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MEDICAL REFERRAL FOR ABORTION AND FREEDOM OF CONSCIENCE IN AUSTRALIAN LAW

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ABSTRACT

This article examines legislative changes related to abortion regulation in Australia that create obligations of medical referral on practitioners who have a conscientious objection to abortion. Despite a significant Australian history of accepting secularized conscience claims, particularly in the field of military conscription, the limitation of conscience claims about abortion can be traced to a failure to appreciate the significant secular arguments that can be made to support such claims. We draw on arguments of plurality and pragmatism as capable of providing a firm foundation for legislative protections of freedom of conscience in the case of medical referral for abortion. These justifications are not dependent on religious grounds, and therefore they have the potential to be relevant and persuasive in a secular society such as Australia. Acceptance of a pluralistic argument in favor of freedom of conscience is a powerful commitment to the creation of a society that values human autonomy and a diversity of opinion. It sits comfortably with the democratic values that are enshrined in the Australian political system and institutions. It avoids the potential damage to the individual that may be wrought when conscience is overridden by state compulsion.

KEYWORDS: abortion, conscientious objection, medical referral, freedom of conscience

INTRODUCTION

The freedom of conscience of medical practitioners to refuse referral for abortion is a vexed issue. In Australia, it necessitates balancing the rights of patients to access abortion, which is a legal and medically accepted procedure, and the rights of medical practitioners not to refer for a procedure that is contrary to their conscience. In 2013, two doctors in the Australian state of Victoria were subject to investigation for potentially contravening their referral obligation enshrined in the *Abortion Law Reform Act 2008* (Vic), which provides that medical practitioners who conscientiously object to abortion must, nevertheless, "refer the woman to another registered health practitioner . . . who the practitioner knows does not have a conscientious objection to abortion."[1] For one of the medical practitioners, the investigation followed revelations that a doctor had refused to refer a patient for an abortion to facilitate sex selection.[2] In the second case, a Facebook conversation involving a doctor who indicated a conscientious objection to abortion was reported to the

1 *Abortion Law Reform Act 2008* (Vic) s 8.

2 Henrietta Cook, *Abortion Law Changes Eyed as Dr Mark Hobart Probed*, The Age (Nov. 7, 2013), https://www.theage.com.au/national/victoria/abortion-law-changes-eyed-as-dr-mark-hobart-probed-20131107-2x2rg.html.

Australian Medical Board. In his defense, the doctor wrote to the chairperson of the Security of Acts and Regulation Committee, "I am unable to refer for an abortion, because reason and logic lead me to conclude that it is murder."[3] The doctor was reportedly cautioned.[4] Following these two cases, a private members' bill was introduced to the Victorian Parliament seeking to remove the obligation to refer.[5] The bill failed to garner support and was defeated in 2016. The Victorian legislative model led to both Tasmania,[6] and more recently, the Northern Territory,[7] introducing an obligation on medical practitioners to refer for abortion despite their own conscience objection. With these reforms, Victoria, Tasmania, and the Northern Territory became the three Australian jurisdictions to take the strongest position in requiring referral for abortion, despite claims of conscience. A bill proposing similar changes in New South Wales was defeated,[8] though concerns about the bill extended beyond the changes to conscientious objection.[9]

These reforms attracted considerable controversy at the time of enactment. After the Victorian Act was passed one commentator noted, "part of the controversy also stems from the fact that the provision is so unique … the anomalous nature of the provision has led to questions about its necessity."[10] The reforms remain inconsistent with legislation in other states, as well as the code of conduct designed to align with Australian national law on regulating medical practice.[11] It may be that this approach indicates a transition in Australian abortion law to prioritize a woman's right to access health care over religious and secular claims of conscience.

Conscientious objection seeks to balance the interests of the individual and the interests of society. At stake is the freedom of individuals to follow their own beliefs in matters of religion and morality. Freedom of conscience protects the right of individuals to adhere to a religious and moral position, independent of others' viewpoints and regardless of others' objections. Conscientious objection also involves complex questions about the interaction between religion and state, morality, personal autonomy, integrity, and individual and societal good. The areas where it is asserted tend to excite passionate disagreement. Issues like euthanasia, abortion, and

3 Mark Hobart, Submission No. 68 to Scrutiny of Acts and Regulations Committee, Parliament of Victoria, *Review of the Victorian Charter of Human Rights and Responsibilities Act 2006*, June 9, 2011, 1.

4 Susie O'Brien, *Controversial Victorian Doctor Who Refused to Refer Women for Abortions Has Defended Himself after an Investigation*, Herald Sun (Nov. 11, 2013), http://www.heraldsun.com.au/news/victoria/controversial-victorian-doctor-who-refused-to-refer-women-for-abortions-has-defended-himself-after-an-investigation/story-fniofit3-1226757706941.

5 On October 20, 2014, Dr. Rachel Carling-Jenkins from the Democratic Labour Party introduced the Infant Viability Bill 2014 (Vic) as a private members' bill into the Victorian Parliament. The bill's title was listed on the Legislative Council's notice paper, and the following long title was incorporated into Hansard: A Bill for an Act to ensure the provision of access to holistic care and support to pregnant women and preborn children so as to promote infant viability, to amend the *Abortion Law Reform Act 2008* and *Crimes Act 1958*, to make consequential amendments to certain other Acts and for other purposes.

The bill was defeated on 25 May 2016. Parliamentary Debates (Hansard) Legislative Council, Fifty-Eight Parliament, First Session, Wednesday 25 May 2016, paras 2405, 2407, 2414.

6 *Reproductive Health (Access to Terminations) Act 2013* (Tas).

7 *Termination of Pregnancy Law Reform Act 2017* (NT).

8 Abortion Law Reform (Miscellaneous Acts Amendment) Bill 2016 (NSW).

9 Miles Godfrey, *Vote to Fully Decriminalise Abortion in NSW Is Lost*, The Daily Telegraph (May 10, 2017), http://www.dailytelegraph.com.au/news/nsw/vote-to-fully-decriminalise-abortion-in-nsw-is-lost/news-story/cdc32f5dead633e02d4cd8034528f4f8.

10 Naomi Oreb, *Worth the Wait? A Critique of the* Abortion Act 2008 (Vic), 17 Journal of Law and Medicine 261, 266 (2009).

11 *Health Practitioner Regulation National Law Act 2009*; Medical Board of Australia, *Good Medical Practice: A Code of Conduct for Doctors in Australia*, Mar. 17, 2014 [hereinafter *Good Medical Practice Code*].

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military service are ones where convictions are often firmly held and contrary views regarded with suspicion, if not disdain. Conscientious objection also emerged as a point of controversy in the course of a national referendum that approved legalizing same-sex marriage. The conservative Coalition Government refused to legislate for freedom of conscience as part of the legislation permitting same-sex marriage, instead convening an inquiry "to examine whether Australian law adequately protects the human right to freedom of religion."[12]

Despite the presence of strongly held views, it is areas such as these that should be particularly open to scrutiny and thoughtful, even if contrary, argument should be entertained. Accordingly, we argue that society has strong reasons to protect the freedom of conscience of medical practitioners from requirements to advise on, provide, and refer for abortion. Our central argument is that freedom of conscience in the context of referral for abortion is worth supporting for two reasons, first, as an approach that values human integrity and promotes a society in which a healthy diversity of views is tolerated (pluralism), and, second, because regulation that seeks to override conscientious objection is generally ineffective in the face of genuine and strongly held beliefs (pragmatism). Finally, we posit that such an approach is consistent with the history of liberalization of freedom of conscience, including by permitting secularized conscience, in Australia.

Although the religious and philosophical arguments relating to conscientious objection have been rehearsed before, mandatory referral for abortion is a relatively recent legal development in Australia. It is, therefore, timely to consider the specific issues arising from legal constraints on the right of medical practitioners who have conscientious objection to abortion not to refer their patients in need of termination to another doctor. We start our analysis in this article by providing a general background and context to Australian abortion law. We then examine the nature of conscientious objection and the traditional debates around the role of the law in regulating conscientious objection. We then turn to the issue of regulation of conscientious objection to referral for abortion. It is here that the unusually limited approach to conscientious objection has been adopted. We consider the arguments that are made in favor of restricting conscientious objection in the abortion context. In particular, we argue that pragmatism and the advantages of a pluralistic society provide strong arguments for permitting conscientious objection.

As a threshold matter we are not suggesting that conscientious objection to abortion should be unlimited. For example, we make no argument that conscientious objection should be permitted in the emergency situation, where a woman's life is at risk. Our focus is on whether a legislative obligation *to refer* is legally and ethically justified.

ABORTION LAW IN AUSTRALIA

Australia is a federation, with the Constitution of Australia dividing power between six state and two territory governments and the Federal government. Laws in Australia regulating the practice of abortion are largely at state level, originating from the criminal law through the English Offences against the Person Act 1861, 24 & 25 Vict. c. 100.[13] Section 58 of this Act prohibited

12 For the terms of reference and membership of the inquiry see Department of the Prime Minister and Cabinet, Religious Freedom Review, https://www.pmc.gov.au/domestic-policy/religious-freedom-review (last visited Apr. 18, 2018). The Review handed down its final report on May 18, 2018; see https://www.ag.gov.au/RightsAndProtections/HumanRights/Documents/religious-freedom-review-expert-panel-report-2018.pdf.

13 Caroline de Costa et al., *Abortion Law across Australia—A Review of Nine Jurisdictions*, 55 Australian and New Zealand Journal of Obstetrics and Gynaecology 105–11, 105 (2015).

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the unlawful administration of "any poison or other noxious thing" or "unlawful use of any instrument" by either the woman "with intent to procure her own miscarriage." The criminalization of abortion was also subject to the case law's interpretation of such provisions. In the case of *R v. Bourne*,[14] the preservation of a woman from becoming "a physical or mental wreck" was a sufficient ground for lawful abortion. Previous to *Bourne*, the only exception that had been read into Section 58 was for the case where an abortion was necessary to save the woman's life.[15] Not long afterwards, Section 58 was copied by the Parliament of Victoria "virtually word for word," appearing in the then Section 65 of the Crimes Act 1958 (Vic).[16] In time, New South Wales and elsewhere followed suit.[17]

From around the early 1970s, abortion became liberally accessible state by state.[18] This is not to say that abortion was actually removed from the realms of the criminal law. Rather, as Barbara Baird, a gender studies scholar, explains, liberalization occurred through "liberal court ruling or legislative reform which delivered a medicalized framework."[19] The first state to liberalize abortion was South Australia. In 1969, the South Australian Parliament passed amendments to the criminal law to liberalize access to abortion and clarify the circumstances in which abortion could be lawfully performed by medical practitioners.[20] Soon after, Justice Menhennitt in the Victorian case of *R v. Davidson*,[21] and Justice Levine in the New South Wales case of *R v. Wald*,[22] handed down judgments clarifying, for the first time, the criteria for lawful abortion in Victoria and New South Wales respectively. Both were landmark decisions, as they held that, in certain circumstances, mental and physical risks to the woman could constitute grounds for abortion. Indeed, in *R v. Wald*, Justice Levine went further and held that economic and social issues could be considered in determining the legality of the abortion. In 2002, the Australian Capital Territory became the first Australian jurisdiction to decriminalize abortion, by passing the Medical Practitioners (Maternal Health) Amendment Act 2002. Since then, as part of their legislation to provide for mandatory referral for abortion by medical practitioners with a conscientious objection to abortion, three Australian jurisdictions—Victoria, Tasmania, and the Northern Territory—have decriminalized abortion and introduced a strong obligation to refer, amidst significant and protracted controversy. This suggests that policy makers believed there should be less allowance for freedom of conscience in the context of a decriminalized procedure that is framed as health care. And it seems to be at odds with the approaches in other contentious areas where conscientious objection to legal processes, such as conscription, is permitted.

14 R v. Bourne [1939] 1 KB 687.

15 H.L.A. Hart, *Abortion Law Reform: The English Experience*, 8 Melbourne University Law Review 388–411, 389 (1972).

16 Peter Brett, *The Origin of the Law in Australia: The Menhennitt Ruling in Victoria*, *in* Abortion: The Unenforceable Law 24, 25 (Tony McMichael ed., 1972). Note, however, that the maximum penalties were different in the two Acts: *id*. at 390.

17 Brett, *supra* note 16, at 25.

18 Barbara Baird, *Medical Abortion in Australia: A Short History*, 23 Reproductive Health Matters 169–76, 169 (2015).

19 *Id*. at 170.

20 Mary Heath & Ea Mulligan, *Abortion in the Shadow of the Criminal Law? The Case of South Australia*, 37 Adelaide Law Review 41–68 (2016); Kate Gleeson, *Still Keeping Women Out: A Short History of Australian Abortion Law*, The Conversation (Jan. 24, 2013), https://theconversation.com/still-keeping-women-out-a-short-history-of-australian-abortion-law-11732.

21 R v. Davidson [1969] VR 667.

22 R v. Wald (1971) 3 DCR (N.S.W.) 25.

Although the intensity of the political debate around abortion is far less constant and heated in Australia than, say, in the United States, any reform to abortion law in Australia has caused fierce debate at the time it was mooted and initially after implementation. While a number of Australian churches, in particular the Roman Catholic Church, are publicly opposed to abortion, many of the groups who vocally oppose abortion in Australia are officially nonreligious and nondenominational, for example, "Right to Life Australia"[23] and the various state and territory pro-life groups.[24] "Emily's Voice" is an anti-abortion organization that runs media campaigns aimed at furthering education about abortion and its consequences.[25] "Women's Forum Australia" is a pro-life, independent women's think-tank that undertakes research, education, and public policy development on a raft of issues affecting women, including abortion. In Australia, many organizations that seek to promote access to abortion are also seemingly absent of religious affiliation, either to an established religion or to atheism, including "Reproductive Choice Australia,"[26] "Children by Choice,"[27] and "Emily's List."[28] The latter has been especially effective as a political force, drafting pro-choice women into political office via the Australian Labor Party. This may indicate that these groups (both pro- and anti-abortion) believe they will be more readily dismissed if they are seen as religiously affiliated. It is also consistent with viewing abortion through the medical and human rights lenses, rather than seeing it as connected to moral or religious convictions.

WHAT IS CONSCIENTIOUS OBJECTION?

Conscientious objection arises where there is a "refusal to comply with an authoritative standard or rule … because doing so entails betraying one or more of [a person's] deepest commitments."[29] Fundamentally, therefore, it involves a process by which a person asserts reasons of conscience to avoid a compulsion.[30]

The history of conscientious objection is long,[31] though the term itself has a less-lengthy pedigree.[32] Formal recognition developed in the context of religious minorities who sought exemption

23 *About Us: What We Stand For*, RIGHT TO LIFE AUSTRALIA, http://www.righttolife.com.au/about (last visited Apr. 18, 2018).

24 *See, e.g.*, CHERISH LIFE QUEENSLAND, http://www.cherishlife.org.au (last visited Apr. 18, 2018); PRO LIFE VICTORIA, http://www.prolife.org.au/contact (last visited Apr. 18, 2018).

25 EMILY'S VOICE, https://emilysvoice.com/about-emilys-voice (last visited Apr. 18, 2018).

26 REPRODUCTIVE CHOICE AUSTRALIA, http://www.reproductivechoiceaustralia.org.au (last visited Apr. 18, 2018).

27 CHILDREN BY CHOICE ASSOCIATION INCORPORATED, https://www.childrenbychoice.org.au (last visited Apr. 18, 2018).

28 EMILY'S LIST, https://www.emilyslist.org.au (last visited Apr. 18, 2018).

29 J. Kassner & D. Lefkowitz, *Conscientious Objection*, *in* ENCYCLOPEDIA OF APPLIED ETHICS 594–601, 594 (Ruth Chadwick ed., 2nd ed. 2012).

30 Nilgün Toker Kilinç, *The Morals and Politics of Conscientious Objection, Civil Disobedience and Anti-Militarism*, *in* CONSCIENTIOUS OBJECTION: RESISTING MILITARIZED SOCIETY 61–74 (Özgür Heval Çinar & Coskun Üsterci eds., 2009) (conscientious objection is most commonly asserted as a right to withdraw, or not act, as in the case of refusing to refer for abortion, but could also encompass the ability, for reasons of conscience, to act); *see* Elizabeth Sepper, *Taking Conscience Seriously*, 98 VIRGINIA LAW REVIEW 1501–76, 1503, 1530 (2012).

31 Michael Duffey, *The Ethics of Conscientious Objection*, *in* ENCYCLOPAEDIA OF VIOLENCE, PEACE, AND CONFLICT 427 (Lester Kurtz ed., 2nd ed. 2008).

32 ANDERS SCHINKEL, CONSCIENCE AND CONSCIENTIOUS OBJECTIONS 485 (2007) (identifies the nineteenth century as the first time the term was used); *see also* HITOMI TAKEMURA, INTERNATIONAL HUMAN RIGHT TO CONSCIENTIOUS OBJECTION TO MILITARY SERVICE AND INDIVIDUAL DUTIES TO DISOBEY MANIFESTLY ILLEGAL ORDERS 2 (2009).

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from state compulsions.[33] In such cases, the nature of the demand of conscience was informed by religious teachings[34] or perhaps an individual's reflection on scripture.[35] Australia shares this religious foundation for conscientious objection but, as in some other jurisdictions, has shifted to recognize conscience claims beyond the religious sphere.[36] So today the possibility of secularized conscience, sometimes described as acting in accord with moral or philosophical convictions, has gained wide acceptance, to the point that the "identification of freedom of conscience with freedom of religious exercise seems much more problematic, if not thoroughly objectionable."[37] For example, the current regulation of military conscientious objection in Australia removed the restrictions on the kinds of beliefs that could found an objection and provided "no indicative or exhaustive list of the reasons that constitute conscientious objection," opening the door to any objection regardless of its foundation.[38] In the abortion context, legislation permitting conscientious objection when treating or advising women about abortion does not make any attempt to define conscientious objection.[39] It is notable that the two Victorian doctors who were subject to investigation both professed conscientious objections without mentioning religion explicitly, though one doctor was described in the media as a "practising Catholic"[40] and a "devout Catholic."[41] The media depiction of objection to abortion as stemming from religiosity is at odds with the doctors in question choosing to base their conscientious objection outside of religion. This seems to fit with the idea that an appeal to religion to ground an objection to abortion is unnecessary and unhelpful, with medical practitioners opposed to referring for abortion relying on human rights arguments to ground their objection.

Social scientist Hugh Smith attributes the recognition of secular conscience to the fact that Australia has no "established religion."[42] It is certainly the case that Section 116 of the Australian Constitution protects religious freedom, but does not enshrine a state role for religion.[43]

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33 Noah Feldman, *The Intellectual Origins of The Establishment Clause*, 77 New York University Law Review 346–428, 357–72 (2002); Duffey, *supra* note 31, at 427–28.

34 *See, e.g.*, Thomas Aquinas arguing that "it is necessary for man to receive from God some additional principles by which he may be directed to supernatural happiness": Thomas Aquinas, *Summa Theologica* Q. 62, art. 1, *in* Introduction to Saint Thomas Aquinas 590–91 (Anton C. Pegis ed., 1948); Edmund D. Pellegrino, *The Physician's Conscience, Conscience Clauses, and Religious Belief: A Catholic Perspective*, 30 Fordham Urban Law Journal 221–44, 227 (2002).

35 The "sola scriptura" approach, prominently espoused by Martin Luther, posited that the scripture itself was the only authoritative source of God's word: H. Jefferson Powell, *The Original Understanding of Original Intent*, 98 Harvard Law Review 885–948, 889–91 (1985).

36 Secular approaches to freedom of conscience were first adopted in Australia in the military context: *Defence Act 1903* (Cth) s 61(2) (compilation as of November 30, 1991).

37 Steven D. Smith, *What Does Religion Have to Do with Freedom of Conscience?*, 76 University of Colorado Law Review 911–40, 912 (2005).

38 Parliamentary Research Service, Defence Legislation Amendment Bill 1992, 1 (1992).

39 *See, e.g.*, *Health Act 1911* (WA) s 334, stating that "[n]o person … is under a duty … to assist or perform in the carrying out of an abortion."

40 Miranda Devine, *Doctor Risks His Career after Refusing Abortion Referral*, Herald Sun (Oct. 5, 2013), http://www.heraldsun.com.au/news/opinion/doctor-risks-his-career-after-refusing-abortion-referral/news-story/a37067e66ed4f8d9a07ec9cb6fd28cf5.

41 Hugo Gye, *Australian Doctor Could Be Struck Off after Refusing to Carry out Abortion on Woman Who Didn't Want to Have a Girl*, Daily Mail (Oct. 8, 2013), http://www.dailymail.co.uk/news/article-2449568/Doctor-Mark-Hobart-struck-refusing-abortion.html#ixzz4jWE6Wjny.

42 Hugh Smith, *Conscience, Law and the State: Australia's Approach to Conscientious Objection since 1901*, 35 Australian Journal of Politics and History 13–28, 16 (1989).

43 Gabriel A. Moens & John Trone, Lumb, Moens and Trone, The Constitution of the Commonwealth of Australia Annotated 799 (8th ed. 2012).

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There is, also, no explicit protection of freedom of conscience in the Constitution. This lack of an explicit constitutional basis for conscience protection has meant that protection of conscience is granted or limited by the legislation regulating areas where conscience may be particularly relevant, such as abortion and euthanasia. A similar approach is evident in the United Kingdom.[44] This approach can be contrasted with the position in the United States. There, the lack of an explicit reference to freedom of conscience in the Constitution has not inhibited conscience protection based on constitutional analysis.[45] And conscientious objection cases tend to be considered and resolved in accordance with the constitutional framework.[46]

Arguments for Allowing Conscientious Objection

A number of arguments have been so regularly advanced as justification for allowing conscientious objection that one commentator has identified them as the "classic rationales."[47] These include the *separate-spheres* argument, the *pragmatic* argument, and the *higher-order* argument. More recently the *plurality* argument has also been canvassed. We argue that the pragmatic and plurality arguments provide strong cases for permitting conscientious objection. Each is considered below, before some of the objections to these arguments are briefly outlined.

Separate-Spheres Argument

This argument posits that there are matters that should be regulated by government but that others are rightly left to the individual and their conscience. It is drawn from the writings of John Locke and became the "basic theoretical ground for the separation of church and state."[48] While the argument has historical significance, it seems to be less helpful as a basis for justifying recognition or denial of conscientious objection today. As American constitutional law scholar of religion and state, Steven D. Smith argues, this suggestion that religion and state, or conscience and state, can be neatly compartmentalized is a fallacy.[49] Military service provides a useful example. If, as Locke argued, the state has primacy in the areas of life, liberty, and property,[50] it would have the ability to compulsorily draft individuals to serve in wartime. However, the idea that military service could be offensive to religious precepts is a familiar one, and this is perhaps an area where conscientious objection has been most commonly recognized. Beyond the military sphere, for many of those with religious convictions, religion suffuses their life, rather than being neatly confined to their personal relationships or arenas that are relatively untouched by state interference. Therefore, as a basis for justifying religious conscientious objection this argument seems to fail to

44 Shawn H. E. Harmon, *Abortion and Conscientious Objection: Doogan—A Missed Opportunity for an Instructive Rights-Based Analysis*, 16 Medical Law International 143–73, 147 (2016).

45 Steven D. Smith, Rise and Decline of American Religious Freedom 49 (2014); Soledad Bertelsen, *Conscientious Objection of Healthcare Providers: Lessons from the Experience of the United States*, 3 Notre Dame Journal of International and Comparative Law 121–48, 129 (2013); Smith, *supra* note 37, at 913.

46 Bertelsen, *supra* note 45, at 131–32.

47 Smith, *supra* note 37, at 916–17.

48 Feldman, *supra* note 33, at 354.

49 Smith, *supra* note 37, at 918–19.

50 John Locke, Second Treatise of Government § 3 (C.B. Macpherson ed., Hackett Publishing 1980) (1690). This idea that there is a separation between those matters that are secular and those that are religious can also be traced to the work of John Calvin (the political kingdom and the spiritual kingdom) and Martin Luther (two kingdoms): see John Witte, *That Serpentine Wall of Separation*, 101 Michigan Law Review 1869–1907, 1883–84 (2003).

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have sufficient explanatory power. It is even less useful for examining conscientious objection based on secular claims of conscience.

Pragmatic Argument

This argument is sometimes described as a "pragmatic" argument.[51] Also canvassed by Locke,[52] this argument recognizes that claims of conscience are "connected to moral judgements" and are of "substantial magnitude."[53] As such, the absence of a sanctioned avenue for conscientious objectors is unlikely to lead to compliance in the sense that it is doubtful that their view that, say, abortion is morally wrong, would change as a consequence of compulsion.[54] The outcome is likely to be futile in the sense of leading to "unproductive conflict and waste."[55] It is also possible that this argument may be overstated at times, as it is likely that coercion could shape the beliefs of some who might otherwise conscientiously object, and discourage others from placing themselves in contexts where they are likely to face compulsion.[56] It may also provide a "sense of fairness" for those who do not object.[57]

It is appropriate that practical concerns including effectiveness be considered in the crafting of regulation in any sphere. Conscientious objection is no exception. Initiatives that discourage conscientious objection might well be part of a regulatory regime that probes the sincerity and basis of the conscientious objection.[58] Considering this, in the context of the abortion debate, might suggest that lawmakers should pragmatically avoid compulsion where beliefs are strongly held. On the other hand, it might also suggest that a regime that discourages claims of conscience will narrow the field of possible objectors to those who are genuinely committed to their claim. Once this cohort has been ascertained, it would also suggest it is futile to force belief in the moral correctitude of abortion.

Higher-Order Argument

The "higher-order"[59] or "morality" argument, proposes that acts of conscience are "worthy of respect because such acts reflect objective moral truths" founded in a religion.[60] It is this claim that was central to the historical development of conscience claims.[61] The claim involves the objector stating allegiance to divine or moral law that is more compelling than mere human law. Regulation that encompasses an evaluation of quality into the assessment of a conscience claim

51 Nadia N. Sawicki, *The Hollow Promise of Freedom of Conscience*, 33 Cardozo Law Review 1389–1449 (2012).

52 John Locke, A Letter Concerning Toleration (James H. Tully ed., William Popple trans., Hackett Publishing 1983) (1689).

53 Kent Greenawalt, *Religious Toleration and Claims of Conscience*, 28 Journal of Law and Politics 91–128, 94 (2013).

54 Luke W. Goodrich, *The Health Care and Conscience Debate*, 12 Engage 121–39, 123 (2011).

55 Greenawalt, *supra* note 53, at 97.

56 Smith, *supra* note 37, at 920–21 (arguing that coercion can be an effective means of overcoming claims of conscience).

57 Greenawalt, *supra* note 53, at 98.

58 The proposed changes to Australian vaccination regimes fall into this category: *Child Vaccination: Government Flags Welfare Crackdown*, The Australian (Apr. 7, 2015), http://www.theaustralian.com.au/national-affairs/health/child-vaccination-government-flags-welfare-crackdown/news-story/7f742c6965360e20590c9a6860cfb40c.

59 Smith, *supra* note 37, at 922–27.

60 Sawicki, *supra* note 51, at 1408.

61 Smith, *supra* note 37, at 923.

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bases its approach on this argument.[62] It also leads to legal arrangements that accommodate conscience claims only where they fall into specifically recognized categories such as religion.

In such cases often engagement in religious practice associated with a "recognized" religion is taken as evidence of the link between the claim of conscience and the moral truth.[63] This argument is not without its difficulties. For some scholars, there are distinct advantages in permitting secular as well as religious claims of conscience and this argument seems to be tied to religious positions.[64] For other commentators, it raises the difficulty associated with identifying the divine will.[65] The use of religious practice as a proxy for moral truth indicates the key difficulty associated with this argument. That is, it requires that we identify an objective moral truth. Furthermore, the adoption of religion as a sole measure of quality is unlikely to be acceptable in an increasingly secularized age, although increasingly notions of "secularized conscience" are being recognized and accommodated.

In modern times, the discussion of the value or otherwise of recognizing conscientious objection is often informed by human rights instruments, which are used to support or undermine arguments for the recognition of conscientious objection.[66] The human rights narrative may offer a secular variation on the higher-order argument, with the human rights framework providing the higher moral truth. This human rights approach allows the emergence of a secularized conscientious objection to abortion. Theoretically, the human rights narrative can offer a methodology for reconciling the competing demands of the objector with the needs of other individuals or society more broadly. For example, the right to object under this paradigm may be seen as "fundamental," in which case it would trump other lower-order rights, or "subjective," in which case it is "hierarchically inferior" to other fundamental rights.[67]

The Pluralism Argument

A final argument made in support of accommodating conscientious objection is focused on the worth of a pluralist society that permits a diversity of opinions and values human autonomy. These arguments are based on the individual and communal "goods" that flow from the recognition of freedom of conscience. These goods include both an internal aspect that responds to individual needs and an external aspect that provides the state with a way of "promoting the capacity

62 *See, e.g.*, *Defence Act 1903* (Cth) s 61CC.

63 *See, e.g.*, Amy J. Shaw, Crisis of Conscience: Conscientious Objection in Canada during the First World War 3 (2009) (explaining that the conscientious objectors to military service in Canada had to establish their active membership of an established religion).

64 Kent Greenawalt, *Refusals of Conscience: What Are They and When Should They Be Accommodated?*, 9 Ave Maria Law Review 47–65, 53 (2010). *But see* Pellegrino, *supra* note 34, at 232 (arguing that there are conceptual difficulties with the concept of secular conscience). For an argument that posits that only secular claims of conscience should be respected in the medical field, see Daniel Weinstock, *Conscientious Refusal and Health Professionals: Does Religion Make a Difference*, 28 Bioethics 8–15, 12–13 (2014).

65 Smith, *supra* note 37, at 923.

66 This is particularly evident in the context of abortion where arguments in favor of permitting conscientious objection are often based on recognition of the physician's right to freedom of conscience, while those who wish to limit or deny recognition of conscientious objection rely on the woman's rights to life and health: *see, e.g.*, Anne O'Rourke et al., *Abortion and Conscientious Objection: The New Battleground*, 38 Monash Law Review 87–119, 104–06 (2012); Bernard M. Dickens, *Legal Protection and Limits of Conscientious Objection: When Conscientious Objection is Unethical*, 28 Medicine and Law 337–47, 338–39, 343 (2009).

67 Bertelsen, *supra* note 45, at 126.

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for moral reflection on the part of citizens."[68] Philosophers Joshua Kassner and David Lefkowitz identify the drivers of respect for conscientious objection as "the value of individual autonomy, the need to preserve individual integrity as a condition for living a good life, and the moral importance of governmental epistemic humility in a pluralist society."[69] Law and religion scholar Stephen D. Smith describes a related justification that is focused on the individual benefits of recognizing conscience claims. He argues that governments should be wary of introducing regulation that coerces people to "act contrary to their core beliefs," because this undermines their identity as a human person, with "the good of personal or human believing [being] subverted."[70]

The decision to deny or permit conscientious objection is one that involves a society reconciling the needs of the community with the rights and needs of the individual. As the Standing Committee on Legal and Constitutional Affairs of the Australian Senate noted in the context of military service, a claim of conscientious objection involves a "clash of fundamental communal and individual rights."[71] The chosen resolution says a great deal about both the value ascribed to individual rights, and the nature of the society itself. The recognition of claims of conscience means that a diversity of views is tolerated.

For this argument, it does not necessarily matter that the claim of conscience is incorrect.[72] That is, that the objector is either incorrectly identifying their motivator as conscience, or, more fundamentally, wrong that the action or inaction is contrary to conscience. In other words, the value of deferring to claims of conscience is such that it can accommodate misguided claims. This approach has some advantages as, while we should act in accordance with what we believe is right, we cannot, in fact, know that we are correct in our identification of "right."[73] As Smith affirms, "[c]onscience . . . is not infallible; outlandish acts and wicked deeds have been perpetrated, sincerely, in the name of conscience."[74] It is also possible that some evaluation could be justified. Insincere or dishonest claims are not deserving of respect.

The more abstract considerations about the intrinsic virtue of a tolerant society have been cited in a variety of contexts. Family law expert Lynn Wardle argues that ensuring a diversity of voices can prevent one view becoming oppressive of others:

> Application of that principle to the rights of conscience in healthcare highlights the value of liberating conscience to cultivate wide diversity, so that no one viewpoint on the moral issue (such as the morality of dispensing pharmaceutical abortifacients or of participating in surgical abortions) excludes all others. Rights of conscience or moral pluralism produce greater liberty for all views of any particular moral issue.[75]

68 Weinstock, *supra* note 64, at 9.

69 Kassner & Lefkowitz, *supra* note 29, at 595. *See also* Armand H. Matheny Antommaria, *Conscientious Objection in Clinical Practice: Notice, Informed Consent, Referral, and Emergency Treatment*, 9 Ave Maria Law Review 81–99, 82 (2010).

70 Smith, *supra* note 37, at 936; *see also* Pellegrino, *supra* note 34, at 228.

71 Senate Standing Committee on Constitutional and Legal Affairs Report, Conscientious Objection to Conscripted Military Service 1985 (Cth) 7.

72 *Id.*

73 Steven D. Smith, *The Tenuous Case for Conscience*, 10 Roger Williams University Law Review 325–58, 338 (2005). *See also* Kassner & Lefkowitz, *supra* note 29, at 596.

74 Steven D. Smith, *The Promise and Perils of Conscience*, Brigham Young University Law Review 1057–67, 1064 (2003).

75 Lynn D. Wardle, *Protection of Health-Care Providers' Rights of Conscience in American Law: Present, Past, and Future*, 9 Ave Maria Law Review 1–46, 11 (2010).

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Feminist philosopher Carolyn McLeod, writing on health ethics, argues that the "fact that conscience has value in health care is clear,"[76] and that the value of conscience (and presumably conscientious protection) is primarily to "encourage us to take our moral values seriously."[77] Philosopher Mark Wicclair influentially argues that accommodating conscientious objections allows "health professionals to maintain their moral integrity."[78]

In Australia, military conscientious objection prompted reflection on the way allowing conscientious objection was appropriate in a democratic society. As the Senate Standing Committee on Constitutional and Legal Affairs has observed, "[t]he relationship between the government and the governed in Australia's democratic society requires and allows for the recognition of conscientious belief. In a democratic society, the bounds of toleration of individual behavior are not as tightly drawn as in an authoritarian, or totalitarian, society."[79] Likewise, in his article on conscientious objection in the workplace, prominent law and religion scholar, Patrick Parkinson, points out the dangers inherent in a society that refuses to accommodate conscience. He argues that there is a risk that policy makers adopt a "policy of moral monoculturalism" that fails to "offer a reciprocal level of respect to those who hold different beliefs."[80] Even if these arguments, make a case for the worth of recognizing conscientious objection, they do not necessarily justify all objections without limit. There may be good reasons why conscientious objection in particular instances should be limited or even denied. Reasons cited for denying or limiting conscientious objection are explored below.

Arguments for Limiting Conscientious Objection

A number of arguments are put forward for limiting conscientious objection in health care that are worthy of consideration in the context of our example of abortion regulation. We can group these arguments into three general themes. The first that emerges is that of balancing the interests or rights of the conscientious objector against the interests or rights of the woman seeking an abortion. The second draws on professional ethics to argue that medical practitioners should not be able to object to anything that is professionally appropriate. The third theme is focused on the practical difficulties associated with the recognition of conscience. Each is considered below.

Balancing of Interests and Rights of Medical Practitioners and Patients

A number of scholars have focused on evaluating or balancing the interests and rights of objectors against those of patients as determining whether conscientious objection can be tolerated. Some scholars draw on a rights analysis and argue that "fundamental" rights of women are at issue and that the "consequences of non-vindication for treatment seeking women are arguably more profound than the consequences to the healthcarers [sic] of participating against their conscience."[81] Presumably this perspective identifies that the consequences for the patient are more

76 Carolyn McLeod, *Taking a Feminist Relational Perspective on Conscience*, *in* BEING RELATIONAL: REFLECTIONS ON RELATIONAL LAW AND HEALTH LAW 161–81, 161 (Jocelyn Downie & Jennifer J. Llewellyn eds., 2012).

77 *Id*. at 172.

78 Mark Wicclair, *Conscientious Objection in Healthcare and Moral Integrity*, 26 CAMBRIDGE QUARTERLY OF HEALTHCARE ETHICS 7–17, 7 (2017).

79 Senate Standing Committee, *supra* note 71, at 29–30.

80 Patrick Parkinson, *Accommodating Religious Belief in a Secular Age: The Issue of Conscientious Objection in the Workplace*, 34 UNIVERSITY OF NEW SOUTH WALES LAW JOURNAL 281–99, 294–95 (2011) (citations omitted).

81 Harmon, *supra* note 44, at 160.

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significant than having to seek an alternative provider. It acknowledges that a health care provider's conscientious objection is an adverse judgment on a patient's decision to procure an abortion. Sometimes this conclusion is reached without an explicit consideration of the consequences for the health care provider.[82] This may indicate that, for the advocate, "the very message sent by acknowledging the claim [of conscience] is unacceptable."[83] For example, objection might be seen as "gender discrimination" in denying women reproductive rights or autonomy over their choice of medical treatment.[84] If this discrimination argument is adopted, the balancing exercise will always be resolved against permitting objection. Another related thread looks systemically at the effect of objection on the broad population of women seeking abortion services. It suggests that as the burden of conscientious objection would fall disproportionally on remote, vulnerable women, it should not be permitted ever.[85]

Human Rights

A further argument for limiting freedom of conscience in the context of abortion is founded in the idea that regulation should preserve and enhance human rights. The human rights argument can be seen as providing a contemporary and secular parallel to the higher-order argument in favor of conscientious objection. The argument is that permitting conscientious objection would inhibit women's human rights. The human rights argued to be at issue include the right to health, reproductive rights (seen as a subset of the right to health), the right to life (related to unsafe abortions), the right to autonomy, the right to equality and freedom from discrimination, and the right to access information and freedom of expression (related to the provision of information about abortion).[86] It is also possible to advance a human rights argument in favor of freedom of conscience based on the personhood of the fetus and their right to life. But those undertaking a balancing exercise appear to place this right as a second order right, in comparison to the health care and gender-based rights above.[87]

Professional Ethics, Identity, and Responsibility

The third theme is focused on the determining of some higher-order framework against which conscientious objections should be evaluated. For some commentators, the professional identity, ethics, and responsibility of the health care provider provides a useful yardstick. This argument is based on the role of a health care provider in practicing medicine, which encompasses a core and foundational role of patient care. This argument suggests that by seeking training medical practitioners volunteer for a particular role that includes providing "appropriate medical interventions that

82 Ronli Sifris, *Tasmania's Reproductive Health (Access to Terminations) Act 2013: An Analysis of the Conscientious Objection to Abortion and the "Obligation to Refer,"* 22 JOURNAL OF LAW AND MEDICINE 900–14 (2015).

83 Greenawalt, *supra* note 53, at 107.

84 Christian Fiala & Joyce H. Arthur, *"Dishonourable Disobedience"—Why Refusal to Treat in Reproductive Healthcare is Not Conscientious Objection*, 1 WOMAN—PSYCHOSOMATIC GYNAECOLOGY AND OBSTETRICS 12–23, 20 (2014).

85 Sifris, *supra* note 82, at 910.

86 Dorothy Shaw, *Best Practice and Research*, 24 CLINICAL OBSTETRICS AND GYNAECOLOGY 633–46, 638–42 (2010). *See also* Ronli Sifris & Suzanne Belton, *Australia: Abortion and Human Rights*, 19 HEALTH AND HUMAN RIGHTS JOURNAL 209–20, 210 (2017).

87 *See, e.g.*, Sifris & Belton, *supra* note 86.

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are legal, beneficial, desired by the patient and part of a just health care system,"[88] or are standard within the specialization to which they belong.[89] By failing to assist a patient in procuring an abortion, this argument suggests that a health care provider is failing to meet a core obligation of their professional identity and responsibility, namely to assist patients in meeting their medical needs. Variations on this theme suggest that there is scope to object conscientiously only to those treatments that are "liminal,"[90] or "professionally contested."[91] The question of whether abortion is a "professionally contested" medical procedure is itself controversial and one that provokes fierce disagreement. This is especially so given that medical practitioners are professionals who exercise discretion in all matters of their work. As indicated by the *Good Medical Practice Code* associated with the National Law, good treatment is a "shared responsibility" between the patient and the doctor.[92]

Practical Difficulties of Assessment

The fourth argument is focused on the nature of the objection and the difficulty of assessing the genuineness of conscientious objection. A recent contribution suggests that in a "liberal democracy" that there is no principled basis by which we can assess the "plausibility of the ideological dicta that lead to conscientious objection" nor can we test whether the ideology is genuinely held.[93] And, as a consequence, no objection should be permitted. Conversely, Sara Fovargue and Mary Neal put forward a series of prequalifying requirements "some or all" must, they suggest, be met for a claim of conscience to be accepted.[94] It is not just the difficulty in assessing the basis and validity of the conscience claim, but also the inherent challenges associated with developing a rigorous procedure (such as the aforementioned tribunal process for conscience claims against conscription) in the contemporary age of limited health care budgets and the push for smaller government and tighter medical administration.

Discussion of Arguments for and against Accommodating Freedom of Conscience Claims

It is possible to see the four main arguments against conscience claims as falling into similar categories as the four main arguments in favor. The balancing process relies on attributing a value to

88 Julian Savulescu, *Conscientious Objection in Medicine*, 332 British Medical Journal 294–97, 295 (2006).

89 Fiala & Arthur, *supra* note 84, at 20.

90 Sara Fovargue & Mary Neal, *"In Good Conscience": Conscience-Based Exemptions and Proper Medical Treatment*, 23 Medical Law Review 221–41, 229 (2015).

91 Ronit Y. Stahl & Ezekiel J. Emanuel, *Physicians, Not Conscripts—Conscientious Objection in Health Care*, 376 New England Journal of Medicine 1380–85, 1383 (2017).

92 *Good Medical Practice Code*, *supra* note 11, § 2.3, at 6.

93 Udo Schuklenk & Ricardo Smalling, *Why Medical Professionals Have No Moral Claim to Conscientious Objection Accommodation in Liberal Democracies*, 43 Journal of Medical Ethics 234, 236 (2017).

94 Fovargue & Neal, *supra* note 90, at 230 (citations omitted):

> (i) the position held must be sincere; (ii) it must fit within a coherent system of ethical belief; (iii) it must be consistent with the H[ealth] C[are] P[rovider]'s other beliefs and actions, particularly those in proximate areas of concern; (iv) it must be key or fundamental in the sense that its violation poses a serious risk to the HCP's moral integrity; (v) reasonable alternatives must have been considered so that the exercise of a CBE [conscience-based exemption] is a "last resort"; (vi) the HCP seeking the CBE must be able to "articulate the basis of [her] position"; (vii) the rationale must reflect a valid view of the ends/goals of medicine; (viii) the position must not be intolerant or disrespect the different conscientious conclusions of others; and (ix) the objection must be to the treatment, rather than to the individual patient.

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the interests of the parties, followed by an assessment of the likely effect of the prioritization of one party over the other, so that might involve prioritizing the interest of the patient over the medical professional or vice versa. These arguments are essentially pragmatic ones. They suggest that reasons of conscience can only be accommodated where the balancing of interests leads to the conclusion that conscientious objection can be allowed. In cases of emergency, where the woman's life is at risk, the objector's needs are sublimated to those of the patient. There is no evaluation of the quality or nature of the claim of conscience, though perhaps there might be a consideration of the sincerity of the beliefs. In the balancing of interests, it could be significant that the beliefs are honestly held. Any suggestion that they are confected would tend to tip the balancing exercise in favor of patient primacy.

This balancing of interests argument for limiting conscientious objection also shares with the higher-order argument for permitting conscientious objection a claim to objective morality similar to that claimed by universal human rights frameworks explored in the second argument. These are invoked to inform the balancing equation. However, this approach runs into difficulty, as there is no generally accepted hierarchy of rights. This means that those who are predisposed to favor freedom of conscience or freedom of religion place these rights at the top of the hierarchy, and those who prefer to advance women's access to health care suggest conversely that it is more fundamental.

The arguments based on professional ethics, identity, and responsibility are also connected to the higher-order argument that conscience claims should only be recognized where they are consistent with a moral truth, or divine law. In this case, the argument is that the professional identity, drawn from the legal framework, statements of professional bodies, or those professional services not seen as controversial, defines the moral truth for the individuals who adopt it. As such, any claim of conscience that diverts from the professional identity is seen as morally wrong. Claims of conscience based on these professional criteria may be seen as displacing religious conceptions of a higher order for a purely secular notion. It also displaces individual convictions for a group consensus model of conscience, assuming that professional identity is readily discernible and uniform for all members of the profession.

The final argument for limiting conscientious objection also seems to have connections to the higher-order argument in favor, but takes a different approach. It accepts that it is difficult to identify a higher or divine order, but its response then is to say that this is a fatal problem for claims of conscience. It suggests that claims of conscience are not deserving of accommodation, because they cannot be objectively measured or evaluated.

To conclude, this analysis suggests that there are four significant arguments deployed in favor of accommodating conscientious objection: separate spheres, pragmatism, higher order, and pluralism. The separate spheres argument runs into difficulties in that it assumes a divided life, rather than an integrated whole. The higher-order approach is also challenging in the context of contemporary society where there is no general agreement on moral positions, and a diversity of opinions is tolerated. The use of human rights instruments and professional identity as an objective way of ascertaining a medical practitioner's professional identity does not seem to be entirely successful in resolving disagreement. While arguments can be made for a special status to be given to religious claims,[95] this approach seems to be unlikely to gain support in Australia. More likely is the possibility that claims of conscience are seen as associated with gender discrimination, and hence unacceptable.

95 *See, e.g.*, Greenawalt, *supra* note 53, at 97.

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In contrast with the higher-order argument, the benefits provided by the pragmatic and pluralist approaches are that they provide a practical and achievable approach that grounds conscientious objection regulation while being open to both secular and religious bases for objection. The next section will turn to the way regulatory regimes have been framed in the context of referral to abortion. It will consider the extent to which the preferred pragmatic and pluralist approaches have been adopted.

CONSCIENTIOUS OBJECTIONS TO REFERRAL FOR ABORTION IN AUSTRALIAN LAW

Despite the prevalence of abortion in Australia,[96] the state of the law is quite unsettled.[97] In some Australian states abortion is still regulated by the criminal law,[98] however other jurisdictions like Victoria, Tasmania, and the Northern Territory have recently transitioned from viewing abortion as a matter regulated by criminal law to one that is dealt with in the framework of health care legislation.[99] Canadian bioethicists and health law scholars Rebecca Cook and Bernard Dickens see this as a general trend: "Modern thinking on abortion law directs policy and legislation away from the historical preoccupation with criminalization and punishment, towards the protection and promotion of women's health and prevention of unsafe abortion."[100]

Some further transition in abortion law is advocated on a human rights basis as indicated in the preceding section.[101] Additionally, the strongly held views of various groups, including women's rights advocates, religious groups, and professional associations on the issue mean that politicians are wary of reform initiatives.[102] As a consequence, change occurs slowly, with policy transition reflected incompletely and inconsistently in the different jurisdictions. Some jurisdictions have retained the approach of criminalizing abortion subject to certain, potentially expansive, exceptions.[103] In others, the shift to a health care approach is evident.[104] It is difficult to discern the basis for the obligation to refer. It is, however, arguable that the Victorian, Tasmanian, and Northern Territory reforms indicate an allegiance to a secular higher-order approach, drawing on a human rights framework that prioritizes the woman's access to abortion.[105] It is also possible

96 Caroline de Costa, *Abortion Law, Abortion Realities*, 15 James Cook University Law Review 6–22, 20–21 (2008).

97 Ronli Sifris, *The Legal and Factual Status of Abortion in Australia*, 38 Alternative Law Journal 108–12, 112 (2013).

98 The following statutes enshrine abortion as a crime: *Crimes Act 1900* (NSW) ss 82–84; *Criminal Code 1899* (Qld) ss 224–26; *Criminal Law Consolidation Act 1935* (SA) ss 81–82; *Criminal Code Act Compilation Act 1913* (WA) s 199 (though this is subject to s 334 of the *Health Act 1911* (WA)). *See also* Ronli Sifris, *A Woman's Right to Choose: Human Rights and Abortion in Australia*, *in* Contemporary Human Rights Issues in Australia 251–273, 251 (Paula Gerber & Melissa Castan eds., 2013).

99 Bernadette Richards & Jennie Louise, Medical Law and Ethics: A Problem-Based Approach 35 (2014).

100 Rebecca J. Cook & Bernard M. Dickens, *Human Rights Dynamics of Abortion Law Reform*, 25 Human Rights Quarterly 1–59, 12 (2003).

101 *Id.* at 21; de Costa, *supra* note 96, at 21.

102 Andrew Pesce, *Abortion Laws in Australia: Time for Consistency?*, 29 University of New South Wales Law Journal 224–26, 224 (2006).

103 *See, e.g.*, *Criminal Law Consolidation Act 1935* (SA) s 82A; *see also* Sifris, *supra* note 97, at 110.

104 *See, e.g.*, *Health Act 1993* (ACT) pt 6.

105 For more on the place of abortion within the human rights paradigm, see Christina Zampas & Jaime M. Gher, *Abortion as a Human Right—International and Regional Standards*, 8 Human Rights Law Review 249–94 (2008).

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that the lack of tolerance for conscientious objections may derive from the discrimination argument that sees any objection as unacceptable, and driven by gender discrimination.

All jurisdictions in Australia provide some basis for conscientious objection. Historically, the approach to conscientious objection in the existing legislative regimes is a generous one, though there is some variation in the degree of recognition of conscience objection across Australia. Of the states that have legislation,[106] the most liberal regimes exist in Western Australia and the Australian Capital Territory. Western Australia simply provides as follows: "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."[107] In the Australian Capital Territory the Health Act 1993 states: "No person is required to assist or perform in the carrying out of an abortion."[108] These provisions provide a safe harbor for practitioners or institutions who wish to assert conscientious objections. There is no limitation on, or scrutiny of, the reasons for nonparticipation. As such this very tolerant regime can be seen as consistent with the pluralistic and pragmatic approaches.

A middle ground can be seen in South Australia. There, the refusal must be due to a conscientious objection, though this is not defined in the legislation.[109] The person relying on a conscientious objection has the burden of proving their objection in any subsequent legal proceedings. An additional provision limits the situations where conscientious objection can be made. It is not available where "treatment is necessary to save the life, or to prevent grave injury to the physical or mental health of a pregnant woman."[110]

South Australia's approach appears to reflect a pluralistic approach in that it permits conscientious objection regardless of whether the motivation is religious or secular. There is also an element of pragmatism in that a claim of conscience could be scrutinized in the course of malpractice proceedings, thus placing some pressure on practitioners to ensure that they have a defensible position, but providing protection for deeply held beliefs. If the practitioner were unable to establish their actions were due to a genuinely held conscientious objection they would be potentially found liable for negligence. There are no reported cases where conscientious objection has been an issue.

Tasmania, Victoria, and the Northern Territory have the most recent legislation in the abortion area. Victoria's was passed in 2008, Tasmania's in 2013, and the Northern Territory's in 2017. These three reforms provide the least accommodation for conscientious objection, and signal a distinct shift away from pragmatism and pluralism. The Victorian legislation, for example, requires the practitioner to "make enquiries or take other steps to inform himself or herself of the views of the health practitioner to whom the referral is to be made."[111] This requirement was said to have been "carefully crafted in order to strike an appropriate balance between the rights of registered health practitioners to conduct themselves in accordance with their religion or beliefs, and to freedom of expression, and the right of women to receive the medical care of their choice."[112] While this suggests that the referral obligation is an attempt to balance the individual practitioner's conviction against the woman's right to receive medical care, the link between the referral and the

106 New South Wales and Queensland rely on the common law.
107 *Health Act 1911* (WA) s 334.
108 *Health Act 1993* (ACT) s 84.
109 *Criminal Law Consolidation Act 1935* (SA) s 82A(5).
110 *Id.* s 82A(6).
111 Explanatory Memorandum, Abortion Law Reform Bill 2008 (Vic) 3.
112 Victoria, *Parliamentary Debates*, Legislative Assembly, 19 August 2008, 2954 (Maxine Morand, Minister for Women's Affairs).

woman's right to medical care is not explained or justified. This may indicate that there is no genuine balancing here, and the reform is shifting towards an approach that sees objections as fundamentally unacceptable as indicators of discrimination.

The 2013 Tasmanian reforms to abortion law also limit conscientious objection. When introduced, the Reproductive Health (Access to Terminations) Bill 2013 (Tas) provided that where a practitioner has a conscientious objection he or she "must refer the woman to another medical practitioner who the first-mentioned practitioner reasonably believes does not have a conscientious objection to terminations."[113] Ultimately, the legislation adopted a softer position, requiring the objector to refer indirectly by providing the woman with "a list of prescribed health services from which the woman may seek advice, information, or counselling on the full range of pregnancy options."[114] In terms of obligations, this is less onerous than the law in Victoria. Nonetheless, it is still more demanding than the Australian Medical Association's (the most prominent membership association for doctors) Code of Ethics as well as the *Good Medical Practice Code* for doctors published by the Medical Board of Australia, a statutory body that registers and sets standards for Australian doctors. The *Good Medical Practice Code* simply states that good medical practice encompasses a medical practitioner asserting a right to conscientious objection in the case of abortion through informing patients and colleagues of their position: "Being aware of your right to not provide or directly participate in treatments to which you conscientiously object, informing your patients and, if relevant, colleagues, of your objection, and not using your objection to impede access to treatments that are legal."[115] The Act also provides medical practitioners with the standard ability to assert conscientious objection to abortion, unless the abortion is necessary to save the pregnant woman's life or to prevent her serious physical injury.[116] Similarly, the Northern Territory has passed its own legislation, adopting the Victorian model, which sets out the obligation of a medical practitioner who has a conscientious objection to a "proposed termination."[117] This reform mandates that a medical practitioner must inform the woman of her conscientious objection and refer the woman "within a clinically reasonable time" to another medical practitioner known to be without a conscientious objection to abortion.

In order to understand the laws in various Australian jurisdictions, it must be understood that "referral" is a term of art in the medical field. As the process of referral is linked to the public health insurance scheme it must be made in accordance with the regulations.[118] Referrals are required to be in writing, dated, and signed by the practitioner.[119] The referring practitioner must consider the need for the referral and provide any information about the patient's condition that is necessary.[120] As legal scholar Wendy Larcombe explains, a referral "establishes and necessitates a working relationship between the primary medical practitioner and the practitioner from whom the referral is sought."[121]

113 Reproductive Health (Access to Terminations) Bill 2013 (Tas) pt 2 s 7(2).
114 *Reproductive Health (Access to Terminations) Act 2013* (Tas) pt 2 s 7(2).
115 *Good Medical Practice Code* § 2.4.6, at 7, Mar. 17, 2014.
116 *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 6(3) pt 2.
117 *Termination of Pregnancy Law Reform Act 2017* (NT) s 11 pt 2.
118 *Health Insurance Act 1973* (Cth) s 132A pt 7.
119 *Health Insurance Regulations 1975* (Cth) r 29.
120 Id. at rr 29(2)–(3).
121 Wendy Larcombe, Rights and Responsibilities of Conscientious Objectors under the Abortion Law Reform Act 2008 (Vic), Paper presented at 'W(h)ither Human Rights': 25th Law and Society Association Australia and New Zealand Conference (December 2010), at 6.

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In Tasmania, Victoria, and the Northern Territory, the restriction on conscientious objection is centered on an obligation to refer, although there is a lack of clarity around whether the referral needs to be directly or whether indirect referral suffices. The varying views about the meaning of "refer" in the Victorian Act have provided some difficulty since enactment. Views proffered to a Tasmanian Parliamentary Committee report, provided a variety of interpretations including that it obliges "standard medical" referral, a "pamphlet" or "brochure," referral "to a practitioner who can give all-options information" and "referral to established family planning centre or an appropriately accredited abortion clinic."[122] The Tasmanian provisions ultimately passed are less onerous than those in place in Victoria and the Northern Territory, as they do not appear to require a direct referral, although admittedly some commentators have expressed the view that the effect of both the Tasmanian and the Victorian provisions are the same.[123] Under the Tasmanian Act, the obligations of the objecting medical practitioner are explicitly drafted to permit an "indirect" rather than "direct" referral as a "list of prescribed health services" is required to be provided to the patient.[124]

The meaning of referral is not just an academic matter. A failure to comply with the duty will, as seen in the two Victorian cases with which this article opens, potentially lead to significant professional sanctions being imposed on medical practitioners.[125] It may also be considered in the context of medical negligence proceedings.[126] It is also likely that a direct referral will be more offensive to objectors than an indirect one. Frank Chervenak and Lawrence McCullough, a medical doctor and a medical ethicist, respectively, have previously argued that the direct and indirect referrals are ethically different.[127] By engaging in a direct referral "the physician is indeed a direct party to the referral and the performance of the procedure." In contrast, they contend, the indirect referral honors the doctor's fiduciary obligation to protect the patient from incompetently performed abortions whilst also ensuring that the physician "cannot reasonably be understood to be a party to, or complicit in a subsequent decision" to pursue an abortion.[128]

Some commentators have characterized the duty to refer as an "unnecessary and gratuitous attack on freedom of conscience"[129] and asserted that it has the potential to make the practitioner "complicit" in the process.[130] Even those who are in favor of the imposition of the duty have suggested mechanisms by which doctors can avoid it by actively discouraging patients from seeking abortion.[131] Options such as recorded announcements for telephoning patients, signs in waiting

122 Legislative Council Government Administration Committee "A," Report on Reproductive Health (Access To Terminations) Bill 2013 (Tas) 54–58 (2013).

123 *See, e.g.*, Sifris, *supra* note 82.

124 *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 7.

125 Under the National Law possible sanctions include cautions, the imposition of conditions, fines, and the suspension or cancellation of registration. *See Health Practitioner National Law Act 2009* (Qld) s 196. This was adopted in Victoria by the *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic) s 4.

126 Danuta Mendelson, *Decriminalisation of Abortion Performed by Qualified Health Practitioners under the* Abortion Law Reform Act 2008 (Vic), 19 JOURNAL OF LAW AND MEDICINE 651–66, 662 (2012).

127 Frank A. Chervenak & Laurence C. McCullough, *The Ethics of Direct and Indirect Referral for Termination of Pregnancy*, 199 AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY 232.e1–e3, 232.e1 (2008).

128 *Id.* at 232.e2.

129 Patrick Parkinson, *Christian Concerns about an Australian Charter of Rights*, 15 AUSTRALIAN JOURNAL OF HUMAN RIGHTS 83–122, 105 (2010).

130 Greg Craven, *Denying People Right to Conscience Akin to Fascism*, THE AGE (Sept. 26, 2008), http://www.theage.com.au/news/opinion/denying-people-right-to-conscience-akin-to-fascism/2008/09/25/1222217428407.html?page=fullpage.

131 *See, e.g.*, Larcombe, *supra* note 121; O'Rourke et al., *supra* note 3, at 108.

rooms and advertisements in the Yellow Pages and other advertising media are advocated as mechanisms by which a doctor with a conscientious objection to abortion can avoid being put in a position of having to refer.[132] These strategies seem to reflect a level of recognition of the referral as an imposition on the practitioner's conscience.

Australian reproductive health law researcher Ronli Sifris, in her article defending the incursion on a doctor's right to conscientiously object to referring for abortion based on her belief in the supremacy of the right to health, states that the indirect approach merely creates "an obligation to refer a woman to someone who does not have an objection to abortion so that a frank, impartial, non-judgmental conversation can take place."[133] However, even the indirect approach does not provide access to "impartial advice" as, just like the doctor with a conscientious objection to abortion cannot be viewed as impartial because they are opposed to abortion, a doctor without a conscientious objection to abortion is not impartial either as they are pro-abortion—they are willing to perform an abortion or make a referral for abortion. In this scenario, even though the latter doctor is the only one of the two not to impede access to abortion, neither medical practitioner can claim impartiality. Both have adopted a particular perspective as to the merits of abortion. Additionally, although, from the perspective of a doctor with a conscientious objection, both an indirect and a direct referral renders them complicit in the process of securing an abortion, the latter involves a more direct contribution to the eventual termination of pregnancy.

Exploring the genesis of the obligation to refer is not just an academic issue. We argue that the provision in Victoria, and the later provisions in Tasmania and the Northern Territory, are unusual when compared with other regulations in place at the time, and represent a shift in approach to conscientious objection away from pragmatism and pluralism and, perhaps, towards a gender discrimination-based approach.[134]

The reason why the limited approach to conscientious objection in requiring practitioners to refer has emerged is not clearly explained in the Victorian Law Reform Commission (VLRC) report, which preceded the Victorian reforms in 2008. Further, as legal scholar Jenny Morgan has identified, "[o]n the basis of the public record, it is not possible to discern the origin of the precise terms of the referral clause or provision that was enacted."[135] It is, however, possible to surmise that the impetus for the provision was, at least in part, garnered from a VLRC report commissioned by the government in 2007. Attorney-General Rob Hulls had provided somewhat unusual terms of reference, from which it was evident that the government was committed to reform but wanted the reform to be "neither too 'radical' nor too 'conservative.'"[136]

The VLRC report recommended provision for conscientious objection in non-emergency situations be included in the proposed legislation. On the issue of referral, the report examines the position of medical practitioners in several other jurisdictions, as well as in Victoria. In coming to its recommendation that doctors be required to provide an "effective" referral, the report suggests that referral obligations are a standard approach in a number of jurisdictions. However, the examples cited do not support this position. The New South Wales example cited as creating an "obligation to transfer the care of the patient to another medical specialist or health professional on site or at another Area Health Service Facility" is drawn from a policy directive to New South Wales

132 Larcombe, *supra* note 121.

133 Sifris, *supra* note 82, at 906.

134 See discussion in section titled "What is Conscientious Objection?" above.

135 Jenny Morgan, *Abortion Law Reform: The Importance of Democratic Change*, 35 University of New South Wales Law Journal 142–74, 162 (2012).

136 *Id.* at 159.

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public health organizations.[137] While it may well be of interest, and it is undoubtedly an indication of the policy position of the relevant health department, it, of itself, creates no legal obligation on practitioners. The discussion of the U.K. framework cites the National Health Service (General Medical Services) Regulations 1992, S.I. 1992/635. These regulations set out the terms of service for providers in the National Health Service and include an obligation to provide "all necessary and appropriate personal medical services of the type usually provided by general medical practitioners" and arrange "for the referral of patients, as appropriate, for the provision of any other services."[138] While this does place a legal obligation on medical practitioners there is no mention of abortion specifically, and, further, its National Health Service context creates a distinctive setting. National Health Service patients must register and reside in a catchment area in order to use a particular general practitioner. This means that there is a degree of patient immobility that may provide a rationale for the referral provision that does not exist in the Australian context given that public health provision does not place geographical limits on where patients seek medical treatment.[139] This limits the utility of the VLRC report's reliance on the National Health Service system as a reason to limit conscientious objection claims in the Australian context.

Further, the discussion in the report of the New Zealand position refers to the legislation permitting conscientious objection and then states the "doctor has an obligation to refer the woman on for assessment if requested."[140] This "obligation" is supported by a footnote to a website written and maintained by Istar Ltd, an organization created by a number of doctors with the aim of making a particular abortifacient drug available to New Zealanders.[141] Contrary to the views expressed on this website, the position in New Zealand was judicially considered in 2010 and the court came to the view that medical practitioners are not under an obligation to refer.[142]

The report does advance some reasons why the duty to refer should be included in the legislation. These include balancing the rights of "individuals to operate within their own moral and religious beliefs with the equally important ethical consideration doctors have to act in the best interest of patients."[143] The other reasons mentioned are access to abortion and the risk that patients be "demeaned or poorly treated if they seek abortion."[144] This seems to gesture in the direction of the gender discrimination argument against conscientious objection.

The legislative approaches in Victoria, the Northern Territory, and Tasmania suggest that pragmatic and pluralist reasons for permitting conscientious objection have been set aside in the context of abortion. While older abortion legislation is accommodating in its approach to conscientious objection, the more recent reforms have restricted the scope of conscientious objection. This represents a significant incursion into the ability of medical practitioners to object conscientiously to anything except direct participation in non-emergency abortions. The Victorian and Northern Territory reforms are the most restrictive in that the text of the legislation appears to require direct

137 Ministry of Health, New South Wales Government, Policy Directive No. PD2005_587, Pregnancy—Framework for Terminations in New South Wales Public Health Organisations § 4.2, at 5 (2005).

138 National Health Service (General Medical Services) Regulation 1992 r 12 (Eng. & Wales).

139 See explanation available at *How to Register With a GP Practice*, NATIONAL HEALTH SERVICE, http://www.nhs.uk/NHSEngland/AboutNHSservices/doctors/Pages/NHSGPs.aspx (last visited Jan. 13, 2016).

140 VICTORIAN LAW REFORM COMMISSION, LAW OF ABORTION: FINAL REPORT 113 (2008) (citations omitted).

141 *Id.* (citing ABORTION SERVICES IN NEW ZEALAND, http://www.abortion.gen.nz/about.html).

142 *Hallagan v. Medical Council of New Zealand* HC Wellington CIV 2010-485-222, 2 December 2010 at paras. 31–34 (N.Z.).

143 VICTORIAN LAW REFORM COMMISSION, *supra* note 140, at 114.

144 *Id.*

referral. The Tasmanian option responds to some degree to the concerns that this option is unduly coercive by focusing on indirect referral.

These reforms also depart from the approach to regulating conscientious objection in other areas. In the context of military service a restrictive process was perceived to be unduly "adversarial" and "expressed and conducted in 'government-against-individual terms.'"[145] A more expansive regime was adopted on the basis that "[t]o be coerced by law into acting contrary to this imperative [of conscience] would be to experience a violation of one's integrity as a human being."[146] Similarly, the legislative attempts to legalize euthanasia have proposed a liberal approach to conscientious objection. A number of bills simply state, "[a] medical practitioner may decline to carry out a request for the administration of voluntary euthanasia on any grounds."[147] In her second reading speech in support of the Rights of the Terminally Ill Bill 2013 (NSW), Member of Parliament Cate Faehrmann highlighted that "the bill recognises that some practitioners have conscientious objections to the concept of assisted dying. Their right to hold such a position will be respected."[148] If the regulation of conscientious objection in the abortion context is anomalous, as this section has advanced, it is important to seek to understand this distinction. Is it because abortion is conceptually and qualitatively distinct to the other areas being considered?

Society is not at one on the question of abortion and a diversity of views is tolerated, which is arguably reflected (and should be reflected) in the makeup of the medical profession. This is because freedom of conscience is worth supporting as a human right for individuals, and also because it promotes a pluralistic society in which a healthy diversity of views is permitted. Medical practitioners possess professional duties with regard to the health and wellbeing of patients. Central to the whole question of conscientious objection is the claim that particular activities are required by society of people who act within a particular professional role. Both the plurality and pragmatic approaches would suggest that barring conscientious objection is the *least* preferable option as both the individual and common good are served by accommodating the medical practitioner's conscientious objection where it does not encompass the vast majority of his or her professional duty. If a medical practitioner chooses not to refer for abortion because of conscientious objection, it is preferable that this is covered by the presence of other medical practitioners rather than excluding the medical practitioner from the profession or forcing the violation of conscience.

Similarly, if the law requires mandatory referral for abortion by medical practitioners, its likely effect is to denote that conscientious objection to abortion is unprofessional and, therefore, dissuade medical practitioners with a conscientious objection to abortion from remaining in the profession, or selecting obstetrics or general practice as their specialty.[149] In addition, it may inhibit medical students with a similar moral persuasion from entering the profession and becoming

145 Senate Standing Committee, *supra* note 71, at 18.

146 *Id.* at 10.

147 Voluntary Euthanasia Bill 2012 (SA) cl 12. This bill failed to garner sufficient parliamentary support. A similar broad exemption can be seen in the short-lived Northern Territory Act, *Rights of the Terminally Ill Act 1995* (NT) s 5. *See also* Voluntary Euthanasia Bill 2010 (WA) (lapsed) cl 5; Voluntary Assisted Dying Bill 2013 (Tas) (failed) cl 31(2)(d); Rights of the Terminally Ill Bill 2013 (NSW) (negatived) cl 5.

148 New South Wales, *Parliamentary Debates*, Legislative Council, 2 May 2013, 19869 (Cate Faehrmann, Member of Legislative Council).

149 For example, this is the likely effect of the law in Sweden where conscientious objection to abortion is not permitted under the law. *See* Anna Heino et al., *Conscientious Objection and Induced Abortion in Europe*, 18 European Journal of Contraception and Reproductive Health Care 231–33, 232–33 (2013).

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general practitioners.[150] Given that the occupation of general practitioner is deemed to be in skill shortage in Australia,[151] such an approach risks "*reducing* the access to health care for everyone who is not seeking abortion."[152] A pragmatic approach would permit conscientious objection while also promoting increased health literacy through facilitating community awareness that abortion can be procured without referral.

CONSIDERATIONS REGARDING FREEDOM OF CONSCIENCE IN ABORTION REFERRAL

In this section we build two central arguments as to why freedom of conscience in matters of referral should be limited. First, drawing on the pragmatism argument, we establish that patients' rights and autonomy in choosing abortion needs to be properly counterbalanced with medical practitioners' rights and autonomy to not participate in abortion. We argue that the distinctive nature of the referral process in Australia is tantamount to participation in the abortion that may result from the referral. Second, we argue that pragmatism suggests a patient's right to choose abortion is more effectively and efficiently addressed through improving public health literacy rather than through compelling medical practitioners with a conscientious objection to abortion to act against their conscience. This also reflects the pluralist argument of the importance of societal accommodation for a diversity of approaches, perspectives, and beliefs. This will have far more positive effects in terms of access to abortion than a legal requirement of referral.

Thus, both arguments are underpinned by the "pragmatism" and "pluralism" arguments outlined earlier. Given the seriousness with which those with conscientious objection to abortion generally regard abortion—as a violation of core tenets of the meaning of human life and when it begins—legal compulsion to refer is unlikely to increase women's access to abortion. A pragmatic approach recognizes the unlikelihood that these practitioners will comply with the law. Nor should they, says a pluralist approach, which is more likely to support improved health literacy so that some members of society who wish to access an abortion can do so through their own means and without threatening the conscience of other members of society.

Patients' Rights and Autonomy

This argument against protection of conscience in the instance of medical referral for abortion stipulates that the rights of a medical practitioner to refuse to refer for abortion need to be counterbalanced against the similarly compelling rights of a patient to follow her own autonomy in choosing the medical procedure. This principle of "patient autonomy"[153] mandates that the patient makes the final decision concerning her medical care and that the medical practitioner should facilitate the achievement of the patient's wishes so long as the requested procedure is not medically contraindicated (since it is both medically effective and not considered unethical within the

150 Fiala & Arthur provide an example of this perspective. They argue that refusing to refer for abortion should be deemed to be "dishonourable disobedience" rather than "conscientious objection": Fiala & Arthur, *supra* note 84, at 20.

151 For a current copy of the State/Territory Nominated Occupations List detailing occupations deemed to be in shortage, *see ANZSCO Occupations*, Acacia Immigration Australia, https://www.acacia-au.com/STNOL.php (last updated Aug. 3, 2017).

152 Goodrich, *supra* note 54, at 123.

153 Martha S. Schwartz, *"Conscience Clauses" or "Unconscionable Clauses": Personal Belief Versus Professional Responsibilities*, 6 Yale Journal of Health Policy, Law, and Ethics 269–350, 277 (2006).

profession's generally accepted concept of ethical practice) and it is not illegal. Beyond these two parameters, there is no room for a medical practitioner's conscience views to constrain a patient's right to access a particular medical procedure.

This argument appeals to the premise that respect for others requires that one facilitates the conscientious choices of others, for example in the scenario given above, the desire to procure an abortion. However, this argument is challenged by notions of "complicity" and requires consideration of the extent to which facilitating the conscientious choice of another to obtain an abortion through referral renders the medical practitioner as complicit in an abortion which later takes place. Our starting point is that medical practitioners are professionals who exercise discretion in all matters of their work. As indicated by the *Good Medical Practice Code* associated with the National Law, good treatment is a "shared responsibility" between the patient and the doctor.[154]

Part of this involves the doctor having a responsibility to refuse treatment on the basis of clinical need and effectiveness, but also due to conscientious objection.[155] Therefore, refusal of treatment is both consistent with the law, and at one with the profession's concept of appropriate treatment and professional conduct. For example, if a patient seeks a course of antidepressants, it is within the medical practitioner's purview to refuse; likewise, refusal is justified if a patient requests a referral to an eye specialist but the medical practitioner cannot find an evidential basis to ground the referral. What is distinct about the abortion scenario is first, patients have a legal right to access abortion and secondly, a medical practitioner's refusal to refer is not based in a difference of opinion with the patient about the best course of action but because of their conscientious objection to abortion.

Therefore, the extent to which we can limit a patient's autonomy is determined by how much value is placed on respecting freedom of conscience and the extent to which referral for abortion is seen as tantamount to carrying out an abortion itself. It is a recognized principle in medical practice that practitioners cannot be forced to carry out abortions except in emergency situations where the life of the mother is at stake; but what about in instances of referral? Put simply, does referral for abortion amount to "participation"?[156] In the Australian medical system, the requirements upon medical practitioners who refer are significant, adding weight to the argument that "referral" is tantamount to "participation." As the process of referral is linked to the Medicare insurance scheme, it must be made in accordance with the regulations.[157] Referrals are required to be in writing, dated, and signed by the practitioner.[158] The referring practitioner must consider the need for the referral and provide any information about the patient's condition that is necessary.[159]

Given that referral is a distinctive and comprehensive process for an Australian medical practitioner, the process of referring a woman on to another individual whom the medical practitioner knows will initiate the abortion, means that the medical practitioner becomes complicit in an act that they conscientiously object to.[160] As the preceding analysis shows, it is no small matter to

154 *Good Medical Practice Code*, § 2.3m at 6, Mar. 17, 2014.

155 *Id.* § 2.4.4, at 6, § 2.4.6, at 7.

156 See the discussion later in this section on the U.K. case of Doogan v. Greater Glasgow Health Board [2013] CSIH 36 (appeal taken from Scot.); Greater Glasgow Health Board v. Doogan [2014] UKSC 68 (appeal taken from Scot.).

157 *Health Insurance Act 1973* (Cth) s 132A.

158 *Health Insurance Regulations 1975* (Cth) r 29.

159 *Id.* at rr 29(2)–(3).

160 *See, e.g.*, the text corresponding to note 140 which particularizes the nature of the referral process in the medical context. It is clear from this that referral requires involvement from the original doctor.

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refer, but is the original process in a patient's journey to obtain medical treatment. Philosopher J.K. Davies notes, "by referring one endorses the act."[161]

The Challenge of Practitioner Complicity

Thus, limitations on freedom of conscience for abortion referral (such as those present in the Victorian, Tasmania, and Northern Territory laws) means that the medical practitioner with a conscientious objection to abortion is compelled to "participate" in the abortion process by being the first step in a woman's decision to terminate her pregnancy. While it is correct that medical practitioners, indeed all people in a pluralistic and democratic society, should have respect for the conscience of others, this is different from requiring individuals to cooperate, facilitate, or aid others in carrying out actions based on beliefs wholly at odds with their own. "From the vantage point of the primary doctor, to knowingly carry out a consultation [refer a patient] to another practitioner who they anticipate will proceed in a way the primary doctor feels is damaging, is to be complicit in harm."[162] Recognizing the same referral concerns, the Canadian Medical Association has stated that "a doctor who refers a patient for a procedure he believes to be wrong, is morally just as culpable as a doctor who performs the procedure."[163]

This notion of "culpability" is interesting because the argument is often made that any involvement short of performance of abortion should not enliven the practitioner's conscience. However, just because the medical practitioner with the conscientious objection does not perform the termination, it does not follow that she is not ethically responsible for facilitating that action.[164]

A recent decision by the U.K. Supreme Court adopted a narrow meaning of "participation" in abortion, using statutory construction principles to determine the meaning of Section 4 in the Abortion Act 1967, c. 87. The Court determined that in providing freedom of conscience protection, Parliament did not have in mind the myriad ancillary, administrative, and managerial tasks that might be associated with the act of abortion. Although these tasks might "in some way, facilitate the carrying out of the treatment involved," Lady Hale stated, "'[p]articipate' in my view means taking part in a 'hands-on' capacity."[165] This overturned the appeal decision, which favored a broader meaning of "participation," where Lady Dorrian stated,

> [t]he right is given because it is recognised that the process of abortion is felt by many people to be morally repugnant . . . it is a matter on which many people have strong moral and religious convictions, and the right of conscientious objection is given out of respect for those convictions and not for any other reverse . . . . It is consistent with the reasoning which allowed such an objection in the first place that it should extend to any involvement in the process of treatment, the object of which is to terminate a pregnancy.[166]

161 John K. Davies, *Conscientious Refusal and a Doctor's Right to Quit*, 29 JOURNAL OF MEDICINE AND PHILOSOPHY 75–91, 82 (2004).

162 S.J. Genuis, *Dismembering the Ethical Physician*, 82 POSTGRADUATE MEDICAL JOURNAL 233–38, 234 (2006).

163 *Cited in* Erin Whitcomb, *A Most Fundamental Freedom of Choice: An International Review of Conscientious Objection to Elective Abortion*, 24 ST. JOHN'S JOURNAL OF LEGAL COMMENTARY 771–809, 794 (2010) (citation omitted).

164 Antommaria, *supra* note 66, at 85–86. *See also* Christopher Kaczor, *Conscientious Objection and Health Care: A Reply to Bernard Dickens*, 18 CHRISTIAN BIOETHICS: NON-ECUMENICAL STUDIES IN MEDICAL MORALITY 59–71, 65 (2012).

165 Greater Glasgow Health Board v. Doogan [2014] UKSC 68 [38] (appeal taken from Scot.).

166 Doogan v. Greater Glasgow Health Board [2013] CSIH 36 [38] (appeal taken from Scot.).

The contrasting positions in the two cases reveal different perspectives on the meaning of "participation" in abortion, with the first case providing greater acknowledgment of abortion as a process that is not limited to participation in the medical procedure itself but part of a process in which the object is the termination of a pregnancy enabled because the work of different actors facilitates the medical procedure to eventually take place. Philosopher David Oderberg argues for the development of a "civil jurisprudence of cooperation" to address situations like that presented in *Doogan* because this would allow the conclusion that although the midwife in question was not participating in the abortion procedure, the seriousness of her belief that abortion results in the ending of a human life requires that even remote cooperation in the procedure (such as organizing the shifts of staff who would perform the abortion) would be seen as unjustifiable cooperation in the ending of a human life.[167] However, even if we accept that referral for abortion is tantamount to participation, as it is a stand-alone act incurring moral culpability on the practitioner, it still needs to be counterbalanced against the issue of a patient's right to access abortion, as a legal and medically accepted procedure in Australia.

Access to Abortion

A fundamental argument against protection of medical practitioners' conscience rights with regard to referral for abortion is that this stymies patients' access to abortion. This derives from medical practitioners' monopoly on the provision of health care and because of the socioeconomic factors limiting the ability of some patients to access medical care. In terms of the latter, although a 2009 Australian empirical study examining, in part, the reasons why women might have limited access to abortion did not mention any reports that conscientious objection had affected access,[168] the report did identify issues around finance, transport, language, and geography as constraining access to abortion. It is reasonable, therefore, that for some patients, these factors, when coupled with their medical practitioner's refusal to refer for abortion, may make it highly challenging to access abortion.

Given that, some women seeking abortion or advice about whether or not to continue their pregnancy will already be in a position of emotional and psychological vulnerability, a refusal to provide a woman with information about all of the options available to her (including referral to another doctor without a conscientious objection to abortion) may cause her substantial distress, and impair her ability to seek medical advice elsewhere. This may affect the poorest and least educated who will be least likely to know of alternative services. From this perspective, such a policy of nonreferral may exacerbate existing disadvantages. For example, as stated by Glynis Flowers, Executive Officer of the Hobart Women's Health Centre in her evidence to the Legislative Council inquiry into the Reproductive Health (Access to Terminations) Bill 2013 (Tas):

> When people are seeking services it is quite easy for us to say, "Wouldn't you just ring a doctor?", or "Wouldn't you just go to that service?", or "Wouldn't you ring up Family Planning?", but a lot of people do not have the ability to work out whether this service is the right one for the specific thing they need—that is a very big aspect of health literacy.[169]

167 David S. Oderberg, *Further Clarity on Cooperation and Morality*, 43 JOURNAL OF MEDICAL ETHICS 1–9, 9 (2016).

168 Heather J. Rowe et al., *Considering Abortion: A 12-Month Audit of Records of Women Contacting a Pregnancy Advisory Service*, 190 MEDICAL JOURNAL OF AUSTRALIA 69–72, 71 (2009) (Access issues reported were "financial or health problems, geographical isolation, lack of transport or child care, being at school, safety fears, alcohol or drug problems, or language or interpreter concerns.").

169 Evidence to Legislative Council Sessional Committee Government Administration "A," Parliament of Tasmania, 3 September 2013, 5 (Glynis Flower, Executive Officer of the Hobart Women's Health Centre).

She also raised concerns over a patient's ability to conduct independent research to access an abortion, observing: "Even abortion services which are transparent in their description in the Yellow Pages are listed under pregnancy headings, not abortion or termination. Given literacy in general and health literacy, it is not surprising people don't find information easily."[170]

This recognition that a refusal to refer impedes access forces a balancing exercise between the need to protect medical practitioner's freedom of conscience versus the right of patients to access medical procedures, particularly for those from socioeconomic backgrounds that render access more challenging. Both are important and recognized in international law. There is emerging case law that abortion provision is part of the international right to health,[171] and part of the World Medical Association's statement on therapeutic abortion is that practitioners must ensure continuity of practice by a qualified colleague.[172] Article 18(1) of the United Nations International Covenant on Civil and Political Rights recognizes freedom of conscience and the United Nations Human Rights Committee, in interpreting Article 18, states that this is protected unconditionally and "does not permit any limitations whatsoever on the freedom of thought and conscience."[173] However, Article 18(3) does constrain freedom of conscience where it is necessary to protect health or the fundamental rights and freedoms of others.

In the Australian context, protecting the rights and freedoms of patients to access abortion is not greatly impeded by accommodating claims of conscience in referral matters. In Australia, access to abortion can occur without referral as patients can go to an alternative practitioner,[174] an emergency department or specialist clinic for an abortion. This fact is often unknown by patients, and in any case, women will often go to their regular general practitioner as a first point of call when faced with a decision concerning pregnancy. In our view, although access is constrained, the *choice* of abortion is not removed by the actions of the refusing medical practitioner because in Australia there are other avenues available to the patient by which she can access lawful abortion. Public health initiatives that publicize the provision of services by willing practitioners, education, and informative health department websites would appear to be more helpful, cost effective, and timely solutions to access problems. Improving health literacy of the general population, and with a particular focus on women from lower socioeconomic backgrounds, could also occur without violation of a medical practitioner's conscience.

Patients' Feelings and Identity

An argument against protecting medical practitioners' freedom of conscience in matters of referral concerns the feelings of rejection and stigma that a patient may experience when referral for abortion is refused. In these situations, a woman requesting such a procedure may experience discomfort, disapproval, and judgment by a medical practitioner with a conscientious objection to the

170 *Id.* at 2.

171 International Planned Parenthood Federation European Network (IPPF EN) v. Italy, App. No. 87/2012 (European Committee of Social Rights) (2012).

172 World Medical Association, Declaration of Oslo on Therapeutic Abortion, adopted by the 24th World Medical Assembly, Oslo, Norway, Aug. 1970 (amended by the 35th World Medical Assembly, Venice, Italy, Oct. 1983; 57th WMA General Assembly, Pilanesberg, South Africa, Oct. 2006).

173 Office of the High Commissioner for Human Rights, General Comment No. 22: The Right to Freedom of Thought, Conscience and Religion (Art. 18) at ¶3, U.N. Doc. CCPR/C/21/Rev.1/Add.4 (July 12, 1993).

174 *See, e.g.*, *Getting an Abortion*, CHILDREN BY CHOICE, https://www.childrenbychoice.org.au/forwomen/abortion/howtogetanabortion (last modified Jan. 11, 2018) ("[n]o referral is needed for either a GP or a private clinic for a medication abortion" and that "[n]o referral is needed for a clinic for a surgical abortion.").

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procedure. This is seen as unjustified because of a patient's autonomy in electing certain medical procedures.

As this argument is often made on speculative grounds through the use of anecdotal evidence, it is hard to ascertain its validity. Clearly a careful, thoughtful, and professional doctor will not impose judgment. While it is certainly possible that doctors can manage conscientious objections sensitively,[175] there is also the possibility that some doctors may not do so. Of course, this is a risk in all doctor–patient interactions. It is quite possible that doctors may be judgmental about a patient's smoking habit, or other lifestyle choice. There is also no guarantee that practitioners who do refer will do so in ways that make the patient feel validated. Nonetheless, a law compelling referral seems a less than adequate response to a concern that a doctor may not be "nice" to a patient.

It is likely that most doctors will adhere to their professional codes of conduct and professional norms when conscientiously objecting, and they will therefore manage the issue in ways that respect the patient. If doctors are judgmental and disrespect their patients, it is unlikely that any law, including the obligation to refer, would change their manner.

Gender Discrimination

Another argument that is sometimes made against accommodating conscience claims against referral suggests that women are disproportionately affected by decisions that have an impact on their ability to procure an abortion. This is because it is female patients who undergo abortions so that "the exercise of conscientious objection becomes a paternalistic initiative to compel women to give birth."[176] This argument sees conscientious objection as a way to subjugate women by blocking their access to abortion. This argument seems to be focused on an illegitimate motivation for conscientious objection. It seems unlikely that any conscientious objectors would profess that gender discrimination is their aim, although some might argue it is the effect of their position. If it is their unspoken, or even subconscious, motivation then this could be addressed by engaging in some process for scrutinizing claims of conscience, although from a pragmatic perspective this may be difficult and time consuming to carry out. It does seem unlikely that this is the motivation for many conscientious objectors, so an outright ban seems to be an overreaction. If the argument is less about motivation, and more about the effect of the objections, then the argument about access to abortion is canvassed above, indicating that there is no evidence of an access problem in Australia, and even if there were, it would be better addressed by increasing health literacy.

CONCLUSION

This article has considered the legitimacy of protecting medical practitioners' freedom of conscience not to refer for abortions. With regard to military service and euthanasia, legislators have been at pains to regulate for the protection of conscience. By contrast, in the case of abortion, the reforms in Victoria, Tasmania, and the Northern Territory containing significant incursions on the conscience rights of medical practitioners seem out of step. While it is difficult to identify definitively the

175 *See, e.g.*, Eva M. Kibsgaard Nordberg et al., *Conscientious Objection to Referrals for Abortion: Pragmatic Solution or Threat to Women's Rights*, 15 BMC Medical Ethics 1–9, 1 (2014).

176 Fiala & Arthur, *supra* note 84, at 15.

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motivation for these changes, they are consistent with the framing of abortion as a health care procedure that supports human rights, rather than a religious or moral issue.

Anti-abortion groups, and those claiming conscientious objections to abortion, have responded to this reframing by defining their objections as nonreligious. In doing so they make a claim that freedom of conscience is broader than, and unmoored from, higher-order or separate-spheres arguments. It rests in the idea of secularized conscience, and can be justified on nonreligious grounds. Consistent with this, our argument is that the societal benefits that accrue from taking a pluralistic and pragmatic approach to freedom of conscience are so significant that they justify its legislative protection, and fit within a secularized society.

Acceptance of a pluralistic argument in favor of freedom of conscience is a powerful commitment to the creation of a society that values human autonomy and a diversity of opinion. It sits comfortably with the democratic values that are enshrined in the Australian political system and institutions. It avoids the potential damage to the individual that may be wrought when conscience is overridden by state compulsion. More specifically, limiting conscientious objection in matters of abortion and departing from this pluralistic argument creates a number of systemic risks. It is likely to dissuade medical practitioners with a conscientious objection to abortion from remaining in the profession. In addition, it may inhibit medical students with a similar moral persuasion from entering the profession, or certain specialties within the profession. Such an approach risks reducing the access to health care for everyone who is not seeking abortion and creating a monocultural medical profession.

The pragmatic argument can also be used to support liberal deployment of conscientious objection in a secularized context. This argument posits that conscientious objections are strongly held and the presence of compulsion or coercion is unlikely to dissuade objectors. As pointed out above, this argument can be over-stated as it is likely that the presence of a compulsion may mean that potential objectors are dissuaded from putting themselves in positions where they might need to object, and it is also likely that some potential objectors will compromise in the face of legislative fiat. Nonetheless, the public revelations about two Victorian doctors indicate that conscientious objection remains a live issue and in such cases the existing restrictions on conscientious objection are not effective.

We have explored legislative changes related to abortion regulation in Australia. In this context both abortion and freedom of conscience have become unmoored from religious convictions. Despite a significant Australian history of accepting secularized conscience claims, the limitation of conscience claims about abortion can be traced to a failure to appreciate the significant secular arguments that can be made to support such claims. Two arguments explored herein, plurality and pragmatism, are capable of providing a firm foundation for legislative protections of freedom of conscience. Their justifications are not dependent on religious grounds and, therefore, they have the potential to be relevant and persuasive in a secular society.

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