Religion and conscientious objection

Australia was one of the eight founding authors of the United Nations Universal Declaration of Human Rights (Australian Human Rights Commission 2021), adopted in 1948. Article 18 of the Declaration (United Nations 1948) states that:

> "*Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance.*"
> — United Nations (1948), Article 18

Clearly, freedom of religion is a right protected under the Declaration, and so it should be: countless numbers of people throughout history have been deprived of freedom and even life merely for their personal religious beliefs.

Importantly and equally, *thought* and *conscience* are protected. That is, religion is not endowed with a unique or pre-emptive privilege in protections under the Declaration. The right to religious freedom is equal to the right to freedom *from* religion — and of non-religious thought, conscience, or belief.

This gives rise to conflicts and moral dilemmas in the "*manifestation*" of belief or religion when different consciences come into contact. Some conflicts have easy answers: one person cannot compel another to attend religious service, nor prohibit another from attending.[37] Manifestation rights are both positive and negative: that is, to do or not do something. To refuse to participate in something for reasons of conscience is "conscientious objection" (CO).[38]

While the resolution of some conflicts is straightforward, others can be more complicated, especially in healthcare, where religious CO can create barriers to access for patients seeking a particular kind of lawful service, such as fertility planning or management, abortion, vaccination using material derived from foetal stem cells, or VAD.

In the first instance it's important to define conscience.

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[37] Assuming competent persons of the age of majority.

[38] One of the earliest records of CO is from ancient Greece: Socrates refusing an order to arrest a fellow citizen (Coady 2013).

> **What is conscience?**
>
> Conscience is the exercise of moral judgement via the interaction of a person's emotions and thoughts on matters of right and wrong, goods and harms (Waldmann, Nagel & Weigmann 2012). It reflects the private, internal judgement of an autonomous moral agent (Durland 2011).

Sulmasy (2008) argues that there must also be a commitment to morality itself, but this is to say that conscience can't exist unless there is prior deliberative reflection for it, which is clearly false.

Fry-Bowers (2020) provides a definition of CO as it relates to healthcare services:

> "[CO is] *refusal by a healthcare provider to provide certain treatments, including the standard of care, to a patient based on the provider's personal, ethical or religious beliefs*."
> — Fry-Bowers (2020)

CO's inherent nature is objection to *personal* participation in a defined course of action for moral (not legal or other) reasons (Coady 2013).

> Importantly, CO is not blanket prohibition, even though the objector may separately argue in favour of blanket prohibition. CO recognises that other consciences may differ and choose to pursue the objected course of action.

Numerous theses have been written in favour of CO (e.g. Goligher et al. 2016; Symons 2017; Trigg 2017). While religious accommodation may fail on "basic good" and "intense preferences" grounds, it has been argued to succeed on "personal good" grounds: the moral integrity of the objecting person (Bou-Habib 2006).

Blanket restrictions against CO are disproportionate and arguments for them are flawed (Maclure & Dumont 2017), with some arguing that CO deserves muscular legal protection (e.g. Fovargue & Neal 2015).

A wide range of legal provisions for CO exists across numerous jurisdictions around the world and is beyond the scope of this discussion. It is worth noting, however, the unusual case of Sweden where there is no right to professional CO, including for religious reasons. This is due to a national conviction regarding equality, non-discrimination, and the equal application of the law in public service provision (Munthe 2017).

Elsewhere, objections to CO are not in short supply. Bespalov (2019) argues that religious CO demands cannot be met without arbitrarily overriding the personal sovereignty of others. While true in many cases, the universality of this claim is open to question.

Other arguments propose that CO is fundamentally incompatible with ethico-legal considerations and undermines societal functioning (Munthe & Nielsen 2017); is an 'anaemic' concept (Giubilini 2014); offends patient requests for legally permissible treatments and interventions that ought to be respected (Beca & Astete 2015; Savulescu & Schuklenk 2017);[39] that such refusal itself violates medical ethics (Dickens 2009); that CO in practice can be indistinguishable from simple prejudice (Smalling & Schuklenk 2017); and that CO claims can be excuses to subvert patient access to the services (Savulescu & Schuklenk 2018) or for ideological agendas or attempts to impose certain moral values on society (Kuře 2016; Undurraga & Sadler 2019).

With such objections in mind, a 2016 international meeting of philosophers and bioethicists signed off the statement, "*Healthcare practitioners' primary obligations are towards their patients, not towards their own personal conscience*" (University of Oxford 2016). Again however, some argue this is disproportionate bias against service providers and symptomatic of increasing intolerance particularly towards religious CO (Stammers 2017).

Perhaps a clearer way of casting this conflict of perspectives is to ask: *to what extent and in what ways* should religious (or any other) objection's intolerance … be tolerated?

[39] Savulescu and Schuklenk's arguments in particular have drawn vigorous responses, see especially Hughes (2018).

> **What do doctors think?**
>
> Most US doctors (86%) believe that doctors are ethically obliged to present all lawful options to a patient, including ones they morally object to. If they morally object to the service the patient has chosen, they should refer the patient to a non-objecting doctor (71%) (Curlin et al. 2007).

Sincerity

One key question about CO is whether the underlying beliefs are held sincerely. Chapman (2017) argues that while it is unlawful to deliberately assess the accuracy or plausibility of a religious objector's beliefs, it is possible to assess whether they are held sincerely. This would be to unfairly target *religious* beliefs. If the sincerity of any CO belief is to be tested, non-religious and religious objections must face the same hurdles. In any case, such assessments are highly problematic for practical resource (administering tests) reasons, workplace (combative) culture reasons, lack of reliable tests (Smalling & Schuklenk 2017), and for other reasons (Su 2016).

Bridging the unrestricted/restricted/banned CO divide

While some argue that objecting doctors should be legally obliged to refer a requesting patient to a non-objecting supplier (e.g. Schuklenk 2015), others argue that CO should not be restricted (e.g. Trigg 2017). Part of the debate's complexity arises because the medical fraternity — or even a group within it — is the exclusive provider of certain services, and it can act as a *cartel denier* of patient rights through a monopoly position fuelled by medical paternalism (Cholbi 2015). There is evidence that the burden of CO "*falls disproportionately on vulnerable populations* [trying to access healthcare services]*, and that legitimate concern exists that moral disagreement is merely a pretext for discrimination*" (Fry-Bowers 2020).

McGee (2020) argues that as a provider of restricted (medical) services, when a doctor refuses to provide a requested service according to their own conscience, mutual respect of a patient's rights to act on their own beliefs entails an obligation to adequately inform the patient in a way that enables the patient to act on his or her own conscience: that is, to provide a referral.

In any case, such a referral is for a consultation and not for provision of the service. The patient may not qualify for the service, or decide ultimately not to pursue the service, which the referring doctor has failed to discern because he or she refuses to participate in even considering it. Thus, in the same way

referral to a heart specialist doesn't guarantee a patient will undergo heart surgery, referral to another supplier for a refused service is not a "prescription" for it.

Balancing the rights of healthcare workers and patients creates many challenges. CO with limitations seems to be the most balanced and reasoned solution (Fovargue et al. 2015) to avoid unwelcome negative consequences (Wicclair 2019), though debates will continue about the precise features of rights and obligations (Wester 2015), and the standards by which they are determined (e.g. Blackshaw 2019; McConnell & Card 2019; Zolf 2019).

Indeed, a key point is that *nobody's* right of conscience is unconditional since that would be to infringe the rights of others (Myskja & Magelssen 2018). Unfettered rights in either direction lack proportionality, regardless of whether they are founded on religious beliefs or not.

Class-based CO is not the same as treatment-based CO

One form of CO seems to draw nearly universal condemnation: refusal to treat a patient because of their background.

> **CO to treating classes of patients is wrong**
>
> "*Health care professionals are not conscripts, and in a freely chosen profession, conscientious objection cannot override patient care. No matter how sincerely held, objections to treating particular classes of patients are indefensible — regardless of whether the objections are based on race, gender, religion, nationality, or sexual orientation (AMA Code of Medical Ethics [Opinion 1.1.2]). A health care professional cannot provide medical services for a white, heterosexual person and conscientiously object to providing the same services to a Hispanic, Muslim, or LGBT person*."
>
> — *in* Stahl and Emanuel (2017)

Rather, it is generally accepted that where CO is permitted, it is limited to forms of *treatment*, not forms of *patient*.

Considerations of CO in healthcare form a useful starting point for deliberations about broader matters of CO across other public spheres like education and aged care services. Most of these services are in law delivered through *organisations* rather than directly by individuals. It is then that an institutional notion of *ethics* may make itself felt.

Summary: The United Nations Declaration of Human Rights grants everyone the right to freedom of thought, conscience, and religion (not just religion). Conscience is the exercise of moral judgement via the interaction of a person's emotions and thoughts on matters of right and wrong.

When a doctor's conscience dictates the refusal to provide a lawful treatment that the patient wants, the appropriate and proportionate moral balance is for the doctor to provide a referral to a doctor who doesn't object to offering the service. In this way, the objecting doctor's conscience to not deliver the service is respected at the same time that the patient's conscience to receive it is. To refuse a referral for assessment (a referral is not an "order" for treatment) is to abandon the patient to moral paternalism.

The confection of 'institutional conscience'

In addition to individual service providers, organisational or institutional providers might seek to object to particular services such as abortion, fertility planning or VAD being delivered within their facilities; or seek to ban people of whom they disapprove (e.g. LGBTI or single mothers) from working in their facilities.

In regard to VAD, state laws differ. Victorian law is silent on institutional objection. Consequently, Catholic healthcare institutions in Victoria refuse to allow not only VAD to occur, but deny access to initial consultations or even information about it in their centres (White et al. 2021). South Australian law, and proposed Queensland law, however, do not permit blanket institutional prohibition. Where the person is ordinarily a *resident* of the facility, the facility does not have a legal right to prohibit the person's access to VAD.

It is common to refer to institutional prohibition as "*institutional conscientious objection*" (e.g. Riga & McKenna 2021).

> The problem with "*institutional conscientious objection*" is that "*institutional conscience*" is a confection. It does not exist. And in practice it's used to entrench and protect religious dogma rather than serve a public of diverse consciences.

Conscience, as we established earlier, is the interaction of the private thoughts and emotions of a natural person in exercising moral judgement. But institutions are not natural persons: they're legal confections of 'personhood'.

While apologists may attempt to cast religious institutions as equivalent to a natural person with the same relevant characteristics, simple examinations show this to be misguided. For example, institutions can't marry but natural persons can. Institutions (of the relevant type) can sell equity interests (shares) in themselves, but natural persons cannot. Natural persons die but institutions don't — though they can in law be "killed off". There are substantial differences.

Conflating agency with conscience

The differences are thrown into sharp relief when a defender of "institutional conscience" argues that institutions are moral agents, and therefore have conscience, "*shaped by the mission of the institution and implemented by the structures of the institution such as budgeting and planning*" (Bedford 2012). This is to conflate *agency* with conscience. Agency is the ability to *act* (or

choose to not act). Conscience is a form of contemplation, not action. Either can exist without the other.

Back to the real nature of conscience: as legal confections, institutions don't *have* thoughts and emotions and therefore don't have consciences (Durland 2011). Neither can institutions *experience* a loss of moral integrity, guilt, shame, or injury to identity (Wicclair 2012).

Mission statements are not conscience: they're idealised descriptions of purpose and objectives.

Ideological *regulation*, not conscience

When an institution seeks to mandate or prohibit particular actions through a Code of Ethics or Code of Conduct (or mission statement or any other enterprise document), this is not "conscience". It's ideological *regulation* (Beca & Astete 2015). Insofar as it aims to apply penalties to violators of its prearranged conditions, it acts like law, not conscience.

In practice it *suppresses* conscience. For example, a patient in good conscience may request a lawful, medical family planning service and a doctor may in good conscience be willing to provide it. However, if the institution's Code prohibits family planning services for religious moral reasons, both the patient and doctor's consciences are arbitrarily suppressed by the rule. The rule demands that there be no moral dilemma or contest[40] because the institution has already arbitrated the matter. In this way, the gravitational pull of religious absolutism tends to rip actions out of others' control (Vacek 2017).

Institutional rules of objection are egregious when the institution is the only practical and realistic provider of the service, for example in a regional or remote centre.

It's even more egregious when the institution provides services to the public under funding from the public purse. That is to say that the community, the government, the doctor and the patient may all agree, and are footing the institution's bills, but the institution unilaterally decides that the service must not be provided.

In such cases an institution is not operating in the service of the public. It's operating in the service of its clerical masters. Such conduct demonstrates profound deficits of context, proportionality and consideration — significant elements of real conscience.

[40] In fact, there was no moral contest in the first place: the patient and doctor were of the same moral view.

This behaviour is not "*institutional conscientious objection*", it's "*institutional agency prohibition*".

From shield to sword

An important characteristic of CO is that it merely seeks to protect the conscience of the objector, not stymie the conscience of another person.

> In seeking to protect only the conscience of the objector, CO generally acts as a shield. However, if the exercise of the CO has the effect of impairing or blocking the objectee's exercise of his or her own conscience — whether intended or not — it is no longer a shield: it's a sword.

By way of example, Queensland is the latest jurisdiction to consider VAD law reform. President of that state's Australian Medical Association (AMA) branch, Dr Chris Perry, argued before a parliamentary hearing that institutions must be given carte blanche to prohibit VAD on their premises (Lynch 2021).

The consequences of failing to grant carte blanche rights to institutions, Dr Perry argued incoherently, was (a) that institutions would be forced to sell and exit so that "the town hasn't got one [a care facility]",[41] and then (b) that "*we don't want to see 30 per cent, potentially, of private hospitals and aged-care facilities being sold on to people whose bottom line is the shareholders and share prices and CEO's wages*."

In other words, the facilities would still be operating (not shut down), but under *other* private ownership: ownership that would respect the consciences of its patients and doctors when it comes to choosing end-of-life options. And shareholders who don't think that their own personal religious convictions should prevail over the clients their institution is sworn to serve.

Dr Perry may genuinely believe these incoherent arguments. But the institutions he refers to haven't come clean.

Bullying and hollow threats

The bullying undercurrent of this institutional incoherence is laid bare by recent developments. South Australia's parliament recently passed a VAD law. It disallows institutions from prohibiting access to VAD for persons who are ordinarily resident, that is, live, in its facilities. In that case, the person must be

[41] By which Dr Perry tacitly admits that in many places, the *only* facility available is a Catholic one, so prohibition by a facility effectively means prohibition in a region.

permitted to consider, be informed about, and finally choose to implement, VAD.

These provisions in the South Australian law were drawn from… the proposed Queensland legislation. They were even extended to include all forms of nursing and aged care homes — places where people *live*. It is now law in South Australia, ready to come into force when the VAD Act comes into effect.

And, since it is now law, what is the threat of mass exodus of objecting institutions from aged and healthcare service provision in South Australia?

The Catholic Leader recently published an opinion piece about South Australia's VAD law being passed, expressly noting that the law banned institutional prohibition for residents (Staff Writers 2021). The appropriate response, argued Catholic Archbishop Timothy Costelloe (of Perth), is for recommitment to strengthening communities of faith, and to support Catholic healthcare workers through prayer and encouragement. No mention of facilities being urgently stumped up for sale before South Australia's Act comes into effect.

Indeed, the Catholic church might have a sense of the substantial negative PR such a move would create — a petulant church that refuses to respect the views of most Australians — contributing to an accelerated exodus of its flock.

That exodus is already biting hard. Melbourne Catholic Archbishop Peter Comensoli has announced a consolidating restructure of almost 200 parishes across Melbourne as a result of parishioners abandoning the pews (Tomazin 2021), warning that the church could "*sink into the sunset*".

There are other reasons the church might be reluctant to sell its care facilities and operations. Sales would convert non-current assets (infrastructure) to current assets (cash), which would make a larger portion of the church's asset base available to compensate victims of sexual abuse that occurred under its auspices. It would at the same time reduce the fixed asset base against which borrowings could be made.

Catholic accommodation already occurs overseas

In any case, in practice, VAD is already being accommodated in Catholic institutions overseas. Professor Barbara Glidewell reports that in Oregon, when a patient is going to consume VAD medication, hospice objectors are advised, and step outside the room so they don't bear witness.[42] "*Then, they step right back in the room and support the patient and family*," she said.

[42] Personal on-camera interview with myself and The Hon. Ken Smith, former Speaker of the Victorian Parliament. Video on file.

Similarly in Belgium, those who object are respected and given plenty of warning so they can avoid being present when VAD is to occur, including within Catholic institutions (e.g. see Julie Blanchard *in* Devos 2021). These compassionate compromises seem consistent with the views of Archbishop Vincenzo Paglia, President of the Pontifical Academy for Life in Rome, who says that priests can be present after consumption of lethal medication because "*the Lord never abandons anyone*" (Brockhaus 2019).

Australia's Catholic hierarchy has yet to demonstrate this compassion, judgement, and respect towards others. As a consequence, many Australians are demonstrating what they think of this brand of institutional regulation: real consciences and their associated bottoms are abandoning the pews in increasing numbers.

Summary: Conscience is the exercise of moral judgement via the interaction of a person's emotions and thoughts on matters of right and wrong. Institutions are confected legal persons and don't have consciences. Institutions arguing for "conscientious objection" conflate agency (the ability to act) with conscience (the mind's ability to weigh thoughts and emotions in judgement).

Institutional documents like mission statements and codes of ethics or conduct are not conscience. They're regulations. The gravitational pull of their religious absolutism *suppresses* real conscience as though it doesn't exist, thereby acting as a sword, not a shield.

In any case, religious institution threats to abandon service sectors unless their absolutist regulatory demands are met have, to date, been demonstrated as hollow.

Religion and authority

Chaves (1994) has argued that the rise in (western) secularisation is not so much about a decline in religion, but a decline in religious *authority*, that is, decreasing confidence in religious leaders. General Social Survey data in the USA shows a clear downward trend of public confidence in religious leaders since the 1970s (Hoffman 2013).

Regarding Australia, we have already established that both religion and religiosity are falling significantly, and that scepticism towards theology and opposition to clerical social conservatism are key factors. These indicators reveal that a decreasing number of Australians are willing to accept religious leaders or their institutions as authoritative in daily life. More detailed data reveals a divide between Australia's most religious, and the rest of the nation.

Democracy = Clerics ultimately interpret the laws

Just 6% of Australians say that a somewhat or quite essential feature of democracy is that religious authorities ultimately interpret laws (Figure 44).[43] Most Australians (80%) actively disagree.

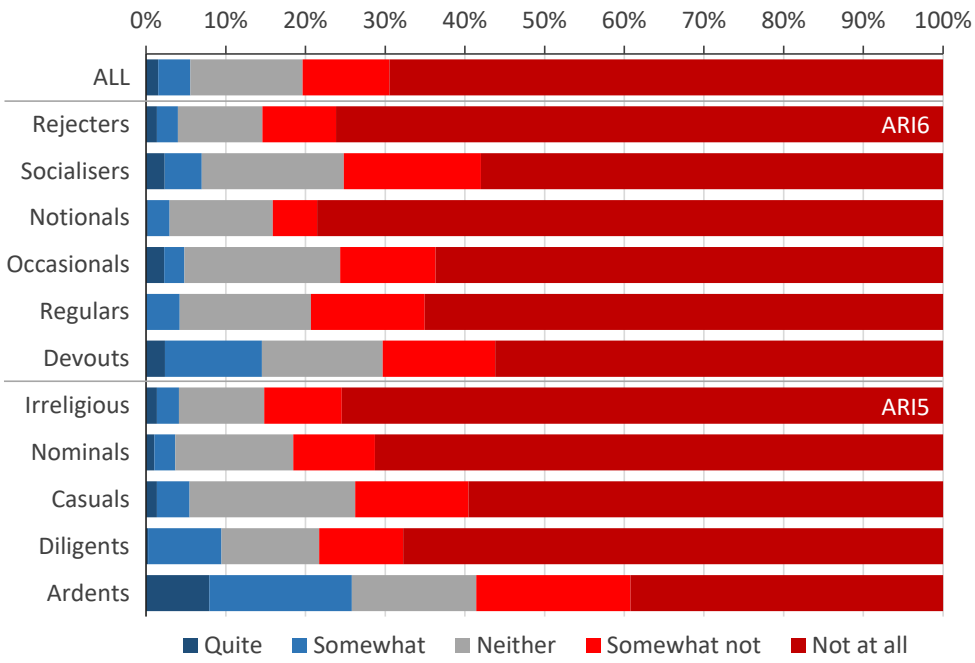

Figure 44: 'Religious authorities ultimately interpret laws' is an essential feature of democracy, by ARI6 and ARI5
Source: AVS 2018

[43] The question doesn't distinguish whether the respondent believes it *is* (normatively) the case, or believes it is *desirable*. The data suggests a small base of normative responses.

Notionals are the most likely to *strongly* disagree with ultimate clerical authority, suggesting that they never attend services because they disagree with what they have heard from religious leaders.

By religiosity, small minorities of ARI6 Devouts (15%) and ARI5 Ardents (26%) are more likely than all others to favour ultimate clerical interpretation of laws.

Of Australians who say that religious authorities ultimately interpreting laws (6%) is a feature of democracy, more than half (57%) say that people should obey their rulers. We might loosely interpret this as just 3% of Australian adults, or fewer than one in 30, saying that Australians ought to obey religious authorities above anyone else.

Democracy = Obedience to rulers

By religiosity, ARI6 Devouts and ARI5 Ardents are more likely than other Australians to say that people should obey their rulers (Figure 45).[44] Notionals, again, are the most likely to disagree.

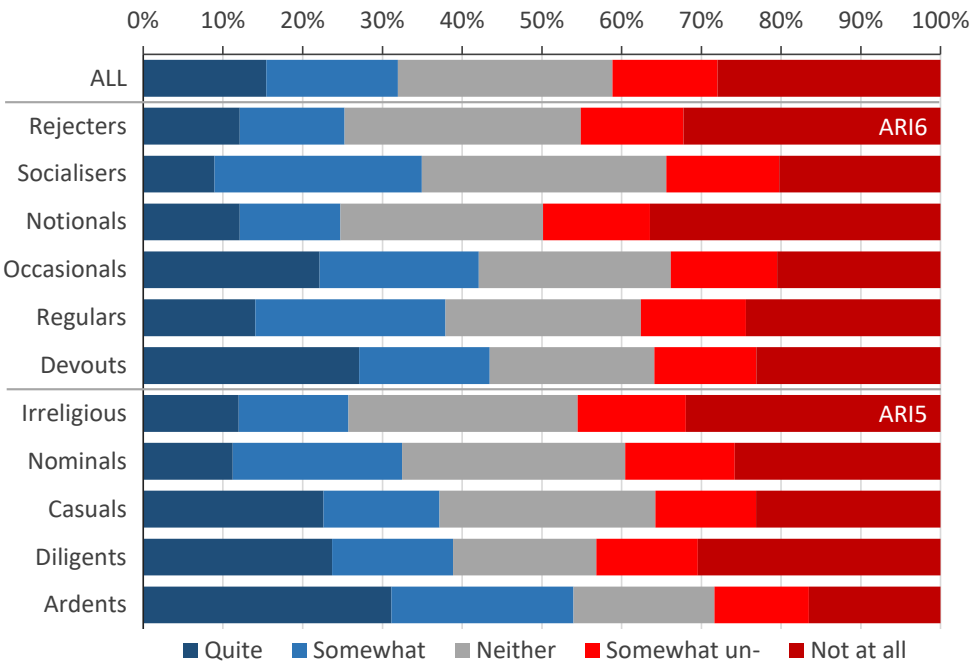

Figure 45: 'People should obey their rulers' is an essential feature of democracy, by ARI6 and ARI5
Source: AVS 2018

[44] There is ambiguity in this question, too, in that obeying government directives is sometimes desirable (e.g. Covid-19 isolation arrangements), but other times undesirable (e.g. don't protest government decisions).

Control of both parliamentary houses of federal parliament

Australia's Devouts are also the most likely to say that democracy is better when a government controls both houses of the federal parliament (Figure 46), showing that their favourable attitudes toward authority and control may be general in nature.

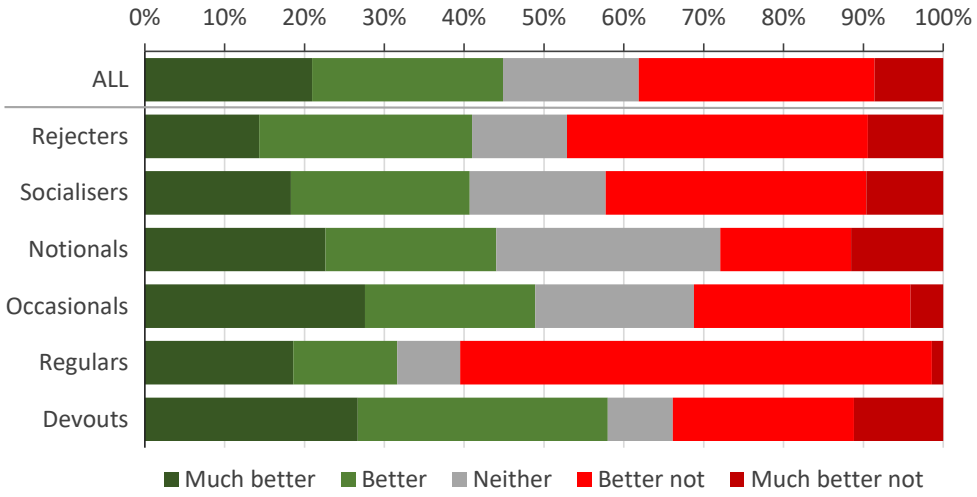

Figure 46: Democracy when government controls both federal houses, by ARI6
Source: AES 2019

Devouts' attitudes toward power and control are not universal, however, as Devouts are the most likely to say that having a strong leader unbothered by parliaments and elections is a very bad idea (Figure 47). They're also the most likely to say that living in a democracy is important, inconsistent with favouring individual strongman politics.

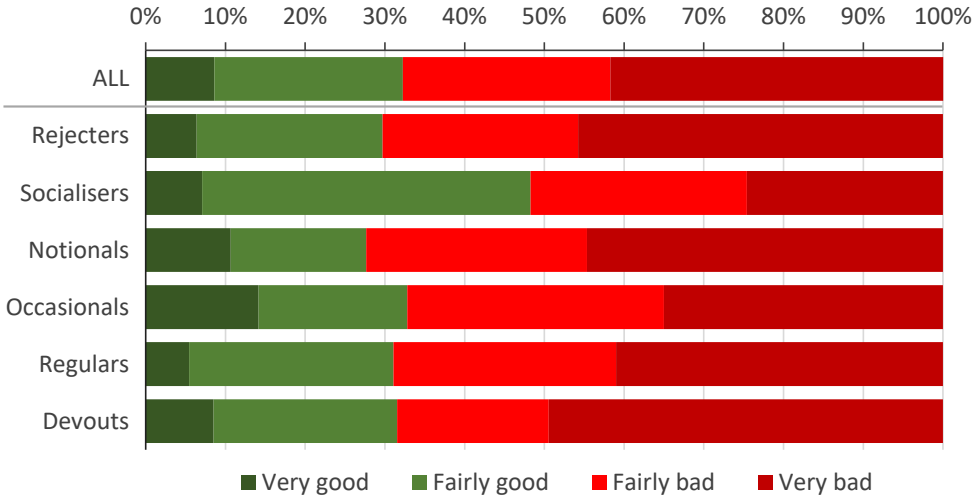

Figure 47: Strong leader unbothered by parliament/elections, by ARI6
Source: AVS 2018

One third (33%) of adult Australians say that a strong federal leader who is unbothered by parliament or elections is a good idea. This suggests that Australia may be somewhat vulnerable to appointing a populist and unconsultative leader as has happened in several other countries. This deserves national attention to ensure citizens are informed about the value of representation and debate.

Citizens should participate in important policy decisions

Devouts' attitudes toward political control are highlighted by the fact that uniquely, nearly two thirds (62%) think citizen participation in important policy decisions is a *bad* idea (Figure 48). This helps explain Devouts' hostility to the government hosting a national plebiscite on marriage equality in 2017.

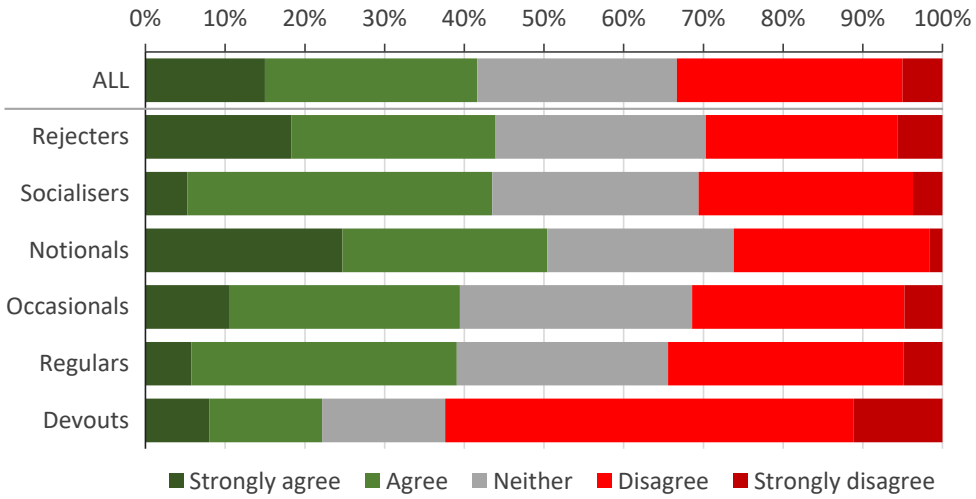

Figure 48: Citizens should participate in important policy decisions, by ARI6
Source: AES 2019

Summary: Small but significant numbers of Australia's most religious, Devouts, believe that religious authorities should ultimately interpret law. Most Australians disagree. Devouts are also somewhat more likely to say that people should obey their rulers, though opinions are divided across the religious spectrum. Devouts favour government control of both houses of parliament more than others do, though they favour a political strongman leader *less*. Nearly two thirds (62%) of Devouts say citizen participation in important policy decisions is a *bad* idea, helping explain their hostility to the federal government hosting a plebiscite on marriage equality in 2017.