Submission No 21

INQUIRY INTO REPRODUCTIVE HEALTH CARE REFORM BILL 2019

Organisation: School of Law, University of Notre Dame Australia

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Ms. Anna Walsh
Lecturer, School of Law, University of Notre Dame Australia

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The New South Wales Standing Committee on Social Issues
NSW Legislative Council

By email: socialissues@parliament.nsw.gov.au

Dear Members of the Standing Committee on Social Issues,

Re Reproductive Health Law Reform Bill

Thank you for the opportunity to comment upon this bill, which seeks to decriminalise abortion. I provide written submissions herein and will make myself available at the public hearing, if required.

Qualifications

1. I am a lawyer with 20 years' experience in Medical Law. Between 2006 and 2016, I was a Principal of Maurice Blackburn Lawyers, where I ran the Medical Law department in NSW, and held specialist accreditation from the Law Society of NSW in personal injury law. Between 2016 and 2018, I held an Adjunct Associate Professorship in the School of Law at the University of Notre Dame, and am currently a full time Lecturer/Academic in that School, where I am also completing my PhD. I am a regular invited speaker at legal seminars organised by the legal profession to educate lawyers on medical litigation and bioethics.

2. I have honour degrees in Law and Nursing, a Master of Laws from the University of Sydney (on abortion law), and a Master of Bioethics from Harvard Medical School. My PhD is a qualitative study on the attitudes and experiences of 35 doctors who have a conscientious objection to abortion and practice in either NSW or Victoria. Whilst data collection and analysis is complete, the findings have not been published. As this study is novel and directly relevant to this bill, I will take the liberty of sharing preliminary findings with you, in the hope they aid deliberations, given they provide direct evidence on conscientious objection.

Preliminary comment

1. Whilst abortion has been decriminalised around Australia, replacing the NSW framework with an autonomy regime, subject to an upper gestational age, is significant. Whilst many people want abortion to be standard healthcare, this change has consequences on others in the community, in medicine, and on the law, as it sets a precedent for others area of medicine that are morally controversial. As such, the extreme haste with which this bill was introduced is concerning. It has stymied the ability of people who oppose the bill, or oppose aspects of it, to engage in public discussion, and educate the community on relevant issues.

2. I do not support the decriminalisation of abortion, but understand the committee wishes to focus upon the amendments that were debated in the Legislative Assembly last week, rather than re-prosecute the case for or against decriminalisation. As such, my comments are confined to amendments that lie within my area of competence, and are set out below.

Informed Consent at not more than 22 weeks: Proposed Amendment c2019-031FA (passed)

1. In clause 5(2), a doctor may perform termination at not more than 22 weeks if the person has given informed consent. Schedule 1 defines informed consent as that which is given freely and voluntarily and in accordance with any guidelines applicable to the doctor in relation to termination. This begs the question of whether there are adequate guidelines for doctors on the content of any warnings they must give to the patient on the relative risks of termination on her. Information on the generic risks of termination *per se* is clearly insufficient, and it is inappropriate to delegate disclosure of risks and alternatives to a non-doctor.

2. The law on informed consent for medical services is well established in Australia. Doctors have a general duty to act with reasonable care and skill when providing services and when warning patients about the risks of the service.[1] When it comes to performing termination, guidelines exist regarding the technical aspects of performing the service, but there is less clarity around the content of any warning the doctor must give that goes beyond the physical risks of termination, and extends to the psychological and mental health risks that termination may have on the particular patient. This is worthy of debate and discussion.

3. The NSW Health Pregnancy Framework for Terminations in NSW Public Health Organizations (which does not apply to private abortion clinics) merely states that 'hospital protocols should give guidance to clinicians on providing appropriate patient information.' There is a lack of medical consensus about what those risks are and how the doctor screens a patient for them. Research into any causal link between abortion and psychological consequences is treated cautiously, but understanding these links must be a priority so doctors meet their legal requirements and their moral duty to provide quality care.

4. Doctors must warn patients about the material risks inherent in the service.[2] Material risks include the need for the treatment, the existence of satisfactory and available alternatives, the extent and severity of a potential injury, and the likelihood of it occurring.[3] What is often neglected is that they also have a reactive duty to warn them about any risks that they know, or ought to know, the patient will attach significance to. If there are psychological risks associated with termination, which are heightened with a history of mental illness, lack of social support, or general fears or concerns, then this must be reflected in the doctor's advice.

5. In advising on satisfactory and available alternatives, there is a real question as to what information doctors give women who may be vulnerable to additional risks of harm, especially doctors at abortion clinics that benefit financially from the termination going ahead. It is not improper to raise this. It is the corollary to the position taken in this bill, about doctors with a conscientious objection to abortion; they must disclose their objection straight away and direct the patient to a doctor who does not have an objection because it is inferred that they cannot be trusted to provide "all options" information due to their worldview.

6. Choice requires the doctor to understand and act on the woman's worldview, not that of the doctor, the clinic, or the state. In some cases, continuing pregnancy, which is the only alternative to abortion, might be explored by her with support from privately funded crisis pregnancy services or church groups etc. This information must not be withheld from her. The safe access zone laws prohibit sidewalk counselling outside abortion clinics and took away this potential information portal for women. The state did not enquire into what abortion clinics say about risks, alternatives, and support services.

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[1] *Rogers v Whitaker* (1992) 175 CLR 479.
[2] Ibid.
[3] *Rosenberg v Percival* (2001) 205 CLR 434.

7. Making abortion lawful healthcare is a second chance to spotlight this and test these assumptions. There is also a need to hear from patients and the experience of consent. By considering a change to the law, there is a need to review policies and educational practices of doctors and students on how to assess risk for abortion, and what alternatives and support services exist. This is because the need to be satisfied that abortion is necessary for her life or health will no longer be the test under the law. Due to the haste of this inquiry, proper discussion about these important issues, and hearing patient testimonials, has not occurred.

Requirement for Information and Counselling: Proposed Amendment c2019-040F (passed) & Abortion Coercion: Proposed Amendment c2019-042, no 13 (did not pass)

1. Comment on these amendments is linked to that of informed consent, the risks of termination, and what training doctors receive on it. Making abortion lawful healthcare for any reason up to 22 weeks may result in increased patient requests to doctors who are unused to the request. Creating a duty that doctors must assess whether counselling would be beneficial to the patient begs the question of whether they are trained on how to assess this. The issue of counselling services for termination is very important for quality patient care. It warrants further inquiry and it cannot be covered within the restricted timeframes of this inquiry.

2. Firstly, the term counsellor is not defined in the bill. For some women, abortion is not just about medical risks of physical harm, but it is a moral issue. Accordingly, it may be that faith based counselling is beneficial to her. It is important that referral to this type of non-medical counselling not be prohibited on the basis that the counsellor does not have formal health qualifications. Secondly, the clause should prohibit counselling by the clinic that is offering to perform the termination. There is a clear conflict of interest. GPs are often told to refer to Marie Stopes where patients will receive counselling on "all options".

3. This is concerning. In my PhD study, one NSW doctor noted as follows:

   I have done a certificate in family planning, which is biased towards the pro-choice ideology. They recommended Marie Stopes as the place you ought to refer patients to. People from Marie Stopes came to talk to us. I heard their speech and they gave me the impression they counsel patients before the abortion. However, one patient I referred there and who did have an abortion told me they received no counselling. I think the overall philosophy of Marie Stopes is there is no need to talk people out of the abortion, so it is not giving patients truly balanced information.

   Doctor # 9 [GP, NSW, Metropolitan, 5- 15 years]

4. Thirdly, if termination is sought because the foetus has been diagnosed with a disability, such as Down syndrome, and there are concerns about the economic consequences that the child's disability will have on the family, it is imperative that the woman is given information about the NDIS scheme. Available for several years now to all people regardless of how they came to be disabled, knowledge that funds will be available for special needs connected to the child's disability, could well be a comfort to the woman and affect her choice. To withhold this information, and not understand that it may be significant to her, is arguably negligent.

5. Connected to this, it is accepted by people on all sides of the abortion debate that abortion coercion occurs within Australia. In fact, the medical director of Marie Stopes Australia concedes in their White Paper, 'Hidden Forces: Shining a Light on Reproductive Coercion' that there are times when coercion is at play, and that a fundamental question they must ask themselves when they see the patient is 'Is my patient in control of the decision she has made?[4] Coercion occurs where a pregnant woman is forced to undergo abortion by her domestic partner or family member, using physical, emotional or financial threats.

6. In this situation, consent is not free and voluntary and there is a higher risk of psychological complications. With what we know, it is disappointing that amendment c2019-042, No 13, did not pass. There should be provision for a specific criminal offence within any bill (or the *Crimes Act*) with appropriate punishment that reflects the severity of this trauma. If abortion becomes standard healthcare, then the scope of the doctor's duty when obtaining informed consent for abortion, as well as their duty to assess the need for counselling, has to be explored given that 'necessity' is no longer the test.

7. Ultimately, the inclusion of clauses that require 'informed consent' and 'assessment of whether it is beneficial to discuss accessing counselling' sound like appropriate checks and balances, but they are of little practical value where the foundation is unstable. To decriminalise abortion without having explored these issues is hasty and unsafe. Asserting that the bill merely codifies the common law is untrue. New issues are being raised during Lower House debate that are worth slowing down to consider. The state should ensure it has properly prosecuted the case for decriminalization.

Suggested amendment Clause 5(3): definition of emergency

1. Clause 5(3) makes an exception for informed consent when termination is performed in an 'emergency'. The term 'emergency' is not defined within the clause, in other clauses where the term is used, or in Schedule 1. This must be corrected because it can be interpreted broadly or narrowly. The term should be defined the "imminent threat of death to the woman". Barring this circumstance, which suggests there is no time, termination must not be performed without informed consent. A definition should be included within Schedule 1. The same definition should apply to other clauses within the bill that refer to emergency.

Termination at Greater Than 22 Weeks: Proposed Amendment c2019-042 No 6 (did not pass)

1. It is unconscionable that this amendment that includes a duty to provide care to the child born alive after a failed abortion, did not pass. The 'my body, my right' line no longer applies after birth. It is a very strange situation that the person who wanted to terminate the person's life in the uterus, has a say in what happens if the attempt fails. Once born, even if damaged from the attempt to terminate him or her in utero, the baby is a legal person with legal rights. It is surely a conflict of interest to permit the mother to decide the child's best interests in this unique situation. The state has a duty to emphasise the child's basic rights.

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[4] I understand that they may be undertaking a pilot program on doctor screening for 'reproductive coercion', which has a wider scope than abortion coercion.

2. The NSW Health Pregnancy Framework for Terminations states that 'where applicable, the woman is to be informed of the potential for the infant to be born exhibiting signs of life and the ramifications should this eventuate'.[5] The policy goes on to acknowledge that 'signs of life warrant the child's right of dignity, maintenance of privacy and physical comfort'. However it is silent regarding the need to actively treat them notwithstanding that they are damaged or unwanted. Rather, the policy emphasises that staff need not provide treatment where the medical consensus is that treatment would be burdensome or futile.

3. Accepting that these decisions are complex and it would be impossible for the law to proscribe criteria for it in the bill, it can nonetheless set out a principle for this unique situation that reminds doctors that once born, the fact an attempt was made to terminate the child a moment ago is irrelevant to the decision the doctor must now make about the type of care to give them. Such persons must not be treated differently from other neonates. The amendment sets a higher bar than currently exists in the NSW policy, and it would be extended to any facilities that do not fall under the purview of NSW Health.

4. This amendment requires a very serious medical reason for late term abortion equating to the life of the mother or another sibling in a multiple pregnancy. Whilst doctors may be offended at the suggestion that a late term abortion would be performed for reasons other than serious medical concerns, clause 6(3)(b), clearly does not reflect this. It requires the specialist doctor to "consider" the woman's medical circumstances and her social circumstances, including those that do not exist at the time of the request. If the intention is that late term abortions are only for genuine medical reasons, then clause 5(3)(b) must be amended to reflect that.

5. Hansard discussion on 8 August 2019 notes the number of late term abortions in Victoria where the child is born alive, and the reasons for termination. I defer to the work of Debbie Garratt, an abortion researcher, on this issue and her recently published piece in the SMH on 10 August. In this article, Ms Garratt notes the increase in late term abortions in Victoria and that between 2008 and 2016, 336 babies were born alive and died after delivery. She notes that there is no information on how long they lived for and whether life saving measures were taken. Surely these facts deserve further enquiry and discussion.

Collection of Data on Abortion

1. If abortion is to be made lawful healthcare, and the Act is to be reviewed 5 years after it commences, it is imperative that any legislation make provision for the collection of data on abortions occurring in New South Wales. This is because without it, the state cannot make an informed judgment about the impact of this Act, the cost to the state, the geographical demand for services, and any social and health issues that arise from trends in the data. Any such data must make a distinction between procedures that are intended to cause abortion as opposed to treatment for a miscarriage. Medicare item numbers must reflect this distinction.

2. Specific provisions for data collection on abortion already exist in South Australia and Western Australia. This can be done in NSW via regulations directing doctors and hospitals to complete prescribed forms capturing specific information. From this, pregnancy statistics can be collated each year. It is important that New South Wales relies on data that reflects its citizens instead of extrapolating data from other states. This is critical in order to evaluate the impact of any legislation in New South Wales, to provide a proper comparison between it and other states, and to consider training and education needs of health professionals.

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[5] This policy, which is dated July 2014 was to be reviewed by July 2019. There has been no public discussion about this document and how its effectiveness was assessed.

Conscientious Objection: Proposed amendment c2019-043D (did not pass)

1. Clause 9 of the bill does not place a duty on a doctor with a conscientious objection to abortion to mandatorily refer the patient requesting abortion or advice about abortion to a doctor that the objector knows does not also have a conscientious objection to. It chooses the 'lighter option' of requiring the objector to provide information on how to locate or contact a doctor who in their reasonable belief does not have a conscientious objection to abortion, or transfer the person's care to another doctor or health service provider who in their reasonable belief does not have a conscientious objection to abortion. This is an unnecessary provision.

2. Firstly, there is an assumption built into this provision that providing information is a reasonable compromise and should not harm the doctor with the objection. This is unfounded. It is not supported by evidence. To know the impact on the doctor with the objection requires asking those doctors. It is not appropriate to ask doctors who do not have an objection. That would be to impose their moral beliefs on all doctors. Accordingly, hearing from conscientious objectors is the first requirement of the state before it takes steps to potentially infringe their rights in order to make laws to benefit others.

3. The impact of forcing a person to perform acts against conscience has been documented in studies that support the finding of moral distress, including one from Norway that explores the experiences of doctors who referred for abortion against conscience.[6] In Australia, there are no published studies from the perspective of doctors with a conscientious objection to abortion, so my study on 35 doctors in New South Wales and Victoria will make a contribution.[7] It is worth noting that even amongst doctors with a conscientious objection to abortion, some still make exceptions. It is not necessarily a binary position.

4. This may be true as well of doctors who claim not to have a conscientious objection to abortion generally, but may have an objection to a request for abortion due to sex selection or social reasons. In that instance, the doctor may have a conscientious objection to not just performing it, but to "facilitating access" to it. The only contact details the objecting doctor could provide for a doctor whom they know or reasonably believe does not have a conscientious objection to performing the particular termination (if under 22 weeks), is an abortion clinic. Otherwise proactive steps are needed to find out other doctors' views.

5. Earlier concerns raised regarding the information abortion clinics provide to women seeking abortion, or their options, are raised again here. If the bill passes and abortion up to 22 weeks is standard healthcare, it does not mean that all health professionals will assent to this. A democratic society permits the expression of differing viewpoints on controversial issues without punishing those that disagree with the state. The state should protect those that do not want to facilitate an abortion. To determine where the burden should fall, I believe the question is whether the doctor holds special information that the woman does not have.

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[6] See, Eva M Kibsgaard Nordberg, Hege Skirbekk and Morten Magelssen, 'Conscientious Objection to Referrals for Abortion: Pragmatic Solution or Threat to Women's Rights?' (2014) 15 *BMC Medical Ethics* 15.

[7] The Human Research and Ethics Committee of the University of Notre Dame Australia approved this study.

6. A doctor's referral is not required to access abortion in NSW. There are no restrictions on advertising abortion services. Information is freely available on the Internet. In Hansard from 8 August 2019, the Member for Newtown stated that a woman leaving a doctor's office with a business card or verbal instructions was not sufficient where the woman is distressed or mentally unwell. That may well be true, however it jars with her earlier comments that women should not be thought of as less capable of engaging with a medical procedure than others. In any case, it does not address the real issue.

7. If information is provided on where to locate or contact a doctor who does not share the first doctor's conscientious objection to the termination, it will not ensure immediate access to abortion. This is the heart of the problem – supply and demand. In my opinion, if the state makes abortion for any reason lawful up to 22 weeks, the burden should lie with it to ensure that there are enough doctors ready and trained to perform it, including in rural and remote areas. A doctor may have a long waiting list or be far away. Whilst this may increase distress, the answer cannot be to force doctors to perform abortion against conscience.

8. This is another reason to collect data: to understand any trends in requests for abortion from particular geographical location so as to consider equity of access to healthcare. It is not appropriate to suggest potential solutions to supply and demand here, but surely this is something that should be considered before bringing in this bill. Understanding how doctors (and other health professionals) feel about facilitating abortion *under the circumstances set out in this bill* is important. Opinions of peak medical groups do not necessarily reflect the views of their membership on this bill (how could they, given the speed of this process?).

9. If the bill passes, it must be accompanied by community education including on conscientious objection and tolerance for diverse views. Just because the law reflects a particular position, does not mean people must agree with it. There is a range of community attitudes towards abortion. We should similarly expect our doctors to have a range of views about abortion. The public (including pregnant women) should not expect all doctors to adopt the mindset of the state when it comes to such a morally complex issue, and demand that they put their feelings and integrity aside so to service the request. Doctors must exercise independent professional judgment when deciding what is in the patient's best interest when providing medical care.[8]

10. In my PhD study respondents were asked, amongst other things, their attitudes about referral and providing information.[9] Preliminary findings are that the majority of respondents object to not just referral but other peripheral acts. These included providing the contact details for abortion clinics, completing paperwork for abortion, and medical tasks such as inserting a cannula to provide venous access for fluids or medication to be used during an abortion. The state's understanding of the scope of conscientious objection when it comes to abortion is deficient.

11. The fact that other jurisdictions of Australia, or indeed countries overseas, have seen fit to place limits on when a health professional may decline to participate in an abortion because of a conscientious objection is not a sufficient reason for NSW to follow suit. If the state is committed to informed, effective, evidence based policy, then there is a real issue as to whether mandating the provision of information achieves the correct balance between freedom of conscience and the need to deliver timely health care. This requires further exploration and research rather than a 'quick fix' via this bill.

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[8] World Medical Association, International Code of Medical Ethics, adopted by the 3rd General Assembly of the World Medical Association, London, England, October 1949 <https://wma.net>. It should not noted here that Victoria has 'navigators' who are contacted via phone or email to provide contact details for the public on doctors willing to assist with physician assisted suicide under the *Assisted Dying Act 2017* (Vic).

[9] The Human Research and Ethics Committee of the University of Notre Dame Australia have approved this study.

12. Imposing such duties on doctors with a conscientious objection without knowing whether they are burdened or harmed or otherwise negatively impacted by a refusal to "provide information" is reckless. There is no requirement that an abortion on demand framework involve limitations to conscientious objection. Whilst Victoria, Northern Territory, Queensland and Tasmania have enacted mandatory referral laws, the ACT, South Australia, and Western Australia have maintained liberal abortion laws whilst preserving a health practitioner's freedom to decline to participate in abortion.[10]

13. The last thing to note before I set out some quotes from my study is that clause 9(4) provides that a doctor may owe a duty of care to perform abortion notwithstanding conscientious objection, in an emergency. As noted earlier, emergency is not defined in this bill. It is important that this word be given its plain ordinary meaning of an imminent significant threat to the woman's life or that of the other foetus, and it is not expanded to suggest that a lack of service due to geographical location, or emotional/financial stress in having to wait for an abortion, is sufficient to compel this type of action against conscience.

14. I now extract some comments from my study that reflect the participants' attitudes and experiences. Firstly, all respondents, regardless of their position on referring or providing information on contact details, thought a law imposing referral on doctors was egregious. A typical response is set out below:

> *"The point of the Abortion Law Reform Act was to make prolife doctors abandon the field. In a sense it's a toothless, but it could still operate to cause harm, we just don't know. It has created a climate of fear, a fear of the unknown and the possibilities. The legislation is so vague and this made doctors scared. How do we know whether someone has a conscientious objection to abortion? What is an 'emergency abortion'? Who can make a complaint about a doctor? It could be a witch-hunt. I know doctors who stopped practicing after the Act came in, or who stopped seeing certain female patients for a while or went interstate."*
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> Doctor # 31 [Consultant, VIC, Metropolitan, > 15 years]

15. Regarding the duty to 'provide information' on a third party that then makes the referral - some participants were agreeable to this in principle but were unpersuaded that any third party would actually provide "all options" and include referrals to church based groups as part of a woman's spiritual wellbeing if this were something that was important to her. A couple of typical responses are set out below:

> *"If the law required me to refer patients to specific third party organizations that dealt with information and referrals for abortion, I would tell patients I was giving them non-directional counselling, as required by the government, and then I would make a personal judgment about the organizations on the list...I know that the government provides clinical guidelines for primary health professionals to follow, which are adapted to your local services. Their resources direct people to Marie Stopes. This is inappropriate, as Marie Stopes has a fiscal interest in providing the service. They don't provide information about adoption, so it is biased. I would tell the patient that the organization was biased, and would then tell them where to find people who lean the other way, that is, people who are prolife."*
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> Doctor # 6 [GP, NSW, Rural, > 15 years]

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[10] See, *Health Act 1993* (ACT) ss82-4; *Health Act 1911* (WA) s334(3); *Criminal Law Consolidation Act 1935.*

"If the state forced me to give specific information to woman about a third party organization that spoke of abortion options and may refer, then this is less of a problem but I would still struggle with that. This is because I cannot verify that they can give the salient objective information to the patient. It depends what is on the pamphlet. If it was a group that was wishy-washy and you could add to that pamphlet, I might add additional details in. I think the state should have input from doctors about what information goes in those pamphlets, what services or organizations are detailed. There should be transparency. Sometimes living with civil penalties is the only option. You can't have freedom of conscience but then have a secondary clause that contradicts that statement."

Doctor # 7 [Consultant, NSW, Metropolitan, > 15 years]

16. Typical methods of dealing with patients enquiring about abortion include the following:

When I worked in a group medical practice, if a patient requested emergency contraception during a consultation, I would go through the information about the effects and the potential side effects of that drug, but I would explain that as a matter of conscience, I don't prescribe drugs that are abortifacient in effect. If the patient still wanted the prescription, they would simply see another doctor. I have never had anyone attack me for approaching the problem in this way. I always did this in a respectful way, gave lots of medical information about their options as part of informed consent, and gave them a range of alternatives."

Doctor # 8 [GP, NSW, Metropolitan, > 15 years]

17. One cannot assume that a change in the law will not harm doctors with a conscientious objection. It is important not to dismiss the doctor's objection and try to force an ideology upon them that suggests they can easily "switch off" their objection or that "further education" will somehow get them to change their minds. These types of responses show an appalling lack of understanding as to how other people think and feel, and an absence of true respect for diversity. Conscientious objection to abortion reflects deep moral beliefs about the sanctity of life and the role of medicine. Changing the law may not alter these beliefs.

18. Finally, a concerning point to raise is that many respondents experienced burden in the form of negative comments from superiors about being a conscientious objector (17/35) leading to a fear of reprisals (18/35), complaints made by supervisors or colleagues (8/35) and loss in the form of job opportunities (6/35). This following example is from a resident medical officer from a tertiary hospital who refused to insert a cannula for a late term foetal disability abortion. Another doctor was available to do it and the abortion proceeded. This is what was said to the doctor by the head of the department after their refusal to insert the cannula:

"Do you know why you're here? I've been told by consultants and registrars that you are judgmental, opinionated, arrogant, and disrespectful, and that you are refusing to do simple jobs like cannulation, and that you think you know better than consultants ...Putting in a cannula for termination will not stain your soul! At your level you are simply a service provider ... if you refuse to put in a cannula for any patient you are not doing the work you are paid for...for now you must work for your consultant and not contravene their decisions for patient care. We don't do social terminations here. The consultant has counselled this patient for a couple of weeks and they've seen a social worker. It is a sensitive issue and how dare you come in and contravene their choice."

Doctor # 26 [Hospital physician, NSW, Metropolitan, < 5 years]

19. This is not how a civilised society should behave. We are not a totalitarian regime. These extracts suggest there is work to be done before decriminalising abortion in NSW. If abortion up to 22 weeks becomes a routine service, we need a robust protection for conscience. The current clause does not do this. Health professionals need to be educated on conscientious objection, the circumstances where a person may exercise that objection, and some solutions that to achieve an "accommodation" that does not involve unjust hardship on the person, the patient, or the hospital/facility. This is something that requires much input from many people.

20. True freedom which tolerates difference is only ever when it comes to things that really matter to us. No doubt we will see other morally controversial services seeking moral validation through the law. How we manage conscientious objection to abortion will serve as template for how we manage it with regards to matters like physician assisted suicide. Accordingly, getting it right with regards to abortion matters. As Doctor # 3 noted:

    "We want more people to be aware that there is such a thing as a doctor who will practice in accord with their conscience, and that they can encounter a doctor who is willing to be counter cultural. If there could be awareness in the public sphere that not all doctors can provide all services, this would be helpful. We need to be able to explain what conscience is, so that patient do not put pressure on doctors in that position."

    Doctor # 3 [GP, NSW, Metropolitan, 5-15 years]

21. The timeframe for making submissions to this inquiry does not permit me to make a more considered response than that which is set out above. I do hope, however, these thoughts provide you with some assistance.

Yours faithfully

Anna Walsh
Lawyer (NSW),
Lecturer, School of Law, University of Notre Dame Australia (Sydney)
PhD Candidate (UNDA), M. Bioethics (Harvard), LLM (Syd), LLB (Hons), B Nurs (Hons)