Conscientious Objection Conundrum:

Objections by Nurses in Hospital Settings

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Introduction

In Australia, all states and territories have passed legislation to make abortion lawful healthcare so long as specific criteria are satisfied.[i] The same applies to practices such as physician assisted suicide, commonly known as voluntary assisted dying. Many Christian health professionals and workers find these services to be morally controversial, contrary to the telos of healthcare, and offensive to their faith, because they involve the intentional ending of human life. Thankfully legislation for each of these morally controversial services contain a 'conscience clause' which can act as a shield to protect the individual health professional who does not want to perform or participate in specific acts.

However, it is important to note that not all conscience clauses are expressed in the same way in legislation. Whilst some appear to offer differing levels of protection for the objecting practitioners, none have been tested in our courts. As such, there can be an element of uncertainty regarding how a health professional can use them in their workplace settings to ensure that he or she can practice their vocation in line with their conscience. This article will focus on the dilemma of the hospital nurse confronted with a patient undergoing an abortion which the nurse has a conscientious objection to participating in.

Oftentimes the focus of conscientious objection can be on the medical practitioner. The plight of the nurse, which can involve similar concerns with both performing and participating in a morally offensive service, is just as

important and pressing. This article will commence by considering the concept of conscience and how a person might be harmed when acting against it, the notion of conscientious objection and the limitations to conscience protection in Australian abortion law for nurses and will finish off by offering some practical tips on how nurses might manage their conscientious objection to abortion in the workplace.

Conscientious Objection

The term 'conscience' has not been defined in any legislation within Australia. Its plain meaning is generally understood to refer to a person's deeply held beliefs and is often considered synonymously with the term 'religion'.[ii] A person expresses a 'conscientious objection' where they object to being compelled to do something, or not do something, which they believe is morally wrong and which will cause them or others harm. In the healthcare setting, the person seeks the law's protection from this harm by requiring his or her employer to recognise and respect their conscientious objection by having someone else step in to perform the action that is objected to without penalty to the person objecting.

The difficulty often experienced by a conscientious objector is that the action he or she does not want to engage in is something that is lawful despite being morally controversial. Many people today take their cues about what is moral from the law. So, if the law permits a particular service, and it is one that has been the subject of intense debate in Parliament, a person may decide to take the view that everyone should be able to make their own choice on the matter. Any objection to the service itself is characterised as judging others and intolerant. When the person with the conscientious objection is a health professional, they can be accused of being unprofessional and unethical.[iii]

Contemporary medical ethics places a high value on respect for patient autonomy with freedom to choose seen as synonymous with human dignity.[iv] In the healthcare setting, a health professional with a conscientious objection to a lawful service is often obliged to declare to his or her patient that they are a conscientious objector and dissuaded from speaking about the service any further.[v] With something like abortion, some laws attempt to

'strike a balance' by allowing the health professional to abstain from performing the service, but obliging him or her to minimise disruption to the delivery of healthcare by referring the patient on to someone who will do as the patient requests.[vi]

However, referring the patient on to another health professional so that the service can be affected may still cause a crisis of conscience for the conscientious objector. Today, limited attention is given to the dignity of the health professional and their right to choose not to be involved with something they believe is wrong. One of the challenges, though, is that health professionals with a conscientious objection to a service can differ amongst themselves as to what actions they object to performing or participating in. This lack of unity can contribute to a lack of enthusiasm from colleagues, managers, and employers about understanding, respecting and accommodating conscientious objection.

Complicity in wrongdoing is a complex area of both moral philosophy and the law. The two approaches do not necessarily align. Morally, there are a number of things to consider when reasoning to a conclusion about complicity. One school of thought asks whether the person who assisted in the action shared the intention of the person performing it. If so, the person assisting is considered to be formally complicit in the act as opposed to being materially complicit. If materially complicit, there are further matters to consider. These include whether the assistance was proximate or remote, direct or indirect, necessary or non-necessary. All of this is fact dependant and can prohibit generic conclusions.

For some health professionals this way of considering conscientious objection to assisting or participating in in act they believe is wrong is far too intellectual. Sometimes this can be because the person with the conscientious objection has a nuanced approach to the morality of a particular service and finds it hard to articulate and justify why they believe some actions performed in certain circumstances are wrong but not in others. It is extremely important, therefore, for health professionals with a conscientious objection to a lawful service to spend time working out the basis of their objection, its limits, and the particular actions they refuse to perform.

Christian people have a certain understanding of human nature and a philosophy of the human person whereby we believe that as rational beings made by God, we are strongly inclined to do good and avoid evil. On this basis, the ways in which a person may be harmed by acting against conscience include harm from being treated badly for refusing to act against conscience; anguish from acting against one's conscience; doing harm to oneself to stave off one's anguish; and lastly, harm that comes irrespective of anguish from having acted against what is right because to act against what is right is to act against our reason and this harms our dignity as a human person.

In international human rights law, freedom of conscience is a fundamental, inviolable right of every human person.[vii] However, what most people do not understand is that this freedom is divided into what is known as the internal and external forums. The internal forum is a person's right to hold a belief, whilst the external forum refers to a person's right to manifest one's beliefs. When it comes to manifesting one's beliefs, international human rights law permits the lawmaker to limit a person's conscience when to do so is considered necessary to protect public safety, public order, public health or the fundamental rights and freedoms of others.

At the time of writing, whilst Australia has ratified the relevant international treaty that recognizes and protects a person's freedom of conscience, it has not enacted the relevant articles into our federal, domestic law. As a result, the treaty is not binding on Australian courts, with the protection of conscience being a matter for the states and territories to decide. Whilst there is a presumption when interpreting legislation that parliament did not intend to limit a person's fundamental rights, where words in legislation are not sufficiently clear, that presumption can be displaced. This means that one must take the time to be familiar with the laws of their relevant state or territory.

Some states and territories have enacted human rights law that includes the protection of freedom of thought, conscience and religion in the same broad terms as the international covenant.[viii] In reality, the lawmaker can still 'read down' the protections for manifesting a conscientious objection by arguing that it only protects the demonstration of a person's religion or belief

in worship, observance, practice and teaching, either individually or as part of a community, in public or in private or that there is a greater need to protect the public health or the fundamental rights and freedoms of others. Accordingly, recourse to human rights law is only a starting point for the protection of conscience.

The anti-discrimination laws of some states and territories recognise the attribute of religion,[ix] but not every person's conscientious objection can be described as religious. Even if it were, there is still a balancing act to be performed regarding the conflict that may occur when pitting the protection of a person's religious beliefs against the fundamental rights and freedoms of others, or the legal rights that have been given to others by the state. The legal concept of proportionality is then employed by the courts, which take into account the particular circumstances of the case where the conflict arises, and an attempt is made to infringe upon the right in question in as limited a way as possible.

It is true to say that managing conscientious objection to morally controversial services in healthcare is still an emerging area for policy and practice. Whilst there are some general concepts, we can all agree upon, there are still issues to be worked out, with a number of areas of great disagreement. The legalisation of services such as abortion and euthanasia has certainly raised the issue of conscientious objection within the health professions. For some health professionals with a conscientious objection to one or both of these services, the reality of having to seek protection from the law is unfamiliar and can be accompanied by the fear of being treated badly and unjustly by managers and employers.

Nurses and Conscientious Objection to Abortion

Each jurisdiction of Australia has its own laws in relation to abortion although they share a similar framework and purpose. That framework and purpose rests on the concept of free choice, with a woman being able, broadly speaking, to request abortion from a doctor for any reason she believes is appropriate. Gestational age limits do apply in the sense that for later term abortions, there is oversight by the medical profession. This usually requires two doctors to confirm that abortion is reasonable in all the circumstances which include medical, psychological, economic and social circumstances.[x]

Theoretically abortion up to birth can be lawful in many jurisdictions of Australia.

When it comes to conscientious objection to abortion, every jurisdiction except Western Australia can override a nurse's conscientious objection to participating in an abortion in an 'emergency'.[xi] The question, of course, is what circumstances will amount to an emergency. In some states, 'emergency' is defined in legislation as where the woman's life is at risk if the abortion in not performed.[xii] Other states take a broader approach and define 'emergency' as where the woman's life or physical health are at risk.[xiii] Others again are silent on what 'emergency' means.[xiv] Ultimately it is for the courts to decide on the meaning of 'emergency' and its application in a particular circumstance.

The very fact that conscientious objection may be overridden for particular people in certain circumstances means that conscientious objection is not sacrosanct in our law. In some states, failure to comply with any statutory duties regarding abortion can be used in a disciplinary hearing against the health professional for professional misconduct or unsatisfactory professional conduct.[xv] Apart from the emergency provision, nurses should be aware of the scope of conscience protection in the relevant legislation applicable to their jurisdiction. In addition, nurses should also look to policies published by the Department of Health, the Nursing and Midwifery Board and their employer.

As an example, the Nursing and Midwifery Board's Code of Conduct for Midwives recognises that conscientious objection can occur in the workplace and in that situation, it provides that 'midwives must respectfully inform the woman, their employer and other relevant colleagues, of their objection and ensure the woman has alternative care options.'[xvi] This Code applies to all midwives in Australia in all settings and sets out the legal requirements, professional behaviour and conduct expectations. The challenge with this requirement is that a plain reading suggests that it is for the midwife to ensure that the patient has alternative care options.

One can make the argument that this places a burden on the objecting midwife that is akin to the requirement some jurisdictions place on doctors with a conscientious objection to abortion to refer the woman to another

doctor that the objecting does knows does not have a conscientious objection to abortion. Some midwives may object to this requirement on the basis that it is participating in abortion in that they form part of causal chain that leads to an abortion being carried out. They may experience anguish from this level of involvement and seek to avoid having anything to do with facilitating an abortion or abortions in certain circumstances.

The law makes a distinction between direct and indirect participation in abortion. For example, in England, the Supreme Court decided that midwives with a long standing conscientious objection to abortion who objected to managing a maternity ward where patients were admitted for abortions had no legal protection because the actions they were required to do amounted to indirect participation in abortion.[xvii] Like Australia, as the relevant English law overrides a health professionals' conscientious objection to abortion when there is an emergency, the Court held that conscience protection can be limited and here, only extended to direct participation and not ancillary actions.

Advice and practical steps

Whilst this decision is not binding on Australia courts, it provides some good food for thought about the concept of participation which goes back to the moral issue of complicity. It is useful for nurses with a conscientious objection to abortion to think about whether their conscience is offended by having to do various actions. Examples include filling out the necessary paperwork to admit a patient to hospital for an abortion, inserting an intravenous line into a patient for the administration of drugs to induce abortion, accompanying a patient to the operating theatre, providing after care to a patient who has undergone abortion and providing information to a patient on how to access an abortion.

The scope of conscience clauses in abortion law throughout Australia can differ. It is important, therefore, for nurses to seek specific legal advice about their situation and not rely on the practices in another state and expect those to apply to nurses practising in a different jurisdiction. In terms of general advice, this article now sets out a number of practical steps to assist with resolving your conscientious objection to abortion in the workplace. The first step is to be clear about why you have a conscientious objection to

abortion, whether it applies to all abortions or only some, and what actions you have discerned you will not perform because it offends your conscience.

This first step may involve prayer, study, and discussion with people whose wisdom you respect. Once this has been determined, you should consider the actual circumstances of your employment and whether it is likely that you will be charged with having to act against conscience regarding a patient who has been admitted for an abortion. If one's objection extends to all abortions, then this may be easier to accommodate when approaching a manager. This is because there is no need to go through a process whereby each patient's circumstances are considered as they are admitted. In many ways, this is an 'efficient' objection whose solution is to find someone to replace the service.

If one's objection is more nuanced, it may be possible to group one's objection together such as an objection to social abortions but not to foetal disability abortions. This can make the process of the nurse considering whether he or she has a conscientious objection more 'streamlined'. The second step is to do some research and find out what other health professionals with a conscientious objection to abortion have done to achieve an accommodation or alternatively what problems they have run into. It is very beneficial to engage with a community of like-minded professionals to keep up to date with developments in this area, and to gain tips on how to make things work.

The third step is that the conscientious objector must be familiar with the policy of their employer and how it has been applied in practice and have decided on some solutions to their dilemma such as who can provide the services to the patient, how this can be put into action, and what level of burden this might place on his or her colleagues and on management to give effect to it. The fourth step is to have a good idea of how often such conflicts are likely to arise in one's workplace. Where is it infrequent, it will be more difficult for an employer or manager to argue that accommodation of a conscientious objection places too significant a hardship on them to consider implementing the measures sought.

It is good to offer to do other work to make up for an accommodation. A gesture like this often contributes positively to cohesion in the team. Try and

remember that for many people in the community, including health professionals, abortion is an extremely fraught emotional issue, and this can affect how people approach the conversation about accommodating a conscientious objection. It serves to be both patient and calm. However, when the incidence of conflict is likely to be frequent or clearly burdensome to accommodate, the nurse with the conscientious objection must at least consider whether it is prudent to remove themselves from certain job opportunities.

The fifth step is to engage with your manager. Armed with self-knowledge about the scope and content of your conscientious objection, a clear idea of how your workplace has decided to manage it, and your own thoughts about a reasonable way to replace your services when required, it is good to assume good will on the part of your manager before becoming defensive or calling in lawyers. Call a meeting and obtain as much information as you can from them about their knowledge and views about conscientious objection in healthcare, their experience with implementing any workplace policy and their readiness to have an honest and confidential discussion with you about a way forward.

The sixth steps occurs if the meeting has been productive. In this case, ensure the process has been documented in writing to your satisfaction and, if needs be, endorsed by the relevant people higher up in the management chain. It may be that the accommodation you have secured might be useful for other members of staff and ought to be shared to assist them in their dilemma. The seventh step arises if the process has not produced an acceptable outcome. In this case, you will need external assistance to resolve your dispute, usually in the form of a lawyer. If you are a member of the union, you might utilise their legal services or you may wish to engage a private lawyer for advice.

The process of disclosing and seeking accommodation of a conscientious objection to abortion in a public hospital setting can be daunting. The reasons for this are many and varied and are touched upon in this article. Having a clear idea about the basis and scope of your conscientious objection that goes above the emotional and intuitive as well as your 'line in the sand' is important when undertaking any type of negotiation. At the end of the day, there is strength in numbers and unity of purpose. Being able to

speak out on a subject as important as this for nurses takes both wisdom and courage. This article seeks to provide some inspiration and guidance in taking those first steps.

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[i] See *Health (Miscellaneous Provisions) Act 1911* (WA; *Health Act 1993* (ACT); *Abortion Law Reform Act 2008* (VIC), *Reproductive Health (Access to Terminations) Act 2013* (TAS); *Termination of Pregnancy Law Reform Act 2017* (NT); *Termination of Pregnancy Act 2018* (QLD); *Abortion Law Reform Act 2019* (NSW)*; Termination of Pregnancy Act 2021* (SA).

[ii] United Nations, *General Comment No. 22: The Right to Freedom of Thought, Conscience and Religion* CCPR/C/21/Rev.1/Add.4, G

[iii] See e.g. Udo Schuklenk and R Smalling, 'Why Medical Professionals Have No Moral Claim to Conscientious Objection Accommodation in Liberal Democracies' (2017) 43 *Journal of Medical Ethics* 234.

[iv] See Tom L Beauchamp and James F Childress, *Principles of Biomedical Ethics* (Oxford University Press, 7th ed, 2013) 101.

[v] Arguably, there is an implicit suggestion in this directive that its rationale is to protect the patient from the conscientious objector who may be unable to discuss the service with the patient in a neutral way without causing offence to the patient.

[vi] See *Abortion Law Reform Act 2008* (Vic) s 8(1)(b); *Termination of Pregnancy Law Reform Act 2017* (NT) s 12(2); *Termination of Pregnancy Act 2018* (Qld) s 8(3); *Abortion Law Reform Act 2019* (NSW) s 9(3); *Termination of Pregnancy Act 2021* (SA) s 11(3).

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

[viii] See *Charter of Human Rights and Responsibilities Act 2008* (Vic) s 14; *Human Rights Act 2004* (ACT) s 14; *Human Rights Act 2019* (Qld) s 20.

[ix] Queensland, the ACT, Tasmania, Victoria, Western Australia and the Northern Territory characterize a person's religious belief as a protected attribute under their anti-discrimination laws. Accordingly, penalties may apply where a person suffers discrimination and is treated less favorably to another person who does not have the protected attribute in the same or similar circumstances. See *Anti-Discrimination Act 1991* (Qld); *Discrimination Act 1991* (ACT); *Anti-Discrimination Act 1998* (TAS); *Equal Opportunity Act 1984* (WA); *Equal Opportunity Act 2010* (VIC); *Anti-Discrimination Act 1992* (NT). However, it is important to note that exemptions may apply. Neither New South Wales nor South Australia consider religious belief or conscience as a protected attribute under their anti-discrimination legislation (and neither has enacted human rights legislation).

[x] See, e.g., *Abortion Law Reform Act 2019* (NSW) s 6(1); *Termination of Pregnancy Law Reform Act 2017* (NT) s 9; *Termination of Pregnancy Act 2018* (Qld) s 6(1); *Termination of Pregnancy Act 2021* (SA) s 6; *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 5; *Abortion Law Reform Act 2008* (NSW) s 6; *Health (Miscellaneous Provisions) Act 1911* (WA) s 334(7).

[xi] See *Health Act 1993* (ACT) s 84A(2)(a); *Abortion Law Reform Act 2008* (VIC) s 8(4); *Reproductive Health (Access to Terminations) Act 2013* (TAS) s 6(4); *Termination of Pregnancy Law Reform Act 2017* (NT) s 13(c); *Termination of Pregnancy Act 2018* (QLD) s 8(4); *Abortion Law Reform Act 2019* (NSW) s 9(5)*; Termination of Pregnancy Act 2021* (SA) s 11(5). In Western Australia, s 334(2) of the *Health (Miscellaneous Provisions) Act 1911* provides that 'No person, hospital, health institution, other institution or service is under a duty, whether by contract or by statutory or other legal requirement, to participate in the performance of any abortion.' There are no exceptions to this provision.

[xii] See *Health Act 1993* (ACT) s 84A(2)(a); *Termination of Pregnancy Law Reform Act 2017* (NT) s 10.

[xiii] See *Abortion Law Reform Act 2008* (Vic) S 8(4); *Reproductive Health (Terminations of Pregnancy) Act 2013* (Tas) s 6(4).

[xiv] See *Termination of Pregnancy Act 2018 (*Qld) s 8(4); *Termination of Pregnancy Act 2021* (SA) s 11(5); *Abortion Law Reform Act 2019* (NSW) s 9(5).
[xv] See, e.g., *Abortion Law Reform Act 2019* (NSW) s 10(1)(c), *Termination of Pregnancy Act 2018* (Qld) s 9(1)(1)(c); *Termination of Pregnancy Act 2021* (SA) s 17(1)(d).
[xvi] Nursing and Midwifery Board of Australia, Australian Health Practitioner Regulation Agency*, Code of Conduct for Midwives,* Effective from 1 March 2018 and updated June 2022*.*
[xvii] *Greater Glasgow Health Board v Doogan and Anor* [2014] UKSC 68.