Parliamentary Inquiry into Freedom of Conscience in Abortion Provision

Information about respondent

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Are you responding on behalf of an organisation or as an individual?

Organisation

Name of organisation (if applicable):

Christian Medical Fellowship

Position in organisation (if applicable):

Head of Public Policy

Profession:

Please describe your interest in the questions raised by this Inquiry.

CMF is an interdenominational organisation with over 4,000 British doctor members in all branches of medicine and around 1,000 medical student members. We are the UK's largest faith-based group of health professionals. We are linked to about 70 similar bodies in other countries throughout the world.

Do you wish for your evidence to be kept anonymous?

No

Inquiry questions

1. Do you think freedom of conscience for healthcare professionals in the provision of abortion is important? If so, why? If not, why not?

The right to practice with freedom of conscience goes to the heart of medical practice as a moral activity. It is striking that the moral commitments underlying medicine can be traced all the way back to the Hippocratic roots of Western medicine. In the terms of the Hippocratic Oath it was recognised that the individual doctor practised before a higher power - a power to whom he or she was accountable. Hippocratic doctors did not swear by the Emperor, by the State, or by local lords and authorities. Their oath was taken before the highest possible authority – it was recognition of transcendence, an appeal to ultimate authority.

Doctors are not just paid artisans who do whatever their paymasters require. They are not just civil servants whose first loyalty is to the state. They are not just salesman whose job is keep the customers satisfied. They march to the beat of a different drum.

Ever since Hippocrates, the practice of medicine has been founded in a number of core ethical values; practising good medicine is a moral and not just a technical activity. These values are foundational and they have provided the basis for historical codes of medical ethics, from the Hippocratic Oath[1] to the Declaration of Geneva[2] and the General Medical Council's Good Medical Practice: 'You may choose to opt out of providing a particular procedure because of your personal beliefs and values, as long as this does not result in direct or indirect discrimination against, or harassment of, individual patients or groups of patients.'[3]

These core ethical values form part of the physician's personal identity, his moral welfare and his understanding of the reasons that he entered medicine. If a person is coerced by employers, or by the power of the state, to act in a way which transgresses such core ethical values then their internal moral integrity (congruence and cohesion between their personal and professional values) is damaged. Any definition of health that fails to uphold the ethical well-being of patients and care providers alike is flawed.

History teaches us that when doctors are subject to coercion from state power or other sources, they may act in ways which deny the fundamental moral values of good medicine. It is an essential safeguard for the moral health of medicine that legal and regulatory systems are maintained which protect the right of doctors (and other clinical and non-clinical staff) to refuse to take part in practices which violate their most profound moral convictions.

This is a right enshrined in Article 9 of the European Convention on Human Rights,[4] that states 'Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to manifest his religion or belief in worship, teaching, practice and observance.' Similarly, the 2010 UK Equality Act[5] also prohibits discrimination on the grounds of religion and belief.

[1] https://www.nlm.nih.gov/hmd/greek/greek_oath.html
[2] http://www.cirp.org/library/ethics/geneva/
[3] http://www.gmc-uk.org/guidance/ethical_guidance/21177.asp
[4] http://www.echr.coe.int/Documents/Convention_ENG.pdf
[5] http://www.legislation.gov.uk/ukpga/2010/15/pdfs/ukpga_20100015_en.pdf

2. Do you think that doctors with a conscientious objection to abortion have adequate protection to fully engage in their profession without compromising their freedom of conscience?

There is general agreement that the Abortion Act protects health professionals from being forced against their consciences to be directly involved in carrying out abortions. But the application of S.4 is much less clear when preparing a patient for surgery, attending them afterwards, supervising others doing abortions, typing a referral letter or in some other way being part of the referral process. The problem is, both case law and professional guidelines vary in how they interpret and apply the conscience clause.

In the Glasgow Midwives case (Doogan and Wood),[6] the Scottish Court of Appeal ruled that the midwives involved could refuse to delegate, supervise or support staff involved in abortions. This was later overturned by the Supreme Court in 2013, Lady Hale ruling that: '"Participating" is limited to direct [hands-on] participation in the treatment involved. It does not cover administrative and managerial tasks.'[7] Furthermore Hale added that any medical professional who refuses to provide an abortion 'must arrange for a referral to someone else who will do so'. By this ruling, referral would be made mandatory.

This legal ruling conflicts with 2013 General Medical Council (GMC) guidance that doctors are not obliged to refer patients seeking abortion to other doctors who will do it, but must 'make sure that the patient has enough information to arrange to see another doctor who does not hold the same objection'. In a letter to Dr Peter Saunders, CEO of CMF, in 2008, the GMC confirmed that doctors with CO to abortion would not be obliged to refer.[8]

If Lady Hale's ruling stands, a doctor will be forced to refer her patient, against her conscience, ensuring that an abortion is carried out, albeit by others. Many doctors would view this as being complicit, via their necessary causal role, in abortion and as a result would be both inwardly conflicted and, in their own eyes, morally culpable. This surely contravenes The UK Equality Act (2010) and The European Convention of Human Rights (ECHR), both of which prohibit discrimination on the grounds of religion or belief (see below, 6).

Following Hale, it is not clear that doctors are able to fully engage in their profession without compromising their freedom of conscience.

A further concern is the scope of the term 'grave permanent injury' in subsection 2 of the conscience clause. Objection on the grounds of conscience to the termination of a pregnancy where the life of the mother is threatened is very unusual, but what is envisaged by 'grave permanent injury to the physical or mental health' of the woman such as to necessitate immediate termination and exclusion of the right to CO? A potentially wide interpretation is cause for concern to those who have CO to abortion and who would see the baby's right to life as taking precedence over the mother's right to health, based on the conviction that both mother and baby are equally human persons.

3. Do you think that other healthcare professionals with a conscientious objection to abortion have adequate protection to fully engage in their profession without compromising their freedom of conscience?

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[6] Doogan & Anor v NHS Greater Glasgow & Clyde Health Board [2013] ScotCS CSIH_36 (24 April 2013)
[7] https://www.supremecourt.uk/decided-cases/docs/UKSC_2013_0124_Judgment.pdf
[8] http://admin.cmf.org.uk/pdf/publicpolicy/2008-03-26-GMC_letter_to_PSaunders.pdf

The position of nurses and midwives who have a conscientious objection to abortion is even more precarious, following the Glasgow Midwives case.

Clause 4.4 of the Nursing and Midwifery Council (NMC) Code allows for conscientious objection in only limited circumstances. But a new position statement on abortion from the Royal College of Midwives (RCM) [9] narrows this protection even further and states that midwives should be involved in all care of a woman undergoing a termination. They have the right to opt out, on the basis of conscience, only from those clinical procedures directly involved in the abortion. Furthermore, both the NMC and RCM make referral to another competent practitioner mandatory.

(That the CEO of the RCM is also Chair of Trustees for the British Pregnancy Advisory Service (BPAS), the UK's leading abortion provider, highlights a concerning conflict of interest.)

Midwives with CO to abortion face having to choose between the dictates of conscience on one hand, and vulnerability to disciplinary proceedings on the other. They are therefore unable to fully engage in their profession without compromising their freedom of conscience.

4. Do you have personal experience of, or do you know of, examples of good practice where healthcare professionals do not wish to participate, directly or indirectly, in the provision of abortions? Good practice might have been shown by the healthcare professional, healthcare organisation, or both.

Support for restricting the law and professional bodies from imposing a duty to refer can be found in the ruling in a 2010 High Court case in New Zealand.[10]

Many of our members have found when they raise this matter sensitively with supervisors that reasonable accommodation is made for them, both in general practice and hospital practice.

This involves being excused from seeing patients with abortion requests, having to refer for authorisation of abortion, doing preoperative anaesthetic checks (clerking patients) and prescribing and administering abortifacient drugs. Almost invariably other staff can be found who will carry out these duties but the onus should not be on the health professional exercising CO to find them.

It often comes down to the attitude of the individual supervisor and their knowledge and interpretation of the law.

[9] https://www.rcm.org.uk/sites/default/files/RCM%20Abortion%20Statement.pdf

[10] HALLAGAN AND ANOR V MEDICAL COUNCIL OF NZ HC WN CIV-2010-485-222 2 December 2010

5. Do you have personal experience of, or do you know of, examples of poor practice where healthcare professionals do not wish to participate, directly or indirectly, in the provision of abortions? Poor practice might have been shown by the healthcare professional, healthcare organisation, or both.

We have been approached by members of our organisation who have been placed under subtle pressure to be involved in abortion pathways and who were unaware of their rights under the law. In other words, the fact that the conscience clause exists does not mean that at hospital shop-floor level coercion does not occur.

Sometimes threats are more direct. We are aware of one doctor who was told in no uncertain terms, 'If you do not sign those abortion forms I'll make sure that you never get a job in this hospital again'. Another doctor was told explicitly that he was not appointed to a house officer post in obstetrics and gynaecology because he was not willing to participate in abortion.[11]

The recent Glasgow Midwives case,[12] eventually heard in the Supreme Court, illustrates the vulnerability of midwives who are conscientious objectors to abortion.

The Janaway case, heard by the House of Lords in 1988,[13] concluded that anything that occurs outside the operating theatre falls outside the ambit of the conscience clause, and illustrates the vulnerability of non-clinical staff who object, on the grounds of conscience, to indirect involvement in abortion procedures.

6. In your view, are there any useful precedents for protection of freedom of conscience from other areas of the UK or from other jurisdictions?

The UK Equality Act (2010) [14] prohibits direct or indirect discrimination on the grounds of religion and belief, amongst other grounds. Though not yet tested in the courts, it is strongly arguable that the 'philosophical belief' in the sanctity of life from conception would be protected under its provisions. A clinician holding this belief, whether for religious reasons or otherwise, and who is required by her professional body to refer her patient for a procedure that is at odds with her convictions, would therefore have a case under the terms of the Equality Act.

The Human Fertilisation and Embryology Act 1990 conscience clause (S38) offers broader protection than the Abortion Act 1967 by using the word 'activity': 'No person who has a

[11] Abortion views cost job, says doctor. *BBC News* 2000; 7 October 2000 http://news.bbc.co.uk/1/hi/health/961169.stm

[12] *Doogan & Anor v NHS Greater Glasgow & Clyde Health Board* [2013] ScotCS CSIH_36 (24 April 2013)

[13] R v Salford Area Hospital Authority ex parte Janaway [1989] 1 AC 537

[14] http://www.legislation.gov.uk/ukpga/2010/15/pdfs/ukpga_20100015_en.pdf

conscientious objection to participating in any *activity* governed by this Act shall be under any duty, however arising, to do so.'[15] In contrast, the word 'treatment' as opposed to the word 'activity' in the Abortion Act's conscience clause has contributed to the lack of coherence and clarity by inviting different legal interpretations of what constitutes actual treatment.

Following a recent European Court of Human Rights decision,[16] the protection afforded under Article 9 of the European Convention of Human Rights (ECHR)[17] has been expanded to protect 'a practice or manifestation motivated, influenced or inspired by religion or belief….regardless of whether it is a mandatory requirement of the religion or belief'. Further, the Court determined that the availability of alternative employment in the workplace, that would accommodate the employee's beliefs, is no longer to be a limiting factor.

A medical secretary asked to type a letter referring a patient for assessment with a view to terminating a pregnancy, or a doctor who is required to refer a patient for abortion, may both be able to claim that to be 'required' to participate in the referral process would make them complicit in any subsequent abortion and would discriminate against them under the terms of the ECHR. Under the ECHR their 'philosophical beliefs' would not have to have a religious basis. They need only show their belief is (a) genuinely held (b) not simply an opinion or viewpoint based on the present state of information available (c) concerns a weighty and substantial aspect of human life and behaviour (d) attains a certain level of cogency, seriousness, cohesion and importance (e) is worthy of respect in a democratic society (f) is not incompatible with human dignity and (g) is not in conflict with the fundamental rights of others.

To weaken the scope and application of its 'conscience clause' could make the Abortion Act incongruent with Article 9 of the ECHR, and encourage conscientious objectors to pursue their claims under the terms of the Convention.

In the Glasgow Midwives judgment, Lady Hale advised the Glasgow midwives that they '*may still claim, either under the Human Rights Act or under the Equality Act that their employers should have made reasonable adjustments to the requirements of the job in order to cater for their religious beliefs'*. In a lecture to Yale Law School,[18] Lady Hale asked: '*would it not be a great deal simpler if we required the providers of employment, goods and services to make reasonable accommodation for the religious beliefs of others?*'

The notion of 'reasonable accommodation' already exists in other jurisdictions, for example in Canada, where an employer must prove 'undue hardship' in order to justify a discriminatory measure.[19]

[15] http://www.legislation.gov.uk/ukpga/1990/37/section/38
[16] [2013] IRLR 231
[17] http://www.echr.coe.int/Documents/Convention_ENG.pdf
[18] 'Religion and Sexual Orientation', 7 March 2014. Available at http://supremecourt.uk/news/speeches.html.
[19] http://laws-lois.justice.gc.ca/eng/acts/h-6/page-2.html#docCont

7. Do you think legislation or professional guidance for healthcare professionals in the UK should be changed or developed? If so, in what way would you recommend?

CMF recommends:

- that the conscience clause in The Abortion Act be retained but consideration be given to clarifying its scope by changing the word 'treatment' to 'activity' as used in the Human Fertilisation and Embryology Act 1990
- that article 9 of the ECHR, prohibiting discrimination on the grounds of religion and belief, be recognised as protecting the conscience clause of the Abortion Act, and that UK law and ECHR be reconciled.
- that clarity and uniformity of interpretation be brought to the scope and application of the conscience clause in guidelines produced by professional bodies
- that those guidelines clearly protect clinicians from the obligation to refer their patients for assessment with a view to a procedure to which they conscientiously object.
- that a similar right of conscience for allied professions be protected by legal and regulatory systems from practices which violate their most profound moral convictions.

8. Any other comments?

Deciding what is right necessitates the freedom to do so.[20] Conscience is the internal 'weighing-scale' by which we judge what is ethically right, and the answer that follows is to do what we 'ought to'.[21] 'If healthcare providers are not permitted to speak out about issues or care that they perceive to be unethical in practice, then the healthcare professions are at risk of having healthcare providers who do not practice according to conscience. They will have lost their right, or freedom to exercise this right, to attain it.'[22] CO is predicated on conscience, and what is missing from the current dialogue on CO is an agreed understanding of conscience rights and their bearing on the moral welfare of healthcare providers.

Proponents of restricting or reducing healthcare professionals' freedom to conscientious objection usually argue that patients will suffer unjustly from the lack of services that objecting professionals refrain from providing. However an appreciation of healthcare provider's right to conscience does not necessarily negate the desire of a patient to have an abortion, even if legally indicated. It may (occasionally) impact service delivery, but this does not necessitate that every citizen, provider or patient alike, mutually support what is available.[23]

Those concerned about reduced service provision can downgrade both the seriousness with which such objections are held and the just freedoms that CO champions. Others

[20] Rhonheimer, M. 2011. The perspective of morality: philosophical foundations of Thomistic virtue ethics. Washington, DC: The Catholic University of America Press.

[21] Lachman, V. D. 2014. Conscientious objection in nursing: definition and criteria for acceptance. Ethics, Law and Policy, 23(3), p196.

[22] Lamb, C. 2016. Conscientious Objection: Understanding the Right of Conscience in Health and Healthcare Practice. The New Bioethics, 22(1). pp33-44.

[23] Lamb, C. Conscientious Objection: Understanding the Right of Conscience in Health and Healthcare Practice, The New Bioethics, vol. 22, no. 1, 2016

argue that upholding one's moral integrity should not require them to trespass on what is perceived to be acceptable, moral practice by others.[24] This is a relativist argument that fails to respect the nature of conscientiously-held conviction.

Provided the patient has capacity, and sufficient information, it should be the responsibility of the patient to seek out a doctor who has no such objection.

[24] Giubilini, A. 2014. The paradox of conscientious objection and the anemic concept of conscience: downplaying the role of moral integrity in health care. Kennedy Institute of Ethics Journal, 24(2), pp.159–185.