

Professional Conscience

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Obstetrics is second only to cosmetic surgery for the proportion of legal claims made against it, and obstetrics is the specialty most exposed to large claims¹. Obstetricians are not likely to be more prone to negligence than any other medical specialty, so one can assume that the risk is related to the nature of the work itself.

Obstetrics and gynaecology is more likely than most specialties to involve differences of opinion about the morality of some of the procedures involved. It often finds itself in controversy. Partly that may be due to the intrinsic nature of a profession that often deals with two patients simultaneously. While what is good for mother is most often good for baby, there are circumstances in which the interests do not so exactly coincide and dilemmas arise. Partly the controversy may be due to the different values our pluralist society attaches to the importance fertility and sexuality.

Partly the difficulty may stem from the demise of the vocation of medicine in which the fiduciary relationship within the Hippocratic tradition has been replaced by a free market model in which the buyer must beware.

In the free market model the doctor simply provides a contracted service according the requirements of the buyer. In the free market model, the dominant ethical concern is the patient's autonomy and ethical concerns are limited to the accuracy of the plain language statement and the consent form.

But medicine as a vocation is something different. It requires that the doctor act beneficently in the best interests of the patient and that the doctor do no harm.

Medicine as a vocation involves decisions about who a doctor is, what the aims of the work are, what makes a good doctor, and what shapes the conscientious application of medical science. Science does not shape conscience. The evidence does not determine the vocation but rather the vocation guides action in response to the evidence. Science cannot tell us what to do.

The free market model of medicine forms the basis of recent Victorian legislation. Both the Abortion Law Reform Bill and the three bills² also to be debated this week which rewrite the reproductive technology legislation, are based not on medicine as a vocation but medicine as a free market service.

¹ Insurance Statistics Australia Limited *Medical Indemnity Report Executive Summary* Medical Indemnity Insurers Association of Australia 29th March 2004 p. 6

² the Assisted Reproductive Treatment Bill 2008; Research Involving Human Embryos Bill 2008 and the Prohibition of Human Reproductive Cloning Bill 2008

The Victorian Law reform Commission which is the source of the new legislation regards medicine less as a professional vocation and more as an expertise, a morally neutral servant to the autonomy of the patient. The values to be applied are the patient's values; the doctor's values do not enter into it. That perception is a sad one, because it diminishes the dignity and integrity of the individual professional. "Professional" comes to mean the application of technical expertise, rather than professional judgement.

In this context of 'deprofessionalising' the health professions, there has been a push for what is called reproductive rights, the right to insist that a doctor provide reproductive medical services whatever the doctor's own personal views about the procedures involved.

In this the four bills³ do not represent current practice but instead reflect a very zealous attempt by proponents of abortion and unlimited access to reproductive technology to enforce their views about the beginning of human life and about family formation on conscientious health professionals and health care institutions. The drafting of the bills clearly breaches the rights of individuals to religious and cultural freedom.

This is not a matter of doctors imposing beliefs: patients are free to go to whom they please. It is a matter of the freedom of a doctor or other health professional to offer what he or she thinks is the best care available. A doctor treating a pregnant woman has two patients and each is equally deserving of care and support. Being required to do or to refer for abortion in all circumstances, as the Abortion Law Reform Bill 2008 requires means the doctor must not only abandon the second patient, but his or her professional judgement about what is best for the woman is also to be overridden. This is not just a matter of overriding moral concerns. It also means overriding professional judgement.

ART and the Rights of the Child

The Assisted Reproductive Technology Bill 2008 to be debated tomorrow in the Lower House requires a doctor not to discriminate on the basis of gender, marital status or sexual orientation. It sets up the circumstances for alternate family formation including by surrogacy. Being required to assist two men in a homosexual relationship to achieve pregnancy through the use of a surrogate requires the practitioner to abandon concern that a child should have both a mother and a father and to disregard professional concern for a woman whose body is to be used as an incubator.

The Bill proposes to broaden the range of persons eligible for assisted reproductive technology, to provide for surrogacy arrangements, substitute parent orders and changes to birth certificates and other records of parentage, and to modify procedures and regulation.

³ The Abortion Law Reform Bill 2008; the Assisted Reproductive Technology Bill 2008; Research Involving Human Embryos Bill 2008 and the Prohibition of Human Reproductive Cloning Bill 2008

The proposals would change the main aim of the current law from protecting the best interests of the child born or to be born, towards treating the technology as a mere service rather than as a means of family formation within which children have rights.

The main effect of that shift is that the biological and relational basis of family formation which currently establish the roles, duties and presumptions of motherhood and fatherhood and protect the rights of children become merely optional. The changes to the law strike out the role and therefore the duties of a father and replace it with a notion of genderless parenthood. Parenthood under the new law would happen by nomination rather than through the biological and social reality of a child being born to a woman and conceived within a relationship to the child's father.

The current law seeks to deal with the new possibilities by recognizing the social and biological reality of natural parenthood and using both natural parenthood and having both a mother and a father as the paradigm for the courts in making parenthood decisions in the best interests of the child. The proposed changes to the law, especially the changes to the Status of Children Act, are not based on a child's right to have a relationship to both a mother and a father, nor on the duties and responsibilities that arise through natural parenthood.

A major issue of conscience will arise for health providers. The bill will require practitioners and institutions to provide treatment or assistance to achieve pregnancy for single women, or on behalf of a homosexual couple, or for the latter via surrogacy.

There is no conscientious objection clause or no disadvantage clause to protect those who do not wish for ethical reasons to be involved in such practices. The NH&MRC Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research contain such a clause:

“Conscientious objectors are not obliged to be involved in the procedures or programs to which they object. If any member of staff or student expresses a conscientious objection to the treatment of any individual patient or to any ART procedures conducted by the clinic, the clinic must allow him or her to withdraw from involvement in the procedure or program to which he or she objects. Clinics must also ensure that staff and students are not disadvantaged because of a conscientious objection.”⁴

Referral

The Abortion Law Reform Bill overrides the professional judgment of the doctor with respect to early abortion. The judgement about whether abortion is the best option for managing pregnancy is to be the judgement of the woman alone. In this, abortion would seem to stand alone amongst medical procedures. Generally patients choose between the options that the doctor as a matter of professional judgement considers reasonable. The Bill requires either provision or referral even if as a matter of professional judgement the doctor considers abortion not warranted. This requirement goes beyond overriding moral objections, it overrides professional medical judgement.

⁴ National Health and Medical Research Council *Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research* Australian Government (2007), n. 5.9 page 23.

With respect to conscientious objection, the Bill requires that registered health practitioners who have a conscientious objection to abortion must refer a woman who requests an abortion to another practitioner whom the practitioner knows does not have a conscientious objection to abortion.

This clause requires the doctor to know the ethical standards of the second doctor. Few doctors would have sufficient knowledge of their colleagues in this respect. In all likelihood the only doctors whose practices are thus known to their colleagues would be those who work for clinics that specialize in abortion. In other words, in practice the law requires referral to abortion clinics.

That is deeply troubling. Generally doctors refer to specialists who are known to them in whom they have developed confidence. Referring relationships develop for the benefit of the patient because they facilitate good communication between the specialist and the referring doctor. The doctor continues to refer to specialists on the basis of both good communication and the history of the specialist managing patients well. That history involves the referring doctor gaining knowledge of the strengths and special interests of the specialist

Private abortion clinics however are not usually staffed by specialist gynaecologists. Most often the doctors who practice in abortion clinics lack specialist qualifications. General practitioners would not normally refer a woman to an abortion doctor for gynaecological procedures. Private abortion, in practice, is something of a second class area of surgical practice, able to recruit a doctor straight out medical school into the lucrative area of being a proceduralist but without specialist training and qualifications..

A doctor who wanted to do the best by a woman requiring surgical gynaecological procedure would normally refer to a specialist gynaecologist. In fact, under Medicare funding, specialist services require a medical referral.

However under the Abortion Law Reform Bill, no referral is required for a doctor to do an abortion. The effect of the Bill is thus to have the normal route of access to specialist procedures by-passed. By requiring referral to someone known to have no conscientious objection to abortion, the GP would in practice not be referring to those who could provide best management, but to the non-specialists who often staff abortion clinics.

A conscientious doctor might otherwise simply have referred a woman, in difficulties during pregnancy and requesting abortion, for on-going management by a specialist colleague. Such a referral would be thus non-specific. By contrast, the Bill would not permit such a referral unless the doctor knew that the specialist had no objection to abortion. In fact many gynaecologists who do abortions in some circumstances would draw the line somewhere. Few would do an abortion in every circumstance in which a woman might request it. Referral to someone whose view on abortion was not known would not meet the requirements of the Bill. The referral must be to someone known not to have a conscientious objection.

Referral to an abortion clinic, which is thus effectively required by the Bill, would have the clear meaning of a referral for abortion. A health professional who believes that abortion is wrong to do, must also hold that it would be wrong to recommend that someone else do it. Anything else would be hypocrisy. The Bill thus requires

hypocrisy. It also, in effect, requires referral for surgical procedures to be done by clinics usually staffed by those who are unlikely to have the specialist qualifications to do gynaecological surgery.

The Catholic Health Australia Code of Ethic Standards states: “Catholic facilities should not provide or refer for abortion, that is procedures, treatments or medications, whose primary purpose or sole immediate effects is to terminate the life of a foetus or an embryo before or after implantation.”

The Bill would put Catholic hospitals in breach of the law by requiring that their staff abide by the Code of Ethical Standards. Many health professionals choose to work in Catholic hospitals because the hospitals do uphold a code of ethics and provide an environment where patients and staff can have high expectations for the ethical standards practiced.

Emergency Abortion

The Bill requires a doctor to perform an abortion in an emergency where the abortion is necessary to preserve the life of the pregnant woman.

The issue of whether direct abortion is ever required to save the life of a pregnant woman is highly contested. It can be argued that in some circumstances loss of the life of an unborn child is a secondary effect of treatments which are intended to save the life of the woman. This may be the case in the management of ectopic pregnancy or in the case of treating cancer where the treatment indirectly causes loss of life of the unborn child. Under the definition of abortion in the Bill, these procedures are classified as abortion. But Catholic hospitals would not consider this abortion.

Nor would they consider inducing a live birth to be an abortion. But this is also defined as abortion under the Bill. That latter would seem to be a consequence of those drafting the Bill wishing to avoid mentioning that abortion in practice means deliberately ending the life of an unborn child.

There is thus confusion over what is an emergency abortion. However there are some types of emergency “abortion” that a Catholic hospital would undoubtedly consider to be a direct abortion and unethical. The controversial late term abortion of a child with dwarfism at the Royal Women’s Hospital a few years ago was claimed to be an abortion on the grounds that the woman would suicide if the pregnancy continued.

There was a clear option in that case of delivering the baby alive. The Bill would require a Catholic hospital to undertake that abortion if a doctor thus judged it to be an emergency and abortion necessary.

Such decisions put the hospital and other health practitioners at the hospital at the mercy of a doctor’s decision that it is an emergency and the abortion is necessary. Catholic institutions who require their health professionals to abide by their code of ethics will find it difficult to maintain their codes of ethics if the Bill is passed and professionals engaged in the institutions are obliged by law to perform so-called “emergency abortion” or to refer for abortion.

Other Health Practitioners

Nurses have an even worse problem because they would be “under a duty to assist” in a late term abortion, if a doctor requests and claims that it is an emergency. Doctors at least can exercise their discretion and many hold that late term abortion is never medically necessary. Attempting live birth is a safer option if the woman’s life is in danger. Late abortion usually involves an additional procedure such as fatal injection to the child in utero. Under the Bill nurses are not permitted to object even though doctors can.

The Bill extends the practice of abortion to permit a registered pharmacist or registered nurse who is authorised under the Drugs, Poisons and Controlled Substances Act 1981 to supply a drug or drugs may administer or supply the drug or drugs to cause an abortion in a woman who is not more than 24 weeks pregnant.

The Bill also allows that a registered nurse or pharmacist may administer or supply a drug or drugs to cause an abortion in a woman who is more than 24 weeks pregnant if the pharmacist is employed or engaged by a hospital and at the written direction of a registered medical practitioner.

In relation to psychologists and social workers, the Australian Bishops Conference provided Advice on Pregnancy Support and Counselling Services (2006). In that advice they noted that

“Decision-making counselling ought not to attempt to direct the patient in relation to her pregnancy or toward any particular decision. The client is most likely to make a good choice if the counsellor serves to reduce the sense of panic and urgency and instead assist the client to regain control of her own circumstances. The aim is to give her greater confidence in being able to cope with pregnancy and to assist her to make a reasonable decision for herself. This provides the best chance of a life-affirming choice.”

and the Catholic Bishops went on to say that government funding could not be accepted if it required a counsellor to refer for or actively encourage abortion procedures.

The Victorian Abortion Law Reform Bill overturns the age old respect for conscientious exercise of professional judgement

Leaving Family Medicine

Finding oneself in a position in which one’s own ethical values conflict with what is expected is not easy. But in Victoria, it is about to become much harder. Pro-life GPs are faced with the prospect of either giving up the practice of family medicine or facing the daunting prospect of being called before the Medical Practitioners Board of Victoria to answer a charge of professional misconduct for not referring for abortion, and then perhaps having to challenge the new abortion law in the High Court or the International Court of Justice as a violation of human rights, as they are defined in the International Covenant on Civil and Political Rights.

The medical indemnity insurers have also given the advice that they would not fund a doctor’s defense where a doctor had deliberately acted in breach of the law. Without funding, there would be no appeal. Faced with such grim prospects, withdrawal from family medicine would seem to be the only viable option.

Conscience and the Myth of Secular Neutrality

The idea of “secular neutrality” puts a person with ethical scruples at some kind of disadvantage. Their freedom to act rationally, sensibly and according to the evidence may be thought to be impeded by their ethical values.

The judgement that we live in a secular society may reflect an historical aberration, a modern phenomenon, and largely an exclusively Western phenomenon, the recent judicial difficulties of Turkey’s ruling AK Party notwithstanding.

The philosopher Charles Taylor in his recent book “A Secular Age”⁵ suggests that a secular society may be one in which one can engage fully in politics without ever encountering God. Apart from some vestigial prayers on such an occasion as the opening of Parliament, now to be preceded by a welcome from the original owners of our land, (or an occasional speech from a member of minority religious party who became elected through the vagaries of the system for electing upper chambers and inter party dealing on preferences), Australian politics are basically secular according to Taylor’s characterisation.

In another sense though, Australia is even more secular than our American counterpart. In 2005, only 40% of Australian marriages took place in the presence of a Minister of religion.⁶ America, despite a rigorous separation of Church and State, is the Western society with the highest statistics for religious belief and practice. Religious practice in Australia is in decline. So a secular society may mean a society in which people are predominantly not religious by belief or practice. In that case, though constitutionally secular, one would not describe Turkey as secular, given the vast majority of the population is Muslim, with 95% declaring their belief in a God⁷.

Taylor however identifies a third sense of secularism, by which he means to refer to the rise of the alternative of secularism as a form of belief.

A society may be secular in the first sense of religion not being a part of public life, the so-called separation of Church and State. It may be secular in the second sense of declining religious belief and practice. Finally it may be secular in the sense of secularism emerging as an alternative belief form.

It seems to me that it is the latter that we are witnessing in Australia, and it appears as a very aggressive exclusionist form of secularism which views personal ethical values, particularly religious values, with arrogant intolerance and dismissiveness. This kind of secularist belief is characterised by attempts to exclude contributions to public discussion on the basis of a kind of bigotry that classifies the contributions of persons who have ethical scruples or who are religious in a nominalist way. Perhaps even more significantly, this kind of secularism is a claim that undermines all those in the health professions who see themselves as more than just technically expert, those who see themselves as having a vocation to serve the human good.

⁵ Charles Taylor “A Secular Age” Harvard University Press: Cambridge, Massachusetts 2007 p.

⁶ Australian Bureau of Statistics *Marriages Australia 2005* Document No. 3306.0.55.001
<http://www.abs.gov.au/ausstats/abs@.nsf/mf/3306.0.55.001> Accessed 1st April 2008

⁷ European Commission “Social values, Science and Technology”Eurobarometer 2005
http://ec.europa.eu/public_opinion/archives/ebs/ebs_225_report_en.pdf Accessed 1st April 2008