ABORTION LAW IN AUSTRALIA: CONSCIENTIOUS OBJECTION AND IMPLICATIONS FOR ACCESS

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As of 2021, abortion has been decriminalised, at least partially, in every Australian jurisdiction; however, barriers to accessing a lawful abortion remain. This article focuses on one of those barriers, namely conscientious objection to the provision of abortion services. It provides an in-depth legal analysis of the nature and scope of the obligations imposed by each Australian jurisdiction's conscientious objection provision and considers how the framing of these provisions facilitate (such as through referral requirements), and in some cases compromise, access. It is argued that there is a case for law reform to address some of the inconsistency, legal gaps and uncertainty identified and that other regulatory strategies and tools can supplement the law to ensure compliance with legal obligations and minimise access issues.

I INTRODUCTION

Abortion in Australia is not uncommon. Around half of all pregnancies in Australia are unplanned, half of which will be terminated.[1] The estimated abortion rate in Australia for 2017–18 was 17.3 per 1000 women.[2] Depending on availability and

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1 Morgan Liotta, 'Abortion Has Now Been Decriminalised Nationwide: What Next?', *NewsGP* (online, 3 March 2021) <https://www1.racgp.org.au/newsgp/professional/abortion-has-now-been-decriminalised-nationwide-wh>.

2 Louise A Keogh, Lyle C Gurrin and Patricia Moore, 'Estimating the Abortion Rate in Australia from National Hospital Morbidity Data and Pharmaceutical Benefits Scheme Data' (2021) 215(8) *Medical Journal of Australia* 375, 375. This article refers to 'women' throughout because it is overwhelmingly women who access abortion services. However, it is acknowledged that abortion may also be relevant to other genders.

gestational stage, Australian women will generally be able to choose between accessing a medical abortion or a surgical abortion.[3] Whilst abortion is widely considered to be a part of routine health care in Australia today, this has not always been the case. Indeed, late last century, 'abortion was a serious crime' in all Australian jurisdictions.[4] As a result, both women and health practitioners were at risk of prosecution for procuring or performing an abortion.[5]

Over time, however, criminal law in Australia has been reformed through the amendment of criminal codes and crimes Acts, case law,[6] and enactment of health legislation which has made abortion lawful in particular circumstances. The reclassification of abortion as a health matter under health legislation as opposed to a criminal behaviour under criminal law, represents a significant socio-legal shift, consistent with modern-day clinical practice and the long-standing goals of feminists and pro-choice activists.[7] Practically, decriminalisation will reduce the prospect of women and health practitioners being prosecuted for obtaining, what the World Health Organisation has defined as, one of the safest medical procedures, when performed properly.[8] Most significantly, reframing abortion as a health issue within a medicalised framework is thought to reshape perceptions, so that abortion will no longer be viewed as a criminal behaviour but rather as a legally permissible and acceptable medical procedure.[9]

As of 2021, all jurisdictions have decriminalised abortion, at least partially.[10] The

3 Danielle Newton et al, 'How Do Women Seeking Abortion Choose between Surgical and Medical Abortion: Perspectives from Abortion Service Providers' (2016) 56(5) *Australian and New Zealand Journal of Obstetrics and Gynaecology* 523, 523.

4 Mark Rankin, 'The Disappearing Crime of Abortion and the Recognition of a Woman's Right to Abortion: Discerning a Trend in Australian Abortion Law?' (2011) 13(2) *Flinders Law Journal* 1, 1.

5 See, eg, *R v Brennan* [2010] QDC 329; *DPP (NSW) v Lasuladu* [2017] NSWLC 11. The first case concerned a Cairns couple, where a 19 year-old Cairns woman was charged for procuring an abortion and her boyfriend was charged with assisting her to procure an abortion. However, the couple were both found not guilty by the jury. In the second case, a young Sydney woman was convicted for procuring her own abortion after sourcing mifepristone on the internet in attempt to end an unwanted pregnancy at home. See also Stephen Cordner and Kathy Ettershank, 'Australian Doctors Charged over Abortion' (1998) 351(9102) *Lancet* 578, 578.

6 See, eg, *R v Davidson* [1969] VR 667; *R v Wald* (1971) 3 DCR (NSW) 25; *CES v Superclinics (Australia) Pty Ltd* (1995) 38 NSWLR 47; *R v Bayliss* (1986) 9 Qld Lawyer 8.

7 See generally Kerry Petersen, 'Decriminalizing Abortion: The Australian Experience' in Sam Rowlands (ed), *Abortion Care* (Cambridge University Press, 2014) 236.

8 World Health Organization, *Safe Abortion: Technical and Policy Guidance for Health Systems* (2003). The guidelines state that '[w]hen performed by trained health care providers with proper equipment, correct technique and sanitary standards, abortion is one of the safest medical procedures': at 14. See also Ronli Sifris, 'Tasmania's Reproductive Health (Access to Terminations) Act 2013: An Analysis of Conscientious Objection to Abortion and the "Obligation to Refer"' (2015) 22(4) *Journal of Law and Medicine* 900, 902.

9 Sifris (n 8) 902.

10 The exception is in Western Australia, where abortion still features in sch s 199 of the *Criminal Code Act Compilation Act 1913* (WA) but is subject to s 334(3) of the *Health (Miscellaneous Provisions) Act 1911* (WA) ('*WA Health Act*'). Additionally, criminal law still regulates some

regulation of abortion through the enactment of health legislation has also assisted to clarify the law. When abortion formed part of the criminal law framework, defence to an abortion relied on sometimes ambiguous common law interpretations.[11] Gestational limits[12] are imposed in all jurisdictions,[13] except the Australian Capital Territory.[14] In Queensland,[15] Victoria[16] and Tasmania[17] abortions are available on request up until the gestational threshold, whereas in other jurisdictions, additional legislative requirements are imposed before an abortion will be performed, even when the abortion is being sought within gestational limits.[18] Once the prescribed gestational period is passed, the

aspects of abortion provisions. For example, offences apply when abortions are carried out by ineligible persons (eg not health practitioners or pregnant women): see *Health Act 1993* (ACT) ss 82, 83 ('*ACT Health Act*'); *Crimes Act 1900* (NSW) s 82; *Criminal Code Act* 1983 (NT) sch 1 s 208A; *Termination of Pregnancy Act 2021* (SA) s 14 ('*SA Abortion Act*'); *Criminal Code Act 1924* (Tas) sch 1 s 178D; *Crimes Act 1958* (Vic) s 65; *Criminal Code Act Compilation 1913* (WA) sch s 199. The *SA Abortion Act* (n 10) was passed in 2021, but only came into effect in July 2022 following the passing of the *Termination of Pregnancy Regulations 2022* (SA): see Government of South Australia, 'New Regulations to Decriminalise Termination of Pregnancy' (Media Release, 23 June 2022) <https://www.premier.sa.gov.au/media-releases/news-items-2022/new-regulations-to-decriminalise-termination-of-pregnancy>.

11 Ashleigh Seiler and Nicole Woodrow, 'In Reproductive Health, Is It Unconscionable to Object?' (2018) 20(2) *O&G Magazine* 34, 34.

12 In this article, gestational limits refer to the number of weeks of gestation at which a woman is able to access an abortion and does not explicitly distinguish between medical and surgical abortions. Notably, in Australia medical abortions are available up to nine weeks' gestation. Women seeking an abortion at a later gestation are only able to access a surgical termination. See Danielle Mazza et al, 'Medical Abortion' (2020) 49(6) *Australian Journal of General Practice* 324.

13 In most jurisdictions, except Western Australia where the legislation is silent, gestational limits do not apply in emergency situations: see *ACT Health Act* (n 10) s 84A(2)(a); *Abortion Law Reform Act 2019* (NSW) s 9(5) ('*NSW Abortion Act*'); *Termination of Pregnancy Law Reform Act 2017* (NT) s 13 ('*NT Abortion Act*'); *Termination of Pregnancy Act 2018* (Qld) s 8(4) ('*Qld Abortion Act*'); *SA Abortion Act* (n 10) s 11(5); *Reproductive Health (Access to Terminations) Act 2013* (Tas) ss 6(2)–(4) ('*Tas Abortion Act*'); *Abortion Law Reform Act 2008* (Vic) ss 8(2)–(4) ('*Vic Abortion Act*').

14 See *ACT Health Act* (n 10) pt 6. While no gestational limits exist in legislation, abortions can generally only be accessed up to 16 weeks in the ACT due to the capabilities of health services: see ACT Government, *Abortion in ACT* (Web Page, 17 June 2022) <https://www.health.act.gov.au/services-and-programs/sexual-health/abortion-access>.

15 Section 5 of the *Qld Abortion Act* (n 13) provides that a 'medical practitioner may perform a termination on a woman who is not more than 22 weeks pregnant'.

16 Section 4 of the *Vic Abortion Act* (n 13) provides that a 'registered medical practitioner may perform an abortion on a woman who is not more than 24 weeks pregnant'.

17 Section 4 of the *Tas Abortion Act* (n 13) provides that the 'pregnancy of a woman who is not more than 16 weeks pregnant may be terminated by a medical practitioner with the woman's consent'.

18 Section 5 of the *NSW Abortion Act* (n 13) permits medical practitioners to perform a termination on a person no more than 22 weeks pregnant provided they have obtained *informed* consent and s 7 provides that the medical practitioner must 'assess whether or not it would be beneficial to discuss with the person about accessing counselling' and, if so, is required to provide the person with 'all the necessary information' about accessing counselling. Section 7 of the *NT Abortion Act* (n 13) permits a medical practitioner to perform an abortion up to 24 weeks' gestation, if they '[consider] the termination is appropriate in all the circumstances', having regard to all

termination is considered to be a 'late termination',[19] and additional legislative requirements (such as the approval of a second medical practitioner) need to be satisfied for the abortion to be considered lawful.[20]

Whilst it may seem likely that these legislative amendments and the liberalisation of abortion laws would result in greater access, women still face several legal and non-legal barriers to accessing abortion.[21] Such barriers include legislative gestational limits imposed by law, as discussed above, which limit the access of abortions beyond certain gestations unless additional legislative requirements are satisfied. Similarly the requirements to provide information about counselling services to women and/or require women to undergo an extensive informed consent process (beyond what is required for other medical decisions) create access hurdles and ultimately undermine women's autonomy by presuming that women are uncertain about their decision, and somewhat imply that abortion is a problematic and a potentially harmful choice.[22] Women also face barriers as a result of the expense of procuring an abortion, limited provider availability in regional and remote towns and the impact of health practitioners claiming a conscientious objection.[23]

While each of these barriers is significant, this article will focus on conscientious objection to the provision of abortion services as an impediment to access.

relevant medical circumstances, the woman's current and future physical, psychological and social circumstances, and professional standards and guidelines. Section 5 of the *SA Abortion Act* (n 10) provides that a termination may be performed on 'a person who is not more than 22 weeks and 6 days pregnant' and s 8(1) provides that before performing a termination, 'a registered health practitioner must provide all necessary information to the person about access to counselling'. Finally, s 334(3) of the *WA Health Act* (n 10) permits abortions up to 20 weeks' gestation to be performed, provided the woman has 'given informed consent' or 'will suffer serious personal, family or social consequences if the abortion is not performed', or serious danger to their physical or mental health will result or has already been caused as a result of the pregnancy.

19 Note that 'late termination' is not the terminology used in the legislation itself but is commonly used in practice to refer to terminations after the prescribed gestation.

20 See *NSW Abortion Act* (n 13) s 6; *NT Abortion Act* (n 13) s 9; *Qld Abortion Act* (n 13) s 6; *SA Abortion Act* (n 10) ss 6, 9; *Tas Abortion Act* (n 13) s 5; *Vic Abortion Act* (n 13) s 5; *WA Health Act* (n 10) s 334(7). These requirements vary across jurisdictions and may include, for example, two or more medical practitioners agreeing that the abortion should be performed in the circumstances having regard to a set of considerations and/or providing access to information about mandatory counselling.

21 See, eg, Caroline de Moel-Mandel and Julia M Shelley, 'The Legal and Non-Legal Barriers to Abortion Access in Australia: A Review of the Evidence' (2017) 22(2) *European Journal of Contraception and Reproductive Health Care* 114; Ronli Sifris and Tania Penovic, 'Barriers to Abortion Access in Australia before and during the COVID-19 Pandemic' (2021) 86 *Women's Studies International Forum* 102470:1–9.

22 Erica Millar and Barbara Baird, 'Abortion Is No Longer a Crime in Australia: But Legal Hurdles to Access Remain', *The Conversation* (online, 4 March 2021) <https://theconversation.com/abortion-is-no-longer-a-crime-in-australia-but-legal-hurdles-to-access-remain-156215>.

23 See, eg, de Moel-Mandel and Shelley (n 21).

Conscientious objection has been found to directly and indirectly impact access.[24] The monopoly that health practitioners have on abortion provision means that if health practitioners refuse to provide abortion, women will be forced to find another willing provider to access the service, [25] which inevitably causes delays.

In Australia, each jurisdiction's legislation regulating abortion contains a form of conscientious objection provision,[26] which allows health practitioners to exempt themselves from participating, to varying extents, in the abortion process.[27] These provisions are framed differently across the jurisdictions in terms of what obligations are imposed (if any) on a person wishing to claim a conscientious objection. These duties range from requiring a health practitioner to provide a referral (whether that be a direct referral to another health practitioner or health service provider, or through the provision of a list of services), and/or to declare their conscientious objection, through to giving health practitioners an unfettered right to claim a conscientious objection without any corresponding obligations.[28] The framing of the conscientious objection provisions and the nature of the obligations imposed, to some extent, influences how accessible the medical procedure will be to women, particularly duties relating to referral which are intended to facilitate access by putting women in contact (directly or indirectly) with willing providers.

This article does not aim to make the case for or against conscientious objection in medicine (and in particular in the context of abortion), but instead undertakes a legal analysis of the current Australian legal landscape. Its goal is to explore the nature of the duties (if any) imposed on health practitioners who elect to conscientiously object to abortion. This article examines how the framing of such duties may facilitate, and in some cases compromise, access to abortion. This article begins in Part II by considering the nature of conscientious objection provisions generally, before specifically focusing on conscientious objection and abortion. Part III traces the evolution of conscientious objection provisions in the context of abortion, noting how they have been reframed over time in Australia. Part IV drills down into the content of Australian abortion law conscientious

24 See, eg, Jasmine Meredith Davis, Casey Michelle Haining and Louise Anne Keogh, 'A Narrative Literature Review of the Impact of Conscientious Objection by Health Professionals on Women's Access to Abortion Worldwide 2013–2021' (2022) 17(9) *Global Public Health* 2190.

25 Christopher Meyers and Robert D Wood, 'An Obligation to Provide Abortion Services: What Happens When Physicians Refuse?' (1996) 22(2) *Journal of Medical Ethics* 115, 117.

26 Section 334(2) of the *WA Health Act* (n 10) does not make reference to *conscientious objection* but has the same effect of a conscientious objection provision by providing that '[n]o person, hospital, health institution, other institution or service is under a duty, whether by contract or by statutory or other legal requirement, to participate in the performance of any abortion'.

27 Abortion, as used in this article, is defined to include medical and surgical abortions. In each jurisdiction's legislation, except Western Australia where the legislation is silent, abortion is explicitly defined this way: see *ACT Health Act* (n 10) s 80(1) (definition of 'abortion'); *NSW Abortion Act* (n 13) sch 1 (definition of 'termination'); *NT Abortion Act* (n 13) s 6(1); *Qld Abortion Act* (n 13) sch 1 (definition of 'termination'); *SA Abortion Act* (n 10) s 3 (definition of 'termination'); *Tas Abortion Act* (n 13) s 3 (definition of 'terminate'); *Vic Abortion Act* (n 13) s 3 (definition of 'abortion').

28 See below Part IV(C).

objection provisions, with a particular focus on the scope of these provisions and the duties which they impose. Finally, Part V offers some legal commentary on these provisions, explores the available empirical evidence about the extent to which they are effective in ensuring women are referred to a non-objecting practitioner or health service, and considers some strategies, over and above the legislation, that may more effectively encourage health practitioners with conscientious objections to comply with legislative duties that are imposed on them.

II CONSCIENTIOUS OBJECTION PROVISIONS IN HEALTH CARE

In health care, conscientious objection occurs when a health practitioner is exempted from providing, or participating in, 'a lawful treatment or procedure because it conflicts with his or her own personal beliefs, values or moral concerns'.[29] Traditionally, conscientious objection was believed to be informed by religious teachings, but over time it has been increasingly recognised that conscientious objection may equally be informed by secular beliefs.[30] The concept of conscientious objection originally arose in the military, in the context of pacificists conscientiously objecting to compulsory conscription and has since been raised in other areas of public life such as capital punishment, marriage licences for same-sex couples, education and health care.[31]

Conscientious objection provisions provide a legal mechanism to respect individual beliefs[32] and essentially provide a 'safe harbour' for health practitioners who wish to assert a conscientious objection.[33] It has been opined that these provisions are the product of 'political compromise' and 'pragmatic necessity'.[34] Some commentators have argued that formally enshrining conscientious objection provisions in law is fundamental to affording respect to the various belief systems that exist within society, and are essential for ensuring that the personal and moral

29 Explanatory Notes, Termination of Pregnancy Bill 2018 (Qld) 9.

30 Joanne Howe and Suzanne Le Mire, 'Medical Referral for Abortion and Freedom of Conscience in Australian Law' (2019) 34(1) *Journal of Law and Religion* 85, 90. See also Casey M Haining, Louise A Keogh and Lynn H Gillam, 'Understanding the Reasons behind Healthcare Providers' Conscientious Objection to Voluntary Assisted Dying in Victoria, Australia' (2021) 18(2) *Journal of Bioethical Inquiry* 277.

31 Wendy Chavkin, Liddy Leitman and Kate Polin, Global Doctors for Choice, 'Conscientious Objection and Refusal to Provide Reproductive Healthcare: A White Paper Examining Prevalence, Health Consequences, and Policy Responses' (2013) 123(S3) *International Journal of Gynecology and Obstetrics* S41, S41–2.

32 Michele Saporiti, 'For a General Legal Theory of Conscientious Objection' (2015) 28(3) *Ratio Juris* 416, 416.

33 Howe and Le Mire (n 30) 100.

34 Wendy Chavkin, Laurel Swerdlow and Jocelyn Fifield, 'Regulation of Conscientious Objection to Abortion: An International Comparative Multiple-Case Study' (2017) 19(1) *Health and Human Rights Journal* 55, 56.

integrity of health practitioners are protected.[35] On this view, a secular society, such as Australia, is believed to benefit from a 'pluralistic and pragmatic' approach to protecting conscience, which is sufficient to justify its formal protection in law.[36]

The use of conscientious objection in health care is a vexed issue. It is widely recognised that a medical practitioner owes a general duty of care to their patient to exercise 'reasonable care and skill in the provision of professional advice and treatment'.[37] However, protection of conscientious objection implies that health practitioners may refuse to provide or participate in a lawful and clinically appropriate medical procedure because it conflicts with their conscience. Commentators have varying views about the extent to which conscientious objection should feature in health care, ranging from not at all[38] to an unqualified right,[39] with some advocating for a compromise position.[40] The 'compromise position' permits conscientious objection but imposes obligations on health practitioners seeking to claim it, in an attempt to facilitate patients' access to particular health services.

Whilst the framing of conscientious objection provisions as they apply to abortion varies greatly across jurisdictions, a point of commonality is that the definition of conscientious objection is typically absent in the relevant legislation.[41] In some respects, this may be unsurprising given the definition of conscience, in which the concept of conscientious objection is rooted, is not universal and is largely absent

35 See, eg, Armand H Matheny Antommaria, 'Conscientious Objection in Clinical Practice: Notice, Informed Consent, Referral, and Emergency Treatment' (2010) 9(1) *Ave Maria Law Review* 81, 82; Mark Wicclair, 'Conscientious Objection in Healthcare and Moral Integrity' (2017) 26(1) *Cambridge Quarterly of Healthcare Ethics* 7.

36 Howe and Le Mire (n 30) 100.

37 *Rogers v Whitaker* (1992) 175 CLR 479, 483 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

38 See, eg, Christian Fiala and Joyce H Arthur, 'There Is No Defence for "Conscientious Objection" in Reproductive Health Care' (2017) 216 *European Journal of Obstetrics and Gynecology and Reproductive Biology* 254; Julian Savulescu and Udo Schuklenk, 'Doctors Have No Right to Refuse Medical Assistance in Dying, Abortion or Contraception' (2017) 31(3) *Bioethics* 162; Alberto Giubilini, 'Objection to Conscience: An Argument against Conscience Exemptions in Healthcare' (2017) 31(5) *Bioethics* 400.

39 See, eg, David S Oderberg, *Opting Out: Conscience and Cooperation in a Pluralistic Society* (Institute of Economic Affairs, 2018); Daniel P Sulmasy, 'What Is Conscience and Why Is Respect for It So Important?' (2008) 29(3) *Theoretical Medicine and Bioethics* 135.

40 See, eg, Dan W Brock, 'Conscientious Refusal by Physicians and Pharmacists: Who Is Obligated to Do What, and Why?' (2008) 29(3) *Theoretical Medicine and Bioethics* 187; Robert F Card, 'The Inevitability of Assessing Reasons in Debates about Conscientious Objection in Medicine' (2017) 26(1) *Cambridge Quarterly of Healthcare Ethics* 82; Christopher Meyers and Robert D Woods, 'Conscientious Objection: Yes, but Make Sure It Is Genuine' (2007) 7(6) *American Journal of Bioethics* 19; Vicki D Lachman, 'Conscientious Objection in Nursing: Definition and Criteria for Acceptance' (2014) 23(3) *MEDSURG Nursing* 196.

41 Section 84A(1) of the *ACT Health Act* (n 10) does provide that a conscientious objection is when 'an authorised person may refuse to prescribe, supply or administer an abortifacient, or carry out or assist in carrying out a surgical abortion, on religious or other conscientious grounds', but the Act fails to describe 'conscientious grounds'.

in the discourse surrounding conscientious objection.[42] Whilst the legislation is generally not explicit in terms of the definition of conscientious objection, it is generally agreed that these provisions do not extend to administrative, managerial, preoperative and postoperative care (where relevant) or other tasks ancillary to the provision of the particular health service.[43] Nor are these provisions thought to extend to instances of non-participation based on mere prejudice,[44] 'mere intellectual persuasion',[45] self-interest or discrimination.[46] Refusal to provide a health service due to a conscientious objection should also be distinguished from instances where health practitioners refuse to provide a medical service or treatment due to a belief it will be futile, outside the ambit of their skills or illegal.[47]

When considering conscientious objection in health care, abortion is typically the health service under consideration. Conscientious objection and abortion came to the fore in the 1960s, paralleling the liberalisation of abortion laws in Western Europe.[48] Whilst abortion has traditionally been viewed as a contentious medical procedure, there is evidence to suggest that it is becoming increasingly accepted in modern society. Indeed, Australian studies reveal that the majority of Australians support access to abortion.[49] Despite the wider acceptance of abortion in the broader community, there is a subset in the various health professions that hold a conscientious objection to abortion. There may be a myriad of reasons behind a health practitioner's conscientious objection, but they can usually be traced back to beliefs about the sanctity of life. For these health practitioners, life may be considered to begin at conception, and accordingly, to perform or assist to perform

42 See, eg, Christina Lamb, 'Conscientious Objection: Understanding the Right of Conscience in Health and Healthcare Practice' (2016) 22(1) *New Bioethics* 33; Natasha T Morton and Kenneth W Kirkwood, 'Conscience and Conscientious Objection of Health Care Professionals Refocusing the Issue' (2009) 21(4) *HEC Forum* 351.

43 See, eg, Explanatory Notes, Termination of Pregnancy Bill 2018 (Qld) 9. See also Wendy Larcombe, 'Rights and Responsibilities of Conscientious Objectors under the *Abortion Law Reform Act 2008* (Vic)' (Conference Paper, Annual Law and Society Association of Australia and New Zealand Conference, 2008).

44 Victorian Law Reform Commission, *Law of Abortion* (Final Report No 15, March 2008) 112 [8.3] ('*VLRC Abortion Report*'), citing Ian Kennedy and Andrew Grubb, *Medical Law* (Butterworths, 3rd ed, 2000) 1443.

45 *LexisNexis Concise Australian Legal Dictionary* (LexisNexis Butterworths, 5th ed, 2015) 'conscientious objection', citing *R v District Court; Ex parte White* (1966) 116 CLR 644.

46 South Australian Law Reform Institute, *Abortion: A Review of South Australian Law and Practice* (Report No 13, October 2019) 363 [17.1.15] ('*SALRI Abortion Review*'), citing Australian Medical Association, 'Conscientious Objection' (Position Statement, 27 March 2019) 1 [1.2]–[1.3] <https://www.ama.com.au/position-statement/conscientious-objection-2019> ('AMA Position Statement').

47 *SALRI Abortion Review* (n 46) 363 [17.1.16], citing 'AMA Position Statement' (n 46).

48 Chavkin, Swerdlow and Fifield (n 34) 56.

49 See, eg, Lachlan J de Crespigny et al, 'Australian Attitudes to Early and Late Abortion' (2010) 193(1) *Medical Journal of Australia* 9; Monica Cations, Margie Ripper and Judith Dwyer, 'Majority Support for Access to Abortion Care Including Later Abortion in South Australia' (2020) 44(5) *Australian and New Zealand Journal of Public Health* 349.

an abortion would be akin to murder.[50] In a similar vein, many conscientious objectors view not only the woman as their patient, but the fetus too.[51] As such, some health practitioners feel compelled to protect the health and wellbeing of the fetus, and assisting a woman to procure an abortion would be perceived as being incongruent with such a viewpoint.[52]

III THE EVOLUTION OF CONSCIENTIOUS OBJECTION PROVISIONS IN AUSTRALIA

In 1969, South Australia became the first Australian jurisdiction to legalise abortion. Although the procedure was not decriminalised (it remained in the criminal law), the *Criminal Law Consolidation Act 1935* (SA) was amended to codify the limited circumstances in which abortion would be lawful.[53] The amendments to the *Criminal Law Consolidation Act 1935* (SA) also saw the introduction of a conscientious objection provision. Section 82A(5) stated:

> [N]o person is under a duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorized by this section to which he has a conscientious objection, but in any legal proceedings the burden of proof of conscientious objection rests on the person claiming to rely on it.[54]

The protection granted by the provision did not apply in *emergency situations*, which were defined to be where the performance of an abortion was necessary to save a pregnant woman's life or prevent grave injury to her physical or mental health.[55] The provision also placed an evidentiary burden on the person claiming a conscientious objection. Despite having the evidentiary burden, the objector would only need to discharge it in the unlikely event that legal proceedings were instituted. Outside these two qualifications, the framing of the provision provided broad protection for persons wishing to claim a conscientious objection in relation to abortion.

Other jurisdictions (the Australian Capital Territory,[56] the Northern Territory,[57]

50 See, eg, Lauren R Fink et al, '"The Fetus Is My Patient, Too": Attitudes toward Abortion and Referral among Physician Conscientious Objectors in Bogotá, Colombia' (2016) 42(2) *International Perspectives on Sexual and Reproductive Health* 71.

51 See, eg, ibid.

52 See, eg, ibid.

53 *Criminal Law Consolidation Act 1935* (SA) s 82A, as repealed by *SA Abortion Act* (n 10) sch 1 item 3.

54 *Criminal Law Consolidation Act 1935* (SA) s 82A(5), as enacted.

55 Ibid s 82A(6).

56 *Health Regulation (Maternal Health Information) Act 1998* (ACT) s 12, as repealed by *Health Regulation (Maternal Health Information) Repeal Act 2002* (ACT) s 3.

57 *Criminal Code Act 1983* (NT) s 174(2), as repealed by *Criminal Reform Amendment Act (No 2) 2006* (NT) s 18; *Medical Services Act 1982* (NT) s 11(6), as repealed by *NT Abortion Act* (n 13) s 22, as enacted.

Tasmania[58] and Western Australia[59]), in the process of enacting legislation to regulate abortion, largely followed the South Australian model when framing their conscientious objection provisions. There were, however, some jurisdictional differences. For instance, the Northern Territory legislation was the only jurisdiction that decided to adopt South Australia's position to impose the evidentiary burden of proof on conscientious objectors.[60] The Western Australian model (which is still in force) and the then Australian Capital Territory model offered a broader protection than the South Australian model by extending protections to bodies, services and/or institutions in addition to individuals.[61]

It was not until 2008, prompted by Victorian developments, that there was a significant shift in how conscientious objection was regulated. In September 2007, the then Attorney-General, Rob Hulls, asked the Victorian Law Reform Commission to provide advice about the regulation of abortion. In particular, he was seeking options for clarifying the law, and for removing abortion services performed by qualified medical practitioners from the reach of the *Crimes Act 1958* (Vic).[62] The Commission's final report offered several recommendations on regulating abortion, including in relation to conscientious objection provisions.[63]

Ultimately, the Commission recommended that the new legislation should include a conscientious objection provision clarifying that individual health practitioners were under no duty to either provide or assist in the provision of an abortion, but were under a duty 'to inform the patient of their conscientious objection and make an effective referral to another provider'.[64] In formulating such a recommendation, the Commission emphasised that it was important that the conscientious objection provision 'balance[d] the rights of individuals to operate within their own moral and religious beliefs with the equally important ethical consideration doctors have to act in the best interest of patients'.[65] The report highlighted that achieving such a balance would be particularly important in the context of women living in rural and regional Victoria, who typically face significant geographical inequities when it comes to accessing abortion services, acknowledging that a failure for a conscientious objector to provide a referral in such contexts would have the effect of exacerbating these inequities.[66]

58 *Criminal Code Act 1924* (Tas) ss 164(7)–(8), as repealed by *Tas Abortion Act* (n 13) s 14.

59 *WA Health Act* (n 10) s 334(2).

60 *Criminal Code Act 1983* (NT) s 174(2), as repealed by *Criminal Reform Amendment Act (No 2) 2006* (NT) s 18.

61 *WA Health Act* (n 10) s 334(2); *Health Regulation (Maternal Health Information) Act 1998* (ACT) s 12, as repealed by *Health Regulation (Maternal Health Information) Repeal Act 2002* (ACT) s 3.

62 *VLRC Abortion Report* (n 44) 12.

63 Ibid 8.

64 Ibid 7.

65 Ibid 114 [8.27].

66 Ibid 75 [5.35].

Ultimately, the Commission's recommendations were endorsed, resulting in the enactment of s 8 in the *Abortion Law Reform Act 2008* (Vic). The provision offers protections to registered health practitioners with a conscientious objection (except in emergencies) but does impose obligations on them to facilitate access. Specifically, the provision requires the conscientious objector to both inform the woman of their conscientious objection and 'refer the woman to another registered health practitioner in the same regulated health profession' known not to have a conscientious objection.[67]

Section 8 marked a significant shift in the framing of conscientious objection provisions in abortion law in Australia. As previously mentioned, earlier conscientious objection provisions gave individuals an unfettered right to exercise their conscientious objection, due to the limited obligations imposed on them. The breadth of such provisions prioritised the rights of conscientious objectors exercising freedom of conscience over women's rights to reproductive autonomy and the right to access a legal medical procedure. The obligations imposed by s 8 resulted in a recalibration of how these rights are balanced. It provides a 'compromise position' as it not only formally enshrines the right to conscientious objection, but also imposes positive obligations on medical practitioners to both declare their conscientious objection to the patient and refer the patient onto another colleague, who does not have a conscientious objection. The purpose of the referral requirement is that continuity of care is preserved, which is widely recognised as an important step in facilitating the highest standard of health and respecting a woman's right to access reproductive health care.[68]

This shift in balancing rights in s 8 was viewed by some as quite contentious and, at the time it was being debated, the provision was subject to much criticism. For instance, it was posited that s 8 was an unnecessary attack on freedom of conscience.[69] The Catholic Church threatened to close its emergency and maternity departments if the law was to pass.[70] Some commentators argued that the law was totalitarian[71] and that the perceived encroachment on a health practitioner's

67 *Vic Abortion Act* (n 13) s 8(1).

68 See, eg, Ronli Sifris, Tania Penovic and Caroline Henckels, 'Advancing Reproductive Rights through Legal Reform: The Example of Abortion Clinic Safe Access Zones' (2020) 43(3) *University of New South Wales Law Journal* 1078, 1083; Sifris (n 8).

69 See, eg, Patrick Parkinson, 'Christian Concerns about an Australian Charter of Rights' (2010) 15(2) *Australian Journal of Human Rights* 83, 104–5. Cf Anne O'Rourke, Lachlan de Crespigny and Amanda Pyman, 'Abortion and Conscientious Objection: The New Battleground' (2012) 38(3) *Monash University Law Review* 87; Sifris (n 8); Rachel Ball, 'Victoria's *Abortion Law Reform Act*' (2008) 33(4) *Alternative Law Journal* 237, 238.

70 Barney Zwartz, 'Archbishop in Abortion Law Threat', *The Sydney Morning Herald* (online, 24 September 2008) <https://www.smh.com.au/national/archbishop-in-abortion-law-threat-20080923-4m04.html>.

71 Frank Brennan, 'Totalitarian Abortion Law Requires Conscientious Disobedience' (2008) 18(19) *Eureka Street* 11.

conscience was akin to fascism.[72] Much of the criticism was targeted at the mandatory referral requirement, with some arguing that the obligation to refer made the referring practitioner complicit in the process.[73] One opponent stated:

> [I]t is this concept of assistance and contribution that lies at the heart of one of the nastiest human rights abuses Victoria ever has contemplated. By compulsorily referring a patient for an abortion, an objecting medical practitioner necessarily makes him or herself complicit in an action they regard as ethically and morally impossible.[74]

Others responded to this argument on the basis that the act of referral results in another health practitioner, not the objector, providing the woman with care.[75] For many commentators, s 8 achieves the appropriate balance.[76] For instance, Maxine Morand, who introduced the Bill into parliament in her role as Minister for Women's Affairs, noted in her second reading speech:

> Clause 8 has been carefully crafted in order to strike an appropriate balance between the rights of registered health practitioners to conduct themselves in accordance with their religion or beliefs, and to freedom of expression, and the right of women to receive the medical care of their choice.[77]

Despite some ardent criticism of the referral obligation, including doubts regarding the need for this obligation,[78] the framing of the Victorian provision largely aligned with international standards recommended at the time, including the 'Ethical Guidelines on Conscientious Objection' that were developed by the International Federation of Obstetricians and Gynecologists,[79] and also the recommendations by the Committee on the Elimination of Discrimination against Women.[80] More than

72 Greg Craven, 'Denying People Right to Conscience Akin to Fascism', *The Age* (online, 26 September 2008) <https://www.theage.com.au/national/denying-people-right-to-conscience-akin-to-fascism-20080926-ge7eqs.html>.

73 See, eg, Lily Partland, 'What Is It about Section 8: Abortion Law Debate Fires Up', *ABC News* (online, 4 December 2013) <https://www.abc.net.au/local/audio/2013/12/03/3903983.htm>; Craven (n 72).

74 Craven (n 72).

75 Partland (n 73).

76 See, eg, Sifris (n 8); O'Rourke, de Crespigny and Pyman (n 69).

77 Victoria, *Parliamentary Debates*, Legislative Assembly, 19 August 2008, 2954 (Maxine Morand, Minister for Women's Affairs).

78 Naomi Oreb, 'Worth the Wait: A Critique of the Abortion Act 2008 (Vic)' (2009) 17(2) *Journal of Law and Medicine* 261, 266.

79 Committee for the Ethical Aspects of Human Reproduction and Women's Health, International Federation of Obstetricians and Gynecologists, 'Ethical Guidelines on Conscientious Objection' (2006) 14(27) *Reproductive Health Matters* 148, 149 ('FIGO Conscientious Objection Guidelines'). Guideline 6 provides that '[p]atients 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'.

80 *Report of the Committee on the Elimination of Discrimination against Women*, 20th sess, UN Doc A/54/38/Rev.1 (20 August 1999) ch 1(A) [11] ('*Elimination of Discrimination against Women*'). The recommendation provides: 'if health service providers refuse to perform such services based

a decade later such recommendations have been maintained, with the World Health Organisation[81] and World Medical Association[82] adopting similar stances.

The reform that occurred in Victoria spurred a raft of reforms in other jurisdictions, though the framing of the protection and the duties imposed on the objector evolved. Tasmania was the next jurisdiction to decriminalise abortion. The initial Bill passed by the Legislative Assembly drew on the Victorian provision by requiring objecting practitioners to refer the patient onto another non-objecting medical practitioner.[83] The Bill also imposed referral obligations on counsellors with a conscientious objection.[84] However, the final Bill departed from this position and reframed the obligation so health practitioners were under an obligation to provide women with a prescribed list of services where they may seek advice, information, and counselling on the full range of pregnancy options.[85] On its face, it appeared that this more generic duty on objectors amounted to a 'watering down' of the provision, but it has been argued that the reframing served a clarifying purpose.[86] This form of 'passive' referral is explored further in Part IV.

The Northern Territory was the next jurisdiction to decriminalise abortion, and its conscientious objection provision more closely resembled the Victorian provision. The Northern Territory's provision went even further by explicitly requiring the referral to be made 'within a clinically reasonable time'.[87] Queensland also imposed a referral requirement but expressed that this could be achieved either via referring to a specific health practitioner or to a health service provider.[88] New South Wales and South Australia followed Queensland's approach of providing for different referral pathways in legislation but also inserted a third pathway, namely that a health practitioner could discharge their referral obligations by providing the patient with information about how to locate or contact a medical practitioner.[89]

on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers.'

81 World Health Organisation, *Safe Abortion: Technical and Policy Guidance for Health Systems* (2nd ed, 2012) 69 [3.3.6] <http://apps.who.int/iris/bitstream/handle/10665/70914/9789241548434_eng.pdf;jsessionid=A711B57496FE9ECFF563052AC60F0DB6?sequence=1> ('*WHO Abortion Guidelines*'). The guideline provides: 'heath-care providers must refer the woman to a willing and trained provider in the same, or another easily accessible health-care facility, in accordance with national law.'

82 World Medical Association, *WMA Statement on Medically-Indicated Termination of Pregnancy* (Policy Statement, October 2018) [8] <https://www.wma.net/policies-post/wma-declaration-on-therapeutic-abortion/> ('*WMA Statement on Abortion*'). The recommendation provides: 'Physicians have a right to conscientious objection to performing an abortion; therefore, they may withdraw while ensuring the continuity of medical care by a qualified colleague.'

83 Reproductive Health (Access to Terminations) Bill 2013 (Tas) cl 7(2) ('Tas Abortion Bill').

84 Ibid cl 7(3).

85 *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 7(2).

86 Sifris (n 8) 908.

87 *NT Abortion Act* (n 13) s 11(2)(b).

88 *Qld Abortion Act* (n 13) s 8(3).

89 *NSW Abortion Act* (n 13) s 9(3); *SA Abortion Act* (n 10) s 11(3).

The Australian Capital Territory's provision has also been amended since the enactment of the Victorian Act; however, the amendment did not introduce a referral requirement and only requires the registered medical practitioner to inform the patient of their conscientious objection.[90] Western Australia has not amended its conscientious objection provision since 1998.[91]

IV OBLIGATIONS ON OBJECTORS UNDER THE CONSCIENTIOUS OBJECTION PROVISIONS

Conscientious objection provisions are designed to provide protection for health practitioners by permitting them to refuse to provide a lawful medical service due to a conflict in conscience. Under the different Australian laws, however, there is variation in the nature of the protection provided, to whom it is provided and also the duties that are imposed on those who conscientiously object. This Part explores these issues in more detail and commences by providing an overview of the statutory conscientious provisions in Table 1.

Table 1: Summary of Conscientious Objection Provisions in Australian Abortion Law

		ACT	NSW	NT	QLD	SA	TAS	VIC	WA
Who is permitted to conscientiously object?									
Individuals[92]		✓	✓	✓	✓	✓	✓	✓	✓
Institutions[93]									✓
Scope of conscientious objection provisions									
Conduct protected	Participating[94]	✓	✓	✓	✓	✓	✓	✓	✓
	Directing[95]							✓	

90 *ACT Health Act* (n 10) s 84A.

91 See *WA Health Act* (n 10) s 334(2).

92 *ACT Health Act* (n 10) s 84A; *NSW Abortion Act* (n 13) s 9; *NT Abortion Act* (n 13) ss 11–12; *Qld Abortion Act* (n 13) s 8; *SA Abortion Act* (n 10) s 11; *Tas Abortion Act* (n 13) s 6; *Vic Abortion Act* (n 13) s 8; *WA Health Act* (n 10) s 334(2).

93 *WA Health Act* (n 10) s 334(2).

94 *ACT Health Act* (n 10) s 84A(1); *NSW Abortion Act* (n 13) ss 9(1)(a)(i)–(ii); *NT Abortion Act* (n 13) ss 11(1), 12(1); *Qld Abortion Act* (n 13) ss 8(1)(a)(i)–(ii); *SA Abortion Act* (n 10) ss 11(1)(a)(i)–(ii); *Tas Abortion Act* (n 13) s 6(1); *Vic Abortion Act* (n 13) s 8(1); *WA Health Act* (n 10) s 334(2). For the purposes of this classification, participating is taken to mean participating, carrying out, performing, or assisting in the performance of an abortion.

95 *Vic Abortion Act* (n 13) s 8(1).

	Authorising[96]		✓		✓	✓		✓	
	Advising[97]		✓	✓	✓	✓		✓	
	Supervising[98]							✓	
Emergency exception[99]		✓	✓	✓	✓	✓	✓	✓	
Nature of duties on conscientious objectors									
Disclosure of conscientious objection[100]		✓	✓	✓	✓	✓		✓	
Referral duty and options permitted	Health practitioner or health service provider[101]		✓	✓	✓	✓		✓	
	Provision of information[102]		✓			✓	✓		

A *Who Is Permitted to Conscientiously Object?*

1 *Protection of Individuals*

While there is variation across Australian jurisdictions, the statutory protections are generally limited to registered health practitioners, and do not extend to all individuals who have a conscientious objection to abortion. The restriction on the

96 *NSW Abortion Act* (n 13) s 9(1)(a)(iii); *Qld Abortion Act* (n 13) s 8(1)(a)(iii); *SA Abortion Act* (n 10) s 11(1)(a)(iii); *Vic Abortion Act* (n 13) s 8(1). For the purposes of this classification, authorising is taken to mean authorising an abortion or making a decision about whether an abortion should be performed.

97 *NSW Abortion Act* (n 13) s 9(1)(a)(iv); *NT Abortion Act* (n 13) s 11(1); *Qld Abortion Act* (n 13) s 8(1)(a)(iv); *SA Abortion Act* (n 10) s 11(1)(a)(iv); *Vic Abortion Act* (n 13) s 8(1).

98 *Vic Abortion Act* (n 13) s 8(1).

99 *ACT Health Act* (n 10) s 84A(2)(a); *NSW Abortion Act* (n 13) s 9(5); *NT Abortion Act* (n 13) s 13; *Qld Abortion Act* (n 13) s 8(4); *SA Abortion Act* (n 10) s 11(5); *Tas Abortion Act* (n 13) ss 6(2)–(4); *Vic Abortion Act* (n 13) ss 8(2)–(4).

100 *ACT Health Act* (n 10) s 84A(4); *NSW Abortion Act* (n 13) s 9(2); *NT Abortion Act* (n 13) s 11(2)(a); *Qld Abortion Act* (n 13) s 8(2); *SA Abortion Act* (n 10) s 11(2); *Vic Abortion Act* (n 13) s 8(1)(a).

101 *NSW Abortion Act* (n 13) s 9(3)(b); *NT Abortion Act* (n 13) s 11(2)(b); *Qld Abortion Act* (n 13) s 8(3); *SA Abortion Act* (n 10) s 11(3)(b); *Vic Abortion Act* (n 13) s 8(1)(b). Section 12(2) of the *NT Abortion Act* (n 13) requires medical practitioners to direct another authorised health practitioner to assist in the termination in the event that the other authorised health practitioner has a conscientious objection.

102 *NSW Abortion Act* (n 13) s 9(3)(a); *SA Abortion Act* (n 10) s 11(3)(a); *Tas Abortion Act* (n 13) s 7(2).

type of individuals who can object is designed to ensure that only those directly involved in the provision of services are offered protection. Accordingly, protection does not extend to individuals such as administrative staff who are considered ancillary to service provision,[103] nor do they extend to medical students or professions outside the ambit of the schedule to the *Health Practitioner Regulation National Law Act 2009* (Qld) ('*Health Practitioner Regulation National Law*') such as social workers.[104]

In Victoria,[105] Queensland,[106] South Australia[107] and New South Wales,[108] conscientious objection protections and obligations apply to registered health practitioners.[109] In the Australian Capital Territory, protections extend to authorised persons, who are defined as doctors and nurses,[110] whilst in the Northern Territory, conscientious objection protections apply to medical practitioners and a selection of registered health practitioners, namely authorised Aboriginal and Torres Strait Islander practitioners, midwives, nurses and pharmacists.[111] Interestingly, whilst the conscientious objection protections apply to the selection of health practitioners in the Northern Territory, the referral obligations imposed by the Act apply solely to medical practitioners. The effect of this is that if a medical practitioner has a conscientious objection, then they are

103 See, eg, Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report No 76, June 2018) 147 [4.149] ('*QLRC Abortion Report*').

104 The *Health Practitioner Regulation National Law Act 2009* (Qld) provides an exhaustive list of health professions: sch s 5 (definition of 'health profession') ('*Health Practitioner Regulation National Law*'). Note that Queensland hosts the legislation giving effect to the National Scheme, and the other jurisdictions give full (or partial) effect to the Queensland legislation: see *Health Practitioner Regulation National Law (ACT) Act 2010* (ACT); *Health Practitioner Regulation National Law (NSW) 2009* (NSW); *Health Practitioner Regulation (National Uniform Legislation) Act 2010* (NT); *Health Practitioner Regulation National Law (South Australia) Act 2010* (SA); *Health Practitioner Regulation National Law (Tasmania) Act 2010* (Tas); *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic); *Health Practitioner Regulation National Law (WA) Act 2010* (WA).

105 *Vic Abortion Act* (n 13) s 8.

106 *Qld Abortion Act* (n 13) s 8.

107 *SA Abortion Act* (n 10) s 11.

108 *NSW Abortion Act* (n 13) s 9.

109 The definition of 'registered health practitioner' is a person registered under the *Health Practitioner Regulation National Law*: *Vic Abortion Act* (n 13) s 3 (definition of 'registered health practitioner'); *Qld Abortion Act* (n 13) sch 1 (definition of 'registered health practitioner'); *SA Abortion Act* (n 10) s 3 (definition of 'registered health practitioner'); *NSW Abortion Act* (n 13) sch 1 (definition of 'registered health practitioner'). The *Health Practitioner Regulation National Law* (n 104) defines 'registered health practitioner' as an individual who is registered under the National Law to practise a health profession, other than a student, which includes Aboriginal and Torres Strait Islander health practice, Chinese medicine, chiropractic, dentistry, medicine, medical radiation practice, midwifery, nursing, occupational therapy, optometry, paramedicine, pharmacy, physiotherapy, podiatry and psychology: s 5 (definitions of 'health profession' and 'registered health practitioner').

110 *ACT Health Act* (n 10) s 84A(5).

111 *NT Abortion Act* (n 13) ss 11–12.

responsible for informing the woman and referring her on.[112] In the case that an Aboriginal and Torres Strait Islander health practitioner, midwife, nurse, or pharmacist is requested to assist in an abortion but has a conscientious objection and chooses not to participate, then, in practical terms, the obligation shifts to the medical practitioner to request another authorised health practitioner to assist.[113] In Tasmania and Western Australia, the legislation indicates that no individual is under a duty to participate in an abortion.[114] Importantly, however, whilst the protection in Tasmania extends widely, there are obligations on certain health practitioners.[115]

2 *Protection of Institutions*

Whether or not institutions should be able to claim an institutional objection has been the subject of extensive debate.[116] Some jurisdictions, in the course of their reform processes, explored the issue of institutional objection, ultimately recommending that protections granted by conscientious objection provisions should apply exclusively to individuals rather than institutions.[117] As a result, the conscientious objections provisions of all states and territories, except Western Australia, extend only to individuals. In Western Australia, the relevant provision states: 'No person, hospital, health institution, other institution or service is under a duty … to participate in the performance of any abortion.'[118]

As most legislation governing abortion is silent on institutional objection, the effect is that institutions are not given statutory protection for refusing to provide medical services, nor are explicit obligations imposed on institutions by law. Whilst legislation is silent, policy guidance on the issue of institutional objection does exist.[119] Furthermore, whilst the law may not explicitly impose obligations on the

112 Ibid s 11(2)(b).

113 Ibid s 12(2).

114 *WA Health Act* (n 10) s 334(2); *Tas Abortion Act* (n 13) s 6(1).

115 The Tasmanian legislation mandates that medical practitioners provide a list of prescribed services from which women seeking a termination can obtain advice, information or counselling, and requires medical practitioners to perform, and nurses and midwives to assist in the performance of, a termination in emergency situations: *Tas Abortion Act* (n 13) ss 6(3)–(4), 7(2).

116 See, eg, Louise Anne Keogh et al, 'Conscientious Objection to Abortion, the Law and Its Implementation in Victoria, Australia: Perspectives of Abortion Service Providers' (2019) 20 *BMC Medical Ethics* 11:1–10, 8 ('Perspectives of Abortion Service Providers'). Cf Sulmasy (n 39) 142–4.

117 See, eg, *VLRC Abortion Report* (n 44) 115; *QLRC Abortion Report* (n 103) 147 [4.149].

118 *WA Health Act* (n 10) s 334(2).

119 In the context of policy guidance on voluntary assisted dying, see Ben P White et al, 'Legislative Options to Address Institutional Objections to Voluntary Assisted Dying in Australia' [2021] *University of New South Wales Law Journal Forum* 3:1–19. See also AMA Position Statement (n 46) 2 [3.1]–[3.2]; Queensland Health, *Termination of Pregnancy* (Clinical Guidelines, October 2019) 10 ('*Queensland Health Abortion Guidelines*'). The AMA Position Statement (n 46) provides that '[s]ome health care facilities may not provide certain services due to institutional conscientious objection … [i]n such cases, an institution should inform the public of their conscientious objection and what services they will not provide so that potential patients seeking those services can obtain care elsewhere': at 2 [3.1]. It further provides that in cases of

institutions themselves, the effect of obligations imposed on individuals by legislation may have implications for institutional objection. To illustrate, if a patient arrives at an institution with an institutional conscientious objection unaware that the service will not be offered at the particular institution, it can be expected that an employee of such an institution would need to individually claim a conscientious objection and hence, the corresponding obligations imposed by law would apply to them in an individual capacity.

B *Scope of Conscientious Objection Provisions*

1 *Conduct Protected*

The protections granted by conscientious objection provisions generally extend to conscientious objectors who are participating in the performance of an abortion, whether that be by directly performing the abortion or assisting to do so.[120] Although participation or equivalent terms are not defined in the legislation, and will ultimately be a matter of statutory interpretation, participation is likely to be limited to direct participation in the procedure and would not extend to administrative, ancillary, managerial or supervisory tasks.[121] Similarly, the protection is unlikely to extend to abortion after care. The legislation in the Australian Capital Territory expressly provides that conscientious objection cannot be used to refuse provision of medical treatment or assistance to a person requiring it due to an abortion.[122]

Some jurisdictions have explicitly broadened the scope of the protection beyond mere participation. For instance, in Victoria,[123] the Northern Territory,[124] Queensland,[125] New South Wales[126] and South Australia,[127] the protection also extends to advising on the proposed abortion. Moreover, in Victoria,[128]

institutional conscientious objection, 'doctors should be allowed to refer patients seeking such a service to another doctor outside the facility': at 2 [3.2].

120 See above n 90.

121 See *QLRC Abortion Report* (n 103), which describes that the course of treatment does not include ancillary, administrative, managerial or supervisory tasks: at 119 [4.15], citing *Janaway v Salford Health Authority* [1989] AC 537, 570 (Lord Keith) ('*Janaway*') and *Doogan v Greater Glasgow and Clyde Health Board* [2015] AC 640, 655 [37]–[38] (Baroness Hale DPSC) ('*Doogan*').

122 *ACT Health Act* (n 10) s 84A(2)(b). See also *Doogan* (n 121) 654 [34] (Baroness Hale DPSC) which indicates that the course of treatment begins with the inducement of labour and generally ends with the delivery of the fetus.

123 *Vic Abortion Act* (n 13) s 8(1).

124 *NT Abortion Act* (n 13) s 11(1).

125 *Qld Abortion Act* (n 13) s 8(1)(a)(iv).

126 *NSW Abortion Act* (n 13) s 9(1)(a)(iv).

127 *SA Abortion Act* (n 10) s 11(1)(a)(iv).

128 *Vic Abortion Act* (n 13) s 8(1).

Queensland,[129] New South Wales[130] and South Australia,[131] protection is also afforded to conscientious objectors in cases where they may be, as a result of their position, required to authorise an abortion or make a decision about whether the abortion should be performed. Conscientious objection protection in Victoria also extends to directing and supervising an abortion.[132]

2 *Emergency Exception*

Importantly, in all jurisdictions, except Western Australia where the legislation is silent, the protections afforded to conscientious objectors do not extend to emergency situations. In most jurisdictions, legislation provides that medical practitioners are under a duty to perform an abortion, and health practitioners are required to assist in performing an abortion in emergency situations. Some jurisdictions elaborate on what constitutes an emergency, for instance, the legislation in the Australian Capital Territory,[133] Tasmania,[134] the Northern Territory[135] and Victoria[136] define an emergency as a situation where the abortion is necessary to preserve the life of the pregnant woman. Tasmania also extends the definition of emergency to include prevention of serious injury.[137] The legislation in Queensland,[138] New South Wales[139] and South Australia,[140] do not elaborate on what constitutes an emergency in their conscientious objection provisions themselves. However, in Queensland and New South Wales, the definition of emergency is given content in earlier provisions in the relevant Acts relating to late termination, where emergencies are defined to include situations where an abortion is necessary to save the woman's life or the life of another unborn child.[141]

C *Nature of the Duties on Conscientious Objectors*

In addition to providing protection to those who have a conscientious objection to the provision of an abortion, the legislation in all states and territories impose various obligations on conscientious objectors.

129 *Qld Abortion Act* (n 13) s 8(1)(a)(iii).

130 *NSW Abortion Act* (n 13) s 9(1)(a)(iii).

131 *SA Abortion Act* (n 10) s 11(1)(a)(iii).

132 *Vic Abortion Act* (n 13) s 8(1).

133 *ACT Health Act* (n 10) s 84A(2)(a).

134 *Tas Abortion Act* (n 13) ss 6(3)–(4).

135 *NT Abortion Act* (n 13) s 13.

136 *Vic Abortion Act* (n 13) ss 8(3)–(4).

137 *Tas Abortion Act* (n 13) ss 6(3)–(4).

138 *Qld Abortion Act* (n 13) s 8(4).

139 *NSW Abortion Act* (n 13) s 9(5).

140 *SA Abortion Act* (n 10) s 11(5).

141 *Qld Abortion Act* (n 13) s 6(3); *NSW Abortion Act* (n 13) s 6(5). The South Australian Law Reform Institute's report defines 'emergency' in its glossary of terms as '[t]reatment which is necessary to save the life, or to prevent grave injury to the physical or mental health, of a pregnant woman': *SALRI Abortion Report* (n 46) 5.

1 *Disclosure of a Conscientious Objection*

All jurisdictions, except Tasmania and Western Australia, require a health practitioner to disclose that they have a conscientious objection if they are refusing to be involved in an abortion on that basis.[142] Whilst in practice it would be difficult to exercise a conscientious objection without disclosing the reason for the refusal, the requirement to explicitly specify that it is due to a conscientious objection is significant. Such a requirement ensures the woman is aware that she could still potentially access the procedure elsewhere and the refusal is not based on clinical considerations or the treatment being unlawful because of eligibility concerns. As was noted in the second reading speech for the Australian Capital Territory's Health (Improving Abortion Access) Amendment Bill 2018:

> [Such a requirement] is important because sometimes people do not realise on what basis they are being refused an abortion and so may make the wrong decision if they feel that the basis is medical when, in fact, it is because of the views of the health practitioner.[143]

In Victoria,[144] the Northern Territory,[145] and the Australian Capital Territory,[146] the disclosure of a conscientious objection must be made to the woman.[147] In Queensland,[148] New South Wales[149] and South Australia,[150] the declaration of the conscientious objection must be made to the person asking the registered health practitioner to perform, assist, make a decision on or advise about an abortion; this need not be the woman.[151] The effect of this latter framing is that, for example, in the case that a woman requests an abortion from a medical practitioner, this would require the medical practitioner to inform the woman. However, in the case that a medical practitioner requests assistance from a nurse who holds a conscientious objection, the nurse must disclose this to the medical practitioner (as the person who asked for this assistance).[152]

2 *Referral Duty and Options Permitted*

As was previously discussed, the *Abortion Law Reform Act 2008* (Vic) heralded a new era of conscientious objection provisions which led to the introduction of a

142 See above n 96.

143 Australian Capital Territory, *Parliamentary Debates*, Legislative Assembly, 21 March 2018, 783 (Caroline Le Couteur).

144 *Vic Abortion Act* (n 13) s 8(1)(a).

145 *NT Abortion Act* (n 13) s 11(2)(a).

146 *ACT Health Act* (n 10) s 84A(4).

147 The ACT's legislation uses the terminology 'must tell a person requesting the abortifacient or abortion': ibid.

148 *Qld Abortion Act* (n 13) s 8(2).

149 *NSW Abortion Act* (n 13) s 9(2).

150 *SA Abortion Act* (n 10) s 11(2).

151 New South Wales and South Australia use the terminology 'first person'.

152 This interpretation is based on the supplemented clinical guidelines: see *Queensland Health Abortion Guidelines* (n 119) 10.

referral requirement for all jurisdictions except Western Australia and the Australian Capital Territory. There is some variation across jurisdictions in terms of the nature of this requirement. Some provisions require a more active approach to referral that demands a high level of involvement from the health practitioner in finding an alternative willing health practitioner/health service provider. By contrast, the more passive approach to referral demands a lesser degree of involvement by the health practitioner by only requiring him or her to provide the patient with a generic list of services.

(a) Active Referral

In the Northern Territory,[153] Victoria,[154] and Queensland,[155] the objector must refer the woman to a health practitioner and/or health service provider who does not conscientiously object to performing an abortion. In New South Wales[156] and South Australia, [157] health practitioners can make an active referral by referring to a health practitioner or health service provider but can also discharge the obligations with a passive referral which will be explored in Part IV(C)(2)(b). Whilst Victoria's legislation and the Northern Territory's legislation explicitly refer to health practitioners, it is likely that the referral requirement will be satisfied if it is made to a healthcare facility that is known to provide abortions[158] or a family planning service.[159] Victoria's legislation does, however, make it explicit that the referral needs to be made to a member of the same regulated profession. As the explanatory memorandum clarifies, this would mean, for example, that if a medical practitioner had a conscientious objection to abortion, they would need to refer the patient on to another medical practitioner, rather than another regulated health practitioner such as a psychologist.[160]

Where referral requirements exist in the various legislation, the term 'referral' is not defined. As evident in the parliamentary debates, there is some confusion as to whether a formal, clinical referral is required.[161] Many commentators have suggested that 'refer' should be interpreted according to its ordinary meaning of

153 *NT Abortion Act* (n 13) ss 11(2)(b).

154 *Vic Abortion Act* (n 13) s 8(1)(b).

155 *Qld Abortion Act* (n 13) s 8(3).

156 *NSW Abortion Act* (n 13) s 9(3)(b).

157 *SA Abortion Act* (n 10) s 11(3)(b).

158 Department of Health (NT), *Clinical Guidelines for Termination of Pregnancy* (Guidelines, April 2019) 22 ('*NT Abortion Clinical Guidelines*').The Victorian Australian Medical Association also produced a template written referral form: see '#117 Fact Sheet: Conscientious Objection to Termination of Pregnancy', *AMA Victoria* (Blog Post, 2019) <https://amavic.com.au/news---resources/stethoscope/stethoscope-archive-2019/-117-fact-sheet--conscientious-objection-to-termination-of-pregnancy> ('AMA Fact Sheet').

159 See, eg, Victoria, *Parliamentary Debates*, Legislative Assembly, 11 September 2008, 3613 (Maxine Morand, Minister for Women's Affairs). See also Sifris (n 8) 906.

160 Explanatory Memorandum, Abortion Law Reform Bill 2008 (Vic) 3 ('Explanatory Memorandum, Vic Abortion Bill').

161 See, eg, Victoria, *Parliamentary Debates*, Legislative Assembly, 11 September 2008, 3609 (Robert Stensholt).

'sending or directing a person to another source', rather than requiring a formal written referral.[162] Although a written referral may not be required by these provisions, the Northern Territory's government has produced recommended referral forms for health practitioners to transfer a woman's care to another medical practitioner for further consultation.[163]

A point of difference between the legislative requirements relates to the extent of knowledge the objector must have about the practitioners and health service providers to whom they are referring. In the Northern Territory and Victoria, the referring practitioner must *know* the other practitioner does not object.[164] The more active approach to referral is clarified in Victoria's explanatory memorandum which states that '[t]his obligation will require the registered health practitioner to make enquiries or take other steps to inform himself or herself of the views of the health practitioner to whom the referral is to be made'.[165]

A lower standard of knowledge is required in other jurisdictions, given they only require the referring practitioner to have a *reasonable belief*,[166] or *belief*,[167] that the practitioner or health service provider does not have a conscientious objection to abortion.

(b) Passive Referral

The more passive approach to referral has been explicitly provided for in Tasmania and is offered as one of three referral options in New South Wales and South Australia, where, as discussed above, the other two referral options (referring to an individual health practitioner or health service provider) demand a more active approach. In Tasmania, the practitioner must 'provide the woman with a list of prescribed health services from which the woman may seek advice, information or counselling on the full range of pregnancy options'.[168] Notably, however, the prescribed health services do not detail services that provide abortions directly. Rather they detail services that are able to provide women with advice, information and counselling about their options; these services may then put the woman in contact with an abortion provider.[169] As Sifris contends, the obligation under the Tasmanian Act is

162 Sifris (n 8) 906. See also Victoria, *Parliamentary Debates*, Legislative Assembly, 11 September 2008, 3609 (Marsha Thomson); Larcombe (n 43) 6; 'AMA Fact Sheet' (n 158). Cf Howe and Le Mire (n 30) 102, who contend it is unclear.

163 Department of Health (NT), *Termination of Pregnancy: Referral for Pregnancy Services* (Form, July 2017) <https://hdl.handle.net/10137/1310>.

164 *Vic Abortion Act* (n 13) s 8(1)(b); *NT Abortion Act* (n 13) ss 11(2)(b).

165 Explanatory Memorandum, Vic Abortion Bill (n 160) 3.

166 *SA Abortion Act* (n 10) s 11(3)(b); *NSW Abortion Act* (n 13) s 9(3)(b).

167 *Qld Abortion Act* (n 13) s 8(3).

168 *Tas Abortion Act* (n 13) s 7(2).

169 The prescribed list of services can be found here: Department of Health (Tas), *Are You Pregnant and Thinking about Your Options?* <https://www.health.tas.gov.au/sites/default/files/2021-12/Pregnancy_options_brochure_DoHTasmania2019.pdf>.

> an obligation to refer a woman to someone who does not have an objection to abortion so that a frank, impartial, non-judgemental conversation can take place. The woman will then be in a position to decide, with all of the information at her disposal, whether or not to continue with the pregnancy.[170]

In South Australia and New South Wales, health practitioners are able to discharge their referral obligations by giving information to the woman on how to locate or contact a medical practitioner without a conscientious objection. For the purposes of both Acts, the practitioner will be taken to have complied with their obligations if they provide information approved by the Minister[171] or Secretary of the Ministry of Health.[172] As is the case with Tasmania, the information does not provide anything about specific providers, only details of a pregnancy options helpline and website, which the woman is expected to contact before being referred to a willing provider. This apparent weakening of the mandatory referral requirement responds to the criticism that health practitioners may not have any special knowledge about other abortion providers.[173] It has also been argued that this form of referral may be less of an affront to the practitioner's conscience[174] as the coordinating and referral role becomes the responsibility of governments and organisations.[175]

These more passive approaches to referral permit medical practitioners to discharge their legislative responsibilities with a direction to a website or a piece of paper, rather than to a health practitioner who can directly assist their patient.[176] This approach places a higher onus on patients to coordinate their own care by requiring them to independently investigate the services provided. Furthermore, a more passive approach to referral arguably assumes a degree of health literacy and inevitably causes delay to access as the patient is required to first contact a service that provides information, and then a provider of the abortion services.

(c) Timeliness of Referral

The statutory provisions vary in terms of the timeliness of the referral that is required. In practical terms, the timeliness of the referral is critical. Delays in finding an alternative willing provider can affect a woman's eligibility to access an abortion given that the legislative criteria vary depending on gestational limits.[177]

Some jurisdictions impose strict time limits within which a referral must occur. For

170 Sifris (n 8) 906.

171 *SA Abortion Act* (n 10) ss 11(3)(a), (4).

172 *NSW Abortion Act* (n 13) ss 9(3)(a), (4).

173 See, eg, Anna Walsh and Tiana Legge, 'Abortion Decriminalisation in New South Wales: An Analysis of the Abortion Law Reform Act 2019 (NSW)' (2019) 27(2) *Journal of Law and Medicine* 325, 335.

174 Ibid.

175 Mike Davis, 'Conscientious Objection to Abortion: An Ethical and Professional Balancing Act' (2014) 22(2) *Australian Health Law Bulletin* 36, 37.

176 Sifris (n 8) 905–6.

177 See above nn 13–19.

instance, the Tasmanian Act mandates that the conscientious objector must provide a woman with the prescribed list of services '*on becoming aware* that the woman is seeking a termination or advice regarding the full range of pregnancy options'.[178] The authors note that this obligation is easily satisfied as the objector will have ready access to that list of services. In the Northern Territory, the referral must occur 'within a *clinically reasonable time*'.[179] Clinical guidelines produced by the Northern Territory government recommend that referral should occur within a maximum of two days following the initial consultation.[180] While not specifying a specific time period, the New South Wales and South Australian provisions require the health practitioner to make a referral 'without delay'.[181]

Queensland and Victorian abortion legislation are silent on the timeframe of referral. However, the Queensland legislation must be interpreted in light of the *Acts Interpretation Act 1954* (Qld) which indicates that the referral must be done 'as soon as possible'.[182] This is consistent with Queensland's clinical guidelines, which provide that the referral should occur '[p]romptly' and 'without delay', specifically 'during the presentation in which the request is made'.[183] Although the Victorian legislation is silent, the relevant explanatory memorandum states that '[the woman] will be referred promptly to another equivalent health practitioner who is able to assist her'.[184]

D *Consequences of Non-Compliance*

Despite legislative obligations being imposed on conscientious objectors, none of the statutes impose penalties for non-compliance. This is perhaps surprising given the potentially significant implications of non-compliance on women's access to an abortion. Nevertheless, a registered health practitioner who fails to comply with their legislative obligations could be the subject of professional disciplinary action.[185] Under the *Health Practitioner Regulation National Law*,[186] non-compliance may result in a finding of unsatisfactory professional performance, unprofessional conduct, or professional misconduct.[187] Such a finding may result in a practitioner being cautioned or reprimanded, or the suspension or cancellation

178 *Tas Abortion Act* (n 13) s 7(2) (emphasis added).

179 *NT Abortion Act* (n 13) s 11(2)(b) (emphasis added).

180 *NT Abortion Clinical Guidelines* (n 158) 10.

181 *NSW Abortion Act* (n 13) s 9(3); *SA Abortion Act* (n 10) s 11(3).

182 *Acts Interpretation Act 1954* (Qld) s 38(4), which provides that: If no time is provided or allowed for doing anything, the thing is to be done as soon as possible, and as often as the relevant occasion happens.' See also *QLRC Abortion Report* (n 103) 148 [4.153].

183 *Queensland Health Abortion Guidelines* (n 119) 10.

184 Explanatory Memorandum, Vic Abortion Bill (n 160) 3.

185 See, eg, *NSW Abortion Act* (n 13) s 10; *Qld Abortion Act* (n 13) s 9; *SA Abortion Act* (n 10) s 17.

186 See *Health Practitioner Regulation National Law* (n 104).

187 Ibid s 243. The definitions can be found at s 5 (definitions of 'unsatisfactory professional performance', 'professional misconduct' and 'unprofessional conduct').

of, or imposition of conditions on the practitioner's registration.[188] In addition, the woman could lodge a complaint about the practitioner to the Australian Health Practitioner Regulation Agency[189] or a state or territory health complaint agency, such as a Health Complaints Commissioner or Ombudsman.[190] To date, there have only been two Victorian cases in the public domain reported by the media relating to alleged contraventions of the conscientious objection provision in Australia.[191]

V RESHAPING REGULATORY RESPONSES TO CONSCIENTIOUS OBJECTION

For the most part, in Australian states and territories, conscientious objection provisions are designed not only to protect health practitioners from being required to act contrary to their conscience, but are also designed to ensure health practitioners act in such a way that their patients, pregnant women who are seeking an abortion, are supported to do so.[192] This Part considers how best the law (and other sources of regulation) can support the achievement of these policy outcomes.

This Part begins by drawing together some global concerns identified in the detailed legal analysis above. These concerns are that Australian law is inconsistent, that some jurisdictions have legal gaps in their conscientious objection provisions, and that this area of law is uncertain in important respects. To conclude this understanding of the current legal position, this Part considers the limited empirical evidence available on conscientious objection to abortion in Australia, finding there are problems with this law in practice. Finally, this Part turns to how best to address these concerns. It proposes that reform to the law is needed, but that this alone will not be sufficient. Effectively achieving the intended policy outcomes also requires harnessing other regulatory tools, such as policy and

188 Ibid s 196(2).

189 See ibid s 25(i).

190 See, eg, the Health Services Commissioner governed by *Human Rights Commission Act 2005* (ACT); Health Care Complaints Commission governed by *Health Care Complaints Act 1993* (NSW); Health and Community Services Complaints Commission governed by *Health and Community Services Complaints Act 1998* (NT); Health Ombudsman governed by *Health Ombudsman Act 2013* (Qld); Health and Community Services Complaints Commissioner governed by *Health and Community Services Complaints Act 2004* (SA); Health Complaints Commissioner governed by *Health Complaints Act 1995* (Tas); Health Complaints Commissioner governed by *Health Complaints Act 2016* (Vic); Health and Disability Services Complaints Office governed by *Health and Disability Services (Complaints) Act 1995* (WA).

191 Howe and Le Mire (n 30) 85–6. One of the cases involved a Victorian health practitioner not referring because a couple were seeking a sex-selective abortion: see Henrietta Cook, 'Abortion Law Changes Eyed as Dr Mark Hobart Probed', *The Age* (online, 7 November 2013) <https://www.theage.com.au/national/victoria/abortion-law-changes-eyed-as-dr-mark-hobart-probed-20131107-2x2rg.html>. Another case involved a general practitioner who had admitted to not referring and was reported after posting a comment on Facebook that 'women who had backyard abortions "deserved" to die': see Susie O'Brien, 'Controversial Victorian Doctor Who Refused to Refer Women for Abortions Has Defended Himself after an Investigation', *Herald Sun* (online, 11 November 2013) <https://www.heraldsun.com.au/news/victoria/controversial-victorian-doctor-who-refused-to-refer-women-for-abortions-has-defended-himself-after-an-investigation/news-story/ec224389210bbc6ccb517a9a3f86aaa0>.

192 See, eg, *VLRC Abortion Report* (n 44) 114.

education, to inform and guide health practitioners' conduct. This section therefore considers a broad suite of regulatory responses, including some initial work already being done, to consider effective ways of governing conscientious objection to abortion.

A *Critique of the Law*

The conscientious objection provisions in the legislation of Australia's eight states and territories were described in detail in the previous Part. Here, the authors draw together some of the problematic aspects of the current legislative framework that were identified in that review.

In some respects, there is broad consistency across conscientious objection provisions in Australian states and territories. Each jurisdiction recognises an individual's right to conscientiously object in relation to abortion. In all but one state, this right does not operate in the case of an emergency. But other than this, there are variations relating to the nature of the conduct that is protected, and the nature of duties that are imposed on those who have a conscientious objection.

Australia has a federal structure, and constitutionally the regulation of health services (such as abortion) rest with the states and territories. Lack of uniformity across Australia is therefore not surprising. That said, this kind of inconsistency is difficult to justify as a matter of principle and, from a national perspective, consideration should be given to harmonisation over time.[193] Inconsistent laws add to the complexity of regulation and make it even more challenging for health practitioners providing health services to know and understand their obligations. While constitutional constraints preclude the Commonwealth government from enacting a national law, uniform law reform across the separate states and territories is technically possible and would address this undesirable inconsistency.[194]

Although there is no scope to explore these inconsistencies and legal gaps in any detail in this article,[195] the authors offer the following examples. As flagged above, Western Australian law has not been updated since 1998 and is therefore out of step with the broad national approach in key respects:[196] an individual's

193 Caroline M de Costa and Heather Douglas, 'Abortion Law in Australia: It's Time for National Consistency and Decriminalisation' (2015) 203(9) *Medical Journal of Australia* 349.

194 Caroline de Costa et al, 'Abortion Law across Australia: A Review of Nine Jurisdictions' (2015) 55(2) *Australian and New Zealand Journal of Obstetrics and Gynaecology* 105, 111.

195 The need for law reform has been argued elsewhere: see, eg, Naomi Neilson, 'WA Looks Ahead to Modernised Laws as "Historic" Abortion Legislation Passes', *Lawyers Weekly* (online, 15 August 2021) <https://www.lawyersweekly.com.au/biglaw/32196-wa-looks-ahead-to-modernised-laws-as-historic-abortion-legislation-passes>; Millar and Baird (n 22); de Costa and Douglas (n 193); de Costa et al (n 194); Lachlan J de Crespigny and Julian Savulescu, 'Abortion: Time to Clarify Australia's Confusing Laws' (2004) 181(4) *Medical Journal of Australia* 201.

196 In August 2021, Western Australia passed the Public Health Amendment (Safe Access Zones) Bill 2021 (WA) creating safe access zones around abortion clinics, becoming the last jurisdiction to do so. Despite being praised for its 'landmark achievement' for enabling safe access to

conscientious objection is protected even in cases of emergency; the right of conscientious objection extends to institutions and not just individuals; and an individual who conscientiously objects is not required to disclose this, or provide a direct referral or information about other health services.[197] Western Australian law is inconsistent not only with other Australian jurisdictions, but also with international trends.[198] The authors also note the Australian Capital Territory's omission of a duty to refer and Tasmania's omission of a duty to disclose a conscientious objection.[199] Introducing disclosure and referral obligations is desirable to bring them in line with other Australian jurisdictions and modern approaches to regulating conscientious objection in abortion.

Part IV also revealed uncertainty and ambiguity in some important respects. Given the nature of these laws — which call for health practitioners to take specific actions — any degree of uncertainty and ambiguity is problematic. Examples identified above include a lack of clarity in relation to the time within which disclosure of a conscientious objection and referral must occur. Such uncertainty is particularly problematic given the significance of gestational limits on access. Ambiguity also exists about the meaning of 'referral' and how an obligation to refer can be discharged. Is a formal written referral to a health practitioner without a conscientious objection required? Is it sufficient to refer a woman to a family planning service rather than an individual health practitioner?

Any degree of ambiguity regarding the nature and scope of a health practitioner's legal obligations is undesirable, particularly when uncertainty can adversely affect a woman's access to an abortion.

B *Empirical Evidence about the Operation of Current Abortion Laws*

While the policy goal of legislation is to ensure both the protection of a health practitioner's right to conscientiously object and access of a woman to an abortion, it is important to establish whether the law achieves this goal. To this end, this article will now consider the available empirical research which examines how the laws operate in practice and their impact on the availability of abortion.

1 *Conscientious Objection as a Barrier to Abortion*

The available research suggests that the ability of a health practitioner to conscientiously object acts as a barrier to timely access to abortion. International studies reveal that conscientious objection has resulted in abortion provider

abortion, access barriers still exist, and recent amendments have spurred commentary calling upon Western Australia to modernise its existing laws: see, eg, Neilson (n 195).

197 See *WA Health Act* (n 10) s 334(2).

198 See *Elimination of Discrimination against Women* (n 80) ch 1(A) [11]; FIGO Conscientious Objection Guidelines (n 79) 149; *WHO Abortion Guidelines* (n 81) 69 [3.3.6]; WMA Statement on Abortion (n 82).

199 See *ACT Health Act* (n 10) s 84A; *Tas Abortion Act* (n 13) ss 6–7.

shortages,[200] particularly in regional and rural areas and populations of low socio-economic status.[201]

The same issues have been identified in Australia with high levels of conscientious objection being reported to exist in both Victoria[202] and Queensland,[203] particularly in rural and regional areas, resulting in access barriers. Indeed, following the introduction of Queensland's Act, Clinical Excellence Queensland,[204] a body designed to drive quality improvement in the provision of health services, wrote to the Royal Australian College of General Practitioners calling for 'better management of conscientious objection' in relation to abortion.[205] Clinical Excellence Queensland was concerned that conscientious objection had become increasingly widespread in rural and regional parts of Queensland, to the extent that a single general practitioner would often be responsible for servicing a large area.[206] Insufficient providers inevitably result in women having to travel long distances to access an abortion, and they frequently lack the financial resources to do so.[207] Moreover, conscientious objection has been associated with delays and longer waiting times for women seeking abortions, the effect of which is compounded in regions with high levels of conscientious objection.[208] In some

200 See, eg, Mary Favier, Jamie MS Greenberg and Marion Stevens, 'Safe Abortion in South Africa: "We Have Wonderful Laws but We Don't Have People to Implement Those Laws"' (2018) 143(S4) *International Journal of Gynecology and Obstetrics* 38; Raymond A Aborigo et al, 'Optimizing Task-Sharing in Abortion Care in Ghana: Stakeholder Perspectives' (2020) 150(S1) *International Journal of Gynecology and Obstetrics* 17; John K Awoonor-Williams et al, 'Prevalence of Conscientious Objection to Legal Abortion among Clinicians in Northern Ghana' (2018) 140(1) *International Journal of Gynecology and Obstetrics* 31; Alexandra Müller et al, '"You Have to Make a Judgment Call": Morals, Judgments and the Provision of Quality Sexual and Reproductive Health Services for Adolescents in South Africa' (2016) 148 *Social Science and Medicine* 71.

201 Tommaso Autorino, Francesco Mattioli and Letizia Mencarini, 'The Impact of Gynecologists: Conscientious Objection on Abortion Access' (2020) 87 *Social Science Research* 102403:1–16, 14.

202 See Louise Keogh et al, 'General Practitioner Knowledge and Practice in Relation to Unintended Pregnancy in the Grampians Region of Victoria, Australia' (2019) 19(4) *Rural and Remote Health* 5156:1–7 ('General Practitioner Knowledge and Practice').

203 Doug Hendrie, 'Conscientious Objection Obstacle to Safe Terminations: Qld Government', *NewsGP* (online, 9 September 2019) <https://www.racgp.org.au/newsgp/clinical/conscientious-objection-potential-obstacle-to-safe>.

204 Clinical Excellence Queensland is a government initiative that partners with health services, clinicians and consumers, intended to improve patient care by driving quality improvement: Clinical Excellence Queensland, Queensland Health, 'About CEQ', *Queensland Government* (Web Page) <https://clinicalexcellence.qld.gov.au/about-us>.

205 Hendrie (n 203).

206 Ibid.

207 See, eg, Autorino, Mattioli and Mencarini (n 201); Awoonor-Williams et al (n 200).

208 See, eg, Autorino, Mattioli and Mencarini (n 201); Marco Bo, Carla Maria Zotti and Lorena Charrier, 'Conscientious Objection and Waiting Time for Voluntary Abortion in Italy' (2015) 20(4) *European Journal of Contraception and Reproductive Health Care* 272; Emily Freeman and Ernestina Coast, 'Conscientious Objection to Abortion: Zambian Healthcare Practitioners' Beliefs and Practices' (2019) 221 *Social Science and Medicine* 106; Chelsey E Brack, Roger W

cases, such delays will affect a woman's eligibility to access an abortion due to strict gestational limits.[209]

2 *Compliance with Legal Duties Imposed on Conscientious Objectors in Australia*

The legal duties imposed on objectors, such as their duty to refer to another health practitioner, are designed to help mitigate some of these access barriers. Yet, little is known across Australia about the extent to which health practitioners are in fact complying with the duties imposed on them.

There has been some empirical research in Victoria that has explored the views of abortion experts on the effectiveness of the obligation of conscientious objectors to refer women seeking abortions to another health practitioner (eg s 8 of the *Abortion Law Reform Act 2008* (Vic)). These studies revealed that not all Victorian conscientious objectors are complying with the mandatory requirement to refer pregnant women.[210] In one study, it was reported that the study participants felt that failure to refer was 'common practice' in rural areas.[211] The same study also found that some conscientious objectors attempted to delay women from accessing abortions by trying to deter them from proceeding with an abortion, and created delays by requiring women to come back and see them at a later stage.[212]

C *Proposed Regulatory Response*

The preceding legal analysis and consideration of available empirical evidence suggest further work is needed to ensure optimal regulation of conscientious objection in the context of abortion. The authors' departure point for this discussion is that desirable policy outcomes of regulation are that an individual may exercise a conscientious objection in relation to abortion, except in emergency cases, provided that there are obligations to disclose that conscientious objection and facilitate a woman's access to treatment by referral (either actively or passively). These policy outcomes broadly reflect a consensus in the national laws and also international trends on regulating conscientious objection, so they form an appropriate basis for designing regulatory responses to achieve those outcomes.

At the outset, it is important to recognise that these outcomes cannot be achieved by legislation alone. Indeed, this is demonstrated by some empirical evidence describing how the law, at least in Victoria, has not been followed, and indeed to an extent subverted. As a result, although the focus of this article is on the law, our suggestions for a possible regulatory response include some initial recommendations in terms of other regulatory tools.

Rochat and Oscar A Bernal, '"It's a Race against the Clock": A Qualitative Analysis of Barriers to Legal Abortion in Bogotá, Columbia' (2017) 43(4) *International Perspectives on Sexual and Reproductive Health* 173; Favier, Greenberg and Stevens (n 200).

209 See, eg, Keogh et al, 'Perspectives of Abortion Service Providers' (n 116) 5.

210 Ibid; Keogh et al, 'General Practitioner Knowledge and Practice' (n 202) 6.

211 Keogh et al, 'Perspectives of Abortion Service Providers' (n 116) 5.

212 Ibid.

1 *Law Reform*

The first component of our proposed regulatory response is to suggest law reform so that the law can be framed to promote the above policy outcomes. Where law does not meet these criteria, the authors propose it be reformed. For example, Western Australian law should be amended to align with other jurisdictions, by not permitting conscientious objection in cases of emergency, requiring practitioners to disclose their objection and requiring some process of referral. Similarly, to promote the identified policy outcomes, Tasmanian law should be amended to include a disclosure requirement and the Australian Capital Territory law should introduce a form of referral requirement.

In addition to these broader reform points, the authors also recommend greater clarity in the law to address the ambiguities identified in Part IV. Ambiguity regarding the legal duties imposed on conscientious objectors is unhelpful to both women seeking an abortion and conscientious objectors, and should be addressed. For instance, clarity is needed about what constitutes a ‘referral’, namely whether the obligation will be discharged by referring to a health service provider and whether a formal written referral is required. Similarly, a specified time period for disclosure of conscientious objection and referral should replace terminology currently used, including ‘within a clinically reasonable time’[213] and ‘without delay’.[214]

2 *Policies and Guidelines*

There is also scope for policies and guidelines to supplement the law to help ensure compliance with these legal duties. Such documents have often been used to convert complex or ambiguous legal requirements into more straightforward and concrete steps that health practitioners can then implement. At times, reliance on extrinsic materials such as parliamentary debates or explanatory memoranda are needed to understand and interpret the law. It is not reasonable to expect health practitioners to consult such documents to determine the nature and scope of their legal responsibilities. Policies and guidelines offer a feasible alternative to capture this additional detail and integrate it into meaningful and accessible guidance for health practitioners. Notably, it has previously been suggested that guidelines could prove useful in clarifying both the scope of protection offered by conscientious objection provisions and the obligations imposed by them.[215]

An example of where a policy has helped clarify conscientious objectors’ legal obligations is in Queensland’s clinical guidelines on termination of pregnancy, produced by Queensland’s Department of Health.[216] The guidelines contain a section on conscientious objection which, in addition to outlining obligations on health practitioners set out in the *Termination of Pregnancy Act 2018* (Qld), also provide further elaboration on what exactly is required by these obligations. The

213 *NT Abortion Act* (n 13) s 11(2)(b).

214 *NSW Abortion Act* (n 13) s 9(3); *SA Abortion Act* (n 10) s 11(3).

215 For Victorian guidelines recommendations, see Keogh et al, ‘Perspectives of Abortion Service Providers’ (n 116) 8.

216 *Queensland Health Abortion Guidelines* (n 119).

guidelines clarify that a referral or transfer of care should occur 'promptly' and '[t]o the nearest/most convenient registered health practitioner or service'.[217] The guidelines also clarify that conscientious objection does not extend to 'administrative, managerial [and] other tasks' or 'institutions'.[218] Additionally, the guidelines stipulate that the disclosure requirements in the legislation require that a health practitioner disclose their conscientious objection to a person requesting the termination (whether that be the woman or another health practitioner).[219]

There is also scope for these legal duties to be supported through improved system design or support within the health system. This is perhaps most significant when considering referral requirements. Whilst referral requirements are intended to facilitate access, they are only effective if health practitioners can discharge such an obligation. A criticism of the more active referral requirements is that they rely on the assumption that health practitioners are in fact aware of willing providers within a reasonable geographic proximity, which may not always be the case.[220] Such a difficulty is somewhat mitigated in jurisdictions that explicitly permit passive referral, as the relevant state governments have created a list of prescribed services including state-based helplines for health practitioners to distribute to their patients.[221]

3 *System Design and Structural Support*

Over recent years, structural support is being established by a subset of Primary Health Networks[222] to introduce Health Pathways.[223] These are established referral networks intended to be used by health practitioners to help them facilitate referrals. Collaborative work is currently occurring to establish referral networks for abortion providers in rural Victoria, with positive results to date.[224] Such a system has the advantage of requiring the health practitioner to find a willing provider (who is likely to be better able to do this than the woman), and assists

217 Ibid 10.

218 Ibid.

219 Ibid.

220 Walsh and Legge (n 173) 335.

221 Prescribed information outlining services are found in New South Wales, South Australia and Tasmania. Victoria does not have prescribed information like the aforementioned jurisdictions, but there is a helpline known as '1800 My Options' which offers a similar service. It is a Women's Health Victoria initiative and is supported by the Victorian government: see *1800 My Options* (Web Page) <https://www.1800myoptions.org.au/>.

222 Primary Health Networks are independent organisations funded by the Australian government that work to streamline health services across the country: see 'Primary Health Networks', *Australian Government: Department of Health and Aged Care* (Web Page) <https://www.health.gov.au/initiatives-and-programs/phn>.

223 See generally *HealthPathways Community* (Web Page) <https://www.healthpathways community.org/>.

224 See Louise Keogh et al, *Increasing Reproductive Choices in the Grampians Pyrenees and Wimmera Regions: A Follow-Up Study to Rural GPs and Unintended Pregnancy in the Grampians Pyrenees and Wimmera Regions* (Report, August 2020) <https://whg.org.au/wp-con tent/uploads/2020/09/Evaluation-Report-FINAL-August-2020.pdf> ('*Increasing Reproductive Choices*').

conscientious objectors to discharge active referral obligations in the event they are unaware of willing providers in a reasonable geographic proximity.

4 *Training and Education*

The discussion of law, policy/guidelines and structural or system supports above all depend on awareness of them by the health practitioners whose behaviour they are intended to guide. If practitioners do not know their legal duties, or do not know of the policies and systems that are intended to support the discharge of those duties, then these will be unable to guide behaviour.

There have been some, though limited, educational offerings on obligations imposed on conscientious objectors. For instance, the Victorian government funds a Clinical Champions project, which is led by the Royal Women's Hospital, and is designed to provide clinicians with training to help support access and availability of abortion services, and explicitly covers conscientious objection.[225] The training details the boundaries and requirements imposed by Victoria's conscientious objection provision and has been found to be beneficial by participating health practitioners as part of an evaluation project carried out in rural Victoria.[226] To the authors' knowledge, outside this initiative, there has been limited education delivered to health practitioners that explicitly addresses abortion conscientious objection provisions. More dedicated training and education for health practitioners is therefore critical. A key challenge, however, may be uptake of such training, as the critical target audience is health practitioners who do not want to participate in abortion. This could be addressed by explaining the relevance and significance of such training for this group, including the importance of knowing legal duties to manage risk.

In order to be effective, training must be legally accurate, clinically relevant and ideally delivered by a source regarded as credible by its intended health practitioner audience. It may be that the relevant medical colleges are best placed to deliver such training given their existing training function, access to legal and clinical expertise, and their credibility as a standard-setting organisation.[227]

5 *Monitoring and Compliance*

A final point relates to the monitoring and compliance aspect of regulation (including law). Although there are a range of different definitions of regulation, the commonly adopted approach is that it includes standard setting, information gathering about behaviour (monitoring) and then taking steps to modify behaviour if it is inconsistent with those standards (compliance).[228] While the law has set

225 'Empowering Rural Clinicians Vital in Improving Access to Abortion Services', *The Women's: The Royal Women's Hospital* (Web Page, 2 August 2019) <https://www.thewomens.org.au/news/empowering-rural-clinicians-vital-in-improving-access-to-abortion-services>.

226 See Keogh et al, *Increasing Reproductive Choices* (n 224) 11.

227 For example, the Royal Australian College of General Practitioners and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

228 See Julia Black, 'Critical Reflections on Regulation' (2002) 27 *Australian Journal of Legal Philosophy* 1, 26; Bronwen Morgan and Karen Yeung, *An Introduction to Law and Regulation: Text and Materials* (Cambridge University Press, 2007) 85.

standards about how health practitioners with a conscientious objection must behave, there appears to be very little by way of monitoring activity or efforts to ensure compliance. The monitoring to date appears to be limited to the above empirical research and collated information gathered by advocacy groups.

Likewise, there appears to be very little action in terms of attempts to secure compliance with the law. It is striking that there are only two cases in Victoria in the public domain where complaints processes have been engaged.[229] This is perhaps surprising in light of existing evidence that the law is ignored or subverted by some health practitioners.[230] Such incongruence may be the product of women failing to make formal complaints, either because they are unaware that their health practitioner has breached his/her obligation(s), a lack of available means of recourse, or a decision to avoid the difficulties of engaging complaints processes.

For these laws to function as intended, more work is needed on monitoring and compliance. A law that is not enforced or is not enforceable is unlikely to be followed. The authors recognise also the educative and normative function of enforcing compliance in some cases. A concrete example of where the law is not followed, and the sanctions are imposed for the breach, may educate those who are not aware of their duties. Enforcement may also help reinforce the binding nature of this legal duty. Similarly, complaints being made publicly available may also serve to educate women of health practitioners' obligations in instances where they are refused an abortion.

VI CONCLUSION

Despite the fact that abortion has been decriminalised, at least partially, in all jurisdictions as of 2021, there are still a number of barriers that impact abortion access.[231] This article aimed to explore one of those barriers, namely health practitioners claiming a conscientious objection to abortion. Whilst each jurisdiction permits health practitioners to claim a conscientious objection, the nature of the obligations imposed on health practitioners vary.

This article explored the nature of obligations (if any) on health practitioners wishing to claim a conscientious objection that exist across each jurisdiction and considered how the nature of the obligations imposed may facilitate, and indeed compromise in some cases, access to a lawful abortion. The legal analysis revealed that not only is there inconsistency, but in some cases, there are legal gaps and uncertainty about what exactly is required by conscientious objectors to fulfill their obligations under law. In light of this finding and through reflecting on the limited Australian empirical evidence,[232] which suggests that conscientious objectors are not fulfilling their obligations, the authors considered how the law can be reformed

229 Howe and Le Mire (n 30) 85–6.

230 See Keogh et al, 'Perspectives of Abortion Service Providers' (n 116).

231 Sifris and Penovic (n 21); Millar and Baird (n 22).

232 Keogh et al, 'Perspectives of Abortion Service Providers' (n 116); Keogh et al, 'General Practitioner Knowledge and Practice' (n 202).

to address some of the access issues. The authors also proposed how other regulatory tools can be used to inform and guide health practitioner behaviour and ensure compliance.

Whilst the authors have proposed some potential solutions to improving the regulation of conscientious objection in relation to abortion, it is acknowledged that the design of an optimal regulatory solution must be informed by empirical research.[233] Nonetheless the authors contend that it is time to rethink the regulation of conscientious objection to ensure that it meets its policy goal of protecting health practitioners from being required to act contrary to their conscience, while also ensuring that women seeking a lawful abortion are supported in doing so.

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