

## **Are Utilitarianism and Patient Autonomy Enough?**

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When my father was sworn in as a Justice of the High Court of Australia 28 years ago, he was welcomed by Hartog Berkeley QC, president of the Victorian Bar and also President of the Australian Bar Association. Berkeley said: “We offer our congratulations to the Medico-Legal Society which Your Honour and Mrs Brennan founded in 1953 and which, I understand, now has nine members, two associate members and two very junior members”. I can assure the Victorian society that the Brennan Medico-Legal Society has continued to thrive these last three decades and is now into its fourth generation. I trust the same is true of your august association. Enough years have elapsed for me now to share publicly my favourite medico-legal anecdote from the intimacy of family. My mother, one of the first women anaesthetists in Queensland, made the observation of the Australian legal profession when her husband was appointed Chief Justice: “The worst thing about the Australian legal profession is that the more your husband is promoted, the more stupid they think you must be.”

I am delighted to accept this speaking invitation from your president Stephen Moloney. 26 years ago, I was his tutor in constitutional law at Newman College. Since then my work has been largely in the field of social justice – agitating the rights of indigenous Australians, refugees and asylum seekers, and the claims of the poor and vulnerable rebuilding their lives and societies in places like Cambodia and East Timor. Being both priest and lawyer, I am often expected to comment publicly on law and policy issues such as stem cells, abortion, and euthanasia. I now serve on the national board of an extensive network of Catholic hospitals.

The consideration of medico-legal problems in the public square of a pluralistic democratic society keeping pace with profound technological change is often marked by simplistic assertions, precluding considerations of comprehensive world views, whether religious or philosophical. It is now commonplace for doctors to be told to leave their consciences at the door, as their patients are consumers and they are suppliers and of course the market decides. Debates about law and policy are often resolved with simplistic assertions about individual rights and autonomy, with little consideration for the public interest, the common good, and the doctor-patient relationship. Even conscience is said to be a matter for contracting out.

This evening I ask whether there are more compelling ways to resolve these problems, while conceding a limited role for law in determining the range of acceptable answers. Do we not need

to accord a higher value to the formed and informed conscience of the individual medical practitioner? Do we not need to maintain a high regard for the common good (including the doctor-patient relationship) and the needs of the vulnerable as we circumscribe the realm of personal liberty especially when considering laws dealing with end of life decisions?

I will make some reference to the use made of the Victorian *Charter of Rights and Responsibilities* during the 2008 debate on abortion law reform. My purpose will not be to debate the morality or appropriate limits on the availability of legal, publicly funded abortion. I will focus rather on the right, if any, of a medical practitioner to decline to involve himself or herself in an abortion. The next time we consider this issue in our parliaments will be when we determine the right of a doctor with a conscientious objection to euthanasia being required by law to refer the patient to a doctor known to have no conscientious objection to euthanasia – what I call the obligatory Nitschke referral option.

In my last book *Acting on Conscience* I write at length about the place of religion in law and public policy. Suffice to say, I think it neither sufficient nor useful to quote Vatican declarations in the public square or indeed even here at the Melbourne Club as if such declarations could settle any controversy, except perhaps with some of my fellow believers and religious adherents. Rational dialogue without too ready recourse to authority is a fine solvent in a group such as a medico-legal society to further the search for the true, the good and the beautiful.

Having been involved in a couple of the national debates on legislation permitting destructive experimentation on human embryos, I was much taken with the observation by Dr Rufus Black when speaking at this academy on stem cells on 4 May 2002 in answer to a question:<sup>1</sup>

And explicitly as a theologian, in relation to your mention of the Church's position, I think the Church has actually got it wrong and that theologians who think that - and there are a decent number of them - need to be very public about it and those of us who are not so heavily policed by authority need to be prepared to speak about it. I think here that the thinking has just simply not been careful enough around the nature of what is the intention of researchers when they're dealing with these entities and exactly what these entities are.

Though from a more hierarchical and some would say authoritarian church than Dr Black, I think I am only effective in addressing such an august society as yours if I speak as one not heavily policed by authority, as one who leaves my religious obedience at the door of the Club if you will. Last year when the New South Wales government gazetted a draconian regulation outlawing any conduct which annoyed World Youth Day pilgrims in a vast array of public places including railway stations, Sydney University and Hyde Park, I criticized the law not only as being overbroad, unworkable and violating a fundamental human right, but also as being contrary to the spirit of Catholic social teaching on human rights. This was too much for His Eminence Cardinal Pell who on national radio said: "I'm tempted to say it's a typically unhelpful remark. On occasion he shows a conspicuous sense of due proportion [but this is a] bit of a lack of common sense. It's a beat-up."<sup>2</sup> I told his Eminence at the time: "As a Jesuit I have no interest in offering typically unhelpful remarks or engaging in beat-ups on issues affecting the good standing of our Church. For what it's worth, many Catholics including Catholic lawyers, have been in contact with me grateful that I was speaking in a measured, considered way on an issue which the Church had needlessly complicated. I suppose this just shows that we are a broad

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<sup>1</sup> R. Black, "Stem Cells" Proceedings of Victorian Medico-Legal Society, 2002, 579 at p. 605

<sup>2</sup> G. Pell, ABC Breakfast, Radio National, 7 July 2008

Church with a number of publics.”<sup>3</sup> As a lawyer, I did feel somewhat vindicated when the Full Federal Court presided over by the now Chief Justice Robert French struck down the law.

Recently in that other place, Sydney, I participated in a public debate on the question: “Should euthanasia be legalized?” Opposing the motion, I sought to distinguish between questions of law, public policy and morality. Many persons of a religious persuasion may reason morally from presumptions such that life is a gift given by God and that it is not for any person including the suffering self to take away that life. Such presumptions cannot ground public policy and law, at least in a society where those presumptions do not enjoy uncontroversial, broad public support.

Those who support the legalization of euthanasia usually proceed by quoting cases of mentally competent patients who are not depressed but who are suffering unbearable pain, facing terminal illness. The easiest and most compelling case to consider is the patient whose relatives fully support the proposed euthanasia. There is no suggestion that the relatives are exerting undue influence on the patient for their own self-interested reasons. There are good palliative care facilities available so it is not as if the patient is under duress, feeling that she has no option but death. The patient has a good and trusting relationship with her medical team. Under existing law and policy, there is every prospect that such a patient will be euthanized or at least given increased doses of pain relief which will hasten death. A 1997 study on “End of life decisions in Australian medical practice” published in the *Medical Journal of Australia* by Peter Baume and Peter Singer et al found that “while 30% of all Australian deaths were preceded by an action or omission explicitly intended to end the patient’s life, in only 4% was the decision taken in response to an explicit request from the patient.”<sup>4</sup>

In the United Kingdom, Lord Joffe has made a number of attempts to have the House of Lords pass his *Assisted Dying for the Terminally Ill Bill*. When last introducing the bill in May 2006, he insisted the bill was restricted to competent and terminally ill adults. He told the House that he intended an “explicit prohibition against ending a patient’s life by lethal injection or act of euthanasia” and that the patient would be required herself to ingest orally the prescribed medication. If the patient were unable to swallow, they would be still required to self-administer the poison by pouring the medication into their feeding tube<sup>5</sup>. Under Lord Joffe’s bill, the patient must not only be suffering a terminal illness but the treating physician must have “concluded that the patient is suffering unbearably as a result of that terminal illness” (Cl. 2(2)(d)).

Once the law and policy move over the “do no harm” divide, are there rational and fair criteria which can be applied? In recent times, the UK has focused on the cases of the 23 year old rugby player Daniel James and the 45 year old MS sufferer Debbie Purdy. Daniel would be ineligible for assistance with dying under Lord Joffe’s bill and Debbie may have to avail herself of it long before she is ready to die. She would prefer to have her husband and doctor euthanase her after she has lost control. Daniel was the 23 years old rugby player who was rendered quadriplegic. He was not suffering a terminal disease. Why should euthanasia be denied him if it be available to the person with the terminal illness? Is not such a law discriminatory? Is it fair? Does it accord equal protection of the law to the liberty interests of Daniel as well as to the person

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<sup>3</sup> Letter from author to G. Pell, 7 July 2008

<sup>4</sup> Helga Kiuse, Peter Singer, Peter Baume, Malcolm Clark and Maurice Rickard, “End of life decisions in Australian medical practice”, 1997 *Medical Journal of Australia*, 161 at

<sup>5</sup> Hansard 12 May 2006, columns 1188-9

suffering a terminal illness? And if euthanasia is to be available to the quadriplegic who otherwise is healthy, why not extend it to the young person who says, "I am not clinically depressed; I am just sick of living; I want to die. Give me an injection." There would not be many such persons. But they do exist. Once we cross the Rubicon of "Do no harm", don't we set out on the road of voluntary euthanasia such that the only coherent approach ultimately is to make the lethal injection or ingestion available to the self-determining, autonomous person who freely seeks it provided only they are diagnosed as not being clinically depressed? Then why not make it available to the person who is perpetually depressed but who seeks the community endorsement and support of physician-assisted suicide rather than the loneliness and indignity of unassisted suicide?

The 45-year-old Debbie Purdy has been confined to a wheelchair since 2001 having been diagnosed with MS in 1995. Last October when going to court to seek an order clarifying that the Director of Public Prosecutions would not prosecute her husband if he were to assist with her suicide once she could no longer control her bodily functions, she said: "We are not asking for the law to be changed for it to be made compulsory for people at the end of their lives to be dragged off to the knacker's yard. But this should be one of the choices available and for it to be available we need to be clear on the law." She told the court:<sup>6</sup>

My dearest wish would be to die with dignity in my own home, with my husband and other loved ones around me. I hate the idea of having to travel to another country when I will be at my weakest and most vulnerable, both emotionally and physically. Going to another country also means that I have to go earlier, because being able to travel such a distance and to make all the arrangements in a foreign country will require me to be physically and mentally capable so that too will mean that my life is further shortened as a result of the lack of a humane law in this country. I hope that one day the law will recognise that this is inhumane and that the law should be changed. My husband has said that he would assist me, and if necessary face a prison sentence, but I am not prepared to put him in this position for a number of reasons. I love him and do not want him to risk ending up in prison. As long as the DPP will not clarify his policy on prosecutions in these circumstances, I worry that as my husband is black and a foreigner, this makes him a more likely target for prosecution.

Given that some medical practitioners presently practice euthanasia when the law prohibits same, is there any point in changing the law? The usual reasons for legal change include the claims that some jurisdictions have been able to develop sufficient safeguards to ensure that only the competent, self-determining patient can avail the service of physician assisted suicide and that without such a change to the law, competent, self-determining citizens have to opt for earlier suicide when they are still able to self-administer the suicide cocktail.

If there is to be any move towards the legalization of euthanasia, there will be considerable difficulty in setting criteria and safeguards. It is all very well restricting its availability to the competent, but what of the claim of the person who says, "I am now competent but I am not yet ready to die. Soon I will be incompetent and I want to have made a binding decision consenting to euthanasia once I have lost my competence. I do not want to go earlier than I need. But I do want to go once I am no longer competent." Inevitably there will be some individuals who in the transition to incompetence or dementia will have changed their flickering minds and decided to cling to life for all that it is worth. At their moment of greatest vulnerability, the law will be invoked with a presumption that their earlier option for death is now binding and unreviewable.

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<sup>6</sup> *The Telegraph*, 19 October 2008

I acknowledge that ageing persons like Peter Baume, Philip Nitschke and Bob Brown could autonomously decide to end their own lives according to their own sense of a good life and a good death, whatever the law was. There would be many Australians who fit their profile. But what of vulnerable groups such as Aborigines in the Northern Territory who were not adequately consulted and who were terrified by the Northern Territory euthanasia law?

There are many other individuals who might be vulnerable though they do not fit any minority group profile – those like the late Alzheimer's sufferer Graeme Wylie and his daughters. When sentencing Shirley Justins for providing Wylie with a lethal dose of the veterinary drug Nembutal to Wylie, the judge observed that it was cruel for those involved in the euthanasia to deny Mr Wylie's daughters an opportunity to say farewell. Given Dr Philip Nitschke's involvement in that case, there would be every chance of there being more Graeme Wylies who would never come to our attention once euthanasia was legalised and doctors like Nitschke were free to practise euthanasia more than they presently do.

Many voluntary euthanasia supporters may enjoy a good death regardless of the law. There are some "oldies" who will be vulnerable if euthanasia is legalised. Not all oldies are vulnerable; but some are. In shaping laws and policies (rather than moral codes), we need to have a care for them, regardless of our religious or atheistic beliefs.

Voluntary euthanasia advocates have joined issue with my description of Graeme Wylie's death. Not having attended the trial of Shirley Justins, I have confined myself to facts on the public record. There was a family dispute about the belated changes made to his will – a not unfamiliar occurrence in Australia. Wylie had previously sought the services of Dignitas in Switzerland but been rejected because he was judged not competent. But letter writers to the *Sydney Morning Herald* (which has a strong pro-euthanasia editorial policy) have seen no problem with this. Dorothy Kamaker (*SMH Letters*, 10 February) thinks he was competent to give orders for his own death. Alan Mann (*SMH Letters*, 10 February) thinks Wylie would be eligible for euthanasia under euthanasia legislation with stringent verification procedures.

Wylie's daughters were denied a chance to farewell him. When Justins was sentenced, Wylie's daughter, Tania Shakespeare, told the media, "I'm heartbroken that I wasn't able to say goodbye to my father". The sentencing judge said Justins was selfish and cruel for denying the daughters an opportunity to say farewell. Kep Enderby who attended Justins' trial disputes the judge's assessment (*SMH Letters*, 11 February).

The complex Wylie case highlights how fraught any euthanasia law would be, regardless of the stringent verification procedures involved. Regardless of our religious affiliations or comprehensive world views, we should exercise great prudence before approving any law which departs from the principle "do no harm", regardless of the utility such change would offer the competent. Let's now consider the issue of conscience and patient autonomy.

Lord Joffe's bill contained a conscientious objection clause. It is helpful to trace the legislative history in the UK and compare what happened here in Victoria with the equivalent conscience clause in the abortion bill.

In his 1789 Letter to the Quakers, George Washington said, “I assure you very explicitly, that in my opinion the conscientious scruples of all men should be treated with great delicacy and tenderness: and it is my wish and desire, that the laws may always be as extensively accommodated to them, as a due regard for the protection and essential interests of the nation may justify and permit.”<sup>7</sup>

This week I have been privileged here in Melbourne to attend a conference with Martha Nussbaum and some of Australia’s leading philosophers and legal scholars. The prolifically published Nussbaum holds a joint chair in law and ethics at the University of Chicago’s Department of Philosophy, Law School and Divinity School. Her latest book *Liberty of Conscience* provides a rich textured treatment of the place of religion in the public square. In her characteristic writing mode, she shares personal anecdotes - this time her conversion from Christianity to Judaism on the occasion of marriage; she treats deftly the classics, and then delves into philosophical reflection on US jurisprudence not all of which travels well across the Pacific. In this book she reflects on the agonising dilemma of Sophocles’ Antigone when the State in the person of her uncle Creon has announced that she may not bury her brother, killed attacking the city. Her religion dictates that she must bury her brother. She speaks of Creon’s alarming rigidity: “He has defined public policy in a way that favours the interests of most people in the city. In the process, however, he has imposed a tragic burden on one person. The great Athenian statesman Pericles boasted that fifth century democratic Athens did things better, refusing on principle to put people in such dreadful predicaments. Athens, he said, pursues the good of the city, but not by requiring its citizens to violate the ‘unwritten laws’ of their religions.”<sup>8</sup>

Nussbaum nicely posits the Lockean position of state neutrality whereby “the state is free to regulate matters concerning property or health or safety even when they bear on religious organisations – so long as it does so impartially”<sup>9</sup> against the more subtle treatment of the seventeenth century American Roger Williams, founder of Rhode Island, who espoused religious accommodation with the declaration, “It is the will and command of God that (since the coming of his Sonne the Lord Jesus) a permission of the most paganish, Jewish, Turkish, or antichristian consciences and worships, bee granted to all men in all nations and countries”.<sup>10</sup>

Nussbaum sets down six normative principles, which I find useful in scrutinising laws and policies that impact on the free exercise of religion and on the broader freedom of conscience. I will take as a case study s.8(1)(b) of the recently enacted Abortion law Reform Act here in Victoria. The issue is not the legality or desirability of abortion on demand. The issue is whether the law ought provide for compulsory referral by a conscientious objector. S. 8(1)(b) provides:

If a woman requests a registered health practitioner to advise on a proposed abortion, or to perform, direct, authorise or supervise an abortion for that woman, and the practitioner has a conscientious objection to abortion, the practitioner must refer the woman to another registered health practitioner in the same regulated health profession who the practitioner knows does not have a conscientious objection to abortion.

Justice Scalia has pursued the Lockean position on the US Supreme Court, as have groups such as Liberty Victoria in pursuing the enactment of the recent Victorian abortion law including this

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<sup>7</sup> Quoted at p. 115

<sup>8</sup> Ibid, 116

<sup>9</sup> Liberty of Conscience, p. 60

<sup>10</sup> Ibid, quoted at p. 34

novel clause stipulating compulsory referral by a conscientious objector. The Williams approach finds expression in the judgments of Justice O'Connor on the US Supreme Court and in the criticisms offered by some of the faith based groups critical of clause 8(1)(b) of the Victorian abortion law. The supporters of clause 8 would be surprised to learn they are *ad idem* with Justice Scalia who has said, "we have never held that an individual's religious beliefs excuse him from compliance with an otherwise valid law prohibiting conduct that the state is free to regulate."<sup>11</sup>

Australia is a signatory to the International Covenant on Civil and Political Rights. The terms of that Covenant provide a convenient benchmark for most individuals and groups who espouse human rights. The freedom of conscience and religion is one of the few non-derogable rights in the Covenant. This means that a signatory may not interfere with the exercise of the right even during a national emergency -whereas other rights in the Covenant can be cut back during times of public emergency which threatens the life of the nation – but only to the extent strictly required by the exigencies of the situation and provided that that cut back applies in a non-discriminatory way to all persons. Furthermore the freedom of thought, conscience and religion is one of the few rights, which can be confined only if it be necessary "to protect public safety, order, health, or morals or the fundamental rights and freedoms of others"<sup>12</sup>.

Let's consider Nussbaum's principles:

1. The equality principle: all citizens have equal rights and deserve equal respect from the government under which they live
2. The respect conscience principle: - providing protected space within which citizens may act as their conscience dictates. All citizens enter the public square on equal conditions
3. The liberty principle: respect for people's conscientious commitments requires ample liberty – and not just a regime of equal constraint in which nobody has much religious freedom
4. The accommodation principle: sometimes some people (usually members of religious minorities) should be exempted from generally applicable laws for reasons of conscience.
5. The non-establishment principle: the state does not operate so as to set up an in-group and an out-group.
6. The separation principle

Nussbaum concedes that there may be a need for religion to bear some burdens "if the peace and safety of the state are really at stake, or if there is some other extremely strong state interest. But it seems deeply wrong for the state to put citizens in such a tragic position needlessly, or in matters of less weight. And often matters lying behind laws of general applicability are not so weighty; sometimes they come down to a mere desire for homogeneity and an unexamined reluctance to delve into the details of a little known or unpopular religion"<sup>13</sup>.

It is useful to compare the UK and Australian responses to compulsory referral clauses placed in laws dealing with the delivery of medical services in morally contested fields. My argument is that the UK has more of a culture and architecture for discussion of rights and their limits than we do, and that is because they have had a Human Rights Act for 10 years and they have been subject to human rights jurisprudence from Strasbourg for decades.

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<sup>11</sup> *Employment Division v Smith*, 494 US 872 (1990) at 878-9

<sup>12</sup> Article 18(3), ICCPR

<sup>13</sup> *Ibid*, 117

When Lord Joffe's *Assisted Dying for the Terminally Ill Bill* was first drafted in the United Kingdom it contained a clause similar to section 8 of the Victorian *Abortion Law Reform Act 2008*. The original Joffe Bill imposed a duty on physicians who invoked their right to conscientiously object, to "take appropriate steps to ensure that the patient is referred without delay to a physician who does not have such a conscientious objection". The Westminster Parliament's Joint Committee on Human Rights remarked:

3.14 We consider that imposing such a duty on a physician who invokes the right to conscientiously object is an interference with that physician's right to freedom of conscience under the first sentence of Article 9(1), because it requires the physician to participate in a process to which he or she has a conscientious objection. That right is absolute: interferences with it are not capable of justification under Article 9(2).

3.15 We consider that this problem with the Bill could be remedied, for example by recasting it in terms of a right vested in the patient to have access to a physician who does not have a conscientious objection, or an obligation on the relevant public authority to make such a physician available. What must be avoided, in our view, is the imposition of any duty on an individual physician with a conscientious objection, requiring him or her to facilitate the actions contemplated by the Act to which they have such an objection.

3.16 In the absence of such a provision, however, we draw to the attention of each House the fact that clauses 7(2) and (3) give rise in our view to a significant risk of a violation of Article 9(1) ECHR.

The UK bill was accordingly amended to provide that "No person shall be under any duty to refer a patient to any other source for obtaining information or advice pertaining to assistance to die, or to refer a patient to any other person for assistance to die under the provisions of this Act" (cl. 7(3)). Under the revised UK provision, the doctor with a conscientious objection would have no additional legal duty other than "immediately, on receipt of a request to do so, transfer the patient's medical records to the new physician". (cl. 7(6))

When confronted with cl 8 of the *Abortion Law Reform Bill*, it was not surprising that the Victorian Scrutiny of Acts and Regulations Committee drew attention to the equivalent attempted provision in the UK, the response by the UK Committee, and the amendment proposed in the UK Parliament. The Victorian committee noted:

The Committee notes that clause 8 sets out the obligations of health practitioners who hold a conscientious objection to abortion, including (in clause 8(1)(a)) an obligation to refer women who request an abortion to another practitioner who has no conscientious objection. The Committee observes that some practitioners may hold a belief that abortion is murder and may regard a referral to a doctor who will perform an abortion as complicity in murder. The Committee therefore considers that clause 8(1)(a) may engage the Charter right of such practitioners to freedom of belief.

The Committee rightly observed that the compatibility of this clause with the Charter "depends on its satisfaction of the test in Charter s. 7(2), including whether or not there are less restrictive means available to achieve the purpose of the clause".<sup>14</sup> The Committee then very properly referred two questions to Parliament for its consideration:

1. Whether or not clause 8(1)(a), by requiring practitioners to refer patients to doctors who hold no conscientious objection to abortion, limits those practitioners' freedom to believe that abortion is murder?

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<sup>14</sup> Scrutiny of Acts and Regulations Committee, Alert Digest No 11 of 2008, p. 6



2. If so, whether or not clause 8(1)(a) is a reasonable limit on freedom of belief according to the test set out in Charter s. 7(2) and, in particular, whether or not there are any less restrictive means available to ensure that women receive appropriate health care?

No credible answers were provided by Parliament. The questions could only have been answered, Yes to the first and No to the second.<sup>15</sup>

Victoria is the first Australian state to have legislated a Charter of Human Rights and Responsibilities Act. It reproduces many of the rights in the ICCPR including the freedom of thought, conscience, religion and belief (s.14). Unlike the ICCPR, the Victorian Charter does not specify that any rights are non-derogable. And all rights can be restricted for reasons other than the need “to protect public safety, order, health, or morals or the fundamental rights and freedoms of others”.<sup>16</sup> Section 7(2) specifies the justified limits on rights:

A human right may be subject under law only to such reasonable limits as can be demonstrably justified in a free and democratic society based on human dignity, equality and freedom, and taking into account all relevant factors including—

- (a) the nature of the right; and
- (b) the importance of the purpose of the limitation; and
- (c) the nature and extent of the limitation; and
- (d) the relationship between the limitation and its purpose; and
- (e) any less restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve.

The Victorian Equal Opportunity and Human Rights Commission purported to answer the questions posed by the Scrutiny of Bills committee when their CEO wrote to *The Australian* on 1 October 2008 stating:

The purpose of the charter is to provide a framework to help us balance competing rights and responsibilities. Freedom of conscience is not the only issue at stake here, and to suggest so is to simplify an extremely complex issue. In this case, a doctor's right to freedom of conscience needs to be balanced with competing considerations such as a patient's right to make a free and informed choice. Sometimes limits on human rights are necessary in a democratic society that respects the human dignity of each individual.

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<sup>15</sup> Some civil libertarians and abortion advocates have made the point that there was no need for the government or the parliament to consider the impact of the proposed law on the freedom of conscience, religion or belief, as s.48 of the Victorian Charter exempts any law on abortion from Charter scrutiny. Legal opinion is divided on scope of that exemption. Neil Young QC and P G Willis advised, “In our opinion, s.48 was not intended to have the consequence that legislation subjecting health practitioners to newly defined rights, authorities or obligations in connection with their involvement, or potential involvement, in abortion advice or procedures concerning abortion is excluded from Part 3 of the Charter.” (Joint Opinion in the Matter of the Abortion Law reform Bill 2008, para 79, 3 October 2008) They then added: “Further and in any event, even if we are wrong about our construction of s 48, it does not follow that it is inappropriate or irrelevant for Parliamentarians debating the bill to test the requirements of the Bill against the standards set out in the Charter...This is especially so given the high principles which the Parliament espoused in enacting the Charter and the fundamental importance of the human rights set out in the Charter.” (para. 81)

<sup>16</sup> Article 18(3), ICCPR

Suffice to say that this simple solution is in stark contrast to the reasoning and conclusion reached by the UK Parliament in its consideration of a similar clause. The AMA Code of Ethics provides:<sup>17</sup>

When a personal moral judgement or religious belief alone prevents you from recommending some form of therapy, inform your patient so that they may seek care elsewhere.

Recognise that you may decline to enter into a therapeutic relationship where an alternative health care provider is available, and the situation is not an emergency one.

Recognise that you may decline to continue a therapeutic relationship. Under such circumstances, you can discontinue the relationship only if an alternative health care provider is available and the situation is not an emergency one. You must inform your patient so that they may seek care elsewhere.

The AMA thought cl.8(1)(b) unwarranted because it departed from the existing AMA Code of Ethics. AMA Victoria advised its members in these terms:

Last week, AMA Victoria met with Minister Andrews' adviser and Department of Human Services legal counsel to seek their understanding of the clause, and we have also sought independent legal advice. The government and the advice confirmed that clause 8 changes the existing law. The existing common law and existing codes of practice require that a doctor with a conscientious objection to a particular service inform the patient of that conscientious objection and ensure that the service is available elsewhere. The existing law and practice also provide that doctors have a duty to assist in an emergency. AMA Victoria supports the existing law and ethical obligation to properly inform patients and ensure that services are elsewhere available.

The AMA asked the Premier to consider removing clause 8 and rely on the existing law, or amend the section to reflect the existing law. That remained the AMA's position right through the debate in both houses of parliament. It is still the AMA's position. In trying to avoid the draconian effect of the anti-conscience clause in the Victorian law, the AMA has now provided its members with a template letter for conscientious objectors stating:

Due to Dr [INSERT NAME]'s moral and ethical beliefs, s/he is not able to offer you abortion services. We do not wish patients who are seeking these services to suffer embarrassment or emotional upset, so we want to make this position clear. We ask that you respect Dr [INSERT NAME]'s beliefs by not requesting abortion services from him/her, as they are against his/her conscience.

To date there has been no challenge or test case on the issue. The abortion law provides no penalty for non-compliance with the compulsory referral provision, though presumably the Medical Practitioners' Board would have power to discipline or even strike off practitioners for non-compliance. Before such action was taken by the Board, it, being a public authority for the purposes of the Charter, would need to ensure that it did not act in a way that is incompatible with the human right of freedom of conscience. Given the Board's latitude for action, it would need to establish that in striking off a member for conscientious objection it could not reasonably have acted differently or made a different decision.<sup>18</sup> This highlights the complete unworkability and incoherence of such a compulsory referral clause for a medical procedure that requires no referral in a jurisdiction which boasts a Charter providing for freedom of conscience.

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<sup>17</sup> AMA Code of Ethics, under the heading "The Doctor and the Patient: Patient Care", Para (p) – (r), p. 2. See the Appendix for recent developments with statements on ethics by various specialist medical bodies.

<sup>18</sup> s. 38, Charter of Human Rights and Responsibilities Act 2006

By requiring a compulsory referral (a requirement additional to the AMA Code of Ethics), s. 8 works interference on the right to freedom of thought, conscience and belief of a medical practitioner with a conscientious objection to abortion.

On 9 September 2008, *Liberty Victoria* issued its only press release on the bill stating, “The *Abortion Law Reform Bill* should be passed without amendment.” Then writing in *The Age* on 24 September 2008, Anne O’Rourke, the vice president who had the public carriage of the issue for Liberty Victoria claimed that the conscientious objection clause was “consistent with the Australian Medical Association’s code of ethics”. She went on to say, “To claim the *Abortion Law Reform Bill* breaks new ground or imposes unprecedented obligations on hospitals or medical staff is wrong and misleading. The bill does not do so.” Her assertion was contrary to the government’s own legal advice to the AMA.

*Liberty Victoria*’s public position was in stark contrast to the position taken by the AMA. In his letter to the Victorian Premier, Dr Doug Travers, the President of the AMA (Victoria Branch) pointed out that doctors are “not currently forced to provide a service they believe to be unethical or immoral”. He acknowledged that “the existing common law and existing codes of conduct require that a doctor with a conscientious objection to a particular service inform the patient of that conscientious objection and ... ensure that the service is available elsewhere”. But he pointed out that the proposed legislation went beyond this: it “infringes the rights of doctors with a conscientious objection by *inserting an active compulsion* for a doctor to refer to another doctor who they know does not have a conscientious objection. Respect for a conscientious objection is a fundamental principle in our democratic country, and doctors expect that their rights in this regard will be respected, as for any other citizen”.

The highly respected Neil Young QC from the Melbourne Bar concluded that the drafting of cl 8(1)(b) “appears to go beyond” the AMA code of ethics. He pointed out that though under the AMA code of ethics, “the conscientious objector is required to provide information”, “the objector is not required to ascertain or know the views of other practitioners or to refer the woman to a specific practitioner who does not have a conscientious objection to abortion”.<sup>19</sup> Young expressed the view that “clause 8(1)(b) cannot be interpreted or applied consistently with the human right set forth in s.14 of the Charter” (the right to freedom of thought, conscience, religion and belief).<sup>20</sup> Young concluded that cl 8(1)(b) cannot be justified by recourse to s 7(2) of the Charter.

Was a less restrictive means available? Yes. As Young says, “cl 8(1)(b) could have adopted the language used in the AMA Code of Ethics, which provides a satisfactory and reasonably available alternative. Other less coercive means can be postulated, such as the maintenance of a public register of practitioners who hold no conscientious objection to abortion”.<sup>21</sup> None of this analysis was done by the Parliament, nor by the advocacy groups like Liberty Victoria, nor by the statutory bodies such as the Equal Opportunity Commission. The outcome was the opposite of that reached in the United Kingdom, and with much thinner, more ideological reasoning.

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<sup>19</sup> N Young and P Willis, Joint Opinion, In the Matter of the Abortion Law Reform Bill 2008, 3 October 2008, para 57

<sup>20</sup> Ibid., para 59

<sup>21</sup> Ibid., para 62

In my opinion, this was the first real test of the Victorian Charter of Human Rights and Responsibilities and it failed spectacularly to protect a core non-derogable ICCPR human right which fell hostage to a broader social and political agenda for abortion law reform and a prevailing fad in bioethics which asserts that doctors should leave their consciences at the door.

Groups such as *Liberty Victoria* provided no coherent answers. Academic experts on the Charter largely remained silent. However Professor George Williams, the principal draftsman of the Victorian Charter, yesterday circulated his opinion to human rights lawyers advising, “It was one thing to exclude abortion from the Charter's coverage, but another again to also exclude all related questions, such as that of conscientious objection. A federal law should be better drafted. There is an irony in the Victorian outcome given that the exclusion clause was not in the form that my committee proposed (it would not have had the same outcome)”. The Equal Opportunity and Human Rights Commission simplistically dismissed freedom of conscience. As recently as two days ago, the official spokesperson from *Liberty Victoria* said the Catholic Church had snookered itself by “lobbying to ensure the Charter cannot be used by women to seek a right to abortion, effectively hav(ing) curbed their own rights to conscientious objection”<sup>22</sup>. This is a serious task of rights protection for all; it should not be a partisan anti-religious game. Given that the referral clause was both unnecessary, unworkable, and more intrusive than state notification of available abortion providers, one can only conclude as did Justice Kennedy in the leading US gay rights decision *Romer v Evans*: the clause “seems inexplicable by anything but animus toward the class it affects; it lacks a rational relationship to legitimate state interests.”<sup>23</sup>

I daresay many civil libertarians and Charter advocates are little worried by this first test of the Victorian Charter because they share the view of Oxford philosopher Julian Savulescu that doctors’ consciences should be left at the door in the name of patient autonomy. Doctors are simply there to provide a service as if they are automatons. In his recent article “Conscientious objection in medicine”, Savulescu commences with a literary reference – not to Sophocles’ *Antigone* but to Shakespeare’s *Richard III*. When *Richard III* roused from his dream before battle he made his declaration:

Let not our babbling dreams affright our souls: conscience is but a word that cowards use, devised at first to keep the strong in awe: Our strong arms be our conscience; swords our law.

Savulescu quotes only the sentence: “conscience is but a word that cowards use, devised at first to keep the strong in awe”. Here is the context. During *Richard III*’s dream, he confronted the eleven ghosts of those he had callously murdered including the Ghost of Prince Edward, son to King Henry VI who proclaimed “Let me sit heavy on thy soul to-morrow! Think, how thou stab'dst me in my prime of youth. At Tewksbury: despair, therefore, and die!” And the Ghost of King Henry VI who proclaimed “When I was mortal, my anointed body by thee was punched full of deadly holes. Think on the Tower and me: despair, and die! Harry the Sixth bids thee despair, and die!”

*Richard III*: hardly the model for the discerning medical practitioner; and his quote on conscience hardly the literary quote likely to evince sympathy for the primacy of conscience, a non-derogable human right. For those who want swords to be their law, there is every reason to view conscience as a word used only by cowards. It is those sorts of people who demand that

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<sup>22</sup> Anne O’Rourke, Vice President, Liberty Victoria, *The Australian*, 27 February 2009

<sup>23</sup> *Romer v Evans* 517 US 620 (1996) at 633

conscience be left at the door.

Martha Nussbaum's concluding chapter in *Liberty of Conscience* is titled with a question: "Toward an Overlapping Consensus?" She makes the point that laws do matter as "good laws and institutions set limits on people's ability to act on their intolerant and inegalitarian views". She describes Roger Williams' challenge to the new colonies: "that they find, and learn to inhabit, a shared moral space, without turning that space into a sectarian space that privileges some views over others".<sup>24</sup> That challenge was not met when the Victorian Parliament, academy and civil society endorsed an unworkable, unprincipled, and useless compulsory referral clause trampling the conscientious beliefs of some medical practitioners with no workable benefit being accorded their patients.

We need to do better if faith communities and minorities are to be assured that a judicially unenforceable charter of rights is anything but a piece of legislative window dressing which rarely changes legislative or policy outcomes. Such groups could perceive a charter as a device for the delivery of a sectarian agenda insufficiently attentive to religious sensibilities – a device which will be discarded or misconstrued whenever the rights articulated do not comply with that agenda. The repeal of s.8(1)(b) or at least a public Charter analysis of the clause would be a welcome contribution to a national dialogue about the desirability of a federal Charter.

Nussbaum finds hope in John Rawls' notion of overlapping consensus whereby those holding different religious and secular comprehensive doctrines can live together on terms of equal respect "agreeing to share a 'freestanding' ethical conception in the political realm, and agreeing, at the same time, to forgo the search for the dominance of any one comprehensive doctrine over the others".<sup>25</sup> Those who think that conscience is but a word cowards use are unlikely to forgo the search for dominance of their comprehensive doctrine over others. We still have much more work to do in Australia if we are to take seriously in law and policy Nussbaum's "respect conscience principle" and her "accommodation principle". Our protection of human rights for all will be much enhanced if we are better able to provide "protected space within which citizens may act as their conscience dictates"<sup>26</sup> and if we can acknowledge that "sometimes some people (usually members of religious minorities) should be exempted from generally applicable laws for reasons of conscience".<sup>27</sup>

Utilitarianism and patient autonomy are not enough; the medical pledge to do no harm no matter what the cost effective benefits for the competent, and the conscience of the doctor are still key elements in any law which promotes good medicine. It is one thing for us to leave our religious and other comprehensive world views at the door of the Club or at the entrance of the public square; it does not follow that the doctor should leave her conscience at the door of the surgery which is so much more than a marketplace.

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<sup>24</sup> M. Nussbaum, op. cit., 360

<sup>25</sup> Ibid., 361

<sup>26</sup> Ibid., 22

<sup>27</sup> Ibid., 24

## Appendix

### Recommendations on Ethical Issues by Professional Medical Bodies

There has been an ongoing tension in the development of codes of ethics between the competing values of providing a requested service to the autonomous patient and honouring the professional and conscientious disposition of the medical practitioner. This has been a particular issue in the field of women's reproductive health. But it is now becoming relevant in other fields of medicine including euthanasia, assistance with dying, transgender surgery and the provision of assisted reproductive services to same sex couples (including men).

The International Federation of Gynecology and Obstetrics (FIGO) has been publishing recommendations on ethical issues in Obstetrics and Gynecology for the last 20 years. FIGO is currently composed of 113 professional societies of obstetricians and gynaecologists worldwide, including the The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). In 1985 FIGO set up a committee to look at ethical aspects of human reproduction and women's health. In 1989, FIGO set out general principles governing sterilization including a statement that "Individuals have a right to seek or refuse health care." FIGO then stated:<sup>28</sup>

While fostering the patient's choice in exercising this right, physicians should retain responsible control of their own decisions and actions so as not to become merely the agents of patients or others, in matters involving medical judgment or personal conscience.

FIGO acknowledged that some practitioners would have conscientious objections not just to performing sterilizations, but also to providing a referral for same. When setting out the specific ethical considerations, FIGO stated:<sup>29</sup>

There are physicians who, because of their own religious or philosophical beliefs, object to sterilization under any circumstances. Physicians may also encounter situations in which, according to their best judgement, sterilization would not be appropriate. It is the right of these physicians to abstain from the performance of sterilizing procedures. It is every physician's obligation to make it clear when personal convictions limit counseling, services or referral. Patients have a right to be informed that sterilization services may be available elsewhere.

In 1994, FIGO drew up a very brief "ethical framework for gynecologic and obstetric care: stating:<sup>30</sup>

If a physician is either unable or unwilling to provide a desired medical service for non-medical reasons, he or she should make every effort to achieve appropriate referral.

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<sup>28</sup> FIGO, Recommendations On Ethical Issues In Obstetrics And Gynecology By The Figo Committee For The Ethical Aspects Of Human Reproduction And Women's Health, November 2003, London, p. 55

<sup>29</sup> Ibid, 56-7

<sup>30</sup> Ibid., p. 10

Then in 1998, FIGO at its meeting in Cairo published recommendations regarding “ethical aspects of induced abortion for non-medical reasons”. FIGO changed its position on referral, stating:<sup>31</sup>

Most people, including physicians, prefer to avoid termination of pregnancy and it is with regret that they may judge it to be the best course, given a woman’s circumstances. Some doctors feel that abortion is not permissible whatever the circumstances. Respect for their autonomy means that no doctor (or other member of the medical team) should be expected to advise or perform an abortion against his or her personal conviction. Their careers should not be prejudiced as a result. Such a doctor, however, has an obligation to refer the woman to a colleague who is not in principle opposed to termination.

Then in 2000, FIGO returned to its consideration of sterilization and decided to drop its acknowledgement of the practitioner’s right of conscientious objection to refer. They stated:<sup>32</sup>

Some physicians may, because of their own beliefs, object to sterilisation. Respect for their autonomy implies that no physicians should be expected to perform a sterilisation against their personal conviction. Such physicians, however, have an obligation to refer the person to a colleague willing to perform the sterilisation. A physician’s personal values or sense of societal objectives should not intrude on a person’s counselling for or against sterilisation.

In March 2005, the FIGO Committee for the Ethical Aspects of Human Reproduction and Women’s Health met with the Committee of Women’s Sexual and Reproductive Rights and issued “ethical guidelines on conscientious objection”. FIGO emphasized that the document was “not intended to reflect an official position of FIGO, but to provide material for consideration and debate about these ethical aspects of our discipline for member organizations and their constituent membership.”<sup>33</sup> By way of background, the joint meeting of the two committees stated:<sup>34</sup>

When in an emergency, patients’ lives, or their physical or mental health, can be preserved only by procedures in which their practitioners usually object to participate, and practitioners cannot refer such patients to non-objecting practitioners in a timely way, the practitioners must give priority to their patients’ lives, health and well-being by performing or participating in the indicated procedures.

They then set out guidelines including Guideline 6:<sup>35</sup>

Patients are entitled to be referred, in good faith, for procedures medically indicated for their care that their practitioners object to undertaking, to practitioners who do not object. Referral for services does not constitute participation in any procedures agreed upon between patients and the practitioners to whom they are referred.

## **RANZCOG**

In Australia, RANZCOG developed its own code of ethical behaviour in 2001 and revised it in 2006. On the issue of conscientious objection and referral, RANCOG states:<sup>36</sup>

Doctors should offer or arrange a further opinion and/or ongoing care with another suitable practitioner if:

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<sup>31</sup> Ibid., 64

<sup>32</sup> Ibid, p. 59

<sup>33</sup> FIGO Committee Report, Ethical Guidelines on Conscientious Objection, International Journal of Gynecology and Obstetrics (2006) 92, 333-4 at p. 333

<sup>34</sup> Ibid, 334

<sup>35</sup> Ibid

<sup>36</sup> RANZCOG Code of Ethical Practice, May 2006, p. 6

- the patient requests this;
- the therapy required is beyond the individual doctor's expertise or experience;
- the therapy required is in conflict with the doctor's personal belief/value system.

If a doctor wishes to discontinue care of a particular patient, he/she must make appropriate referral and with the patient's consent communicate relevant information to the new practitioner. Doctors should not unreasonably refuse to accept referral or provide care; this applies particularly in an emergency or if no other appropriate practitioner is available.

## **AMA**

It is fair to say that the relevant codes for obstetricians and gynecologists have now for some years emphasized the patient's right to receipt of service over and above the conscientious objection of the health practitioner. This has not been the case for the general code of ethics for the medical profession generally. The AMA Code of Ethics provides:<sup>37</sup>

When a personal moral judgement or religious belief alone prevents you from recommending some form of therapy, inform your patient so that they may seek care elsewhere.

Recognise that you may decline to enter into a therapeutic relationship where an alternative health care provider is available, and the situation is not an emergency one.

Recognise that you may decline to continue a therapeutic relationship. Under such circumstances, you can discontinue the relationship only if an alternative health care provider is available and the situation is not an emergency one. You must inform your patient so that they may seek care elsewhere.

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<sup>37</sup> AMA Code of Ethics, under the heading "The Doctor and the Patient: Patient Care", Para (p) – (r), p. 2.