

## AMICUS CURIAE BRIEF

### Conscientious Objection: Article 119 of Bill 9895 – 11 on Interruption of Pregnancy.

*Bernard M. Dickens.*

#### I. Introduction.

I am Professor Emeritus of Health Law and Policy in the Faculty of Law, Faculty of Medicine and Joint Centre for Bioethics at the University of Toronto, Canada. I have published widely on the topic of conscientious objection to participation in lawful medical treatments, particularly regarding voluntary induced termination of pregnancy, and was a member and subsequently chairman of the Ethics Committee (the Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health) of the International Federation of Gynecology and Obstetrics (FIGO) that developed the FIGO 2005 Ethical Guidelines on Conscientious Objection (See Appendix A).

I graduated in law in the United Kingdom at the University of London (King's College), earning the degrees of LL.B., LL.M., Ph.D. (law/criminology) and LL.D., and hold an honorary LL.D. degree from the University of Sherbrooke in Canada. I qualified professionally in law in England as a barrister (Inner Temple), and am similarly qualified in Ontario, Canada, as a barrister and solicitor. After teaching for the English Bar for ten years in London, U.K., I joined the Faculty of Law at the University of Toronto, Canada, in 1974, specializing in medical law and ethics, and have been Professor Emeritus since 2003.

#### II. The Right to Conscientious Objection.

The Universal Declaration of Human Rights provides in Article 18 that "Everyone has the right to freedom of thought, conscience and religion...". Legal force is given to this declaration by Chile's ratification of the International Covenant on Civil and Political Rights, Art. 18(1) of which repeats that "Everyone shall have the right to freedom of thought, conscience and religion". The Covenant's Art. 18(1) adds that the right shall include a person's freedom "...in public or private, to manifest his

religion or belief in worship, observance, practice and teaching". Separate references to "conscience and religion" indicate that conscience is distinguished from religion, but individuals are not obliged to make this distinction, and may shape their conscientious beliefs according to their religious beliefs.

Accordingly, in Art. 119, the Bill's accommodation in principle of the right of a surgeon conscientiously to object to participation in interruption of pregnancy respects the human right to freedom of conscience and religion. The same accommodation is ethically due to other professionals that participate directly in the procedure, such as an anesthetist and nurse required to attend the surgical procedure.

### III. Limitation of the Right to Conscientious Objection.

Human rights, even when fundamental and significant to individuals' dignity and enjoyment of their lives, are not absolute. The International Covenant on Civil and Political Rights acknowledges this in Art. 18(3), which states that "Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others". Accordingly, patients' rights to health care, dignity and choice of lawful health treatments may legally and ethically limit health service practitioners' claims to conscientious objection. The FIGO Ethical Guidelines on Conscientious Objection state the priority in Guideline 1 that "The primary conscientious duty of obstetrician- gynecologists (hereafter "practitioners") is at all times to treat, or provide benefit and prevent harm to, the patients for whose care they are responsible. Any conscientious objection to treating a patient is secondary to this primary duty".

Subordination of a practitioner's conscientious objection to a patient's fundamental rights and freedoms is shown in the provision in Art. 119 that objection cannot be invoked when a woman requires immediate and urgent medical attention and there is no other surgeon available who, with no objection, can perform the procedure. In fact, induced interruption of pregnancy may fall outside the religious prohibition of abortion when continuation of pregnancy risks a woman's life or seriously endangers

her continuing health, since religious teaching accepts the philosophical doctrine of “Double Effect”.

This doctrine distinguishes intended effects from known but unintended or incidental effects. The doctrine permits causing good intended effects, such as preserving a woman’s life or health, when unavoidable incidental effects of the same act, such as terminating her pregnancy, would in themselves be prohibited if intended. For instance, the New Catholic Encyclopedia (Connell, 1967) recognizes four conditions of Double Effect that must all be present, that (1) the act itself must be morally good or at least indifferent (2) the practitioner does not positively intend the unavoidable bad effect but may permit it (3) the good effect must be produced directly by the act, not by the incidental bad effect, and (4) the good effect must be sufficiently desirable to compensate for the bad effect. Under these conditions, conscientious objection should not be invoked or accommodated when a life-preserving act or treatment protecting health from risk of severe prolonged impairment would incidentally terminate a pregnancy. The pioneering U.K. legislation, the Abortion Act, 1967, accommodates conscientious objection in subsection 4 (1), but subsection 4 (2) provides that “Nothing in subsection (1) (...) shall affect any duty to participate in treatment which is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman”. The doctrine accordingly justifies Art. 119 in excluding conscientious objection in these emergency cases.

#### IV. The Duty to Refer.

The limitation on freedom of conscience and religion that requires health service providers to protect the health and fundamental rights and freedoms of their patients cannot unnecessarily deny providers their rights not to participate in procedures that offend their conscience. In the same way that practitioners cannot legally abandon their patients, patients, except in the life-endangering or health-endangering cases addressed in 3 above, cannot legally compel particular providers to deliver services to them to which the providers have rights of conscientious objection. The commonly adopted compromise between rights of patients to continuity of care and practitioners’ rights not to participate in patients’ care the practitioners find

objectionable is in practitioners' duty of referral. Laws and health professional codes of ethics almost invariably provide that practitioners must refer their patients to other appropriate providers for lawful treatments that the practitioners cannot or will not deliver.

The Supreme Court of the United Kingdom expressed this legal principle in its 2014 judgment in a case concerning midwives (*Greater Glasgow Health Board v. Doogan* [2014] UKSC 68), where the Court unanimously observed that "it is a feature of [enacted] conscience clauses generally within the health care profession that the conscientious objector be under an obligation to refer the case to a professional who does not share that objection. This is a necessary corollary of the professional's duty of care towards the patient. Once she has assumed care of the patient she needs a good reason for failing to provide that care. But when conscientious objection is the reason, another health care professional should be found who does not share the objection" (para. 40). The Supreme Court accordingly accepted conscientious objection as a good reason to withdraw from the patient's care, but subject to the obligation to refer. The FIGO Ethical Guidelines similarly provide that "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" (Guideline 6), adding that "In emergency situations, to preserve life or physical or mental health, practitioners must provide the medically indicated care of their patients' choices regardless of the practitioners' personal objections" (Guideline 8).

In its instructive 2008 ruling on the lawful accommodation of both conscientious objection to participation in abortion procedures and patients' rights to lawful care, the Constitutional Court of Colombia reinforced the right to objection, subject to a practitioner's legal duty of referral (Decision T-209 of 2008, applying the Court's Decision C-355 of 2006). The duty of immediate or timely referral, depending on the urgency of the patient's condition, may personally bind the individual objector, unless the objector's health facility or association arranges for the objector's patient to be referred to an available non-objecting colleague. The Constitutional Court ruled that health facilities whose physicians would invoke conscientious objection must have,

on staff or by other means, available physicians who do not object to whom patients have convenient, timely access.

This ruling may be made a legal condition of public health facility licensure. It is properly incorporated in Art. 119 of Bill xxx, and reflects the European Court of Human Rights' finding on abortion services that "States are obliged to organize the health services system in such a way as to ensure that an effective exercise of the freedom of conscience of health professionals in the professional context does not prevent patients from obtaining access to services to which they are entitled under the applicable legislation" (R.R. v. Poland, Application No.27617/04, Eur.Ct.H.R. (2011), para.206).

Guideline 6 of the FIGO Ethical Guidelines on Conscientious Objection reflects the general law in observing that "Referral for services does not constitute participation in any procedures agreed upon by patients and the practitioners to whom they are referred". A referring practitioner's non-participation is confirmed since the referral is for consultation on legal options for a patient's care which include but may not result in abortion, the common legal and ethical rule that there can be no sharing of fees between a referring physician and the physician to whom a referral is made, and the referring physician not being a party to any negligence, offence or other wrong committed by the physician who subsequently treats the patient.

#### V. Religion and Complicity.

The International Covenant on Civil and Political Rights in Art. 18(1) protects "the right to freedom of thought, conscience and religion", but Art.18 (3) sets limits on freedom "to manifest one's religion or beliefs". The American Convention on Human Rights in Art. 12(1) similarly protects "freedom of conscience and of religion", but Art. 12(3) sets limits on freedom "to manifest one's religion and beliefs". An implication that an exercise of conscientious objection is likely to be a manifestation of religious belief supports the 2008 ruling of the Constitutional Court of Colombia that a claim of conscientious objection cannot be arbitrary or capricious, but must be reviewed by a medical professional or governmentally designated officer or committee to ensure that it is legitimately founded on well-based convictions such as teachings of

an acknowledged religion. The provisions of Art.119 that prior notice of conscientious objection be provided to a facility director in written form is consistent with the scrutiny of its consistency and integrity that a claim of conscientious objection requires.

There is a religious basis to the claim of some conscientious objectors that their beliefs are violated not only by participation in termination of pregnancy but also by the requirement to refer their patients who request that procedure to others willing to provide it. Some go further and refuse to disclose to their patients that this procedure is an option they may consider. A practitioner's refusal or failure to inform his or her patient of a lawful option of care violates the patient's legal right of informed choice of indicated treatment. This refusal or failure constitutes the practitioner's legal negligence, and possibly negates the patient's consent to alternative treatment, because the consent was not properly informed. Without legally effective consent, active treatment of a patient constitutes an assault. Refusal or failure of disclosure may also violate professional ethics. For instance, the FIGO Ethical Guidelines require that practitioners give their patients "timely access to medical services, including giving information about medically indicated options of procedures for their care and of any such options of procedures in which their practitioners object to participate on grounds of conscience" (Guideline 2).

#### VI. Voluntary Surrender of the Right to Conscience.

Art.119 of the Bill is in accordance with widely enacted legislation accommodating conscientious objection consistently with women's access to lawful services. Some leading contemporary commentators on health care access have argued from principles of philosophy and ethics that medical and related practitioners should have no right of conscientious objection, and exceptionally laws, such as in Sweden, may favour this view. From a human rights perspective, this approach is unnecessarily severe and disproportionate, because a workable balance between practitioners' rights of conscientious objection and patients' rights of access to care can be struck through observance of the practitioner's duty of timely and effective referral. This compromise places a burden on states to ensure adequate availability of non-

objecting practitioners, because excessive resort to objection, as for instance in southern Italy, can violate women's human rights to health services and control of their family composition. Art.119 accordingly requires the Ministry of Health to establish protocols for appropriate accommodation of both conscientious objection and women's rights to treatment.

#### 7. Human Rights of Individuals, not Institutions.

Human rights, such as to freedom of conscience and religion, are attributed to natural, human persons, not to artificial legal persons, institutions or corporations. For purposes of convenient regulation, these are often granted analogous limited legal personality, such as to hold land and make contracts, but this does not afford them claims to rights as human beings. Accordingly, as the Constitutional Court of Colombia and the United Kingdom Supreme Court have recognized, healthcare facilities such as hospitals, cannot claim an institutional right of their own to conscience or religion, nor object to delivery of particular services on grounds of personal conscience or religion. Institutions cannot join a religious community, such as through a sacrament of baptism, and cannot qualify to hold a license to practice clinical medicine. Corporate agencies might owe legal duties of care to their patients, but these are discharged through the licensed medical, nursing and comparable personnel and staff they engage. Under human rights principles of non-discrimination, such personnel and staff cannot be selected, nor excluded, on grounds of their individual religious convictions.

Where a duty to provide general health services to a dependent community is imposed on a public or quasi-public facility by state authority, the state cannot accommodate a power of the facility itself to object to delivery of a service within a required specialty, such as obstetrics and gynecology, on grounds of conscience. The European Court of Human Rights has observed a state's obligation to "organize the health services system...to ensure that ...freedom of conscience of health professionals... does not prevent patients from obtaining access to services to which they are entitled" (R.R.v. Poland, see 4 above). This obligation denies a right of a

state-authorized health facility itself to prevent patients' access to such services by claiming an institutional right of conscientious objection.

## VII. Conclusion.

Art. 119 conforms to the laws of almost all countries, and with legally enforceable international human rights covenants, in affording legal protection to physicians' conscientious objection to direct participation in termination of pregnancy. Protection is subject to objecting practitioners' duty to refer eligible patients to service providers who do not object. Many laws place the duty of referral primarily on objecting physicians, but Art.119 relieves objectors of this primary responsibility by obliging practitioners' health institutions to reassign other surgeons who do not object to performing the procedure to treat objectors' patients. If none is available, within an institution or presumably by suitable referral outside, the duty of referral falls on the objecting practitioner. If that practitioner cannot make an appropriate referral, the patient's right to care takes priority over the objection, and the practitioner first requested is obliged to conduct the termination. Further, when treatment is immediately necessary to preserve life or continuing health against serious peril, the physician who in other cases would object is required to serve the patient's urgent needs, perhaps finding comfort in the absolving doctrine of Double Effect.

Conscientious objection to direct participation in termination of pregnancy is properly accommodated in Art.119, and objection is properly disallowed to referral of patients to non-objecting practitioners, to disclosure of lawful treatment options in which a practitioner objects to participate, and to discharge of management, administrative or supervisory functions. Similarly, as a human right, conscientious objection is available only to human individuals, not to institutions. The Constitutional Court of Colombia, for instance, rejected the argument that a hospital could claim a right of conscientious objection for itself, and Art. 119 properly does not allow such a claim.

Art. 119 must be interpreted in the context of the Bill as a whole, and the framework of the background law. Background law usually provides that delivery of post-abortion care, including completion of threatened or incomplete abortion, whether spontaneous or attempted legally or illegally, is not governed by the restrictions of



law on initiation of abortion, and does not attract the right of conscientious objection. Further, the duty of referral that is part of the legal duty of care practitioners owe their patients is not applicable between practitioners and non-patients of theirs, such as individuals seeking to become their patients. That is, the duty of referral for services practitioners decline to undertake on grounds of conscientious objection applies only where a physician-patient relationship exists. Within this framework, Art.119 conforms to laws widely applicable that provide for lawful interruption of pregnancy.