brochure.

Doctor # 18 [Hospital physician, VIC, Metropolitan, Christian, 5-15 years]

My preference would be to explain the alternatives and provide a referral where I knew those options would be discussed. The patient does not get to pick and choose from me who they get referred to. If they don't like whom I refer to, there is always someone else who can accommodate them.

Doctor # 20 [Consultant, NSW, Metropolitan, LDS, > 15 years]

If there was a brochure that was even handed with details of places that do non-directive counselling, that included details of where to go for financial or social support or adoption and not just termination, then giving that information would be better than being mandated to refer. I think adoption is put into the too hard basket. You tend to refer to what you know. We don't get any training at all on this at medical school or in the GP training program.

Doctor # 22 [GP, VIC, Metropolitan, Catholic, 5-15 years]

Again, we see as part of the caveats attached to this 'third way,' the assumption by all participants that the doctor is free to voice their objection about abortion, comment negatively upon the organisations listed in the brochure, and add their own suggestions. It is unclear what impact the ideology about abortion embedded into recent safe access zone laws, which prohibit communication about abortion outside abortion clinics, will have upon the private discussions between doctor and patient.

6.5.4.3 WILL REFER

This section focuses on the five participants who expressed a willingness in some situations to refer patients for abortion. The table below provides a summary of the variables, the circumstances of the request(s) and the action they performed that they perceived to be a referral. Verbatim quotations from their interviews provide context for the reader as to how the participant arrived at his or her decision to perform the action that constituted a referral to him or her or any caveats to their referral. They also clarify what other actions the participants felt did or did not constitute a referral in his or her mind.

Table 1: Summary of Circumstances where Doctor has Referred Patient for Abortion

No.	State	Specialty	Religion	Frequency	Reason	Action
9	NSW	GP Metropolitan	LDS	Twice	Patient adamant, has been counselled by them, legal and professional duty to refer	Provide contact details for Marie Stopes but patient must arrange themselves
13	NSW	GP Metropolitan	SDA	Several times	Patient adamant and was counselled by them	Formal referral to Marie Stopes
15	VIC	GP/Ob Rural	SDA	Several times	- Maternal health - Patient adamant and has been counselled by them, legal duty to refer	- Formal referral to Marie Stopes - Provide contact details but patient must arrange themselves
25	VIC	GP Metropolitan	Christian	Several times	Various reasons	Formal referrals to Marie Stopes
33	VIC	O&G Metropolitan	Christian	Twice	- Maternal health - Foetal disability	- Endorsed request - Steered patient to doctor they knew would perform abortion

The reader will recall that doctor # 9 did not believe a viable human life begins at conception and he or she felt under a legal and professional duty to refer for abortion. In this context, the participant had provided patients with the contact details for Marie Stopes, whom the participant was led to believe would assist patients with counselling before abortion. After receiving negative feedback from a patient whom they referred to Marie Stopes for abortion, the participant was disinclined to continue to provide their details to patients due to the lack of balanced information the patient was likely to receive.

> I write the contact details for Marie Stopes on a piece of paper for them, but I don't write referral letters and I don't ring up for them…
>
> In the past I told patients they can go to Marie Stopes. I have done a certificate in family planning, which is biased towards the pro-choice ideology. They recommend Marie Stopes as one place to refer patients to who would assist them with counselling and abortion services. People from Marie Stopes came to talk to us. I heard their speech, and they gave me the impression they counsel patients before the abortion. However, one patient I referred there and who did have an abortion told me they received virtually no counselling. It was essentially assumed that they were there for abortion. I think the overall philosophy of Marie Stopes is there is no need to talk people out of the abortion, so it is not giving patients truly balanced information. ….
>
> …If I were confident Marie Stopes gave balanced information, then I possibly would refer a patient to them. If I was required by law to refer to a third party who made the referral to an abortion service, then that would be an easier option, but I would still like to know beforehand that their information was balanced. If abortion were a bigger part of my practice, I would take the time to think and know more about this.
>
> Doctor # 9 [GP, NSW, Metropolitan, SDA5-15 years]

Interestingly, doctor # 9 did not favour the idea of referring patients to religious organisations that perform counselling and provide support for women with crisis pregnancies. The participant expressed concern that the profession would view him or her negatively and would see the referral as an attempt to proselytise, and that such a referral could result in a news headline about a general practitioner coercing a patient. However, the participant qualified this statement by indicating that in the participant's opinion, not all religious organisations provide a better service than secular groups. This raises interesting questions about how who is qualified provide counselling and support.

> In the medical profession, you are viewed negatively if you refer to religious organizations. If not for this obligation to refer, I would be more inclined to not give details of abortion providers. If I gave referrals to Church based groups, it would be seen as biased and indirect proselytizing. Ideally, these groups are helping patients, and I would like to think they provide a better service than secular groups but that is not always true. There are a few exceptions such as the Salvos, St. Vincent de Paul, and the SAN Hospital because they are not viewed as being particularly religious. … Abortion is so emotive. If you referred a person seeking abortion to a religious group, you can just see the headlines about the GP coercing the patient. I am more comfortable recommending secular groups however if the patient identified as a Christian, I would be less concerned about referring them to a Church group.

Doctor # 13, a general practitioner from New South Wales, took this point further, stating:

> Information about abortion should be transparent, and clinics that offer abortion, should also offer counselling. If the abortion provider does not agree to provide counselling, they should be required to refer to someone who does offer it. My understanding from patients that I have referred to abortion clinics is that their counselling was limited to the physical effects of the procedure…Any referral for counselling needs to be someone who understands the issues. I'd like to see an avenue where a person can go to have a discussion about the pros and cons of abortion. It should include organizations that offer alternative discussion about abortion and that could be a church group. We have to look at services in the community that help people and keep an open mind. Church groups usually have a lot of experience with dealing with people. They are not necessarily saying 'come and join our Church'. If it's a good service, I don't care what denomination it is…I like the idea of a brochure that lists all services that may benefit a crisis pregnancy. This would provide GPs with some guidance if they do not personally know where to refer someone. In my practice, all the doctors generally have a discussion with the practice manager before any brochures are placed in the waiting area.
>
> Doctor # 13 [GP, NSW, Metropolitan, LDS, > 15 years]

Doctors # 9 and 13 raise important issues. Earlier, doctor # 13 noted that even after a referral has been provided, there is still the opportunity for the patient to change their mind. This is true, and it is a hope repeated by other participants who refer, but it is unclear how this might occur without free speech. If a brochure listing services for crisis pregnancy was available to general practitioners to give to patients, who decides what services are to be included on a brochure, and what is standard by which this is measured? It is unclear what doctors know about the quality of services that exist.

Doctor # 15, a rural general practitioner, tried to avoid referrals where possible.

> One of the GPs in my clinic does abortions. One will not have a bar of it. I usually say to the patient that they can talk to one of my colleagues and I send the colleague an inter-office e-mail, which I guess is a referral, asking them if they will have a consultation with the patient. Most of the time we get away without giving a referral. If people choose to go ahead with it, I tell them where they can get a service performed if they wish, but I tell them to arrange it themselves. I think when someone is in a distressing situation, it can be a bit hard to tell them to go ahead and find the details themselves.
>
> Doctor # 15 [GP, VIC, Rural, SDA, 5-15 years]

However, on one occasion, the participant prepared a formal letter of referral to Marie Stopes for a patient requesting termination of a planned pregnancy that had resulted in twins, but which she wanted to abort because the pregnancy was causing her hyperemesis (nausea and vomiting). The patient was refusing treatment for hyperemesis and doctor # 15 struggled to understand why the patient wanted an abortion, especially as the patient's family was against it. After attempting to talk the patient out of it, and with no local doctor prepared to perform the abortion, doctor # 15 made the referral.

> If I write a referral I get a copy of the notes about the procedure, and then I know what happened. We need the communication back from the doctor who performed the procedure, to make sure that contraception is in place for the future and that the person has appropriate post-procedure care. Does it necessarily mean that I am complicit in the act? I don't know…
>
> Doctor # 15 [GP, VIC, Rural, SDA, 5-15 years]

For doctor # 25, who believed that the non-viable foetus had less value than the viable one, he or she had nonetheless referred a patient for a late term abortion. Again, the context in which the referral occurred included the participant attempting to convince the patient not to undergo abortion. However, as the participant felt the patient was adamant, the participant referred the patient for abortion on the basis that to decline to do so would cause the patient not to return to them for post-procedure care. Unlike doctor # 15, this participant made a clear distinction between direct and indirect participation.

> Even though I think viable life has value, I referred one patient to a clinic for a late term abortion. I felt the patient didn't have strong views against abortion and I'd spend time trying to convince her otherwise. If I held the line about not doing a referral, I am closing off my relationship with this patient and they won't come to see me about other things including any complications of the termination. To me, that's important. Doing an abortion and referring for me is not quite the same thing because it is still up to the patient if they use the referral.
>
> Doctor # 25 [GP, VIC, Metropolitan, Christian, > 15 years]

Doctor # 25 had a different view from the other participants about the quality of service in abortion clinics, noting "I think the clinics that do abortion on a regular basis are good at doing them, from a clinical point of view." However, the participant echoed the sentiments of doctors # 9, 13 and 15 regarding free will, and recollected an occasion where simply giving the patient space and a different perspective led to the patient freely changing her mind.

> I had one patient who was an older woman who thought she was post-menopausal but after an examination I knew her uterus felt pregnant. We did a test, and this was confirmed. She was stunned. She was in a second marriage and had children from the first marriage and hadn't been married long to the second husband. She felt it was quite difficult in her early 50's to have a baby. We discussed it all, and I asked her to come back the next week after she had time to talk with her husband rather than me giving her a referral. When she came back, she told me that her husband was quite delighted, as he had never had children so that solved her problem. This incident made me think that it is really worth exploring the situation with the patient and not dashing in and doing a referral straight away.
>
> Doctor # 25 [GP, VIC, Metropolitan, Christian, > 15 years]

Finally, for doctor # 33, a consultant from Victoria, 'the patient takes responsibility for their own decision.' Doctor # 33's position was:

> [Request for referral] happens very rarely. I would normally get a sense in a consultation that a patient is moving in that direction, and I say I am not comfortable talking about this issue and that I will get someone else to see you. For me, that's not necessarily referring the patient on for an abortion. Rather its referral for consideration of all the issues, which is something I would rather not be involved in…
>
> Doctor # 33 [Consultant, VIC, Metropolitan, Christian, > 15 years]

Doctor # 33 recalled a time when they had referred a patient for abortion for foetal disability. Giving them information about someone the participant knew would perform abortion on her, this referral was executed with doctor # 33 being aware of coercion of the patient by the husband. Earlier, doctor # 33 characterised referral as not being for abortion, but for someone to consider all the issues. There is an expectation that the next doctor will discharge their professional duty to ensure that the patient has capacity to give consent and the doctor will provide informed consent.

> Years ago, I worked with a midwife who got pregnant with a baby that had Down syndrome. She was a Christian and was married to a Minister of religion and he did not want the pregnancy. There was a lot of coercion of her by him to have an abortion. I told them I could not do this. We had long discussions, and he was furious with me. I steered them into the direction of someone else that I knew would do it. She was around 15 weeks, and the termination went ahead.
>
> Doctor # 33 [Consultant, VIC, Metropolitan, Christian > 15 years]

However, the reader will recall that for a time, doctor # 33 referred patients seeking abortion to a doctor in their hospital that performed the abortions for it, and as a result, they ‘don’t feel very good about [referrals]’ they have made in the past. A number of doctors willing to refer for abortion in this study were open with their concerns about the quality of counselling and informed consent patients will receive at Marie Stopes, the main abortion provider in Australia. This raises an issue worthy of research: what do we know about what happens inside these abortion clinics?

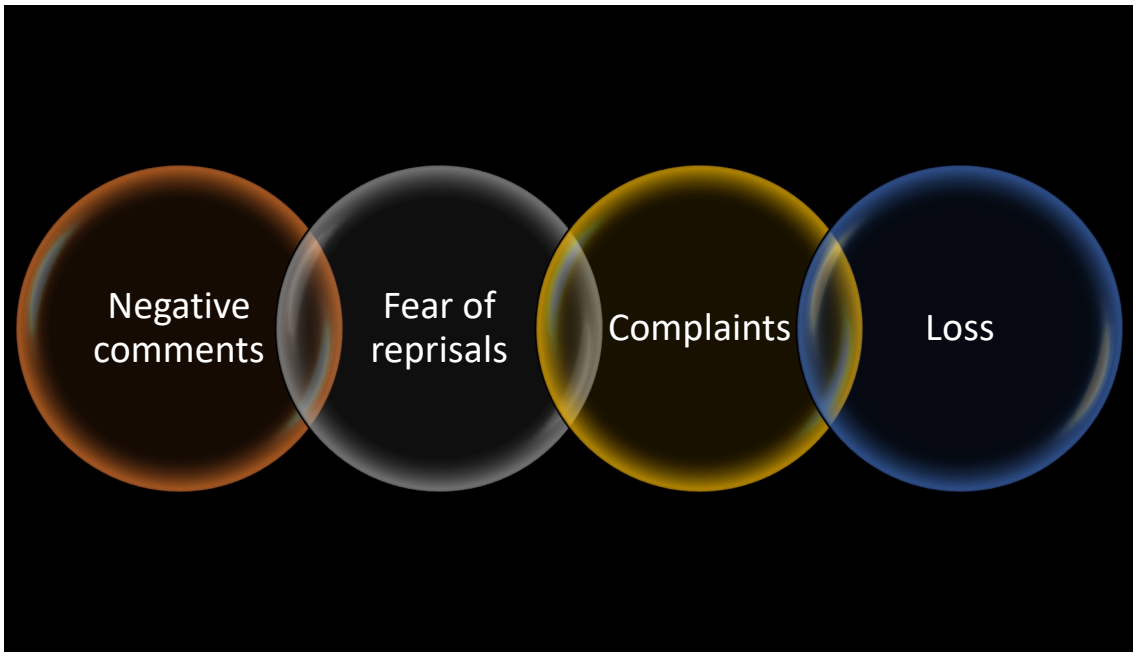
The next two global themes deal with participants’ experiences rather than their attitudes. The first looks at the burdens they believe they have experienced on account of being a doctor with a conscientious objection to abortion and subdivides into four types of burden. Secondly, it documents the times when they were able to achieve accommodation of their conscientious objection to abortion. It considers the context in which this was achieved, and the key actors involved such as the patient, their colleague or supervisor, or a professional college of organisation.

6.6 THEMATIC ANALYSIS: ATTITUDES

6.6.1 BURDENS

One of the sub-questions for this study was 'what burden do these doctors believe that having a conscientious objection to abortion had had upon their professional life?' Accordingly, burden was pre-identified as a global theme, with four themes flowing from the data: negative comments, fear of reprisals, complaints, and loss. Not all participants experienced all categories of burden. The first two themes were more common with less experienced participants, and last two themes were more common with more experienced participants.

Figure 5: Theme 5 - Burden Caused by Status as Conscientious Objector to Abortion



6.6.1.1 NEGATIVE COMMENTS

Less experienced participants had tales to report about the behaviour of educators at medical school or during clinical placements, where participants either observed or were the subject of, negative comments about people of religious faith who believe abortion is morally wrong. They describe a pervasive, 'pro-abortion' environment at university, with no particular association by state. It is clear these experiences as medical students deeply affected these participants and contributed to their decision to be silent about their objection out of a fear of reprisals.

> I recall one instance when doing my obstetrics and gynaecology rotation, my supervisor talked about another obstetrician who was pro-life. She openly spoke about his religious views in a denigrating way. This was a particularly tricky situation for me. She was a strident feminist gynaecologist and she graded me, and I felt my results were dependent on what she thought of me as a person. … I did not proactively raise my objections with her because you worry about reprisals.
>
> Doctor # 2 [Hospital physician, NSW, Regional, Catholic, < 5 years]

> In third year, an obstetrician who held an important position at the College gave a lecture. Part of his talk was on the medical aspects of obstetrics however the other part was blatantly making fun of people with religious beliefs. I remember he showed us a derogatory cartoon of Christ and was trying to belittle religious people and trying to get other people not to go down the same path. A lot of things in medicine are unprofessional. That lecture could not have been given in an accounting firm or law firm. The idea of making crude jokes about a religion would just never happen.
>
> Doctor # 4 [Hospital physician, NSW, Metropolitan, Catholic, < 5 years]

> We had to discuss abortion at University. I recall two students took the pro-life view. Whilst people questioned them in class, so much negative talk happened behind their back. These students were already ostracized before this, as they were strong, practicing Christians. A lot of talk behind their back was a complete refusal of their opinion because of their religion. Even their opinion based on biology was dismissed. They were ridiculed as being 'anti-science'. Unfortunately, in medicine, your reputation follows you everywhere. As a result, I am cautious about what I say about any politicized issues.
>
> Doctor # 12 [Hospital physician, NSW, Metropolitan, Catholic, < 5 years]

> I recall one guest lecturer in first year was particularly nasty, and ridiculed people who were pro-life. They inferred that the profession mainly held a pro-choice view, and it was a little less intelligent for a doctor to hold a pro-life view.
>
> Doctors # 24 [GP, VIC, Rural, Catholic, 5-15 years]

> I recall we had a lecture on abortion given by a gynaecologist from the Royal Hospital for Women. She put up some distorted slides on the historical obstacles to abortion and one was the Catholic Church. A colleague and I composed an email to her, expressing how disappointed we were in how she represented the Church … She generated a long response, and her tone was furious.
>
> Doctor # 26 [Hospital physician, NSW, Metropolitan, Catholic, < 5 years]

> In O&G, we had anti-Catholic lectures with rants from lecturers about what the Church was doing wrong in Africa and it didn't feel safe for me to say I had an objection, Even sitting in on consultations about abortion, or with referrals, many clinicians do not see these as moral issues. They say if you are not involved with the procedure or the patient, what's the problem? Are you being particularly sensitive? ... I've had doctors make jokes about my faith and for being part of a minority when controversial topics come up.
>
> Doctor # 30 [Hospital physician, VIC, Metropolitan, Catholic, < 5 years]

Catholic Universities were not immune from criticism from participants who had attended them and were disappointed there was not more support for their position.

> …I went to a Catholic university. Ethical issues were raised about one's role as a doctor, and issues like consent, but not about conscientious objection. We once had a panel to discuss abortion, but it was quite soft. I felt the lecturers were nervous and worried about offending students. You could feel the nerves of the people on the panel. You need an alpha dog on the panel.
>
> Doctor # 1 [Hospital physician, NSW, Metropolitan, Catholic, < 5 years]

> I attended a Catholic medical school and was in a lot of classes where you want to talk about these issues, but the vast majority of teachers do not encourage the traditional Catholic view. Some are quite aggressive about their opposing view…
>
> Doctor # 4 [Hospital physician, NSW, Metropolitan, Catholic, < 5 years]

More experienced participants were not immune from hearing negative comments. Worth noting is the experience of doctor # 10, a rural general practitioner from New South Wales with greater than 15 years' experience. Identifying as a Catholic, this participant made the decision to cease referring patients for abortion or prescribing hormonal contraception after having provided these services to a rural community in the past. The backlash the partiicpant received came from an unusual source - the local Catholic priests.

> The lack of support from the parish, and the censure of the priests, upset me. The first of the two priests called me a 'fundamentalist Christian'. I felt off loaded by him. It didn't change my faith at all, or the belief that what I was doing was right. The second of the two priests accused me of taking religion into

> the surgery. He told me he had heard complaints about me from parishioners and that I had to 'answer [my] critics.' He used to scoff at me and make little jibes.
>
> Doctor # 10 [GP, NSW, Rural, Catholic, > 15 years]

6.6.1.2 FEAR OF REPRISALS

Fear is the unsettling of the soul. Its power resides in the person's belief that he or she cannot overcome the evil. The less experienced participants who experienced negative comments also reported a fear of reprisals. Specifically, they feared negative impact on their career occasioned by superiors who are open about their low opinion of doctors with a conscientious objection to abortion. Not having established themselves in the profession and with only personal keenness to offer, their response to this fear was to choose silence.

> There are a lot of people in medicine, from my cohort at university, who agree with me, but won't say anything. But one thing you feel in medicine is the hierarchy and the power gap. It is very competitive for jobs. Your opportunity to get into a training program depends upon your references. You never want to say 'no, I can't do that', or 'I don't want to be involved' because it looks weak. The sense is that to get where I want to be, I have to do this … you don't have a lot to offer other than keenness.
>
> Doctor # 1 [Hospital physician, NSW, Metropolitan, Catholic, < 5 years]

> At University, you don't have any power to speak out against it. There is an expectation that everyone will practice as per the consensus. It is not even raised by the lecturers or tutors that there might be people who believe differently. I felt like there was no point in speaking out …I was concerned about how the law would affect my practice. At that time, I did not know many doctors who had the same beliefs as I did and who could give me the confidence to practice in line with my beliefs. Having to speak out to supervisors made things more difficult. I was concerned about how it would affect me as a junior doctor … I thought being a GP would be easier, but we are at the forefront of life issues. When I applied for the training program, I did not disclose my objection in interviews because I thought it would have a negative impact on me. I decided to handle the situation when it arose, although I didn't have a plan about what I would say.
>
> Doctor # 23 [GP, VIC, Metropolitan, Catholic, 5-15 years]

> I am a Resident Medical Officer in obstetrics. I didn't disclose my objection before I started the rotation for fear of reprisals. I wanted to wait and give myself enough time to show I was a conscientious worker and a good practitioner.
>
> Doctor # 26 [Hospital physician, NSW, Metropolitan, Catholic, < 5 years]

> …people with my views choose silence because they are afraid of the consequences. It's not because the overwhelming majority of doctors are anti-Christian, but those who are, really are, and are vocal about it, and angry with people who hold my views…. Joining medicine is like joining a club. They pick you on your personality as well as your skills. It is a very social profession…. When they are picking someone to join them, they say: 'Who do I want to spend the next 40-50 years working with?' and that influences their decision when they interview you … People don't push these issues much as they don't want to be known as 'the weird Catholic guy' that makes the job just that little bit harder because he won't do those things.
>
> Doctor # 30 [Hospital physician, VIC, Metropolitan, Catholic, < 5 years]

> I've never really expressed my views on abortion outside of people who share my beliefs because of fear …knowledge of a doctor's position on abortion could very easily be abused. I have a fear of not being able to practice medicine because of my beliefs.
>
> Doctor # 32 [Hospital physician, VIC, Regional, Catholic, < 5 years]

One Victorian participant did report having the courage to speak up at university. At the time when the *Abortion Law Reform Act* was being debated, and emotions were running high, they describe their experience below.

> I actively opposed abortion law reform when I was a medical student at University, and I was bullied for it …I would regularly say things in class to remind lecturers that not everyone agreed with abortion. … The lecturers would usually just look at me, listen to what I said, and then dismiss me and keep talking. The rest of the class was just quiet …I was scared to speak up and I shiver in my boots every time I do it, but God is my God, and someone has to speak up for these babies' lives … I talked to the few other students I knew were like-minded, but they said they were too scared to speak up. However, they did stand with me when I had to give a speech against the law and a couple came with me to a pro-life march during the debate on the law and held a banner that identified as 'student doctors' … Being the only medical students willing to speak up made me feel very isolated. I had to fight against depression, especially when I started to get hate mail. All my supervisors were pro-abortion.
>
> Doctor # 18 [Hospital physician, VIC, Metropolitan, Christian, 5-15 years]

More experienced doctors have the advantage of having more to offer employers and colleagues. Whilst they still might experience fear of reprisals, their reaction to the fear differed to that of the less experienced participants in that they did not choose silence. Their mentality was that they were willing to lose opportunities in order to practice medicine in line with their beliefs. To act as a contrast to the quotations from the less experienced participants, verbatim quotations of experienced participants follow:

> I sought advice from a Catholic priest who does not beat around the bush. He encouraged me not to be cowardly and helped me see that my supervisor's biggest fear would be that I would have no fear. I went away from that meeting feeling two inches taller and feeling that there was nothing illegal about what I was doing …I think it may well take a few doctors going to jail for the absolute injustice of this situation to be highlighted and tested in court. I have to steel myself to be that doctor.
>
> Doctor # 3 [GP, NSW, Metropolitan, Catholic, 5-15 years]

> I believe we need to be integrated and have unity. I believe my private life should influence the way I practice medicine. I cannot be two different people … My background and personality are not as someone who insists upon their rights. I do what I need to do, I don't like confrontation, but also I have never cared what other people think of me.
>
> Doctor # 5 [GP, NSW, Metropolitan, Catholic, 5-15 years]

> I had other consultants saying things to me like, 'Others are sharpening their knives out the back.' In a way, this reaction stimulated me. If there is a fight to be had on matters of principle, I tend not to consider what I have to lose. I strongly believed in and was convinced of my position and if they were prepared to get me over an ethical point, I would be up for that fight.
>
> Doctor # 11 [Hospital physician, NSW, Metropolitan, No religion, 5-15 years]

> …I raised an objection with the scheduling officer and told her I don't participate in abortion. For me, I was not particularly worried about having this conversation because I was prepared to walk away from the job if they did not accommodate me. I had thought it out beforehand and I knew that I would stand my ground if I were challenged.
>
> Doctor # 20 [Consultant, NSW, Metropolitan, LDS, > 15 years]

> … people don't usually mess around when you take a strong stance, unless a lot of people find out about it. It's when you are wishy-washy that you get problems.
>
> Doctor # 29 [GP, NSW, Metropolitan, Catholic, > 15 years]

The reader may ask whether less experienced participants' fears are reasonable, or whether their fears are merely the result of a weak will. According to Aquinas, fear must be regulated by reason. How does the fear manifest? Does it have an internal cause, which reflects a person's actions, or an external cause, where the threat is far greater than the individual can overcome?[220] Legitimate fear requires the possibility that the threats associated with it can be executed and are likely to be executed.

[220] Thomas Aquinas, *Summa Theologiae, Volume 11 Man (Ia. 75-83)* (Cambridge University Press, 1966) 22-48.

At the time of the study, New South Wales doctors did not have a statutory duty to contend with such as those contained within the Victorian *Abortion Law Reform Act*, but they did have professional obligations which meant that doctors often paid a price for speaking up, disclosing their conscientious objection to abortion, and pressing superiors for a reasonable accommodation. Doctor # 11, a hospital doctor from New South Wales who found opposition by superiors to their conscientious objection "stimulating," reveals the consequences of displaying courage.

> I was able to finish my general practice training, although I felt anxious and nervous. You don't enjoy turning up to work when you are in a hostile environment. I had a reason to fight the good fight, but I didn't particularly enjoy turning up to work. I was nervous about what was going to happen to my job and having to find alternative employment. My relationship with people around me was not damaged, but I did feel I was seen differently. However, when I did leave, my supervisor thanked me and said they learned so much from having to deal with this issue of conscientious objection.
>
> Doctor # 11 [Hospital physician, NSW, Metropolitan, No religion, 5-15 years]

To date, no doctor in Victoria has been successfully prosecuted for breaching the statutory duty in section 8 of the *Abortion Law Reform Act 2008* for failing to refer a patient seeking abortion to a non-objecting doctor or failing to perform abortion in an emergency to preserve the mother's life. On this basis, doctor # 14, a general practitioner from Victoria who does not refer or provide information on where to obtain abortion, no longer fears prosecution by the medical regulator. Importantly though, the participant noted the law continues to intimidate doctors who oppose abortion.

> Over the ten years, I started off very cautious. I did not want to get into trouble. The way you get in trouble is if someone makes a complaint to the regulator, i.e., the Medical Board of Australia. I have become less paranoid with the passage of time. If you are sensible, and civil about things, they are not going to complain about you. It is only someone with an agenda who might make a complaint, and normal people don't have an agenda. If someone comes in to talk about an unwanted pregnancy, there is no doubt that even now, it would make me vigilant, a bit anxious. I would be very careful what I said, I would monitor myself to play my cards right, and not do anything that might put myself at risk. In the early days, I was terrified about it. Younger and less experienced, with the prospect of being prosecuted for breaking the law, I was very frightened. I recall saying to a few people requesting abortion in the early days: 'Are you sure you are not going to regret it?' I felt this conversation was risky. Even saying this is a thought crime. But if you care about them as a person, it's the right thing to do. It (abortion) is not something that anyone should take lightly. I think this whole thing is designed to get in the way of dissuading anyone from having an abortion or encouraging them to re-think their decision. This law is

> like the 150-meter zone around clinics to stop people re-thinking this. But now, I've realized it's not actually likely that someone will complain about you. I am not very afraid about being prosecuted because I think a complaint is unlikely to be made by a patient. And I don't think they would have the grounds (or the nerve) to actually de-register anyone over this. I believe section 8 exists primarily to intimidate, not to be enforced.
>
> Doctor # 14 [GP, Victoria, Metropolitan, Christian, 5-15 years]

Of course, the fact there have been no successful prosecutions of conscientious objectors to date does not rule out some in the future. As doctor # 23, another general practitioner from Victoria who does not refer for abortion, notes:

> I feel insecure about the mandatory referral law as it has not been tested. It's still up in the air about how it would be challenged in court.
>
> Doctor # 23 [GP, VIC, Metropolitan, Catholic, 5-15 years]

Finally, doctor 31, a consultant from Victoria describes the impact of the Victorian law and its ambiguity, as creating a fear of the unknown that can have significant consequences on how doctors with a conscientious objection to abortion.

> The point of the *Abortion Law Reform Act* was to make prolife doctors abandon the field. In a sense it's a toothless tiger, but it could still operate to cause harm, we just don't know. It has created a climate of fear, a fear of the unknown and the possibilities. The legislation is so vague, and this made doctors scared. How do we know whether someone has a conscientious objection to abortion? What is an 'emergency abortion'? Who can make a complaint about a doctor? It could be a witch-hunt. I know doctors who stopped practicing after the Act came in, or who stopped seeing certain female patients for a while or went interstate."
>
> Doctor # 31 [Consultant, VIC, Metropolitan, Catholic, > 15 years]

As the reader will see in the next section, the regulator can, of its own motion, raise a complaint against a doctor for failing to refer, even where the patient does not suffer loss and even where the patient continues to consult with the doctor who is the subject of the complaint.

6.6.1.3 COMPLAINT

Eight participants had been the subject of a complaint, either formally to the regulator, or to their employer or supervisor due to their conscientious objection to abortion. A selection of incidents is extracted here, with a summary of each incident and where appropriate, a verbatim quotation from the interview to express in the participant's own words how they felt about the incident, the process, and the outcome. Whilst one incident clearly raised the ambit of Victoria's mandatory referral legislation, other incidents occurred in New South Wales when there was no statutory duty to refer at the time of the interview.

For doctor # 19, a general practitioner from Victoria, a patient requested a sex selection abortion at an advanced stage of pregnancy. The participant refused and the patient accessed abortion elsewhere but returned to see the participant for other matters and in doing so, provided the participant with the letter which confirmed an abortion had been performed and who performed it. The participant felt compelled to report the abortionist to the Medical Board. Whilst the Board did not believe the doctor who had performed abortion had broken the law, the doctor was ultimately, de-registered for other behaviour.

The Medical Board commenced its 'own motion' and investigated the participant for failing to initially refer the patient for an abortion in line with Victoria's law, and for the participant publicly stating his or her refusal to refer. Whilst the participant received a caution only, and not a finding of professional misconduct, the incident took up to a year to resolve and involved money, time, and stress for the participant. The participant was disappointed with the lack of support from key medical groups like the Australian Medical Association and the College of General Practitioners.

> I did toss and turn, had difficulty sleeping at night. I did question myself and ask, 'Am I doing the right thing?' It totally dominated my thinking for a year or more. I didn't get depressed or anything. I had good support from other doctors I knew, but I lose income. I lost money out of my pocket for lawyers, and I spent a lot of time at meetings.
>
> Doctor # 19 [GP, VIC, Metropolitan, Catholic, > 15 years]

Doctor # 26 from New South Wales refused to insert a cannula into a patient to affect a late term abortion for foetal disability. Communicating by text with his or her supervisor, the participant refused on the basis of a conscientious objection to participating in the abortion. Told again to cannulate and take blood, the participant held the line with their objection and eventually their supervisor attended the ward to insert the line. A few hours later, the participant was in a meeting with the head of the department, whom they recalled made the following comments in words to the effect of:

> Do you know why you're here? I've been told by consultants and registrars that you are judgmental, opinionated, arrogant, and disrespectful, and that you are refusing to do simple jobs like cannulation, and that you think you know better than consultants …Putting in a cannula for termination will not stain your soul! At your level you are simply a service provider … if you refuse to put in a cannula for any patient, you are not doing the work you are paid for…for now you must work for your consultant and not contravene their decisions for patient care. We don't do social terminations here. The consultant has counselled this patient for a couple of weeks, and they've seen a social worker. It is a sensitive issue and how dare you come in and contravene their choice.
>
> Doctor # 26 [Hospital physician, NSW, Metropolitan, Catholic, < 5 years]

The participant had not previously disclosed his or her conscientious objection to abortion before undertaking their rotation to obstetric and wanted to wait until an incident arose. The incident shocked the participant, who felt emotional and misrepresented. Interestingly the participant also felt some peace as a result of the incident, because 'unlike my experience at medical school, my conscientious objection is now out on the table.' Ultimately, doctor # 26 failed their rotation in obstetrics, because he or she was deemed unreliable when it came to cannulation and blood collection for 'high risk' patients.

> I experienced sleeplessness. I had flashbacks. It was big news on the ward. Everyone knew and some registrars changed their attitude towards me. The registrar involved in the termination case refused to speak with me again …I'm not in a very confident space right now. I'm wounded … I don't feel like I can trust anyone …I cannot make a complaint about what happened to me. I don't think making a complaint about the Head of Department would stop the problem at my hospital. The ramifications for me would be wide reaching particularly as I need to do an obstetric placement for another year at least in order to qualify as a GP-Obstetrician.
>
> Doctor # 26 [Hospital physician, NSW, Metropolitan, Catholic, < 5 years]

As has been explored above, in this study, a conscientious objection to abortion was more often than not accompanied by a conscientious objection to prescribing hormonal contraception. For those participants, the two objections were rationally intertwined on the basis that hormonal contraception has the potential to act as an abortifacient and terminate human life. Some general practitioners had complaints from patients for declining to prescribe the pill, and on one occasion the participant was on the receiving end of a formal complaint from another doctor.

For doctor # 10, an experienced rural general practitioner from New South Wales, a complaint was made against them by another doctor to the Royal Australian College of General Practitioners. The complainant was a registrar who had come to do their training with the participant's medical practice. The basis of the registrar's complaint was that the participant was not qualified to teach due to their conscientious objection to prescribing hormonal contraception. The complaint, however, did not proceed due to intervention from someone in the College who defended the participant.

For doctor # 3, a general practitioner from New South Wales with a conscientious objection to abortion and other related services such as hormonal contraception, sterilisation, and referral for in vitro fertilisation, the participant had secured acceptance of their conscientious objection from their employer. If patients did request these services, the participant would declare his or her objection, offer to discuss other options, indicate that other doctors might help, and not bill the patient. However, complaints by a few patients to their supervisor about their objections led to meetings with supervisors.

> My supervisors accepted that I had a conscience, and verbally said they had no problem with me acting in accord with my conscience…A few patients complained about this and that led to lots of meetings and interventions with my supervisors…I was brought before the two supervisors. They told me it was not so much whether what the patient said was true or not, but it was more about the impression it left, they were more concerned about complaints on social media rather than the notion of truth. I left this practice and joined my present practice.
>
> Doctor # 3 [GP, NSW, Metropolitan, Catholic, 5-15 years]

For doctor # 32, an incident occurred when the participant was a medical student, employed as a blood collector. Involving a conversation, the participant had with a patient they were taking blood from for a Down syndrome screening, the participant asked the patient whether she had spoken with her general practitioner about what the test meant. The participant asked this because he or she understood that women are often not informed about what the test is for. The patient seemed confused about the test, and the participant ended the conversation with 'Down syndrome children are children too.'

Whilst the participant believed the patient was content to have the conversation with him or her and seemed to agree with them about Down syndrome children, the patent made a complaint about the participant. On the same day in a separate incident, the participant asked a colleague to take a semen sample from a patient, as they were not comfortable with it. The participant was asked to attend a formal meeting with the participant's direct supervisor and two other people from the hospital about both incidents. Ultimately, the participant was severely reprimanded for unprofessional behaviour.

> I was so worried about how this might impact me for future employment at the hospital as a doctor. So, I spoke with a Professor of Medical Ethics. He was disgusted with what happened to me and wrote an eight-page letter to the hospital in support of me that was placed on my file. On reflection, perhaps it was imprudent for talking to the pregnant patient that way, but it did not justify the severity of the punishment I was given by the hospital. I was taken aback and disgusted with the hospital, which was a Catholic hospital. Years later, I still feel angry because they have the wrong idea about ethics yet think they are right …
>
> I am indignant and angry and that is a problem in itself. I have really withdrawn from talking about this stuff at all. It's not because I don't want to lose my job, but because I think it's unprofessional for doctors to get emotional….
>
> I felt abused by this incident. Conscientious objection does hurt and the worst thing that can happen to a conscientious objector is actually questioning why I object and the whole point of it all. Aside from that, if fools can object to a blood transfusion, then what is the weight of my argument in society? If you look at it rationally, what is conscientious objection if there is no solid moral platform where one group thinks there is a problem with blood transfusion, but others don't? I agree with the fact that if I want people to respect my objection, I have to respect theirs. But have we ruined it for ourselves by using that term to describe things like objecting to baking a cake for a gay wedding?
>
> Doctor # 32 [Hospital physician, VIC, Metropolitan, Catholic, < 5 years]

6.6.1.4 Loss

For four participants, their disclosure to their employer or supervisor of their conscientious objection to abortion led to the loss of their job or denial of an offer for placement in a training program. For doctor # 5, a general practitioner from New South Wales, the disclosure of his or her conscientious objection to abortion, prescribing artificial contraceptives and sterilisation to the participant's supervisor occurred when the participant commenced training as a general practitioner. The response from the supervisor was that this was fine, and that the supervisor would try to work around this.

Unfortunately, after a few incidents where the participant declined to perform those services and several patients were apparently upset, the participant was asked to leave the training program notwithstanding he or she had only six weeks before the term ended. The participant's response was as follows:

> I took the view as a trainee, I was transient, and that this practice was their livelihood. The main partner was a Protestant Irishman, and he took exception to my views. I took the view that as I as training as a registrar, they were doing me a favour by providing me with training. I was not pulling my weight or carrying my share, so to speak. So, I perceived a difference in this context than if I were an employed doctor in the practice who was asked to leave.
>
> Doctor # 5 [GP, NSW, Metropolitan, Catholic, > 5 years]

For doctor # 8, another general practitioner from New South Wales, the participant disclosed his or her conscientious objection to abortion, prescribing hormonal contraceptives, and sterilisation to a representative of the College of General Practitioners. When the participant was informed that he or she needed to do an obstetrics and gynaecology term, the participant stated that he or she did not want to be involved in organising drugs or procedures that involved abortion. The participant was worried that in disclosing their objection he or she might not be able to qualify as a general practitioner.

After several trouble-free placements where the participant was able to decline participation in abortion, the participant was required to complete a six-month stint in an inner-city practice. The participant was interviewed and was told he or she was accepted, but at the conclusion of the interview the participant disclosed that an inability to participate in euthanasia or any abortion procedures including referring for abortion. The participant was then asked if he or she would help lesbian couples with artificial insemination. When the participant said no, the offer of employment was withdrawn.

> The doctor contacted the College and said that they would not employ me. I contacted the College independently and was told I would have to wait six months for the next round of offers. I felt very strongly that I was being directly discriminated against because of my conscience and ethics as a doctor, where not wanting to be involved with the killing of innocent human beings, or with assistive reproductive technology, could potentially conflict with my religious beliefs. At the time it was very upsetting, but I still hoped I could work in general practice where there as not pressure from senior medical colleagues to be involved in those activities.
>
> Doctor # 8 [GP, NSW, Metropolitan, Catholic, > 15 years]

For doctor # 21, a consultant from New South Wales, the participant was denied a placement as a registrar in public hospitals because at the time, public hospitals were performing first trimester abortions. As consultants did not want to have to perform the abortions themselves, abortions were left to the registrars.

> When I graduated, I was told that there was no place for a registrar who would not do terminations in a public hospital … The hospital I applied to made it clear to me that it was not amenable to registrars being on their scheme who would not participate in first trimester terminations. I tried a few other hospitals and realized there was no point in applying, so I chose to go overseas and work in countries where it was not an issue.

On their return to Australia, with enormous experience dealing with obstetric emergencies without resorting to abortion, the participant applied again for the training programs. Whilst he or she initially experienced the same push back as before, the participant was accepted on the basis that whilst he or she continued to have a conscientious objection to abortion, the consultants would be better off knowing that they could sleep all night knowing that the participant would attend to the complex cases, as there were more than enough registrars willing to do terminations.

For doctor # 22, a general practitioner from Victoria, their conscientious objection to abortion proved problematic in general practitioner training. On the whole, the participant found the whole process to be stressful and anxiety provoking. Reasons proffered to the participant for not being offered a placement included that it was not practical, or it was too challenging to accommodate this type of objection. In one instance, the participant was told they would need special training for what was described as the participant's 'problem'. So the participant did not explore the opportunity further.

For doctor # 6, a general practitioner from New South Wales, the participant did not suffer provable loss but believes his or her conscientious objection was the reason for not being asked back to manage a medical team for a television company overseas. Doctor # 6 refused to prescribe the 'morning after pill', which was a common request on the trip. The participant disclosed the objection to their team, and then asked the company not to force him or her, or their team, to act against their personal ethics. The request got back to the participant's employer who had to tender for the contract, and the participant was never asked back again.

For doctor # 7, a consultant who had refused to assist at abortion in the operating theatre on a number of occasions and refused to refer patients requesting hormonal contraception to other doctors the participant knew would prescribe it, he or she was led to believe by colleagues that certain doors had been closed to the participant on the basis of their Catholic religion. The participant was accepting of this situation.

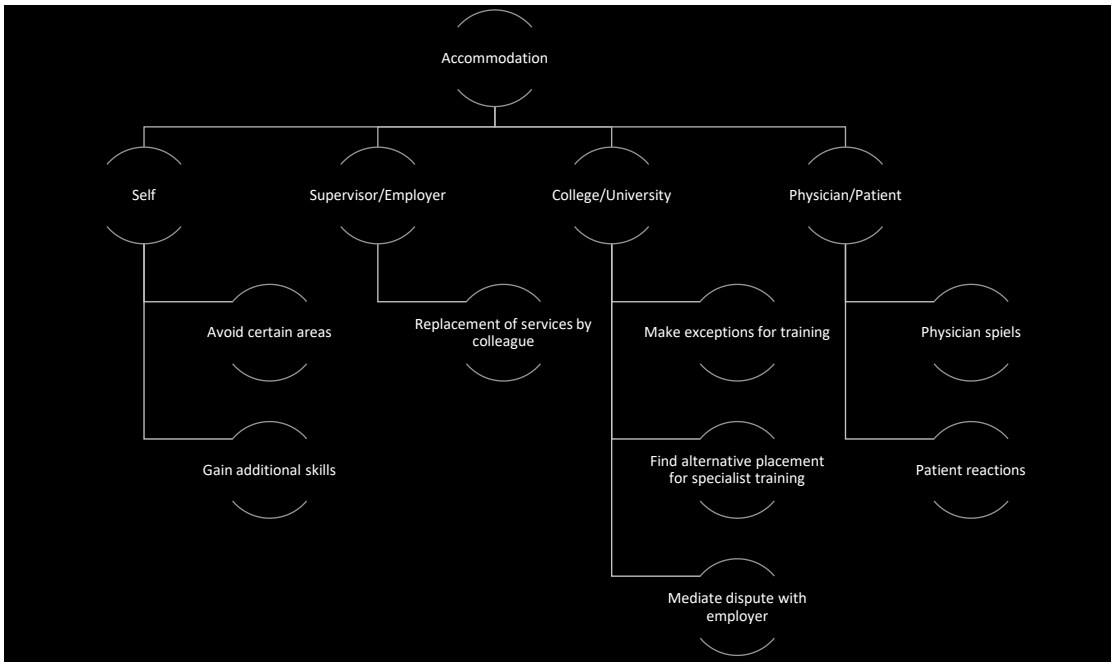
> I have been told through the grapevine that I would never get a job as an Intensivist at a particular tertiary hospital because I was 'too Catholic'. When one door closes, another opens…
>
> Doctor # 7 [Consultant, NSW, Metropolitan, Catholic, > 15 years]

The next theme focuses upon successful accommodation of conscientious objection to abortion. Given the study was open to doctors in a variety of specialties and geographical locations within New South Wales and Victoria, the reader is able to not only consider alternative means of accommodation that are worked out informally by participants with themselves, patients, employers and Colleges, but be informed about the particular contexts in which conflict arose in the first place, and therefore reflect upon the usefulness of a policy or law that provides a 'one size fits all' solution.

6.6.2 ACCOMMODATION OF CONSCIENTIOUS OBJECTION

Whilst the study has detailed fears about reprisals and actual reprisals, this theme focuses upon successful incidents of accommodation of conscientious objection to abortion. Whilst some requests were well received, others came at the price of awkward and painful exchanges where the participant experienced stress and anxiety. The factors present in achieving accommodation will be noted. The sub-themes will focus on the actors involved with achieving accommodation; the participant, the participant's supervisor/employer, the College of University, and the patient.

Figure 6: Theme 6 - Accommodation of Conscientious Objection



6.6.2.1 SELF-ACCOMMODATION

For a number of general practitioners, conflicts arising from their conscientious objection to performing or participating in medical or surgical abortion was a secondary concern compared to their objection to prescribing hormonal contraception. This is because the latter is a more common request in general practice, but the objection is less understandable by most people. As noted earlier, as the basis of their objection to hormonal contraception is merely an extended application of their objection to abortion, this study includes it when considering accommodation.

Several participants working in group practice secured additional training in natural family planning so that they can offer alternatives to patients and the practice. In this way, they are still seen as pulling their weight. None had an issue with working with colleagues who do refer for abortion or prescribe hormonal contraception.

> … in the medical community, whilst doctors understand that some won't refer for abortion, it's almost unheard of for a doctor to refuse to prescribe contraception. I became interested in napro technology, which helps couples with infertility and people wanting to avoid conception naturally and was able to move into another position where I could offer it as an alternative to artificial contraception for family planning …The other doctors are supportive if me because I don't just say no, I offer the alternative of napro technology.
>
> Doctor # 23 [GP, VIC, Metropolitan, Catholic, 5-15 years]

As discussed in previous chapters, the burden on patients to locate another doctor is often raised in the academic literature as a 'public health' justification for compelling doctor in rural or remote areas to either act against conscience or be denied job opportunities. Whilst acknowledging the 'inconvenience argument', the premise that abortion is the termination of human life is a premise that is in dispute and an inability to genuinely accept this before considering the relative burdens, is deeply problematic. The concerns of participants are set out below in selected quotations.

> In an extremely remote and rural area, people usually have the same access to information as in a metropolitan and city area. I have worked in a small country town for twelve months, where people could find their way to what they needed through word of mouth, or the yellow pages, or Google. There is no restriction on abortion clinics advertising themselves. The only barrier in remote or rural areas might be cost, and a GP cannot solve that for you … In real life, if a pregnant woman could not get a timely abortion because of geographical location, that sort of thing is extremely rare, and you cross that bridge when you come to it. If your ideological opinion is that abortion is a human right, then if you are in a rural location, you need to make medication more accessible to people, but they cannot force doctors to do this. In a state like Queensland, they might say that if you're somewhat remote then you are obliged to refer to someone like Dr. Caroline de Costa and you have to get them to there before nine weeks. But it creates a law that binds everybody, including people who work in the city. The law is a blunt instrument to solve a problem that affects a small proportion of the community. They would be making a law based on exceptional circumstances that every doctor has to abide by and can be disciplined about.
>
> Doctor # 14 [GP, VIC, Metropolitan, Christian, 5-15 years]

For participants who, unlike doctor # 14, have a conscientious objection that extends to hormonal contraception, additional inconvenience applies. As doctor # 23 noted above, it is more difficult for the community to comprehend and be sympathetic towards this objection than it for them to accept an objection to abortion. These doctors display a more conciliatory attitude to accommodation. This does not include them referring for abortion or prescribing hormonal contraception. Rather, it includes them removing themselves from job opportunities in certain situations.

> As a rural physician, I cannot practice in ultra-remote areas. I have worked as a locum in remote Australia, and it was difficult. The biggest difficulty has been with a conscientious objection to prescribing contraceptives… … In a one-doctor town, I have to consider what refusing certain services that are wanted by the community is appropriate …If I had prior knowledge of the community's health needs, and they went against my beliefs, it could affect the community. If there were a complaint, it would affect my reputation.
>
> Doctor # 6 [GP, NSW, Rural, Catholic, > 15 years]

> In regard to rural area, I don't think I could put myself up to work in those area. The Medical Board clearly states that doctors should not act in ways that impede access to legal treatment. I have thought about practicing in a rural area. I loved my training in rural medicine, but I would have to visit the area, introduce myself to the people, disclose my objections and if it were a problem, I would not take the position.
>
> Doctor # 6 [GP, NSW, Metropolitan, Catholic, 5-15 years]

> If I were a female GP and were being asked by patients to prescribe the pill ten times a day, your boss would not be happy with you. There may be an implication for the practice. Once they hire you, things can get messy, as it might be seen as discrimination, but I can understand a Principal saying that they are not able to let the doctor only see old male patients to avoid the situation if the practice is filled with young women. It may fall to the doctor with the objection to find another situation.
>
> Doctor # 24 [GP, VIC, Rural, Catholic, 5-15 years]

For doctor # 31, a consultant from Victoria, self-accommodation of their conscientious objection means only doing obstetric anaesthetics in Catholic hospitals. However, for an anaesthetist, issues can arise with not just surgical abortion, but with inserting intra uterine devices that have an abortifacient action. Additional effort and action on their part is needed to try and avoid co-operating in wrongdoing.

> I only do obstetrics at Catholic hospitals. Occasionally there are problems with managing the list. When I work in private hospitals, I do not offer to do obstetrics and gynaecology cases … For insertion of an IUD like the Mirena IUD, which can be used for other purposes, I look at the age group of the patient on the operating lost. If a 19-year-old is having a Mirena inserted, I clarify the reason for this and I might decline to do the anaesthetics if it is for contraception.
>
> If I was not aware that a patient was having a vasectomy, and I know that declining to be involved has a big impact on the patient and the surgeon, I will explain my objection to them and know that I am not going to work with them again. However, if the person has booked a holiday and has to come back for the surgery, as there is no other anaesthetist to fill in at short notice, and the impact is significant, I will weigh all that up and decide whether I will do that list. I feel that I am somewhat removed. I make the distinction between formal and material co-operation in evil. I organize my practice to avoid this. I choose who I work with, and which hospitals I work at. If I don't know who is doing the list, I will look at the area of practice, so if it is orthopaedics there is not going to be a conflict, but there might be with a surgical, urological, or gynaecological list. That is the reality and the cost of the position I have taken."
>
> Doctor # 31 [Consultant, VIC, Metropolitan, Catholic, > 15 years]

For the general practitioner working in a group practice, or the doctor training in a hospital, there is no real opportunity to self-accommodate for their conscientious objection. As the objector lacks the authority to unilaterally make changes in order to avoid certain work, they look to their supervisor or employer to understand and respect their objection and work with them to achieve mutually acceptable accommodation. This may also involve input from the College or University involved with any hospital-based or general practice-based training.

6.6.2.2 SUPERVISOR/EMPLOYER

Doctor # 22, a general practitioner from Victoria, achieved accommodation of his or her conscientious objection to abortion, but only after prolonged discussion with the participant's supervisor. Suggesting the participant treat any referral for abortion like a request they do not know how to manage, the supervisor suggested the participant tell the patient they needed to speak to their supervisor who would prepare the referral, and the participant would handle the referral to the patient. The participant refused on the basis that this would still involve the participant's direct participation in abortion.

The participant told their supervisor that such a plan could raise legal concerns given the supervisor had not personally examined the patient before writing the referral. The participant offered to inform the patient that other practitioners in the practice provided referrals for abortion and invited them to see another doctor. The supervisor declined this offer, saying the participant was using their conscientious objection to impede access to a legal service and they did not want patients feeling uncomfortable or inconvenienced.

Ultimately, the supervisor agreed that the participant would explore options with patients requesting abortion, and then the patient would consult with the supervisor. Harking back to an earlier issued raised by other participants, is the importance of doctors being able to talk and consult with patients about abortion notwithstanding the doctor's conscientious objection to it. Here, the participant did not want to close off seeing these patients but wanted the opportunity to properly consult with them and ensure that the patient was aware of all options. The process took its toll on them.

> I found the whole confrontation very stressful. In addition, she accidently copied me into e-mails she sent to the association. I learned that she had not had to deal with a trainee who had a conscientious objection to abortion before. She told them I was only there for six months, and her patients would be there a lot longer and she did not want staff copping a blast at the front desk. Learning about this made me feel small. I found this out in the first two weeks of the [six months] placement … I found the whole training period distressing, anxiety-provoking, and de-moralizing to the point where I had to take a couple of weeks off work.
>
> Doctor # 22 [GP, VIC, Metropolitan, Catholic, 5-15 years]

Doctor # 24, a general practitioner from Victoria, provides a contrast to doctor # 22, in that the accommodation the participant achieved was with their employer and did involve the supervisor preparing a script for hormonal contraception without having seen the patient themselves. The reader will appreciate that doctor # 24 seemed to have a better relationship with their supervisor than doctor # 22. Whilst this strategy for achieving accommodation was deemed acceptable by doctor # 24, it is clear he or she would have preferred not to have to do this.

> I don't prescribe abortifacient contraception. I refuse to do that and it's very problematic in general practice. Prescribing contraception is a touchy subject for doctors with a conscientious objection. There basically three ways of dealing with it; you can put up a sign and avoid dealing with it; you can deal with it discretely by getting someone else to write the script; or you just prescribe it …I have a discrete arrangement with my supervisor. I consult with the patient and then excuse myself to see my supervisor. He trusts me regarding the information I have taken from the patient, and he writes up the script. I go back to the patient and hand them the script. It's making the best of a bad situation…
>
> Doctor # 24 [GP, VIC, Rural, Catholic, 5-15 years]

Contrasted with these general practice examples, is the hospital doctor in the operating theatre, where it is not a person seeking a referral or a script, but rather an abortion being performed and the doctor co-operating proximately and directly in the act of abortion. Doctor # 18, a hospital doctor from Victoria, explains some of the practical problems of working in a hospital and having an abortion procedure sprung upon him or her in the operating theatre, but how the participant nonetheless displayed courage, disclosed their objection, and sought an accommodation.

> When I did my obstetrics rotation, I had a supervisor who performed abortions, and this made it very awkward. She would ask me why I believed what I believed. When I first had to attend surgery, I was concerned about observing an abortion with surgery, you don't see the list until you get there, and they use a special code that says 'D&C.' Dilatation and curettage is a procedure performed for a lot of women who are not having an abortion, such as for fibroids or heavy periods. It's not until the surgery is being performed that you realize the D&C is to remove a baby.
>
> As soon as I got into the operating theatre, I asked the nurse in charge whether there were any abortions on the operating theatre list that day. She said yes and then asked me why. Instead of answering her, I thanked her and spoke with the consultant. I had to have this conversation with him in front of other medical students. I hardly knew him, and I was terrified, but I asked if I could come to a different list because I did not want to observe an abortion.

> His response did not exactly put me at ease. He did not verbally assault me, but he gave me the 'what's wrong with you?' look on his face and ultimately said yes. It took a lot of guts for me to stand up and say that. I know so many colleagues who object to this stuff, but they don't exercise their conscience because they are afraid.
>
> Doctor # 18 [Hospital physician, VIC, Metropolitan, Christian, 5-15 years]

This problem in the operating theatre, coupled with the absence of any system for replacing a conscientious objector, is echoed by doctor # 7 a consultant from New South Wales. As a consultant, this participant opines on how the burden ought to fall on the consultant to organise a replacement, who ought not assume that all health professionals support abortion as standard healthcare, notwithstanding the position of the domestic law. The participant also highlights the hierarchy in the hospital system, and how it can just take one person to object to empower others to do the same.

> When I was doing anaesthetics, we had women coming in for a D&C (dilatation and curettage of the uterus). There can be problems if you don't remove human remains but sometimes the D&C is actually a termination. So, I would look on the list every day so I would not get caught out. One day I saw that a D&C was listed which was actually a termination, so I spoke with someone, and then some of the nurses did not want to get involved either. We objected and we were not forced.
>
> There is no formal system for replacing a person. As a junior doctor, I think it is for the consultant to organize any replacement. As a consultant, I would have no problem with this. I think things are in place, where a consultant knows their junior doctor is opposed to something, and that they cannot impose their beliefs on the junior. You do get the occasional jerk, who thinks they are completely morally superior on some issue and gives you a hard time.
>
> Administrators can be less sympathetic. Nurses have less protection than doctors. It is a very hierarchical system that is less regulated…I recall another occasion at a different hospital I was at, an abortion was on the operating list. Some others and I were told to assist. None of us wanted to do this. So, I told the consultant one would get involved and then I asked him if the abortion was legal and whether the patient had seen a psychiatrist, and if not, I would refer the matter to the HCCC. I was definitely nervous before I spoke up, but I talked to a lawyer friend of mine to make sure I had the law right. The consultant said: 'Just get over it … it's just an abortion, it's not a life…' one of the doctors and one of the nurses caved in and said that they would assist as someone had to. He did not force the rest of us."
>
> Doctor # 7 [Consultant, NSW, Metropolitan, Catholic, > 15 years]

Doctor # 34 highlights the practical difference in seeking accommodation when training in surgery or obstetrics, compared to anaesthetics. With the high number of anaesthetists available to offer replacement services at short notice, doctor # 34 felt far less fear or concern about seeking an accommodation from their consultant.

> …there are so many anaesthetists available that it is not such a problem to get someone to replace you. There have been a few occasions where a termination has been on the operating list. I went to my consultant and said: 'I'm not comfortable doing this.' They were fine and someone replaced me. I didn't know the consultant very well, but I didn't feel uncomfortable because I knew it wasn't a big problem. In anaesthetics, there are fewer egos, and you can move around a lot more than a surgeon, who works in specific areas. For a surgeon, it would depend upon the attitude of the boss on the day."
>
> Doctor # 34 [Hospital physician, VIC, Metropolitan, Catholic, 5-15 years]

Of interest, despite declaring that he or she does not agree with contraception, doctor # 34 was not prepared to seek accommodation for surgeries involving the insertion of intra uterine devices and implanon. The participant justified his or her involvement on a two-fold basis; first, that the partiicpant's objection to these services is not as strong compared to that of abortion, and second, that it was impractical and would cause disturbance.

> I don't think about it very much. The risks are different compared to abortion … I don't agree with contraception myself, but I have been involved with inserting implanon and other contraceptive devices, but the decision to insert these devices was already made by the patient and I don't feel I have the right to question what they are doing …Practically speaking, it's too hard to step out of those cases when you are training. Also, it can be done at the last minute without you being aware of that. The only way not to be involved with it is to cause problems and be disruptive. People would start questioning your reasoning and it would not be a procedure you could easily avoid in training. The only way to stop that process is earlier on when the patient was having the discussion.

Finally, doctor # 34 notes that if the person with the objection insists upon it, accommodation will be made, or at least an attempt will be made to address it.

> If you have a strong belief about a service, you have an obligation to minimize its impact on others … You should not put yourself in that predicament. However certain religious groups won't allow male doctors to examine them and so we find a female doctor in the department, and we will accommodate that. There are many reasons why a doctor will say they cannot look after the patient, you can even say it's for personal reasons and I've found that it will be accommodated. So, it's all about the context. I support accommodating objections where it is practical to do so.

6.6.2.3 COLLEGE/UNIVERSITY

For doctor # 1, a hospital doctor from New South Wales, clinical placements in general practice at medical school were a cause of great anxiety to the participant due to their conscientious objection to abortion and to prescribing hormonal contraception. The participant was placed in situations where patients were seeking advice about crisis pregnancy and abortion, as well as seeking a new script for the pill.

> I was very stressed here. I lost five kilograms. I was stressed about this issue and not knowing what cases would come through the door. Knowing that you are dis-empowered … These people are marking you. You might have to repeat the rotation, which would lead to more stress.
>
> Doctor # 1 [Hospital physician, NSW, Metropolitan, Catholic, < 5 years]

The partiicpant's fear of raising the issue was dispelled, somewhat, after a positive reaction from a supervisor following a patient consultation for abortion. The participant felt the patient was conflicted and would have gone immediately to an abortion clinic but for the fact the general practitioner knew the patient and her family. The participant felt the patient wanted the general practitioner to confirm that abortion was morally appropriate. One of the barriers to the participant raising their conscientious objection to this supervisor was how busy the supervisor was.

> It was hard to have a discussion with my supervisor about me being a conscientious objector as she was very efficient at seeing patients and as a result, she saw a lot of them and had little spare time. However, I felt strongly about it, and I broached the subject even though she was busy, and I referred to this particular consultation. I told her I was not comfortable getting involved. She was fine and said she did not get involved with abortions beyond nine weeks as they 'look like a baby' …I told her that for me, I needed to be able to go to sleep with the decisions I made in the day. As I said this, she seemed a bit surprised, like this was what she was struggling with, and then she agreed with me … This made me feel a lot less scared about expressing my opinion. Seeing a person who does abortion and feels uncomfortable with their position, I could see that I don't need to feel anxious about talking about it. However, it made my cynical about politicians who want all doctors to be comfortable doing abortions. They don't know what they are talking about. They have no idea about the psychological distress this would place on a lot of clinicians.
>
> Doctor # 1 [Hospital physician, NSW, Metropolitan, Catholic, < 5 years]

Doctor # 28, a hospital doctor from Victoria, recalled during his or her time at medical school, being placed in a women's health clinic where patients were given referrals for abortion. The participant did not disclose his or her conscientious objection to abortion up front, as the participant did not realise abortion would come up in the placement. The participant described an incident where a couple sought a referral for abortion from the supervisor. Lawful under Victorian law, the participant was perturbed at the perfunctory discussion between the patient and the doctor. The participant described his or her reaction as follows:

> I spoke with someone quite senior at the medical school and told them that I did not want to attend more sessions at the clinic. I told them I felt abortion was murder… I was asked to explain myself when I felt like I shouldn't have to. The reaction of the senior person was quite interesting. They were pushing me for answers. They seemed genuinely taken aback that I would have this position and actually remarked that everyone else participates in it. I was made to feel like I was the only person who had ever had this position on abortion. I had the impression they felt I might need psychological counselling and I couldn't help but see the irony. I was not the one needing the counselling but the woman who sought the abortion at the clinic did. Eventually they said they were happy to accommodate my objection and I was relieved of going back again.
>
> Doctor 28 [Hospital physician, VIC, Metropolitan, Catholic, < 5 years]

For doctor # 5, whose experience of being terminated from their trainee position in general practice for their conscientious objection to abortion and other related services was recounted earlier, the College found the participant another trainee position.

> The College found me another GP trainee position. Here, the Principal was older, an atheist, and he was fine with me having a conscientious objection. He said: 'I understand this. If there are any problems, leave the patient to me.' It was a different set up. At the first place, I saw patients on my own. As a sole GP practitioner, patients come to see you. In a larger practice, they come to see a doctor and it does not matter who they are. So, in this context, it was not a problem as I would be on my own seeing patients and upsetting them.
>
> Doctor # 5 [GP, NSW, Metropolitan, Catholic, > 15 years]

For doctor # 3, joining the general practice residency program was fraught with challenges in obtaining an accommodation for conscientious objection abortion and issues including hormonal contraception. When the participant's supervisor offered a 'partial' accommodation wherein the participant was told they had to dispense a subsequent script for the pill, but new patients could be referred to the supervisor, it was accompanied by the comment: 'Your faith stays at home … We have to train you, and you have to be exposed to all scenarios.'

Doctor # 3 enlisted the assistance of the general practitioner registrar's organisation that, whilst supportive of the participant's right to conscience, placed the burden on the participant to come up with a solution where a patient asks for abortion. The participant drafted a clause to be inserted into his or her employment contract and mediation was arranged with the supervisor and a locum from Medicare to try and resolve the issue and finalise the clause. The locum supported the participant, and the following is the final version of the clause:

> Dr. X. will not refer for termination of pregnancy, nor prescribe any therapy considered to be abortifacient, as a matter of carefully considered conscience. Dr. X needs to be fully cognizant of his ethical duty (as outlined in the Australian Medical Association's Code of Conduct) to inform patients that the above services cannot be rendered as a matter of conscience so that patients can make an informed decision.
>
> To address this, there will be a mechanism in place such that, patients requesting such referral will be informed by pamphlet or other confidential means that Dr. X is not in a position to refer for termination of pregnancy nor prescribe medications that would interfere with implantation of a fertilized embryo. These patients will be referred to other Medical Practitioners in the Practice or elsewhere. As in any case of life-threatening emergency due to pregnancy, Dr. X would naturally arrange to stabilize the patient and arrange emergency care and request for investigations at an appropriate tertiary hospital.
>
> Dr. X is aware that his status at this Practice is as an employee and a basic GP Registrar trainee. Under these circumstances, he is obliged to inform and refer patients to his Practice colleagues, including his Supervisor, if he is unable to manage them.

Whilst training as a general practitioner, doctor # 11 also experienced significant issues with achieving accommodation of his or her conscientious objection to abortion, and associated issues including hormonal contraception. The participant describes the elevation of his or her disclosure of a conscientious objection as a major issue in the training period to become a general practitioner. It involved multiple meetings with the participant's supervisor, and then the divisional head of the General Practitioner training program, to try and find a mutually acceptable solution.

> I didn't ask the GP practice to formally put a clause in my employment contract about accommodating my conscientious objection and the discussions were not reduced to writing. I didn't want to do that because I don't want to make an admission that I am an exception … It's not good for me to give assent to their position that I am different to everyone else and an aberration when my practice is a determination to stick to the practice of medicine and avoid others' distortion of medicine and misappropriating their knowledge and skill to issues outside of human pathology. I am practicing in line with what is good medical practice and good ethical practice.
>
> Doctor # 11 [Hospital physician, NSW, Metropolitan, No religion, 5-15 years]

Asked to display a sign listing all the services the participant objected to, doctor # 11 took advice from his or her medical indemnity insurer and declined on the basis that it was not patient-centred and collapsed the patient into one aspect of their health and denied the participant the opportunity to work on other health outcomes with the patient. Ultimately, when doctor # 11 informed the training program that the participant's legal advice was against displaying a sign, the supervisor and college accepted this, but still told the participant they wished the participant would refer.

> I told them I would never refer because to do so constitutes material cooperation. So, for patients who requested abortion or the other services I objected to, I would say something like: On that particular issue, I don't consult. I don't believe it is medicine.' Then I would explain my reasoning about what acts are within the bounds of what a doctor's training entitled them to consult on. I would usually say something like: 'I respect your right to request this, and I accept that you may request it elsewhere, but I want you to mutually respect my right not to refer." I found that patients were quite satisfied with this. I would then immediately see if there were medical issues, I could assist them with. Any patients I had a difference with about the service they still wanted to come back and see me again about other medical issues.
>
> Doctor # 11 [Hospital physician, NSW, Metropolitan, No religion, 5-15 years]

6.6.2.4 PATIENT

Earlier comments have emphasised the position of many participants, which is that they do not want to lose the ability to consult with patients presenting with crisis pregnancy, notwithstanding that they are not able to facilitate one of the potential medical and legal options available in both states, albeit with different criteria. It is important for the reader to note that when disclosing their conscientious objection to facilitating abortion, many participants left it until the conclusion of the consultation, when it became clear the patient was not interested in other options.

Doctor # 5, a general practitioner from New South Wales with greater than 15 years' experience, employs a delicate strategy for disclosing conscientious objection to patients about abortion and hormonal contraception. As was noted in the earlier quotation from doctor # 5, the participant chose not to mention his or her religious faith. The reader should note the participant's desire to consult with the patient and not offend unnecessarily. The participant's phrasing is not so much directed towards protecting him or herself, but concern for the patient's health.

> I had a friend who advertised on his reception desk that he did not prescribe contraception. I thought this was an interesting way of dealing with it. For me, it's a matter between my patient and me. On our practice website, it alludes to me being interested in natural family planning. I want to be able to talk to patients about other options. I don't expect they will change their mind, but I do hope it prompts them to think about it. I am very happy to talk about it. It's one on one, in a confidential space, a secure and safe environment. I tell them that for medical reasons as well as personal reasons, I don't think it is in their best interests. If I were told I could not do this, it would be a gross invasion of privacy and freedom. On any other subject, people would be up in arms.
>
> Doctor # 5 [GP, NSW, Metropolitan, Catholic, > 15 years]

Doctor # 8, a general practitioner from New South Wales had a similar strategy:

> When I worked in a group medical practice, if a patient requested emergency contraception during a consultation, I would go through the information about the effects and the potential side effects of that drug, but I would explain that as a matter of conscience, I don't prescribe drugs that are abortifacient in effect. If the patient still wanted the prescription, they would simply see another doctor. I have never had anyone attack me for approaching the problem in this way. I always did this in a respectful way, gave lots of medical information about their options as part of informed consent, and gave them a range of alternatives."
>
> Doctor # 8 [GP, NSW, Metropolitan, Catholic, > 15 years]

Doctor # 21, a consultant from New South Wales, regularly consults with patients who have a crisis pregnancy. This participant's strategy for this consultation, which is lengthy, draining, and compassionate, is extracted in full. The reader will note that like doctors # 5 and 8 above, the participant leaves his or her disclosure until the end and the emphasis is on the health and wellbeing of the patient and giving her space to 'unload.'

> Rarely a week goes by when I don't see a vulnerable woman with a pregnancy where she is struggling to find it within herself to continue because of pressure from family or friends, a medical condition that could affect long-term health, or financial concerns. I try and allocate that patient the last booking appointment of the day or a day when I don't have patients, because it is not something you can do in 15 minutes. You could be there for a few hours. I don't have a spiel. Every woman has her own reasons why she feels she cannot continue with the pregnancy. The only way to approach it is to not let on you are never going to do it.
>
> I ask them to tell me why they feel they can't do it. I let her unload completely on to me. I encourage them to talk and talk and say why they feel that way. I let her go at her own pace and in her own way. It can take 25-30 minutes or up to an hour. Then we chat about options, and other considerations.
>
> Some patients are easy. They just want reassurance they can go on with it. They might have some medical concerns such as being told at a young age that a childhood accident meant pregnancy would be very difficult for them. Some want to continue in their heart of hearts, but a partner is putting them under terrible pressure. So, you take the pressure off them. Some need financial assistance. I work with Right to Life where people contribute financial assistance that can be offered to these women.

Once I have moved through options, I try and encourage them to have a look at their baby with the ultrasound, but I leave this decision up to them. I would never force a woman to look at her baby on ultrasound, but when they see the baby's heartbeat and see the baby jumping around, it's a different ball game.

I never believe I have talked a woman into not going ahead with a termination or that I have saved a baby. It is always the mother's decision. All you are doing is giving her some room to move and bring the child into her space again. Up until that time, all she sees is this darkness. She cannot see a baby in this, just darkness and despair. In lightening the load, there is space for her to contemplate bringing a child into that space with her. That space was always there. We just make it possible for her to recognize it was always there.

My counselling is never judgmental, never intrusive, never dominating. You are there as an instrument, to allow the mother's love which is already there by its very nature and which we cannot create nor destroy, to come through. Two thirds of the women continue on with the pregnancy, and of the one third that don't, half never come back, and we part on good terms. There is no bad feeling on her part that I did not provide her with what she wants. With the other half of that one third that come back and see me, you know there is a real struggle going on and they are invariably under pressure from their partner who is making them choose between them and the child.

I try to get them to bring the partner in. I find it draining. The thought that a child is ever terminated is awful. I just try not to think about it. What I feel is nothing compared to what happens to the woman. I never use the word 'God' or 'religion' unless they already have. If they have mentioned 'God', I might say that if you do believe, then you must know that God would never, ever, give you a child unless He loves you beyond all measure and He has given you this child out of love, not in an attempt to try and punish you.

I've never been compromised. A patient has never asked me for a referral for a termination. I had a colleague who when confronted with a woman who wanted a termination would get up and say: 'I'm a practicing Catholic and would never do this.' I take a different view. I see it as a wonderful opportunity. I believe you can achieve just as good outcomes without bringing religion into it. You have to move into the darkness with her, or she won't feel you understand her predicament and understand her situation. She has to feel that you are only here to help her.

Some people think that if you don't take a stand and show total abhorrence, you are somehow co-operating in it. They might think that the person who wants the termination is evil. They may lack interpersonal skills. They may have no plan B if the woman doesn't follow their advice. They may find it hard to share their vulnerability with others. There were times I would see up to seven women a week saying that they did not think they could go on with this. Over the years, they have helped me see where the truth lies. I used to struggle more initially. I saw it as more of a battle between the mother and me.

> The thought of this child not experiencing the beauty of life was awful. I would think I just have to move heaven and earth to stop this happening.
>
> If you allow yourself to be open to the woman, you try and become part of her despair and predicament, and then you are no longer in battle or opposition with her. You are just a passer-by who is on the side of the road. You have your donkey and bag of food and everything you need, and they have nothing, and you just want to share it. Anything short of that is a cop out. Pregnancy counselling requires the patient to see that you are vulnerable. When you are both vulnerable, that's when the relationship starts. I want them to know that if they have a change of mind, they can come back to see me."
>
> Doctor # 21 [Consultant, NSW, Metropolitan, Catholic, > 15 years]

A Victorian participant recounted similar strategies, except that the participant was arguably more circumspect due to his or her statutory duty to refer. As previously discussed, the ambiguity that exists around referral provides some cover. As doctor # 31 notes:

> … a lot comes down to the definition of what referral is. A referral is, in a medical sense, a particular thing that implies the continuation of the doctor's involvement with that person. The College of GPs has very specific requirements for a referral. It is not the case of 'I can't help you, go see someone else'. That's not a referral. Even your accreditation of your GP practice hinges on proof of the referral letter and the means by which you do referrals. The legislators say you have to 'refer to a willing provider who does not have a conscientious objection to abortion.' How would I know this? I don't actually have that discussion with anyone, and I would have to get more involved to know this. Ideally there should be a website that the government sets up to find out who does it, but they argue that they don't do this because the law requires conscientious objectors to perform emergency abortions.
>
> Doctor # 31 [Consultant, VIC, Metropolitan, Catholic, > 15 years

Doctor # 35, a general practitioner from Victoria, wanted to avoid patients with crisis pregnancy. So, the participant produced a pamphlet for female patients of reproductive age that indicated: 'As a medical practitioner, I believe in first doing no harm, and as a consequence I cannot refer for abortion …' The pamphlet highlighted services that could be done for the patient however it was abandoned when the participant realised another doctor could refer the patient for abortion without sufficient counselling or practical help. After offering alternatives to the patient and referring them to a support service or psychologist, doctor # 35 says:

> I'm sorry, but I cannot help you with this. This is a serious issue, and you should take your time. I can help you with these other things … If you decide you want an abortion, you will have to see someone else.
>
> Doctor # 35 [GP, VIC, Metropolitan, Catholic, > 15 years]

For doctor # 14, a general practitioner from Victoria, the fact that women can self-refer for abortion is central to the participant's decision to not disclose his or her personal beliefs to the patient, and to take the following position towards patients considering abortion:

> To practice in accordance with my convictions, I have to break the law. But most of the time, you can carry on in the knowledge that the patient won't complain if you have treated her courteously and professionally and you won't get into trouble. So, you get to the point where you don't like it, but you can live with it …If this is what you would like to do, you can go down that track without me. I don't need to give you a referral. You are welcome to search for an abortion service yourself to get that done, to rung them up and follow it through yourself without any letter or recommendation from me.
>
> Doctor # 14 [GP, VIC, Metropolitan, Christian, 5-15 years]

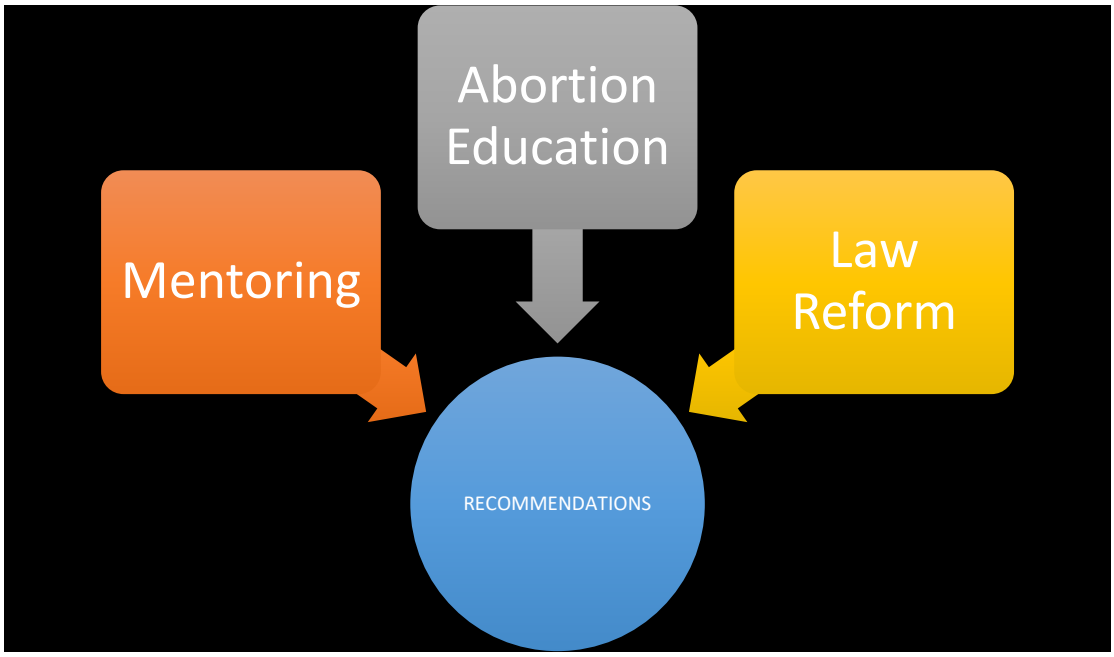
It is sufficient for the writer to say at this point that these participants have demonstrated that accommodation of a conscientious objection to abortion can and does occur in both New South Wales and Victoria, but it requires the doctor to take a practical approach and remove themselves from certain situations where the frequency of requests for abortion and hormonal contraception are common, or to show courage and initiative in pressing for a mutually acceptable solution to the conflict from employers and supervisors, and display respect and compassion for the patient.

However, there is no guarantee that burdens can be avoided. Arguably then, the fears of the younger practitioners seem justifiable, although they appear to need assistance with acquiring courage and perhaps the social skills and confidence to engage in these discussions with superiors. The last theme identified in this analysis of the data is 'recommendations.' This theme focuses upon what participants believe can be done to make things better for not just him or herself as a conscientious objector, but for women who are experiencing a crisis pregnancy and seek information, guidance, and support from their doctor.

6.6.3 RECOMMENDATIONS

This final global theme of 'recommendations' divided into the three themes of 'mentoring and support', 'abortion education', and 'law reform.' Whilst there was general agreement amongst participants about the recommendations on mentoring and support and abortion education, the theme of law reform had divided views. These included participants who supported specific laws to protect doctors' freedom of conscience, those who did not, concerns about whether policies designed to educate supervisors might fail without cultural change.

Figure 7: Theme 7 – Recommendations



6.6.3.1 MENTORING AND SUPPORT

Less experienced participants wanted mentors to turn to in order to gain knowledge and support about how to progress in the profession as a conscientious objector, and how to handle conflict in the current political climate. Although they concede that a few organisations do exist that might assist them, they wanted more, with some noting a lack of structure to assistance, or being unaware of where to go to obtain assistance and support.

Having a conscientious objection to abortion causes a lot of anxiety. There are not a lot of people to talk to, and you need to be careful whom you talk to…. There is no official structure for what you should do. You feel isolated… You wonder why there is not more effort to create structure to help people."

Doctor # 4 [Hospital physician, NSW, Metropolitan, Catholic, < 5 years]

It's good to hold events where we can learn about ethics and the law. There is a new national Catholic Doctor's Association that holds events. The point is to try and have a voice politically, and in the media, and to try and protect each other. I know doctors who share my beliefs, and we talk amongst ourselves to get awareness and we do things like the 'March for Life' every year. So, there is a sense of awareness and support for each other, but events are infrequent, such as two or three a year at most. The rest of the time you are just left to do your job well … doctors are so busy. Whilst all this type of activity is integral to practicing morally, in reality it's probably not a priority to doctors unless you are working as an obstetrician or a palliative care doctor, where you have to counter this issue of referral or participation."

Doctor # 28 [Hospital physician, VIC, Metropolitan, Catholic, < 5 years]

It would be great to have something more formal at the universities where we are taught. A lot of us had to find fringe societies like the Catholic Doctors Association, but it is a very small organization that has only recently been resurrected. Before that, you really had nothing. There are prolife groups out there, but not for health practitioners. We need practical lectures on how to deal with these issues in the workplace and we need an official group at the university where people share common beliefs on this topic, so people did not feel alone …

A friend of mine and I tried to start a Melbourne chapter of the group called 'Solidarity' which is for health professionals, but it was difficult to get off the ground. Any group that serves this need to educate and support health professionals speak up for conscientious objection needs to be more formalized and have a proper identity and mission. Our group ended up being about educational workshops. Whilst this is good, it really needs to include mentoring from doctors in the field who have lived through this stuff and can share these prolife beliefs. We need to network and get Melbourne talking to Sydney, so we can get other universities to be involved. Something like this needs a critical mass.

Doctor # 30 [Hospital physician, VIC, Metropolitan, Catholic, < 5 years]

There's a lack of role models within the profession and I don't know what I am looking for. They are probably out there, but they are quiet.

Doctor # 32 [Hospital physician, VIC, Regional, Catholic, < 5 years]

More experienced participants acknowledged and supported the need for mentoring younger doctors, and some indicated they were active in it. However, with the fear of being identified in the wider community as a conscientious objector, and limited time, it is unclear how many of these experienced participants can actively work to create a visible presence as a mentor or assist in organisations in order to reach those less experienced doctors who are not part of an established community, and work in areas where they believe they are the only health professional with an objection.

> We need better networks for the young doctors. We need to provide them with examples of doctors who have lived with the system and survived. We need to give them encouragement and ways to express themselves, education, and advice on alternatives.
>
> Doctor # 35 [GP, VIC, Metropolitan, Catholic, > 15 years]

> I think young doctors would be assisted by having someone familiar with the issues, ethical or otherwise, to counsel them. You would not want to prejudice their career or ongoing training in O&G. You need such people. We need more pro-life influence in the profession.
>
> Doctor # 33 [Consultant, VIC, Metropolitan, Christian, > 15 years]

> For young doctors, they need to be in an environment of good formation …We don't have enough great leaders in all of society. The St Luke's Guild should be prominent. But it cannot be just talk. They should recruit, meet regularly, and be a very strong voice for anything that came up if it was an issue … With younger doctors, they come from a schooling system in which philosophy is not taught directly or indirectly ... A medical student at university is typically taught by the worst of the worst.
>
> Doctor # 29 [GP, NSW, Metropolitan, Catholic, > 15 years]

> I have huge empathy for new doctors who have a conscientious objection. They have a lot to lose. They need our support so much, to get through it. My experience has been different. I am worried for them, and so concerned for their wellbeing and future. It is much harder for this young generation. They will have great difficulty qualifying in obstetrics and gynaecology, due to the 'weeding out' College culture."
>
> Doctor # 10 [GP, NSW, Rural, Catholic, > 15 years]

For those currently involved in mentoring younger doctors with a conscientious objection to abortion, the types of activities they are involved in include one-on-one mentoring of young doctors whom they know have a conscientious objection to abortion. Alternatively, they may simply use their position as an experienced doctor to disclose their religious faith to young doctors or start a discussion with colleagues on a range of bioethical issues so as to encourage them to see such discussion as acceptable, even where people do not agree.

> What I want to do is to have medical students hear that you can still be a good GP even if you practice in accord with your conscience. That's why I want to make this current practice I am in, into a training practice for them where doctors with a conscientious objection are welcome.
>
> Doctor # 3 [GP, NSW, Metropolitan, Catholic, > 15 years]

> When I am teaching medical students, whilst I am open about where my faith sits, it is not the first thing that comes up, but it does eventually come up. I want to bring up bioethical issues with my students. Most take this well, perhaps because I am in a position of authority over them.
>
> Doctor # 6 [GP, NSW, Metropolitan, Catholic, 5-15 years]

> I have encouraged many registrars who came to me with concerns about their religion and obstetric practice and I try and encourage them to continue, It usually involves a cup of coffee and I get them to talk about their experience, their feelings, where they felt under pressure, and take through how ultimately there is no barrier to them living and fulfilling their vocation as an O&G if that is what they want. It's a bit like the vulnerable woman. You try and provide them with the space to work in.
>
> Doctor # 21 [Consultant, NSW, Metropolitan, Catholic, > 15 years]

> A lot of my discussion about abortion has been with staff and colleagues where I try to get them to talk about the moral issues associated with medical issues. I can accept that not everyone must agree with me, and I often tell him or her that they have right to be wrong. I am in a privileged situation where I can speak out and people don't speak out against me too often, although if I speak out in the workplace on something controversial, I could be reported but has not happened yet.
>
> Doctor # 27 [Consultant, NSW, Metropolitan, Catholic, > 15 years]

Doctors # 31 and 34 provided examples of the type of advice they would give to a younger doctor with a conscientious objection to abortion.

> I would tell young doctors not to leave it until the last minute and to declare their conscientious objection early, and to be conscious of the impact that exercising your objection has on others when they cannot prepare for it in advance. They should not declare their conscientious objection over the phone, but in writing after someone has checked it. I would tell them not to pick a fight, and to be civil and polite in articulating your position and act in a way that is consistent with your conscience, without going into the fray unnecessarily. There's a good way of going about this and when done well, most people will respect that. One should not expect push back, although it might happen. You need to know where that line is that you won't cross, and it needs to be well formed from an intellectual point of view.
>
> Doctor # 31 [Consultant, VIC, Metropolitan, Catholic, > 15 years]

> For doctors who want to train to be obstetricians and gynaecologists, they have a duty to disclose their objection to the College and the College has to try and balance that request. They already do this for people who want to work part time because of a mental health issue or for other reasons. There are certain hospitals like St Vincent's and Cabrini that are Catholic hospitals which do not perform abortion and the doctor should be choosing to do those aspects of their training that might expose them to abortion at those places. I've had a few friends who have been able to do this so it's possible. But I think you have to accept the potential consequences for having your view. It might not always be fair to you, but in choosing to expose your personal beliefs, you have to weigh these things up.
>
> Doctor # 34 [Hospital physician, VIC, Metropolitan, Catholic, 5-15 years]

6.6.3.2 ABORTION EDUCATION

This sub-theme encompassed three areas recommended for further education thought to be helpful in aiding the doctor's confidence in articulating their conscientious objection and discussing accommodation with patients, colleagues, and supervisors. The first area was the facts and figures associated with abortion and hormonal contraception. The second area was training in ethical decision-making. The third area was information on crisis pregnancy and support services that encourage women to continue pregnancy.

> They need to educate themselves and be familiar with the data on termination of pregnancy and its effect on a woman's health …They must learn the facts, especially if they are going to be a GP or a GP/Obstetrician. Patients are not given the truth. It's not about protecting yourself but protecting your patients who need to know about this. …we need to have much more rigor about training on contraception. to patients ... I want to see a scientific, evidence-based presentation to all patients about artificial contraception and abortion.

This needs to include information on the percentage of women who commit suicide after abortion, and the link between breast cancer and contraception … We need much more rigor so medical students hear all of the evidence, not just the politically correct evidence."

Doctor # 10 [GP, NSW, Rural, Catholic, > 15 years]

We need to be able to talk about the dangers of abortion. This is vital information that is being shut down… like any other operation or procedure, you have to give the patient the downside. With abortion, they are told everything will be fine.

Doctor # 19 [GP, VIC, Metropolitan, Catholic, > 15 years]

With abortion, medical students need to be clear about the science, about the time of fertilization, about where they stand, and when they will intervene and why. They have to decide whether they have the right to take a life or if the mother has that right and if so, why. In these areas, doctors are treated as technicians, and it's a big problem. Opinions about abortion are held very strongly, and it is often very uncomfortable for a doctor to exercise their beliefs when the profession has trained them to have a fixed view. There is pressure today by society and in medicine that if you won't provide women with all their options, you will fail as a doctor.

Doctor # 27 [Consultant, NSW, Metropolitan, Catholic, > 15 years]

I want more people to be aware that there is such a thing as a doctor who will practice in accord with their conscience and that they can encounter a doctor who is willing to be counter cultural. If there could be awareness in the public sphere that not all doctors can provide all services, this would be helpful. We need to be able to explain what conscience is, so that patients do not put pressure on doctors in that position.

Doctor # 3 [GP, NSW, Metropolitan, Catholic, > 15 years]

I would love to see an ethics section in the medical curriculum at university that is not run by university staff. I think it should be run by outside people, with bioethicists from a different range of backgrounds. For example, you could have lectures from Catholic Bioethicists, Anglican Bioethicists, and secular Bioethicists. Students need to be exposed to other opinions, and they must not think that ethics is like being in a rowboat they can row in any direction. Most universities just teach what Julian Savulescu says which goes against the Hippocratic Oath and medical ethics.

Doctor # 10 [GP, NSW, Rural, Catholic, > 15 years]

There needs to be education on conscientious objection in medical school because the environment doesn't allow flourishing of one's individual conscience. You almost get caught up in a tide of following the status quo and not given a safe space to explore and challenge different ethical dimensions of medical practice. Medical ethics has a big place in medical education. If it is not taught, you just become a service provider and you lose the heart and soul of medicine. You only learn the science…

Doctor # 22 [GP, VIC, Metropolitan, Catholic, 5-15 years]

In the medical fraternity, they need a better understanding of medical ethics consistent with an understanding of the dignity of human life, or the sanctity of human life. People do not understand that. It is not done in the medical schools. They need to understand that people have different opinions that must be respected, and not just give lip service ... There has to be provisions within training, the various colleges, and the AMA, to implement an understanding that where a trainee has stated their objection, it must be respected. The AMA has a fantastic Code of Ethics, and each college should have the same type of Code. All the colleges are made up of specialists who have opinions on moral issues. It's tricky where we are in a world of relativism where there is no truth apart from the one chosen on the particular day. We need to agree on a minimal form of behaviour that we can abide by.

Doctor # 7 [Consultant, NSW, Metropolitan, Catholic, > 15 years]

I support GPs with a conscientious objection having an online-learning module to equip us to learn more about social services available that can support women in choosing options other than abortion. I don't always know what information women need or is available for them to access. My secular GP regional training provider did not teach us about this. It would be good to have a handout, with some on-line counselling for patients and I think it should be free.

Doctor # 15 [GP, VIC, Rural, SDA, 5-15 years]

I think there may be a need for training of doctors regarding services for crisis or unplanned pregnancy. It takes more time to explore the woman's background and psychosocial/spiritual state compared to a standard 15-minute appointment. The abortion clinics send their advertising material to us. We don't get the same material from crisis pregnancy centres and so doctors just don't know what's out there.

Doctor # 22 [GP, VIC, Metropolitan, Catholic, 5-15 years]

6.6.3.3 LAW REFORM

This final theme of law reform had three sub-themes, namely, full legal protection of conscience, repeal of section 8 of Victoria's *Abortion Law Reform Act 2008*, and the implementation of policy that provides guidance to employers about how to deal with a conflict in conscience in the workplace rather than the doctor having to come up with solutions. The reader will note, however, that there was caution and caveats placed on some of these recommendations by participants. The feasibility of any of these recommendations will be taken up in chapter 7.

6.6.3.3.1 Full Legal Protection of Conscience

The reader should note that participants supporting full conscience clauses in legislation, that is, clauses that do not make a distinction between direct and indirect participation in the service, did not take a narrow view of these clauses as applying only to abortion. Rather, they anticipated that such clauses would encompass conscientious objections to other services or areas in medicine. Many participants mentioned a conscientious objection to euthanasia, and others expressed discomfort with aspects of transgender health including sex change surgery and the administration of cross sex hormones.

> Full protection of freedom of conscience for doctors in the law would be good. Some of the medical associations have had something like this in their statements and code of ethics, but over time it has eroded, and there is a move for AHPRA to change its stance. Overseas, there is a move to ban all prolife doctors. It's just extraordinary to me, the idea that you would force people to do something against their conscience.
>
> Doctor # 35 [GP, VIC, Metropolitan, Catholic, > 15 years]

> I would like to see clearer protections in the law that acknowledges the existence of doctors who will not transgress their conscience, with clear language, so that if I have a patient, I could fall back on it and show them the law without having to explain myself further.
>
> Doctor # 3 [GP, NSW, Metropolitan, Catholic, 5-15 years]

> It should not be necessary to have some sort of federal law that guarantees religious liberty but with the way things are going, a religious liberty law would probably be beneficial.
>
> Doctor # 14 [GP, VIC, Metropolitan, Christian, 5-15 years]

6.6.3.3.2 NO CONSCIENCE CLAUSES

Other participants took a different view and felt that to insert conscience clauses into legislation might cause problems, both with its interpretation and application, and the fact that they suggest that freedom of conscience is a right granted by the state and therefore subject to the whims of those in power, rather than being a pre-existing fundamental freedom necessary to ensure human existence. One participant suggested simply ensuring in the law that conscientious objectors would not be punished, which is similar to clauses in the legislation of other states in Australia.

> We should not need to have a law that protects freedom of conscience. It should just exist and not be something that can be taken away from us. I worry about ascribing in the law a right that is mine in the first place, because of the possibility it could be taken away from me. In the law, it should just be assumed. However, I think there is a place for protection of conscience in the policies of Colleges. It needs to be clear. At the moment, when it comes to conscientious objection, the various colleges, and organisations each seem to require you to refer.
>
> Doctor # 10 [GP, NSW, Rural, Catholic, > 15 years]

> …I am reluctant to support legal protection of conscience because of the way that these things can get out of hand. I think we should accept that some people have a conscientious objection, and it could be to something that I may not personally understand, but we try and accommodate. I don't want to prescribe any specific way of handling it.
>
> Doctor # 33 [Consultant, VIC, Metropolitan, Christian, > 15 years]

> In an ideal world, there should be no need for a law to protect freedom of conscience. To me, the more legislation in these areas, the less freedom there is. I take the point, though, that the law has a protective effect and I guess if the societal wish is for litigation, or persecution, or prosecution of people who think differently, then there could be a need for protective laws, but we should be able to work these things out individually.
>
> Doctor # 5 [GP, NSW, Metropolitan, Catholic, > 15 years]

> We should only have legislation to clarify that there will be no prosecution or punishment for having a conscientious objection.
>
> Doctor # 11 [Hospital physician, NSW, Metropolitan, No religion, 5-15 years]

6.6.3.3.3 REPEAL SECTION 8

All Victorian participants, and some New South Wales participants, wanted to repeal or amend section 8 of the *Abortion Law Reform Act,* noting concerns not just with the requirement to refer to a doctor who the objector knows does not have a conscientious objection to abortion, but also the requirement to perform an abortion in an emergency when the mother's life is at risk.

> I agree in principle with repealing section 8. I think people pushing this legislation wanted to put the fear of God into prolife doctors. It's a nasty section in the sense that they legally compel you to play the game, and it's coming through the medical ethics of Julian Savulescu and other prominent ethicists. They say a doctor who cannot provide these services should not even go to medical school, but it doesn't seem purposeful or practical or necessary.
>
> Doctor # 24 [GP, VIC, Metropolitan, Catholic, 5-15 years]

> I agree with repealing section 8 of the Victorian law. Lawyers say it is written very badly. The emergency provisions are totally contradictory as delivering a baby is far safer than terminating a pregnancy. The reference to providing a referral should be changed to providing information.
>
> Doctor # 34 [Hospital physician, VIC, Metropolitan, Catholic, 5-15 years]

> The concept of 'emergency termination' where you have to perform abortion is one, I found very peculiar because there is no such term in medicine. The legislation uses terminology to govern medicine which was not defined and which we don't have.
>
> Doctor # 11 [Hospital physician, NSW, Metropolitan, No religion, 5-15 years]

> I would abolish section 8 of the law. It shouldn't be there and does not need to be there and does not serve any real purpose that helps patients. It's an ideological thing. A politically pragmatic thing however would be to alter the wording so it said something lie you must inform the patient that they can seek assistance elsewhere without having to direct them anywhere specific.
>
> Doctor # 14 [GP, VIC, Metropolitan, Christian, 5-15 years]

> …the law compels doctors with a conscientious objection where there is an emergency, but it's open to interpretation. It should be worded as a 'serious, imminent and unavoidable risk to the mother's life.' That would cover the scenario of an ectopic pregnancy. I would not be able to be complicit in termination for the risk of suicide, because I think there are other ways of ensuring safety in that circumstance.
>
> Doctor # 15 [GP, VIC, Rural, SDA, 5-15 years]

6.6.3.3.4 POLICY

Finally, the concept of a policy refers to a document giving guidance to someone outside the doctor's department to educate them on what conscientious objection is and provide a framework for how to handle the escalation of a conflict. The reader will note, however, the concern participants had for how this might work in practice.

> I agree with the introduction of a protocol in hospitals that sets out a procedure for employees who have a conscientious objection to a common form of treatment, with it being handled by someone outside the department who understands what conscientious objection is, but there is a strong culture against this in obstetrics. I fear any policy would not be upheld on a day-to-day basis. There is no one in the hospital I feel I could talk to about this without word getting out. It would be miraculous if someone outside obstetrics could handle my request.
>
> Doctor # 26 [Hospital physician, NSW, Metropolitan, Catholic, < 5 years]

> I would support a policy for junior doctors that set out how to exercise their conscientious objection and the steps they need to take, with a dedicated person in the hospital who understands the issue, being on hand to help find a way to make it work.
>
> Doctor # 18 [Hospital physician, VIC, Metropolitan, Christian, 5-15 years]

> Having a written policy that sets out how to deal with a conscientious objection is important, as is ensuring that the person you raise it with is not the junior doctor's supervisor. As a junior doctor, you are always worried about how anything may affect the outcome of your placement. The bullying that has come out in the media shows that doctors don't want to speak out if it will affect their future career.
>
> Doctor # 23 [GP, VIC, Metropolitan, Catholic, 5-15 years]

> Having a policy in place where doctors can candidly voice their conscientious objection to certain practices would be helpful if it impacted on the culture in the profession. Medical education should focus on respecting conscientious objection, but for people in charge of hospitals and medical education, the vibe is that they are interested in *not* allowing these things to happen. They chip away at people's objections, such as by making you refer in order to orchestrate a certain outcome. A lot of people have been indoctrinated into this position at medical school and this has created a culture that has been in place for a number of years. If we started at medical school with the idea that people should be able to voice their conscientious objection, and that it is reasonable for a person to not refer for an abortion, we could change the culture.
>
> Doctor # 30 [Hospital physician, VIC, Metropolitan, Catholic, < 5 years]

6.7 DISCUSSION

The phenomena under investigation in this thesis has been conscience within the context of conscientious objection to abortion by doctors practicing in two states of Australia. The reader is reminded that the methodology chosen for analysis of the data, focused discourse, reflects a foundational assumption in this thesis, which is that the data on its own is not meant to create a new theory of conscience. Rather, its aim is to demonstrate how the underlying theory which anchors the belief system of these 35 participants plays out in the real world and influences their behaviour.

As discussed in chapters 3 and 4, there is a strong narrative in the academic literature and in decisions of various courts and human rights organs that impeding a woman's timely access to abortion will cause the woman harm. The nature of this harm varies and includes harm that can be measured such as loss of her life, significant physical injury as well as economic loss. Other harm includes harm to her mental health however its causation is far more complicated, controversial, and not the subject of consensus. Finally, it is also contended that she may suffer an unquantifiable harm to her dignity through a denial of her right to bodily autonomy.

A strong presumption in the bioethics literature which defends limiting conscientious objection by doctors to abortion is that a doctor harms a patient by simply having this particular conscientious objection, disclosing it to their patient, and wanting to act in accordance with it by not assenting to, supporting, or facilitating a request for abortion. This harks back to the earlier observations made in chapters 1 and 2 regarding the contemporary notion of tolerance. Instead of focusing on the doctor's freedom as a human person to hold a belief, the belief itself is attacked, with its manifestation seen as something dangerous that must be controlled.

All doctors who hold this belief are then characterised as trying to impose their views on others. This can act as an unfounded prejudice which de-emphasises the potential harm the doctor may experience in being compelled to act against it and having their deeply held belief about what is right, disrespected. In the same way, all women seeking abortion are seen as being vulnerable and in need of protection, but why this should be so is never really discussed. The findings of this study challenge this negative presumption about doctors by demonstrating how these particular doctors approach conflict in everyday practice and how they may be harmed.

On the whole, participants did not seek to change the law on abortion. This is an important point. Participants simply sought a fair balance between regulating abortion under health law and protecting their right to freedom of conscience to prevent themselves being harmed using the existing legal framework. It is hard to see how this approach can be characterised as a doctor imposing his or her views on others. However, it may speak more to the practical question of what responsibility the state has to educate the public about access to abortion given it was the state's decision to legalise this morally controversial service.

As Trigg notes, 'mutual respect is easy between people who agree.'[221] Refusing to assist a woman obtain an abortion may seem unintelligible to some people. However, where objective moral truth is the core of a doctor's conscientious objection, then the law of non-contradiction applies. Here, a person cannot hold two contradictory assertions as true at the same time. Accordingly, abortion cannot be both wrong because it is the taking of innocent human life and right because it is freely chosen by a woman as necessary for her wellbeing. One of these assertions is false. If the doctor accepts and acts in accord with a falsehood, they suffer harm.

The majority of participants do not refer for abortion. Much thought went into how they disclosed their objection and conveyed their objector status to their patient. The verbatim quotations of their usual spiel or of a particular exchange with a patient suggest a very gentle approach. These participants were clearly concerned with the wellbeing and dignity of their patients and took time to understand the patient's request for abortion, its surrounding circumstances, and provide information. These findings cannot be extrapolated to all doctors with a conscientious objection to abortion, but they may provide good guidance to others.

Interestingly, most participants downplayed their religion or belief in God as a basis for their conscientious objection to abortion. Instead, there was a heavy reliance on science meaning the fact that the unborn child is a human being, and a general assumption that it is wrong to take innocent human life. The negative opinions of co-workers and people in authority, and the impact this might have on their career progression, was a dominant theme. Dovetailing with this, was the concern that those in authority had not considered the complexity of the issues which conscientious objection raises and were not open to fair and creative solutions.

[221] Roger Trigg, 'Accommodating Conscience in Medicine' 41(2) *Journal of Medical Ethics* 174, 174.

This led to self-censoring by some participants, usually less experienced doctors, who either avoided situations where they would need to express their conscientious objection to abortion, or deliberately remained silent. The junior doctor participants seemed to be very affected by the recollection of their experiences at university where lecturers acted in a scathing manner towards the 'pro-life' perspective. It seems apparent that participants' habit of self-censoring by a failure to register or defend their position for fear of reprisals commenced at this time. These reprisals were more in the nature of social ostracisation.

The need for mentoring of younger doctors with a conscientious objection to abortion seems urgent. The building of courage takes time. According to participants, little time is spent on philosophy and applied ethics in medical school. The legal system has not assisted by setting down clear principles on the value of freedom of conscience to the individual and to society. Without formal protection in the law the responsibility for improving the situation has fallen on the doctors themselves but it seems that more needs to be done by them in forming communities to support, inform, and educate each other and help achieve accommodations.

For those who sought an accommodation, the process was often fraught with anxiety and the fear of losing one's job or losing favour with colleagues and supervisors in circumstances where personal relationships are important. However, some participants obtained suitable outcomes. This was done by either securing an agreement with co-workers to step in and provide the service at the time a scenario presented itself, or by pre-arrangement. Some joined practices where other doctors' facilitated abortion, or they obtained additional qualifications in natural family planning to be able to offer other services to patients of the practice.

Such informal accommodations rely upon the goodwill of colleagues who recognise that some legal services are morally offensive and are willing to step in and supply those services to patients. It also requires objectors to be willing to minimise any inconvenience caused. Participants who worked in rural areas took the view that doctors working in remote areas should ensure that they are not the only doctor in town if abortion was regularly requested by the community. The use of the emergency provision to override conscientious objection based on the need to provide abortion in a timely manner was recognised by them as a possibility.

The ‘middle way’ of dealing with requests for abortion by referring to a third-party ‘all options’ organisation was acceptable to some participants, but with one caveat. As has been discussed in chapters 3 and 4, there were real concerns by participants about the competency of such organisations to provide information on the option of continuing with pregnancy and birth. Accordingly, for those who would accept discharging their duty to refer patients to a non-objecting doctor by referring to these organisations, participants wanted to offer additional organisations to the patient as an option.

These findings support the theoretical discourse advanced in this thesis. It explains why these doctors think and behave in the way they do when it comes to abortion. It also demonstrates ‘fragmentation of the discourse’ where doctors share core beliefs but have acted outside the expectations of the primary or dominant discourse. The findings provide examples of harm these doctors experienced as a result of being an objector. Half the participants feared negative reprisals, half experienced negative comments, almost a third had been the subject of a complaint, and more than a fifth had lost a job or placement.

As a final comment, the reader will remember, the underlying theory of conscience chosen for this thesis, being the natural law theory as enhanced by the relevant systematic teachings of the Catholic Church, provides clear action guidance for doctors in certain areas, but was less clear regarding the issue of actions which qualify as moral complicity with abortion. This is due in part to the multiple variations in the domestic landscape regarding the delivery of healthcare. These findings highlight, therefore, the important role of private conscience when it comes to morally controversial healthcare.

This concludes the reporting and discussion of the findings of this empirical study. The final chapter will make some general observations about conscience, conscientious objection to abortion and reasonable accommodation. It will comment on the participants’ recommendations to improve the current situation and consider their feasibility. It will also identify what further research might produce a deeper understanding of the issue of conscience protection for doctors and health professionals in Australia, as well as the perspectives of all stakeholders in order to work towards a just solution in a pluralistic society.

CHAPTER SEVEN

RECOMMENDATIONS AND CONCLUSION

> Margaret told him he was not asked to swear against his conscience, in order to keep other men company, but to instruct and reform his conscience by the consideration that such and so many men considered the oath lawful, and even a duty since parliament required it. He replied that parliament might err and explained at considerable length when a man is bound to give up his own private opinion or judgment. This should be done at the infallible decree of a general council, but not at the enactment of a parliament.[1]

The life and death of St. Thomas More provides a brilliant illustration of conscientious objection as a *private* act of a person. More took great care in articulating and manifesting his conscientious objection to taking the Oath of Supremacy. He would not elevate the laws of parliament above the courtroom of his conscience. For this, he was held prisoner in the Tower of London, and literally lost his head, which was placed on a stake on London Bridge to be exhibited to the people for a month, but not before proclaiming famously that he died 'the king's good servant, but God's servant first!'[2]

No doctor is being decapitated for having a conscientious objection to abortion, but it is arguable that the same machinations are in place where a law compels doctors who oppose abortion to perform an action which dilutes the integrity of the doctor's belief that abortion is the taking of human life, and therefore wrong. More was required to take the corporal oath, which included an affirmation of the truth of the Act's preamble which declared Henry VIII's first marriage to be invalid, and his second to be valid, notwithstanding the Pope having declared this to be untrue. Accordingly, the oath implicitly rejected the Pope's authority.[3]

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[1] T E Bridgett, *Life and Writings of Sir Thomas More: Lord Chancellor of England and Martyr Under Henry VIII* (Burns & Oates, 2nd ed, 1892) 371-2.
[2] Ibd 434.
[3] Ibid 349-50.

On reading the Act, More made it clear that his purpose in refusing to take the oath was not to condemn the conscience of anyone, including those who wrote the law and those who swore the oath, rather, it was an act of preservative freedom wherein he knew he would be gravely harmed if he took it. We can compare this to participants in this study, none of whom could be described as fanatics without focus, wanting to impose their view of abortion on the state or on others. Instead, their request was for protection from the law so that their workplaces accommodate them with the least amount of disruption to colleagues and to patients as possible.

There will be some people who fail to see the value in More's actions or in the actions of doctors who refuse to refer for abortion. Elevating obedience to conscience above one's life or career, may seem unintelligible to some people, but it certainly highlights the link in More's worldview between conscience, objective truth, and freedom. Bridgett notes that More's death was 'willing, rather than wilful.'[4] He did not desire death, he desired to be free not to take the oath. The fact that he lost his life after having an opportunity to re-consult with his conscience should show that death to him was a better fate than to say the words but not mean them.[5]

Despite the push for abortion to be declared a human right, abortion is a legal right, with varying conditions attached to it. In Australia, its legality is the result of legislation and as such, aspects of its legality can be expanded or abrogated by that same process. Freedom of conscience is a fundamental freedom that can be constrained in certain circumstances. The degree to which the law respects conscience for its own sake and accommodation and dissent can be seen in the way it protects, facilitates, and encourages or denies protection, interferes with, and discourages effective accommodations.

[4] Bridget (n 1).
[5] Ibid. These words were deeply repugnant to his beliefs about the relationship between sovereign power and the Church.

As Trigg notes, 'if, as citizens, we cannot all equally live according to our deepest and most important beliefs about what is right and good, how can we properly contribute to the welfare of any democratic society'?[6] In this vein, the goal in resolving any conflict in beliefs about what is right should be through an attempt at reasonable accommodation. Exemptions to laws of general applicability do not undermine the law or conscience. Rather, they celebrate diversity and promote tolerance. Arguably, laws which try to force action that undermines a deeply held belief can cause harm to the individual and ultimately weaken all beliefs.

As a world first, the findings of this research fill a gap in knowledge and contribute to academic discourse in law, medical education, and bioethics. Potentially, it has a reach beyond the issue of abortion given the many developments in medicine and technology, such as artificial intelligence, that pose fundamental issues about human life and its limitations. Reasonable people will be bound to disagree. Therefore, principles that guarantee space for disagreement and dissent are important in the future in areas that do not fit neatly into a religious/non-religious paradigm. Accordingly, conscience protections are important for everyone.

The central research question of this thesis was: 'What are the attitudes and experiences of doctors with a conscientious objection to abortion and who practice in New South Wales and Victoria?' The findings of this empirical study answer this question by explaining the participants' attitudes to abortion, contraception, and referral, and the basis and scope of their conscientious objection to them. Their experiences were explored in the first sub-question. The first sub-question was: 'What burden do these doctors believe that having a conscientious objection to abortion has had upon their professional lives?'

The findings identify and explain the nature of the harm participants say they have experienced as a result of having a conscientious objection to abortion. In addition to the harm from being asked to hold and act in accordance with two contradictory beliefs, half the participants feared negative reprisals, half experienced negative comments, almost a third had been the subject of a complaint, and more than a fifth had lost a job or placement in a training programme. These are very serious consequences for people seeking to exercise a fundamental aspect of human dignity and qualify as a type of 'moral harm' referred to in bioethics literature and studies.

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[6] Roger Trigg, 'Freedom of Conscience and Freedom of Religion' (2010) 99 (396) *An Irish Quarterly Review* 407, 410.

Accordingly, the findings of this study should be included in any review of studies on the phenomena of 'moral harm' in health professionals. Participants in this study displayed many of the same feelings expressed by participants in those studies referred to earlier in this thesis at 3.3. However, these feelings were accompanied by other types of measureable harm, and in addition, these doctors often experienced a lack of support from within the profession. That their distress arises from a morally controversial issue should not be a reason to ignore the fact that they have experienced harm. This would not respect the scientific process.

The second sub-question was: 'Is there an association between the attitudes or experiences of these doctors based upon their religious affiliation?' The findings identified common core beliefs but there was some fragmentation between Catholic participants and their Christian and CJCLDS counterparts regarding how they applied these core beliefs in practice. Whilst there were fewer participants from religious faith traditions other than Catholicism in order to draw a clear association here, it was undeniable that the Catholic participants used a common moral reasoning that allowed them to apply their beliefs in similar ways.

This moral reasoning derives from the natural law tradition. It is available to everyone as can be seen by the participant who identified as being of no religion but who adopted the same reasoning as the Catholic participants, and was opposed to contraception, abortion, and referral. This study highlights that for these doctors, further education is unlikely to dilute their conscientious objection. Rather, there is an urgent need to include education on conscience at the University level so that others in the profession might have the tools to discuss a more inclusive, nuanced, and sensitive approach to managing conscience conflicts.

The third sub-question was: 'Is there an association between their attitudes and experiences based on which state they practice medicine?' The attitudes and experiences expressed by participants were common between these two states, which now have very similar legal regulation of abortion. Whilst the need for laws that protect freedom of conscience and freedom of religion was supported by many participants, others highlighted that a better solution or necessary adjunct to laws was the education of the profession about what conscientious objection is and how its members are harmed by laws which force them to act against it.

One of the challenges about managing conscience conflicts in health care is the incremental approach where problems are resolved service by service, without the need to consult with a general framework. As Oderberg notes, the situation where case law is limited and legislation uses imprecise terms, denotes a lack of appreciation by lawmakers for the complex philosophical issues which conscience provokes.[7] The 'middle way' approach to referral for abortion adopted by Tasmania, New South Wales and South Australia demonstrates there is room for discussion about the scope of conscience clauses and what acceptable solutions are.

Cracks have started to appear in the legal framework for abortion in Australia which is underpinned by the autonomy principle and the right to bodily self-determination, subject to certain limitations.[8] The New South Wales *Abortion Law Reform Act 2019* and South Australia's *Termination of Pregnancy Act 2021*, have either condemned the practice of social sex selection abortion or prohibited the practice altogether. This represents a significant shift in community attitudes to the use of autonomy as a basis for abortion for any reason and arguably demonstrates the shaky edifice of the reasoning used in this area of law.

Accordingly, the time may be right for agitating further law reform, particularly as New South Wales's *Abortion Law Reform Act 2019* is due for review in 2023. Some participants wanted the conscience clause to cover refusal to participate and co-operate in abortion including in an emergency. Others believed it was unnecessary to insert a conscience clause because as a fundamental freedom, it need not be written down given it might be open to misinterpretation. Commonly though, participants wanted any reference in law or policy to a duty to refer to a non-objecting doctor to be repealed on the basis that it is unnecessary and damaging to them.

[7] See David S Oderberg, 'Further Clarity on Cooperation and Morality' (2017) 43 *Journal of Medical Ethics* 192, 199.
[8] Anna Walsh and Tiana Legge, 'Abortion Decriminalisation in New South Wales: An Analysis of the Abortion Law Reform Act 2019 (NSW)' 2019 27(2) *Journal of Law and Medicine* 325, 337.

The views of the medical profession regarding how to manage conscience conflicts is vital to the development of sound policy. Without push back from them, there is no impetus for change. However, as these findings have revealed, freedom of thought within medical schools may be stifled by educators pushing one of a variety of 'liberal progressive' agendas regarding abortion with no real discussion about conscience accommodation and their importance to the profession and society. Without education and informed discussion on these issues, doctors with conscientious objections are more likely to suffer in silence.

The medical profession should consider the results of this study and selected studies reviewed in chapter 5 and ponder the confused results of the latter. Why is it that so many participants in the chapter 5 studies were unable to articulate their objection in a coherent and principled way and discuss its application in practice? As many of the participants of this study had reflected on the scope and content of their objection it suggests, and this thesis recommends, a course on conscience and accommodation in medical schools and, most particularly, in a Catholic medical school where it might also, quite appropriately, highlight a religious ethos focus.

Education on conscience needs to extend to the public and in this instance, to women seeking abortion. As noted in chapter 5, studies have started to be published on the experiences of women seeking abortion and the negative impact which conscience protection for doctors has had upon them and their ability to access timely abortion. As key stakeholders, the views of women seeking abortion are very important. Whilst sample sizes were small, these studies highlighted behaviour by certain doctors which suggested their intention was to delay or obstruct access to abortion by not telling the patient they could self-refer to an abortion clinic.

These experiences stand in stark contrast to the attitudes and practices of doctors in this study. However, experience has raised the point that the law in both New South Wales and Victoria places the burden on doctors with a conscientious objection to abortion to inform women where to obtain abortion. If there are other means available to achieve the same outcome, and where objecting doctors see the provision of information as co-operating in abortion, then other options need to be explored. Ultimately, as it is the state that has made abortion lawful, it should be the state that ensures supply and demand for the community, not individual doctors.

This study has uncovered one of the problems with referral which is that even where it is arguable that the causal chain for procuring abortion is broken by an objecting doctor referring to a third party 'all options' organisation, the quality of the information the woman might receive from these outlets could fail to satisfy the referring doctor that she is being given sufficient information on all alternatives to abortion (if she seeks this). Without this, her consent may be vitiated. However, we know very little about the experiences of women seeking information from these 'all options' organisations and crisis pregnancy centres.

This thesis was completed during the Covid-19 pandemic when there were tensions between freedom of conscience of individuals and public health. In all states and territories of Australia, public health laws were passed requiring people in certain occupations to be vaccinated against Covid. In the private sphere, workplace health and safety laws have been used to require vaccination of other employees as a condition of employment, irrespective, in some cases, of whether a person has any contact with vulnerable people. Whilst extremely narrow medical exemptions are available, conscientious objection has largely been ignored.[9]

The lack of discussion in Australia about freedom of conscience as a concept independent of that which is objected to has not assisted in providing the philosophical infrastructure to be able to discuss the case for respecting conscientious objection to these Covid vaccines and proposing reasonable accommodations.[10] Instead, the state's public health narrative that people will die or be seriously injured if they do not take them has gone largely uncontested, with doctors facing the prospect of disciplinary action if they undermine the public's confidence in the government's policy for managing this pandemic.

[9] Largely, the legal culture in Australia is one dominated by legal positivism in which fundamental rights are not seen to exist unless clearly stipulated in legislation. See, eg, *Athavle v State of NSW* [2021] FCA 1075 and *Kassam v Hazzard* [2021] NSWSC 1320. Cf *Thiab v Western Sydney University* [2023] NSWCA 57. At first instance, the Supreme Court permitted the dissenting view on Covid vaccines to prevail, but this was reversed on appeal.

[10] Some people describe themselves as having a conscientious objection to taking drugs because of a reasoned risk assessment. In other words, the potential risks to them from adverse effects of these new drugs outstrip any potential benefit they may offer in protecting them from becoming ill or dying from Covid. In addition to, or alternatively, some people object to taking these new drugs on the basis that they are produced or tested or developed on electively aborted babies. They believe this makes them morally complicit in supporting the pharmaceutical industry which relies on abortion and uses human beings for the benefit of others.

If a person's objection to taking Covid vaccines lacks the 'religious' angle and is based solely on the relative risk/benefit analysis of reducing the risk of becoming ill from Covid versus being harmed by these new drugs, this might be considered something having significant weight and lacking the religious or supernatural element which accompanies the unfathomable questions about human life associated with abortion. Therefore, it raises the questions: What is the definition of religion? What qualifies as a conscientious objection? Should the role of non-religious beliefs be accorded the same respect and protection given to religious beliefs?

Finally in conclusion, doctors with a considered position on abortion who work in areas where a request for abortion may be made, need to be willing to reveal their status as objectors, without hindrance or fear of reprisals, and suggest reasonable accommodations. This allows employers the time to give proper consideration to the objection and consider how accommodations might be made. This may be difficult for objecting doctors who are afraid of suffering severe penalties, where there is no policy on accommodations, and where there is an absence of legal protection or adequate respect for the category of conscience.

However, if their conscientious objection is to mean anything, if it is to be deserving of respect, it must be that society provides a better understanding of both the possibility of assertions of conscience objections and the means to provide effective accommodations. Though the root of the word 'accommodation' is 'to make comfortable', it is clear that the current situation does anything but offer comfort and is in need of change. This study shows the need for better education and legislation in this important area. In this way, the doctor has the freedom to say 'no' and be an important part of dialogue in relation to contested debates in society.

As the US Supreme Court recently held, abortion is 'a profound moral question, between legal but irreconcilable beliefs.'[11] Shutting down one side of the debate based on the religious beliefs of some people uses non-recognition of conscience as a proxy for maintaining and advancing the morality of the 'progressive' perspective. Harm to either the doctor or the patient seeking a morally controversial service must take into account the weight to be given to the legitimacy of the dispute and give greater attention to the pressing question of who bears the onus for provision of services. These areas are ripe for research but beyond the scope of this thesis.

[11] *Dobbs v Jackson Women's Health Organization*, 597 U.S. _ (2022) 78-9.

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DATA COLLECTION TOOL

INTERVIEW GUIDE

1. What impact has your conscientious objection to abortion had upon where you work as a doctor?

2. Do you feel that you have the freedom to express your conscientious objection to abortion in the workplace? What is your understanding of your professional and legal obligations as a doctor who has a conscientious objection to abortion?

3. What has been your experience with exercising your conscientious objection to abortion in the workplace?

    - Have you ever disclosed your objection to a patient/colleague/supervisor/employer?
        - What was the context in which the disclosure was made?
        - Why did you make this disclosure?
        - How did you feel about making this disclosure?
        - What long-term impact, if any, resulted from the disclosure?
    - Have you ever believed that you should disclose your objection to a patient/colleague/supervisor/employer but failed to do so?
        - What was the context in which your concern arose?
        - Why did you not make a disclosure?
        - How did this experience make you feel?
        - What long-term impact, if any, resulted from this failure to disclose?

4. Are there any circumstances where you have referred a patient seeking abortion on to another doctor?

    - What was the context in which this referral occurred?
    - What did the referral process involve?
    - Why did you make this referral?
    - How do you feel about having made this referral?

5. How do you feel about *[the law in Victoria] or *[a future law in New South Wales] requiring doctors with a conscientious objection to abortion to refer a patient seeking abortion to another doctor who does not have a conscientious objection?

6. What impact *[has this had] or [do you think this would have] on your practice as a doctor?

7. Would your response differ if the law required you to refer the person to a third-party organization that would ultimately refer the patient to a doctor who would perform abortion?

8. In your opinion, what factors make the accommodation of conscientious objection by doctors to abortion difficult to achieve in the workplace?

    - Are there any settings or circumstances where you believe that an employer's accommodation of a doctor's conscientious objection to abortion causes undue hardship on the employer?
    - Are there other healthcare services that you believe doctors ought to be able to conscientiously object to?

9. In your opinion, do you believe you received adequate education and training regarding the legal and ethical issues about conscientious objection to morally controversial health services during your medical training?

CONSENT FORM

Without Hindrance or Fear of Reprisals: Exploring the Experiences of Physicians in Victoria and New South Wales Who Have a Conscientious Objection to Abortion

Physician # X

- I agree to take part in this research project.
- I have read the Information Sheet provided and been given a full explanation of the purpose of this research project, what is involved, and the types of questions I will be asked.
- I understand that I will be interviewed, that the interviewer will manually record and later transcribe my responses, and that I will be given the opportunity to review the transcription for accuracy and completeness.
- The researcher has answered all my questions and has explained possible risks that may arise as a result of the interview and how these risks will be managed.
- I understand that I do not have to answer specific questions if I do not want to and that I may withdraw from participating in the project, without prejudice so long as its withdrawal occurs prior to the completion of data analysis.
- I understand that all information provided by me is treated as confidential and will not be released by the researcher to a third party unless required to do so by law.
- I agree that any research data gathered for the study may be published provided my name or other identifying information is not disclosed.
- I understand that research data gathered may be used for future research, but my name and other identifying information will be removed.
- I confirm that I have provided the Information Sheet concerning this research project to the above participant, explained what participating involves, have answered all questions asked of me, and obtained a verbal consent from the participant.

Signature of Researcher		Date	

Signature of Participant		Date	

PARTICIPANT INFORMATION SHEET

Without Fear of Hindrance or Reprisal: Exploring the Experiences of Physicians in Victoria and New South Wales Who Have a Conscientious Objection to Abortion

Dear Dr.

You are invited to participate in the research project described below.

What is the project about?

The project undertakes descriptive research into the attitudes and experiences of physicians with a conscientious objection to abortion, and who practice medicine in either New South Wales or Victoria, which are two states that display a spectrum of receptivity in their laws and policies about accepting or not accepting conscientious objection.

As the first study of its kind to be conducted in Australia, it has relevance for public health law policy in both New South Wales and Victoria.

Who is undertaking the project?

This project is being conducted by the writer, Anna Walsh, and will form the basis for the degree of Doctor of Philosophy at The University of Notre Dame Australia, under the supervision of Professor Iain T. Benson and Associate Professor Keith Thompson. I am a lawyer specializing in Medical Law and have a Master of Laws degree from University of Sydney, and a Master of Bioethics degree from Harvard Medical School.

What will I be asked to do?

If you consent to take part in this research study, it is important that you understand the purpose of the study and the tasks you will be asked to complete. Please make sure that you ask any questions you may have, and that all your questions have been answered to your satisfaction before you agree to participate.

The project involves an in depth face-to-face or skype interview. The interview will be semi-structured and involve open-ended questions. It is expected to take at least 30 minutes and will occur at a location that is mutually convenient to you and me.

The types of questions that will be asked include the following:

1. Do you feel you have the freedom to exercise your conscientious objection to abortion in the workplace?
2. How do you believe that your status as a conscientious objector to abortion has affected your practice of medicine, and your relationships with patients and colleagues?
3. In your experience, what factors make the accommodation of conscientious objection to abortion difficult to achieve in the workplace?
4. How do you feel about referring a patient seeking abortion to another doctor? Would you feel comfortable making enquiries as to that doctor's views on abortion?
5. In your opinion, do you believe you received adequate education and training regarding legal and ethical issues such as conscientious objection during your medical training or as a physician?

Your response will be manually recorded by the writer and will be converted into a typed document within 48 hours. You will be asked to review the transcript of the interview to ensure the accuracy of the recorded responses and provide feedback to the writer within 14 days. There may be a need for a follow up interview.

Please note that our discussion during the interview will be strictly focused on the matters described above. I will not be providing any legal advice to you about abortion law in your state, or on other legal questions or issues you may have.

Are there any risks associated with participating in this project?

There are no foreseeable risks to you in participating in this research project. All care is being taken to ensure your privacy and anonymity so that you can feel comfortable discussing and recounting your experiences to me (see below 'Will anyone else know the results of the project?').

What are the benefits of the research project?

There are no direct benefits to you as a participant. However, it is hoped that the published results of your participation in this research project will permit others to better understand the burden that such laws will have upon the human rights of physicians with a conscientious objection to abortion and contribute to discussions about the formation of sound public health law policy.

What if I change my mind?

Participation in this study is completely voluntary. Even if you agree to participate, you can withdraw from the study at any time without discrimination or prejudice, up until the completion of data analysis. If you withdraw, all information you have provided will be destroyed.

Will anyone else know the results of the project?

Information gathered about you will be held in strict confidence. This confidence will only be broken if required by law. Information obtained from you will be de-identified. In order to minimize the risk of deductive identification, no direct identifiers (such as your name, email, address, telephone number, place of employment) or indirect identifiers (such as age, gender, postcode) will be recorded.

In order to minimise the risk of re-identification, participants will be given a pseudonym such as 'physician 1' et cetera. When recounting any relevant personal experiences you had with patients, colleagues, or employers, no direct or indirect identifiers of those persons will be recorded. The de-identified transcript of your interview will be stored on a computer with password protection.

I will retain your contact details on a computer with password protection, and I undertake to delete these details at the conclusion of the project.

Once the study is completed, the de-identified data collected from you will stored securely in the School of Law at The University of Notre Dame Australia for at least a period of five years. The results of the study will be published as a thesis and is likely to be published as a journal article and in conference papers.

Will I be able to find out the results of the project?

Once we have analysed the information from this study, we will either mail or email you a copy of the thesis chapter that pertains to the results and analysis. You can expect to receive this feedback towards the end of 2018. If for any reason this research project is discontinued, you will be notified.

Who do I contact if I have questions about the project?

If you have any questions about this project please feel free to contact either the writer by email (anna.walsh1@my.nd.edu.au) or Professor Iain Benson (Iain.Benson@nd.edu.au). My supervisor and I are happy to discuss with you any concerns you may have about this study.

What if I have a concern or complaint?

The study has been approved by the Human Research Ethics Committee at The University of Notre Dame Australia (approval number 017177S). If you have a concern or complaint regarding the ethical conduct of this research project and would like to speak to an independent person, please contact Notre Dame's Ethics Officer at (+61 8) 9433 0943 or research@nd.edu.au. Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

How do I sign up to participate?

If you are happy to participate, please contact me by email to arrange a time and place to conduct the interview.

Thank you for your time. This sheet is for you to keep.

Yours sincerely,

Anna Walsh

PhD Candidate, School of Law, University of Notre Dame Australia, Sydney
Adjunct Associate Professor, School of Law, University of Notre Dame, Sydney
M. Bioethics (Harvard), LL.M (Syd), LL. B (Hons), B.Nurs (Hons)

Transcripts of Interviews

Doctor # 1

Interview conducted by ALW, 20 February 2018
Start: 6.00pm
Finish: 8.00pm

Antecedents of Doctor # 1

Doctor # 1 is female, identifies as a Catholic, and is working as a resident in a tertiary hospital in New South Wales.

Consent

Verbal consent was obtained for the interview by ALW.
The interview guide was varied to take into account the respondent's background and in order to explore issues as they arose.

The basis of your conscientious objection to abortion

I grew up in a Catholic environment and as such, the immorality of abortion was not something that we questioned. At about 15, I developed an interest in philosophy. Then, with my medical training, I had the tools to be able to have a discussion about abortion based completely based on science and philosophy. I can argue that the baby has human DNA, and that there is nothing else it can scientifically be identified as.

In my experience, most people know that it is a human, but cannot bring themselves to say that it is OK to kill a human. So they get around this this by saying that say that they don't know what it is, that it is a complicated issue; or that it is up to each person to decide. It's just a mask. I think the scientific argument fares better amongst medical colleagues. I do engage in a faith-

based argument with Catholic people who are faced with an unplanned pregnancy but for me, the scientific argument is so strong that I don't really have to go there.

The idea that it is a human being with a soul is something I can bring up with a Catholic person who understands that concept, but it is lost on other people. The person either denies the science or accepts that it is a human.

Your experiences with disclosing a conscientious objection to abortion

During my medical training, I did a clinical placement at a GP clinic. I knew that abortion was an issue that might come up and also that of prescribing contraception. On one occasion, I was consulting with a woman whose child suffered a sports injury. As she was leaving, she asked for a new script for the pill. The process to do this was minor. It involved clicking a few buttons, and the script would simply come out on the printer. There was absolutely no skill involved. I was taken by surprise and my response was to fake a coughing fit so I could excuse myself to go the bathroom. My male supervisor had to complete the consultation.

After this, I had a discussion with him about having a conscientious objection to prescribing contraceptives or referring for abortion. I was shitting myself. I was really scared. I used the term 'conscientious objection' with him. I said that if the request came up, I would let him take over the consultation. We had a one-and-a-half hour discussion about religion and beliefs until his secretary came in and said patients were waiting. I had built up a rapport with him. He was an eccentric character, and he told me that he was a lapsed Catholic. He said:

> 'Gees not even contraception? That is very orthodox of you.'

He challenged my beliefs but did not try to change my mind. There were so many another female practitioners in the clinic that I felt that it would not be a huge issue in terms of accommodating my conscientious objection.

On another occasion, I was supervised by a female GP Registrar, which means she was training to be a fully registered GP. She was a lovely person, and she had previously trained to be an O&G. However as this is very rigorous training, she opted out but felt that as a GP she could still be involved with women's health concerns. She had a second job in a women's health clinic to stay involved. She was happy to perform medical abortions and to insert contraceptives like the IUD.

A woman came in 8 weeks pregnant. She had 3 other kids and said she couldn't afford another child and wanted an abortion. She said she wanted to get it done without having to tell her husband. I froze. Normally, medical students get asked to do minor tasks in the clinic, but as I was keen, this supervisor got me involved with more things. I thought she handled it very well. She expressed to the patient her concerns about not telling her husband and asked them to come back together.

The woman and her husband came back for a consult and the husband was crying. Holding their 18-month-old on his lap, he kept saying that he did not want his wife to have an abortion, as it would be killing the child. My supervisor referred them to a psychologist. After this, I decided to have a discussion with her about my beliefs.

It was hard to have a discussion with my supervisor about me being a conscientious objector as she was very efficient at seeing patients and as a result, she saw a lot of them and had little spare time. However I felt strongly about it and I broached the subject even though she was busy and I referred to this particular consultation. I told her I was not comfortable getting involved. She was fine and said she did not get involved in abortions beyond 9 weeks as they 'look like a baby'.

I listened to her, and she talked a lot. She was very nice. It was a very personal conversation, and she gave me her e-mail and said that some doctors do not even prescribe contraceptives. I told her that for me, I needed to be able to go to sleep with the decisions I made in the day. As I said this, she seemed a bit surprised, like this was what she was struggling with, and then she agreed with me.

I felt like she was a bit stuck, and struggled with the idea that babies are dying for the sake of women's health. I think she was very conflicted. She said, 'it can really get to you… if I gave anything up, it would be my woman's health job first.' She then said she told her patients who get a medical abortion, not to look at it as it as it comes out, as it 'looks like a baby and it will really upset you.'

I felt like she needed to talk. I felt sorry for her. This made me a lot less scared about expressing my opinion. Seeing a person who does abortion and feels uncomfortable with their position, I could see that I don't need to feel anxious about talking about it. However, it made me cynical about politicians who want all doctors to be comfortable do abortions. They don't know what they are talking about. They have no idea about the psychological distress this would place on a lot of clinicians.

There are a lot of people in medicine, from my cohort at university, who agree with me, but won't say anything. But one thing you feel in medicine is the hierarchy and the power gap. It is very competitive for jobs. Your opportunity to get into a training program depends upon your referees. You never want to say no, I can't do that, or I don't want to be involved, because it looks weak. The sense is that to get where I want to be, I have to do this.

I think the patient who came in seeking a referral for abortion in my GP placement went there because she was conflicted. She could have just gone straight to an abortion clinic, but this GP knew her and her family. She would not have received this type of discussion at a private abortion clinic. I felt the woman wanted someone her GP to confirm it was morally OK. When the couple came back from seeing the psychologist, the woman said "the psychologist kept calling it a baby and it didn't make me feel good". She ultimately had the abortion and I recall the husband saying that he felt OK about it, and that the psychologist helped him feel better about it.

I was very stressed here. I lost 5kgs. I was stressed about this issue and not knowing what cases would come through the door. Knowing that, you are dis-empowered. As a medical student you are expected to be keen and be involved. These people are marking you. You might have to repeat the rotation, which would lead to more stress. I am very enthusiastic. I like getting involved. I didn't want my supervisor to think I was judging her. You don't have a lot to offer other than your keenness. There is a lot of gossiping with judgments about the medical students

by the clinical supervisors. I know this because once they trust you, they will say those things about other students in front of you. You don't want to be the person they talk about.

On my emergency department rotation, I feel scared that I would have a moment of weakness and not be able to express my objection. My friends with similar views feel the same. On a string of night shifts, you could be asked in theory to assist with an emergency abortion. This would be very rare, but with 700 patients and only 2 of you covering the hospital, to be put in this situation, where someone says you have to come and help me to assist in theatre, saying no is hard.

The amount of pressure to just go and do it is really scary. If you were to say no, they would have to call another surgeon in which would cause a delay or swap with another junior.

I would say that I am not getting involved, and they need to get someone else. I have not spoken pre-emptively to my supervisor at the hospital. I will probably just wait for the incident to happen. There is usually some time taken to get a theatre ready. You can stabilize the patient in time. I would at that point tell them they have to call another person. But it makes me wonder whether I was complicit in the abortion by telling them to call someone else. I feel like I would have to give the directive because under stress, people would just yell at you and say 'well what are we supposed to do? In theory they should just call another surgical trainee in, or the other junior, but if you were allocated to surgery for that shift, you would be expected to do it.

In all hospitals there is a director of pre-vocational training (DPET). Their job is to monitor the learning of all junior doctors. There is another regulatory body for the education of junior doctors that they report to in NSW Health, called HETI (Health Education and Training Institute), to say that all junior doctors are being trained properly, supported and their performance is satisfactory.

I have thought about approaching my Director about my CO, but I need to build up a rapport with him. The environment can be very 'cliquey'. If someone likes you, they will move mountains for you. To date, I do a risk/benefit analysis. When I started at the hospital, I was on a renal rotation, and that is not a rotation where I would run into this type of situation, so I said nothing.

Whereas in a field like medical oncology, for example, you have to talk to people about freezing eggs and sperm and as a result I would never enter this field. I would do Obstetrics, but only at a Catholic hospital. In my emergency rotation, there is a big board where you can see a list of patients and their condition. So, any patients with vaginal bleeding or pregnancy, I did not pick up. Technically, you can do your own thing more although you should see patients in order of need. However as interns never see category one (must be attended to immediately - true emergency) patients, I did not feel like I was putting anyone at risk by not picking up certain patients.

Performing peripheral acts

I had a placement at a small Catholic hospital on an anaesthetic rotation. The patient had a caesarean section delivery and then asked for a sterilization to be performed at the same time. I was surprised that the hospital had the 'clips', and was performing elective sterilisation, as it was a Catholic hospital.

It was a very political environment. I felt the hospital wanted to keep certain doctors, so they let them perform sterilisation for non-emergency reasons. I struggled with this. As I knew that the hospital was changing hands to another Catholic healthcare organization that was more orthodox, staff thought it would be less likely that those doctors could get away with this. So, I felt it was better not to say anything.

I worked out that I would feel OK to perform ancillary tasks, such as inserting a cannula, for a patient undergoing a Caesarean + sterilization, with the ethical rationale that I am happy to facilitate the Caesarean. I am not yet sure what I would do from the Anaesthetic point of view for a sterilisation alone. I spoke with others about this. As the operating theatre in hospital has to be regimented, they must have a list of the cases coming in. So I made it a point to check the list the day before. As luck would have it, there was nothing I had to be concerned about, but it was still stressful.

Factors that affect being able to disclose a conscientious objection to abortion

The team you are working with matters. On shift work, as a resident, you do not necessarily know the patients or the nurses or senior doctors. You just cover the hospital. It is really hard to have this conversation unless you know the people you work with. I know that there are several doctors who have different opinions to me, but I feel comfortable telling them this because I know them. A lot of what happens in medicine is rapport building and getting to know people.

I perform a risk benefit analysis when I start a job. I consider the likelihood of it coming up. I don't create unnecessary drama because it's controversial. Everyone is stressed. Extra stress is crippling. You think about the impact of what you are saying will have on others, and that we already have enough drama in our jobs without having ethical discussions. There is no formal process for registering as a conscientious objector. It is not even a consideration. The burden is on me.

There are times I have felt like a coward, not about abortion, but about other clinical decisions where I have not spoken up. I think about whether it is a good time to bring something up, and whether I know the person well enough to bring something up. In the back of my mind, I need to make sure people like me in case I have to tell them I have a conscientious objector to abortion. I don't think I have changed my personality, but I have become a bit calmer, and learned not to become feisty and go at it, I have learned to pick my moments.

The more you express anxiety and stress, and freak out, others pick this up and think you are not coping and then you become a target. Many people in this profession prey on the weak. Therefore, I have learned to cultivate a calm demeanour. I read 1984 recently…I learned to be more like Winston Smith. The thought police watch expressions. Like him, I have learned not show it so they will leave me alone. I get anxious when I don't know what is coming through the door. It has helped me cope with that better, but I resent the fact that the system has put me in this position.

There is no pathway to express conscientious objection. There are some things where it is OK not to be OK. Such as where all your patients have died that week, people will be kind to you. It would not be acceptable in medicine, to say ‘don’t ask this person to do this because it goes against their conscience’. Some male GPs will say that they do not perform vaginal examinations. They use the excuse that they have not done one in a while, and are not skilled, and that there are plenty of others to do this. But it is not acceptable in this social political environment to say you cannot refer for abortions because it is against my conscience. There is no respect for this.

Referrals

Through further education, and hearing from senior colleagues, I have thought a lot about whether I would refer, and I have decided that I would not refer a patient seeking abortion to another doctor. I base this on the analogy of someone seeking a service that involved killing someone. I would feel complicit.

I am not comfortable with giving a patient a pamphlet that has the names of doctors who will do abortions. I would however tell people that the information is readily available on the Internet. A brochure that sets out the contact details of a third party that provides information and referral could be considered like the Internet.

I had a conversation with my ex-boyfriend last night. He had a friend wanting an abortion. I made my beliefs known, but upon further pressure from him, I gave him the details of resources like the pregnancy support line and adoption agencies that I felt were morally acceptable. I felt this would give the couple more time to think about it. I withheld information about the time frames for medical vs. surgical abortion. This was not a professional setting and I felt comfortable with this.

If this were a professional setting, I would probably not disclose my beliefs. I would ask a lot of questions of the patient and would probably refer them to a psychologist to get their issues sorted out, and then give them referral for support services. If the patient did not want this, and just wanted an abortion, I would tell them they had to see someone else.

If I decided to become a GP, I would try and get a job with a Catholic GP service, where it is the policy of the practice, rather than an individual GP, so that I felt the support would not change. My mental health is more important than my job. If at any point I felt that the stress of being a conscientious objector was getting too much, I would change my career.

If they changed the law in NSW and made mandatory referral a duty

I would think about not being a GP. The bulk of that burden falls on GPs. If I did become a GP and this law was in place, I would have a discussion with the practice. I would still try and get the job and would offer to do other tasks for colleagues.

Other services subject to conscientious objection

It is really hard in a pluralistic society to judge others' beliefs. With services like abortion and euthanasia, I believe doctors' consciences should always be protected. However I object to circumcision because I do not believe there is a medical indication for it. It used to be thought of as having medically benefits, but not anymore. In this profession we push evidence-based practice so much, but there is still doctors who will put this to one side if the family wants circumcision. I get annoyed about it. I don't think it should be co-opted into medicine. I don't think governments should allow people with medical training to do services that have no medical basis. The same applies to some cosmetic procedures. They are often not of any medical benefit in terms of curing a disease or illness.

Education received about conscientious objection during medical training

I think we got better than the average training, as I went to a Catholic university. Ethical issues were raised about one's role as a doctor, and issues like consent, but not about conscientious objection. We once had a panel to discuss abortion, but it was quite soft. I felt the lecturers were nervous and worried about offending students. You could feel the nerves of the people on the panel. You need an alpha dog on the panel.

The medical students are incredibly arrogant. They can yell and shout over the top of lecturers. They go for the weak. It can be awful. I think appealing to the students' civility is an essential, so that they know the ground rules and there can be civilized debate. You have to get the tone right. It is such an emotional issue. One of the lecturers was a philosopher and I really liked the way she discussed the issue, however for many of the students, philosophy probably did not appeal to them.

Doctor # 2

Interview conducted by ALW on 14.3.18
Start 8.00am
Finish 9.00am

Antecedents of Doctor # 2

Doctor # 2 is male, identifies as a Catholic, and has an internship with a large regional hospital in the public health system in New South Wales, with rotations in a tertiary hospital.

Consent

Written consent was obtained for the interview by ALW.
The interview guide was varied to take into account the respondent's background and in order to explore issues as they arose.

The basis of your conscientious objection to abortion

There are two parts to my objection. Firstly, the conscience part and secondly, the medical part. In my mind, a conscientious objection is one where your opinion differs from the medical majority. My conscience tells me that the unborn child is human life, and you cannot destroy human life as part of your professional requirement to care for a patient. My medical training tells me that there is evidence of genuine side effects for the woman who undergoes abortion, both physical and psychological, and these are underplayed. There needs to be greater consideration of these medical risks by those physicians who perform or refer women for abortions.

The impact of being a conscientious objector to abortion on choice of workplace

Being a conscientious objector to abortion has definitely had an impact upon where I will choose to work and where I will specialize. I cannot work in Victoria, or in countries overseas, where the laws require doctors to refer and perform abortion, and this limits my choices geographically. In terms of specialization, whole areas are affected. Obstetrics and

gynaecology is just too morally complicated. I would find it very difficult or near impossible to become an Obstetrician. It's a shame as I really enjoyed my Obstetrics and Gynaecology term whilst a medical student. It is an exciting field, where you really make a difference. Your intervention around labor can mean a live baby or a dead baby. However, it is not an area I feel I can specialize in and as a result I am thinking about neurology.

Your experiences with disclosing your conscientious objection to abortion

I did medical research for a year. When talking about a project with my supervisor, he said we would be using cell lines to explore the expression of a particular gene. I had to ask where the cell lines were coming from. When he said aborted foetuses, I told him immediately that I could not do that. It was an awkward and difficult conversation. Fortunately, he accepted this and there were no reprisals from that.

However when speaking with colleagues about abortion, a lot of people talk or gossip. I think it is a human thing to gossip and it is interesting to talk about other people. As a result, I would only tell a couple of people that I was opposed to abortion, but then I would get a lot of people coming up to me, wanting to talk to me about it. This does give you an inkling about what the future holds, and whether your colleagues will talk about you in a negative way; saying that you are backward, that your beliefs are not evidence based, or even that you are a religious nut case.

I recall one instance when doing my obstetrics and gynaecology rotation, my supervisor talked about another obstetrician who was pro-life. She openly spoke about his religious views in a denigrating way. This was a particularly tricky situation for me. She was a strident feminist gynecologist and she graded me, and I felt my results were dependent on what she thought of me as a person. Fortunately, I was never asked to assist at a termination of pregnancy, so I never had to raise my conscientious objection to abortion with her. I did, however, raise my objection to eugenics, and I did a research project on the link between breast cancer link and abortion, so she probably guessed my views.

I felt like I had a good relationship with her, and I did fairly well. I did not proactively raise my objections with her because you do worry about reprisals. When you commence a conversation, you know where it starts, but you just don't know where it ends. You don't know where it is going to go. You may never be challenged with having to bring it up proactively, because a relevant situation does not arise. Bringing it up without a clinical context could be seen as you purposefully making an issue of it. So, I play it by ear, and I make choices about whether it is appropriate to disclose to my supervisors that I have a conscientious objection to abortion.

As a result, I do feel I have to be 'likeable'. It is not a conscientious thing, as I enjoy robust discussions. You can have a meeting of the minds on some points, it may not be perfect, but it is a journey towards an end point. Having a foundation of friendship before the discussion starts makes it easier. I would not say that I have lost any close friends from these robust discussions, but I have certainly not made any new friends, and I have probably lost people I'd loosely call friends because of this issue.

Factors that affect being able to disclose a conscientious objection to abortion

In 2013, NSW Health instituted a framework for conscientious objection to abortion. You must disclose your conscientious objection to patients before you talk to them about it. You also must refer to a practitioner you know will counsel them and refer for abortion. The hospital guidelines say they protect against discrimination, but this is in a general sense, and not specific to conscientious objection to abortion, and you just don't feel they are strong enough. Then again, even if they were strong enough, they would not matter. What you are worried about is a different type of discrimination that comes out in you not getting jobs or referrals for jobs.

If you are different, then you are always worried that people won't like you, and if your supervisors don't like you, you won't get into training programs, or consultancy positions, which are very competitive to start with. They will find someone else.

I have heard stories of people being passed over. It is hard to confirm, as I have never spoken with a doctor who had this happen to them. Certainly, the fact that a few pro-life doctors have gotten into training programs for obstetrics gives hope. They are impressive for what they did, and older doctors particularly are really impressed with what they have done.

Performing indirect abortion

I don't have a problem with performing an abortion where the direct intention is not to kill the child. So I would consider an indirect abortion, such as where there is fetal demise and the woman needs an induction that you know will result in miscarriage, or where the woman needs chemotherapy and the result will be death of the child.

Referral for abortion

I would not refer for an abortion. Referral for abortion is a moral act causing irreparable harm to the woman. It's lethal, and there are other places people can go to get this done. My response to a patient requesting abortion would probably be, 'it is legal and you can get it elsewhere'. If you direct them to a location, that is where the line is. I would not give them any direction, not to a place or a person.

If a patient genuinely did not know where to obtain an abortion, and asked where they could get it from, I would be honest with the patient and respond by saying that 'I never refer, I don't involve myself in them, and I can't answer that question for you.'

I would probably try and talk to them about options such as adoption, crisis pregnancy services, and social services available from both the government and church-based groups. In psychiatry, we refer all the time to church based groups. In psychiatry, referral to church-based groups occurs all the time. Churches provide an enormous amount of care that people take for granted which are unfunded by the government and provided for by money put on the plate on Sunday. So I don't feel restricted in whom I refer to, or give information about, regarding continuing with pregnancy.

If they changed the law in NSW and made mandatory referral a duty

I went into medicine in 2012, after the Victorian laws came into place. It horrified me that abortions could take place up to 40 weeks, but since then I have learned that late term abortions do take place not so infrequently, in all parts of Australia.

If the law in NSW required mandatory referral, I would speak with a lawyer and find out exactly what the law requires me to do. I would look at the case law in other states and look at my patient list, consult my conscience and try to work out a solution where I did not have to violate my conscience.

Third party referrals

Referral to a third party that provides information about abortion, but also provides information about continuing with pregnancy, would still offend my conscience. It still provides information for people on how to get an abortion, and I would feel a part of that, I would feel like an accessory. Like I morally assent to it. I would not do that.

Instances where accommodating conscientious objection is too burdensome

Obviously, an abortion clinic cannot accommodate conscientious objection.

If you had more than one obstetrics and gynaecology registrar in a main hospital with a conscientious objection to abortion, you would be in deep trouble. It would put strain on the consultant, who would have to pick up the slack.

I don't think being a GP and having a conscientious objection is an issue, because you don't need a referral to access abortion from a private clinic, unless the patient wants the pill, RU486. Abortion is just so open and accessible, you know the patient can get it if they really want it, and there are just so many GPs around.

If a patient is asking a GP about abortion, and they really like their GP, then you would have to think that they actually wanted to know what the GP's views about abortion were, and about other options. Otherwise, they would just book into a private clinic for abortion.

For people in the country, where there are not a lot of GPs, they are very used to travelling for services. Having to wait to get another GP, might give the patient more time to consider other options.

Other services subject to conscientious objection

I work in psychiatry and there are new frontiers in conscientious objection such as with the issue of transgender pronouns and the treatment of transgender patients. I think it is unethical to treat these patients and promulgate their mental illness by supporting them in the use of their pronoun that differs from their biological sex.

If the whole department is telling you to use a certain pronoun but you believe it is harmful to the patient, then you are in a bit of a bind. It differs from abortion in that with an abortion request, you can step back from the issue and choose not to take the interaction further. In this instance, you want to help the patient and are willingly in an interaction with them, and ultimately you have to address them.

I had an experience where the patient was very ill, and in the end, I compromised by using the neutral pronoun. This was confusing to the patient because I was referring to them in the plural when they are a single person, but it is one of the acceptable pronouns you can pick. I was OK with this choice. Using a plural pronoun was indirect involvement in affirming their mental illness, but I felt it was so far down the line, that it was not causing any disproportionate harm to them.

This compromise is different to abortion because the outcome of indirect involvement through referral is different to using a plural pronoun.

Education received about conscientious objection during medical training

At medical school, the teaching of ethics was very relativistic. We were taught ethics frameworks such as utilitarianism, consequentialism, virtue ethics, communitarian ethics, and the public health perspective. What they didn't express explicitly, however, was that the real grounding for medical ethics in Australia is principlism.

They spoke about conscientious objection a bit, but there was no close examination of the dividing line between the rights of the patient, and the rights of the doctor. I think they did a reasonable job. I didn't feel uncomfortable in those classes, I am used to it, and I think hearing and engaging with opposing views, helps shape you.

I recall having a very intense discussion with a good friend about 4th trimester abortion for disabled children, where half the class was sympathetic to how hard it is for the mother to have a disabled child, but not considering how hard it was for the disabled child to be killed for being disabled.

What would you change to make being a conscientious objector easier?

It needs to be written into the law what protection of conscience entails, with a clear outline of what it means to be an accessory to abortion. We need a clear delineation, with facilities specifying that they do, or do not, provide these services.

Ultimately though, I would want the whole profession to be pro-life, because no matter how strong the protections are, you can never avoid conflict. You will always suffer discrimination where the people in power disagree with your beliefs. There is a tendency towards totalitarianism where those in power want to crush those who dissent. We need the support of organizations. We need to be in the majority.

Organizations such as RANZCOG have endorsed two Bills that support termination up until birth. The AMA used to be supportive but is now taking a pro-abortion position. Whilst the NSW AMA is a little softer than Victoria, they are still wishy-washy, and I would not anticipate much support from them on this issue.

Transcript of Interview

Doctor # 3

Interview conducted by ALW, 14 March 2018
Start: 4.50pm
Finish: 6.15pm

Antecedents of Doctor # 1

Doctor # 3 is male, identifies as a Catholic, has been a doctor for six years, and is working in private practice as a GP in New South Wales.

Consent

Written consent was obtained for the interview by ALW.
The interview guide was varied to take into account the respondent's background and in order to explore issues as they arose.

The basis of your conscientious objection to abortion

I think conscience is the voice in your head telling you what is right or wrong. As a practicing Catholic, I want to remain faithful to the teachings of the Catholic Church as much as possible. I don't want to be divorced from my faith. I believe there is a connection between work life and faith life, and that only a 'fake Catholic' would keep their faith at home.

The impact of being a conscientious objector on your place of employment

I agonized over where to specialize. I got married whilst I was an Intern and in my last year as a Resident, I gravitated towards general practice because I liked the idea of helping families. Initially, however, I thought I could not be a GP because they would not let me finish my training because of my conscientious objection.

I had heard from my dad about what happened in Victoria to Dr. Mark Hobart, who was reprimanded for failing to refer a woman for a late term abortion, but I felt no one could force me to be competent at a procedure that I did not want to be competent at. I felt I would be able to steer my career so as not to put myself in that situation.

Your experiences with disclosing your conscientious objection to abortion

Before joining the GP residency program, I had a conversation with a very balanced Sri Lankan lady who ran a practice with another lady GP. They said if someone was seeking abortion, I could speak with them, and they would work it out. This gave me some confidence that my conscientious objection would be respected.

Ultimately, I was offered training with another practice, and I had the same conversation with my potential supervisor about my conscientious objection to abortion and other services, but was very surprised to be told by him:

> 'Your faith stays at home… We have to train you, and you have to be exposed to all scenarios… If you work here, we need an understanding that if a patient wants another script for the contraceptive pill, you will give it to them… However, for any new patients, you can send them to me.'

My first reaction was that it did not feel like he was giving me any choice. It did not sit right with my conscience, but I agreed to it because I could not see any other way of becoming a GP. Later, I talked it over with my dad. Even though participation in writing a script for the contraceptive pill made me morally culpable, I decided I would do my training and deny myself the sacraments for a few years. My dad's reaction was that if the father of the family falls, the whole family falls. He told me I was giving up something of myself, and the distress it would cause me from being duplicitous, would cause my whole family to suffer.

I sought advice from a Catholic priest who does not beat around the bush. He encouraged me not to be cowardly, and helped me to see that my supervisor's biggest fear would be that I would have no fear. I went away from that meeting feeling two inches taller, and feeling that there was nothing illegal about what I was doing.

So I obtained information from the Medical Board of Australia, and the Australian Medical Association ('AMA') on conscientious objection. I also went to the GP training program and told them what the practice supervisor had proposed regarding an accommodation. I had not yet signed the contract. I told them that it was not right.

The GP Registrar's organization was not very helpful. Whilst they upheld my right to conscience, they put it back on me as to what I would do if a patient requested an abortion. Before taking up the training, mediation was arranged with the practice supervisor and a locum from Medicare. The locum backed me up and said that I could practice in accordance with my conscience as a trainee GP. I drafted a special clause to be placed in any contract of employment to accommodate my objection as follows:

> 'Dr. X will not refer for termination of pregnancy nor prescribe any therapy which is considered to be abortifacient as a matter of carefully considered conscience. Dr. X is fully cognizant of his ethical duty (as outlined in the Australian Medical Association's Code of Conduct) to inform patients that the above services cannot be rendered as a matter of conscience so that patients can make an informed decision.
>
> As such, neither termination of pregnancy nor prescription of abortifacient will hold a duty of care burden. To address this, there will be a mechanism in place such that, patients requiring such referral will be informed by pamphlet or other confidential means that Dr. X is not in a position to refer for termination of pregnancy nor prescribe medications that would interfere with implantation of a fertilized embryo. As in any case of a life-threatening emergency due to pregnancy, Dr. X would naturally arrange stabilise the patient and arrange emergency care and request for investigations at an appropriate tertiary hospital".
>
> Patients requiring therapy for other women's health problems (including but not limited to sexual health, obstetric and gynaecological problems, discussions about contraception or family planning options) will not be discouraged from seeing Dr. X. Patients wanting to discuss any issues regarding the above topics (as a matter of fairness for the patient burden of other doctors at X Family Practice and for the sake of teaching) should not bypass Dr. X. Dr. X will treat all patients with respect, irrespective of their views, upholding patient autonomy and providing comprehensive, evidence-based and

> unbiased information to patients about all options so that they can make an informed decision about their health.'

Following mediation, the agreed clause inserted was slightly amended, as follows:

> 'Dr. X. will not refer for termination of pregnancy, nor prescribe any therapy considered to be abortifacient, as a matter of carefully considered conscience. Dr. X needs to be fully cognizant of his ethical duty (as outlined in the Australian Medical Association's Code of Conduct) to inform patients that the above services cannot be rendered as a matter of conscience so that patients can make an informed decision.
>
> To address this, there will be a mechanism in place such that, patients requesting such referral will be informed by pamphlet or other confidential means that Dr. X is not in a position to refer for termination of pregnancy nor prescribe medications that would interfere with implantation of a fertilized embryo. These patients will be referred to other Medical Practitioners in the Practice or elsewhere. As in any case of life threatening emergency due to pregnancy, Dr. X would naturally arrange to stabilize the patient and arrange emergency care and request for investigations at an appropriate tertiary hospital.
>
> Dr. X is aware that his status at this Practice is as an employee and a basic GP Registrar trainee. Under these circumstances, he is obliged to inform and refer patients to his Practice colleagues, including his Supervisor, if he is unable to manage them.'

Despite this, my supervisor made comments to me about the Dr. Mark Hobart case. When he would see patients in the waiting room enquiring about seeing another GP, for services I refused to perform, he would say things like: 'We still have to talk about this Michael…' It was clear that he did not like this solution. I felt this was not good sportsmanship on his part, given the mediation.

I managed to stay for six months in this Practice. During that time, no situation arose regarding abortion, only requests for the contraceptive pill. In this scenario, I would say to the patient: 'I cannot provide you with that referral, but I am happy to look at other options for you.' If they declined, I would document this in their notes, declare that I had a conscientious objection to

providing the service, and then tell them that there might be other doctors who could help them, and closed off the conversation. I left it open for them to come back and see me about other things. I did not bill them because I had been advised that if the patient got offended, and then got a bill, they might be more likely to lodge a formal complaint against me.

When I left, I did not worry about being unemployed. As it turned out, I was able to obtain employment here and there until I found another GP Practice to work in. My main concern was that I not be de-registered. I think it may well take a few doctors going to jail for the absolute injustice of this situation to be highlighted and tested in court. I have to steel myself to be that doctor. That is why I keep dipping my toe in the water, to test myself. I always have this possibility in the back of my mind.

My reason for being proactive in discussing my conscientious objection with potential employers is the impact on the practice right. They need to know where I stand so that it does not disrupt them. Since that experience with the GP practice, I learned I have to be forthright and assertive if I am going to make it as a GP with a conscientious objection. I am an introverted person and I have had to learn some skills. I know that if I play the nice guy, someone out there will exploit me.

I went to another practice. I immediately disclosed my conscientious objection, and they were very welcoming and understanding. I then went to palliative care for six months and again, the supervisor was really supportive of me, but my conscientious objection to abortion and other such services, did not apply to palliative care.

I then went to another practice run by two ladies, who were very successful. I worked there for 16 months to finish off GP training. My supervisors accepted that I had a conscience, and verbally said they had no problem with me acting in accord with my conscience. When I got Fellowship as a GP, I started to be more vocal with patients about supporting sexual morals. A few patients complained about this and that led to lots of meetings and interventions with my supervisors.

I recall one complaint where a patient asked me at the end of the consultation for a referral for IVF. I said I was not able to participate because of my conscience and Catholic faith. She went away and complained to supervisor that I said I did not believe in IVF and that she was made

to feel that the child she had with her in the consultation, who was born via IVF, was somehow worth less.

I was brought before the two supervisors. They told me it was not so much whether what the patient said was true or not, but it was more about the impression it left. They were more concerned about complaints on social media rather than the notion of truth. I left this Practice and joined my current Practice. Here there is a different milieu with lots of wealthy people, married, with families, and a lot less psychosocial distress. Here, the message of sexual morality is more welcomed by patients.

Performing peripheral acts

I have rarely been in the situation of having to perform peripheral acts for something I have a conscientious objection to. I recall I once observed a vasectomy as a medical student. At that time, I was content to use the experience as one where I learned more about anatomy and surgical technique. I told the supervisor of my conscientious objection, and it was fine. He laughed and said I would probably not specialize in urology. However, if I were asked to cannulate a patient for abortion, I would simply refuse. In my opinion, they can always find someone else.

Referrals

It is not OK to make an effective referral. It makes you part of the causal chain. If a patient asks for a referral for abortion, I say that I am aware that there are some doctors who will help you, but that I know certain doctors in my practice will also not refer for abortion, and I suggest they talk to the receptionist about that. I don't lead the patient to the door of the doctor who will assist them.

Some patients are quite happy to keep seeing me. They can see I am still committed to looking after their health. People are highly mobile with regard to their GP. They often get opinions from other GPs. Consulting with a GP is not about taking part in a transaction. We are not ATM machines. We are not a script dispensary service, or a referral dispensary service. We are supposed to act in the patient's best interest. I am also a human being, I have a conscience, and I don't want to transgress any moral laws in being a GP. I want to be a good doctor.

At the start of my medical career, I had anxiety and stress about how other doctors would perceive me because of my conscientious objections. I think the antidote to worrying about what other doctors say about you when you have a conscientious objection is to simply be a good doctor. My patients are happy, and they know the quality of my work. As a result, being a good doctor is an obsession of mine. I must ensure all patients believe a very good doctor treated them, and that they tell the receptionist and other doctors in the practice, that I am a very good doctor.

Scenarios where accommodating conscientious objection is too burdensome

In regard to rural areas, I don't think I could put myself up to work in those areas. The Medical Board clearly states that doctor should not act in ways that impede access to legal treatment. I have thought about practicing in a rural area. I loved my training in rural medicine, but I would have to visit the area, introduce myself to the people, disclose my objections and if it were a problem, I would not take the position.

If they changed the law in NSW and made mandatory referral a duty

I don't like anything being mandated. I don't think mandated referral represents good practice, and it does not lead to better care. I think mandating referral is simply a way to root out those of us with a conscience, to make it harder for us to practice in accord with conscience.

If a law came in mandating referral, but permitting referral to a third-party organisation that offered all choices, then being honest, I think I would probably be risk averse and take the view that giving information about the third-party organisation would not be akin to guaranteeing any particular outcome.

However, in providing the patient with a pamphlet containing the contact details for the third-party organisation, I would annotate it and give them additional numbers such as 'Sarah's Place' or Church support groups, and I would schedule a follow up to see what their decision was. I would feel bound to do this as a good doctor who cares about their patient.

When you refer patients to specialists, the patient will always come back and tell you if the specialist was awful and you feel bad because you were the one who referred them. Annotating a pamphlet and directing them to additional places they can go, is simply an extension of this. The way I see it, I did not cut off an option. Rather, I extended their options.

Other services you have a conscientious objection to

I had a young patient once who went to a lot of nightclubs, had lots of one-night stands, and wanted me to prescribe him Viagra so he could feel more confident. I told him that it was not something I could participate in, because I was a Catholic and I don't prescribe Viagra for people wanting it in the context of extramarital relationships. I realized then that it was not just female patients who could put me in this position of having to defend my conscience.

I had another patient who was a police officer who came in and very gruffly reeled off a list of things he wanted, with the last thing being Viagra. I knew his social situation and so I said the usual spiel about not being able to provide that service. It killed the chemistry immediately and it was an extremely uncomfortable encounter because I had to stand up to an older male, who yielded authority in society as a policeman.

I once had a patient who wanted me to give him oestrogen because he was in the process of transitioning into a woman. The guy was severely psychosocially distressed, with severe mental health issues. He had a very sad family situation that included abusive relationships with his parents. He told me that if there were one person he could kill, it would be his mother.

I told him that I did not believe that the oestrogen would help him, and the funny thing was, he kept coming back to see me. I wrote him a referral letter to a psychologist, and I remember thinking that the transgender issue is so clearly secondary to a primary distress. I told him that the distress he was feeling was related to what happened to him as a child, that we needed to manage this distress, and that I didn't think that giving him a script for oestrogen would help him. I told the patient I would not participate in referring him to an endocrinologist or plastic surgeon, for the purpose of receiving a work-up so that he could go on to receive sex hormones. I quoted to him the results of a Harvard study that found that sex change operations were not leading to a reduction in suicide outcomes and that for the same reasons as set out in the study, I would not be giving him oestrogen.

I told him I was very happy to do other things for him. I documented the consultations carefully, because I knew my supervisors read my notes, and they had a habit of sending me e-mails if they felt that I had been inappropriate or judgmental. He ended up getting oestrogen easily enough from another doctor in the practice, but interestingly, he stayed with me for other things.

Education received about conscientious objection during medical training

I don't recall receiving much training on ethics at all during medical school. We may have talked about ethics, and I recall doing an ethics essay on abortion, but I cannot now recall what I said and if it differed to what I think now. Once qualified, I do recall doing exercises in ethics led by a GP who worked for a medical indemnity organization, which were helpful.

What would you do to change the situation and make it better?

I want more people to be aware that there is such a thing as a doctor who will practice in accord with their conscience, and that they can encounter a doctor who is willing to be counter cultural. If there could be awareness in the public sphere that not all doctors can provide all services, this would be helpful. We need to be able to explain what conscience is, so that patients do not put pressure on doctors in that position.

Whilst there is a power imbalance between doctors and patients, the law is there to protect patients. I would like to see clearer protections in the law that acknowledges the existence of doctors who will not transgress their conscience, with clear language, so that if I have a patient like that policeman, I could fall back on it and show them the law without having to explain myself further.

I only want the law to require doctors to act in the best interests of their patient. It does not have to require them to do certain things, like provide a referral, as doctors are not automatons. Automating the profession will only put good people off becoming doctors.

I don't have much hope. Whilst the AMA was initially on our side, it will probably back the status quo, and the government's position. We've had several big changes in 2017 with respect to attempts to change the law on abortion, to make euthanasia lawful etc.

However, it's not inevitable that certain sectors of society will get what they want. We can still fight for our freedoms. I'm just glad I am in in this state.

I left the AMA last year over their statement on same sex marriage. I do wonder if they have a database of doctors who have left. I do wonder whether it leaves me open to some kind of reprisal, but I had no financial reason to stay with them, and I have kept up my medical indemnity.

What I want to do is to have medical students hear that you can still be a good GP even if you practice in accord with your conscience. That's why I want to make this current practice I am in, into a training practice for them where doctors with a conscientious objection are welcome.

Transcript of Interview

Doctor # 4

Interview conducted by ALW, 19 March 2018
Start: 6.15pm
Finish: 7.35pm

Antecedents of Doctor # 1

Doctor # 4 is male, identifies as a Catholic, worked as a doctor for one month in a tertiary hospital in New South Wales, and has now left medicine to return to work in a corporate environment.

Consent

Verbal consent was obtained for the interview by ALW.

The interview guide was varied to take into account the respondent's background and in order to explore issues as they arose.

The basis of your conscientious objection to abortion

To me, conscientious objection is a situation where you are asked to do something that goes against your deeply held convictions that causes you to not want to do the service. The obvious issue is abortion, although it does occur in other areas.

The basis of my conscientious objection to abortion is my religious convictions. I have never really seen any evidence that can argue for abortion being an ethical thing to do. I have never really been convinced otherwise. I also object to contraception.

The impact of being a conscientious objector on your place of employment/career choices

In my first year of practice as a doctor, I worked in a tertiary hospital, and I deliberately chose rotations to areas where this issue would not arise. I left medicine after one month and returned to work in a corporate environment. My having a conscientious objection to abortion probably had an indirect impact upon that decision. It just added to the stress that you feel as a doctor.

I would have liked to be a GP. It's a good route to do down. It takes fewer years to qualify, and it is family friendly. However, I thought for me, there are also issues around prescribing the pill. I thought that prescribing the pill is so common that it will be a big issue. I didn't want to be in this situation of continual conflict my whole life. There are not many GPs around who share these views that I could talk to about it. I spoke to one but it's pretty rare. I know some GPs make it work, but it is difficult.

If there was some sort of policy where you could put a standard clause in your contract that you don't refer for abortion, or prescribe the pill, then that would have made it much easier for me. You don't want to spend the rest of your life in a fight.

I did a psychiatry rotation, and a few times issues came up regarding transsexual people. A guy came in after a suicide attempt. He wanted to transition from male to female. A few days later we were sitting down with the head psychiatrist. He said to each of us, 'How would you approach this?' His view was to encourage this person because as with Freud, these powerful urges need to be encouraged. I didn't think this was right but when he went around the table, he asked people, 'Are you homophobic?' Of course, all of us said, 'No, of course not!' A lot of the staff there were homosexual, and I got the impression that in psychiatry this was an issue, and this pushed me away from psychiatry, which would have been a potential area for me.

Your experiences with disclosing your conscientious objection to abortion

I attended a Catholic medical school and was in a lot of classes where you want to talk about these issues, but the vast majority of teachers do not encourage the traditional Catholic view. Some are quite aggressive about their opposing view. When I started off in 1st year, I was quite up front about my beliefs on abortion, however after a while, I changed my approach.

At the end of my degree, I was really hiding it. A big reason for this was seeing a person in my year that was bullied for actively taking a prolife position. People ignored him and would not talk to him.

He was a little bit inflammatory and aggressive about it. He would start face book arguments. Seeing what happened to him made me think it was not worth expressing my views. I didn't want to be in the same situation as him so I tried to back away from it. I found this decision very difficult, because you want to do the right thing, and you question whether the reason you are not being open is a lack of courage. Ultimately, I came to the conclusion that it is ok in some situations to not speak up, because one needs to be prudent. With this guy, his tactic was to be aggressive and to me, that is not the right thing to do. However, being too open may also not be prudent.

I remember doing a week of obstetrics and gynaecology. The small group discussions were highly explosive. I was in the minority position, with a few on the fence, and the others more aggressively pro-choice. The tutor was a little aggressive. I remember she asked me in front of others whether a doctor is obliged to notify the father of a patient seeking an abortion. I tried to respond and say that it was a complicated situation, but she was quite forceful in telling the class that this was not allowed.

In 3rd year, an obstetrician who held an important position at the College gave a lecture. Part of his talk was on the medical aspects of obstetrics, however the other part was blatantly making fun of people with religious beliefs. I remember he showed us a derogatory cartoon of Christ, and was trying to belittle religious people, and trying to get other people not to go down the same path. A lot of things in medicine are unprofessional. That lecture could not have been given in an accounting firm or law firm. The idea of making crude jokes about a religion would just never happen.

When people in authority do this, it creates a real culture that the default position is being pro-choice, and if you did not hold that view, you are not encouraged, and are in fact ostracized. A friend of mine was very upset by this lecture and wanted to make a complaint.

I felt that even if it causes me distress, I must put my views forward. I knew this topic was coming up, and I knew it was going to be so painful but that if I spoke out, people would think I was a lunatic. At the time, I thought it was best not to do this. I felt guilty, but then over reflection, I decided there is no obligation to speak out when it is not prudent.

I came to the conclusion that the best approach was not to fight back, but to accept these things, be a good person, do the right thing for you, and be an example to others, rather than get involved in a war.

It was always difficult to find people to talk to. There were not many students or doctors who were prolife. I felt pretty anxious all throughout medical school. There was a constant underlying level of anxiety and even fear of reprisals.

Having worked in the legal environment, and comparing it to medical environment, there's a big difference. How you approach abortion in medicine is a determinant of how you approach many things in your life, and it instantly puts you in a category of how you will deal with other issues. It's a core topic and it naturally comes up. Nobody has to share their opinion about abortion in a legal environment. In medicine, it was always in the back of my mind… that the topic was going to come up.

As a student, I did a rotation with a GP, and I could tell her views were towards the prochoice spectrum. At her practice, they were doing Implanon insertions. Her personality was a bit aggressive and she was regularly inserting Implanon. Doing that rotation caused me anxiety. I didn't feel like I could speak with her. As the whole practice seemed the same way, that put me off having a conversation with her about it. I thought if my views got out there, who knows what will happen.

I wasn't too worried about my views affecting my grades. Rather, I was always very worried about whether I would suffer the same as that other guy at medical school. The social consequences worried me more. I thought it would be same. People would ignore him, would not sit next to him in lectures, and make snide remarks about him. It also caused problems for me. He was my friend to start with, then this all happened. I thought he was being over the top and too aggressive. I thought that if people knew I was Catholic, and held those views, that I would also be thought of as too aggressive.

I think I was too scared about being associated with him. I started pretending not to be his friend. Looking back now, I was too worried about being seen as his friend. He was affected by the social reaction he got. He was a highly intelligent guy but he was quite blunt. He would be a lot quieter in class, he would talk with less confidence, and if he had to give a talk, and he needed to ask someone in class to do something for him, no one would say anything. It really added to anxiety through medical school. It caused me an underlying anxiety throughout medical school. I expected more from a Catholic University.

I did an O&G rotation at medical school, and you had to attend a certain number of surgeries. I did not want to attend any terminations because you are required to do more than just observe, you are required to be involved. This made me very anxious, but I was very wary about talking about it because medicine is a very small world. I worried about what to do if one of the surgeries was a termination. I had a few friends at other medical schools, and I asked their opinions about an exit strategy. I didn't want to lie, and the plan was to think up something that sounded reasonable.

One day, I looked on the board that lists all the surgeries and saw that there were no terminations on that day. So, I sat in the whole day in order to tick off the required number of surgeries I had to attend, so I stayed much longer than required.

Performing peripheral acts and providing referrals

I am a bit unsure about the correct approach here. If it ever came up, I would talk to other people. Doing things like inserting a cannula for a procedure I am morally against, could be seen as too remote, and if so, then it would be OK.

This issue about referrals was talked about a bit at medical school under the abortion umbrella. If a patient was on a script for the pill, I would not want to write that script, however I don't blame some people for having the view that it's just a script, and for being bemused by the objection.

I find a lot of these technical situations about what you would do in certain situations hard to comment upon. For me, I would look for a stance that has been approved and was in accord with my religious convictions and use that as a guide. Distinctions are very difficult to decide on your own.

Scenarios where accommodating conscientious objection is too burdensome

It's important that they do accommodate people with these views. Sometimes they are so deeply held, and it causes the person a lot of anxiety and distress. Saying it is too burdensome sounds a bit unlikely to me. I think you can usually accommodate.

Even as 1st year doctors working in a hospital, the O&G wards call in their own staff even at night to assist at an abortion.

Education received about conscientious objection during medical training

My experience with teachers was that in subtle ways they would try and put pressure on students to adopt prochoice attitudes. In small group discussions, the teacher would subtly try to push one view, and slightly embarrass someone who didn't have the prochoice view.

There is a real need to for teachers to do things like acknowledge that there are opposing ethical views. I came to the conclusion that at my university, they were trying to push a certain view, and there was no point in making any noise. Maybe other universities have a different view.

What would you do to change the situation and make it better?

Having a conscientious objection to abortion causes lot of anxiety. There are not a lot of people to talk to, and you need to be careful whom you talk to. There are all sorts of pressures on you, and you do feel a bit like you are charting new borders. There is no official structure for what you should do. You feel isolated. In Australia, there is the St. Luke's Guild, which is trying to reinvigorate itself. You wonder why there is not more effort to create a structure to help people.

There are lots of demands of study…a lot to worry about. I worked in a corporate environment for several years, and then a general practice. The stress levels are nowhere near that of medicine.

In medicine, people are type A personalities, and over the top. They don't just want to do a good thing; they want to do it very well. These bioethical issues are such an underlying issue in medicine. They determine so many things, such as whom you associate with. For junior doctors in Sydney this is a real issue. The way it is at the moment, it not good. Some things need to really change to improve for them. Particularly around my university, it's pretty sad. It's difficult enough for junior doctors but to then have to deal with this issue. It's too much.

Transcript of Interview

Doctor # 5

Interview conducted by ALW, 21 March 2018
Start: 9.00am
Finish: 10.30am

Antecedents of Doctor # 1

Doctor # 5 is male, identifies as a Catholic, has been a doctor for 30 years, and has worked as a GP in the same medical practice based in New South Wales for 24 years.

Consent

Written consent was obtained for the interview by ALW.
The interview guide was varied to take into account the respondent's background and in order to explore issues as they arose.

How would you define conscientious objection

Where I would not do something I believed to be wrong.

What is the basis of your conscientious objection to abortion?

I have a conscientious objection to 'life' questions based on my Catholic faith and reason. Clearly, taking life is the major issue and I also don't prescribe contraception or refer patients for sterilizations. In general practice, the request for contraception is more common than referrals for abortion, but the mentality is linked.

The presumed wisdom is that contraception prevents abortion, but I believe the mentality leads to abortion. A significant proportion of unplanned pregnancies occur when people are using contraceptives. The approach of the person is that they didn't want the baby in the first place. Therefore, the next logical step is to get rid of it, to consider abortion. It's one more push.

Through human error, people can forget to take the pill, or they may vomit or have diarrhea, or it can interact with other medication. Now, they are pushing long lasting contraception through implants. Whilst it takes away the human error, they don't necessarily work 100% of the time. If we were robots, then potentially they could, but the human body is not a machine, and it changes constantly. Despite the particular quest in this area, we will never get 100% efficiency.

My Protestant partner in the practice would still refer for abortion, if pushed by a patient. She tells the patient, 'This was my medical view… now I would like to talk to you as a Christian.' She has the view that when I am at work, I have my doctor's hat on, and when I go to Church on Sunday, I have my Christian hat on. I don't subscribe to that. I believe we need to be integrated and have unity. I believe my private life should influence the way I practice medicine. I cannot be two different people.

The impact of being a conscientious objector on your place of employment

I have been in my current GP practice for 24 years now, a very long time, and there is no issue with accommodating my conscientious objection. The two other partners in the practice understand my viewpoints, respect them, and have been supportive of that. One is an evangelical Christian, and the other is Agnostic.

I don't get a lot of patients asking for a referral for abortion or to discuss a crisis pregnancy. I have been in my current practice for a long time, and the patient population is stable. It is different to a bulk billing practice with lots of walk ins and transient patients. The vast majority of patients, more or less, have an idea of my views. I imagine this filters them out to other doctors.

In my first year of practice, I was at a tertiary hospital, where you are required to service two peripheral hospitals. At the peripheral hospitals, you are given more responsibility. I have a clear memory in my 4th year, when I did a 6-month Diploma of Obstetrics at one of those peripheral hospitals. The head of the Department of Obstetrics was a practicing Catholic and understood these things. The Superintendent of the hospital was also a Catholic. Whilst terminations were done, it was through a few doctors admitting their patients, rather than a policy of the hospital.

The fact that these two doctors worked there was part of the reason I chose to do my Diploma there, as I knew it would not be an issue. In another hospital, I would have been more wary of it. I would have been more careful of the place I went to.

Your experiences with disclosing your conscientious objection to abortion

I talked to a number of older doctors about how to handle my conscientious objection to abortion and contraception, and their advice was to be upfront, and discuss my beliefs in a non-confrontational way, and how it will impact upon the practice.

At my current practice, I knew the Agnostic partner before I started. He was a friend from university, and we had family connections. At the time I started, I proactively brought it up with the Principal of the practice, who is no longer there. I was a little bit nervous about this, but by that time, I had done it a few times before. Our families knew each other, so there was a bit of a connection, and he understood.

I recall one time a patient requested abortion. The normal response by me is ‘I would not be able to help you terminate your pregnancy, but I am quite happy to support you in any other way.’ I am not aware of any complaints by patients for that response.

A long time ago, I talked to a lady about the contraceptive pill. She had two or three children. I explained my situation, and she was not upset. However, the next day, when I was working in a different practice, her partner walked in, shouting at everyone, kicking doors in etc. The doctors there, the two partners, were very good, very supportive of me, and more annoyed at this fellow being disruptive.

When I first started training as a GP, I was in a group practice in a regional area. The length of the term was to be 13 months. In my first interview with the responsible partner of the practice, I was late, and I tried to explain my conscientious objection position, and his response was that it was fine and they would try to work around this.

However, there were a couple of instances where I declined to prescribe contraceptives, and there was one request for a referral for sterilization that I did not proceed with. As a result of that, I was asked to leave six weeks before my term was due to end. They told me that several patients were upset.

I took the view that as a trainee, I was transient, and that this practice was their livelihood. The main partner was a Protestant Irishman, and he took exception to my views. I took the view that as I was training as a registrar, they were doing me a favour by providing the training. I was not pulling my weight or earning my share, so to speak. So, I perceived a difference in this context than if I were an employed doctor in the practice who was asked to leave.

I think a student would find it harder to raise their conscientious objection, as you are part of the system, a small cog in the wheel, and beholden to other people. For me, their request that I leave was not a surprise. The Partner had made a few comments to me such as:

> 'Surely you could just do this…'. … My father-in-law is a Catholic and he thinks it is reasonable to prescribe contraception…. What if the Pope or the Church said it was ok to prescribe contraception?

I thought about that last argument, but the reason why I would not prescribe contraception or refer for abortion or sterilization is based on reason, and it would not change the way I reason, so I don't see how I would change my view.

I didn't find his attempts to change my mind offensive. My background and personality is not as someone who insists upon their rights. I do what I need to do. I don't like confrontation, but also I have never cared what other people think of me.

Although it didn't affect my greatly, it affected my father. He said to me 'Oh my gosh, how are you going to practice ever again!' The College of GPs who run the training program have a policy that these days is probably more lip service, but where they are tolerant of people of all beliefs. I went back to the College and told them what happened, and they said they would try and find a position for me.

At the time, I was young, single, and it did not really worry me. A friend of mine who was a prolife doctor gave me a job at a hospital for a short period. I also did some locum work. During that time, I recall a lady took great offence to me when I said I could not prescribe contraceptives because I was a Catholic. She said, 'Well I'm Catholic too!' and stormed off. Interestingly, another one responded with: 'Really, why is that so?' We talked amicably for about 10 minutes, and she volunteered that she was an Anglican and we parted ways.

The College found me another GP trainee position. Here, the principal was older, an atheist, and he was fine with me having a conscientious objection. He said: 'I understand this. If there are any problems leave the patient to me.'

It was a different set up. At the first place, I saw patients on my own. In this setting, I sat in with him. In a business sense it ran differently. As a sole GP practitioner, patients come to see you. In a larger practice, they come to see a doctor and it does not matter who they see. So, in this context, it was not a problem as I would not be on my own seeing patients and upsetting them.

My original approach as a GP was to say, 'I don't do this because I am Catholic and these are my beliefs.' Now I say:

> 'For personal reasons, I don't prescribe contraception, and if you would like to talk about it, I would be happy to, otherwise I'll take you back out to reception to find another doctor.'

I think that in today's postmodern age, raising religious beliefs is a red rag to a bull. People think that you believe what you like privately, but you don't raise it publically. If you refer to personal reasons, tolerant people will respect that, and it is less antagonistic to the person, and less confronting, than referring to religion.

In a certain sense it would be more honest of me to say that the reason is my religion, but it's more of a practical thing. I had a friend who advertised on his reception desk that he did not prescribe contraception. I thought this was an interesting way of dealing with it. For me, it's a matter between my patient and me.

On our practice website, it alludes to me being interested in natural family planning. I want to be able to talk to patients about other options. I don't expect they will change their mind, but I do hope it prompts them to think about it. I am very happy to talk about it. It's one on one, in a confidential space, a secure and safe environment. I tell them that for medical reasons as well as personal reasons, I don't think it's in their best interests.

If I were told I could not do this, it would be a gross invasion of privacy and freedom. On any other subject, people would be up in arms.

Performing peripheral acts and scenarios where accommodating conscientious objection is too burdensome

Peripheral acts are difficult. If you are a junior doctor in a hospital, you are admitting patients coming into hospital and doing the paperwork. I don't recall having to admit patients for abortion, probably because of the hospitals I worked in. There were two other pro-life doctors, and I recall one time he was called to admit the patient and he declined. The nursing staff asked the other doctor, and he declined. If I were asked to do that, I would have declined.

In reality in a hospital someone else can probably do it. Yes, I would be causing problems for the nursing staff, but it is more of an inconvenience, and not a major problem. On a day where you absolutely flat chat, you'd imagine they would get annoyed. You could cave under the pressure. Nursing staff can react in a number of ways, either in finding someone else, or ringing the medical superintendent and telling them that you refuse to admit a patient and causing problems.

Once I was assisting with a caesarean section, and the doctor performing it was a registrar, a Catholic but not practicing. When we finished the caesarean, he said to me, 'Just stand over here for a minute'. He then put clips on the woman's ovaries to sterilize the woman, and then he said to me 'You can come back now.' So, he created a way for me to not be directly involved and it has been both the system and individuals who have supported me, apart from that time I was asked to leave the GP practice as a trainee.

Things have changed over time. My training days were in the 80's and 90's. The penetration of ideas into the colleges and the upper echelons is not what it is today. The 'left' idea, whilst around, was not dominant, and there was more of a live and let live attitude. Whereas today, such as with the same sex marriage debate, the left is very militant and aggressive and do what they accuse us of doing, that is, pushing beliefs down people's throats. The very idea of corporations supporting SSM, and the need to be seen to be LGBTQI friendly, was something unheard of 20 years ago.

Mandatory referrals to third party organisations

If there was a law that required me to refer someone for abortion, it is still a doctor patient relationship. It's about how I handle this personally. I would say for personal reasons, I cannot refer you for an abortion, I am happy to support you in any way I can, and the government has this information for you regarding different options. I would verbally add to that pamphlet, other services not on it, and I would write on it as well. I would stress that say I can help you as much as I can with the other options.

More and more, we are seeing patients treated as if they were children who cannot make decisions for themselves, with the profession required to hold the patient's hand and take them where they need to go. My job is to give the patient information, indicate what I think is the best and preferred option, and then it's up to them to decide what to do. We all have free will. If a woman wants to have an abortion, she will have one regardless, whatever the law says. In this day and age, everybody has a smart home, and nobody has no access to information. In two seconds, a woman can find the nearest abortion mill. We are all given free will and can choose what to do. For me, freedom is choosing the right thing. This is not the view most people have.

Would you perform surgery to remove sex organs at the request of a transgender patient?

The evidence that it is a disorder does not stack up scientifically or medically. Whilst a significant number of adolescents will go through this identity-seeking phase, the vast majority comes out of it. It might be different if a 50-year-old said he had been trapped in this body… but I have only been faced with this more peripherally, in that a couple of families we are seeing are undergoing this process. My role has been to support the parents.

Practically, I would never have to perform sex change surgery, but I would definitely refuse to refer for that surgery as I think that it would be mismanagement. Perhaps I am living in an ivory tower, but I think the milieu through which people are doing this is the Internet and city life. In the suburban areas, you just don't have psychologists pushing this, or people wanting this.

Education received about conscientious objection during medical training

I definitely did not receive education about conscientious objection during medical training. It's all been through networking with other pro-life doctors.

What would you do to change the situation and make it better?

In an ideal world, there should be no need for a law to protect freedom of conscience. To me, the more legislation in these areas, the less freedom there is. I take the point, though, that the law has a protective effect, and I guess if the societal wish is for litigation, or persecution, or prosecution of people who think differently, then there could be a need for protective laws, but we should be able to work these things out individually.

I think there is a little bit of me trying harder to be a good doctor because I have a conscientious objection, but notwithstanding that, I already feel I need to do my job well. If I were exposing myself to potential criticism then yes, there would be an awareness that I need to be a very good professional. If I did nominate for a position such as in the College of GPs, or on the obstetric training committee, I think it would be harder for me to succeed because of my conscientious objection to abortion.

Transcript of Interview

Doctor # 6

Interview conducted by ALW, 21 March 2018
Start: 8.30pm
Finish: 10.15pm

Antecedents of Doctor # 6

Doctor # 6 is male, identifies as a Roman Catholic, and has been a doctor for 11 years. A fellow of the Royal College of GPs for six years, doctor # 6 has an advanced diploma in obstetrics and rural generalist qualifications in medicine. Currently working as a GP in a large general practice in a regional town of New South Wales, doctor # 6 was delivering babies up until 2018, when he ceased for family reasons. He works part time as a clinical lecturer in medicine at a university.

Consent

Written consent was obtained for the interview by ALW.
The interview guide was varied to take into account the respondent's background and in order to explore issues as they arose.

How would you define conscientious objection?

A conscientious objection occurs where there is a circumstance entailing a course of action, which someone objects to, and does not wish to follow.

From a medical point of view, I have a conscientious objection to termination of pregnancy, contraception, and some vaccinations. I don't object to vaccines per se, but I do object to vaccines developed from a purposively aborted foetus. In such cases, I consider the remoteness of my action in prescribing the vaccination, and the risk/benefit to the population in not prescribing it. If there are ethically viable alternatives, I recommend to the patient that they choose those.

I do believe that 'fringe beliefs' that are not supported by objective empirical evidence should be protected by freedom of conscience and I don't think they are mutually exclusive, rather I think they can work together. I think if we say there is conscientious objection, we cannot differentiate the actual beliefs people have.

What is the basis of your conscientious objection to abortion?

I have a faith-based objection to abortion, but this is not confined to Catholicism. Christianity and Judaism respect human life from its natural inception to its end, and they recognize that rights should be accorded to the human person regardless of whether the person displays consciousness. I also have a scientific objection to abortion that can be found in the Hippocratic oath – I shall respect life.

Since around 1965, pregnancy has been defined in medicine as occurring at implantation, with conception occurring at some point between fertilization and implantation. The traditional view, that conception occurs at fertilization, is the one I hold to, not an arbitrary point in time between fertilization and implantation.

The impact of being a conscientious objector on your place of employment

It's been difficult. As a rural physician, I cannot practice in ultra-remote areas. I have worked as a locum in remote Australia, and it was difficult.

The biggest difficulty has been with a conscientious objection to prescribing contraceptives, although I will prescribe oral contraceptives in certain circumstances, such as bleeding. The basis of my conscientious objection to contraception is twofold. Firstly, there is the *Humane Vitae* side of things, and secondly, there is the post conception potential of hormonal contraception destroying a human life, which is medically speaking, an entirely reasonable possibility.

I met a staunch Catholic doctor who gave me the confidence to live out my values and showed me how my position could be medically defensible. Doctors that are known to be confrontational about their beliefs, by raising the issue directly with patients or management, or with hospitals, can come across as being very un-diplomatic at times. Now, I am looking at how to deal with expressing my objections in different forums, so it is not just pushing a point. There are wars and there are battles.

You can become a target, and not trusted by peers and superiors. I do feel the stigma in my practice. One doctor prescribes drugs for medical abortions, and he knows where I stand. There are a number of Catholic doctors, but some of them prescribe the pill. Whilst I would like to practice with like-minded people, this is the closet I have come to it. I don't care now about the stigma, and sometimes I actually enjoy the challenge. However, I am not always right about how I go about things, and it is good to hear how to do it better, but there aren't many role models.

Your experiences with disclosing your conscientious objection to abortion

As a student, I remember being intimidated, and wanting to speak up, but not speaking up. I had not formed myself enough regarding what I believed, and its scientific basis. Recently, I mentored a young pro-life doctor, and she was talking about a situation where she did not speak up. I don't think it is an uncommon thing for students to feel that way.

When I started working as a doctor, I worked in a hospital in a regional area. I was able to avoid stuff, as people knew where I stood. When I did my O&G rotation, there was a good Christian registrar who I felt supported by. I brought up my having a conscientious objection with her. Simply being overtly Christian was a good connection for me, and made it easy to broach the issue, but she didn't agree with what I was doing. She was a Protestant, and whilst her belief system did not go into *Humane Vitae*, she supported me.

I probably avoided contexts where I might need to disclose my conscientious objection to patients, such as passing on a request for a script for the pill. I remember I was always careful not to organize someone else to do it. I would say to the patient that someone else would sort it out. I would then speak with another doctor and say: 'this goes against my beliefs. Can you deal with this patient?'

I did have a reluctance to disclose my conscientious objection to contraception to patients. This is because of the stigma that goes with having that belief. It's a lot easier with abortion.

After hospital training, I started training as a GP registrar. I went to a regional area in another state and I recall an incident involving a 15-year-old girl who was sexually active. Her mother, who had depression, came in with her and asked me to prescribe the pill for her daughter. I talked to them about contraception in general. I said this was not something I could personally deal with because of my personal beliefs. The mother broke down and stormed out saying, 'I can't believe you are doing this! It's your fault if my daughter gets pregnant!' There was a waiting room full of people.

I told the daughter that I didn't believe the consult was finished, and that I wanted to talk about it a bit more, but I didn't see them again, I think they went to the hospital clinic where there was another GP. I remember the Practice nurse critiquing the way I handled this, and telling me that in her opinion, I should prescribe contraception.

I was born in the country and wanted to do rural medicine. After this incident, I called a bioethicist who had a medical background. Her advice to me was that if there is urgency to provide a service, you have to perform the service, and consider what is appropriate for the population that you are serving. In a one-doctor town, I have to consider whether refusing certain services that are wanted by the community is appropriate. I thought this was reasonable advice. If I had prior knowledge of the community's health needs, and they went against my beliefs, it could affect the community. If there were a complaint, it would affect my reputation.

Today, I do think it is reasonable for people to be aware of my views. In my current practice, we have a TV monitor in the waiting room that has information about coughs, colds, appointment times etc., and each of the doctor's profiles. My profile states that I do things like women's health, fertility, skin cancer etc., but I don't prescribe the oral contraceptive pill on the first appointment. In this way, there's no expectation by the patient. People around town know my beliefs.

I have undergone formal training in sexual health and family planning, so I am qualified to speak about this stuff. Now I am comfortable with reasoning through it. I am more confident. In the town I am in now, I have had a few incidents since the one with the 15-year-old-girl and her mother. In a town with 1000 people, a 22-year-old came in to get a repeat script for the pill. She was visiting family whilst on university holidays. I went through my spiel with her about the pros and cons of each method of contraception, which took about 20 minutes, and I then told her that I would not prescribe the pill. It didn't change her decision about wanting the pill and I only bulk billed her for the consult, but her mother made a complaint to the Practice Manger for taking up her daughter's time. As a result, the Practice started screening women of childbearing age, who were seeking an appointment with a doctor for repeat script for the pill. The number of patients requesting the pill from me dropped off.

The next year, I was managing a medical team in another country for a TV company. It became known that I would not prescribe the 'morning after pill'. I just told people that I would not do it. I told my team they were bound by their own health ethics, but I specifically requested the company not to pressure my team to go against their personal ethics. That request got reported back to my employer who had to tender for the contract, and I did not get asked back again for that work.

A few years later, I was working in an antenatal pro-life medical clinic. I refused to refer patients for abortion. I remember seeing a woman who was ambivalent about having an abortion. She asked about the effects of alcohol on her baby. I told her out right that I would not refer her. We spent a few weeks talking it through. However, I later learned that she had an abortion, as I worked at the hospital and saw her medical notes. About 10 months later, she was pregnant again and requested a dating scan from me. I don't know what she decided to do, but it was a case of being used by someone clever enough about the system. At that time, to get a medical abortion, you needed to get an ultrasound scan confirming pregnancy from a different doctor to that prescribing the medication. Now it is different. The same place can do it.

When I talk to patients about my objection to abortion and contraception, I do at times open up and if it is appropriate, talk about the faith-based aspect to my conscientious objection, but I don't think it is unreasonable to present things from a purely medical perspective. It is really important that I do not compromise my medical integrity.

When I am teaching medical students, whilst I am open about where my faith sits, it is not the first thing that comes up, but it does eventually come up. I want to bring up bioethical issues with my students. Most take this well, because I am in a position of authority over them.

Performing peripheral acts

I would have to look at the context. If a woman was undergoing abortion and I had to bring up a medication chart, it is an easy task to pass off to someone else. The abortion would take place with or without that, it is not necessary. However, inserting a cannula is proximal co-operation in evil, and I would not take part in that.

I do not refer for abortion, but. I am happy to care for women after they have had an abortion and I tell them that.

Mandatory referrals to third party organizations

I don't refer for abortion. I think a law that compels doctors with a conscientious objection to refer for abortion is authoritarian. I would be active in trying to mobilize against this. Such a law goes against the autonomy of health practitioners. I would get together with a group of doctors to talk about the wording of the law, and figure out ways to get around it, and then wait for it to happen. If it happened, I would become active in promoting what it does, and letting people know where we stand.

If push came to shove, and it was the law of the country, then I think there are other Codes of Ethics that would support defying the law. I feel there is a higher responsibility. If it came to me, I would defy the law. I would go against it. I would be like St. Peter and say, 'I will not deny you'.

If the law required me to refer patients to specific third party organizations that dealt with information and referrals for abortion, I would tell patients I was giving them non-directional counselling, as required by the government, and then I would make a personal judgment about the organizations on the list.

I know that the government provides clinical guidelines for primary health professionals to follow, which are adapted to your local services. Their resources direct people to Marie Stopes. This is inappropriate, as Marie Stopes has a fiscal interest in providing the service. They don't provide information about adoption, so it is biased. I would tell the patient that the organization was biased and would then tell them where to find people who lean the other way, that is, people who are prolife.

Would you perform surgery to remove sex organs at the request of a transgender patient?

I haven't had to face this yet, and I haven't thought about it much, but it would present as a difficulty for me. I would not be able to do the referral. The strongest of my convictions come from my faith, but I have to defend myself medically.

If I was uncertain about my clinical expertise in an area, and there were some arguments in the clinical literature about potential future adverse events, then on that basis, I would not engage with it, as I would not be certain enough of the benefits.

Education received about conscientious objection during medical training

I cannot recall being exposed to the issue of conscientious objection. There was nothing formal in place. Not even a recommendation as to how to have the conversation. We had one lecture on the ethics of abortion where we heard both sides for 30 minutes, and then had a further 20 minutes on why abortion is ok.

What would you do to change the situation and make it better?

Ideally, legislation that explicitly supports conscientious objection would be helpful, not just a Code of Ethics.

Transcript of Interview

Doctor # 7

Interview conducted by ALW, 22 March 2018
Start: 2.00pm
Finish: 3.30pm

Antecedents of Doctor # 7

Doctor #7 is male, identifies as a Catholic, and has been a doctor for 20 years, currently practicing as an intensive care specialist and general physician in a tertiary hospital in New South Wales.

Consent

Written consent was obtained for the interview by ALW.
The interview guide was varied to take into account the respondent's background and in order to explore issues as they arose.

How would you define conscientious objection?

Objecting or having an issue with something that transgresses an aspect of morality, where you will not act despite a request, because it is against your conscience. Your conscience is an inner reasoning… it is intellectual, and states what is right and wrong. Conscientious objection covers not just withdrawing from an activity, but also requiring you to act. An example would be the Good Samaritan requirements, where you have to act even where you may put yourself at risk morally or legally.

What is the basis of your conscientious objection to abortion?

I adhere to the teachings of the Catholic Church, whose understanding of humanity over 200 years is very strong and impressive, and its philosophy for respect for life is quite impressive, detailed, strong and hard to argue against.

From high school to university days, I have had a conscientious objection to abortion. I remember at O week, I joined friends running a pro-life stall, and there were very aggressive encounters with feminist groups. At medical school, there was very strong opposition, which forced you to think and reason, and to think about how you deal with colleagues and superiors when it comes to moral issues.

I have learned with time, that with good reading, you can argue your position calmly. I learned this the hard way from bad experiences at university and from getting too agitated and in people's faces. It doesn't work. I am aware of the way the public perceives someone who is against abortion or who is pro-life. You are judged more harshly than someone on the opposite side. You need a consistent life, being good both professionally and personally. It is harder, but you have to wear it. You are going to suffer for the truth and this has happened through history…

I recall one encounter, during a histology lecture, and I mentioned to the person next to me something about abortion and four other people got involved, including the lecturer. I didn't feel I had to bring up God at all. I almost refrain from doing this, as it's quite easy to defend my position on a secular level without adhering to a spirituality or God. The way people think today, they respond less to faith and more to rational and scientific arguments. The environment is toxic and has got more so with time, so it is probably unwise to start a discussion from a faith-based perspective, as it would immediately turn others off. I can't see the need to do so.

Eventually yes, I am happy to comment on my faith if asked. I do feel a little bit deflated that I have to make this science/religion divide. Any comment you make on faith is labelled as being fuelled by religious prejudice. They consider themselves superior by relying on secular arguments.

The impact of being a conscientious objector on your place of employment

You mainly come across abortion in anaesthetics, O&G, or GP registrar training. Whilst I work in intensive care, there are still many moral issues. My conscientious objection has not guided me away from any areas of practice.

At University, people would argue with you, subtly reject you, and scoff at things you said, and you would get sidelined a little. But it's not a popularity contest. I think if you try and live well, goodness attracts. If I was denied an opportunity and it meant a lot to me, I would fight it, because it is unjust. I have been told through the grapevine, that I would never get a job as an Intensivist at a particular tertiary hospital because I was 'too Catholic', but where one door closes, another opens…

Your experience exercising your conscientious objection to abortion

I remember this one patient, a pregnant woman who had an underlying condition that worsened with pregnancy, and this was a recurring theme. Whenever she got pregnant, she was advised to have a termination. I was peripherally involved with the case, and there was a big discussion, with most people advocating for termination, and me, and a couple of others, advocating for human life. However, after each of those doctors had to look after the patient personally, they refused to recommend it and make it happen when they were in charge. For specialist physicians, only a small percentage would support abortion or euthanasia.

When I was doing angynaesthetics, we had women coming in for a D&C (dilatation and curettage of the uterus). There can be problems if you don't remove human remains, but sometimes, the D&C is actually a termination. So, I would look on the list every day so I would not get caught out. One day I saw that a D&C was listed which was actually a termination, so I spoke with someone, and then some of the nurses did not want to get involved either. We objected and we were not forced. There is no formal system for replacing a person. As a junior doctor, I think it is for the Consultant to organize any replacement. As a Consultant, I would have no problem with this. I think things are in place, where a Consultant knows their junior doctor is opposed to something, and that they cannot impose their beliefs on the junior.

You do get the occasional jerk, who thinks they are completely morally superior on some issue, and gives you a hard time. Administrations can be less sympathetic. Nurses have less protection than doctors. It is a very hierarchical system that is less regulated. Despite policies, Nursing Unit Managers may eat them alive. They can be very practical and they live in a smaller world so there are repercussions, and they talk a lot.

I recall another occasion at a different hospital I was at, an abortion was on the operating list. Myself and some others, were told to assist. None of us wanted to do this. So, I told the consultant none of us would get involved, and I then also asked him if the abortion was legal, and whether the patient had seen a psychiatrist, and if not, I would we refer the matter to the HCCC.

I was definitely nervous before I spoke up, but I talked to a lawyer friend of mine to make sure I had the law right. The Consultant said: 'Just get over it… Its' just an abortion, it's not a life…' One of the doctors, and one of the nurses caved in and said that they would assist as someone had to. He did not force the rest of us.

If someone is having a termination of pregnancy, anything pre-op, no way, but post op care I have no problem with. I don't think you should have to perform actions you find objectionable. At one tertiary hospital, they used to have a line in the employment contract that you had to be aware that they provided abortion services. I think this might have been to cover themselves for problems like this.

I recall once when I was working in oncology, there was a medical miscarriage, and I was asked to go down and chart a chemotherapy drug, to help expel the foetus. I didn't know if the foetus was still alive and I was prepared to tell my boss of my objection. I felt nervous, because it's awkward, and there could be a confrontation, and others may feel it is an inconvenience. But, if I strongly believe in something, am I really going to do find someone else to do this? That is like me carrying the bullet.

I spoke with my boss, and he said yes, we do this, but he told me that he had a Christian background and there was no way he would perform an abortion, and that here, the foetus was not dying, but was already dead. He said he only got involved if life is extinct.

So far, I have not had any adverse outcome from voicing my objection, like being referred to a higher authority, but I know of junior doctors who have had this happen to them, and medical students who have been roasted by their medical school, for refusing to get involved in an abortion.

Referrals, and mandatory referrals to third party organisations

I will not refer. Referral may not be carrying the gun, but it is giving someone a bullet. Referral is the bullet.

If the state forced me to give specific information to woman about a third-party organisation that spoke of abortion options and may refer, then this is less of a problem but I would I would still struggle with that. This is because I cannot verify that they can give the salient objective information to the patient.

It depends what is on the pamphlet. If it was a group that was wishy-washy and you could add to that pamphlet, I might add additional details in. I think the state should have input from doctors about what information goes in those pamphlets, what services or organizations are detailed. There should be transparency.

Sometimes living with civil penalties is the only option. You can't have freedom of conscience but then have a secondary clause that contradicts that statement.

Do you have a conscientious objection to other issues?

The contraception objection is harder to explain to people. There is an assumption that the law presumes contraception is right, and this means that they believe in an objective reality, and objective right and wrong. If that is so, then I will argue that the objective reality is the opposite of what they say it is.

At medical school, me and another student were asked by a senior registrar to talk to a patient about a particular type of contraception. The senior registrar said that was fine, but then advised us that in future, we should tell a patient we had a conscientious objection and then give her an alternative practitioner who would give her contraception or refer off for abortion.

We argued back to her that whilst at a distance, this was still part of being involved with the management of a patient, it compromised our conscience, and that the request did not involve a disease, rather we were being asked to prescribe a medication to alter hormonal levels which has known side effects.

People do find an objection to contraception bewildering, particularly Protestants who may be against abortion. Sometimes nurses have asked me for a repeat script for the pill and I have had to decline. When I have explained my position, some people have found it quite intriguing. I recall a nurse once said to me: 'That is extremely sexy.'

If a nurse at work asks me at prescribe the pill. I enquire as to why they want it. If it is for contraception, I usually say:

> 'I personally disagree with contraception, and I am not your treating doctor. I don't mean any disrespect, but I don't do this. You don't want me imposing your views on me, and vice versa. There are lots of GPs who will prescribe it.'

A few might say 'Oh come on!' But I say no. Most nurses have been ok with this.

Would you perform surgery to remove sex organs at the request of a transgender patient?

The data on this issue is such a quagmire, regarding both surgery and hormonal surgery for transitioning. The outcomes from science show it does not benefit the person, as a fair proportion of people who have it, want to go back to their original state. The psychological impact is massive, but control over these medications is quite tight by specialists. Usually, these people have a lot of issues, and you have to consider the impact of hormones on them in terms of making decisions. I think you can make a distinction with regards to those of indeterminate sex.

I would never perform surgery or refer someone for surgery. The evidence from trials is not there. There is a good strong body of science against it. People opposing this are often attacked.

What would you do to change the situation and make it better?

There's a lot to change, in the medical fraternity and in society generally. In the medical fraternity, they need a better understanding of medical ethics consistent with an understanding of the dignity of human life, or the sanctity of human life. People do not understand that. It is not done in the medical schools. They need to understand that people have different opinions that must be respected, and not just give lip service.

Junior doctors need to know their legal rights and responsibilities, and know what is out there to support you so you can act with a little more confidence and speak out. People cannot feel inhibited in speaking out if they are going to be affected professionally. That has to be brought into it. Your position on this issue cannot affect your training. There has to be provisions within training, the various colleges, and the AMA, to implement an understanding that where a trainee has stated their objection, it must be respected.

The AMA has a fantastic Code of Ethics, and each college should have the same type of Code. All the colleges are made up of specialists who have opinions on moral issues. It's tricky where we are in a world of relativism where there is no truth apart from the one chosen on the particular day. We need to agree on a minimal form of behaviour that we can abide by.

In medicine, if a trainee has a problem, there is a system for complaints, and you are protected and respected in accordance with College Guidelines and the Medical Board. The stress levels among junior medical staff are high, and the desire to get on to a trainee scheme is high, and they put so much work into it. So, to be held back by something they could compromise on is tempting.

You should not be quarantined from being able to consult with a patient who is seeking an abortion or contraception. Whilst you cannot provide care, you are still giving them something. There is a whole thing about being a doctor, and the relationship with the patient. It is not a business relationship, and they are not clients. The basis of the relationship is trust, where you both entrust yourselves to each other. You are giving the patient your professional understanding of what is morally and physically right.

There is more to a person than their body, and you have to be sensitive to psychological and spiritual aspects. In palliative care, you can talk about spiritual matters. In fact, it is written into documentation in palliative care. We ask patients, 'Are you religious? Do you want to see a priest or minister of religion?' That is spiritual care. Look at Japan. It is not a religious country, yet they have praying places for the unborn child who is aborted. If the person is just physical, and not spiritual, then that should not happen. There is grief. There is post abortion syndrome, and I have patients and relatives who are still traumatized over it, sometimes many years later. There are some things that are fundamental, that are independent of religion. There may be different streams of religion that t have nuances of what you might do in a particular situation,

but they don’t impact in a permanent way about whether these things like abortion, contraception, euthanasia are right or wrong. Anything involving life and death, it’s pretty basic. Nature never forgives and never forgets.

Transcript of Interview

Doctor # 8

Interview conducted by ALW, 9 April 2018
Start: 9.00am
Finish: 12.00pm

Antecedents of Doctor # 8

Doctor # 8 is female, identifies as a Catholic, and has been a doctor for 26 years and works as a General Practitioner in the suburbs of New South Wales.

Consent

Written consent was obtained for the interview by ALW.
The interview guide was varied to take into account the respondent's background and in order to explore issues as they arose.

How would you define conscientious objection?

When a person objects to participation in a particular activity that fundamentally goes against their conscience. There have been many instances when a culture or legal system has expected doctors to participate in things like gendercide, infanticide, abortion, or genital mutilation. There must be recognition of human rights. If that does not happen, then an unethical or manipulative political leader can influence doctors to be involved with the killing of innocent human beings.

Participation can be in degrees. If you are in a major institution, and there are medical colleagues doing something unethical, you are not necessarily agreeing or participating in that unethical activity, however if working at the institution you have a direct financial gain from that activity, or if you are doing something in terms of the documentation, or part of the procedure, then that is a form of participation.

For example, I have a moral objection to working at an abortion clinic. Even if I were not performing abortion, the work I was doing a doctor, would be funded by the abortions being performed. Similarly, if I was arranging paperwork for abortion, or referring a patient for abortion, then that is an essential first step in an abortion occurring and is therefore participation in it.

In New South Wales, a woman does not need a referral for abortion. However, it should never be the law that the doctor should be forced to be involved with either the active or passive killing of a human being. Forcing a doctor to participate also can come in the form of a hierarchical system in medicine, not just the law.

For example, in most medical training programs, there is a definite hierarchy and there is a stringent interview process where you can be asked questions, and where your responses are documented, as to what you will or will not participate in. That has been used in the past to discriminate against doctors on the basis of their conscience, especially those not wanting to be involved in abortion and euthanasia.

We need protection for freedom of conscience so you don't have people fearful of losing their jobs, or not being able to get a job because they have a belief that they don't want to be involved with the killing of innocent human beings. It's a right of all workers that their freedom of conscience and religion is respected. If there is a law that allows euthanasia or abortion up to birth, there must be laws that protect workers who do not want to be involved with the killing of human beings. It's fundamentally important for society as a whole. If we are expected to be robots, programmed to do whatever the leader says, that can result in the harming or killing of innocent human beings, and there are countless examples in history where that has occurred.

In the context of regional Australia, there are many procedures that don't fall within a general practitioner's area of expertise or practice, and which they should be able to decline to provide. People in rural and regional areas are used to having to travel for a whole range of medical and surgical services, such as complex cancer assessment and treatment not usually provided by a small general practice in a remote area. In addition, transport options exist to allow patients to access a second opinion.

For patients wanting a medical abortion, the drugs used have a complex range of side effects for the woman including haemorrhaging and death. To say that dispensing a script for these drugs is a simple matter, assumes that medical abortion is safe, easy, and not a complicated process. A script for drugs that kill a human being is fundamentally different from a script for a medicine the doctor believes is treating a medical condition and improving the patient's health.

The drugs used for medical abortion are usually mifepristone and misoprostol. Both drugs are 'class X', which means they are known to cause damage to the baby including brain deformities, renal and genital abnormalities. Doctors have an ethical obligation to not give medication that will cause abnormalities to babies in addition to the basic ethical principle that first one must do no harm. This is being replaced by a shopping market mentality where the patient is a customer and if they want a product or service, they must be given it. Doctors should not be there to provide drugs or procedures that harm or kill patients even if the patient may request this.

According to an article in the *Lancet,* medical abortion has a higher death rate for women than surgical abortion (reference http://abortionpillrisks.org/health-risks/deaths/) The FDA in the United States has documented women suffering from uncontrolled haemorrhaging as a result of medical abortion. In the early stages, women may present with pain and bleeding and are told this is part of the normal process of having a medical abortion, but some women end up with very serious complications, particularly women who don't tell their family and friends they have taken an abortion drug.

There was the death of 18-year-old Holly Patterson, who didn't tell her parents that she had taken the abortion drug and it was only when she was in the intensive care with severe bleeding that her parents were told this was a result of an abortion drug. Her father came to Australia and gave evidence to the government when it tried to lift the ban on RU486.

Medical abortion involves taking a course of drugs according to a regime, which the patient may follow, or which may be interrupted if the patient has vomiting, which is a listed side effect, or which the patient may fail to follow through. The latter is a well-known phenomenon for doctors involved with prescribing a course of treatment. The patient is supposed to have follow up with their doctor 14 days later to check if they are still pregnant, as 8-11% of patients

who have taken mifepristone and misoprostol may still be pregnant, and then are pressured by abortion providers into having a surgical abortion.

Counselling is a very important process for women with unplanned pregnancies. If a woman presents for an immediate referral for abortion, the vast majority will not access counselling. The counselling that occurs at abortion clinics is procedure based, and does not in an independent way, provide supportive counselling for a range of options. In fact, the federal government does not permit doctors with an affiliation with abortion clinics to access the Medicare item number for pregnancy counselling because they recognize the conflict of interest. All patients can get a second opinion. It allows a little bit more time to think through options, and to seek independent, confidential support, and understand the benefits and risks of those options.

In the case of abortion, to force the doctor to be involved just so they can hurry the process is unethical and denies the human rights of that doctors. Also, it is not in the best interests of the patient. It is not a procedure that should be rushed and it should involve confidential supportive counselling for that woman so as to explain a range of options for her unplanned pregnancy and allow that woman time to do talk through issues, if she wishes, with her partner and close family and friends. As well as understanding that there may be some solutions for underlying problems, such as financial stress. If she has to travel for access certain services, it allows her a little more time, and that may be a very appropriate thing for such a big decision.

I've done decades of counselling for women who have had abortions and some of the anxiety and grief they are experiencing comes from feeling rushed or pressured into having an abortion. Some experience post abortion grief syndrome, some experience regret about having an abortion, which is then compounded when they are trying to have a baby later on. I estimate that 95% of people I have counselled have symptoms of post abortion grief syndrome.

What is the basis of your conscientious objection to abortion?

It's a scientific fact that life begins at the moment of conception and ends at the point of death. As a doctor, if a person asks me to be involved with the killing of a human being I must refuse. I choose to respect the life of all of my patients, irrespective of their age or disability, as every person has innate dignity and human rights. Dignity to me means not denigrating that person

or harming them or killing them. It's very different to how I view animal life. To me a cockroach or fly has no dignity, which means that I don't have to respect their life. If they are causing some harm or problem, I could kill that cockroach or fly without feeling I have done anything wrong.

As a human being, we are not just physical but spiritual and emotional. We cannot function in a human society if there is anarchy or a mistaken philosophy that equates animals with humans, such as Professor Peter Singer might do.

The impact of having a conscientious objection on your place of employment

I have always wanted to be a general practitioner. I have worked as a sole general practitioner for 14 years. Before that, I worked in a medical centre with four other doctors. I left that practice primarily because I prefer continuity of care and seeing the same patients. You get to know them and their family. You are involved with initial investigations, and diagnosing an underlying condition that should be treated. You also focus on preventative health and counselling, so it is a holistic approach to health, with patient centred care. It is a rewarding experience that comes from listening.

Your experience in exercising your conscientious objection to abortion

In January 1995, when I was doing my basic training to be a GP, I received a letter from the Royal Australian College of General Practitioners, informing me that I had to do an obstetrics and gynaecology term. I had an interview with a representative of the College and informed him that I did not want to be involved in organizing drugs or procedures that involved abortion.

I did not know the person who interviewed me, and I felt very nervous making this disclosure. I felt that if I couldn't do this O&G term, it was going to prevent me from qualifying as a GP. The GP training involved both basic training and advanced training. For the basic training component, the College allocates you to a practice, but for the advanced training component, the doctor is free to choose the practice.

Fortunately, I was still employed at the time, and I was able to do my term in a way that when at various points I was asked to participate in abortion, I was able to decline, and I did not lose my job.

However in 1996, I had to do a six-month rotation to an inner city practice. The interview went well. The doctor said I had been accepted, and offered me certain shifts, however at the end of the interview, I told the doctor that I had trained in palliative care as a junior doctor and did not want to participate in euthanasia, and that I had done a special course in pregnancy counselling and did not want to participate in any abortion procedures or referring for an abortion.

The doctor then asked me:

> 'What is your position on helping lesbian couples with artificial insemination? We do this frequently in our practice, usually with a donor sperm.'

I said:

> 'I would not want to be involved with IVF for lesbian couples.'

She then said to me:

> 'Because of your position on these issues, we cannot employ you in this practice. Referring for abortions and helping lesbian couples with IVF are things we regularly do in our practice, so we cannot employ you.'

For me, assisting any couples with IVF was not something I was trained in. I would not have participated in this even if it were for heterosexual couples either, but she didn't ask me about this. I think there are issues about the rights of that child, their identity, to not know their father, or know whom they are related to. The child is intentionally brought up never knowing their father. My objection comes from having concerns about the fundamental rights of that child.

The doctor contacted the College and said that they would not employ me. I contacted the College independently and was told I would have to wait six months for the next round of offers. I felt very strongly that I was being directly discriminated against because of my

conscience and ethics as a doctor, where not wanting to be involved with the killing of innocent human beings, or with assistive reproductive technology, could potentially conflict with my religious beliefs. At the time, it was very upsetting, but I still hoped I could work in a general practice where there was not pressure from senior medical colleagues to be involved in those activities.

With the oral contraceptive pill, I prescribe it for certain conditions to benefit the woman's health. There are many types of contraceptives on the market including those termed 'emergency contraceptives', which act as abortifacient drugs. I don't want to prescribe an abortifacient drug. There are a multitude of doctors who have different personal ethics who do prescribe those drugs, and it is very obvious and easy for patients to get a second opinion from other doctors. Most general practices are group practices and have doctors who prescribe a range of contraceptives including emergency contraception.

When I worked in a group medical practice, if a patient requested emergency contraception during a consultation, I would go through information about the effects and the potential side effects of that drug, but I would explain that as a matter of conscience I don't prescribe drugs that are abortifacient in effect. If the patient still wanted that prescription, they would simply see another doctor. I have never had anyone attack me for approaching the problem in this way. I always did this in a respectful way, gave a lot of medical information about their options as part of informed consent, and gave them a range of alternatives.

In my current practice, I do prescribe the oral contraceptive pill where it is for the benefit of the woman, such as where the woman has severe endometriosis that has not been controlled by other measures. I do not prescribe oral contraceptives for birth control, but I do offer natural methods that are scientifically based and effective. Some women actively seek out non-hormonal treatment for birth control. Some have had a stroke after the pill, or suffer bleeding from the pill, or are having treatment like chemotherapy, where the pill is contraindicated, or some have liver disease. Some have had side effects from hormonal contraception such as Depo Provera, or Implanon and are seeking effective, scientifically based methods of family planning that are natural.

I have researched natural methods extensively, as well as the effects of the abortifacient drugs and the oral contraceptive pill. The pill is classed as a carcinogen, a cancer-causing agent, so I can say honestly say to patients that there are a range of different approaches the woman may take, and they must balance the benefits against the side effects. I have helped thousands of couples avoid pregnancy through natural methods. It is not up to the doctor to say how many children that couple should have. I am very respectful of couples that decide for various reasons to avoid a pregnancy. This is a matter for the conscience of each couple. Medical professionals should offer a range of options for couples for family planning. It shouldn't be that it is only drugs, or devices or procedures. It should not be that treatment is only limited to that, given we know there are a range of methods of fertility awareness and natural family planning that can effectively avoid pregnancy.

In very rare cases, 1-2% of couples I have treated, and who have followed the instructions for avoiding a pregnancy, have conceived. There is some upset by them, and I always offer to review the case management and offer confidential support and counselling. All of the patients I have seen in this situation have opted to continue the pregnancy. Over a period of weeks, they underwent a change from being upset or shocked, to adjusting to loving their baby. Subsequently, they were given additional means of support for periods of time they wanted to avoid pregnancy, to ensure that all means possible were used to prevent a pregnancy such as hormonal monitoring.

Referrals and mandatory referrals

I don't refer patients for abortion.

I would not refer a patient for a service I have a moral objection to, or a concern that the service or procedure is harmful to them. I would disclose to them that my objection was moral and that I respect their right to obtain a second opinion.

If the law required doctors to disclose a conscientious objection and then did not let you speak further with the patient, then I think this is causing a disservice to patients. Doctors should be trusted to give medical advice about the effects and side effects of drugs, devices and medical procedures.

For example, a part of medical practice is to give advice about the effects of smoking, marijuana and methadone. To have a law that says that if a patient wants those drugs or substances, doctor that don't support the use of that drug are legally banned from discussing it is absurd. It leaves the patient then with only doctors who support the use of marijuana or cigarette smoking, and the patient may be missing out on some very important medical information, which could be more objective and scientifically based and in their best interests to know, from another doctor.

Do you have a conscientious objection to other issues?

I have a conscientious objection to euthanasia. In 1993, while working as a junior doctor at a major teaching hospital, I was doing a geriatric term. One morning I found an elderly man in his 70s who three days prior, had presented with a stroke. He had a cannula inserted but when he was transferred to the ward, the Registrar removed the cannula and wrote in the notes that he was to be nil by mouth and given morphine.

Three days later, the man was severely dehydrated to the point where his blood vessels were very difficult for me to access in order to insert an intravenous cannula so I could give him fluids. After three attempts to insert a cannula, I called the Registrar and he told me I was not to attempt to put a cannula in, and that the patient was to be nil by mouth and morphine. He said he had discussed this with the patient's wife, and that the patient's stroke was against a background of dementia and his wife expressed concern to the Registrar about her husband suffering.

The Registrar interpreted this as the wife not wanting her husband to suffer any more, and he explained to me:

> 'Technically euthanasia is illegal, but sometimes we do withdrawn treatment and the patient dies peacefully because the patient is written up for morphine.'

I responded:

> 'I am concerned that your decision to withdraw food and fluids for this patient and write up a sedating type of pain relief is a form of euthanasia. I do not want to be involved. This person should not be left to die of dehydration or malnutrition.'

The Registrar responded:

> ‘You’re a junior doctor. The decision is not up to you for this patient’s management.’

I sought advice from Medico-legal experts and senior medical colleagues, but I was not able to intervene. It was not within my power to do further intervention. I felt very upset, and frustrated. I thought the practice was quite deceptive, as the Registrar knew the euthanasia was illegal but wrote in the notes something that could be acceptable as a temporary treatment measure… but where the intention is to end the life of the patient, in a patient such as a stroke patient who cannot get out of bed to get a drink of water himself, that is, a patient who needs basic care and due to his difficulty from the stroke, his attempts to speak and his expression of pain were responded to by repetitive doses of morphine.

Dehydration has very uncomfortable symptoms such as severe thirst, headache, dry mouth and a multitude of other symptoms. It is a terrible way to die, which is why doctors who do this kind of euthanasia write up pain relief. But by definition, it is euthanasia if the intention is to end the life of that patient. That is different from a palliative care setting, where the person is offered a sip of water or ice. A decision is made not to have burdensome life sustaining treatment. You are not obliged to do every type of procedure where the patient is at the final part of their life. Stroke patients can have severe symptoms for a few days, but if given intravenous drugs and fluids, most can recover a lot of their function such as their speech or alertness.

Euthanasia is not legal, but we see a window of opportunity when we can withdraw treatment at a certain time and the patient will die, but if we give treatment like intravenous fluids and they start to recover, they will live but may have impairments.

I don’t need to refer people for sterilization unless there is a medical indication, such as where a woman has severe tubal disease and specialists have recommended a removal of the tubes. This very rarely occurs. Another example is women who have severe menstrual bleeding and need devices or hysterectomy to stop severe bleeding. Apart from that, I think there are better alternatives. There is a fairly high proportion of marriage breakdowns where people with a new partner or people with a change in their circumstance, want to have more children after

sterilization. If a patient sought sterilization for purely family planning purposes, I think there are better alternatives.

Would you perform surgery to remove sex organs at the request of a transgender patient or refer someone to have this done?

I have never had a situation of having to refer a patient for an operation to remove genital organs for a sex change procedure. I have certainly treated patients who have been transgender. I am very respectful of all of my patients, and I provide them with the best medical care. If I were in a situation, where a young person had gender dysphoria and wanted to be the opposite sex, I would go through information about the effects and side effects of that kind of procedure. But as there are very significant side effects, both physical and psychological with having that sort of operation, it's not a medical operation I would recommend.

What education if any, have you received about conscientious objection including at university?

The issue about conscientious objection was not covered in detail at university except a brief mention as a part of medical ethics.

What would you do to change the situation and make it better?

At a number of levels, freedom of conscience needs to be respected and acknowledged in our law and health system. There needs to be acknowledgement during the training of health professionals that just as patients have a range of beliefs that need to be respected, the same applies for health professionals.

If the religious beliefs of the health practitioner are aimed at respecting the fundamental human rights of the patient, such as not wanting to be involved in the killing of innocent human beings, then that is a fundamental right of any worker and must be respected under the law.

If there are rogue health practitioners who support the killing of innocent human beings through euthanasia or support genital mutilation because it is part of their cultural belief, those health

practitioners need to realize there is a fundamental code of ethics that apply to all health practitioners to not harm or kill patients.

In New South Wales, there is mandatory reporting of practitioners who harm patients. Fringe beliefs of small minorities of cultural groups, such as in countries like China, have permitted traditional birth attendants to engage in gendercide. In Africa, health practitioners may take part in female genital mutilation of young children and might say that their ethics, religion, or culture gives them a belief system that allows those procedures to occur. The patient may even agree to that, but in Australia, we have a standard that does not accept those practices.

In Australian society, there is a preference for patients to have their family doctor be someone who has an understanding of their culture, language, and practices. It makes for a better doctor/patient relationship and can meet the needs of that patient in a more culturally sensitive way. However, I see some dangers in accepting a principle that all religions and their practices are acceptable in Australia. They are not on a level playing field.

If a doctor refused to examine a patient of the opposite sex because it was against their faith or culture or had any other belief that derived from their faith or culture, then we before we accept that in Australia, we need to consider whether exercising that belief may impair diagnosis and patient care, and cause harm.

Doctors can be de-registered or censured in one state for not being involved with abortion or euthanasia at the level of referral or participation, but not in another. Yet the Australian Health Regulation Authority has changed the understanding of what is ethical practice to fit the more liberal laws and practices of one state.

There may be certain ways of protecting freedom of conscience and religion in the law, for health care practitioners, but it is very dangerous to set up a system with a relatively small group of people who have the power to de-register health practitioners if they don’t agree with the aspects of the ethics or religious practices of those doctors.

Transcript of Interview

Doctor # 9

Interview conducted by ALW, 27 April 2018
Start: 3.30pm
Finish: 5.00pm

Antecedents of Doctor # 9

Doctor #9 is male, identifies as a Christian in the Seventh Day Adventist tradition, and has been a doctor for 14 years. A Fellow of the Royal College of General Practitioners, doctor # 9 has an advanced diploma in obstetrics and gynaecology and has worked as a GP Obstetrician in rural areas of Victoria, as well as a GP in the suburbs of New South Wales and Victoria.

Consent

Written consent was obtained for the interview by ALW.
The interview guide was varied to take into account the respondent's background and in order to explore issues as they arose.

How would you define conscientious objection?

It is a moral objection to practice something that goes against conscience. For me, I use empathy to try and understand where the patient is coming from. My conscientious objection is not always absolute, that is, it is not black and white.

What is the basis of your conscientious objection to abortion?

For me, the basis of my objection is the sanctity of life. God has the ability to create and destroy. How do I have a right to destroy an unborn child who had no choice in being made? God has given us the ability to procreate not destroy.

Even though medical doctors understand scientific evidence, I also believe divine revelation trumps scientific evidence in that properly understood, scientific evidence should perfectly align with divine revelation. There should be no conflict and I don't see this as a huge dichotomy. With regard to some religions like Jehovah's Witnesses, I think they have a biblically inaccurate understanding of certain Biblical texts leading to an unreasonable or unscientific moral position such as refusing blood transfusion.

When it comes to abortion, it is not simple. I can't say I would never do it. The debate on abortion has been blown out of proportion largely due to people who are inflexible lack empathy, and some who appear to have little compassion. My view is more nuanced.

I draw the line where the baby is likely to become viable, so 4-6 weeks, when there is a heartbeat. Prior to that, it is not a human life form. It has no life sustaining force. Under 10 weeks, it comes down to why the abortion is sought. It is not about the different methods of abortion. I don't have an issue with copper IUDs or emergency contraception. When the sperm hits the egg, it does not create a viable human life.

There can be medical reasons why abortion is legitimate such as chromosomal abnormalities, where the foetus is unable to survive or it has a syndrome that is incompatible with life, something like Edwards's Syndrome.

Making a decision about someone's quality of life is a tough call to make. You speak with a Down syndrome child's family, and they will say their child has a number of qualities. As a parent, I am unsure what I would do, but I have a slight leaning towards not aborting. In saying that, I have no desire to pass judgment on people who do abort a Down syndrome baby. I don't feel I have any right to tell them they are making a poor moral decision.

I haven't faced this scenario as a doctor where a patient has requested an abortion for Down syndrome. If I was faced with a firm decision by parents to abort, I would want to ensure they had some level of counselling regarding that decision, and that it was adequately worked out. If they had come to a firm decision to abort, I am not sure what I would do. I think I would probably assist them with this.

Legitimate reasons for an abortion could be stretched to social reasons, but this is a grey area for me. In my experience, and thinking these issues through, they never happen in a vacuum. As a parent, I know it is not easy to look after kids. There are psychological as well as financial pressures. It is not unreasonable to think that these matters may have a downstream effect on the child. I would also consider that rape could possibly be a legitimate reason for abortion although even this is not a black and white decision.

For long term patients of mine, I would have some knowledge of social and financial factors but not for a first-time patient who walks in requesting an abortion for social or financial reasons. I would manage the situation individually, not across the board. If it were heading down a moral pathway, I am not comfortable with, I would say:

> 'I respect your right to make this decision. I can't be involved further. You need to find care elsewhere.'

There can be maternal reasons where the mother's life or her health is at risk and I would assess these as they arise. To date, I have not been faced with this scenario, probably because it is very rare. The law gives precedence to the life of the mother and I don't have any objection to that but it is a very difficult scenario and I would need better information from the woman's specialist re the impact of pregnancy and childbirth on her, but in principle, I support abortion for maternal medical reasons.

The impact of having a conscientious objection on your place of employment

I have always worked as a GP. I have an interest in broad areas of medicine and I enjoy consulting with people and having a personal connection. My faith had an indirect impact on wanting to be a GP. In the Seventh Day Adventist tradition, there is a strong interest in health and a mission to reach out to people to heal them.

I worked with a number of GPs who were not Christian, and some were even antagonistic towards Christians. When I worked in a small rural community, my boss was one of those who were antagonistic, but he was very respectful to me. I felt he gave me personal respect. I haven't really had colleagues who berated me.

I don't go promoting on a mountaintop that I am a GP with a conscientious objection to abortion but in my biography for my practice, it lists that I am a Christian. If there is open disclosure that the GP is a Christian, the patient has a clearer expectation but I think having a disclosure sign so patients know you have a conscientious objection to abortion is out of proportion to what you are trying to achieve.

It is needlessly creating polarization and doing a disservice to the community, given the amount of times the scenario comes up. There is an immediate judgment made by patients as to why you have that view, and further assumptions based on that disclosure. Some battles you fight, and others you don't worry about. This is one I don't feel needs to be emphasised.

I don't want to see only people who have the same mindset as me. I don't discriminate amongst patients, as I want to see all people. There are very few scenarios where I have a conscientious objection. Jesus did not treat only some people. He would go out to the community to people who were sinners, and he didn't offer selective treatment of them, he healed people of all walks of life.

However in a truly remote area, you may need to be a bit more specific on your website about what services you are not prepared to be involved in, such as abortion in certain situations because you may be the only person offering medical care in the region, and in that situation, it would be fair that patients are aware of your stance so they can plan accordingly, but even then, having a conversation with them in a consultation to explore their views would be valuable.

Your experience in exercising your conscientious objection to abortion

When I have disclosed my conscientious objection, I have had one or two patients feel that I have judged them. They did not say anything in words, and to my knowledge there were no formal complaints, but I inferred this from their body language. I don't try and be confrontational. I say something like:

> 'I really respect your views, but I cannot be involved with your case as it conflicts with my moral viewpoint.'

I don't say things like 'you're killing your baby'. You read stories of post abortion regret and the conflict the person felt in coming to a decision. It's a very tough decision and I don't want to create additional burden. Most of the time they will say, 'Thank you, I understand.'

I persuaded one person to think about it differently. After counselling them they ended up deciding against abortion. I didn't push it. I did present the options and I explored conflict and the reasons why they sought abortion and gave them time. It was actually a very lovely experience.

I think it would be ridiculous, and bad medicine, if doctors were prevented from speaking further with a patient about abortion because of a conscientious objection. It goes against logic because we know that many women regret the decision to abort. If provided with better information, and accompanied by empathetic discussion, they may have decided differently. To ban discussion is medically ridiculous.

It is very uncomfortable to have that discussion with a patient. You don't know if the patient will stand up and yell and call you a dickhead. It has not happened to me yet. My core values drive me to say this person deserves care despite me disagreeing with their moral positions.

Referrals and mandatory referrals

During general training as a GP, we were told if we had a CO to abortion, we had an obligation to refer patients on to another doctor who would help. It was framed from the perspective that it is bad practice and unprofessional not to refer.

Pro-choice and abortion service providers stress the need to stop backyard abortions and I don't disagree with this. In the past I have told patients they can go to Marie Stopes. I have done a certificate in family planning, which is biased towards the pro-choice ideology. They recommended Marie Stopes as one place to refer patients to who would assist them with counselling and abortion services.

People from Marie Stopes came to talk to us. I heard their speech, and they gave me the impression they counsel patients before the abortion. However, one patient I referred there and who did have an abortion told me they received virtually no counselling. It was essentially

assumed that they were there for abortion. I think the overall philosophy of Marie Stopes is there is no need to talk people out of the abortion, so it is not giving patients truly balanced information.

If a patient does not want to change their view about wanting an abortion, and it was sought for non-medical reasons, I don't have any protection and I must refer them to someone who will help. In the past I have written the contact details for Marie Stopes on a piece of paper for them, but I don't generally write referral letters and I don't ring up for them. I would struggle if the patient asked me to refer them for abortion where it was a scenario I morally disagreed with. In one situation because of the patient's insistence, I did write a referral letter to Marie Stopes, and I have felt some level of regret for this because I did it against my conscience. I don't really want to be involved in abortion for non-medical reasons.

If I were confident that Marie Stopes gave balanced information, then I possibly would refer a patient to them. If I was required by law to refer to a third party who made the referral to an abortion service, then that would be an easier option, but I would still like to know beforehand that their information was balanced. If abortion were a bigger part of my practice, I would take the time to think and know more about this.

In the medical profession, you are viewed negatively if you refer to religious organizations. If not for this obligation to refer, I would be more inclined to not give details of abortion providers. If I gave referrals to Church based groups, it would be seen as biased and indirect proselytizing. Ideally, these groups are helping patients, and I would like to think they provide a better service than secular groups but that is not always true. There are a few exceptions, such as the Salvos, St. Vincent de Paul, and the SAN Hospital because they are not viewed as being particularly religious.

Abortion is so emotive. If you referred a person seeking abortion to a religious group, you can just see the headlines about the GP coercing the patient. I am more comfortable recommending secular groups however if a patient identified as a Christian, I would be less concerned about referring them to a Church group.

The idea that the patient is left in no man's land if one does not refer them I feel is naïve. It does not rest on me to provide information and to find a provider for them. There is easy information available on the internet and other sources. However, there are people who don't know where to go. A lot of people may assume that all GPs agree with abortion. I would imagine the vast majority of people believe abortion is legal in New South Wales. Religious views are antiquated for modern physicians and medicine.

In Christendom, not all of us have the same level of objection to abortion. I believe that if a church denomination or group has a strong objection they should have the same level of obligation to look after women and give them options so they understand why the woman wants an abortion, and that the woman understands there are options like adoption, and there is time to re-think the decision about whether she can look after the child. This should also include adoption services, and social support for disadvantaged parents to assist them in bringing up children as if we are asking them to keep a child and not abort, I think this is only fair.

Do you have a conscientious objection to other issues?

I am not comfortable with euthanasia or medically assisted suicide however this is a very difficult decision as well. I am very empathetic to those facing a terminal condition, and I am not sure my conscientious objection is absolute. I also would object to some other medical services. Eg. providing steroids to bodybuilders, providing medically futile treatment to keep people alive etc.

Would you perform surgery to remove sex organs at the request of a transgender patient or refer someone to have this done?

I would certainly not personally treat a transgender patient, as I do not feel I have the expertise in this area. I do object to children being treated with gender reassignment surgery or hormone therapy before they are a consenting adult and before they have matured, because there is some good evidence that children may take some time to work this out and should not be rushed into a very life changing decision.

What education if any, have you received about conscientious objection including at university?

There was some education, but minimal conscientious objection training in medical school. We certainly learnt the legal and ethical aspects, and I must say I had a really good teacher at University who was respectful of the issues and had a good debate in lectures and class. We even had a whole lecture from a transgender person about their experience.

What would you do to change the situation and make it better?

These issues have been going on for many years. There should be a legally protected right for a doctor to conscientiously object to any part of a medical decision including an objection to referring on. It should not be something that results in any level of prosecution, de-registration, or disciplinary action. It's not a fair outcome.

At the same time, I think there is an onus on the individual to be reasonable. There needs to be some limits. If you have an objection to cutting up people and refusing to be on the surgical team, you probably should not be a doctor. Surgery is a huge part of medicine. Abortion is not. We are not there yet.

I observe the Sabbath and don't go to work, and make it a spiritual day, but I have no objection to working in a medical setting as even Jesus healed on the Sabbath. However some Orthodox Jews and Christians won't do that. Some Muslims observe fasting during Ramadan. This may create headache for administration, but that is not a reason to not give leeway and try and achieve reasonable accommodation for people in these situations.

Transcript of Interview

Doctor # 10

Interview conducted by ALW, 2 May 2018
Start: 2.10 pm
Finish: 4.10 pm

Antecedents of Doctor # 10

Doctor # 11 is female, identifies as a Catholic, and has worked as a GP in a semi-rural medical practice in New South Wales for more than 30 years. With an Advanced Diploma in Obstetrics and Gynaecology, doctor # 11 has worked as a GP/Obstetrician, and currently provides prenatal care to patients in her GP practice, as well as at another centre, and is also a visiting medical officer at the local hospital.

Consent

Written consent was obtained for the interview by ALW.
The interview guide was varied to take into account the respondent's background and in order to explore issues as they arose.

How would you define conscientious objection?

A doctor or other health care practitioner has a right to exercise their conscience and their conscientious views in a manner that is in accord with both their faith, and the principles of medical ethics. The Hippocratic Oath, which used to be taken by doctors up until the '70s, suggests that conscientious objection in medicine should be consistent with that. If a doctor has a conscientious objection that is incongruent with the Oath, I would still uphold their right to not have their beliefs infringed, but because their belief is incongruent, I have an expectation the doctor would hand on the care of the patient to another practitioner.

What is the basis of your conscientious objection to abortion?

Human life begins at conception, and we have a medical duty to attend to its wellbeing. I am a Catholic, however my objection is not based on an encyclical of the Church. I believe that the Church's teachings, which have been around for 2000 years, are consistent with science. I don't specifically avoid mentioning my faith to patients when talking to them about abortion, but I just don't think I need to mention it. They are there to see me about their health.

The impact of having a conscientious objection on your place of employment

I always wanted to be a GP, ever since I was a child. After graduating, I spent five years working in various hospitals to experience different types of medicine. At this time, they did not have the GP training like they do know. I then looked for a GP practice that would suit the needs of my family.

When I first started out as a GP, I did refer for abortion but I had a change of heart in the 80's. My conscientious objection has not hindered the practice. We attract doctors who want to join the practice. Whilst I would like to work with like-minded doctors, there aren't a lot of people who think like me, and I don't have a problem working alongside doctors who refer for abortion.

Your experience in exercising your conscientious objection to abortion

I used to prescribe contraception and assist with investigations required before an abortion i.e. I would organize the ultrasound and blood groups and write a letter for them to take to an abortion provider. My letter never said the abortion was needed. Ever. It was merely a covering letter for the results, not a medical opinion, and would not have met a legal requirement for a second medical opinion. However, in the late 80's, my beliefs started maturing and I was better informed by science, and by my faith, and I decided I would not do this anymore. I felt it was not right, and it was not good for the patient's health.

The first thing I did was I told my colleagues of what I was going to do and why. I hoped my reasons would resonate with them. The most senior GP in the practice was not happy about it, but had a noble attitude that each person must follow one's beliefs.

I then arranged for a sign to be put up in the waiting room of the practice saying that I would not 'endorse or facilitate termination of pregnancy'. [Not contraception, this wasn't on the sign]. The sign was there to warn people so they did not have an expectation about the services I offered, and did not get angry or waste their time in coming in for an appointment with me about these services, and also to take a stand

I also started to explain to patients the pros and cons of family planning from a truthful perspective and patients got it. In Britain, you have to tell people that the pill is linked to breast cancer. We don't do this here. I tell patients this and they are grateful. In the early days, because there was an expectation in the community that I would provide these services, my decision was talked about all over town.

My parish priest at the time, supported me, and gave me a lot of strength. However the next two priests assigned to the Parish did not. They did not agree with what I was doing in refusing to prescribe contraception and refer for abortion. The lack of support from the parish, and the censure of the priests, upset me.

The first of the two priests called me a "fundamentalist Christian". I felt off loaded by him. It didn't change my faith at all, or the belief that what I was doing was right. The second of the two priests accused me of taking religion into the surgery. He told me he had heard complaints about me from parishioners and that I had to "answer [my] critics." He used to scoff at me, and make little jibes.

However, before he left the Parish, we had a conversation where he asked me:

> 'Think very carefully about this. Do you really think deep down that prescribing contraception is a sin?'

I said:

> 'Yes, I do. It's harmful to the person and their relationship and when you know what you are doing is causing harm, it is sinful.'

He seemed taken aback with that, but he was more respectful and normal with me after that.

As a result of that decision to not prescribe contraception or refer for abortion, my clientele shifted around. I lost about 30 patients, I don't know where they went, and it took about two years for the issue to settle down. But I had supportive friends, and doctors from the wider area that supported me and I got through that initial period.

Ever since then, I have had supportive clientele. They value what I do. I have never lost a baby or a mother. They know I am looking after their health at a much deeper level, and I am booked out weeks in advance. I have never been stuck for patients.

After the floods a few years ago, the sign came down and we have not bothered to put it up again because everyone in the community knows my position. I have a good relationship with people. I engage a lot with the community, and I do this because I like it, not because I want to be protected. Since that initial period, I have not had any negative experiences with patients about my conscientious objection.

As the practice is affiliated with a university and with the Royal Australian College of General Practitioners, we have doctors come and do their training with us. One of the registrars complained to the College that I was not fit to teach them because I did not prescribe the pill. I only heard about this complaint through a friend of mine who was high up in the College and who strongly defended me. The complaint went no further.

Referrals and mandatory referrals

If a patient comes in to see me and is not aware of my views, and they want a referral for abortion I proceed with a normal examination. I work out the context, such as are they in a relationship? Is there domestic violence? Are there financial problems? Why do they think they cannot manage the pregnancy? We also look at how far along they are, and any health issues impacting the pregnancy. I always organize for all the pregnancy tests to be done as if the pregnancy is going ahead.

I try to find out if counselling is needed. They need help at that point to make the best decisions they can. I am not a counsellor. If they need a mental health care plan, I will try and explore that in the consultation. I have a network of counsellors who will try and help them as mothers, and not as patients who want an abortion. I refer to specifically trained mental health

counsellors. If you listen and hear them out, they know they are pregnant and there is a body within. What they see are insurmountable problems, and they also see that you are trying to help them. I try to get them to see past the terror and give them a glimpse into the future.

It has not happened yet, but if the patient objected to how I handle this, I would tell them:

> "If you decide on a termination, you need to have some counselling. I'm not telling you what to do, just helping you make the best decision I can."

If they made a law that prevented doctors like me from even consulting with patients who were considering abortion, I would be concerned. I wouldn't change what I do. As you get older, you get tougher. I feel pretty confident in who I am, and what I stand for, and am well-resourced in my knowledge. I would become politically active to advocate against that. I would start writing letters.

If the law required me to refer to a doctor who did not have a conscientious objection, I just would not do it. Referral is being complicit. You are facilitating and enabling it. You are actively facilitating the death of that child. I cannot imagine a penalty I would not subscribe to, such as jail or de-registration. Once you accept that these can be actual outcomes for you, it gets easier. You are no longer fearful of it happening and you just work the problem.

Do you have a conscientious objection to other issues?

I have a conscientious objection to prescribing hormonal and barrier contraception. Hormonal contraception is known to have various risks and complications such as depression, mood changes and weight gain. So to inflict those onto a well and healthy person who does not require hormonal treatment, infringes the ethical principles of medicine set out in the Hippocratic Oath.

With barrier methods of contraception, women are at greater risk of suffering pre-eclampsia in their first pregnancy. This occurs where the mother's body mounts an immune reaction to the baby, which can translate into preeclampsia in susceptible people. Implantable hormonal contraception carries risks just as the Pill does.

If people want to avoid having children, I am only comfortable with teaching natural family planning methods. I will educate them on the risks and complications of hormonal and barrier methods, but I tell them that if they want these, they need to see another doctor. I always enquire into why they want to avoid having children. I need to know this as a GP, and I believe they are entitled to have information about natural family planning and how it compares to these other methods.

I treat a lot of patients who, after switching to natural family planning, speak with me about their concerns about the abortions they have had in the past and what it has done to their bodies. Practice of natural family planning seems to awaken in them the truth.

I have a conscientious objection to Euthanasia.

I also have concerns about the HPV vaccine, which is given to teenage girls to protect against ovarian cancer. There is no ovarian safety research on this vaccination, only animal research on male rats. Whilst they did do human trials, they did not look at the impact of this vaccination on girls' periods. Nothing is recorded. The mean age of participants in the vaccine target group was 11.9 years and many of the participants would not have been having regular periods anyway.

Claims made about its ovarian safety are not supported by evidence. I have reported seven cases of teenagers suffering from premature menopause after having this vaccination to the TGA and have undertaken peer-reviewed research in this area.

A few girls have presented to me requesting this vaccine. I tell them about these cases and the evidence we have to date, and if they still want to go ahead with it, I will administer it to them because the causal connection is not yet proven. If doctors speak against vaccinations that are on the national register, we can be de-registered. If there were research that supported the causal link between this vaccination and premature menopause, I would refuse to provide it, notwithstanding the law and any penalty.

Would you perform surgery to remove sex organs at the request of a transgender patient or refer someone to have this done?

I would not perform surgery like this on a patient, or refer them for it, as it contravenes the Oath. I have the same position about prescribing someone hormones or referring a patient to someone who will do this. I have looked at the evidence about hormone blockers and cross sex hormones and they have no therapeutic benefit for the recipient. Worse, there is evidence of harm. It comes under the same objection I have to abortion, contraception and euthanasia.

What education if any, have you received about conscientious objection including at university?

Zero.

What would you do to change the situation and make it better?

I would love to see an ethics section in the medical curriculum at university that is not run by university staff. I think it should be run by outside people, with bioethicists from a different range of backgrounds. For example, you could have lectures from Catholic Bioethicists, Anglican Bioethicists, and secular Bioethicists. Students need to be exposed to other opinions, and they must not think that ethics is like being in a rowboat they can row in any direction. Most universities just teach what Julian Savulescu says which goes against the Hippocratic Oath and medical ethics.

In addition to that, we need to have much more rigor about training on contraception. The British guidelines note that women who take hormonal contraception are at risk of breast cancer. Yet in Australia, we do not disclose those to patients. How many young girls are told about what the Implanon rod will do to their mood and affect, and how it will affect their relationships? Or that it may cause them bleeding? What about the Mirena IUD which is sold and marketed as something that solves a lot or problems, yet they still come to me with partners complaining about their moodiness and irritability that all started when this device was inserted?

I want to see a scientific, evidence-based presentation to all patients about artificial contraception and abortion. This needs to include information on the percentage of women who commit suicide after abortion, and the link between breast cancer and contraception, which has been confirmed by a recent Chinese Study, but which Royal Australian and New Zealand College of Obstetricians and Gynaecologists ('RANZCOG') criticized in an almost racist way. We need much more rigor so medical students hear all of the evidence, not just the politically correct evidence.

Last year, RANZCOG sent a letter to Parliament endorsing the abortion reform bill. It was a dreadful letter and if you analysed the legalities, abortion could be carried out by any means, by any person, up to and including during labour. In their superficial reading of it, and only because they wanted to protect members of the College who were concerned about being on the wrong end of applications of the current law, they supported it. If RANZCOG is not looking after the baby, who is?

The AMA is the same. It does not respond to their rank and file, are not accountable to their membership, and make statements without consulting their membership.

We should not need to have a law that protects freedom of conscience. It should just exist and not be something that can be taken away from us. I worry about ascribing in the law a right that is mine in the first place, because of the possibility it could be taken away from me. In the law, it should just be assumed. However, I think there is a place for protection of conscience in the policies of Colleges. It needs to be clear. At the moment, when it comes to conscientious objection, the various colleges and organizations each seem to require you to refer.

Reasonable accommodation

I have a problem with 'death services' being offered in public hospitals. I don't think hospitals should offer 'death services', where doctors and nurses are expected to offer services with no therapeutic benefit. I have to be able to do my job and explain the therapeutic benefit of a service to the patient. Work that is subject to a roster system should only consist of services consistent with Hippocratic principles. I was told that on a hospital roster system, if they have a need for staff, they will employ doctors with a conscientious objection, but then they will quickly "weed them out".

I have huge empathy for new doctors who have a conscientious objection. They have a lot to lose. They need our support so much, to get through it. My experience has been different. I am worried for them, and so concerned for their wellbeing and future. It is much harder for this young generation. They will have great difficulty qualifying in obstetrics and gynaecology, due to the 'weeding out' College culture. The advice I would give them, is that they need to have a good support network. They need to educate themselves and be familiar with the data on termination of pregnancy and its effect on a woman's health.

The same goes for contraception and euthanasia. They must learn the facts, especially if they are going to be a GP or a GP/Obstetrician. Patients are not given the truth. It's not about protecting yourself but protecting your patients who need to know about this. New doctors who are pro-life should perhaps talk to people who have gone before them and learn what helps and works, and what does not. Most importantly, they must not go it alone.

Transcript of Interview

Doctor # 11

Interview conducted by ALW, 9 May 2018
Start: 4.30pm
Finish: 6.00pm

Antecedents of Doctor # 11

Doctor # 11 is male, identifies as no religion, formerly Catholic and educated in a Catholic institution, has been a doctor for 7 ½ years, and works in medical oncology at a public hospital in regional New South Wales.

Consent

Written consent was obtained for the interview by ALW.
The interview guide was varied to take into account the respondent's background and in order to explore issues as they arose.

How would you define conscientious objection?

It is a refusal to participate in an agent's act, on the basis of a philosophical objection to that act.

What is the basis of your conscientious objection to abortion?

My objection is two-fold. Firstly, I have a physiological objection. My test for the bounds of practice in medicine is that I must be either preventing pathology or treating it. I don't engage in any act directed against normal physiology and therefore, termination of pregnancy is beyond my scope of acceptable practice. Secondly, I have a human rights objection based on the fact that from conception, there is a human life present and any act that interferes with that constitutes murder, and I cannot be involved in that act.

The impact of having a conscientious objection on your place of employment

My conscientious objection to abortion has not affected the areas I have wanted to work in, but I have had to exercise my conscientious objection to abortion, as well as other issues, when doing my general practice training as a resident, and to hastening death when working in radiation oncology.

In my current area of medical oncology, unborn children tolerate chemotherapy quite well and there is not often an ethical dilemma. In medical oncology, there is no evidence that a patient does better after having a termination. So on a straight physiological approach I can support my position and this is where it ends. There is no medical reason for a person to approach someone in this field for a termination.

Your experience in exercising your conscientious objection to abortion

As a resident medical officer, I had to do a term in general practice. Initially, I perceived my objection to abortion and referring for abortion would cause friction. So I made an appointment to see the supervisor and principal of the practice before my term started. The principal was not available for that meeting and was quite angry that I had gone ahead with it without them, but after I had the chance to discuss my reasoning for my objections with them, they seemed satisfied.

During my time there, three scenarios came up with patients that required me to exercise my conscientious objection. The first one was an objection to chemical contraceptives and this came up maybe a dozen times; the second one was patients requesting unnecessary tests which had been recommended to them by non-allied health, alternative therapy practitioners; and the third one was requests for sterilization procedures.

Ultimately, the principal of the GP practice passed on to the divisional head of the GP training program that I had a conscientious objection to abortion and other services. This person had a very strong reaction to what I was doing, and this led to several meetings about it, and formal assessments of me. I felt that there was latent pressure placed on me to leave the program and I was treated differently to other candidates. I had to have several meetings with my supervisor

that other residents did not have to have, and these were always about my conscientious objection.

During one of the meetings, my supervisor proposed I display a sign in the practice that stated all the services I objected to. I was opposed to this, and the supervisor encouraged me to discuss it with my medical indemnity company. I put the situation neutrally to the medical indemnity organization and they advised me against this. Their reasons were that if I did this, I would be denied the opportunity to discuss other medical matters with the patient. It would limit the number of patients I was seeing, and there would be patients that I would never then have contact with. They further stated that it risked being seen as arrogant rather than patient-centred, came across as judgmental and risk collapsing the entire patient in to one health aspect for which there was a difference between the patient and doctor when the reality of the situation was that the number of other health outcomes I could be working for the patient were myriad.

For me, I really wanted to be able to see these patients about other medical issues they had so I was confirmed in my decision not to agree to a sign. When I told them of the legal advice I had been given, they accepted this and did not make me put up a sign, although they did say to me that they still wished that I would refer. I told them I would never refer because to do so constitutes material cooperation.

So for patients who requested abortion or the other services I objected to, I would say something like:

> ‘On that particular issue, I don’t consult. I don’t believe it is medicine.’

Then I would explain my reasoning about what acts are within the bounds of what a doctor’s training entitles them to consult on. I would usually say something like:

> ‘I respect your right to request this, and I accept that you may request it elsewhere, but I want you to mutually respect my right not to refer.’

I found that patients were quite satisfied with this. I would then immediately see if there were medical issues I could assist them with. As far as I am aware, no patients complained about

me. Any patients I had a difference with about the service they wanted would still come back and see me again about other medical issues.

I didn't ask the GP practice to formally put a clause in my employment contract about accommodating my conscientious objection and the discussions were not reduced to writing. I didn't want to do that because I don't want to make an admission that I am an exception. There should be a presumption that doctors are humble, and only do what they are trained to do, and what they have skills in, which is to practice medicine. It's not good for me to give assent to their position that I am different to everyone else and an aberration when my practice is a determination to stick to the practice of medicine and avoid other's distortions of medicine and misappropriating their knowledge and skill to issues outside of human pathology.

I am practicing in line with what is good medical practice and good ethical practice. Oftentimes when a doctor is reviewed for malpractice, the test is whether what they did would be acceptable to their peers, but it does not have to be a majority of their peers, it could be a minority of them. I think my position on abortion and these other issues is correct. You cannot misappropriate your medical skills in order to participate in such acts.

The majority view does not determine what is ethical. We don't determine what is good, or not good, through some sort of plebiscite. It's up to our independent judgment. I didn't feel it was necessary for me to mention religion nor education in a religious institution when discussing my conscientious objection with patients. I am not so condescending to think my patients cannot deal with an argument with me, and I have no issue with riling people up, or having an argument with them. Patients sometimes make bad decisions and I have to respect their autonomy. Working in a rural area, people are happy to have a robust discussion with me, and I don't take it personally. It was more that mentioning religion was unnecessary. I didn't want to be seen as pontificating and being high and mighty about it. The most accessible points are the basic physiology and basic evidence.

If you do mention faith, it can work the other way, and some patients will want to have a theological discussion with you. If this happens, I usually say I am not a trained theologian, I would probably embarrass myself trying to discuss issues on this level, and that it's not my place to have this discussion. However, I am quite prepared to listen to patients and discuss their concerns in this area, but I only stick to what I know and what I am trained in.

I've been politically active all my life and have had dust ups. I have been told I have an over developed sense of justice. So, in my job and vocation I would rather stick to the most accessible argument I have. By not mentioning my faith, I do not believe I have compromised my principles, because good medical practice is good medical practice. In one sense, good medical practice tends to coincide with good ethical practice, and I think that's an indication that both the medical and ethical perspectives are normative and are different ways of arriving at truth. It's not a compromise of my principles to not mention my faith, and if someone pushed me, I would absolutely tell them my objection, but it just not necessary.

If you do focus on your faith, it could mean that you are someone who is on a crusade. In this space of conscientious objection to abortion, I think doctors have done this fairly well. I have taken a lot of advice from people who have had to tread this path before me.

There was a person who was a Catholic, and who put a large sign in front of their practice that said: 'Dr. X is a Catholic doctor and does not refer for X'. For me, this is not a good way to practice, as it's a bit more aggressive. But you have to put that into context. That was done at about the time the abortion law reform bill was being discussed in Victoria, so there were other moral and political considerations. It was an act of civil disobedience. It's understandable, but in circumstances where you don't have overt threats made against you for having a conscientious objection, it's a damaging way to go. It limits the number of people you are likely to care for. It limits any opportunity to have a rational discussion about your position. If you were a patient seeking abortion, you would likely never have contact with that doctor. And then the patient may never have that discussion where a doctor can explain their philosophical reasons for objecting to abortion, and the patient may never come into contact with people who have that objection and can explain it and can offer good medical care.

I was able to finish my general practice training, although I felt anxious and nervous. You don't enjoy turning up to work when you are in a hostile environment. I had a reason to fight the good fight, but I didn't particularly want to turn up to work. I was nervous about what was going to happen to my job and having to find alternative employment. My relationship with people around me was not damaged, but I did feel I was seen differently. However, when I did leave, my supervisor thanked me and said they learned so much from having to deal with this issue of conscientious objection.

While there was no overt attempt to ‘get me’ when I was doing general practice training, there was when I worked in radiation oncology. At least in general practice, people could see you were sincere in your beliefs. In radiation oncology, I had a boss who disagreed with my decision to commence a palliative patient with renal failure on hydromorphone which would not accumulate in this setting.

My boss changed all the medications to morphine which is renally cleared and will accumulate in a patient with renal failure He called me into his office and said he did this because when he saw the patient’s renal function was compromised, “it just speeds everything up.” I had an argument with this boss and said:

> ‘This is a red line for me. If you asked me to do this, I would decline to do this. Your intent is to hasten the death of the patient. I have given high doses of opioids to patients where there is a risk it might lead to their demise, but I have used the principle of double effect.’

I ended up leaving that job after two years. I had other consultants saying things to me like, ‘Others are sharpening their knives out the back.’ In a way, this reaction stimulated me. If there is a fight to be had, on matters of principle, I tend not to consider what I have to lose. I strongly believed in and was convinced of my position, and if they were prepared to get me over an ethical point, I would be up for that fight.

Ultimately, I could not work with that department very well because of this conflict. My conscientious objection did harm my prospects of advancement. It’s a small field, everyone talks, and I heard stories about me that were simply false. There is a lot of gossiping going on that can ruin a doctor’s reputation. It doesn’t concern me too much, because I don’t put too much stock in what people think of me. But it wears you down, and occasionally you do question it. You ask yourself, ‘Is it just me? Am I doing the wrong thing?’ You are constantly examining your position, and being prepared to revise it, at the same time. It’s draining.

Further, while I did not consider there was a choice between being principled and unemployed and unprincipled but employed there is no denying the whole experience took me two years down a training program to end up without a Fellowship, delayed me by at least that much from specializing in another field and whereas I would have at this time been close to

completing my Fellowship I have absorbed a very significant delay in terms of independent practice and advancing to a significant pay grade.

After some time, I decided it was not my calling. This was based on the type of personalities that were in that specialty, who were quite phlegmatic, and I just didn't get on with them. But I stayed longer than I wanted to so they would not see that they got me. I worked harder. I put pressure on that department. I got them to a position where they realized they had failed in their plan to performance managed me out. Once they got the point, I left.

Thankfully I have not had to formally exercise any conscientious objection in medical oncology. I once had a patient who had breast cancer and underwent surgery and then adjuvant chemotherapy and radiation therapy with a curative intent. The patient then had a recurrence of her cancer and we had to re-stage the cancer. The patient called me up and asked for advice about getting a referral for a termination as she would need to have chemotherapy.

My response was that we did not yet know the staging of the cancer and therefore we did not know whether chemotherapy was required and if so, what type. Even if she did need chemotherapy, the foetus would tolerate it well, so in my opinion, an abortion was not necessary. I gave her my opinion that she didn't need that referral and she did not receive one from me. I was pretty neutral in discussing this with her, but I got the impression that her mind was already made up.

She was not rude or dismissive at all, but she was not receptive to my message, and not convinced by what I told her. She thanked me and hung up the phone. Later on, I found out she went to her GP and got an abortion. Ultimately, the re-staging showed diffuse metastatic disease, and she had to have palliative chemotherapy.

Any objection to peripheral acts associated with abortion

I find this to be a particularly difficult problem to understand. My understanding is that to formally co-operate in a bad act is definitely out, as is immediate material co-operation. However there are certain circumstances that would be regarded as mediate material co-operation in a bad act, but where I am obliged to act for the patient. So I would not insert a cannula for a patient to receive fluids or anaesthetic for a termination. However for acts like

filling out paperwork, it really depends at which stage that is required, and how remote it is, in time or place to the termination.

Giving after surgery care to a woman who had a termination, to the best of my knowledge, would be material co-operation, but not mediate co-operation. There is no causal link between my act and the as termination because the termination has already happened. My act of caring for that woman is not required for that bad act to occur and is therefore permissible. After the procedure, the patient now has pathology and I feel obliged to care for them. So to be consistent in my position, I must care for them.

I recall there was a South African nurse who was required to check the remains of a foetus after a termination. Her act had no causal link to the abortion, and what she was doing was making sure there were no, what they call, 'products of conception', retained by the patient that might cause septicaemia and death. While her actions do seem mediate to the situation, there is no causal link, and her intent is to look after patient who has had an assault on her body. Any act she performs does not enable the bad act to occur and is permissible.

Whilst you might have a visceral reaction to circumstances like this, and don't want to be involved, this is not a good enough test to as to whether the act is good or not. You have to look at its remoteness. In that situation, she was obligated to do something.

Referrals and mandatory referrals

I don't refer for abortion. It is not just providing information. It is a specific request to continue the care of the patient. You are putting yourself on the side of the patient asking someone else to consider that treatment. It is material co-operation in that bad act. I would not do it.

Do you have a conscientious objection to other issues?

I have a conscientious objection to prescribing chemical contraception, referring for sterilization, and being involved with artificial insemination, and futile treatment.

Would you perform surgery to remove sex organs at the request of a transgender patient or refer someone to have this done?

No, I would not. I don't think gender is pathological. I would not cite evidence to a patient, as I don't know the evidence well enough. However, I do know that the majority of people in their teens who undergo sex changes regret their transition.

What education if any, have you received about conscientious objection including at university?

Yes, we got training on conscientious objection. I went to a Catholic university, and you had to do philosophy, theology and ethics. So, I got taught the theory but not how to put it into practice. I learned that in practice from others. If a patient is shouting or combative, I have been taught certain techniques to diffuse the situation. I ask them some questions where you will get a 'yes' from them. It could be re-stating the obvious, but it is hard for someone to stay angry if they are repeatedly saying 'yes'. I ask them questions and try to re-clarify their position in my own words, so they can see I am trying to understand where they are coming from.

What would you do to change the situation and make it better?

The first thing to change is help students understand what medicine is, and what it is not; and what pathology is, and what it is not. They generally don't understand that. For doctors in their late 20s and 30s that I have talked to, it piques their interest, and they say to me that it's the first time they have ever heard that.

I don't think you need conscience clauses in the law, so long as the law is not going to punish conscientious objectors. It has never been a huge problem until you had situations in Victoria and Tasmania, which said there are limits to conscientious objections. The concept of an 'emergency termination' where you have to perform abortion is one I found very peculiar because there is no such term in medicine. The legislation uses terminology to govern medicine which was not defined and which we don't have. When you go out of the way to prohibit conscientious objection, there is a problem. We need to reverse that legislation. We should only have legislation to clarify that there will be no prosecution or punishment for having a conscientious objection.

In Tasmania, where there is arguably a difference in the requirement to refer compared to Victoria, I still think having to provide information to patients about organisations that will make the referral is poor practice. It is poor practice to have someone offer counselling and also provide the service, but this is so often the way it works for abortion, and it is a conflict of interest. The counselling is done in house, by a private organization that makes a fee from termination of pregnancy.

I provide more information about certain procedures such as abortion than those doctors who don't have a conscientious objection, so I think my patients are better educated from speaking with me. If a patient seeks treatment about fertility, I tell the patient about all the methods such as chemical and mechanical methods, but I also mention natural family planning. Other doctors don't discuss all options.

It's the same thing for doctors who refer for termination. The patients are very poorly educated and the doctors are very poorly educated. This is a problem, as the patient's request then becomes a fait accompli. The doctor thinks they are being pro-choice, but they are not discussing options like adoption. I am not into withholding information from patients. For some doctors, there is a sincere belief that they may do harm to the patient by going through the details of what the procedure involves. No one I have known who refers patients for these procedures thinks of them as pleasant, and they seem to want to protect the patient from the reality of the procedure. The more cynical approach is that there is a fee to be made for this either a private fee or a Medicare fee. As termination is procedural, it attracts a higher fee for consultation, and there can be a conflict of interest.

If you are present an alternative argument to the patient, it is assumed that you are opposed to termination. There does not seem to be a consideration for whether it is good for this patient in this situation. As misguided as this is, some doctors who don't educate patients on all options think they are violating the patient's autonomy because to do so might sway them against having a termination, and that must mean you are against terminations.

Transcript of Interview

Doctor # 12

Interview conducted by ALW, 29 May 2018
Start: 10.30am
Finish: 12.00pm

Antecedents of Doctor # 12

Doctor # 12 is male, identifies as a Catholic, has been a doctor for less than five years, and works in a tertiary public hospital in New South Wales.

Consent

Written consent was obtained for the interview by ALW.
The interview guide was varied to take into account the respondent's background and in order to explore issues as they arose.

How would you define conscientious objection?

It's where your particular values, beliefs, and understanding about what is good for a patient and what might harm them, affects what you do in your practice, and whether you withhold, or condone, a type of treatment or advice, that may put those beliefs at risk.

The basis of your conscientious objection to abortion

I believe that abortion is wrong based on the science. My Catholic faith aligns with the biology. I used to be pro-choice. I felt I was doing a service to women. I still felt I was religious as a Catholic, but abortion was a way to help women. It is intellectually inconsistent, but at the time, I felt it was right.

Around this time, I saw two women who came into the emergency department. The first one miscarried and had to deliver the baby. She had counselling, the baby had to have a funeral, and they took the baby's handprints as a keepsake for the parents. The other woman had an abortion at a clinic and came to the hospital due to complications. I walked into the operating theatre, and we had to remove the rest of the baby in the uterus and leave the body parts in a bucket by the side of the table. There was no counselling. No one talked to her about what happened. I had to go back and re-learn my embryology.

I became pro-life about two years ago, and it took nine months to make the leap, and it was a ground-breaking moment for me.

In my first year in practice, I came across Diamond Support Services. I heard about them a few years earlier when I was in an O&G placement, and I was starting to doubt my pro-choice position. I had re-leant embryology, and I wanted to know what health services were available to women. I attended in-services put on by an organisation called 'WOMBS' for GPs that discussed post abortion counselling, as well as information from organizations like 'Life Choice'.

Your experience in exercising your conscientious objection to abortion

The only reason I am in medicine is because I want to uphold my personal values and to help people in a way I see fit. I didn't anticipate that I might have to disclose my conscientious objection to abortion in the emergency department. Most practitioners don't like to discuss these political issues, which means that you don't get much education on it. As a junior, you are required to run things past the senior. I tend to take more initiative than my peers, but on this issue I did not.

I did not have a conversation with my superior about my conscientious objection to abortion. This is because it is a very busy environment, and it is very hard to have a politicized discussion without people judging you. Some superiors will say this is an emergency department, not a counselling service, and that psychosocial issues are better handled in an environment that is not time pressured. I understand this because this was the position I took when I used to be pro-choice.

We had to discuss abortion at University. I recall two students took the pro-life view. Whilst people questioned them in class, so much negative talk happened behind their back. These students were already ostracized before this, as they were strong, practicing Christians. A lot of the talk behind their back was a complete refusal of their opinion because of their religion. Even their opinion based on the biology was dismissed. They were ridiculed as being 'anti-science'. Unfortunately, in medicine, your reputation follows you everywhere. As a result, I am cautious about what I say about any politicized issues.

In the emergency department, I had a conversation with other doctors about the protesters outside the hospital at the Marie Stopes clinic. Everyone was ridiculing them, saying things like,

> 'Someone should have tripped them… how can anyone be so ignorant about science?'

I piped up and said,

> 'I think people should have their own opinions, but no one should harass them.'

The conversation continued, and then progressed to premature babies. Someone said,

> 'They look like aliens… they're so ugly', and I said, 'But you know they are human?' and she replied, 'Are you one of those people?' I said: 'Maybe I am' and we left it there.'

After this conversation, I spoke with others about how I should have approached the discussion. We concluded that it was probably the right approach to take at the time. There is probably an element of intellectual justification, but medicine is practice and experience, and afterwards I did feel I had done something wrong by not saying more, but I felt it was OK as long as I learned from it. If there was less judgment from my peers, I would have felt more comfortable talking about it.

At this stage, I have not dealt with someone wanting emergency contraception or an abortion. I have not worked out exactly what I would say. Whilst I uphold the value of life from womb to tomb, it is important to be sensitive and nuanced. I would need to understand why they requested it. If it were a case of potential rape, I would have to escalate it to superiors anyway. Most people would go to the pharmacy to get emergency contraception and bypass the hospital.

If a patient did complain about me refusing to refer them for abortion, I am happy to defend myself. I would have an opportunity to explain my position. I would stick to the biology, as that is the thing that is most likely to convince anybody.

Scientifically, there is no argument that it is not a human life and of our species. Even if doctors want to obscure this fact, it is unequivocal that life begins at conception, and this is more apparent now with technology. Philosophically, they are a member of our human community.

When I talk to the patient, I have to ascertain their level of scientific understanding in order to explain the science. The philosophical aspect is much harder to communicate but it is here that my conscientious objection comes into play. I might use examples such as asking them to consider the harm that occurs to a child in utero following decisions that are made in pregnancy. I might use an example like thalidomide. This underlines that they existed before they were born, and the argument that a person is only a person if they are wanted does not hold.

In the emergency department, people have asked me about abortion. I explain to them what the procedure is about, and then I explain to them my view, and the biology behind it. I had a patient who was 18 and came into the emergency department with vaginal bleeding. She mentioned she had just had an abortion, and no one had told her it would hurt that much. I asked her more questions and referred her on to pregnancy support centres that would help her with counselling. The hospital does not dictate whom we can refer to. I know where to refer based on my own research.

At my hospital, we do elective abortions up to eight weeks. I did a rotation in O&G because it is helpful for me in trying to specialize in Paediatrics. I spoke with the person who organises the rosters and I explained to them that I wanted to go overseas and attend World Youth Day, and the March for Life. She asked me some questions and then I raised concerns about having to do anything for people seeking medical abortions. I was very nervous broaching this subject.

I had not intended to do so, but the moment seemed right as it was a one-on-one conversation in her office, and she was very nice. I was told that I could conscientiously object.

The impact of having a conscientious objection on your place of employment

I was thinking of applying to a particular children's hospital in Australia, but on their Facebook page, they want to uphold their use of puberty blockers, so I would not apply there anymore. It is unfortunate, because it is only by working at those hospitals that you make the connections in order to progress in your career. But you have to sign a note saying that you uphold the values of that hospital, and I could not do that.

It's scary. In medical school the idea is to make doctors who are well rounded and formed but you don't get the diversity of opinion or opportunity for discussion, and no one provides you with suitable answers to any differing questions. In a learned environment it is crazy. So now I feel like if I put all this effort in, to get into training programs, it is very easy for your reputation to be harmed, to set your application aside, because of what one person thinks of you. That is why you have to tip-toe around this issue. I cannot control what people think of me.

I am far more cautious when I might want a reference. I have chosen not to go down certain routes and say what I want to say. As I am quite junior, you want to show yourself as a leader in the pack. It's really tough being a junior member of the team; you know enough to do the common things, but you are always seeking advice and help. When you can take your skills further than others, you feel good. You are constantly trying to impress those above you and as a result, you try not to damage those relationships.

Referrals and mandatory referrals

I would not have a hesitation to say no to a referral after I have had the conversation with the patient and explained the biology and the risks for abortion. I feel I have the confidence and experience to say no.

I never use religious arguments. I use scientific based reasoning to support my medical and ethical decisions. When it comes to elective abortions, the scientific arguments suffice. It's in those peripheral cases, the 1%, where the medical ethics component arises. I would have no qualms is bringing this up and highlighting to the mother my beliefs about it. That being said, we are not in the UK, where people have to see a certain GP. People here can attend any GP. I don't necessarily have to refer patients elsewhere. People do doctor shop. I want to show the patient I have thought this issue through, I have strong views about it, and that ethically, beneficence is an important part of my practice and character.

I do know that I don't want to be associated with abortion at all, but I have heard anecdotal stories about retribution against doctors who conscientiously objected and in doing so, inconvenienced others and were then given a bad roster. I had a recent situation where a high level doctor escalated an incident alleging I had not answered my pager when on call. This caused me a lot of concern and anxiety. While it resolved, it showed me how these sorts of things can get out of control and are hard to fix and can affect your reputation.

The AMA Conscientious Objection policy has a clause where when you refer a patient, you cannot talk about things that will cause them distress. This needs to be removed. Whilst it is not a breach of the law to continue talking about abortion, it would be a breach of standards, and this could result in disciplinary proceedings.

As to ancillary procedures and acts, like putting in a cannula or writing up paperwork, I have not formed an opinion on that, but I have not wanted to be involved with clinic appointments and early pregnancy and contraception clinics. I'd feel uncomfortable and would refrain from being involved. It is not that I don't want to discuss the issue with the patient, it is that I do not want to have to refer them on.

If there was the option to refer to a third-party organisation rather than someone who will perform the abortion, I would be ok with that so long as the patient has information for both sides. I could not refer my patient on and wash my hands. I'd refer them to places that are beneficial. I would uphold the duty to the law, but I would also act in a manner that was consistent with beneficence. If I were in that position, I would tell the patient that I was happy to refer them, but we need to have a conversation because you came to me and broached the issue and your choice needs to be informed with all the information.

We pride ourselves on autonomy and informed consent. Not informing the patient of all choices is a disservice to them and irresponsible. If we trust patients to make their own decisions to pursue a particular medical service, then we trust that if they go against medical advice, they should be informed of all the information that is available to highlight the risks, benefits and all alternatives. Some say that discussing your opinion with the patient where the patient may disagree with you can be distressing for the patient. That is quite arrogant. We are not the only ones who can handle that information. It is a difficult choice she has to make but if she is not fully informed, we open ourselves up to liability.

Informed consent is access to information. Women will be harmed either way. It's not about protecting them – that is a reflection of our paternalistic culture. We think we know everything. We need to give them all information including the long-term effects of abortion. A lot of this information can be hard to find. It is a very big issue. To minimize bias, you have to look at all literature. Abortion is very politicised, and if I were to search the literature, I would probably have trouble finding studies that support that harm. There is evidence for mental health repercussions, and I am aware of anecdotal evidence which indicates that there can be long term PTSD, and this should not be discounted just because it does not fit with the overall socio-political-medical ideology of the time.

Do you have a conscientious objection to other issues?

I have a conscientious objection to contraception, and I am unequivocally opposed to euthanasia.

I also have a conscientious objection to the use of puberty blockers for treatment of gender dysphoria. With gender dysphoria, it is a difficult issue to ignore and it makes me uncomfortable. I avoided putting down certain rotations, especially psychiatry, because you must take part in clinics, and I'd feel uncomfortable being part of that process. In endocrinology, I'd be concerned about what I might have to prescribe. There can be legitimate medical reasons to prescribe puberty blockers and that would be appropriate, but so late in my training, I don't want to have to justify my views. I run the risk of being discriminated against and this has caused me stress.

I have gotten better at being extra careful to navigate these waters. I'm very guarded about what I say. Despite being diplomatic, your words can be misconstrued. I don't want to broach the subject if a person is passionate about their position, because I don't think I can have a rational discussion on gender dysphoria. The person might have personal or professional links with my supervisors. Even attending lectures on the topic, I have not heard a compelling argument for gender dysphoria and the use of puberty blockers.

In those lectures, counter point arguments are made by others, but people are usually shut down. There is a lot of reliance on qualitative research regarding how people feel, and those who support prescribing puberty blockers feel that they are therefore saving lives. When it comes to harm, the medical paradigm has shifted from a biomedical to a biopsychosocial view with emphasis on the positive impact treatment has on a person's mental health and psychiatry. The trap comes when you equate the two, the psychological and medical with medical meaning organic disease, tangible and treatable and psychological being not as well defined, vague with a variety of treatment protocols. You consult 10 different psychiatrists you will get 10 different treatment regimes.

Would you perform surgery to remove sex organs at the request of a transgender patient or refer someone to have this done?

With transgenderism, I feel that there is not enough research for me to feel that this is something that will benefit the patient. I can definitively say that we do not understand the impact of hormones and it would be imprudent to refer you to someone who will prescribe these medications.

In paediatrics we do a lot of things that cause our patients to feel pain, to feel sad in the short term as part of making them feel better. For example, you have to force a child to have hydration even if they don't want it. We routinely tell kids they cannot do things. I feel there is more ridicule for being against abortion than being against transgenderism. Abortion has been more politicized in the non-medical culture, and as the trans issue is more recent, it is easier to hold an objection to it, as it has more nebulous concepts and is easier to pick apart.

What education if any, have you received about conscientious objection including at university?

We got two lectures about medico-legal issues, such as not posting things on Facebook or talking about patients in public. In regard to conscientious objection, people just assumed you knew what it was. In hindsight they should have done more.

What would you do to change the situation and make it better?

I got into medicine to help people. It upsets me that I might be forced to do something because I fear the ramifications. I would want legal protection to say I am allowed to say no, rather than feel I can only say no if I refer to someone who can definitely say yes. In this situation, it is still undermining my objection. I say no because I have researched this, and I believe it is in the best interests of patients.

In this day and age where medicine is trying to be less paternalistic, doctors should make decisions because they have researched them. I think it is demeaning to say that if you are withholding services because of personal beliefs, you need to make sure that the patient gets that service. As a doctor, I should be trusted to make that medical decision. I should be allowed to decline the service. You cannot protect all patients, and the patient can find someone else to do it.

It would be helpful to have someone neutral in a hospital that you could approach for support, but I just don't think you could trust him or her. Even they would have particular powers in regards to your training.

You look up to consultants who have stood up for the euthanasia legislation. I will have to talk to a consultant about how to do this when I am about to start my O&G placement. It is important to know people to go to for advice about how to have that discussion with superiors.

I think there should be legal protection for the right to say 'no' based on a person's views regardless of whether their views are completely religious or non-science based. The opportunity to say 'no' to a treatment if, in my opinion it does not uphold non-maleficence and

beneficence and conflicts with my personal values, is something that would be useful to legislate for.

Non-science based and potentially harmful religious beliefs, such as performing female genital mutilation (‘FGM’) is different to saying no to providing a service that conflicts with my own personal values. As long as a doctor’s beliefs are underpinned by an intention for non-maleficence and beneficence, they should be protected, but if a medical procedure was to cause harm, then despite it being a genuine belief of the doctor, I don’t think it should be protected.

That being said most proponents will put forward the issue of a lack of access to 'healthcare' as a reason to override conscientious objection, but it should be noted that not all medical issues, and especially heavily politicised issues, are a matter of grave urgency that require acute and emergent treatment. If a person is unable to breathe because they are choking on something they have eaten, then after exhausting normal manoeuvres, doctors will consider a 'needle crico-thyroidectomy'. This bypasses the throat and allows a person to breathe through a tube - the classical biro in the neck manoeuvre that TV shows and movies always highlight. This is an emergency procedure. There are specialists who do this but if push comes to shove and a doctor does it, they can potentially save a life. In this situation, you are able to conscientiously object, but you lose far more if you don't try than if you do and do it incorrectly.

An abortion, assisted suicide, puberty blockers etc. are NOT emergency procedures/treatments that save lives. Pro-abortionists will declare that it potentially 'saves the life' of a mother but if it came to a woman who was dying because she had a miscarriage and her miscarried baby was infected (think of the case of Savita in Ireland), she would be airlifted from a rural/regional area to a tertiary centre and her life would be saved.

The services required in those emergent situations (intensive care and high dependency care) are few and far between in rural/regional areas and that's not an inequity issue, that's a logistical and funding issue where it doesn't make sense to fund a service that won't benefit the most people. Just in order to provide 'equal access.’

Transcript of Interview

Doctor # 13

Interview conducted by ALW, 5 June 2018
Start: 10.00am
Finish: 11.45am

Antecedents of Doctor # 13

Doctor # 13 is male, a member of the Church of Jesus Christ and Later Day Saints, and has been a doctor for over 30 years, with around 10 years' experience in public hospitals, and around 20 years' experience as a GP, both in a metropolitan area of New South Wales.

Consent

Written consent was obtained for the interview by ALW.
The interview guide was varied to take into account the respondent's background and in order to explore issues as they arose.

How would you define conscientious objection?

A person's feeling or attitude about a particular issue where they are so committed to that belief, that nothing would sway them in any shape or form from that position.

The basis of your conscientious objection to abortion

I believe that a life has been created and we don't have a right to terminate it. There are always some areas where I understand why they want an abortion, such as rape or where people fall pregnant and they feel it is inappropriate to continue, but it is still a life. In that instance, I would allow that person to do what they want.

I think all women who undergo abortion should have very good counselling about the pros and cons they are embarking upon. In my experience, some women who have had abortion have a sense of guilt, and it might be years later that they experience grief. I have dealt with this a few times with patients and it does not seem to be something that is discussed with them prior to the abortion.

Your experience in exercising your conscientious objection to abortion

I did not become a member of the Church until my 20's and after I had become a doctor. I know my belief structure and I feel happy with that. We all like to be liked and appreciated, but faith and belief in God comes first. When I first became a doctor, a few colleagues had the attitude that I did not have a right to tell people what to do with their life. They were critical of my objection. It made me think about things a bit more deeply. It made me think I need to discuss things more with a patient and go beyond just stating my belief and explain why I don't believe in abortion.

For patients who want an abortion, I always state my view and say something like:

> 'I don't believe in abortion, but I respect you as a human being and your right to decide what you want to do with this pregnancy and your body… You should have some counselling. This is not something that should be done in an off-handed fashion… I have come across post abortion grief in some women, maybe not straight away, but down the track. We don't know what the future holds. People's views change with age and experience. …Have you looked into other alternatives? Have you thought about adoption? There are many couples that have not had the opportunity to have children because of infertility. Wouldn't it be better to have the child and give it to someone who will love them?

For some patients, I might disclose my faith, where it is appropriate, but it may not be the first thing I say. I prefer to start with the biology of it. Some people lack spiritual beliefs and as a result, they have an off-handed view of life in general. I might ask people if they have spiritual beliefs, and what they think about life and death. This is to see if they have any structure for their belief system.

In the demographic I deal with, most young women are in a stable relationship and so have decided to have the baby. Having a stable clientele, allows you to gain their trust and earn respect, but there are still patients who want abortion.

Referrals and mandatory referrals

I don't have a problem with referring for abortion. I had one patient request a referral after I went through my spiel. She stood her ground and said, 'Thank you for what you have said, but I really want you to refer me to Marie Stopes so I can get an abortion.' She was adamant and had a friend with her at the time. Nothing deterred her.

So, I did the referral. I felt OK about it. I felt I had explained everything to her. I felt that if ultimately, I did not give her a referral, she would have gotten it done anyway. I hoped that after giving her the referral, and before she went to the abortion clinic, she might think about what I said and change her mind at the last minute. It does happen.

However, I feel that in a doctor/patient relationship, there must be trust. I felt this patient needed to know I was going to support her, even though I did not agree with her decision. I think a large percentage of doctors, perhaps 60-70%, would not have engaged in a conversation like I had with her. They would have just referred.

If I were working in a public hospital that did abortions, I would decline to take part in both the abortion, and any ancillary procedures surrounding it. This would include paperwork, inserting a cannula, or assisting at surgery. I would probably have a discussion with the chief executive officer in advance and tell them they have to find someone else, but if the hospital did not regularly perform abortions, I would probably not have a formal discussion and would just wait until the occasion arose.

Years ago I did prescribe the morning after pill to a patient. We had a long discussion, but the patient wanted to try this way of ending a pregnancy, if it had occurred. In the circumstances, as there was no confirmation of a pregnancy, and it was very early on, I felt that if this was what the woman felt was appropriate, I should prescribe it.

The impact of having a conscientious objection on your place of employment

It had a partial impact. I moved back into the hospital system for a number of years because of something that the government was doing about general practice. Being back in the hospital gave me a rest from dealing with issues such as contraception and abortion, but I eventually went back to general practice. Most people in the practice I work in now know that I have a conscientious objection to abortion, and they respect my point of view. I think some have similar views.

Do you have a conscientious objection to other issues?

Euthanasia. I would not do a referral for euthanasia. I don't think I have the right to help a person standing in front of me to be euthanised. With abortion, it's a bit different. The person standing in front of me asking for the service is not going to be dead after it. It's the body inside her body and she is its spokesperson.

Contraception is tricky for me. My Church does not endorse premarital sex, but it states that contraception is an issue between a husband and wife and the number of children a couple have is up to the couple involved. On the one hand, you don't want to tell people how to run their lives, but on the other hand, you must let them know that it is not a small thing they are embarking on, and certain behaviours carry risks such as STDs, and cervical cancers. However, the patient has a right to determine what to do with their bodies and I tell them to be careful.
Sometimes parents send their child to the GP to talk about contraception. I had a patient once who was almost 16, and who wanted the oral contraceptive pill. We had a long discussion about whether this was what she realty wanted, and whether she had really thought about it. As she was not yet 16, I told her we needed to talk more about it and if this was what she decided, we could talk about prescribing her the oral contraceptive pill when she turned 16.

Would you perform surgery to remove sex organs at the request of a transgender patient or refer someone to have this done?

It's not an area I feel very comfortable with. I would be honest with the patient and tell them that I don't agree with it on a number of fronts. I would say to them that I believe that barring any genetic issue; people are born either male or female.

As a medical student, I once saw a man having a sex change operation and it was the only time I had a physical reaction. I felt nauseous. I have seen open-heart surgery and neurological surgery but this was different. It was a sense of harming the patient. Why are we doing this operation to change them into a female? It didn't make sense to me. It seemed to go against all the beliefs I had about what medicine is trying to do. I didn't feel it was right. I had a deep feeling that what we were doing was wrong, and I couldn't understand why we were doing it.

I have been in situations before with transgender patients and I have told them 'I think it is more appropriate that you deal with another GP.' I recall one patient who was taking hormones and was waiting to have the surgery done and was not open to other ideas. A couple of patients got irritated with me. I think they were a bit surprised and just assumed that I would refer them on.

I don't want them walking away without understanding what they are embarking on. I feel there are underlying psychological issues that may impact on consent. I'm not sure about endocrinologists, but I believe surgeons have to refer the patient for counselling before sex change surgery. Even though I would not refer the patient on for that treatment, I would still offer them a referral for counselling or someone to talk to about it.

What education if any, have you received about conscientious objection including at university?

Nothing. I recall students at University who were Catholic and against abortion and I really admired them. I recall there being something special about them. They cared a lot, and they excelled in their studies. They were not overbearing when expressing their views. I would have benefited from being taught ethics and philosophy, and how to run a business. As a doctor there are regular seminars for medico-legal issues, but I have not seen anything specifically on conscientious objection.

What would you do to change the situation and make it better?

People change their attitudes over their life. They may have an off-hand attitude to abortion, but something may happen years later that makes them re-think this. There should be a legal requirement to refer people for counselling before abortion. If the man is willing, both he and the mother should have counselling.

Adoption is just not discussed. Why not try to encourage a pregnant woman to have the child and adopt it out? Why is everything focused on abortion? We are we denying this chance of a child being loved by a family.

Information about abortion should be transparent, and clinics that offer abortion, should also offer counselling. If the abortion provider does not agree to provide counselling, they should be required to refer to someone who does offer it. My understanding from patients that I have referred to abortion clinics is that their counselling was limited to the physical effects of the procedure.

Any referral for counselling needs to be someone who understands the issues. I'd like to see an avenue where a person can go to have a discussion about the pros and cons of abortion. It should include organizations that offer alternative discussion about abortion and that could be a church group. We have to look at services in the community that help people and keep an open mind. Church groups usually have a lot of experience with dealing with people. They are not necessarily saying 'come and join our Church'. If it's a good service, I don't care what denomination it is.

I like the idea of a brochure that lists all services that may benefit a crisis pregnancy. This would provide GPs with some guidance if they do not personally know where to refer someone. In my practice, all the doctors generally have a discussion with the practice manager before any brochures are placed in the waiting area.

Transcript of Interview

Doctor # 14

Interview conducted by ALW, 19 June 2018

Start: 2.30pm

Finish: 4:10pm.

Antecedents of Doctor # 14

Doctor # 14 is male, identifies as an Evangelical Christian, and has been a doctor for 14 years, and a GP for 10 years, practicing in a metropolitan area of Victoria.

Consent

Written consent was obtained for the interview by ALW.

The interview guide was varied to take into account the respondent's background and in order to explore issues as they arose.

How would you define conscientious objection?

It's refusing or declining to do something based on belief or principle. I don't think a conscientious objection has to be religious. An atheist should be entitled to say no. A sincerely held belief should be protected, as long as you are not harming someone, and it's not an emergency situation, its fine. Who am I to force them to do it? I strongly believe people should be allowed to live the way they want, and not be forced to do things that are against their beliefs, whatever the reason.

I think there is a difference between positive and negative acts. All of this is about negative rights, the right not to be compelled to do something. It's about opting out. There's a difference between a positive and a negative act. If something is beneficial by refusing to provide it you are not stopping them from getting it from someone else.

The basis of your conscientious objection to abortion

I believe abortion is wrong, unethical, and the taking of a life. There is a scientific understanding that a human becomes a human individual when they are conceived, because that is when they have their own DNA. The value judgment is at what point life should be protected. The idea that human life ought to be protected comes from values. There is no science that says you cannot murder somebody. Science tells you when a human is a human, but your values tell you whether you shouldn't take a life or murder someone or be a part of doing that.

Referrals and mandatory referrals

The law in Victoria changed in 2008, right at the time when I went into practice. I have never practiced in a GP setting without this issue being there. I was conscious of it from the start. From the beginning of my practice as a GP I have had to think how I respond to this situation. Rather than just go with what is intuitive, I have had to have a thought through procedure or response when it arises.

I was very angry about the Victorian abortion law. I read things and I wrote to members of Parliament. I have not referred anyone and would not do so. I wouldn't work in those contexts.

To practice in accordance with my convictions, I have to break the law. But most of the time, you can carry on in the knowledge that the patient won't complain, and you won't get in to trouble. So, you get to the point where you don't like it, but you can live with it.

From the very start, there was a few times where I said:

> 'This is against my beliefs (or something to that effect). It's not something I participate in because of my views on this.'

But as time has gone on, I have felt it was not necessary to say anything about my beliefs. You can just say to people thinking about an abortion:

> 'If this is what you would like to do, you can go down that track without me. I don't need to give you a referral. You are welcome to search for that yourself to get that done, to ring them up and follow it through yourself without any letter or recommendation from me.'

As people can self-refer for, I have come to the position that I don't have to disclose my beliefs. No referral is required. Patients are usually fine with this. It is not something that comes up a lot, maybe a couple of times a year. As a male GP, women are more likely to go to a female GP. As most people self-refer for abortion, they don't have to go to their GP, although they might tell us about it after the fact.

Requests from walk in clients for abortion are more likely to occur as a new doctor, as you have time slots available, and you don't have a regular clientele. For most of my colleagues, it is not something they get asked about often. They might see someone who is in that process of making that decision. Everyone knows you can go and do it yourself. In Melbourne, in an area where people are self-sufficient, they find their own way to a clinic. I think that when this law came in in 2008, we hadn't quite got to the point where people could look up things on-line. Now everyone is so native with their devices, you can look up whatever you want whenever you want, you don't need help from a health professional.

A reason why this law is so bad is that it does shut down, and I think it is designed to do this, to take pro-life people doctors of the picture. To make them end the consultation and go to someone with a different ideological view. That is happening in effect. You end up saying, if you follow the law, I cannot go any further with you, we are ending it there and you have to see someone else. If they are your usual patient, that is the usual scenario, then you are their doctor, why should you end it there? To send them to see someone else that they have not chosen to see?

Over the 10 years, I started off very cautious. I did not want to get in trouble. The way you get in trouble is if someone makes a complaint. I have become less paranoid. If you are sensible, and civil about things, they are not going to complain about you. It is only someone with an agenda, and normal people don't have an agenda.

If someone comes in to talk about an unwanted pregnancy, there is no doubt that even now, it would make me vigilant, a bit anxious. I would be very careful about what I said, I would monitor myself to play my cards right, and not do anything that might put myself at risk. In the early days, I was terrified about it. Younger and less experienced, with the prospect of being prosecuted for breaking the law, I was very frightened. I recall saying to a few people requesting abortion in the early days:

‘Are you sure you are not going to regret it?’

I felt this conversation was very risky. Even saying this is a thought crime. But if you care about them as a person, it’s the right thing to do. It is not something that anyone should take lightly. I think this whole thing is designed to get in the way of dissuading anyone from having an abortion or getting them to re-think their decision. This law is like the 150-metre zone around clinics to stop people re-thinking this.

But now, it’s not actually likely that someone will complain about you. Today, it’s their choice. Today, I am less afraid. At the start, there were a couple of seminars on what to do now. There was great uncertainty that we were going to be forced to practice in a way that was against our beliefs. There was a climate of uncertainty and fear, and anxiety about everything. Everyone was uncomfortable and wanting to know how to protect oneself. One piece of advice was to put a sign up in reception that said, ‘this doctor does not discuss abortion.’ I didn’t like this idea. You are advertising your views out the front for everybody. I don’t have to do for anything else, why should I do it for this and out myself? It is pushing people away from me.

To date, I am not aware of a patient who has dobbed in a doctor in for not referring them. That is the normal course of things. If you are not dobbed in by a patient, there are no grounds to investigate you. Anyone with strong enough convictions is not going to change their practice, but they are going to be more careful about this.

Abortions are done at places like Marie Stopes and a limited amount of abortions are done in the public system. In the public system you may need a referral but the Royal Melbourne Hospital has its own pregnancy advisory line and you don’t need a referral. I would feel a bit uncomfortable telling patients about this, as I would wonder whether I am still involved by doing this. I don’t know what information they give about options. If I had to guess, I imagine it would be two choices with a list of places you can do to if you want one, and if they are financially disadvantaged, they might have it done at the hospital or if it is complicated. They might offer a talk with a counsellor, but they would also present abortion as a good and legitimate option.

I would not want to recommend a patient to a ‘family planning’ organisation, as they are very pro-abortion. I would truthfully say that I don’t know a gynaecologist who does it. Another

way out is to say that I don't know, but they can speak with one of the other doctors in the group practice.

In an extremely remote and rural area, people have the same access to information as in a metropolitan and city areas. I have worked in the country, where people could find their way to what they needed through word of mouth, or the yellow pages, or Google. There is no restriction on abortion clinics advertising themselves.

The only barrier in remote or rural areas might be cost, and a GP cannot solve that for you. For medical abortion you have to have done a training module, which you can do on-line, and the most state insurers won't let you do it unless you insure yourself as a procedural doctor. This is a disincentive and is a barrier.

In real life, if a pregnant woman could not get a timely abortion because of geographical location, that sort of thing is extremely rare, and you cross that bridge when you come to it. If your ideological opinion is that abortion is a human right, then if you are in a rural location, you need to make medication more accessible to people but they cannot force doctors to do this.

In a state like Queensland, they might say that if you're somewhere remote then you are obliged to refer to someone like Dr. Caroline de Costa and you have to get them to here before 9 weeks. But it creates a law that binds everybody, including people who work in the city. The law is a blunt instrument to solve a problem that affects a small proportion of the community. They would be making a law based on exceptional circumstance that everyone has to abide by it and can be disciplined about.

The impact of having a conscientious objection on your place of employment

I have not chosen to go into an area that is too affected.

Some of the people I work with are aware of my position on abortion. Some of the newer ones are not. We are a friendly place, and I am fortunate to find a place to work where you can talk about things, and we trust each other. Fairly early on I brought it up and I am the person with the strongest views in my practice with half the doctors I work with having a religious affiliation.

Do you have a conscientious objection to other issues?

Euthanasia. I don't generally have an issue with oral contraception. I am not Catholic and don't have a moral objection to it, but I understand others do and I respect that.

If a patient wanted a referral for hormones or to an endocrinologist or a gender identity clinic, I would have to think about this further. There is no law forcing me to do it. I wouldn't want to do it. I don't agree with any of this, and I am free to say I am not comfortable with speaking about this. The current medical board's code of conduct says you are not obliged to do anything about their beliefs so long as you don't obstruct them. You are not obliged to comply with a request that goes against your beliefs.

I would feel uncomfortable about a lesbian couple that want IVF and need a referral. I would have to find some way out of it. You can say they are going to get a referral anyway, and it's not such a stain on my conscience as with abortion where a human life is being killed. I don't agree with it, but I don't have the same desire to stay completely clear of it. There are single people who might want a referral for IVF. It's not something that has happened yet, and I also don't agree with it, and there are lots of reasons why it is not right, not just moral reasons. But I would prefer not to help someone to do this. It's not a life or death thing, it is like cosmetic surgery.

Would you perform surgery to remove sex organs at the request of a transgender patient or refer someone to have this done?

No. There are plenty of secular people who are pro-choice, but they think this concept is ridiculous. It is common sense, and a fad that will probably fade away.

What education if any, have you received about conscientious objection including at university?

None.

What would you do to change the situation and make it better?

The Victorian law is a terrible law, but looking at the bigger picture, if you want to be an endocrinologist to help kids with diabetes, but you have to work in a transgender clinic for a year, you are shutting people out of areas. In an ideal world, people would respect others right to say no to things. If would be good if people knew how to navigate conscientious objection and assert themselves. The good thing in my area as a GP is that you have a lot of autonomy. It's hard to think of a GP situation where a person is forced to do something they don't want to do.

If you are going to say up front that you have a conscientious objection, you may run into problems. If you just fly under the radar, you might be more likely to be ok. If the problem arises, you deal with it and speak with the patient courteously. If you put the flag up, you increase your chances of someone having a go at you. I understand the desire to be up front about what I believe in, because it is an act of courtesy and integrity to say to your employer that these are my beliefs, but you don't need to tell your boss your moral position about everything before you take a job. It's impractical. You don't have to say, 'Before I take this job I have a problem with this …'. You might be creating a problem that is not really there, and that you could have solved through other means.

If you don't want to prescribe contraception, that could be very difficult for you, especially going through the two-year training program, where you have to be under a supervisor. For a female GP, the request is made every day, and for a male GP, every week. You could not avoid this conflict, but it can be accommodated. The doctor can tell the patient that it is not part of their practice, and they have to see another doctor. They should not charge the patient. For most of the other things, there are ways to navigate around it. No doctor knows everything, and there are going to be times when you have to tell the patient you don't know much about it, or they have to go and see someone else.

I would abolish section 8 of the law. It shouldn't be there and does not need to be there and does not serve any real purpose that helps patients. It's an ideological thing. A pragmatic thing however would be to alter the wording so it said something like you must inform the patient that they can seek assistance elsewhere, without having to direct them anywhere specific. It should not have to be necessary to have some sort of federal law that guarantees religious liberty.

Transcript of Interview

Doctor # 15

Interview conducted by ALW, 26 June 2018
Start: 2.30pm
Finish: 4.00pm

Antecedents of Doctor # 15

Doctor # 15 is female, is a member of the Seventh Day Adventist Church, has been a doctor for 10 years, and a GP/obstetrician for 3 years, practicing in Victoria.

Consent

Written consent was obtained for the interview by ALW.
The interview guide was varied to take into account the respondent's background and in order to explore issues as they arose.

How would you define conscientious objection?

The right of a medical practitioner to act within the moral or ethical confines of their faith or conscience, and not be required to participate in something that is against this.

The basis of your conscientious objection to abortion

I believe life starts at conception.

The impact your conscientious objection had upon your choice of employment

My only question when I was interviewed for the obstetrics component of the GP training program was whether I would be obliged to perform abortions. I was prepared to pick something else if it was going to be a problem, but their response was that I did not have to. The GP I ended up taking over from did not do abortion either. So, I felt there was already a

precedent at the clinic. One of the anaesthetists won't do the routine clinic lists at the hospital, only the emergency cases, in case he finds himself in a situation where he is required to provide an anaesthetic for an abortion. He has made that sacrifice.

Some of my colleagues have just started doing medical abortions in my area. Given all of us provide an on-call service for emergency cases, it is likely that if one of these women presents with an incomplete abortion or heavy bleeding, a D&C would be necessary. If the woman had really heavy bleeding from taking the medication, and had a partial abortion, I don't know exactly what I would do, as I have not had to deal with this yet. I think I would probably do the D&C if it was absolutely necessary for the woman's physical well-being and I would liken it in principle to an emergency operation for an ectopic pregnancy. However, if they experienced only mild cramping or spotting and wanted a D&C, I would not do this. I would give the patient pain relief, and let the usual doctor take care of it in the morning.

I did my obstetrics rotation at a public hospital in NSW that did not perform abortions. However, on the first day I started my obstetrics diploma training in Victoria, I had a theatre list that described one operation as *tba*. I later learned this was a code for termination. I was a little anxious and uncertain, but I got up the courage to chat with the surgeon and asked him if I could be excused from this surgery.

He asked me if this was because it was an abortion. I said yes and he told me I did not need to have anything to do with it and to come back for the next case. The obstetrics diploma requirements include competency in second trimester terminations. I asked if I could just do the management of second trimester miscarriages (i.e. foetal demise already occurred) rather than terminations and the consultants said this was fine. One of the female consultants also did not do abortions and was a Christian. The other two Consultants respected our stand, but would sometimes say

> 'Is this woman centred care or is it not? How do we combine these two things?'

But it was never said in an angry or nasty tone.

Your experiences with managing patient requests for abortion

That case where the doctor got into trouble for not referring a woman who was 19 weeks pregnant and wanted a sex selection abortion infused a lot of fear into doctors who have a conscientious objection. Is there a doctor who will go against their belief? I would want a doctor who would do the best regardless of the consequences.

To give pregnancy counselling, you have to be non-judgmental. Initially, I felt anxious doing these sessions. I usually say:

> 'Don't consider termination as an easy way out. Some people find it easy, some find it difficult. You might regret your choice later, no matter what it is, so why not write down the pros and cons for you to all options, and then keep it so you can look back on it later regardless of what the outcome is.'

Sometimes I have people come back and thank me because they decided not to have an abortion, or they had it done and tell me I was right, and they would not do it again.
For some, once they see the heartbeat, they cannot go through with it.

I don't think Marie Stopes provides counselling about all the options. If someone asks for an abortion, I never tell them about Marie Stopes up front. Rather, I tell them to go and get their blood tests +/- ultrasound done and come back to see me. When they come and see me, it is the only time they get counselling, as they usually don't see the point in being referred to a psychologist, or they cannot afford to see one.

I try to give non-directive counselling, as we were taught to do at medical school and postgraduate training. I try not to let patients know that I have an absolute objection to abortion unless there is no way of avoiding it. There is a fear… If they still want an abortion, I will tell them at the end that I don't do this procedure, but this is where it is done if you still want to consider it, and please come and see me afterwards. I generally keep faith out of any discussion with a patient unless they ask. If they do ask, I will talk about it.

There was one occasion when I went the full hog. That person was of the Exclusive Brethren faith and was 18 weeks pregnant. She had just found out she was having a third girl and she was beside herself and wanted to get rid of it. We had a long conversation, and I brought up what the leaders of her faith would say, which was that abortion was murder. I tried to help her see a different side of things. I used a bit of scriptural examples as to why females are just as valuable as males in order to help her adhere to her faith in a more willing matter. I told her that if she wanted me to stop any part of the conversation, I would. She still comes back to see me.

I also had a Pakistani Muslim lady, who was 27 weeks pregnant, struggling with nausea, and was absolutely distraught at having another girl because she believed females were of lesser value in her culture. I referred her to a psychologist who shared her faith, and this seemed to help.

When I was a young doctor, I had a mother scream at me that I had ruined her 16-year-old daughter's life because her daughter had decided to keep the early pregnancy. She came in with her daughter to see me, and the daughter had tears streaming down her face. I asked the mother if I could speak with the daughter by herself, and she willingly agreed at that stage. I then asked the daughter if everything was ok, and she cried and she 'I can't do it.' I then asked if she felt pressured to have an abortion and she said:

> 'I cannot do it, I have seen the heartbeat.'

I said we would check to see if the heartbeat was still there, as a miscarriage would take the decision away from her, but the heartbeat was still there. The mother came back to scream at me a week later and said:

> 'How dare you show her the heartbeat'? What do you think that is going to make her feel like? If this baby is born, it will be all your fault!

I remember sitting down and shaking and needing to get a drink before the next patient came in.

Referrals and mandatory referrals

I started off at university thinking I would never make a referral for abortion. I thought it would make me complicit in it. However, having talked about it with a doctor, who was a Baptist, I do provide women with information on where they can go to get a termination if after much counselling they still insist that that is the only option they feel they can proceed with. I have become aware that in other areas of medicine, referrals are often facilitating a request for a second opinion to which patients are entitled and it does not necessarily mean I agree with it or that a given procedure will happen. I don't know if the doctor I spoke to had any training in philosophy behind these concepts, but I certainly haven't. I get my theology from my reading of the Bible, but I think you can philosophize until the cows come home and you won't have everyone agreeing with it. It is more about how I feel convicted about it based on my prayerful study of Biblical principles, combined with insights gained from discussing the topic with other Christian medical professionals who have a conscientious stance in regard to this.

If you cannot provide a service, letting people know where else to go is their right and prerogative. I don't necessarily like it, but it doesn't necessarily make you complicit in it. Looking at it from the bigger picture, the devil came and ruined this world and God put in a plan to remedy that. In the meantime, God has his law, and he knows people can choose either his law or the devil's way. People have free will. It is not our job to tell people what to do. That is between their conscience and the creator.

It's tricky. Maybe I have compromised to make it work. It's quite a grey area. I think it is hard when you feel like you are the only one. The fear factor about being hauled in front of AHPRA is real, but I don't want to compromise my faith over that. One of the colleagues in my clinic would probably not provide the back-up service if a person had a medical abortion and had bleeding and wanted a D&C unless it was absolutely torrential, life-threatening bleeding. I respect that. One of the GPs in my clinic does abortions. One will not have a bar of it. I usually say to the patient that they can talk to one of my colleagues, and I send the colleague an inter-office email which I guess is a referral, asking if they will have a consultation with the patient.

Most of the time we get away without giving a referral. If people choose to go ahead with it, I tell them where they can get a service performed if they wish, but I tell them to arrange it themselves. I think when someone is in a distressing situation, it can be a bit hard to tell them to go and find the details themselves.

If I write a referral, I get a copy of the notes about the procedure, and then I know what happened. We need the communication back from the doctor who performed the procedure, to make sure that contraception is in place for the future and that the person has appropriate post-procedure care. Does it necessarily mean that I am complicit in the act? I don't know. But if someone does something I don't agree with – or dare I say it makes a mistake – that does not mean I do not treat them afterwards. I still treat smokers, alcoholics, etc. It does not mean I agree with the situation that led to their need for medical care. I think God cares for us in the same way.

I once spoke (refused to refer initially but felt the need to speak to them for the purposes of essential information transfer) to a Marie Stopes clinic in Melbourne. The case was psychosocially difficult, and no one was prepared to perform an abortion on this patient locally. The patient had a planned pregnancy, but it was a twin pregnancy and she had hyperemesis. She had to be admitted to hospital a couple of times and she was on an intense oral drug regime which worked while ever she actually took it.

The regime was working but then she just decided to stop taking it. A few days later she was not well and came into the clinic for IV fluids for dehydration. She agreed to have a nasogastric tube inserted, but then declined when she actually got to the hospital to get it done. Next, we arranged a PICC line (long intravenous line for fluids), she agreed, got all the way to radiology to get it inserted then declined it again. She then asked for an abortion. Her husband and mother were pleading with her not have an abortion. I asked her if she was under pressure. She told me that apart from the nausea and vomiting she would keep it. I told her I did not understand her decision given she was refusing all treatment for the nausea and vomiting, and additionally she had this condition with her previous pregnancy, and this was a planned pregnancy knowing all that, but she just said to me:

> 'No, I just have a choice.'

I said:

> ‘Yes, but it just didn’t seem to make sense that the treatment worked, you won’t have the treatment, but you say you would keep the twin pregnancy if the nausea and vomiting wasn’t there.’

I thought the ramifications were significant and she might come back and say that I did not give her adequate counselling. She wanted the termination straight away, but I had spoken with my only colleague who performs abortions, and even he felt the above unusual features meant that it was a case we should not get involved with at all but should allow the experts to deal with it. As it was a twin pregnancy, I told her we could not accommodate it and that she was welcome to contact Marie Stopes if she really wanted to. We also arranged a psychologist visit I think. After several days in hospital on fluids, while waiting for the day she had booked the procedure (with us hoping she would change her mind after spending great lengths of time talking to her, and her berating us for not providing the service locally), I gained the patient’s permission to ring Marie Stopes to make sure they got all of her history with my concerns and her medical issues (ie low potassium from vomiting excessively etc). I understand from her usual GP that she did get the abortion and after that, was regretting it a bit.

I often feel sad about the people who have gone through with abortions. I wonder how old the baby would be. I see ladies lose babies who desperately want them, and then those who get rid of them. I saw a person who was supposed to be about 16 weeks pregnant, who told me she an abortion 2 weeks ago. You then get back the pathology and see an arm or a leg or a kidney and you shudder.

Do you have a conscientious objection to other issues?

Euthanasia. We do a lot of palliative care in my hospital. This might become an issue given euthanasia is lawful in Victoria, that but I don’t think I am the only one who objects.

With prescribing contraception, I understand this that objection to this is often a Catholic thing and based on God wanting us to fill the earth. I have been raised to believe that God wants you to be responsible. My understanding is that the oral contraceptive pill is not an abortifacient. I

believe this because I see so many people get pregnant on it. If you have not been taking it for a week, it won't work at affecting the lining of the uterus.

I don't like inserting the copper IUDs, as you can use it as emergency contraception. I don't use it for that. People can get the morning after pill from a pharmacy. The copper in the IUD is embryo-toxic. I have been cornered before twice, where patients wanted to have a copper IUD inserted. On one occasion, the patient had seen a gynaecologist and was sent back to see me for insertion. I did not feel I could say no, as that was the only reason the patient had come to see me, it was awkward to explain the reasons for saying no, and I was junior at the time. I do feel bad about that decision, but I think mistakes can be turned into something positive for next time.

Another time, I reluctantly agreed to insert a copper IUD for a woman who had two kids, a year apart, and where the pill and the Mirena IUD had resulted in unwanted side effects for her. The action of the Mirena is not abortifacient, and it cannot be used as an abortifacient. So I recommend that option to patients, as it is better for them and is also much cheaper.

Would you perform surgery to remove sex organs at the request of a transgender patient or refer someone to have this done?

No. My objection is purely faith based. I think God creates us the way we, for our happiness, and I think there are underlying psychological reasons why people are in distress and seek this surgery.

I feel some anxiety discussing this issue. One patient wanted to see me because their son thought he was a girl, but she ended up not coming in. I would probably suggest some counselling as part of that decision making process and I would tell them it needs to go on for quite some time before they start hormone therapy or surgery. I would spend time acknowledging the distress that brings them to ask me for it in the first place, in order to show the patient that I care.

What education if any, have you received about conscientious objection including at university?

We had an ethics lecturer who spent time talking about this stuff, but there were no clear answers. It was more about how you know about right or wrong. You always worry about what other people in the class think. Others in the class are vocally pro-abortion and pro-choice.

What would you do to change the situation and make it better?

I think there needs to be a little bit more recognition that there are doctors with a conscientious objection to abortion Victoria. I wish there wasn't such a fear of being identified as someone who does not agree with abortion. The law should protect people like us. I would prefer the law not compel doctors to refer people to places like Marie Stopes. I would support a change where patients can access information on a pre-printed brochure put out by the government, but still permitted doctors to counsel patients.

I think once the person goes to a standalone clinic, they probably have already made their decision. I still want the opportunity to counsel patients who have not decided to have an abortion. I am not in favour of people standing outside abortion clinics when the decision is difficult already. In theory I don't have a problem with people protesting outside abortion clinics, but I have seen on US YouTube videos, banners that were unkind and un-Christian. I have had a couple of patients who told me they were traumatized by the antics of sidewalk counsellors outside abortion clinics.

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists recently put out a release that studies do not support the conclusion that women have emotional injuries following abortion, but I think that often studies can prove entirely opposite viewpoints and I have seen enough people who carry heartbreak after these procedures, and others for whom it doesn't appear to matter.

I support GPs with a conscientious objection having an on-line--learning module to equip us to learn more about social services available that can support women in choosing options other than abortion. I don't always know what information women need or is available for them to

access. My secular GP regional training provider did not teach us about this. It would be good to have a handout, with some on-line counselling for patients and I think it should be free.

I found out that one of the psychologists I refer women to for counselling about abortion, has the same opinion about abortion as I do but I don't know if it is faith based. The pastor of my Church does abortion counselling, but I would not send someone to him in case a patient complained I imposed my religion on her. However, to refer patients to a psychologist may involve a 4-6 week wait, and patients have to pay for it and don't understand most of the time why they would need it, let alone have the time to wait that long.

Having this conversation has brought up for me that there is not a lot of support for people with a particular ideology that is not considered mainstream. You make adjustments just to survive… I think having a mentorship or support program on how to counsel patients seeking abortion would be really helpful. I don't want to slip or slide on it.

I don't think the wording of section 8 of the Act is ideal. So far as I understand it, the law compels doctors with a conscientious objection where there is an emergency, but it's open to interpretation. It should be worded as a 'serious, imminent and unavoidable risk to the mother's life.' That would cover the scenario of an ectopic pregnancy. I would not be able to be complicit in termination for the risk of suicide, because I think there are other ways of ensuring safety in that circumstance.

I recall a pregnant patient who had a 10cm mass on her cervix and they had to do a hysterotomy to remove the baby. The parents were devastated. They asked the Consultant for an ultrasound, so that they could have one last look at the baby. He said yes and told me it was one of the hardest decisions he had to make. She then had treatment for her cancer but died a few months later. This scenario was a bit like withdrawing care and taking the baby away from the life sustaining force. I think doctors should be able to decline to do a termination and defer to another clinician without it being illegal, while at the same time allowing the patient the right to a second opinion if that is what they choose.

If it were me, I would probably not let someone do an abortion on me if it involved a hysterotomy at 15 weeks. I'd let the baby mature as much as possible so it might be born alive and just let nature take its course and let God call the shots. But I'm not in that situation now so I don't expect to tell someone else what they should do, other than exercise great caution.

Transcript of Interview

Doctor # 16

Interview conducted by ALW, 28 June 2018
Start: 10.00am
Finish: 11.30am

Antecedents of Doctor # 16

Doctor # 16 is female, identifies as a Christian (non-specified), and has been a doctor for 25 years and a GP for 22 years, practicing in a major metropolitan area of New South Wales.

Consent

Written consent was obtained for the interview by ALW.
The interview guide was varied to take into account the respondent's background and in order to explore issues as they arose.

How would you define conscientious objection?

If I disagree with something that I would normally be required to do, because of a strong conviction against it, often based on religion, then you can say that you are a conscientious objector.

In medicine, we respect the patient's right to say no and if you were a Jehovah's Witness surgeon and you won't do a blood transfusion, then you would not be a trauma surgeon. However, you could be a brain surgeon or an ENT. There are plenty of areas where you would not necessarily need to do a blood transfusion.

It's the same for an obstetrician. A Christian obstetrician against abortion would not work in a termination clinic. Most obstetricians go into it to deliver babies and you could go through a whole career without ever having to do an elective termination. If you were objecting to a life-saving termination, you might have problems. If they bring elective abortions into public

hospitals, I don't know what doctors who don't have a conscientious objection would do. Whilst they are trained to do it, it is not seen as a significant part of their everyday life as an obstetrician.

I've talked to Christian doctors from The Netherlands, where every doctor must perform abortions, and there are less and less obstetricians who are Christians. It's very worrying.

The basis of your conscientious objection to abortion

It's a life and embryology supports this. I do not want to be involved with ending a life, but I am happy to give a woman space to discuss it, and I spend time with women thinking about it. Lots of patients have thanked me for giving them space to think about it.

The impact your conscientious objection had upon your choice of employment

Half of the GPs in the practice I work in are Christian and my boss is a Christian. I knew him previously as a mentor and that is why I wanted to work here but I didn't necessarily want to work solely with Christians. I have done lots of locum jobs where the boss is not Christian. I have not felt the need to disclose my objection in those jobs, but this is only because requests for abortion were not something I encountered a lot of. Now my books are open again to new patients, and I am meeting new people who have not met me before, but even so, request for abortion is not a frequent presentation. In the future I would like to do locum work overseas in rural areas. As the people may not have an alternative to seeing me, I would put on my resume that I will not refer for terminations so that the principal of the practice knows and can make other arrangements.

Your experience in managing patients who request abortion

I make sure they are actually pregnant and work out how far along they are. They are usually 8-weeks and they can get an abortion up to 12 weeks. I usually say:

> 'Tell me your story? How did this come to be? What are your circumstances?

I would take time to discuss it. Then I draw four columns made up of the pros and cons of 'If I were to have this child', which includes adoption and 'If I were to have a termination'. I want their partner or mother to come to a consultation with them so they can have a good solid think about the options, all of which have positives and negatives. You try and give them as much information as possible, so they know more about what is going on. At some stage I will say:

> 'Because I am a Christian, I am not happy to refer you personally, but it is not difficult to find people who will refer. I am definitely happy to discuss things with you, go through the pros and cons go through the medical and emotional side, follow up with you after a termination, and do family planning afterwards. I would rather not write the referral myself, and in fact you do not need a referral.

I keep the disclosure about my faith to the end, because it is about them and not about me, but I have bible verses up on my wall and I don't think anyone would not know that I am a Christian, but I think they would still come and see me to talk about it. I tell people I am a Christian so they will understand why I object to giving a referral. I have had people storm out. One said:

> 'You are my doctor, and you have to do what I want. I pay your bills through Medicare, and you have to do this.'

I said:

> 'No, if you came in demanding antibiotics and I did not think it was good for your health, I would not do that either. I work within a framework for what I think is good medical care and that includes a good spiritual component for you and me. I can't force you to do something you don't want to do, and you can't force me to do something I don't want to do. There are many doctors who would be happy to work with you.

Once a woman in her 30's came to see me wanting an abortion. She did want children, but not until the end of the year. She also had a history of mental illness. I told her I was worried about her going ahead with an abortion without some thought about the difficulties she might face with falling pregnant because you cannot micromanage these things. I wanted her to know the physical problems of having children even in the future. I talked to her and her husband and

sent them away to come back another day to talk with her usual GP. She ended up going ahead with the abortion, but then had had trouble falling pregnant later.

Referrals and mandatory disclosure of conscientious objector status

If there was a law in NSW like in Victoria requiring me to refer for abortion, I would feel sick to my stomach. I have family in Victoria and that law would be a stumbling block to me working there. I don't know what I would do. I would want to have some consultations before referral was required. There are so many people who will refer and you don't need a referral.

I would like to send the patient to a pregnancy counselling service. One service that I am associated with reports that about 20% are lost to follow up, 15% of patients go on to have a termination and some come back for post termination counselling, about 10% miscarry, and the rest might continue forward and have the baby. I would rather refer women there than to somewhere that says, 'You're fit, healthy and we can fit you in for termination on Wednesday.'

I would say to people:

> 'Most problems come when people are unsure what they want to do. There are consequences to terminations that can come over years. About 80% of women say they would have gone forward with a pregnancy if they had known one person who would have supported them. What would it look like if you went forward with the pregnancy? What impact would there be on your uni, family, reputation etc. and what would it look like if you had the termination? I don't know any patient who regretted the decision to continue with their pregnancy. You have a month to think about it and talk about it before you decide. Of course there is fear, apprehension, and worry but let's not make an irreversible decision too quickly, let's make a decision with some thought and support.'

If we were required to give patients a brochure that listed where they could get abortion, I would want it to also list crisis pregnancy centres. Before I gave the brochure out, I would ring those centres first to see what information they give.

I would also give patients a warning that if they are distressed about this decision, they need to take the time to consider it, as it can have long terms affects and that the Marie Stopes type organizations might just fast track them through the system. With one in four people having anxiety, this sort of thing can have quite big effect on someone's anxiety or depression. I would say:

> 'The more thought and energy you put into the decision now, the less long-term sequelae you will have. Otherwise, the likelihood is that you will have more problems later on. I'd rather we stopped and had a chance to talk things out, so you are making a decision that is not rushed.'

I think having to make a disclosure that you have a conscientious objection to referral for abortion up front is counterproductive. Doctors who do not follow evidence-based medicine have patients who do not get as good an outcome compared to those who do. However, patients who do not think they had good rapport with their doctors also have poor outcomes. So, this says that the doctor is a part of the medicine and part of the outcome. So, the relationship is a significant part of your good health, whether it is emotional, spiritual, and physical.

To start a conversation with 'I can't give you a referral' would be poor for the therapeutic alliance. I would not comply with a law requiring me to do this.

I train registrars and I ask them their views and what they think, and tell them that even now, people can get an abortion up to 20 weeks for gender selection. I get them to read Melinda Tankard Reis' 'Giving Sorrow Words' which are stories about women who have had abortion just to give insight into the potential longer-term effects, so they don't see it as just writing out a referral for something insignificant.

Do you have a conscientious objection to other issues?

Euthanasia and physician assisted suicide.

I don't have an objection to contraception, but I do have an objection to the morning after pill as it can prevent implantation of an embryo. The patient can get it without referral, and it is up to them, but I want them to know where they are and what is happening. Earlier in your cycle

you are delaying ovulation so you can't conceive. Later in your cycle you are stopping implantation. I talk to a lot of Christians who might not want to use the mini pill or the Mirena IUD. I know some Catholic doctors who do not prescribe contraception but they will use cycle contraception.

I once had a lesbian couple come in and requested a referral for IVF. I asked them about why they wanted this, their relationship histories etc. In the end, I did not feel that I could refer them for IVF in good conscience. I was also worried that the relationship would not last and then there would be a child involved. So, I told them I could not give them the referral. They never came back to see me.

Controversial issues are about 1% of my practice. I tell people:

> 'I am not a robot. I am a person. Yes, this job gives me the opportunities to be quite involved in your personal life, but I am still a person in my own right and I need to work out how much I can be involved in these things.'

Would you perform surgery to remove sex organs at the request of a transgender patient or refer someone to have this done?

I would have to think and pray a lot about it if someone wanted hormones to be prescribed. I have a faith-based objection to it, but there is a huge chunk of science to support it. For patients who are transgender, I would have long conversations before I took any action. Many of the kids are aspergic and have been labelled by their peers as transgender and this has made them acceptable. By the time they reach 25, a large proportion are heterosexual. About 90% of boys and 70% of girls are not transgender by the time they have gotten through puberty.

Now there are so many options on the table. It's important for kids to go through puberty. It's important to have these discussions. Asperger's is more gender biased with boys. They don't read social cues very well and don't feel the same as everyone else and latch on to gender dysphoria as the reason they don't feel right.

I saw a patient recently who came from a Christian background. When I saw him earlier, he was working out whether he was gay, and ultimately went overseas and married a man. When

it didn't work out, he came back and is now transitioning to be a woman. He asked me for a referral to an endocrinologist. I asked him who gave him the original diagnosis and he was ping ponging from doctor to doctor. I told him I would spend time to talk to him, as I didn't want him to go down an irreversible path.

I did write his referral to an endocrinologist, partly because he was already down that path, and partly because he was bouncing between practitioners, and I wanted him to keep coming back to see me. I didn't think saying 'no' first up would be terribly helpful, and he could get that referral from somebody else. I wanted him to know I would spend the time with him even if I disagreed with him, and it was important to keep the door of the relationship open.

What education if any, have you received about conscientious objection including at university?

None.

What would you do to change the situation and make it better?

I would love to see more pregnancy crisis counselling taught in undergraduate training. I got taught nothing about contraception. I did a pregnancy-counselling course. In general practice training, you should get taught about how to have these conversations. We need protection of conscience in the law. I would like to see far more in the law to protect conscientious objection.

Young doctors need encouragement. They need someone to talk to, so they don't feel like their hands are in a bind. There is a Christian Medical Students conference where they have workshops on how to have these conversations. I would love to see the Christian doctors and the Christian lawyers join forces and work together.

Transcript of Interview

Doctor # 17

Interview conducted by ALW, 30 June 2018
Start: 11.00am
Finish: 11.40am

Antecedents of Doctor # 17

Doctor # 17 is male, identifies as a Catholic, has been a doctor for 19 years, a paediatrician for 12 years, and practiced in Victorian at the time the *Abortion Law Reform Act* came into force, but has re-located to another state.

Consent

Written consent was obtained for the interview by ALW.
The interview guide was varied to take into account the respondent's background and in order to explore issues as they arose.

How would you define conscientious objection?

The concept of conscientious objection is not well understood or defended. ….

The basis of your conscientious objection to abortion

You may have a personal disagreement and/or clinical reasons for being against abortion such as increased negative risks to one's mental health, physical health, increased risks of breast cancer and miscarriage, and prematurity in the next pregnancy.

The impact your conscientious objection had upon your choice of employment

Training for paediatricians includes working in youth services. This includes having to give advice about contraception and refer for abortion. When I did my training, which was in another

state, I advised my supervisor that I had a conscientious objection to both prescribing contraception and referring for abortion. There was no real issue and any requests for these services were diverted to another department.

Prior to the Victorian legislation, I used to do locum work as an after-hours GP. When I told patients that I did not do those things, some patients might have been a bit annoyed, but they usually came in for multi-purpose visits and had other things to discuss with me. Many people who see a GP have not made up their mind about abortion. They may not agree with your advice but you used to be able to at least have the conversation without fear of being reported because you disagree that abortion is in the best interests of their health.

The impact that the Victorian law has had upon you

When the law came in requiring Victorian doctors to refer a person seeking abortion on to a willing provider, I worked in a private paediatric practice, but had visiting rights at a public hospital that required me to attend ward rounds and do work in the emergency department.

Referral has a specific meaning in the Medicare sense. Physicians generally try and refer a person to someone of quality. Referral is active, not passive. The legislation says it must be to a doctor that '…you know does not have a conscientious objection…' How can you know whether another doctor has a conscientious objection to abortion? Unless they are an abortion provider, how can you know the minds of others? It's a two-edged sword as you would need to know the names of pro-abortion physicians.

There are no legal requirements surrounding the second doctor who is needed for an abortion above 24 weeks. That doctor must agree that the abortion is appropriate in all the circumstances, but they could be another doctor in an abortion clinic, where there might be standing orders to agree to these requests. They could be an out of state doctor, as there is no requirement that they be resident in Victoria. They could even be doctor who has trained overseas who is not licensed to practice in Australia.

I felt that to put up a sign and disclose that I had a conscientious objection to abortion would be potentially incriminating and set me up for prosecution. The ramifications of anticipatory disclosure of conscientious objection are unknown. My concern was that someone might try to entrap me with a request for abortion. The intention in reporting me would not be because they could not find an abortion provider on their own, but to report doctors who oppose abortion and the new law.

The Australian Medical Association suggests we refer to the out-patient department of a public hospital citing 'management' of their pregnancy, but this is just hair splitting. You are still morally complicit in the referral and its outcome.

In an after-hours locum role, I would have been trapped, as there is no other doctor to see the patient for you. To combat this, I declined to see female patients who were 12 years old or above. As there was low access to paediatricians in my geographical location, the decision to stop seeing those patients was not neutral.

I also stopped doing after-hours locum GP work.

There is a continuing obligation on doctors to disclose any finding of professional misconduct or unsatisfactory conduct to your employer on a yearly basis. This can create a burden regarding future employment applications, and it could affect clinical privileges in private hospitals. I made some comments about the law that were made known and they were subsequently raised with me in a job interview I had.

I have ultimately left Victoria to work in another state. Whilst I moved mostly for family reasons, the change in the law and the potential consequences for me was a motivating factor.

What education if any, have you received about conscientious objection including at university?

None. Ethics is not prescribed as part of a doctor's continuing education. If we were forced to undertake ethics training, its content would most probably be influenced by people such as Julian Savulescu. Hospital ethicists tend to be utilitarian in approach and have an emphasis on autonomy.

What would you do to change the situation and make it better?

My preference is that people who want abortion should look up the details themselves.

If the government had a referral system, and you were directing patients to this, it would be less of an issue and more of an arms-length referral.

Transcript of Interview

Doctor # 18

Interview conducted by ALW, 4 July 2018
Start: 9.00pm
Finish: 11.00pm

Antecedents of Doctor # 18

Doctor # 18 is female, identifies as a Christian (non-specified), has been a doctor for 8 years, and practices in paediatrics in various regional public hospitals in Victoria.

Consent

Written consent was obtained for the interview by ALW.
The interview guide was varied to take into account the respondent's background and in order to explore issues as they arose.

How would you define conscientious objection?

If you have an internal belief that something is not moral or right, you object to being involved or associated with it.

The basis of your conscientious objection to abortion

My belief is that all life is valuable and needs to be held with the same respect regardless of where that life is, or how intelligent it is, or how useful it is in productive terms. This belief is totally supported by my faith. I think science and faith go together. I cannot explain the laws of science without explaining God and vice versa. They complement each other and I don't think you can separate them.

The impact your conscientious objection to abortion has had upon your choice of employment

I had my heart set on obstetrics and paediatrics, but I soon realised I would not be able to take it further. One time I was working as a resident in obstetrics and was called down to emergency to see a girl who requested a medical abortion. I struggled with that and asked another resident to prescribe RU486, so it was not my signature. Whilst they looked at me as if I had two heads, they did it. If I was a registrar, it would have been much more difficult to object, because there are less people to ask to step in.

I have seen all of kinds of reprisals against doctors in areas that have nothing to do with conscientious objection to abortion. As a more hostile topic, I cannot believe the treatment would be any less than that, and this is why my colleagues are too scared to say anything. Whilst the patient might make a complaint, most of the anxiety comes from the response of your colleagues. If you give handover in a manner your consultant does not like, you will be humiliated in front of colleagues and left to handle patients on your own, which is very unsafe. There could be gossip, comments made on ward rounds, or your contract might not be renewed.

Your experience in exercising your conscientious objection to abortion

I actively opposed abortion law reform when I was a medical student at University, and I was bullied for it. There was one very vocal girl in my year at university who was against me for speaking up. She did not take me on in front of the lecturer, but she did take me on before or after class and didn't care whether other students heard. She posted hate mail on the Internet about me, and this increased after I spoke out against the law. I would not say my colleagues supported me. They agreed with her about abortion, but they did not try and tear me down. I think this was because they saw the way this girl treated me, and they could see that I was at least respectful.

I would regularly say things in class to remind lecturers that not everyone agreed with abortion. I would also raise issues as questions, such as how babies survive very early birth. I would try and sandwich the question in with being respectful and not causing disharmony. The lecturers would usually just look at me, listen to what I said, and then dismiss me and keep talking. The rest of the class was just quiet.

I was scared to speak up, and I shiver in my boots every time I do it, but God is my God, and someone has to speak up for these babies lives…I saw a fight at a train station once as a young girl, and I stepped in because no one else would. I talked to the few other students I knew who were like-minded, but they said they were too scared to speak up. However, they did stand with me when I had to give a speech against the law and a couple came with me to a pro-life march during the debate on the law and held a banner that identified us as 'student doctors.'

Being the only medical student willing to speak up made me feel very isolated. I had to fight against depression, especially when I started to get hate mail. All my supervisors were pro-abortion. None of my friends were in that situation because they were too scared to say anything and didn't understand what it was like.

When I did my obstetrics rotation, I had a supervisor who performed abortions and this made it very awkward. She would ask me why I believed what I believed. When I first had to attend surgery, I was concerned about observing an abortion. With surgery, you don't see the list until you get there and they use a special code that says 'D&C'. Dilatation and curettage is a procedure performed for a lot of women who are not having an abortion, such as for fibroids or heavy periods. It's not until the surgery is being performed that you release the D&C is to remove a baby.

As soon as I got to the operating theatre, I asked the nurse in charge whether there were any abortions on the operating list that day. She said yes, and then asked me why. Instead of answering her, I thanked her and spoke with the consultant. I had to have this conversation with him in front of other medical students. I hardly knew him and I was terrified, but I asked if I could come to a different list because I did not want to observe an abortion. His response did not exactly put me at ease. He did not verbally assault me, but he gave me the 'what's wrong with you?' look on his face and ultimately said yes. It took a lot of guts for to stand up and say that.

I know so many of my colleagues who object to this stuff, but they don't exercise their conscience because they are afraid.

I have not had to disclose my conscientious objection with a patient yet, but I am sure it will come up. It is something that will come up in paediatrics, for example, in the context of sexual abuse. They always prescribe contraception for teenagers. I am still trying to figure out what I will do. I don't have any mentors in my area to help me with this conversation and how to handle this. It would be detrimental for me to simply decline to see female patients under a certain age. I need to work out how to handle this conversation, ask God to help me, and hope that I can help children to be born. I would hope the law would not legislate so that I cannot speak with a patient wanting an abortion because I have a conscientious objection. All procedures have pros and cons and doctors must be able to explain these to patients.

I studied at the Royal Women's Hospital where architects of the abortion law are based. We would have lectures at the time law reform was being debated, where they presented abortion as a wonderful way to give charity to the Third World because these poor women have no access to contraception and cannot support babies. They tried to encourage us to go on a medical mission to the Third World to perform abortions and help. There was no reference at all to the baby.

It's so ironic, as the Royal Women's Hospital treats babies born at 24 weeks gestation up one end of the hospital, and down the other end they are aborting them.

I asked one of the lecturers:

> 'Do you think it is OK to euthanize the elderly for economic welfare? How is it different? Why can't we find another solution?'

He just laughed it off.

I also worked at the Royal Children's Hospital, and I recall one time there was a baby who was born at 28 weeks and needed extensive surgery but was too sick to even be moved to the operating theatre. His parents were very devoted to him and so the hospital did the surgery at the bedside.

At the same time, there was a baby born at the same age whose parents were on drugs and whose mother never came to visit him. My consultant said:

> ‘We will withdraw treatment from this baby because of its dire social circumstances… Why would you pour everything into one baby when it’s baby they don’t want it, that will have developmental disabilities, and will have to live in foster care?’

I was appalled. Both babies would have been developmentally delayed to some degree, but the mentality was that the worth of the baby is tied up into whether it is wanted and it’s the same argument they use for abortion. My argument is that all life has inherent value. This baby ended up surviving and was transferred back to the original hospital, whilst the other baby that was wanted by its parents ended up dying.

That was the first time I saw the abortion ideology filter into areas other than abortion. At the end of that day, I asked other doctors what they thought about the consultant’s decision. Everyone agreed with him.

Mandatory Referrals

I believe the Victorian law requires me to refer a woman to a service that will perform an abortion and give them a phone number and address. It may require a formal letter from myself on occasion.

I would be very hesitant to give a phone number to a patient, but I would prefer this to writing a formal latter. A referral is inviting the other specialist to join you as a team in the care of this patient. You are entering into a contract, and agreeing with the request you are referring the patient on for.

I would never give a formal referral. I would prefer to lose my job. Losing my job would have massive consequences for me and my family, but writing a formal referral would make me feel that I am sinning before my God.

I would be OK with a government brochure that set out information on where to obtain an abortion if it also contained balanced information about crisis pregnancy services. I would want to check the services out in the brochure, talk to the woman and support her, and give her information about any additional services, such as those that provide accommodation for

teenage pregnancies, and support them through schooling. If I were a GP, I would probably make my own brochure.

Do you have a conscientious objection to other issues?

I object to hormone treatment to change the gender phenotype in a child, breast binding and penis tucking, any referrals for transgender surgery or to the sex clinic at Memorial Children's Hospital. I thought I was getting out of this, but I have just stepped into another minefield.

Originally my objection was a faith-based, but now I am more educated on the scientific evidence, I see that there is so much support for the belief that giving children hormones or performing sex change surgery is only going to harm the children and they are much worse off. Most parents are told that if they don't go through with this, their child may suicide and do they want this on their head? There is a lot of evidence around the world such as about suicide rates, but in the future, evidence will be skewed because the other options are not going to be permitted.

I would prescribe contraception to teenagers, but only if I could talk to them first, about what the medication does, whether it can cause an abortion, and even about sex itself, such as the facts about the impact teenage sex has on psychological health. Sex is not just limited to the physical body. The body it just the tip of the iceberg. We have to be able to speak to the depths of that iceberg, to their soul and mind. If you have knowledge, you must be able to talk to your patient so they can make an informed decision. Doctors must not just deal with the patient's bodies.

Some contraceptives don't suppress ovulation at all and just have an abortive effect (such as intrauterine devices). A lot of people don't know about this. So many of my friends who hold the same views as me, are mortified that their GPs put them on a particular contraceptive not knowing that it was going to cause abortion.

I know some doctors that don't prescribe contraception at all, and I respect that, but I have worked through this and believe that the purpose of taking an oral contraceptive is to prevent conception. Maybe one in a hundred thousand woman will experience breakthrough ovulation and conceive. As the womb is made a hostile environment through the action of the pill, the

embryo will not implant, and an abortion will take place. Other contraceptives like the intrauterine device create a hostile environment and the woman who uses this should know that they may be conceiving and aborting.

I am at peace with prescribing oral contraception to patients. The prescriber should have a full discussion with the woman and tell her that there is no fail-safe contraception. I would tell the patient the only 100% effective contraceptive is abstinence. Oral contraception has a failure rate of 0.01%, compared to condoms, which have a failure rate of 20%. I would discuss with the woman what would happen if they did fall pregnant and reinforce that contraceptives just reduce your chance of falling pregnant. I would emphasize that if they did fall pregnant, they should come back and talk to me so we can discuss what to do.

I would struggle if I were a partner in a private clinic where my partners were referring people for services that I had a conscientious objection to.

What education if any, have you received about conscientious objection including at university?

None. We had a compulsory ethics component but never received a lecture on this topic. We had lectures on euthanasia but everything to do with abortion was shut down as if an alternative view did not exist. There was no discussion about options other than abortion, or education about other support out there for women. They never once presented evidence about trauma associated with abortion. It was just seen through rose-coloured glasses, and presented as the solution that solved all problems. I recall being taught that ‘the only feeling after abortion is relief.’

What would you do to change the situation and make it better?

I would support a policy for junior doctors that set out how to exercise their conscientious objection and the steps they need to take, with a dedicated person in the hospital who understands the issue, being on hand to help find a way to make it work. They do it for halal, or for students who are fasting, or need to go and pray three times a day. They make exceptions for other faiths, but it is considered despicable and shameful to be pro-life. You are treated as a second-class human being.

With the clause that requires you to perform abortion if the woman's life is at risk, it's against all logic. Medically speaking, the safest thing to do is to deliver that baby. It's more dangerous to cause an abortion than to deliver the baby. The only exception is an ectopic pregnancy. If they rupture, the woman can bleed to death.

I don't think doctors realize how significant it is to legislate against something, and the flow on effect it will have on the practice of medicine in other areas outside of abortion. Once they legislate against conscience, who is going to respect our conscience in a hospital?

It would be amazing if the MP Rachel Carling Jenkins' amendment to the abortion law goes through to remove the referral clause, and to bring in a requirement to provide care for babies born alive. Her amendments got rejected, but she is going to alter her proposal and submit it to Parliament. If they take out that the conscientious objection clause in the law, we would have a foot to stand on in hospitals so as to educate staff about freedom of speech, and the College would have to change its mindset about requiring doctors to be part of these procedures as part of training.

This gender fluidity and homosexual movement is about accepting people as they are, but they don't respect our views. Our views just don't exist and are not respected. Because they have legislated against conscience for abortion, I am very anxious about the future with regards to other moral issues such as the transgender issue.

Transcript of Interview

Doctor # 19

Interview conducted by ALW, 5 July 2018
Start: 2.00pm
Finish: 3.30pm

Antecedents of Doctor # 18

Doctor #19 is male, identifies as Catholic, has been a doctor for over 30 years, and practices as a GP in Suburban Victoria.

Consent

Written consent was obtained for the interview by ALW.
The interview guide was varied to take into account the respondent's background and in order to explore issues as they arose.

How would you define conscientious objection?

It's where you object to doing something based on a deeply held belief. Where you have a genuine, sincere belief, you should be allowed to follow it.

The basis of your conscientious objection to abortion

I believe life begins at conception. This is an empirical fact based on science, and it is backed up by my faith. After I had children, I realized how valuable life was. I was agnostic until that point, and then I embraced Christianity, and my objection became stronger. So I had a conscientious objection to abortion prior to the *Abortion Law Reform Act,* but section 8 really brought it to the fore for me.

Your experience in exercising your conscientious objection to abortion and dealing with the mandatory requirement to refer patients to a willing provider

Before the law changed, I had one or two patients a year come to my practice requesting abortion. I would usually tell them that they had time to think about it and they probably got the impression I was against it and didn't come back to see me.

How to write a doctor's referral is taught in medical school, and it's taught to you as an intern in a hospital. It's always written and signed and has the other doctor's name on it. If you give a referral to a woman to an abortion clinic, you are condoning her action. As I know from my experience, if you refuse to do it, the woman may not have an abortion and she might change their mind.

Early on in my career, I did refer a woman to the hospital for abortion, but since then I have changed my views on that. I wouldn't do that again. There is no medical condition where abortion, that is, feticide, the intentional killing of an unborn baby, is treatment.

In the Victorian law, abortion is defined as 'termination of pregnancy' and I don't have a conscientious objection to that because it covers situations like early deliver for pre-eclampsia. Here you must terminate pregnancy to deliver the baby in order to preserve the life of the mother and the baby, and I have no objection to that.

If I just had to give the woman information about where to get an abortion, so not on a letterhead, I still wouldn't be happy to refer a patient to a family planning clinic because they are pro-abortion. I have suggested people go and talk to the Caroline Chisholm society where people can talk about their pregnancy.

Since the law changed, I have had about 10 women come and see me requesting an abortion but after talking with me, none has pressed me for a referral. After the law changed, I had two immediate requests for abortion. The first patient wanted to know where to go to have an abortion. She told me all the reasons why she wanted one, which was that she wanted to go back to work and she had another little baby. We talked and when I said to her that I had a conscientious objection to abortion and that I could not refer her, she stood up and said:

> ‘Half the time I don’t want to really have an abortion, I’m in two minds about it. You know what, I’m not going to have an abortion, and I’m going to keep the baby.’

I still see her as a patient. Shortly after, another woman came to see me requesting an abortion. She was with her husband, and we had a chat and I told her about my conscientious objection. She then said she didn’t want the abortion, and that her husband was the one who wanted it, and then she got up and left.

After that, I put up a sign that had been suggested by the AMA to comply with the law. It said something like,

> ‘Please don’t ask Dr. X for abortion services because it is against his conscience.’

When I checked on the template a while later, I noticed the AMA had changed it and added in that after disclosing the objection, the doctor should refer the patient to various family planning clinics. As I could not do this, I took the sign down. I don’t have a set spiel of what to say. It’s a bit different and depends on the patient. Do I know them? Are they a new patient? A couple of women who requested abortion were long standing patients and they wanted to have a talk about it. In the context of that talk, I would say:

> ‘I am unable to refer you, but I am happy to talk to you about it.’

Around three patients decided not to have an abortion after talking with me, and I continued to see them and their babies as patients. For the others who went on to have an abortion, the exchange was very cordial, and they were not upset. They did not push me to give them a referral. Most came back to see me as continuing patients.

Only one exchange got heated. This woman wanted to have an abortion because she thought the baby had a birth defect. I had not seen her before. I tried to find out on what basis she thought the baby had a defect, but her answer made no sense. So, I said I was happy to send her to the genetics clinics at the hospital, but I was not happy to send her for an abortion.
She left the room, and I heard her boyfriend yelling at her in the reception area. I came out and we had a confrontation. It became very heated, and he threatened me, and I reported him to the police but ultimately nothing happened.

If the patient is new, the first thought that comes to my mind is, is this a step up? This is because my views on abortion are well known in the community. I worry about someone reporting me because they don't like my views, and want to make trouble, not because they genuinely want medical advice on their pregnancy.

I had a woman come to see me requesting a sex selection abortion at an advanced stage of the pregnancy. I refused and she went elsewhere and had the abortion. She came back to see me after the abortion for other matters and during the course of that consultation, gave me the letter which confirmed an abortion had been done and it named the doctor.

She became pregnant again and saw me about 14 months later, with her husband, in early pregnancy. The husband asked me if there was a test that could be done to determine the sex of the baby in case it was another girl. This upset me and I told him not to ask me about this sort of thing, as he knew my views already. He smiled at me and put his hand on my shoulder! I became increasingly worried as the weeks passed.

Eventually I felt compelled by my conscience to report the original abortionist to the Medical Board in case they sought his services again. I knew they probably would say he had done nothing illegal and wouldn't stop him, but it was all I could do in the situation. I heard back from them and they said the doctor had not broken the law but three months later, they de-registered him for inappropriately prescribing narcotics.

Then, the Medical Board did its 'own motion' and investigated me for denying a woman her rights by not referring her. I had made some comments about sex selection abortion in the media, as I wanted the public to understand the consequences of the law, which the Board learned about. The patient did not complain at all, and in fact she is still my patient. About a year later, they issued me with a caution for stating in the media that I knowingly broke the law.

I don't have to disclose that I received a caution from them, like you would for a finding of professional misconduct, but the whole thing took up a hell of a lot of time. I was very fired up about it. I couldn't believe that the Medical Board would support such a thing. There was little support from other medical groups. The AMA didn't support me.

During that year, they were trying to change their conscience statement saying that doctors don't have a right to freedom of conscience in these cases. I was involved in that too. Thank goodness they did not change it.

The RAGCP were of no help. Most of the medical community is pro-abortion. It makes you feel very sad. All these people who have control of society are pro-abortion. Even the media is pretty much all abortion. Such an obvious thing you would think you could put a stop to. It's not the way it should be.

I did toss and turn, and difficulty sleeping at night I did question myself and ask 'Am I doing the right thing? It totally dominated my thinking for a year or more. I didn't get depressed or anything, I had good support from other doctors I knew, but I lost income. I lost money out of my pocket for lawyers, and I spent a lot of time at meetings.

I haven't had a request for abortion for a while. I have thought through what I would do today if a patient pushed me for a referral. To comply with the law, I would give them a referral to the Royal Women's Hospital, and I would say:

> 'Dear Dr.
>
> This lady has come to see me wanting a referral for abortion. I can see no medical reason for her to have an abortion. She is perfectly healthy, and the pregnancy is going alone fine. I have explained to her the risks of having an abortion. The only reason I am writing this letter is to comply with section 8 of the *Abortion Law Reform Act*. I wish to state again that I do not believe that there is any medical reason for an abortion and in fact, I believe an abortion would be detrimental to her health.'

The argument that GPs who practice in remote areas must refer because of distance is a poor argument. Today, a patient can call the Tabbot foundation and speak to someone over the telephone and be sent a form to get blood tests and an ultrasound and they will post out the pills for abortion and tell you how to take them. You can get them anywhere. You don't need the local GP to be involved.

Do you have a conscientious objection to other issues?

I object to euthanasia, and to all hormonal contraception and intrauterine devices. I object to the latter because they cause abortions. The intrauterine devices will prevent ovulation, but a percentage of the time it will prevent a fertilized ovum from implanting.

The oral contraceptive pill is dangerous to women, and there is more and more evidence coming out about that. It's classed as a Group 1 carcinogen by the WHO, causes depression, and breast cancer. I tell patients I don't prescribe it for medical reasons. It tells them it has an almost 10% failure rate.

Patients are usually very happy. They have never heard this information before. I show them the WHO pamphlet that confirms it is a group 1 carcinogen. I once had a mother come in wanting her daughter to be put on the pill. I showed them this pamphlet and the daughter's reaction was, 'Well I am not taking this stuff!'

I object to prescribing cross sex hormones. I think it is quite possibly harmful to give a man female hormones, but I don't know as much about this issue. I don't think it's natural, but it is not as clear-cut as abortion. I once had a man came out from the city to specifically see me to requested oestrogen to turn him into a woman. I refused and he reported me to the Human Rights Commission. It was a set up and I had to ring up and explain to them the situation. Ultimately the complaint was dismissed.

What education if any, have you received about conscientious objection including at university?

No, there was nothing. No talk about ethics. At the Royal Women's Hospital, we had to spend an afternoon with an abortionist whilst he did the vacuum extractions. They didn't exactly promote abortion, but more or less said this has to be done, and it is part of medicine. Today the push to reduce doctors' right of conscience is all through the world now. Victoria was one of the first. It's just getting worse and worse. I don't know how you can stop it.

What would you do to change the situation and make it better?

You have to be a little bit careful of these conscience clauses (that seek to give full protection to health professionals from participating in abortion) as they might still expect you to refer.

The Victorian law is a bit vague. Section 8 does not clarify whether it applies to abortion generally, or to abortion in the specific circumstances where it is requested. If you don't have an objection to all abortion, you are not a conscientious objector (which means that most doctors would have a conscientious objection as there would be times where they do object to it in a specific case).

I once had a patient who had been to an abortion clinic for medical abortion but changed her mind. She asked me for the abortion reversal pill, which I gave her. Afterwards, the clinic rang her up and said that if she did not complete the process, she might die. They wrote her a letter saying that taking the abortion reversal pill would cause birth defects. These are lies.

We need to be able to talk about the dangers of abortion. This is vital information that is being shut down. One of the main things is that women who have abortions have an increased risk of breast cancer that increases with the number of abortions they have had. About 50 out of 70 studies say this, and 35 of them show that the risks are statistically significant. Doctors just cannot talk about that. The Medical Board will get on to you if you try and dissuade a woman from getting an abortion. If you said this, you could be in trouble for it. But like any operation or procedure, you have to give the patient the downside. With abortion, they are told everything will be fine.

Transcript of Interview

Doctor # 20

Interview conducted by ALW, 9 July 2018
Start: 10.00am
Finish: 11:00am

Antecedents of Doctor # 20

Doctor # 20 is male, identifies as a member of the Church of Jesus Christ and Latter Day Saints, has been a doctor for over 30 years, and practices as a specialist in intensive care and anaesthetics, working in various public and private hospitals in New South Wales, and in other parts of Australia.

Consent

Written consent was obtained for the interview by ALW.
The interview guide was varied to take into account the respondent's background and in order to explore issues as they arose.

How would you define conscientious objection?

It's an objection to doing something based on one's values and beliefs systems. For medicine, I don't think there should be limits on what you can have a conscientious objection to.

The basis of your conscientious objection to abortion

I believe in the sanctity of life based on knowledge of embryonic development. This was not always my position. I changed when I joined the Church, and I recognized it had a stance or foundational belief about whether abortion was acceptable or unacceptable. The Church believes that abortion is acceptable in only three circumstances; where the pregnancy occurs following rape, where a child cannot be delivered in a live state, and where the mother's life is at risk.

I cannot explain exactly why the church permits abortion for rape, but I think it has to do with the fact that conception following rape can be very hard for the woman and it is left as her personal choice. I accept the teaching of the Church on this, which is a universal teaching. The Church does not permit abortion for fiscal or social reasons.

Your experience in exercising your conscientious objection to abortion

When I was a trainee in a specialist department in the public hospital system, I knew I might have to deal with patients scheduled for abortion. So, I raised an objection with the scheduling officer and told her that I don't participate in abortion. For me, I was not particularly worried about having this conversation with the scheduling officer, because I was prepared to walk away from the job if they did not accommodate me. I had thought it out beforehand and I knew that I would stand my ground if I were challenged. As it turned out, there was no problem and no backlash.

However, I choose not to specialize in obstetric anaesthetics, but as it turned out, because of federal and state funding issues regarding rebates for abortions performed in public hospital, they stopped doing them so it has not been much of a problem for me as there are no elective abortions in the places I work at, as far as I am aware of.

Times have changed though, especially over the last few decades, and it is harder now to have a conscientious objection to something like abortion because of the changing perception of values and standards. I haven't really thought about this, but if a law compelled me to perform obstetric anaesthetic services for elective abortions, I would not have a problem raising my objection. I don't care about others' opinion of me.

Accommodating conscientious objection in medical practice

I had two incidents in the mid 90's where I was called in by another hospital to take over the role of anaesthetist in an organ retrieval operation because the original anaesthetist refused to do it. The first incident required me to fly to Canberra to join the team for an operation that took about 4 ½ hours. The original anaesthetist did not agree with the concept of brain death. From my point of view, I thought this was fine, and that no one should be forcing them to do something they find morally reprehensible. I was happy to take their place. For the rest of the

team, they were incredulous that the doctor refused, but there were no reprisals against that doctor.

The second incident involved a private hospital in New South Wales where the on-call anaesthetist refused to be involved because he could not raise a fee for it. I went and did it, and whilst I had to get credentialing done at that hospital at very short notice, it was no problem whatsoever. I think today however, there would be more push back from colleagues because of the industry's acceptance of this type of treatment. A similar person who refused to take part in organ retrieval today might be hauled up administratively and might even have their credentials revoked.

I spent some years as head of department in a public hospital where we did organ retrieval and transplants. Sometimes, we had to remove mechanical ventilation on someone whose heart has stopped but where there was no brain death in order to harvest the organs. Whilst it is very rare to find colleagues who are against organ retrieval in a situation where a patient is brain dead, there was one doctor who told me he found it personally challenging, but he did not raise it to the level of a conscientious objection.

I want to try and facilitate a person's conscientious objection because I believe they have a right to it, but we are also providing a service and I need people who are going to staff services in the direction I am leading the department in. So, when I was head of department, we made the facilitation of organ and tissue donation a specific area of the interview process and an essential criterion for the job, together with another 8-10 criteria. It was also set out in the advertising material for the job so that applicants had an expectation that they might not be offered a job if they could not fulfil one of the essential criteria.

It's a big process and while it probably only occurred in about 1% of cases in the intensive care unit, a lot can go wrong, and you don't want people messing it up for the families or the staff. No one ever applied who had a conscientious objection but if they did, I think they would have to sit lower on the list than other applicants who met all the criteria.

If there were an issue in the intensive care unit involving a pregnant patient whose life was threatened by the pregnancy, I would have no problem in sacrificing the baby before the mother. If it was not the mother's life at risk, but her health, then I would also have no objection to participating in an abortion if the risk was of a major morbidity such as organ system failure that might progress to death.

To make this decision, you must involve the major decision makers. This would be the senior treating clinician such as the obstetrician/gynaecologist, the infectious diseases specialist or the neonatologist, then the family, and then all support staff. If a nurse had an issue with being part of the team, I would leave this to the nursing unit manager to work out and I would assume they could find a replacement as there are potentially hundreds of nurses, and the individual nurse is not a decision maker. It's different with a clinician. There aren't as many, and they are a decision maker and so I would respect their decision not to take part.

Referrals, mandatory referrals and peripheral acts

I'm not in a position where I have to refer anyone for abortion but if I were, I would struggle with that. My preference would be to explain the alternatives and provide a referral where I knew that those options would be discussed. The patient does not get to pick and choose from me who they get referred to. If they don't like whom I refer to, there is always somebody else who can accommodate them.

If I were in a remote location, I would have more of a dilemma. I would find it harder to justify only referring to where I wanted to because of limited choices.

When I was training in anaesthetics, I would see patients for a pre-anaesthetic assessment and would run through their medical history and what medications they were on for maybe 5-10 minutes. That was my job, and I had no objection to that. As I had refused to be in the operating theatre for the abortion, I felt it was an appropriate compromise. If I refused to do the assessment, someone else was going to facilitate it anyway, and I was not part of the decision-making to have an abortion, so I felt my involvement in doing pre-anaesthetic assessments had no impact on the outcome.

Do you have a conscientious objection to other issues?

I won't participate in euthanasia, although I have no problem with double effect reasoning where I know, hand on heart, that the reason I am giving pain medication is for pain relief. I look after transgender people when they are sick, and I'll look after someone who has had complications following an abortion.

What education if any, have you received about conscientious objection including at university?

We didn't talk about it, and I really don't recall us even talking about abortion.

What would you do to change the situation and make it better?

With doctors, knowledge of the law is extremely poor for a whole series of issues. However, as the profession has become more fragmented, so too has the approach been to a particular issue. There may even be a different approach to an issue adopted by the College that regulates a doctor's registration, compared to the organization or society that is the political arm of the specialty. Industry can push to get a certain procedure accepted by the profession in order to make money. They use salami-slicing techniques that lead to death by a thousand cuts.

I want a lot less legislation, but we have too much bureaucracy and it won't be turned back. There has been a lot of pandering to the left wing for the last few decades, and every time we create new legislation, regulation, or policy, we create 99 other problems. Whilst I don't think we should have to legislate to protect conscience, as it should be obvious, if they brought in legislation that compelled me to do something I didn't want to do, then I would want legislation that helps me.

Transcript of Interview

Doctor # 21

Interview conducted by ALW, 9 July 2018
Start: 3.30pm
Finish: 6.00pm

Antecedents of Doctor # 21

Doctor # 21 is male, identifies as a Catholic, has been a doctor for over 40 years, and practices as a specialist obstetrician and gynaecologist, working as both a private consultant and as a visiting medical officer in a tertiary level public hospital in New South Wales.

Consent

Written consent was obtained for the interview by ALW.
The interview guide was varied to take into account the respondent's background and in order to explore issues as they arose.

The basis of your conscientious objection to abortion

I believe in the preciousness of life. I would like to think that if I were an atheist, I would still have the same opinion. Every part of us is so complex. Life is so extraordinary, and I don't just mean molecular life. Not a day goes by that I am not enthralled by what life has to offer.

Nobody has the right to deny anybody else the preciousness of life. If there is a right in life, it is the right to experience what life can offer. I hate the expression 'quality of life'. Who can judge the quality of someone's life? Nobody knows what another's quality of life is. Disabled people can teach us what quality of life is, not vice versa.

I don't believe terminating a child will make life better for the parents. There are people in the system where if a woman elects to continue on with pregnancy with a disabled child, they are

made to think that they are bringing a disabled child into the world that will suffer all his or her life. That to me is just as bad as saying you have no right to not have a termination.

Your experience in exercising your conscientious objection to abortion

When I graduated, I was told there was no place for a registrar who would not do terminations in a public hospital. At those times, in 1978-1979, abortion law reform had been around for a few years and public hospitals were doing first trimester abortions. There were no preterm clinics in those days, and consultants did not want to do terminations, so they left these for registrars and it was known as 'the registrar's list'. The hospital I applied to made it clear to me that it was not amenable to registrars being on their scheme who would not participate in first trimester terminations.

I tried a few other hospitals and realized there was no point in applying, so I chose to go overseas and work in countries where it was not an issue. I spent 18 months in South Africa and Ireland and got my 'Part 1' in England and Ireland. After that, I had a fair bit of experience. In the hospital I worked at in South Africa, they delivered 90,000 babies a year.

I went to Dublin, and for the first time I realized that all I had been told back home about difficult pregnancies requiring termination was not true. In Dublin, they managed difficult pregnancies and maternal diseases, and they had the best outcomes in the world, yet they did not do terminations. My eyes were opened to the fact that you can look after a woman with all manner of diseases and still achieve good outcomes for mothers and babies.

So now I had not just the theoretical knowledge that I would never do terminations, but I had the practical knowledge that you can give good obstetric management to women with co-existing medical conditions without it being too dangerous. When I came back to Australia, I had enormous experience. I applied to a tertiary hospital in Sydney to do my 'Part 2' training. The interview was going well until one of the obstetricians said:

> 'We've been led to believe you don't do terminations.'

Another obstetrician piped up and said:

> ‘I don’t think this question is appropriate. I think the consultants would prefer to know that they could sleep all night knowing that Dr. X can handle the complex cases. That’s worth more than him not doing terminations. There are more than enough Registrars willing to do terminations.’

So if they felt you would provide a service to the Unit, they were more amenable to taking you on and by this stage, preterm clinics were starting to open their doors around Sydney, which took the pressure off public hospitals to do terminations. I finished my training and went back to Ireland and did another year as a Fellow and then went over to UK and did another 9 months in a busy surgical job.

I returned to Sydney and worked as a locum at a tertiary hospital and ended up taking on a job there as a visiting medical officer and I maintain a private practice. I have never been compromised. I work closely with ‘pregnancy help’ and I counsel women who have crisis pregnancies. I have never had a complaint from a patient about my religion interfering, adversely impacting, or biasing a patient.

Rarely a week goes by when I don’t see a vulnerable woman with a pregnancy where she is struggling to find it within herself to continue because of pressure from family or friends, a medical condition that could affect long-term health, or financial concerns. I try and allocate that patient the last booking appointment of the day or a day when I don’t have patients, because it is not something you can do in 15 minutes. You could be there for a few hours. I don’t have a spiel. Every woman has her own reasons why she feels she cannot continue with the pregnancy. The only way to approach it is to not let on you are never going to do it.

I ask them to tell me why they feel they can’t do it. I let her unload completely on to me. I encourage them to talk and talk and say why they feel that way. I let her go at her own pace and in her own way. It can take 25-30 minutes or up to an hour. Then we chat about options, and other considerations.

Some patients are easy. They just want reassurance they can go on with it. They might have some medical concerns such as being told at a young age that a childhood accident meant pregnancy would be very difficult for them. Some want to continue in their heart of hearts, but a partner is putting them under terrible pressure. So you take the pressure off them. Some need

financial assistance. I work with Right to Life where people contribute financial assistance that can be offered to these women.

Once I have moved through options, I try and encourage them to have a look at their baby with the ultrasound, but I leave this decision up to them. I would never force a woman to look at her baby on ultrasound, but when they see the baby's heartbeat and see the baby jumping around, it's a different ball game.

I never believe I have talked a woman into not going ahead with a termination or that I have saved a baby. It is always the mother's decision. All you are doing is giving her some room to move and bring the child into her space again. Up until that time, all she sees is this darkness. She cannot see a baby in this, just darkness and despair. In lightening the load, there is space for her to contemplate bringing a child into that space with her. That space was always there. We just make it possible for her to recognize it was always there.

My counselling is never judgmental, never intrusive, never dominating. You are there as an instrument, to allow the mother's love which is already there by its very nature and which we cannot create nor destroy, to come through. Two thirds of the women continue on with the pregnancy, and of the one third that don't, half never come back, and we part on good terms. There is no bad feeling on her part that I did not provide her with what she wants. With the other half of that one third that come back and see me, you know there is a real struggle going on and they are invariably under pressure from their partner who is making them choose between them and the child.

I try to get them to bring the partner in. I find it draining. The thought that a child is ever terminated is awful. I just try not to think about it. What I feel is nothing compared to what happens to the woman. I never use the word 'God' or 'religion' unless they already have. If they have mentioned 'God', I might say that if you do believe, then you must know that God would never, ever, give you a child unless He loves you beyond all measure and He has given you this child out of love, not in an attempt to try and punish you.

I've never been compromised. A patient has never asked me for a referral for a termination. I had a colleague who when confronted with a woman who wanted a termination would get up and say: 'I'm a practicing Catholic and would never do this.' I take a different view. I see it as

a wonderful opportunity. I believe you can achieve just as good outcomes without bringing religion into it. You have to move into the darkness with her, or she won't feel you understand her predicament and understand her situation. She has to feel that you are only here to help her.

Some people think that if you don't take a stand and show total abhorrence, you are somehow co-operating in it. They might think that the person who wants the termination is evil. They may lack interpersonal skills. They may have no plan B if the woman doesn't follow their advice. They may find it hard to share their vulnerability with others.

There were times I would see up to seven women a week saying that they did not think they could go on with this. Over the years, they have helped me see where the truth lies. I used to struggle more initially. I saw it as more of a battle between the mother and me. The thought of this child not experiencing the beauty of life was awful. I would think I just have to move heaven and earth to stop this happening.

If you allow yourself to be open to the woman, you try and become part of her despair and predicament, and then you are no longer in battle or opposition with her. You are just a passer-by who is on the side of the road. You have your donkey and bag of food and everything you need, and they have nothing, and you just want to share it. Anything short of that is a cop out. Pregnancy counselling requires the patient to see that you are vulnerable. When you are both vulnerable, that's when the relationship starts. I want them to know that if they have a change of mind, they can come back to see me.

Referrals, mandatory referrals

If the law compelled me to refer a woman to a willing provider, I would not change what I do. With pregnancy counselling, some women connect, others don't. Sometimes there will be silence for minutes while she is waiting for me to write a referral to Marie Stopes. The silence is my struggle to come up anything that will resonate with her. I may say a Hail Mary in my mind. Then I will usually say:

> 'I will look after you during the whole pregnancy…I won't charge you a cent. …I cannot do a termination, everything bar that I will move heaven and earth for…. Your child is my child...What would you do if I was not here?'

It's then clear to them that I am not going to co-operate with them. They understand where I am coming from. They think, 'what's the point of pursuing him for a referral?' I don't think you are giving women total freedom if you are giving her the referral. The woman knows that she can get a termination without the referral. She is free to take the referral from you, but if you give the referral, you are not operating freely. If the state tells us to do this, we cannot give you unequivocal freedom.

I will not send a patient to a hospital with a diagnosis of a foetal anomaly for termination and say that I don't agree with it but am trying to comply with the law. I will not co-operate with termination in any shape or form. Once I put my name to a letter, I am co-operating. If I wrote a letter like that, I would think 'what's the point? I would prefer to go to jail.' I did not work as hard for that child as I should have.

A woman's choice is a different argument to the doctor materially co-operating with abortion. I have never had a woman think I was thwarting her or stopping her from doing what she wants to do. I want to make her freer by giving her 10 more options as opposed to one. You are freer to make a decision with more options on the table.

Conscientious objection to peripheral acts and other services

I don't prescribe the pill, I don't do sterilisations, I don't put in IUDs, and I don't refer for terminations. I will never write up a drug for termination, I will never do anything about the process. It's not part of my medical training and it will go towards materially co-operating in a termination.

My hospital has a foeto-maternal unit. All the disability abortions come here. Trisonomy-13 is a condition incompatible with life. The child is stillborn or will succumb in an hour or two after birth. If the woman terminates and has a problem with a retained placenta, I will attend to her and take her to theatre and do what is necessary for her health and wellbeing. My colleagues know they can call me up and I would help out in a medical emergency because I was not involved in the termination.

What education if any, have you received about conscientious objection including at university?

No. In those days it was just not an issue. Catholics worked alongside anyone. It didn't matter. Termination changed everything. When it became legal, the public hospitals had to provide it. Consultants did not want to do it and left it to the Registrars. The whole game changed there and then.

What would you do to change the situation and make it better?

You have to start at day one at medical school and teach students that your conscience is an integral part of your life as a doctor. You are going to reach a certain standard of knowledge. How you apply that knowledge to medical situations, to people's predicaments, is another matter. Every person must have space and scope to apply their knowledge to that person to the best of their ability and within a framework where they feel completely free to practice and impart that knowledge to people.

You cannot force a doctor to only practice in a certain way. It is anti-doctor, and anti-human. We have so much evidence of when doctors were forced to act in accordance with the state's views and every time it ended in disaster. As part of the curriculum, they should teach students the historical precedents of where the state has forced doctors to practice within state sanctions, and study the outcomes.

Just as the patient must have the freedom to choose, the doctor should be able to do so as well otherwise, there is an imbalance in the relationship. Freedom involves choice and options, and people need as many scenarios as you can come up with, otherwise how can anyone be free?

I have encouraged many registrars who came to me with concerns about their religion and obstetric practice and I try and encourage them to continue. It usually involves a cup of coffee, and I get them to talk about their experience, their feelings, where they felt under pressure, and take them through how ultimately there is no barrier to them living and fulfilling their vocation as an O&G if that is what they want. It's a bit like the vulnerable woman. You try and provide them with the space to work in.

At the hospital level, there is probably more tolerance of good doctors who have demonstrated that they are only interested in women's health and wellbeing. Recently, the College (RANZCOG) accepted 2 trainees out of 20, who were unequivocally opposed to terminations and made their feelings felt by saying they won't co-operate in terminations in any way. I think there are three reasons why this happened:

1. Elective first trimester terminations are not routinely done at public hospitals. All are done at private clinics.
2. The College is more amenable to transparency and good governance about who gets jobs. The interview process is more transparent. People have recourse to appeals and to claim discrimination, and Colleges don't want to bring this on themselves.
3. Both trainees were considered to be exceptional candidates. They did not have to prove that they could function in a public hospital. They had already demonstrated this and showed their heart is in the right place. For example, they would stay back for two hours for unpaid work to help a surgeon.

If public hospitals start doing elective terminations, obstetricians who would not normally consider themselves to have a conscientious objection, might object. I knew one Resident who wanted to be in the hospital's O&G training scheme was asked to hold the ultrasound for termination of a baby with ancephaly. He refused, and was told that if he did not do it, the VMO would be called in. He still said no. The next day, the VMO told him he respected his decision, and it was fine and as a result, another doctor who was in the hospital's training scheme told him that she would go and tell the Registrar that she also did not want to be involved with terminations. She did so and was told that this was ok.

Terminations might make up 2-3% of an obstetrician's private practice and all they do is the referral. This coercion in the law is about social engineers not wanting people of faith being anywhere near women and the public square. Even if it was not terminations but something else, their whole attitude is that people of faith have no place in the public square. It's an existentialist belief that your religion should be kept in the privacy of your own home and should never venture outside your front door. It's based on a much broader argument, and it has a long way to travel.

There's no other branch of medicine where you are not permitted to counsel the patient just because you are not doing the procedure yourself. I don't do circumcisions, but patients want to know about it from me. There are lots of things GPs talk to their patients about regarding procedures they don't do. They go through the pros and cons. To not allow a doctor to talk about a procedure is anti-medicine.

People have to have the confidence to argue the case that people of faith and people of conscience have to co-exist with a secular state sanctioned regime. Not where one dominates another. I do not support a theocracy. It didn't work in the 10th and 11th centuries and a lot of harm came out of that. There is just as much a lack of freedom where the state legislates, and you are not allowed to survive in the public square. To me it is all about mutual respect and co-existence rather than dominance.

Transcript of Interview

Doctor # 22

Interview conducted by ALW, 10 July 2018
Start: 2.00pm
Finish: 3.30 pm

Antecedents of Doctor # 22

Doctor # 22 is female, identifies as a Catholic, has been a doctor for 10 years, and practices as a GP in Metropolitan Victoria.

Consent

Written consent was obtained for the interview by ALW.
The interview guide was varied to take into account the respondent's background and in order to explore issues as they arose.

How would you define conscientious objection?

I see it as the ability to have and hold on to your beliefs. I like the current definition in the 'Good Medical Practice: A Code of Conduct for Doctors in Australia, 2009.' It says that you must be aware of your right to not participate in treatment that goes against your conscience, but you may not use your conscientious objection to impede patient access to treatment that is legal.

The basis of your conscientious objection to abortion

My objection is based on the Hippocratic tradition of medicine where medicine is a healing profession, and we must not do anything that directly takes a life, together with the known scientific fact that human life begins when the sperm and egg unite.

Your experience of exercising your conscientious objection to abortion and dealing with the mandatory referral requirement

I didn't always know what type of medicine I wanted to practice, but I realized that I liked all areas of medicine, so I settled on being a GP. I graduated in 2007 and the law in Victoria on abortion changed in 2008. It didn't put me off being a GP, however my conscientious objection did affect my ability to get certain training positions.

My first preference for GP training was the Melbourne metropolitan area. I succeeded, but I had to then secure a number of placements that required an interview. I decided to declare my conscientious objection in the interviews because I wanted to be open and transparent. I also saw it as a way for me to screen the clinic as to whether it could be a place I could work in whilst exercising my beliefs.

My conscientious objection to abortion caused a bit of tension and I got some negative responses. I feel it did hamper my ability to find clinics that would be more open to my conscientious objection. The whole process was quite stressful.
Some clinics felt like it would not be practical to accommodate me. One clinic had experience with a previous GP with a conscientious objection and they found that difficult to manage and so thought it would also pose a challenge with me.

One doctor that interviewed me at a different clinic told me that if I were to work at her clinic, I would have to do special training for 'my problem'. She kept using that term, and I didn't take that opportunity further.

Another doctor I interviewed with was happy with my conscientious objection, but he was not the supervisor of the practice. When the supervisor got back from holidays, she and I discussed how to manage it, and this caused conflict.

I told her I would be uncomfortable referring for termination of pregnancy. She said she did not want me to use the word 'uncomfortable' with a patient as it might upset them. She said her preference was for me to treat a request for termination like any other query where I do not know how to manage it, and tell the patient I needed to speak to my supervisor. The supervisor would write up the referral, and I would hand it to the patient.

I wasn't sure how to respond to this at first, so I sent her an email a few days later and told her that I felt that what she was proposing was still direct participation in abortion. I quoted the Code from 'Good Medical Practice' and added that there might be medico-legal issues with this, as the supervisor writing the referral had not actually seen the patient. I told her that I accepted that the word 'uncomfortable' might potentially cause a patient to feel uncomfortable if they felt termination was the most appropriate for them, so I suggested that I still see the patient to explore their needs and advise them on all the options and if they still wanted a termination, I would say 'I don't provide those services but others in the practice do' and the patient would be invited to book in to see another doctor.

Her response was that whilst she understood the participation aspect, what I proposed transgressed that part of the Code where it states that you must not use your objection to 'impede access to a legal service'. She said she did not want any patients feeling uncomfortable, or inconvenienced and that they should have prompt access to services they need or want.

She asked if I felt comfortable telling patients that they don't need a referral, but the problem is that some may want to see a private doctor and in that case, they definitely need a referral. Ultimately, she was happy to see any patients who came to see me for termination, after I had gone through the options with them. So, this was what we agreed on. As it turned out, however, I never had a request for termination in the 6 months I was there.

I found the whole confrontation very stressful. In addition, she accidently copied me into e-mails she sent to the association. I learned that she had not had to deal with a trainee who had a conscientious objection to abortion before. She told them I was only there for 6-months and her patients would be there a lot longer and she did not want staff copping a blast at the front desk. Learning about this made me feel small. I found this out in the first two weeks of the placement.

In another rotation I did, the clientele was of a lower socio-economic status and there was a higher incidence of patients seeking termination. In that clinic, they had a system where the patient just turns up and they see whatever doctor is available. I thought this might work well for me, in that if you could not see the patient because of your beliefs, you would just put the patient back into the queue for another doctor to see, however I did not think it would be good for me long term.

I found the whole training period distressing, anxiety-provoking, and demoralizing to the point where I had to take a couple of weeks off work. I spoke with a doctor in the training program who was supportive, and he asked me how much I believed in what I was doing. He felt that in the long term, I would settle into a practice that accepted my conscientious objection and I would attract patients that respected my belief. I met other supervisors along the way who had the same approach too.

Conscientious objection to peripheral acts and other services

I object to artificial contraception if not used for medical purposes. My objection goes back to the ability of hormonal contraception to be abortifacient and to prevent implantation of the ready-formed embryo. When I have taught medical students about how they work, many are surprised. I don't think the profession knows a lot about it.

In my area of holistic women's health, you come to appreciate that normal ovulation and menstruation are a sign of wellbeing. If there are issues with periods or irregular cycles, it means that something in the body is not working properly and that needs to be identified and treated instead of using synthetic hormones to mask signs.

I felt more protected by the law with my conscientious objection to the artificial contraception and when I disclosed my conscientious objection to abortion, I would always include contraception. I also object to sterilisation, euthanasia and organ retrieval, if you were not sure the patient was 100% brain dead.

The transgender issue is not one I know enough about medically and has not crossed my radar in practice. I don't think I would give a direct referral for hormonal treatment. I would want to make sure the patient had a more comprehensive psychological and physical assessment before embarking on hormonal treatment.

What education if any, have you received about conscientious objection including at university?

I don't recall any. In first year medical school, there was a presentation on genetic screening and Down Syndrome with the presumption that you screen to terminate. I was fairly shocked

to encounter this, but after I talked to other students, I realized this was the prevailing attitude. I had my obstetrics and gynaecology rotation in a rural setting and the obstetrician did not perform termination of pregnancy, so I did not have to observe any during my training. She did tell me about one she did on a baby with a genetic abnormality because in her mind, the baby wouldn't survive beyond birth. So, she did an early induction to deliver the baby at a time when it would not survive the process. I did my paediatric rotation in that same rural town, and the obstetrician was quite shocked to find out that a child with the same chromosomal abnormality to the one she terminated was alive and well. It really challenged her.

What would you do to change the situation and make it better?

There needs to be education on conscientious objection in medical school because the environment doesn't allow flourishing of one's individual conscience. You almost get caught up in a tide of following the status quo and not given a safe space to explore and challenge different ethical dimensions of medical practice. Medical ethics has a big place in medical education. If it is not taught, you just become a service provider and you lose the heart and soul of medicine. You only learn the science.

I have had more hostility to my conscientious objection amongst doctors than from patients. I get a sense that the community is more understanding of conscientious objection than doctors, who seem more black and white. Maybe that is the way we are trained. The culture of medical school is to get through each stage and please your superiors who have power over your career progression.

We are taught to be sensitive to the patient's needs and beliefs, but we are never taught to explore our own in a healthy way and nor how to manage the tension between the two. Culturally, medicine today is about service provision. We have lost the vocational concept that was noted in the Hippocratic tradition, the Judeo-Christian tradition, and other major religions and traditions of the world.

In regards to the law, the main amendment would be the section on conscientious objection as it is a widely recognized fundamental human right. There was never an issue with access to abortion. I don't think access has gotten better as a result of this law. It was more about providing protection to abortion providers.

Looking back on it now, I feel that having a conscientious objection to abortion has allowed me to have a greater depth of understanding in women's health and fertility and allowed me to become very well versed in these areas. If the patient wants to know why the doctor objects to abortion, the doctor should be able to explain why, but most people inherently know why you are objecting. It might not be as apparent with something like contraception where I think there is a role for discussion with the patient. There is often time pressure in consultations, and it can be practically difficult. It has taken me many years to form my beliefs and to do study in Bioethics and it is hard to give an adequate explanation in a short space of time.

I think there may be a need for training of doctors regarding services for crisis or unplanned pregnancy. It takes more time to explore the woman's background and psychosocial/spiritual state compared to a standard 15-minute appointment. The abortion clinics send their advertising material to us. We don't get the same material from crisis pregnancy centres and so doctors just don't know what's out there.

If there was a brochure that was even handed with details of places that do non-directive counselling, that included details of where to go for financial or social support or adoption and not just termination, then giving that information would be better than being mandated to refer I think adoption is put into the too hard basket. You tend to refer to what you know. We don't get any training at all on this at medical school or in the GP training program.

I didn't have a long-term plan on how to deal with my conscientious objection in medicine. You cannot guarantee you will never encounter it. Catholic hospitals are allowed to object to performing abortions, but there is no equivalent in general practices. You would have to start a clinic from scratch with a code of ethics. Long term, this is the needed approach for GPs to manage conscientious objection in the community. In reality, there would only ever be a small number of clinics that would operate like that, and patients would seek out those types of doctors.

Transcript of Interview

Doctor # 23

Interview conducted by ALW, 14 July 2018
Start: 8.00pm
Finish: 9.10pm

Antecedents of Doctor # 23

Doctor # 23 is male, identifies as a Catholic, has been a doctor for 10 years, and practices as a GP in Metropolitan Victoria.

Consent

Written consent was obtained for the interview by ALW.
The interview guide was varied to take into account the respondent's background and in order to explore issues as they arose.

How would you define conscientious objection?

I am not a moral relativist. I believe there are certain acts that are objectively wrong. A conscientious objection to abortion in the healthcare context is similar to someone having a conscientious objection to military service. The objection is based on the fact that someone is being asked to kill a person. Even if I am not doing the abortion, I am still morally complicit if I provide a referral.

The basis of your conscientious objection to abortion

I believe that life begins at conception. There is a new human being created through unique DNA, with all the other characteristics that apply to a new human being. This approach is different to relativism, where a person is defined at another stage of life, such as when they can feel pain or when they can think.

Your experience of exercising your conscientious objection to abortion and dealing with the mandatory referral requirement

Because I believe that life begins at conception, there are implications for the way I practice medicine. I graduated in 2008, the same year when the Victorian abortion law was passed. The University I went to was not really open to discussion on life issues. At university, you don't have any power to speak out against it. There is an expectation that everyone will practice as per the general consensus. It is not even raised by lecturers or tutors that there might be people who believe differently. I felt like there was no point in speaking out. I was just focused on what I needed to know for exams in order to get through. In hindsight, there might have been others who had the same view, but I didn't know anyone at university who spoke out.

I was concerned about how the law would affect my practice. At that time, I did not know many doctors who had the same beliefs as I did and who could give me the confidence to practice in line with my beliefs. Having to speak out to supervisors makes things more difficult. I was concerned about how it would affect me as a junior doctor. I considered doing obstetrics and met an obstetrician in 2007 whose practice was more life affirming. He was the only doctor I knew who could act as a mentor, but he was retiring. So I chose not to do any obstetrics.

I thought being a GP would be easier, but we are at the forefront of life issues. When I applied for the training program, I did not disclose my objection in interviews because I thought it would have a negative impact on me. I decided to handle the situation when it arose, although I didn't have a plan about what I would say.

During one placement, a patient requested a termination. I explored all aspects of her request, such as her situation, her reasons, and any available support. I then explained to her I won't refer for abortion and told her that I had to speak with my supervisor. My supervisor then consulted with the patient and provided the referral. Afterwards, my supervisor told me I should have raised this with her at the start of my placement.

This made the rest of the placement uncomfortable. After that, both the supervisor and the receptionist were aware of my objection. If the receptionist knew the reason for the patient's visit, I believe she would direct the patient to another doctor however there was no formality

around this arrangement. As it turned out, I didn't have any other requests for termination at that placement.

In other places I have worked, I have had requests for termination. You have to appreciate that some women come in and they are not sure that they want a termination, so it is more important to have good rapport and explore the uncertainty and the issues around that, rather than make my objection the focus of the discussion. So, I don't disclose my objection at the start of a consultation. When I do raise it, I don't mention my religious beliefs. I don't believe they directly impact on my objection. Yes, my beliefs are in line with my faith, but the source of the belief is science and the fact that life begins at conception.

I had one patient who requested a termination and when I explored with her the reasons for the request, it turned out she had an abortion at 15 and purposively conceived at 17 to have a baby. She was 24 when I saw her, and felt the time was not right and that she did not have a supportive partner. She still had psychological issues form the first abortion and told me that she received no counselling from the abortion clinic, other than being told the risks of the procedure.

There was no education about psychological issues following abortion at university or in the GP training program, but I did read a book by Melinda Tankard Reist about the consequences. In the circumstances, I suggested a non-directive counselling service, which she ultimately took up. I did disclose to her that I don't refer. I felt that we had good rapport and she returned to see me for a follow up consult and told me she had made the decision to still have a termination. She didn't request a referral from me and after the abortion, she has come back to me several times.

Whilst you don't need a referral to an abortion clinic, it is possible a patient may want a referral to a private gynaecologist in order to get a Medicare rebate, but they would have to get the referral from the GP, book in to see the gynaecologist, and come back to have the procedure done at a hospital. In practice, most patients will book into an abortion clinic, where GPs are ready to do the abortion.

I feel insecure about the mandatory referral law as it has not been tested. It's still up in the air about how it would be challenged in court. If the law required me to disclose my objection up front with a patient and deny me the opportunity to explore other options with her, I feel this

would be bad medical practice. Even if a doctor refers a patient for an abortion, they have to explore the background situation impartially. I am pretty sure other doctors wouldn't explore the situation fully with the patient and because of time constraints, and they might just write a referral.

This is a problem because counselling at abortion centres is quite restricted. I have not come to a conclusion about the AMA's recommendation that a GP put up a sign to warn patients that the doctor does not refer for abortions. There was a doctor who refused to refer for abortion who got reported and had disciplinary action taken against him. I wonder whether identifying yourself as a conscientious objector might attract troublemakers who disagree with your beliefs and despite the signage, try to get you to refer, and then when you refuse, report you to the Medical Board.

I have had patients express frustration that they didn't know I wouldn't refer for abortion, but I have not had any formal complaints. I do feel anxious every time a patient comes to see me and requests abortion. I spend a longer amount of time with them to ensure that they don't make a complaint, and I don't charge them for the consultation.

Conscientious objection to peripheral acts and other services

I would not agree to put in a cannula or perform documentation related to abortion. These actions would still make me morally complicit in the abortion.

I don't prescribe artificial contraception. In the past, I did prescribe it even though it made me feel anxious, and it was unpleasant, but I just felt like it was such a widely accepted part of medicine. I felt odd because I had unease with it because in the medical community, whilst doctors understand that some won't refer for abortion, it's almost unheard of for a doctor to refuse to prescribe artificial contraception.

I became interested in napro technology, which helps couples with infertility and people wanting to avoid conception naturally and was able to move into another position where I could offer it as an alternative to artificial contraception for family planning. The few patients who ask me for artificial contraception usually come to see me for other reasons, so they are not upset when I refuse to provide that. Most are fine with my position, but I think it would be

difficult for me to practice in another clinic. Artificial contraception for family planning is a frequent request in a GP practice. The other doctors here are supportive of me because I don't just say no, I offer the alternative of napro technology.

The receptionist will try and triage patient requests, but they don't always know why a patient wants to see a doctor, so it helps that other doctors in my practice will prescribe contraception so patients can be easily re-directed.

I also have a conscientious objection to euthanasia and any artificial reproductive technology. Regarding transgender treatment requests, I need to explore it more because I do have concerns about it, but I have not had this type of request yet. I don't know if this is as clear-cut for me because it does not involve the direct destroying of life.

What education if any, have you received about conscientious objection including at university?

None. We had one or two workshop tutorials about ethics, but this was limited to learning about different ethical theories.

What would you do to change the situation and make it better?

I would repeal section 8 of the law dealing with conscientious objection. There needs to be explicit protection in the law for doctors and health professionals with a conscientious objection to abortion, so they do not have to participate in it either directly or indirectly. Otherwise, this situation could spread to euthanasia now the legislation has passed.

I am concerned about this, and how I am going to practice medicine. There must be an acceptance within the profession that doctors have different beliefs and that is ok. Having a written policy that sets out how to deal with a conscientious objection is important, as is ensuring that the person you raise it with is not the junior doctor's supervisor. As a junior doctor, you are always worried about how anything may affect the outcome of your placement. The bullying that has come out in the media shows that doctors don't want to speak out if it will affect their future career.

For GPs, we need to make it a requirement to provide referrals to support services for women with crisis pregnancies. We need to address the causes for why women are having abortions. We need more support for single mothers. Charities provide some services, but it should also be government funded so that women have real choices.

As far as I know, adoption services in Australia are non-existent. Many couples want to conceive with IVF, and never consider adoption as a real option. When I have mentioned adoption to patients, they say they won't consider it, but I don't really know why that is. I don't know what information to give a patient about adoption. If the patient were considering adoption, they make these enquiries without our assistance. If we don't facilitate access to adoption for patients, why do we have to facilitate access to abortion for patients?

I would be worried about being the only doctor in a rural practice and declining to refer for abortion where the next doctor is 50-100 kms away. However, the actual abortion would not occur there anyway, and the patient would have to travel to a regional centre to have it done. In remote areas, people are used to travelling for their medical needs. So, in that sense, not referring for abortion would not restrict patents.

I would be OK with directing patients requesting abortion to a government brochure that contained non-directional information on all the options, located in the waiting area along with all the other pamphlet information we display. This would include information on applying for adoption, as well as pregnancy support services including church-based services, as well as the location of abortion clinics. If the brochure didn't mention services that I know to be good, such as a pregnancy support service, I would give the patient that information as an addition to what was in the brochure.

Transcript of Interview

Doctor # 24

Interview conducted by ALW, 14 July 2018
Start: 8.00am
Finish: 9:15am

Antecedents of Doctor # 24

Doctor # 24 is male, identifies as a Catholic, has been a doctor for 9 years, and practices as a GP in a rural area of Victoria.

Consent

Written consent was obtained for the interview by ALW.
The interview guide was varied to take into account the respondent's background and in order to explore issues as they arose.

How would you define conscientious objection?

Conscientious objection in healthcare practice is the ability to practice in accord with one's morals and convictions. However, whilst I believe in conscientious objection, I think there should be some limits on it in medicine. For example, I know some doctors don't agree with vaccination, but I believe in the medical and social benefits of vaccination and I'm not sure how their objection can stand given what we do.

The basis of your conscientious objection to abortion

I believe in the sanctity of life and in the foetus as a human life. I don't believe in the wilful destruction of human life. I had a concrete view on abortion before I became a doctor, but through my medical studies, I began to appreciate the beauty of unborn life, and that has been supported by further study I have done later on in life. Leaning about the science has given me a unique insight into the development of life.

Your experience with disclosing your conscientious objection to abortion

I was at medical school when the abortion law came through and it was quite controversial. The university was not overt about their opinion, and I think they probably wanted to avoid the topic. However, amongst the students, it was very controversial. There were not many forums within which to speak out against it. I recall one guest lecturer in first year was particularly nasty, and ridiculed people who were pro-life. They inferred that the profession mainly held a pro-choice view, and it was a little less intelligent for a doctor to hold a prolife view.

When I did my registrar training, we were never confronted with the ethics of abortion but when we had interviews for placements, I decided to bring it up with the practice manager. I thought long and hard about how I could express it. I knew it was important to let them know and I did not want to ambush them.

I found a statement that Avant [the medical insurer] had put out for employers on how to manage registrars who don't prescribe certain medication. They suggested you had to be careful when an employee brings up a religious view and you should ask questions, so you aren't caught out later. So, I brought that article along to my discussion with my practice manager and supervisors and made it a talking point. I took the attitude that I was trying to make things easier, and I was trying to come up with a solution together rather than just state my objection and expect them to solve it.

The practice manger discussed this with the partners, and they begrudgingly accepted the views I held. Since then, I've been with a Christian employer who has been quite accepting of who I am, and I have worked out a way to deal with this.

I think the problem is that conscientious objection comes up so rarely for practice principals that they may not have a 'go to' solution for this. Maybe only 1 out of a thousand doctors has this objection so practice principals have not heard of it, but when it does happen, it's a problem. You cannot assume your colleagues have the same ethics as you do. Avant is raising topics like this and its good, because we live in a world of changing ethics. Because of challenging legislation and social expectations and ethics, now is a good time to discuss conscientious objection in medical practice.

Your experience dealing with requests for abortion

I believe in informed consent, and I believe a woman considering abortion should have full information about other options such as adoption services and keeping the baby. My first question in that circumstance is to investigate if anyone has given her information on the options open to her. I have an unbiased discussion to see whether she is even acknowledging options other than termination.

This takes about 20 minutes. It's a unique consultation and cannot be rushed. You have to give the process its due. I feel I should spend the extra time with her, as it might be a crisis situation. I see how she feels and what information she wants. I print out information on the options from the Royal Women's Hospital and go through them with her and I discuss with her the complications with termination of pregnancy.

Some people are single minded about the service they want and may not have thought through the options. If someone is single minded about the services they want and I am not going to provide those services, then if I were to continue the consultations with that patient, I would run into trouble with the patient and with myself. So I spend 99% of the consultation on a neutral position, and I spent the last 1% saying:

'I think if you want to take this further, you might have to see someone else.'

So, without being explicit, I hint at my position. I then ring up the practice booking staff and facilitate a process where the patient can choose a more obstetric trained doctor in the practice. I know the doctors in my practice who don't have a conscientious objection to abortion although I don't know if there are any specific situations when they don't agree with it.

I have found that people are very appreciative of me trying to get the best doctor for them, and the practice bulk bills so it doesn't cost them anything. People want to be listened to. After that type of discussion, they know they have a professional they can talk to. After listening and taking a neutral, non-judgmental approach, you'd be hard pressed to get a complaint, and as you can self-refer for termination in Victoria, you'd be hard pressed to say the doctor denied you access. In any case, in approaching consultations this way, the patient does not request

abortion from me. So whilst it's not my primary objective, the by-product is I comply with the law.

Conscientious objection to peripheral acts and other services

I will not be involved in any way with abortion. I won't write a direct referral because it would make me morally complicit. If I were in a hospital setting, I wouldn't be involved with the consent process because if you can't give a fair description of the service, you can't be involved with the consent. I don't have a problem putting in a cannula for fluids before the surgery, but I won't go into the surgery and provide services. I draw the line with that, although I would provide post abortion care.

I object to euthanasia. I believe many general practice doctors will not want to have any involvement in the right to die option. I also object to IVF and I won't refer patients to that service.

I don't prescribe abortifacient contraceptives. I refuse to do that and it's very problematic in general practice. Prescribing contraception is a touchy subject for doctors with a conscientious objection. There are basically three ways of dealing with it; you can put up a sign and avoid dealing with it; you can deal with it discretely by getting someone else to write the script; or you just prescribe it.

I mainly have male geriatric patients or emergency consults, so I rarely get asked to prescribe contraceptives but if I do, I have a discrete arrangement with my supervisor. I consult with the patient then excuse myself to see my supervisor. He trusts me regarding the information I have taken from the patient, and he writes up the script. I go back to the patient and hand them the script. It's making the best of a bad situation.

I think many doctors have not really understood the way the pill works, and some of them doubt if it is truly an abortifacient. It works to prevent ovulation and creates a barrier to stop sperm travelling into the uterus. But if there is breakthrough ovulation, and the sperm gets through and there is implantation, then it works as an abortifacient. Some people doubt whether this ever actually happens and reconcile their ethics that way, but because it's possible, I have a real objection to it.

I haven't had to deal with the transgender issue yet, but I object to it on the basis that it's wilfully destructive to go against one's physiology and counterproductive. I like to look at things medically when I am practicing as a doctor. I have a medical objection to it in that there are no long-term studies on the effect of transgender services. I cannot refer where there is no long-term data on the service. I would start any consultation with a patient on neutral ground, and ask them whether they have had psychiatric assessment, and work out if there are other health services they need.

What education if any, have you received about conscientious objection including at university?

None. I only heard the term 'conscientious objection' later on as a doctor.

What would you do to change the situation and make it better?

Companies themselves need to understand that employees will have different ethical viewpoints and there will be moral distress if the employee has to do something against their conviction. They should not expect employees to have the same ethical viewpoints as them. A solution lies in more robust policies that acknowledge this.

However, people with a conscientious objection should be more overt about where they stand. One of the ways is to gather like-minded people and have more of a discussion. We need to understand what conscientious objection is and when it applies. A lot of these subjects are taboo. If we had more discussion, people would come to appreciate that there is a diversity of views. I think doctors are peacekeepers and some of these topics are really contentious. If you gathered 10 doctors together to talk about abortion, you'd be asking for a bush fire. We, as a society, have lost the ability to discuss things rationally and that people disagree and that's ok.

If you were a female GP and were being asked by patients to prescribe the pill 10 times a day, your boss would not be happy with you. There may be an implication for the practice. Once they hire you, things can get messy, as it might be seen as discrimination, but I can understand a Principal saying that they are not able to let the doctor only see old male patients to avoid the situation if the practice is filled with young women. It may fall to the doctor with the objection to find another situation.

I know of one incident like this in a regional training program. The doctor didn't mention her objection to prescribing contraception in the interview even though she was being employed primarily to fill in for a doctor who had a lot of maternal health patients. Instead, she mentioned it on the first day. So, the program arranged for the doctor to be placed in a different setting to avoid her objection.

I agree in principle with repealing section 8. I think people pushing this legislation wanted to put the fear of God into prolife doctors. It's a nasty section in the sense that they legally compel you to play the game, and it's coming through the medical ethics of Julian Savulescu and other prominent ethicists. They say a doctor who cannot provide these services should not even go to medical school, but it doesn't seem purposeful or practical or necessary.

I'm surprised euthanasia advocates did not copy the referral provision, but I think abortion is their sacred cow. Of course, it's possible these ethicists think referral is a solution for you. They have a structure in their head about what doctors should do and how ethics should play out in medical practice where the doctor cannot restrict the patient's autonomy. They don't understand why referral is anything more than writing something down on a piece of paper. There's an underlying view that doctors are supposed to think a certain way. I object to that kind of grand culture. There should be lots of different viewpoints. We need more ethical forums for doctors.

Transcript of Interview

Doctor # 25

Interview conducted by ALW, 26 July 2018
Start: 1:30pm
Finish: 2.35pm

Antecedents of Doctor # 25

Doctor # 25 is female, identifies as a Christian (non-specified), has been a doctor for over 50 years, and practices as a GP in both suburban and country Victoria. Doctor # 25 noted she was not as strong about her conscientious objection to abortion as she expected other doctors in this study might be and wanted to participate in order to provide balance.

Consent

Written consent was obtained for the interview by ALW.
The interview guide was varied to take into account the respondent's background and in order to explore issues as they arose.

How would you define conscientious objection?

Not wanting to do something you know is wrong.

For medicine, I think there are some things that you should not be able to do, even if you thought it was right though I cannot think of any off the top of my head. I read something recently about a nurse being asked to do female circumcision in a healthier way. She didn't agree with it, but thought that if she did it, it would be less invasive, with less risk of infection, and would be better for the girl. In that situation, I don't know what I would do. I think if I knew that if I didn't do it, and the girl would be put at a lot more risk, there would be a lot of pressure to do a safer procedure.

While I was at University many young men had conscientious objection to being sent to the Vietnam War. This did not impact on me personally, but there were reports of people being imprisoned because of their refusal to participate. Would I be willing to risk this due to a conscientious objection? I guess the answer re abortion is No – but I think the answer to euthanasia would be Yes. I believe that good palliative care can make the end of life comfortable, and that I should not deliberately end a person's life.

The basis of your conscientious objection to abortion

I don't think abortion is a good idea. I think God provides life and determines death and I don't think it is up to us to take that into our own hands. I have the same objection to end of life issues. My objection is predominantly based on my faith, and I believe that at conception a new life is there, however I don't feel it is as valuable until it is viable outside the mother. I believe there is forgiveness for taking a life, and a loving response is important, but I still would not agree to actually perform the abortion, or to euthanize a person.

Your experience with disclosing your conscientious objection to abortion

In many situations, I have been the only doctor in the clinic and so have not really had to deal with this. When I worked for Family Planning Clinic Victoria (formally Family Planning Association), which was a long time ago, I told the nurses that I didn't really believe it was good to have an abortion, and that I was not terribly comfortable with referring for abortion, but that I would discuss it with the patient.

Some of the nurses who had worked in family planning clinics before thought it was just part of the job to refer. One nurse I worked with later on at a suburban family planning clinic run by the Department of Health Victoria, was a Christian and she and I talked about the ethical issues a lot.

Your experience dealing with requests for abortion and referrals

I have been pregnant four times, with two being planned, and two being unplanned. My second pregnancy occurred when my first child was 10 months old, and I was not happy with being

pregnant although I would not have had an abortion. As it turned out, I had a spontaneous miscarriage, and I was very happy about that.

The second time I had an unplanned pregnancy, we had two children and I was considering getting my tubes tied so I could not have any more. At that time, my husband had lost his job and he was concerned about the financial implications if I was unable to continue working because of the pregnancy. It was very difficult and at times he would refer to '…that blood baby….' So, I told him that if he wanted me to have an abortion I would, but I was pleased when he said no.

I have referred a number of patients for an abortion.

Early in my career, I worked for Family Planning Clinic, Victoria. At that time, I thought the work would purely involve giving contraceptive advice, but early on I was confronted with a patient who was pregnant and wanted an abortion. I didn't really want to refer her, and in any case, I didn't really know where to refer her. So, I referred her to my O&G hoping he would persuade her against it, but he told me that he did not do abortions and so he referred her to a doctor who did. Later on, the Clinic had a list of doctors who did abortion, and the list was left with the nursing staff, although a doctor still had to sign off that an abortion was needed.

I recall having a 14-year-old girl come into the general practice with her mother wanting an abortion. The mother was very domineering in the consultation. In those days, children didn't have any rights to say anything, but I got the feeling the girl really didn't want an abortion. I palmed it off by asking them to see my employer. I thought he would believe it was illegal, but as it turned out, he signed the form, and got me to sign it as well, stating that I agreed with her having an abortion.

I felt obliged to put my signature on the form, as he was my boss. He arranged for her to go into a private hospital to have it done. Looking back on it, I should have objected a bit more, which would have meant they would have to see another doctor to get the second signature as there were only two of us at the clinic.

Over the years, I have mulled over that decision, wondering what happened to her, and to others I referred for abortion, but over time, I don't think about it as much.

Later on, I worked in suburban clinics, focusing on family planning. In those clinics, I used to discuss a lot of the ethical issues with the nurse who was a Christian and I came to the conclusion that I would tell the patient that I believed it was a life and that she would be killing a life, but I would ask them how they thought about it, and if they had any strong views about it.

I recall a young fellow came in once with his girlfriend who was pregnant. His mother was very involved with the Right to Life movement. It gave me the opportunity to explore how patients felt about abortion and I realized that for most of them, they had not really thought about it and just wanted to get rid of the inconvenience.

I remember another client who was in a stable relationship and wanted an abortion so she could go on a trip. I told her that people often regretted the decisions they made, and some people experienced ill effects afterwards, but her mind was made up. I didn't think this was good reason to get an abortion and I couldn't bring myself to give her a referral, so I just gave her the address of the clinic that meant she still had to find a doctor to sign the form. I saw her later on and she had a lot of pelvic pain, and I wondered if this was all related to the abortion.

For women in stable relationships wanting an abortion, I would say something like: 'How would you feel if you made this decision after you married? You might regret not having kept your first child?' I would tell most people there is a small risk of complications after an abortion that may make conception impossible later.

In the Family Planning Clinic, I had time to have these discussions because the Victorian Health Department paid my salary and the nurse's salary, so our pay didn't depend on how long we spent with each client, but we were paid for a clinic session. I didn't have the same time constraints you do in a GP clinic, and if people had to wait, they accepted that. This changed over time and eventually we had to bulk bill which affected how long you were taking and it changed a little bit of what I would say to patients requesting abortion, but not a lot. I just had to be more aware of the length of the consultation so as to bill Medicare appropriately.

I had one patient who was an older woman who thought she was post-menopausal but after an examination I knew her uterus felt pregnant. We did a test, and this was confirmed. She was stunned. She was in a second marriage and had children from the first marriage and hadn't been married long to the second husband. She felt it was quite difficult in her early 50's to have a baby. We discussed it all, and I asked her to come back the next week, after she had time to talk with her husband rather than me giving her a referral. When she came back, she told me that her husband was quite delighted, as he had never had children so that solved her problem.

This incident made me think that it really is worth exploring the situation with the patient and not dashing in and doing a referral straight away. However, if her husband had a different reaction, I probably would have referred her to a clinic for a termination. I think the clinics that do abortion on a regular basis are good at doing them, from a clinical point of view.

I do hope that in talking to patients about these things it will give them pause about the implications. I am trying to convince them not to have an abortion, but sort of knowing deep down that I am not going to change the minds of some of them. If they have not thought deeply about the whole thing, and I have come to the conclusion that I am not going to change their mind, then if I don't write a referral, they will just go somewhere else and get one. This makes it more straightforward for me to refer them, and for them to come back later and see me so we can make sure they are using good contraception. It just makes it more complicated for them if I don't write a referral.

Even though I think viable life has value, I referred one patient to a clinic for a late term abortion. I felt the patient didn't have strong views against abortion and I'd spent time trying to convince her otherwise. If I held the line about not doing a referral, I am closing off my relationship with this patient and they won't come to see me about other things including any complications of the termination. To me, that's important.

If the law said I had to make the referral, I would in that type of situation, while telling the person that I was not in agreement with it, and my reasons why, and that I was giving the referral only because the law said I had to Sometimes I think it is like Jesus to listen to the person and let them make their mistakes, but to show loving care in it all. God does not stop us making mistakes - but is ready to forgive us when we realise that we have done the wrong thing and ask his forgiveness and learn by our mistakes.

I saw a woman at a suburban Family Planning Clinic. She was very upset at finding she was pregnant. She was a Catholic and working as a teacher in a Catholic school. She was single and she had an affair with a married man and became pregnant. She knew she would lose her job if it became obvious that she was pregnant out of wedlock. She had strong views against abortion but could see no other way to deal with the situation, as she needed the income from the job.

No matter what she did, she sinned; by having a relationship with a married man and allowing that to become obvious by looking obviously pregnant if she continued with the pregnancy, and by having an abortion. I was able to explore all this with her and help her to express her feelings. I don't remember if I gave her a referral for abortion; I probably did, but it was her decision to go ahead or not.

Doing an abortion and referring for one is not quite the same thing because it is still up to the patient if they use the referral. I would never do an abortion myself. When I was a junior resident, I had plenty of experience doing curettes so even though I know the technique for abortion, I would not do one.

Conscientious Objection to other services

I have an objection to euthanasia. If someone wanted a referral for one, I would spend a lot of time with the patient and try to convince them that life is worthwhile. I have had a few patients who wanted me to put them off quickly and I said no, but we can make you as comfortable as you can be. I feel more strongly against referring for euthanasia that for abortion. I would try and find a way to get out if having to refer, and to convince them to use palliative care.

With euthanasia, the person has a history whereas with abortion, only viable life has value and that is around 23-25 weeks. By that time, it is problematic to have an abortion, and there are a lot more risks of bleeding.

I haven’t really considered transgender health issues and I don’t have a strong view about all of this. I think people will do a lot of counselling before any surgery and if a specialist ordered hormones to be prescribed, I would probably write a script.

What education if any, have you received about conscientious objection including at university?

None.

What would you do to change the situation and make it better?

Even though I don't have a big problem with referring, I know other doctors that do. I think if people have indicated that it is their position not to refer, they should not be required to refer to someone who will.

Over time, clinics get a reputation that certain doctors won't refer you and you have to go somewhere else. There may be a case for putting up a sign that doctors won't refer for abortion or euthanasia but add in that they are very happy to discuss the issues. The problem though is the consult may not be covered by Medicare, and some people can't afford to pay to go twice. But it's helpful for the public to have more information and they may not get that information at a clinic.

Transcript of Interview

Doctor # 26

Interview conducted by ALW, 4 August 2018
Start: 10:00am
Finish: 11.30am

Antecedents of Doctor # 26

Doctor # 26 is female, identifies as a Catholic, has been a doctor for almost 2 years, and practices as a Resident Medical Officer in an Obstetrics and Gynaecology Department in a tertiary hospital in New South Wales.

Consent

Written consent was obtained for the interview by ALW.
The interview guide was varied to take into account the respondent's background and in order to explore issues as they arose.

How would you define conscientious objection?

To have a conscientious objection is to choose not to participate in an act based on a firmly held belief. In medicine, this usually means not prescribing certain medications or participating in certain procedures. Therefore, I define conscientious objection as a passive rather than an active expression of a firmly held belief.

For example, if I saw another doctor performing female genital mutilation on a patient who had given informed consent, I would not actively obstruct this process, despite believing the act is wrong. I would respect the deeply held beliefs of both the doctor and the patient. Similarly, if I saw a doctor performing an abortion on a patient who had given informed consent, I would not take drastic steps to interfere in that doctor-patient relationship. However, if I was asked to enter into that doctor-patient relationship and participate in any way in that abortion, I would choose not to be involved.

However, my opinion is probably shaped by my experience with exercising a small conscientious objection, which got out of hand and resulted in the Head of the Obstetrics Department declaring that I should not be an obstetrician.

The basis of your conscientious objection to abortion

That it is not right to end someone else's life. The basis of my objection is a mixture of both my faith and my understanding of the science, but it is probably more faith based. The origin of my values is my faith. The science is straightforward, but it's very hard to talk to obstetricians in scientific terms about abortion. I've been called judgmental and arrogant. They bring in emotional arguments to hide the science. I think that obstetricians who participate in termination of pregnancy insist on being ignorant of the science.

Your experience with disclosing your conscientious objection to abortion

In my third year of medical school, I did a rotation in Obstetrics and I was in awe of the possibility of being involved with the birth of a new person. I had my heart set on being an Obstetrician.

Before I started the rotation, I took the view that I would not disclose my conscientious objection to abortion to my supervisor at the start of my rotation. Instead, I decided to wait until a situation arose. It would have been unnatural for me to bring this up beforehand. I guess I am very weak and was out to please my supervisor as ultimately, I ended up participating in a procedure to insert an intrauterine contraceptive device. I missed the opportunity to preface my objection in the appointment with the patient; I missed the opportunity to express it before the operation started; and I left the clinic appointment without telling my supervisor that I did something that compromised my values.

The situation was sprung on me and I had no notice, but I was so thrilled that a consultant would let me participate in a procedure and I did not fully contemplate the weight of what I was to do until after it was done. Once I left the room, I grasped the seriousness of what I'd done and I felt very guilty, very used, like a technician… that I'd performed dirty work…like I was part of a circus act. It was like the consultant led me in a dance. He was very jovial and his way of developing rapport with his patient was like a performance.

I went straight to confession. In conversation with the priest, I felt the full weight of what I did and I was extremely remorseful. The emotional consequences lived with me for many weeks. I never saw that consultant again and I never thought of seeking him out to talk to him about it.

I spoke with like-minded colleagues, and some were disappointed with me for being so fickle. These conversations confirmed to me that I'd done the wrong thing. So, I started to formulate responses for the future and I would practice these in my head:

'I'm sorry for the inconvenience but I don't want to participate in this process.'

If pressed, I decided I would say:

'It conflicts with my values.'

In my current job, I am a Resident Medical Officer in obstetrics. I didn't disclose my objection before I started the rotation for fear of reprisals. I wanted to wait and give myself enough time to show I was a conscientious worker and a good health practitioner.

Recently I had an incident in disclosing my objection. It was a significant day in my life and I made notes about it. I was the resident on the antenatal ward. The midwife told me that there was a 'loss patient'. This is the vernacular used at my hospital to describe a woman who has had an incomplete miscarriage and requires a form of induction of labour to deliver the deceased baby.
But a 'loss patient' also includes a patient with a live baby that has chosen to undergo the same treatment with the same drugs to effect termination. So, in one case, the baby is dead, and in the other the baby is alive.

As an aside, it's very interesting how rhetoric affects the minds of midwives, medical students and doctors. They allow the language of the culture to blur the truth and their own consciences. It is easier for them to consider miscarriage and termination of pregnancy as one concept.

So, I was asked to cannulate the ‘loss patient’ and take her blood. I began to question the midwife about the patient’s history and was told she was 23 weeks pregnant with a child who had spina bifida and she had presented for a termination.

Suddenly, the whole situation changed for me. I looked the midwife straight in the eye. I was genuinely sad about the choice to end the life of a baby that was 23 weeks gestation. At my hospital, we resuscitate ‘wanted’ babies who are delivered any time after 25 weeks and send them to the Neonatal Intensive Care Unit. It was not a matter of piety. I choked on my words:

> ‘I feel compromised… I’m pregnant myself and I don’t want to be involved with ending this pregnancy…’

I used the vernacular. I didn’t say ‘baby’ or ‘killing’. I felt I had already communicated my message to her as I could see it in her face. She put her hand on my shoulder and said:

> ‘That’s OK… this is the worst part of obstetrics.’

I was surprised at her response. I expected judgment based on the culture of the ward. Late term abortions for foetal anomalies occur a few times a week at my hospital, so I expected my objection to be unusual.

The next step was to contact the registrar. For non-emergencies, it is the custom to text the registrar rather than call. On reflection, I should have called, but on this day I sent a text:

> ‘Sorry but I cannot participate in a termination of pregnancy on the ward.’

He replied:

> ‘Can you please put the cannula in and take the blood.’

I replied:

> ‘I don’t want to participate in any way. Sorry.’

I re-wrote the text several times, especially about whether to say ‘sorry’. I never heard back from him regarding the termination. However, I learned that he came to the ward, cannulated the patient and started the termination. A few hours later, the Head of the Obstetrics Department called me to her office. She was furious. She was sitting back in her chair, with her hands behind her head and said:

> ‘Do you know why you’re here? I’ve been told by consultants and registrars that you are judgmental, opinionated, arrogant and disrespectful and that you are refusing to do simple jobs like cannulation and that you think you know better than consultants.

I was really taken by surprise. I had never spoken to her before, or the consultant involved with the care of that patient. In three hours, a lot of conversation had obviously gone on behind my back. I was shocked. She then said:

> ‘One consultant said you should not be an obstetrician. Why would you not cannulate the woman and take her blood?

I said:

> ‘It’s a matter of participation, and for me, being involved in any part of the process is participation.’

She replied:

> ‘Putting in a cannula for termination will not stain your soul! At your level you are simply a service provider… if you refuse to put in a cannula for any patient you are not doing the work you are paid for.’

I said:

> ‘Am I just a robot?’

She said:

> ‘No, later in your career you can form your own patient group to suit your beliefs. But for now, you must work for your consultant and not contravene their decisions for patient care. We don’t do social terminations here. The consultant has counselled this patient for a couple of weeks, and they’ve seen a social worker. It is a sensitive issue and how dare you come in and contravene their choice.’

I was getting emotional. I realised I needed to show her that I was a good person. She was painting me to be the evil person in the room. I had to demonstrate my humility and let myself be emotional in front of her. I told her:

> ‘I have many faults… but I don’t think I am judgmental, opinionated, arrogant or disrespectful. I’ve never had a problem working with my team members and this has all taken me by surprise. I am particularly upset because I was hoping for a career in obstetrics, so being told this is pretty upsetting.’

She made me feel so evil, I had to show her I’m a human being and what she said was very hurtful. I didn’t want to talk back at her or argue my point. I wanted to see if I could improve her opinion of me. I was thinking that those consultants and registrars had taken my small objection and misrepresented me. She assumed I was Catholic, even though I never conceded that I was, and said:

> ‘I’ve known a lot of Catholic obstetricians in my time. They’ve all come to a good balance between their beliefs and good patient care. Dr X now runs a contraception clinic.’

She was trying to enlighten me on my faith. I remained expressionless. Her advice to me was to go home and talk to my family about my beliefs in order to strike a balance. There was a real power play going on. She had at least 40 years’ experience in obstetrics. She reinforced several times that at my level I was a technician and a service provider. Where possible, I honoured her authority and, in response to most of what she said, I did not disagree. To some of what she said, I nodded. I conceded, subtly.

In the end she said:

> ‘I’m sorry for ruining your day... I don’t know you. I just had to say something about it…given multiple consultants have approached me about you…. Personally, I find you delightful.’

She told me to take a break. As it was around 1pm, I had about 4-5 hours left of work… Even after the break, it was very hard to get on with the day.

I went home and talked about it a lot with my husband. I felt some peace because unlike my experience at medical school, my conscientious objection was now out on the table. I experienced sleeplessness. I had flashbacks. It was big news on the ward. Everyone knew and some registrars changed their attitude towards me. The registrar involved in the termination case refused to speak to me again. He was close friends with the senior registrar who rostered the residents, so he made sure we were never rostered on together.

The day following the incident, I went to see the woman who had the termination. I learned that her baby had been born alive and had lived for 60 minutes the previous evening. I was in the room with another registrar. I was extremely affected. The woman said:

> ‘No one told me my baby was going to be born alive!... He looked perfect.’

She had to take the baby in her arms while it gasped for 60 minutes and then took its final breath. She was completely traumatised.

The registrar was unmoved. She got the tissue box for the woman and tapped her on the shoulder, but the whole thing was just bouncing off her. At my hospital there is a protocol for miscarriage that includes getting the baby’s hand and footprints and offering counselling and referral to a social worker. The registrar told her:

> ‘I know it is painful now, but it was the best choice for you… the baby would have suffered… you would have suffered so much…’

The registrar completed the death certificate and recorded the cause of death as a cardiac arrest secondary to premature birth. There was no mention that it was the result of a deliberate termination.

The next time this happens, I want to ask the registrar why termination is not listed as the cause of death. They seem content to be vague and say the baby died of a cardiac arrest, without acknowledging what caused it.

I'm not in a very confident space right now. I'm wounded. I have 4-5 more weeks of work in Obstetrics, and it is most likely that this situation will come up again. I don't feel like I can trust anyone. My Junior Medical Officer Manager is not happy with me because I'm pregnant and this has caused him inconvenience. It would be extremely difficult to discuss this with him. I don't think he would support me. Even if I had disclosed my objection before I started this placement, it would have gone to the Head of Obstetrics.

If something happened now, I would be at breaking point. If the Head of Department was verbally abusive to me again, I would say, 'I'm happy not to work in Obstetrics.' It's not the ideal. I'm very fragile at the moment. I'll try to get through the next few weeks and gather more support and set some personal goals for myself… I'll try to refine my response to termination and contraception and think about being more proactive in the future and identify my values with my supervisor earlier rather than later.

I'm less scared now about what my colleagues think of me, and more deeply upset that these terminations are going on in the ward. It's enough to drive me to despair.

Conscientious Objection to other services

I have no objection to looking after a woman who has had an abortion or to do the discharge paperwork.

I have a conscientious objection to contraception. It is firmly based on the fact that most contraceptives are abortifacient in their mechanism of action, and I would give a patient that scientific explanation. However, it is harder to explain that contraception separates the unitive, from the procreative, purpose of sex. I hope that I would be strong enough to tell a patient this, if it was appropriate.

I have a conscientious objection to permanent sterilisation and euthanasia.

I also have a moderate objection to investigations that lead to choices about termination such as the first trimester nuchal translucency scan. I would not deliberately leave it out when caring for a patient in early pregnancy, but I would characterise it as an option, rather than a necessary investigation as other doctors seem to do. The test has a low positive predictive value, and yet our culture places so much value on it. You are seen as negligent if you do not have this test.

Regarding transgender health issues, I am developing my views on this. It is still a grey area for me. I am aware of how strong the cultural influences are on distorting true biology.

What education if any, have you received about conscientious objection including at university?

None. At medical school we were launched into a culture of being hard working technicians, pleasing our bosses, making sacrifices for our patients and upholding patient autonomy… It was indoctrinated from day one that obstetrics is about self-sacrifice, however not in a good way. To be an obstetrician is to be a technician, or a robot. This one small event I experienced has wounded me. I could not endue this for another decade (in training as an obstetrician).

I want to be a rural GP-obstetrician because it is more family friendly, however unfortunately the provision of medical abortion and contraception is rife in general practice. I have found a pro-life GP-obstetrician who can supervise me for the next two years, so I can have some support.

I recall we had a lecture on abortion given by a gynaecologist from the Royal Hospital for Women. She put up some distorted slides on the historical obstacles to abortion and one was the Catholic Church. A colleague and I composed an email to her, expressing how disappointed we were in how she represented the Church. We put a lot of time into the email. She generated a long response, and her tone was furious. It obviously opened a wound for her. She brought in a lot of propaganda about the Church. We replied asking her to remove the slide for future presentations and my recollection is that whilst she did not remove it, she agreed to change it.

What would you do to change the situation and make it better?

I would like to see a change in the level of the law to properly protect conscientious objection. However, I also see how many abortions take place in NSW even though abortion is still in the Crimes Act. So, I don't have a huge amount of trust that even if there was protection of conscience in the law, I would be able to practice within my legal rights.

I cannot make a complaint about what happened to me. I don't think making a complaint about the Head of Department would stop the problem at my hospital. The ramifications for me would be wide reaching particularly as I need to do an obstetric placement for another year at least in order to qualify as a GP-obstetrician.

As it was, my supervisor ultimately failed me for my term in Obstetrics. The supervisor said that her decision was based on input from multiple consultants and registrars, who described me as 'unreliable' especially when it came to cannulation and blood collection for 'high risk' patients. I believe they are referring to the case of the termination, because honestly, I have strived to perform to the best of my ability in every other clinical situation. Their opinion of me has been completely coloured by my objection to that termination, ultimately leading to my failure of the term.

I think it's unjust, and I feel weak, I feel squashed, and I have never seen a good example of someone complaining about this kind of thing and it turning out well.

I agree with the introduction of a protocol in hospitals that sets out a procedure for employees who have a conscientious objection to a common form of treatment, with it being handled by someone outside the department who understands what conscientious objection is, but there is a strong culture against this in obstetrics. I fear any policy would not be upheld on a day-to-day basis. There is no one in the hospital I feel I could talk to about this without word getting out. It would be miraculous if someone outside obstetrics could handle my request.

Transcript of Interview

Doctor # 27

Interview conducted by ALW, 25 August 2018
Start: 1.00pm
Finish: 2:30pm

Antecedents of Doctor # 27

Doctor # 27 is male, identifies as Roman Catholic, has been a doctor for 29 years, and works as a specialist orthopaedic surgeon in a suburban area of New South Wales.

Consent

Written consent was obtained for the interview by ALW.
The interview guide was varied to take into account the respondent's background and in order to explore issues as they arose.

How would you define conscientious objection?

When you are faced with a dilemma where you have to go against what has been recommended in the workplace, or against logistics, because you see it as being morally wrong. It could be either an act or an omission. In my experience, there is a lot of conscientious objection in medicine. Health is not what the patient wants it is what the patient needs. You don't have to do what the patient wants you to do. There is a difference between surgery that needs to be done and surgery that can be done.

For example, removal of bunions is a cosmetic issue unless there is a functional problem. To go ahead with cosmetic surgery, the patient could end up with an infection, a damaged nerve, or a scar. For me, the surgery needs to be medically necessary otherwise it is just cosmesis.

I liken that type of surgery to cultural genital procedures. They are all completely, medically unnecessary, and not true health issues. There are life or limb threatening interventions, but after that, surgery is cosmetic. Patients can get hostile when you won't agree to do the surgery they want. The conversation can be very uncomfortable, but I won't do surgery that won't give them the best outcome. You are just courting litigation and why get involved?

Jehovah's Witness patients who require surgery are counselled vigorously about the risks of death. For the most part, Jehovah's Witness patients can have their blood re-cycled but some of my colleagues refuse to do surgery on a Jehovah's Witness patient or give them an anaesthetic. As the doctor, you can say that the risk is too great, and you are not prepared to do this. Both the doctor and the patient have to sign on for the treatment and if it is foot or ankle surgery, it is like being married to the patient for eight weeks.

I will tell the patient their diagnosis, tell them their options, and explain that the options have pros and cons, and it is very much their decision, I tell them I enjoy the carpentry, but we are in this together and I try to get the patient take responsibility for the risks. I say to them that they don't need to have anything done unless it is a life-threatening situation and that if they really want the surgery; they have to go to their local doctor and get referred to someone else.

They may get upset about being charged for the consultation, but that's the way it is. Most of the time the patient is very reasonable. If you are uncomfortable, the patient will find someone else. Very rarely will someone stand up and say: 'I have a right to have this surgery.'

The basis of your conscientious objection to abortion

It's a human rights issue, but it's also a scientific issue that life begins at the beginning. So, if you terminate a life in the womb, you are killing someone. It's just that black and white for me. If you try and take another point in time after conception to try and distinguish when life is life, it's a very arbitrary timeline.

Your experience with disclosing your conscientious objection to abortion

As a surgeon, it doesn't happen that often for me with regards to patients. I've rarely had to do surgery on a pregnant woman and I refuse to do elective surgery on a pregnant woman.

So far, no one has had a problem with me refusing to do that. The risks to the baby are small, but for me, they are not worth it.

A lot of my discussion about abortion has been with staff and colleagues where I try to get them to talk about the moral issues associated with medical issues. I can accept that not everyone must agree with me, and I often tell him or her that they have the right to be wrong. I am in a privileged situation where I can speak out and people don't speak out against me too often, although if I speak out in the workplace on something controversial, I could be reported but it has not happened yet.

As a younger doctor, I was busy and didn't get that involved, but I had the same position on abortion. I didn't have the same opportunity to have the same discussions I'm having now. It's very hard to speak out, as the culture is so pro-abortion.

Referral for abortion

For me, you are either involved or you are not involved. Referral for abortion is involvement with abortion. I have Christian friends who don't agree with abortion but are happy to refer patients on for abortion. I try to talk them out of this, and give them other options, but the universities push on them that you are obliged to refer people on. Universities are very in your face and pro-abortion and pro-contraception. Even means of contraception is advertised everywhere.

Some means of contraception are abortifacient. The whole issue is subversively introduced. Young GPs don't know that by prescribing contraception, they have been complicit in abortion.

Conscientious Objection to other services

I have an objection to any peripheral actions associated with the abortion. But I don't object to giving post abortion care.

To actually object to performing a peripheral action would be uncomfortable. If you were merely an intern, you would get absolutely mauled by the nursing staff. In the big teaching hospitals, if you want to stream into specialty training, your referees are non-medical.

So, the NUM might have to give a reference for job prospects, and they can make it very difficult for you and a reason to simply go along with it.

I object to artificial contraception. Knowing basic science helps because if you want to protect that life, you have to start from conception. If you look at the mechanics of how contraception works, it affects the maturation of the foetus and implantation of the foetus in the uterus. The Catholic teaching is the clearest teaching in this regard. Otherwise, you could argue that you should be able to abort a 1-year-old child.

I object to euthanasia, as well as many plastic surgery procedures, and any unnecessary medical interventions.

What education if any, have you received about conscientious objection including at university?

Not that I can remember.

What would you do to change the situation and make it better?

Coming to medicine as a post-graduate has the great benefit of allowing someone to mature in terms of their ability to form opinions and stand by them before they get into medicine.

With abortion, medical students need to be clear about the science, about the time of fertilization, about where they stand, and when they will intervene and why. They have to decide whether they have the right to take a life or if the mother has that right and if so, why. In these areas, doctors are treated as technicians, and it's a big problem. Opinions about abortion are held very strongly, and it is often very uncomfortable for a doctor to exercise their beliefs when the profession has trained them to have a fixed view. There is pressure today by society and in medicine that if you won't provide women with all their options, you will fail as a doctor.

The biggest protection we have is the human right to live. If we don't protect this, then first its foetuses, then it's the over 85's, and then we point the finger at Jews, blacks, or Catholics. If you don't respect people in the little things, you lose the battle. If someone strongly has the strong feeling about what is right, it doesn't mean you as the doctor have to participate. We should have the right to defend ourselves against being forced to do this, and in doing so, defend the wider community. But we just don't have the platform to speak out. There are Christian medical societies, but they are just not taken seriously and the response to them is predictable. I think protection of conscience for doctors should be written into the law. I feel strongly about it.

Transcript of Interview

Doctor # 28

Interview conducted by ALW, 13 August 2018
Start: 4.30pm
Finish: 5.45pm

Antecedents of Doctor # 28

Doctor # 28 is male, identifies as a Catholic, has been a doctor for 2 years and is a resident working in a metropolitan hospital in NSW.

Consent

Written consent was obtained for the interview by ALW.
The interview guide was varied to take into account the respondent's background and in order to explore issues as they arose.

How would you define conscientious objection?

Having a fixed belief about a particular issue that I don't feel comfortable going ahead with, or being involved with, despite being considered lawful or regarded as normal in secular society.

The basis of your conscientious objection to abortion

Plainly speaking, it is murder of a human child. Being a human, they have rights, such as the right to life. No one has the right to take that right away, especially a doctor. My faith plays a part in my objection, but it is more scientific for me. The religious influence is the belief that life is sacred and has a spiritual element.

Your experience with disclosing your conscientious objection to abortion

In my third year at medical student, I was put into a placement for a women's health clinic in Victoria. The clinic was one where women could seek a termination of pregnancy for any particular reason.

I was not prepared for this situation, as I had no idea what happened at the clinic. I didn't have the opportunity to object to it before I started there. As it turned out, on the day I went, I was an observer in the room. The doctor was consulting with a patient who was seeking an abortion. The doctor discussed with the patient what would happen, asked the patients about any concerns she had, and then offered her time to ask any questions and discuss it further. I remember the patient telling the doctor how she and her boyfriend could not afford to have a baby. The doctor did not refer the woman for crisis counselling or give her information about social and financial support that might help her to continue the pregnancy.

I didn't feel comfortable being there and I felt powerless in the situation to say anything. But I know it didn't feel right. In fact, I felt very emotional and after the patient left, I spoke with the doctor.

I told the doctor that I didn't feel comfortable and that I didn't think it was right because the reasons the patient wanted an abortion were purely social and financial. I asked the doctor what percentage of patients where there to get abortions for social and financial reasons, and I started to get tears in my eyes. I was very surprised by my reaction, but it was the first time I had had a close up experience with abortion. I had never prayed outside abortion clinics before. I felt very hopeless… Like I couldn't do anything… All I could think of at the time, is that this poor child will no longer be there in the afternoon…

I also worried about whether I had committed a sin of omission. I wondered whether I should have done something to change the patient's mind. I went to confession about that. Since the incident I resolved in my mind that if I did intervene as a medical student into the doctor/patient relationship, I could be questioned before the medical school board and it might have put in jeopardy my fitness for graduation.

I was supposed to do around four sessions at this clinic but when I left, I did not feel like going back. Before I went to attend again, I was called in to the medical school to discuss what happened. As it turned out, the doctor at the clinic contacted the medical school, and I got the impression the school was worried about my mental health. I felt angry with this. It felt like an attack, but I was a bit more prepared for this discussion than I was at the clinic, although I was still not sure what I was going to say.

I spoke with someone quite senior at the medical school and told them that I did not want to attend more sessions at the clinic. I told them that I felt abortion was murder, but I remember that I did not use this language when I was talking to the doctor at the clinic. I was asked to explain myself, when I felt like I shouldn't have to. The reaction of the senior person at the medical school was quite interesting. They were pushing me for answers. They seemed genuinely taken aback that I would have this position, and actually remarked that everyone else participates in it. I was made to feel like I was the only person who had ever had this position on abortion.

I had the impression they felt I might need psychological counselling and I couldn't help but see the irony. I was not the one needing the counselling, but the woman who sought the abortion at the clinic did. Eventually, they said they were happy to accommodate my objection and I was relieved of going back again.

In my current job, I don't need to disclose my objection, because it shouldn't come up in the wards that I work on, being intensive care, paediatrics, and emergency. It's a tough decision about whether to say anything or not. You worry about discrimination.

If a request for abortion did arise, I would try and counsel the patient as much as I could. I would try and offer that patient support and try and be more informed about the long-term statistics about outcomes for abortion because if I don't tell them, who will? That experience at the clinic made me realise how important it is to be able to talk to patients about abortion and offer support and information.

I have spoken with other doctors and it's been suggested that a good line to use is:

> 'That's not part of my practice…. I don't know how to give proper informed consent."

However, for me, I feel it is important to express to the patient that I have an objection. It might be something that makes them rethink their decision, but it's also important for me personally, to have expressed my objection and not hidden it.

Referral for abortion and performing peripheral acts

I feel the Victorian law is unnecessary, and unnecessarily burdens the people with the conscientious objection, because the majority of women can seek out another doctor because you don't need a referral. The further we go with euthanasia, the more I feel referral will come in at some stage, but it's very odd and I'm not sure how it would work. Euthanasia is the other end of the spectrum. They reason they say referral for abortion is needed is because it is an emergency for psychological reasons. That's not really the case with euthanasia. I would feel worse about referring for abortion than euthanasia as you are taking away the life of a child. It's not the child's choice, whereas with euthanasia it is seen as the patient's choice.

I would not perform any acts that are peripheral to abortion such as putting in a cannula that I knew would be used for drugs to effect abortion. I have no objection to performing any services for a patient in the post abortion period. However, I am not sure how I feel about performing documentation for a patient admitted for an abortion. I would have to think about that further.

Conscientious Objection to other services

I object to contraception, which fits with my objection to abortion. Medical contraception, and contraception by any of the other means, such as the Mirena IUD, are abortifacient and studies have shown that they can kill the developing embryo. Again, my objection to contraception comes from both my scientific belief, and my religious belief, that life begins at conception.

I would not give a child who identifies as being transgender cross sex hormones or refer them for surgery. I would say to a parent that children are at a very pliable and malleable time in their life psychologically speaking and are still working out what they feel. So, their inclinations or orientations do not mean we must comply with those fleeting feelings.

I would try and rely on what the experts have said. The head of the American College of Paediatricians has come out with statements that they do not support treatment for gender

transitioning, and that what these children really need is psychological and alternative therapies that will address the issue. The main factor in this condition is a history of abuse, either physically or psychologically. The child is scared and confused from that. I think there always needs to be more research done.

Whilst my faith comes into that objection, it's really based on natural law and the idea that we are made male and female, and the general order of the universe is orientated that way, biologically speaking, for the persistence of our species. More senior people should explain this so that society can see they are talking sense. However, gender ideology is gaining such momentum. I wouldn't be afraid to voice those opinions, in a charitable way and I would certainly still treat that patient, but I feel that it is easier to speak up against abortion. This is because I think abortion is a graver injustice than treatment for transgender patients and my views are more developed in regards to abortion. The transgender issue takes more finesse, and the outcomes are not as clear-cut, with not as much experience in practice. Also, there is a loud minority just waiting to shoot anyone down who speaks out about it.

I think doctors really fear that if they speak up about abortion their practice would be affected and they would have to respond to questions from the AMA and might even be sanctioned. This would lead to a lot of bad publicity. These are real fears. You need a number of people to support someone brave enough to do these things, and to turn out for marches and political activities.

For someone very expert and senior, and in the later stages of their career, I can understand them lacking the courage or time to do something and to make a difference. They probably just can't be bothered to risk all they have worked hard for. It's pretty sad. A senior doctor I know who spoke out about abortion was ruined and attacked. It's not encouraging.

What education if any, have you received about conscientious objection including at university?

We were given nothing. No one ever raised it, and as you are so busy with all your courses, it's not something you think of asking about.

What would you do to change the situation and make it better?

It's good to hold events where we can learn about ethics and the law. There is a new national Catholic Doctor's Association that holds events. The point is to try and have a voice politically, and in the media, and to try and protect each other. I know doctors who share my beliefs and we talk amongst ourselves to get awareness and we do things like the 'March for Life' every year. So, there is a sense of awareness and support for each other, but events are infrequent, such as two or three a year at most. The rest of the time you are just left to do your job well.

There are differences in how we might deliver a response about abortion because there are nuances in people's beliefs on abortion, just as there are with contraception amongst Christians. But we should try and work towards having a similar standpoint as this would help. However, doctors are so busy. Whilst all this type of activity is integral to practicing morally, in reality it's probably not a priority to doctors unless you are working as an obstetrician or a palliative care doctor, where you have to counter this issue of referral or participation.

If there is going to be a law about a service such as abortion, then there also needs to be a clause about conscientious objection that offer full protection.

Transcript of Interview

Doctor # 29

Interview conducted by ALW, 14 September 2018
Start: 1.00pm
Finish: 2:00pm

Antecedents of Doctor # 29

Doctor # 29 is male, identifies as a Catholic, has been a doctor for 21 years, and has worked as a GP for 18 years in a suburban part of NSW.

Consent

Written consent was obtained for the interview by ALW.
The interview guide was varied to take into account the respondent's background and in order to explore issues as they arose.

How would you define conscientious objection?

The capacity to avoid participating in anything that I feel is immoral.

The basis of your conscientious objection to abortion

Number one, because it is teaching of the Catholic Church, and number two, because I object to murder.

Your experience with disclosing your conscientious objection to abortion

I have had to disclose my objection to patients maybe three or four times in my career when a patient has requested an abortion. I just sit and have a long conversation with them and ask them questions about what led them to make this request, how else I might help, if I can get someone to speak with them in more detail.

After I have told patients that I object to abortion, none were ever upset or angry with me. None of them changed their mind, and they went somewhere else.

If a law came in that would not let a GP with a conscientious objection to abortion consult with a patient considering abortion, this would be very immoral. This is because you need to understand what they are asking for, and it is part of the whole consent process.

I find it difficult to justify why a GP would need to put up a sign about having a conscientious objection, because why is it just restricted to this? What other things must I put up a sign for? I am happy to keep my practice open and will speak with any patient.

I am a strong man and people don't usually mess around when you take a strong stance, unless a lot of people find out about it. It's when you are wishy-washy that you get problems. I had one significant issue in my career when I did a diploma of obstetrics and gynaecology. One of the gynaecologists had an abortion list and asked me to be involved with the list and do one. I told him no and he kept pushing me to do it, but I refused. When he saw that there was no way I would do it, he accepted it.

Referral for abortion and performing peripheral acts

I would not refer anyone for abortion, but if they made it the law, I would not follow it. I would continue to speak with the patient in the same way I do so now and try and find out what has left her in this position and try and help her. There are a couple of places that I know like Sarah's Place and Diamond Pregnancy Counselling that are very good and I have met the people at functions and feel comfortable telling patients about their services.

I understand what other doctors might say about how they personally are opposed to abortion, but they do not want to disrespect the patient or impose their beliefs on them. But our conscience needs to be well formed and this is what happened to me with regard to contraception. I object to participating in an immoral action, in any capacity. For abortion that would extend to doing any paperwork associated with procuring the abortion.

If I was in a hospital setting and I was asked to put in an intravenous line for a woman who was going to have an abortion for any reason, I would probably do it, but only because she probably needs the line to save her life. So that would be an exception.

Conscientious Objection to other services

I have an objection to contraception but when I first started out, I used to prescribe it. How I used to think about it was that I would differentiate who I was, and my ethical stances versus my patients.

This was until I sat and had a chat with a friend of mine who was a priest and a doctor and he said if something is wrong and it is wrong because it is sinful, then it is wrong for all, not just for me. If an action is sinful, I cannot excuse the stance of another person for that sin. So participating in it is always wrong, no matter what the other person thinks or feels.

I had a number of women I prescribed the pill for at that time. So when I changed my position, I had to do this in a heart filled way, not a cold way. What I decided to do, and it was difficult for me, is that for every woman who came in who I had previously written a prescription for, I would write it one more time, because I felt it was wrong to dismiss her, and that it was a wrong that had repeated many times. I would write it and explain to her my stance, and this would be the final time I could do this. All were very accepting excepting bar one, but I was disappointed in that they accepted without questioning. I hoped a number of them would ask further questions, but they didn't.

One was very aggressive towards me and we had several conversations. I think that to be told that what she did was immoral was unacceptable for her and would go against the teachings of her church and it becomes an intrinsic identity crisis and a crisis of faith. Her husband was present at these discussions, and he brought me a book on medical ethics by an Anglican doctor that justified contraception. When he returned, I asked him if I could give me a copy of something and he said yes. I gave him a copy of *humane vitae* and he never discussed it with me again.

I keep a copy of *humane vitae* near to me on my desk in case anyone needs it. I call it my emergency medication. I have had patients cease using contraception after chatting with me. It could be that if they are married, they take up natural family planning. I have also had a couple of single Catholic woman request the pill for contraception from me but after chatting, decided to stop having intercourse.

I work in a GP practice with other GPs. My colleagues know my position and if I get a new patient who doesn't know my stance on abortion or contraception, they may see another doctor in the practice or they may go to another practice. No one has been angry or upset with me, including my colleagues.

I object to euthanasia of course and hand in hand with my objection to contraception is my objection to vasectomy. If a patient comes to see me for a referral for a vasectomy, I chat with them and tell them my position. They are usually very bewildered, particularly if they already know me. They think a vasectomy is like Panadol for a headache but again, they go away, and no one has been angry.

For transgender health, I don't have a firm stance and I don't think there is a firm moral stance. I do think a psychiatrist needs to be involved and I think I would tell the patient that I could not be involved in any detail. For me, this issue is more of a scientific/medical issue rather than a faith one, and I would rely upon the studies about whether it has helped people.

What education if any, have you received about conscientious objection including at university?

At university they were very poor about this thing. Since then, the only time I have heard about this is if I go to talks given by Catholic organisations. I can't think of any put talks put on by any professional medical organization.

What would you do to change the situation and make it better?

The only true solution is to return to our understanding of who we are, why we are on this planet, and our role on this planet, which is to love God. How you do that in a society that has moved so far away from God is difficult to answer.

For young doctors, they need to be in an environment of good formation. In Western culture we have not suffered for our faith, except in circumstances such as the Reformation or the French Revolution and that's why African, Asian and Middle Eastern Catholics are so strong in their faith, and it's the suffering that has gotten them there.

I have been involved with the group Solidarity to a minor extent, and my door is ajar for more opportunities to get involved. I get involved with writing submissions on Bills to do with abortion and euthanasia, and on doctor's forums.

What I used to do was make my name very open, and my contact details, and not hide my identity but I was getting phone calls from media, and I could see it as part of an intimidation process. You need to do this with sensibility, and you can be too passionate. It can put you into a provocative position that leads you to a place where you have no power.

We don't have enough great leaders in all of society. The St Luke's Guild should be prominent. But it cannot be just talk. They should recruit, meet regularly, and be a very strong voice for anything that came up if it was an issue.

When I talk about abortion with colleagues, I'm respectful but I do say that it is 'murder'. I think your language has to reflect your mind. The great lesson from Lenin and the Communist Revolution is if you want the people to accept the unacceptable, you have to get them to speak the language you want them to speak. So, you have to say what's on your mind.

With younger doctors, they come from a schooling system in which philosophy is not taught directly or indirectly. We live in a society where truth is made to be relative so if that's the case, then you cannot take a firm stance because your stance is not someone else's and what they say has to be respected and that is rubbish. A medical student at university is typically taught by the worst of the worst.

Transcript of Interview

Doctor # 30

Interview conducted by ALW, 26 September 2018
Start: 1100am
Finish: 1215pm

Antecedents of Doctor # 30

Doctor # 30 is male, identifies as a Catholic, has been a doctor for 18 months years, and is a Resident medical officer in a tertiary hospital in Victoria.

Consent

Written consent was obtained for the interview by ALW.
The interview guide was varied to take into account the respondent's background and in order to explore issues as they arose.

How would you define conscientious objection?

When one makes a decision to act in accordance with your conscience and where it seems to fly in the face of what others expect of you.

Today in medicine, a lot of patients have a consumerist mentality, where doctors are just a gateway for services and medication to be provided safely. They don't see them as someone who has a vocation and is concerned for the health of individuals.

It flies in the face of what medicine has been about for centuries. The philosophy of medicine has changed from being concerned with the patient and achieving the best outcomes, to a consumerist mentality. I think this is sad, and it corporatizes medicine and destroys something special about it. It's also really dangerous to not allow doctors to practice medicine in line with their conscience. That worries me a lot. I know from experience, that my colleagues have gotten angry and vocal about this point.

It happens commonly when someone wants the contraceptive pill, or has an expectation you will provide a referral for abortion without counselling, and it happens less commonly with requests for euthanasia. They think that if you sign up to be a doctor, it is part of your profession to provide those services on request. When you say to a doctor that if you are not willing to prescribe contraceptives, you should not be a doctor in the first place, it makes someone who objects to prescribing contraceptives feel very marginalised.

The basis of your conscientious objection to abortion

I believe life begins at conception. I became a doctor to increase the health and wellbeing of the person including the person in the womb. It goes against that oath we make as doctors to 'first do no harm'. It's often quoted but not always lived out. I try to think of both issues.

My faith quite clearly states in its teaching that life begins at conception, so my views are in line with my faith. But even before I read scientific literature and philosophy, I was pro-life. I think most people are pro-life in mentality. I'm in this profession and I know that faith does not necessarily stand up by itself in the public square so I feel I can stand on both faith and reason on this topic [of abortion].

I focus on the science when talking with colleagues. I don't think I have ever used my faith as an argument at all. I think it's partly because I am already fairly open about my beliefs so instinctively, people think that when I hold a position on controversial moral dilemmas, my faith is where I are starting from, so I like to argue from a scientific and philosophical side.

I feel a little uncomfortable in the workplace and amongst colleagues talking about my faith. I don't mind using faith-based arguments if they are effective, but I just think they are rarely effective. Generally, medicine is a secular profession. The culture is that we don't really talk about religion. I don't work with many Catholics, and the Christians I know don't talk about their faith at work either. There is no open hostility to it in everyday discussion, but there's an undertone that if you take a position on a controversial service because of your belief, you must be willing to sacrifice that belief to work in this industry.

At medical school, I remember discussing the case of a pharmacist who did not want to prescribe contraceptives and I said I thought this was reasonable as they were running their own business and wanted to run it in accordance with their conscience. One of my classmates said: 'If you won't prescribe contraceptives, you shouldn't practice that profession.' The tutor was actually quite reasonable and tried to tone down the discussion. However, I've been in tutorials discussing abortion where it has been everyone in the class in favour of it except me, and the tutor would ask me at the end of class, in a condescending way, 'Are you ok?'

In O&G, we had anti-Catholic lectures with rants from the lecturers about what the Church was doing wrong in Africa and it didn't feel safe for me to say I had an objection. Even sitting in on consultations about abortion, or with referrals, many clinicians do not see these as moral issues. They say that if you are not involved with the procedure or the patient what's the problem? Are you being particularly sensitive?

I've had doctors make jokes about my faith, and for being part of a minority when controversial topics come up. For example, one of my colleagues noticed me saying grace before meals and made a comment about it calling me 'a good Catholic boy.' None of what I have personally experienced has been too harmful but people with my views choose silence because they are afraid of the consequences. It's not because the overwhelming majority of doctors are anti-Christian, but those who are, really are, and are vocal about it, and angry with people who hold my views.

The vibe is that it just makes the work so much harder when this guy won't do abortions or refer for abortions or prescribe contraception. So, whilst the majority of people might be tolerant of these views to a point, they are uncomfortable about them nonetheless, and this makes it uncomfortable for people like me to voice our views.

Joining medicine is like joining a club. They pick you on your personality as well as your skills. It is a very social profession. Even in surgical programs, the approach I have had from lots of consultants and registrars is that when they are picking someone to join them, they say: 'Who do I want to spend the next 40-50 years working with?' and that influences their decision when they interview you. Everyone is perfect on paper and what discriminates you on the day is what kind of person you are.

People don't push these issues much as they don't want to be known as 'the weird Catholic guy' that makes the job just that little bit harder because he won't do those things. When I have spoken out, I haven't seen any practical benefits yet, but it at least allows these people to see that the majority view is not held unanimously.

Your experience with disclosing your conscientious objection to abortion

I have had situations where I wished I had raised my views, where I failed to raise them, and it landed me in some trouble. When I was a medical student in O&G I was in a gynaecological clinic and assumed I would be seeing the standard gynaecology stuff and then a couple came in requesting a termination. I was sitting in the room with the consultant, and I didn't know what to do. When the consultant left the room, I was with the couple for 20-30 seconds. I could have had a discussion with them, and I didn't because I was petrified of what the consultant would do to me. I also didn't know how much time I had with them before he returned. I was unprepared and that was tough. When I think back, I could have said:

'Have you thought about your other options, do you want to talk about this more?'

The couple had been together a long time and they were a little bit young and decided it was not convenient for them. An alternative view might have changed their minds. Also speaking up would have done something for me. At least I would have been trying to speak up for the unborn child. When I went home, I was very distraught.

I didn't speak with the consultant about it, and as I was at the end of my rotation, I just left it, but I have thought about it often. You think you are prepared, but in the moment you are not. The lesson I learned from that experience was to be mentally prepared for when something like this happens so I can act. I tell younger doctors now that they have to prepare for it. They need to be trained in a way nowadays on how to react. At the time, I didn't know what to do.

I've been in the ED when a woman has come in with crisis pregnancy and the consultant has said to them, 'You know where to go for an abortion'. Fortunately, the consultant did not ask me to make the referral.

I haven't forewarned my bosses of my views. If I had, it would have been helpful, but most days in the ED there is a different boss every day and it is not practical to tell them: 'Hi, I'm a Catholic, can you adhere to my views?' Also, it depends on the roster.

Having a policy that protected conscientious objection would be a great idea, but you would need a culture in the department where if a doctor had a conscientious objection, they would feel safe to voice it. The whole department would need to be aware and agree to respect that. However getting that type of policy through would be difficult as in Victoria the law does not enshrine that position. Hospital culture reflects the law and there would need to be quite a bit of pressure to get that type of policy off the ground.

Referral for abortion and performing peripheral acts

I think it would be very hard to force someone to do an actual abortion. It would only be people who are so far gone that would force you to perform that act. Most people have this internal disquiet about it performing abortion, but the remoteness of referring is fine for them. They see the difference between referral and performing the act. It's like euthanasia. Many doctors might think the service should be provided, but don't think that all doctors should have to perform it.

I have never done a referral but it is unlikely that I will be confronted with this situation because of the surgical area I want to specialize in. But if I were asked to insert an intravenous line for a patient before they underwent an abortion someone else was performing, I would feel involved that I assented to the abortion in some small way. I would have to say no. It is a big deal for me, and it is important to voice your moral concerns over it. I would say to the person requesting that I insert the line or whatever the request was, that I don't want to be involved in any way.

With regards to documentation such as writing up pre-admission paperwork, I would feel some culpability. I think I would be OK with writing a discharge summary or discharge script, but I would have to think this some more.

Conscientious Objection to other services

I object to providing contraceptives, euthanasia, and abortion.

I would not assist in sex change surgery although it's unlikely to ever come up for me given what I want to do. If it did, I can make arguments from both my faith and the literature, especially with the high rates of suicide following surgery. I don't think psychological therapy is given enough credit before we jump to surgery. Even though there is ambiguity in the literature about this, that's the point, there is not enough evidence that it works and that speaks volumes with doctors. You can make a good argument that surgery is very negligent and we need to be cautious.

What education if any, have you received about conscientious objection including at university?

We had ethics classes in second year medicine, but it was about trying to form an ethical basis to practice medicine, not about voicing concerns on these topics. It was more about benign topics such as about confidentiality. When it came to issues likely to affect Christians, like abortion, it was seen as something that has already been decided; an unfortunate necessity and if you don't want to do it, just refer on. Euthanasia, however, was something we did discuss more than abortion.

What would you do to change the situation and make it better?

Having a policy in place where doctors can candidly voice their conscientious objection to certain practices would be helpful if it impacted on the culture in the profession. Medical education should focus on respecting conscientious objection, but for people in charge of hospitals and medical education, the vibe is that they are interested in *not* allowing these things to happen. They chip away at people's objections, such as by making you refer in order to orchestrate a certain outcome.

A lot of people have been indoctrinated into this position at medical school and this has created a culture that has been in place for a number of years. If we started at medical school with the idea that people should be able to voice their conscientious objection, and that it is reasonable for a person to not refer for an abortion, we could change the culture.

There are a lot of cultural Marxists at medical school. At Melbourne University, they fly in speakers like Dan Savage, and people who talk on transgender issues, and doctors against climate change, and all these political issues that really have nothing to do with the scope of medicine. Medicine is becoming increasing politicized in medical schools and there are more radical young doctors coming out. There is this idea that as a doctor, you have standing to wield social change and you should use your position to do that. The left is doing better at this than the right.

It would be great to have something more formal at the universities where we are taught. A lot of us had to find fringe societies like the Catholic Doctors Association, but it is a very small organization that has only recently been resurrected. Before that, you really had nothing. There are prolife groups out there, but not for health practitioners. We need practical lectures on how to deal with these issues in the workplace and we need an official group at the university where people share common beliefs on this topic, so people did not feel alone.

A friend of mine and I tried to start a Melbourne chapter of the group called 'Solidarity' which is for health professionals, but it was difficult to get off the ground. Any group that serves this need to educate and support health professionals speak up for conscientious objection needs to be more formalized and have a proper identity and mission. Our group ended up being about educational workshops. Whilst this is good, it really needs to include mentoring from doctors in the field who have lived through this stuff and can share these prolife beliefs. We need to network and get Melbourne talking to Sydney, so we can get other universities to be involved. Something like this needs a critical mass.

Transcript of Interview

Doctor # 31

Interview conducted by ALW, 12 October 2018
Start: 11:00 am
Finish: 1:00 pm

Antecedents of Doctor # 31

Doctor # 31 is male, identifies as a Catholic, has been a doctor for 26 years, and works as an anaesthetist in both private and public hospitals in Victoria.

Consent

Written consent was obtained for the interview by ALW.
The interview guide was varied to take into account the respondent's background and in order to explore issues as they arose.

How would you define conscientious objection?

It's the ability to act in accordance with your well-established moral view of reality, your profession, your life, and your identity. It's where you are true to yourself at the deepest level.

However, in medicine, a conscientious objection must be part of a larger framework that goes beyond the individual, and links into universal principles, or at least to a larger tradition that can be articulated using reason, such as the Hippocratic Oath or the Judeo-Christian tradition. It would have to be based on consistent and comprehensive principles that fit in with what we know about the human person, their nature, purpose and meaning, what is good for a human being and what health is, or is linked to time honoured ideas and philosophies. It must cohere in this way. If you break that and follow the logic of going against those principles, it has dire and injurious consequences to what it is to be a human being and to live in society.

It's not just a feeling, although feelings matter. One's revulsion about an act coheres with the rational for a reason. It's more than just a personal opinion, emotion or pure reason. It has to have practical implications and be larger than the individual. Conscience has to be well formed and not arbitrary and rely upon others and something greater than itself. Catholics are fortunate in this way because we have the Church. I know some Protestants who don't want to be Catholic, but are happy that the Catholic Church is there to reassure them of their beliefs.

The basis of your conscientious objection to abortion

It's a fundamental injustice for an individual or society to take the life of an individual without engaging that person's perspective.

With abortion, there's a battle between the vulnerable and the more vulnerable. The mother, who is vulnerable, is often forced into a position where she chooses against a more vulnerable individual. It's an arrangement that's tragic, and inherently harmful to the very notion of relationships and how we are supposed to care for the more vulnerable. The focus is supposed to be on the less vulnerable in our society, and abortion goes against concepts of motherhood, which looks out for the other who is weaker and more vulnerable. That relationship informs society, and it is very perilous.

I can understand that the most vulnerable is unseen and is an abstract thought, and therefore not part of the equation. It's sort of an intellectual failing talking about the 'potential human', a failure of comprehending the nature of the act and what they are actually doing. It puts the mother in an untenable position, and it changes her against her will. She carries the burden, and everyone else coerces and pressures her, and she has to live with the consequences, as does her family. It's an inversion of a proper loving relationship and how we are meant to engage with each other.

When speaking with colleagues about abortion, my faith and reason always come into it because the scientific position is still inherently about faith. Everyone has their beliefs, whether they are aware of them or not, and whether they can articulate them or not. There is not a hard and fast separation between science and faith, although there are different approaches. It doesn't make sense to separate out the scientific as it ultimately rests on something more philosophical.

But when speaking with someone who has a scientific view and is unaware that their position still rests on philosophical grounds, you can only go along a certain number of steps of reason.

You shouldn't be afraid to say 'I believe...' as everyone else has their belief system, even if they are unaware of it. Most people have an idea of the good even if its means are not something I agree with. There is a fundamental notion that every human being is of equal worth, and we all agree, at least on some level, that that is a reasonable position, and we understand what it leads to when we don't respect that.

I haven't experienced push back from colleagues when I have discussed ethical issues in medicine in this way. I tend to do it from the 30,000 feet view, where I point out that there are various options and then I show them the problems with these options. It's not the place for me to explain the basis of my belief, my conversion or my way of seeing things. You don't need to go into that. How we arrive at our conclusions can be quite mysterious, and not through a scientific, logical way. It could be a mixture of our family upbringing, our experiences etc. You just cannot walk someone through this and necessarily lead them to your conclusion.

Your experience with disclosing your conscientious objection to abortion

Years ago, when I was doing my anaesthetic training, I was initially accepted into a Catholic Hospital but was then was told I was going to a public hospital. I contacted the training program straight away and I told them I did not want to go to the public hospital because I did not want to be involved in abortions. Their response was to tell me that the registrars usually did the abortion list, but I was very clear and definite with them that I wouldn't be doing that.

So, I knocked the problem back to the training program directors. I didn't experience any reprisals. I saw it as an administrative nuisance for them, but it wasn't something I could change, so I didn't dwell on it too much. I also assumed that I would get some respect for it. I know that some of the registrars at the public hospital felt a bit of respect for me, and acknowledged that I had benefitted from my stand, because they didn't like doing abortion themselves.

If I had to do that today, instead of years ago, I would be more aware of the impact it would have on me as well as others. I would tell young doctors not to leave it until the last minute and to declare their conscientious objection early, and to be conscious of the impact that exercising your objection has on others when they cannot prepare for it in advance. They should not declare their conscientious objection over the phone, but in writing after someone has checked it. I would tell them not to pick a fight, and to be civil and polite in articulating your position and act in a way that is consistent with your conscience, without going into the fray unnecessarily. There's a good way of going about this and when done well, most people will respect that. One should not expect push back, although it might happen. You need to know where that line is that you won't cross, and it needs to be well formed from an intellectual point of view.

For an anaesthetist, you don't have primary responsibility for a particular patient or a theatre list, so you can decline to do the anaesthetics for a patient. At another hospital, I told them I wouldn't be involved with abortions. Their response was that it was not unusual for them to experience difficulty in finding anaesthetists prepared to assist them with abortion and as a result, many abortions didn't go ahead.

In abortion clinics, you don't have to be an anaesthetist to do anaesthetics. No one wants to shine a light on what goes on there. However, for the same type of procedure in a day surgery clinic, like a dilatation and curettage, the clinic must meet all the requirements of the College regarding the staff's level of training, and their experience in airway management and use of defibrillators. They have to make sure they have certain equipment, drugs and recovery set up available before they can do those procedures because when things go wrong it usually involves anaesthetics. A lot of effort has been placed on pushing medical abortion at home with pills, where they can cover it in a veil. We don't know what goes on in these practices.

I only do obstetrics anaesthetics at Catholic hospitals. Occasionally there are problems with managing the list. When I work in private hospitals, I do not offer to do obstetrics and gynaecology cases. I was doing an emergency list once at a Catholic hospital, with a woman with chorioamnionitis, who was 18-weeks pregnant. Usually, this would be planned surgery, and talked about by the doctors the day beforehand. Here, there had been no foetal death in utero, so I went to have a chat to the patient to see if this was a genuine emergency.

She had a complex history, and viability of the foetus when there is chorioamnionitis is a controversial area. There is evidence that the baby can survive this, so I raised a lot of issues with the staff, such as what they going to do with the baby after it was born and whether there was going to be a paediatrician present etc. However, while there were lots of things they had not done, I could not say that it was imprudent to go down this path of an emergency caesarean, and the patient was fine with the baby not surviving. So ultimately, I told them they had to get another anaesthetist.

In my work now, people know that I won't just go along with things like this. I am a bit out of the group, but I feel confident in my position, and I feel theirs is quite inadequate, so at the end of the day, I don't have a lot of respect for them. I don't want or need to impress them. I don't spend a lot of time in the hierarchical structure or need to work my way up. I don't think I would be able to, even in a Catholic hospital.

When the abortion law reform was debated 10 years ago, the Archbishop said he would close all the Catholic hospitals, and this was effective. The political threat that Catholic hospitals had to perform emergency abortions was not based on any law. So, I know that under the threat of closing hospitals, they will not push the agenda.

Referral for abortion

It's the forced participation in abortion. I won't do it. If you take that analogy and apply it to something else, like with euthanasia, you wouldn't do it. Ringing up a doctor to try and see if they will do this would make you an accessory. You are not exempt from the moral culpability.

But a lot of it comes down to the definition of what referral is. A referral is, in a medical sense, a particular thing that implies the continuation of the doctor's involvement with that person. The College of GPs has very specific requirements for a referral. It is not the case of 'I can't help you, go see someone else.' That's not a referral. Even your accreditation of your GP practice hinges on proof of the referral letter and the means by which you do referrals.

The legislations say you have to "refer to a willing provider who does not have a conscientious objection to abortion". How would I know this? I don't have that discussion with anyone and

I would have to get more involved to know this. Ideally there should be a website that the government sets up to find out who does it, but they argue that they don't do this because the law requires conscientious objectors to perform emergency abortions.

Performing peripheral acts

I would not insert a cannula into a patient that is needed for an abortion procedure. I don't wish to participate in the process of abortion, including finding another person to insert the cannula. Being a medical person, and an anaesthetist has implications. If I did this, then I am participating in the abortion by having some level of co-operation in it, and a junior doctor might be scandalized and think I am ok with it. Your statement and action have to be consistent. But at what point is it too remote?

I think a resident doing paperwork for an abortion is still being part of the process. Writing up drug charts and the after care of a woman who has undergone abortion is probably OK, as you are managing the sequelae of what has already happened.

Conscientious Objection to other services

I am conscious of the difference between sterilization and contraception, and abortion and that the former are not about life or death, and that they are not moral absolutes.

I object to sterilisation and do not do the anaesthetics for it. For insertion of an IUD like the Mirena IUD, which can be used for other purposes, I look at the age group of the patient on the operating list. If a 19-year-old is having a Mirena inserted, I clarify the reason for this and I might decline to do the anaesthetics if it is for contraception.

If I was not aware that a patient was having a vasectomy, and I know that declining to be involved has a big impact on the patient and the surgeon, I will explain my objection to them and know that I am not going to work with them again. However, if the person has booked a holiday and has to come back for the surgery, as there is no other anaesthetist to fill in at short notice, and the impact is significant, I will weigh all that up and decide whether I will do that list. I feel that I am somewhat removed.

So, I make the distinction between formal and material co-operation in evil. I organize my practice to avoid this. I choose who I work with, and which hospitals I work at. If I don't know who is doing the list, I will look at the area of practice, so if it is orthopaedics there is not going to be a conflict, but there might be with a surgical, urological, or gynaecological list. That is the reality and the cost of the position I have taken.

Today, a plastics and paediatrics operating list can involve transgender surgery. I object to being involved with this because I don't think it is proper healthcare. It's like doing liposuction for an anorexic. I can approach it diplomatically and ask questions rather than stating that I have an objection. You can push the implications of that decision to undergo surgery. People often get uncomfortable with the logical consequences of where that decision leads. The contradictions are everywhere. I certainly don't launch into it and talk about transgender surgery being a sin.

What education if any, have you received about conscientious objection including at university?

None.

What would you do to change the situation and make it better?

The point of the *Abortion Law Reform Act* was to make prolife doctors abandon the field. In a sense it's a toothless, but it could still operate to cause harm, we just don't know. It has created a climate of fear, a fear of the unknown and the possibilities. The legislation is so vague and this made doctors scared. How do we know whether someone has a conscientious objection to abortion? What is an 'emergency abortion'? Who can make a complaint about a doctor? It could be a witch-hunt. I know doctors who stopped practicing after the Act came in, or who stopped seeing certain female patients for a while or went interstate.

The Medical Board suggested we put up a sign to say that we did not want to be involved. So if someone insisted on a referral, they could be seen as vexatious. We made a proposal that the government make lists of people willing to be involved but they said rejected that because there is a requirement in the law for all doctors to do an emergency abortion regardless of a conscientious objection.

The only good thing about the legislation is that the relevant section does not apply to medical students, so if it were repealed, medical students would lose that protection. Because there have not been any complaints since the legislation came in, people have learned how to manage it through their experience, and not through any direction or guidance from the AMA. People have found their own way of practicing in line with their conscience.

The consensus within the medical sphere, that there are ethical principles apart from what the state gives you, has now largely gone. The law has broken into it. The AMA still has its Code of Ethics, which is contrary to the legislation in Victoria. The WMA still supports conscientious objection to euthanasia and abortion, and the national medical associations also support conscientious objection, with acceptance of these practices still only at the margins. A strong, consistent ethic in medicine is one that does not rely on legislation, which is at the mercy of the totalitarian state. Doctors need the freedom to operate outside of logical positivism. The state should not prescribe healthcare. There needs to be in the social sphere, institutions that operate independently of the state, such as the Church and the family. There are some things that are beyond the competence of the state to interfere with.

Transcript of Interview

Doctor # 32

Interview conducted by ALW, 12 October 2018
Start: 2.15pm
Finish: 4.15pm

Antecedents of Doctor # 32

Doctor # 32 is male, identifies as a Catholic, has been a doctor for 5 years and works as a Registrar in a regional hospital of Victoria.

Consent

Written consent was obtained for the interview by ALW.
The interview guide was varied to take into account the respondent's background and in order to explore issues as they arose.

How would you define conscientious objection?

The objection to a particular act or treatment, that is reasonable, and is based on one's understanding of ethical values. In medicine, a conscientious objection to blood transfusions by a Jehovah's Witness is tolerable and can be worked around. I try to understand the consequences for the person who is asked to breach their conscience.

However, I don't support a conscientious objection to vaccination. There is more of a moral imperative with vaccinations as there is a risk to your child in not vaccinating them. I think those who object to vaccinations have a clear error in their reason in how they view the scientific evidence, but they also have an issue in their ability to trust a large organisation like a medical authority. We know that for vaccinations, the harms outweigh the benefits and there isn't enough flexibility because of that.

We ask non-medical people to decide what reasonable medical treatment is. So for a blood transfusion, I need written consent from everyone in order to get blood and I don't think that should be a requirement. The patient is not in a position to make a reasoned medical decision apart from a doctor/patient consultation. It's giving power to patients in the wrong place.

The basis of your conscientious objection to abortion

I didn't used to think much about it. I have been brought up in the faith and know there is a problem with abortion, but I now understand it from a logical perspective, that there is a new life from conception. I remember being lectured at medical school by a gynaecologist on the RU486 drug who said that it is basically an abortion and people know what it means. This idea that we need an arbitrary cut-off date for abortion is ridiculous. It plays on this 'feelings' culture where our emotions dominate the way we think.

So people think maybe its ok to abort a child that has a nervous system but whilst it sounds reasonable, there is more to human life than just a nervous system. And even if they don't have one, there's the potential for one to develop. Yes, a baby cannot feel they are being aborted, but that doesn't change the mere act. You can't define a human being by its parts.

I've never really expressed my views on abortion outside of people who share my beliefs because of fear. I think today we are good at making character judgments and so knowledge of a doctor's position on abortion could very easily be abused. I have a fear of not being able to practice medicine because of my beliefs. As a medical student I worked as a blood collector in a Catholic hospital, and I had a few situations where my beliefs got me into trouble even though I hadn't even spoken with colleagues about having any 'conscientious objections'.

Once I was taking blood for a pregnant woman who was getting a Down syndrome screening. It was probably inappropriate for me to talk about this with her, but we were having a conversation and I asked her whether she had spoken with her GP about what the test meant and she said no. I said to her something like: 'Down syndrome children are children too.'

The reason I said this was because I'd just finished a course on this and I knew that women are often not informed by their GP about what the test is for. I wanted to help her, so that she understood what she was doing, and maybe go back to her GP to ask some more questions.

Also, I had written an essay on this issue and had an intellectual desire to share that knowledge with her. I was thinking that the only reason you would want to do this test is to kill this baby. She seemed ok with me talking to her about it. She seemed a bit confused about the test and agreed with me. However, she ended up complaining about me, and said that I made her feel uncomfortable.

On the same day, I also had to take a semen sample from a patient. I didn't interact with the patient at all, and I didn't really say to anyone that I had an objection to taking it. I just asked a colleague to take it and I think I might have said I wasn't 100% comfortable with it. Somebody must have picked up on this, as both incidents became part of a formal meeting I was called to attend with my direct supervisor and two other people from the hospital.

My direct supervisor told me it was just a talk but I brought a friend along who was a lawyer and the only way I can describe the meeting was that it was a 'kangaroo court'. I was not prepared for anything, and I did not know what to say or how the process would work. I was made to feel like I was emotionally unintelligent for having that conversation. I actually didn't tell them that I said 'Down Syndrome children are children as well' because I was scared I would lose my job.

I ended up being sent a letter where I was severely reprimanded for unprofessional behaviour with both patients. I was worried about how this this might impact me for future employment at the hospital as a doctor. So, I spoke with a Professor of Medical Ethics. He was disgusted with what happened to me and wrote an 8-page letter to the hospital in support of me that was placed on my file. On reflection, perhaps it was imprudent for talking to the pregnant patient that way, but it did not justify the severity of the punishment I was given by the hospital.

I was taken aback and disgusted with the hospital, which was a Catholic hospital. Years later, I still feel angry because they have the wrong idea about ethics yet think they are right. The biggest problem was that it made me question myself as to whether I was right or not. I thought 'Is the reason why we are a minority because we are wrong?' I felt cheated by a Catholic hospital that was supposed to abide by a Charter. There incident taught me that it doesn't really matter if I am at a Catholic hospital or not, they just pay lip service to the teachings of Jesus and it is just another public hospital, though there are some hospitals that try and enforce Catholic teaching.

At the time, I was a sensitive medical student struggling with group dynamics and competition and I had this job that would empower me to get a position later on. I thought the whole thing was gutless. This idea that you can't have a moral disagreement with this or any issue because 100 years ago you were wrong, but now you are right. You know why? Because slavery used to be ok in America so we have 'changed' our morality. But it was always wrong. So, they use that argument, and also arguments about mixed marriages to say morality has changed. People use misinformed ideas. I am indignant and angry and that is a problem in itself. I have really withdrawn from talking about this stuff at all. It's not because I don't want to lose my job, but because I think it's unprofessional for doctors to get emotional.

Other colleagues seem to have already made up their mind and won't change it. I don't think it's worth me having those one-on-one conversations at all at the moment except for euthanasia as the palliative care societies in Australia and New Zealand have disagreed with it. More doctors have questioned it. There is a fraternity of doctors who deal with this problem every day, and have authority, and that makes it easier. I don't think I can hold myself properly and be rational and not get angry. I need to improve my prudence but I have never had guidance on it.

I felt abused by this incident. Conscientious objection does hurt and the worst thing that can happen to a conscientious objector is actually questioning why I object and the whole point of it all. Aside from that, if fools can object to a blood transfusion then what is the weight of my argument in society? If you look at it rationally, what is conscientious objection if there is no solid moral platform where one group thinks there is a problem with blood transfusion, but others don't?

I agree with the fact that if I want people to respect my objection, I have to respect theirs. But have we ruined it for ourselves by using that term to describe things like objecting to baking a cake for a gay wedding.

Referral for abortion

We could become material co-operators if we referred. I don't agree with it. The law tells medicine that it will dictate our terms as to how we treat patients and how we decide and orchestrate clinical management plans. It's interfering with what we are doing.

It really says something about the nature of this particular problem, that it is not a medical problem. With abortion, we are not behaving as doctors. We can hire a butcher to do safe abortions although I agree it needs to be medically safe.

If someone came to me requesting an abortion, I would put a sign on the door before they enter stating that I don't refer for abortion. I want to protect myself. I think people respect that more. Not all women are aggressively pro-choice and think that the government is needed to endorse abortion.

Performing peripheral acts

I would probably insert a cannula into a patient's arm before they underwent an abortion because the reason you insert it is help the patient. Chances are that pain relief and fluids would pass through it but yes, it would also be material co-operation in abortion, but you are just splitting hairs.

With filling out paperwork for patients undergoing abortion, I would divert the prescribing of the abortifacient drugs to the doctor the patient is admitted under, but I would write up the other medications. I often make an excuse and say to the nurse that I think the obstetrician should prescribe it and in medicine, that's not that unusual.

The reason I make an excuse is that nurses can be very hard to work with, and I don't know how well my approach is going to be taken. It's happened to me before with non-ethical issues. So, I would try to avoid it tactfully.

I don't trust nurses, and some doctors, with my personal beliefs. I think it can be blown out of proportion with nursing staff, as they are oppressed in the workforce so any wrongdoing by a doctor will be taken up. There is a lot of hypersensitivity.

Conscientious Objection to other services

I don't prescribe contraception. I don't think it is medical treatment. I say to a patient that this is something between you and your doctor, and you should ask your GP. I think there is a different gravity of objection to contraception compared to abortion, but it's on a spectrum.

I only object to things the Catholic Church objects to. So that includes euthanasia and sterilisation. The Church is the moral authority.

With transgender health, genital mutilation is a crime and an issue that has even been flagged by Amnesty International. It's an emotional disorder. I have dealt with transgender patients before. We always identify them as, for example, a man identifying as a woman. We need to develop a lot of careful rapport with the patient and ensure good psychological and social work input. There's not enough evidence to suggest that this will be a long-term problem.

With parents who want to promote or encourage transgender identity in their child, this is also a psychological issue for the parents. I don't agree with giving chemical or surgical treatment to children at all. My objection is a faith based moral objection. I don't think we should be assigning gender at a whim. I think our ideas have been distorted and confused in a hyper sexualized society.

What education if any, have you received about conscientious objection including at university?

We had ethical training and learnt about the four principles in bioethics. If you could recite the four of them, then your ethical understanding was acceptable, and you can make any decision you like.

I remember doing a talk as a medical student about the use of condoms to reduce HIV. I got a well-known Professor of Medical Ethics to talk against it, and another expert to talk about over population. We had a lot of good argument, but in arranging this talk, I exposed my belief system to others, and this further isolated me at medical school as I got subliminal social backlash.

What would you do to change the situation and make it better?

I think the issue is how do we speak with people who don't use reason? We need to re-build that. That's a cultural shift. This is why I don't want to get political and try and change laws because I don't think it's going to work. These social laws are changing as culture is

deteriorating. However, I would get behind moves to repeal section 8 of the abortion law and I did write submissions against euthanasia.

I think writing submissions is an exercise to help us sharpen our tools, and know why we are right, that there is a problem, and be able to identify it. I think it's a myth that we can get back to the 1950's. Going backwards is bad. There is a lot of good that happens in this country, and in fact we enjoy a lot of privileges and freedoms and benevolence from the good that liberalism pushed for.

A new approach would be to become more emotionally intelligent. Understanding virtue and vice and using that to better understand people and reach them emotionally. The breach of trust in institutions like the sex abuse scandal has made this problem worse directly and indirectly. I am not sure what that change is going to be so I don't know how to act. Laws can only go so far and whilst I will support them, I don't think that's the answer. The system is never the problem, but its people who are the problem. When we blame systems and structures it is inherently irrational in one sense. We are hiding from the fact that it is our attitudes that break down and we have forgotten that and hide behind hubris and self-conceit so we can't see this.

I don't like to be political. Politicians today lack statesmanship and the ability to know what is truly good. There's a lack of role models within the profession and I don't know what I am looking for. They are probably out there, but they are quiet. When more is given, more is expected and that is not demonstrated in the little things. The way we talk about our patient, or quickly judge them, can show we lack integrity. Doctors are not quite doing enough. If they do great things, it has to be put up in lights and used for career advancement…The AMA has no real power to change anything. They offer lots of benefits that just promote a self-centred lifestyle.

Transcript of Interview

Doctor # 33

Interview conducted by ALW, 22 October 2018
Start: 2.00 pm
Finish: 3.10pm

Antecedents of Doctor # 33

Doctor # 33 is male, identifies as a Christian (non-specified), has been a doctor for 46 years and an obstetrician and gynaecologist for 44 years, and currently works as a consultant at both a tertiary and large suburban hospital in Victoria.

Consent

Written consent was obtained for the interview by ALW.
The interview guide was varied to take into account the respondent's background and in order to explore issues as they arose.

How would you define conscientious objection?

I think it exists on at least two levels. There are those who resolutely don't want anything to do with abortion, and then there are those that do not want to make the decision, but are ready to refer to a sympathetic colleague and will look after the patient in the labour ward setting, after someone else has taken the ethical responsibility to make the decision to abort.

The basis of your conscientious objection to abortion

I used to perform terminations until I had a gradual change in my ethical position. When I started practice, abortion was a black and white issue, and nobody did terminations. They were only done as backyard jobs. But then there were several deaths a year from gangrene from backyard abortions and that swung opinion that they needed to be done safely.

After the *Menhennit* ruling, there was an epidemic of abortions in the public hospital system. I remember that I didn't know what to think. It was sprung on us. I probably did a couple of dozen of abortions in private practice.

But now, I have a much clearer focus on human life, going right back to early pregnancy. I'm a little bit vague as to when that it starts, either conception or later, but I don't want to be involved with it. I don't think science has the full answer. It's much more in terms of philosophical questions as to when life begins and has value.

I gradually began to work my way through it to where I would not do abortion personally. The one exception was two years ago, where the woman was very sick, had kidney failure halfway through the pregnancy, and was psychiatrically ill with her other children in foster care. On the basis of kidney failure and the fact that the pregnancy was going to precipitate it, I agreed to a termination although I did not do it personally. I was a co-signatory as is required by the law.

I have had several people help me refine my thinking about my involvement in abortion. I met a person from England at a Christian meeting, and as I had such a vague view of my ethical position on abortion, I felt very exposed to his questions. But I had reached the point where I could not toss out the implications it was having on my practice. I was deeply involved as I was doing ultrasounds for women and looking for abnormal foetuses. As imaging got better, you could more easily pick up the abnormalities and I had to face the fact that the philosophy of what I was doing was basically eugenic and I had to step away from it.

The doctor I was teamed with for the ultrasounds was the unofficial hospital abortionist and did about 20 per week. He knew my attitude to abortion and even he tackled me on my involvement in screening ultrasounds and pointed out that I had an inconsistent position because the consequence of my ultrasound might be termination, yet I didn't believe in it. He was a great help to me.

Your experience disclosing your conscientious objection to abortion

When I told my colleagues I was stepping away, they accepted that. I replaced my ultrasound work with more obstetric work and shifted my emphasis in ultrasounds to third trimester

ultrasounds, which is looking at the 'at risk' normal foetus in order to get the best possible result for baby and mother.
I support foetal palliative care and I believe people should accept what they have been given, if they have the courage and heart to do it. We do have patients coming through for foetal palliative care, that we support them all the way through. You are even prepared to do a caesarean early to give them more time together.

Most people know my position. Word gets around. Certainly, the Director knows as we go back a number of years and he knows my Christian background. I have not really had any negative experiences in disclosing my objection. This is probably related to my maturity and standing in the profession and the fact I was already established when I came to my position.

It's more and more difficult to avoid ethical issues in obstetrics today. The fact is most people shy away from termination of pregnancy, and it only attracts a few doctors. Abortion is unpalatable for most of my colleagues. In my experience, there is sympathy for people who have an objection to it.

Very few people believe there is ever a risk to the woman's health from continuing pregnancy. The psychological threshold in law is a very dubious indication, but this is the one put forward. In fact, you can argue that a woman is more likely to suffer adverse psychological consequences from undergoing a termination when she has psychological issues, than if she does not. It's just very hard to prove because if you look at the literature, there is such a bias in the papers that argue against this finding.

Referral for abortion

This happens very rarely. I would normally get a sense in a consultation that a patient is moving in that direction, and I say I am not comfortable talking about this issue and that I will get someone else to see you. For me, that's not necessarily referring the patient on for an abortion. Rather it's referral for consideration of all the issues, which is something I would rather not be involved in.

Years ago, I used to send patients to the doctor who did abortions in the hospital. I thought he would take responsibility for the decision the patient had already made. In retrospective, I don't

feel very good about that. However, if someone were unsure about abortion, I would not send her to that doctor, but to someone else.
Years ago, I worked with a midwife who got pregnant with a baby that had Down syndrome. She was a Christian and was married to a minister of religion and he did not want the pregnancy. There was a lot of coercion of her by him to have an abortion. I told them I could not do this. We had long discussions, and he was furious with me. I steered them into the direction of someone else that I knew would do it. She was around 15 weeks, and the termination went ahead.

If I sense the person is open-minded about not having an abortion, I keep counselling that patient. I have had a patient change their mind about going ahead. It is an intuitive thing, learning how to sense when a person has already made up their mind or not. It's not easily to train people in it.

I don't have a particular problem with referring people on to someone else to make the decision to do abortion, or to refer them to a private doctor so they can get a Medicare rebate rather than going to a clinic where they have to pay up front.

Some people are very ethically tight on this, and black and white, but that's not me. In my view, the patient takes responsibility for their own decision, but I understand other people might take a different view and won't refer and that is their right to decline to do this. I've thought a lot about the mandatory referral laws in Victoria. It's social engineering. They are trying to change the attitudes and ethics in society, to impose a progressive agenda. It's a bit leftist, and certainly anti-Christian.

Peripheral acts

I have no issue dealing with the complications from an abortion. I had a woman who had a late term abortion at an abortion clinic and had to have a hysterectomy. I was called in to save her as she had a cardiac arrest on the operating table. There is no question I should have been involved with that. I took no responsibility ethically in the decision to perform the abortion that caused her to be there.

I think it's a bit over the top for people to object to things like documentation and taking blood for a patient having an abortion. It can get too legalistic trying to work out what you can and cannot do. I haven't really thought about any other acts apart from the actual abortion and scanning for abnormalities that I would not do.

Conscientious Objection to other services

I have a conscientious objection to euthanasia. I would not refer a patient seeking this to a willing provider. It's an instinctual reaction, and I have not really thought through why I object to referring for this but not for abortion.

I think it has to do with the gradual maturity of intrauterine life. If a woman has a miscarriage at 6 weeks, she will usually flush it down the toilet. But if it occurs at 18 weeks, she will bring the foetus in a jar to the hospital. It indicates a change in attitude according to maturity of the nascent life and I think carrying that through to mature adulthood, you could argue that the full potential of the person has been released and the person has a different degree of value.

I am also very disturbed about transgender health decisions. My objection is based on a mixture of science and faith. We know that 80-85% of people who want to change gender revert later on within 2-4 years. For the state to have an agenda about safe schools in order to favour a choice at any early stage is very disturbing.

What education if any, have you received about conscientious objection including at university?

None. These issues did not really exist when I was at medical school.

What would you do to change the situation and make it better?

I would support repealing section 8 of the Act that requires mandatory referral. I am reluctant to support legal protection of conscience because of the way that these things can get out of hand. I think we should accept that some people have a conscientious objection and it could be to something that I may not personally understand, but we try and accommodate.

I don't want to prescribe any specific way of handling it. It very rarely crops up in the hospital I work in, except for foetal abnormalities. Normally, people just go to private hospital or termination clinics. This has been a policy in place for many years. There are ethics committees for late term terminations in one hospital I work in, and after the decision has been made, the patient might come to us for it to be done.

I think that even if the ethics committee has made a decision that it can go ahead, we should still understand that some people might still be uncomfortable. There are a few female Muslim obstetrician and gynaecologists in the service I work in, and a few Catholics, who object to abortion. There's not very many of them, and if abortion crops up, which it rarely does, it has to be scheduled in, and you have a few days' notice. It's not hard to make an accommodation and everyone accepts this because we respect different viewpoints.

I think young doctors would be assisted by having someone familiar with the issues, ethical or otherwise, to counsel them. You would not want to prejudice their career or ongoing training in O&G. You need such people. We need more pro-life influence in the profession.

Transcript of Interview

Doctor # 34

Interview conducted by ALW, 24 October 2018
Start: 12.15 pm
Finish: 1.35 pm

Antecedents of Doctor # 34

Doctor # 34 is female, identifies as a Catholic, has been a doctor for 7 years and currently works as a doctor as Registrar training as an anaesthetist at a tertiary hospital in Victoria.

Consent

Written consent was obtained for the interview by ALW.
The interview guide was varied to take into account the respondent's background and in order to explore issues as they arose.

How would you define conscientious objection?

It's based on a combination of medical knowledge and moral beliefs that make me feel that a treatment option is not appropriate. There is a disparity between clinicians about what is valid or not, and when something is doing harm or not and now. At this time laws are changing so quickly. Services that were not originally deemed to be medical options are now valid medical options. So, we need to allow people to make a conscientious objection.

However, that is balanced against the need of the doctor to consider the consequences of their actions on society. So, there is some onus on a doctor to ensure that their choice of specialization and location of work is the most appropriate based on their beliefs. An obstetrician and gynaecologist who is against abortion but is working in a rural location, is not a good choice.

The basis of your conscientious objection to abortion

I believe that human life starts at conception. I base this on what the geneticists showed us in the 50's and 60's. The process is never stopped, and there is no point at which you can pin-point when it became human. So, I err on the side of caution and believe it is human life from conception.

Termination of pregnancy exposes the woman to harm. I cannot justify exposing her to that harm which includes the usual harm from any medical procedure and the harm that I know comes from having an abortion as I have spent time counselling women for post abortive grief. It's also the ending of another life. My faith is intertwined with my belief.

Your experience disclosing your conscientious objection to abortion

Abortion is not that frequent where I work, and there are so many anaesthetists available that it is not such a problem to get someone to replace you.

There have been a few occasions where a termination has been on the operating list. I went to my consultant and said: 'I'm not comfortable doing this.' They were fine and someone replaced me. I didn't know the consultant very well, but I didn't feel uncomfortable because I knew it wasn't a big problem. In anaesthetics, there is fewer egos, and you can move around a lot more than a surgeon, who works in specific areas. For a surgeon, it would depend upon the attitude of the boss on the day.

I'm very socially aware. I have never had a bad interaction with someone when talking about my opinion on abortion. I pre-emptively decide whether to say anything or not. I'd prefer to say nothing than for someone to get angry because it's not productive. I have had a lot of practice talking to people who don't share my views and I have received positive feedback about how I approach these discussions.

Referral for abortion

I don't agree with having to write a referral for abortion where you have a conscientious objection. It's like a morbidly obese person wanting a joint replacement where you don't think it's medically safe. Extend the logic. A referral is on a letterhead, with your name and provider number and the name of the other doctor. There is some degree of responsibility by providing a referral.

If you had to write a referral, you need enough information and would have to be allowed to have a full consultation. You couldn't make a doctor stop the consultation, disclose their objection, and then write a referral without going through the process.

However, if it's just providing a person with information on where to get an abortion, then it depends on the context. I'm quite pragmatic about this. If someone wants a late term abortion, there are physical and mental risks. You can't tell her to go to Marie Stopes. She has to go to a tertiary hospital like the Royal Women's Hospital, where there is appropriate medical back up, proper patient care and ethics committee oversight. There's no getting around the fact that these treatments are allowed. If she wants one, she can get one. My concern is to do it with minimal harm to her.

Peripheral acts

As an anaesthetist, I have never had to think too much about this before although I have put in a cannula for a woman undergoing abortion. I didn't feel that my action was wrong. I just had concerns about how distressed she looked. But it's not my place to say anything unless she actually says something first. I would not involve myself with talking to her about it or trying to change her mind. It's also very hard to talk to distressed patients and to get history out of them and go through the normal process of care. They usually don't want to interact and just want to get it done.

Conscientious Objection to other services

I have an objection to euthanasia and doing anaesthetics for IVF therapies.

I assist with inserting IUDs frequently. I don't think about it very much. The risks are different compared to abortion. Practically speaking, it's too hard to step out of those cases when you are training. Also, it can also be done at the last minute, without you being aware of that. The only way not to be involved with it is to cause problems and be disruptive. People would start questioning your reasoning and it would not be a procedure you could easily avoid in training. The only way to stop that process is earlier on when the patient was having a discussion. For an IUD, the patient's wellbeing is not as at risk as an abortion and the process doesn't involve another life.

I don't agree with contraception myself, but I have been involved with inserting Implanon and other contraceptive devices, but the decision to insert those devices was already made by the patient and I don't feel I have a right to question what they are doing.

I think for things like writing up admission notes and drugs, I'm a bit more pragmatic – the harm done by me from writing up an admission note is not going to change the outcome, as someone else will just write it up. If you are constantly being faced with a predicament with writing the admission notes or providing referrals, then maybe you are at the wrong hospital. It is not tenable to keep working that way. If you have strong beliefs about a service, you have an obligation to minimize its impact on others. You should not put yourself in that predicament.

However certain religious groups won't allow male doctors to examine them and so we find a female doctor in the department, and we will accommodate that. There are many reasons why a doctor will say they cannot look after the patient, you can even say it's for personal reasons, and I've found that it will be accommodated. So, it's all about the context. I support accommodating objections where it is practical to do so.

What education if any, have you received about conscientious objection including at university?

I went to a Catholic medical school and in that a context, it was easier to speak your mind as you knew there was some authority behind your position.

What would you do to change the situation and make it better?

There are more and more people who have an objection to a medical service, whether or not it is a conscientious objection, and who just refuse to do it. It's not just abortion, you hear about this in plastic surgery where someone wants breast implants and in other areas of medicine. We have a problem when the procedure is wanted by society, but not wanted by the medical profession. There are real concerns with patient access to care in rural areas and that is why conscientious objection is being pushed as an issue. We can only resolve this tension if there are enough doctors willing to do the procedure. Then if there are plenty of people around to replace them, having a conscientious objection is no big deal at all. But we just don't have enough hospitals to train doctors. Monetary incentives do not work. That's been proven.

At the moment you cannot train more doctors, so it looks like the only solution is to force people to do it or widen the type of person who can do it. With euthanasia, they can train nurses or other people to do it. But it is difficult for time critical services like abortion, where the laws may not allow you to have an abortion past a certain point, or clinics can only do abortions up to a certain point. In countries like Scandinavia, they don't allow conscientious objection at all. That could happen here.

I agree with repealing section 8 of the Victorian law. Lawyers say it is written very badly. The emergency provisions are totally contradictory as delivering a baby is far safer than terminating a pregnancy. The reference to providing a referral should be changed to providing information. I agree with the government designing a pamphlet listing where people can get an abortion, as well other services, is reasonable.

For doctors who want to train to be obstetricians and gynaecologists, they have a duty to disclose their objection to the College and the College has to try and balance that request. They already do this for people who want to work part time because of a mental health issue or for other reasons. There are certain hospitals like St Vincent's and Cabrini that are Catholic hospitals which do not perform abortion and the doctor should be choosing to do those aspects of their training that might expose them to abortion at those places. I've had a few friends who have been able to do this so it's possible. But I think you have to accept the potential consequences for having your view. It might not always be fair to you, but in choosing to expose your personal beliefs, you have to weigh these things up.

Transcript of Interview

Doctor # 35

Interview conducted by ALW, 26 October 2018
Start: 4:20 pm
Finish: 5:50 pm

Antecedents of Doctor # 35

Doctor # 35 is female, identifies as a Catholic, has been a doctor for 40 years and currently works as a GP in suburban Victoria.

Consent

Written consent was obtained for the interview by ALW.
The interview guide was varied to take into account the respondent's background and in order to explore issues as they arose.

How would you define conscientious objection?

It's where you have a strong belief that something is right or wrong and you act according to that belief, and don't want to be forced into acting against that belief. In medicine, there are actions that should just not be done such as deliberately taking a life or harming somebody. Harmful actions include things like female genital mutilation but also surgeries or procedures where there is no fully informed consent, such as where people are exploited due to vulnerability or a lack of knowledge.

The basis of your conscientious objection to abortion

It is the taking of an innocent human life, there is harm done to the mother in that process, harm to her near associates, and harm to the society in general. It's a multi-layered harm. Science backs up the notion that life begins at conception and my faith aligns with the science.

Your experience disclosing your conscientious objection to abortion

I work in a big GP practice, with doctors who have a variety of views including a few who have the same views as me. When I first mentioned my objection, one of the doctors who was quite pro-abortion and had performed terminations suggested we invite a well-known Bioethicist to come and talk with us about it. At the end of the discussion, he told me that I could refer any patients seeking abortion to him.

When I told patients that I did not refer for abortion, they were very calm and understanding. They understood that you could not help them. A few might get angry or indignant, but I never got any complaints. A few new patients saw me recently who were of reproductive age and had reproductive health concerns. So, I discussed their problems with them, and highlighted that I didn't refer for abortion so if there were ever to be a concern for them here, there would be no reason to see me about that. They were fine with that explanation, and they didn't come back to see me.

Referral for abortion

It's an ideological stance. Women don't need a referral to get an abortion. When the law first came in, there was a lot of anxiety and fear. We all knew it would just take one patient or one doctor to complain to cause a problem.

Initially, I produced a pamphlet that was to be given to my female patients of reproductive age. It said something along the lines of "As a medical practitioner, I believe in first doing no harm, and as a consequence I cannot refer for abortion…." It then went on to outline the other things I could do for them. It was meant to be for new patients, my existing patients already knew that I did not prescribe contraceptives or refer for abortion. Eventually, though, I abandoned the pamphlet as I realised I would not get to see pregnant patients and be able to help then. They might then just see another doctor who would refer them on.

If a patient consulted me today with a crisis pregnancy, I think you must have some positives on hand and not just say no. You need to know the name of a good psychologist, or a pregnancy agency that you trust. You should bulk bill and use certain words like 'I'm sorry'. I would probably say something like:

> ‘I’m sorry, but I cannot help you with this. This is a serious issue and you should take your time. I can help you with these other things…If you decide you want to have an abortion, you will have to see someone else.’

The law requires you to refer to a doctor that you know does not have a conscientious objection to abortion, but the truth is, I don’t know anyone’s views. I can’t absolutely know if another doctor will do the abortion and I can’t go around asking everybody. There are lots of doctors around. Most patients actually have no idea what the law is.

Peripheral acts

I don’t want to be involved with any acts associated with abortion. So hypothetically, it would include inserting a cannula before the abortion or paperwork etc., but in my practice, I haven’t had to think about this because I am unlikely to be asked to do anything other than refer.

Conscientious Objection to other services

I have a conscientious objection to prescribing the contraceptive pill. Initially when I started practicing, I would do a re-script for the pill, but not the initial one. I then decided I would not do that and had to tell my employer. It’s an awkward conversation and it is more problematic as it is far more common than someone wanting a referral for abortion. Some people can get quite cross and not understand why you won’t give them a script. One Catholic doctor even refused to employ me. However, as I teach fertility awareness as an alternative for family planning, I say that prescribing contraception does not fit with that aspect of my practice and the patient should be referred to someone else. I offer a replacement service, and I think that’s important, as the patient cannot be left with nothing.

I’ve found that most patients have no idea of their fertility and don’t really want to be on the pill because of all the side effects but nothing else was offered to them. They were very happy to have the information on alternatives and as something they might consider down the track. Whilst you can have the receptionist screen patients you don’t want to lose the opportunity to talk to all patients. Screening is a bit intrusive but you can have information about each of the

doctors that might say that Doctor X doesn't prescribe contraception, but I think it is really up to the practice.

I have a concern about prenatal testing. Women think it's routine. They are often not adequately informed about why it is being done and where it is heading. There's no counselling. There's such a disconnect in society with regards to disability. With the Invictus games, we rejoice for them. We want intensive care for premature babies, but at the same time, you can destroy them at will up to 24 weeks.

I also object to euthanasia, IVF services, and sterilization.

With regards to transgender health, I don't know enough about it. I believe a lot of the inclination in early adolescence, goes away if the child is supported. It's such an extreme intervention, and a distressing psychological issue for children. I have medical concerns about it. If parents came to me with a child and wanted a referral, I might give them a referral for an opinion, which is different to recommending they have a particular procedure. I have done this before for patients wanting sterilisation.

What education if any, have you received about conscientious objection including at university?

We didn't learn anything about bioethics and the ethics that was taught was more focused upon business ethics such as issues that might arise when setting up your medical practice.

What would you do to change the situation and make it better?

I would repeal the whole law on abortion. In an ideal world, you wouldn't allow terminations up to 40 weeks. You are not going to stop terminations happening, but to have a law that says it is acceptable to permit late term abortions is really unhealthy.

There aren't enough pro-life doctors generally. Even at Catholic hospitals, you may go to a lecture and the person will say that as a Catholic hospital they cannot offer X, but they personally do this outside the hospital. Some doctors are so busy that they just want to do their job. It's awkward if you take a stance from your peers.

We have organisations such as the Australasian Institute of Restorative Reproductive Medicine, which is an alternative to IVF. Because of our approach, we do not refer for artificial technologies. It's not a Catholic organisation and people can join as a full member and agree with our Code of Ethics or be an associate member where they don't have to abide by our Code. There is also Solidarity which is a group aimed at younger health professionals and the National Catholic Medical Association.

We need better networks for the young doctors. We need to provide them with example of doctors who have lived with the system and survived. We need to give them encouragement and ways to express themselves and survived. We need to give them encouragement and ways to express themselves, education, and advice on alternatives. And if legal things happen, we need to be able to put them onto lawyers who can help them.

Full protection of freedom of conscience for doctors in the law would be good. Some of the medical associations have had something like this in their statements and code of ethics, but over time it has eroded, and there is a move for AHPRA to change its stance. Overseas, there is a move to ban all prolife doctors. It's just extraordinary to me, the idea that you would force people to do something against their conscience.