Members of the Christian Medical and Dental Fellowship of Australia (CMDFA) are grateful that our country is a signatory to the International Covenant on Civil and Political Rights (ICCPR), part of which concerns the protection of religious freedom. We are grateful as Christians but also on behalf of Australians who adhere to different religions, or to no religion at all.

We appreciate, therefore, the intent of Article 18 of the ICCPR that:
1. ‘Everyone shall have the right to freedom of thought, conscience and religion... (and the right) to manifest his religion or belief in worship, observance, practice and teaching.’
2. ‘No one shall be subject to the coercion which would impair his freedom to have or adopt a religion or belief of his choice’

We are concerned with the consideration of the ICCPR that:
3. ‘Freedom to manifest one’s religion... may be subject only to such limitations as are prescribed by law’...

but we understand and accept that such limitations include those ‘necessary to protect public safety, order, health, or morals, or the fundamental rights and freedoms of others’.

In the light of the ICCPR, we wish to raise our concerns over Section 8, subsections 5 and 6 of the Religious Discrimination Bill 2019 as conveyed in Exposure Draft (29 August 2019) because we fear those provisions may strengthen or, at least, fail to reduce current restrictions on the ‘observance, practice and teaching’ of our beliefs.

The subsections confirm the Commonwealth accepts that the legitimate conscientious objections of health practitioners should be overruled by state laws despite the promises that the Commonwealth has made to the international community to fully protect those legitimate conscientious objections. We hold this unfortunate because we consider the current Victorian and Queensland laws with regard to abortion provide inadequate protection for conscientious objection. We
consider it tragic that genuine and reasonable concerns about the taking of human life should be trampled upon by state laws. Because the practice of medicine is regulated by the Australian Health Practitioners’s Regulatory Authority (AHPRA) at a Commonwealth level, we think the conscience of medical practitioners should also be protected at a federal level and that inconsistent state laws should be rendered inoperative by Commonwealth laws passed to protect medical practitioner conscience.

The Victorian Abortion Law Reform Act 2008 Part 2, section 8, declares that if a ‘woman requests a registered health practitioner to advise on...or to perform, direct, authorise or supervise an abortion...and if the practitioner has a conscientious objection to abortion, the practitioner must...

(a) Inform the woman that the practitioner has a conscientious objection to abortion and
(b) Refer the woman to another registered health practitioner...who the practitioner knows does not have a conscientious objection to abortion.

Similar legislation pertains in Queensland’s Termination of Pregnancy Act 2018 according to which, if a woman requests a ‘registered health care practitioner to perform ...or advise (on an abortion)’ and the practitioner holds conscientious objections ‘the practitioner must refer the woman, or transfer her care, to...’ a health care provider without such objections.

Few, if any, would, object to the exemptions on conscience contained in both Victorian and Queensland law with regard to medical emergencies in which continuation of the pregnancy would endanger the life of the mother, or in the situation of multiple foeti, in which one was endangering the life of another.

As declared in the Victorian Act Section 8 subsections 3 and 4, a ‘medical practitioner is under a duty to perform an abortion in an emergency where the abortion is necessary to preserve the life of the pregnant’ and, under those circumstances ‘a registered nurse has an obligation to assist’. We understand the reasons for these provisions and are glad such life and death considerations are rare, and almost always managed by specialist obstetricians and others, in specialised units in our country.

Our concerns are based on broader, ‘social’ issues with limited or no medical relevance. Perhaps they are best exemplified by the plight of Dr Mark Hobart in Melbourne, who, according to the Herald Sun in 2013 ‘refused to refer a couple for an abortion because they only wanted a boy’. Subsequently, Dr Hobart received a letter from AHPRA advising him the Board had initiated an inquiry into “your professional conduct, following receipt of information that indicates you may have... Failed in your obligation to refer a female patient seeking treatment or advice on abortion to a non-objecting practitioner.”

With legalisation of late term abortions, requests for termination are predicted to intensify the issues of life and death. Abortions may be induced in one delivery suite with babies of similar gestation undergoing resuscitation in another. We worry about the effect this dichotomy will have on the morale of staff and students. Furthermore, the lives of otherwise viable babies may be terminated, simply for being of the wrong sex. As the least desired sex appears to be female, the worries are compounded by sexism. Finally, we worry about the spectre of an aborted baby who has managed to survive delivery but will be consigned to wriggle, gasp and get colder until death.

It appears it is hard for some to understand the degree of distress that others feel over the taking of human life, and their repugnance, one way or another, in being forced into the process. It has become unfashionable to recall the ugly, but not distant, history of human behaviour under the National Socialist Party of Germany in the 1930’s and 40’s. Some recollection of those events are, however, relevant, especially because their depredations inspired current manifestoes of human rights.

Much condemnation was levelled at perpetrators of the horrors of Germany who claimed they were merely ‘following orders’ and were, therefore, not guilty: they were merely following the laws of the Socialist state. After the war, outsiders wondered why human conscience did not raise more objections? Why did so many medical practitioners capitulate? The answer lies, at least, in the power of intimidation reinforced by the example of punishment.

Though, clearly, Australian society is not that of earlier Germany, the Victorian and Queensland states’ abortion laws are intimidatory and promise to be punitive. They fail to recognise that the conscience of a medical practitioner may be as challenged as that of a person in Germany who was demanded by the state to identify a person of Jewish faith or, simply, a
child of less than acceptable intelligence. Though not actually closing the door on an oven, or administering a lethal concoction, that person would have to live with a conscience that recognised personal responsibility for initiation of a process. And, what about the conscience of practitioner or student who stumbles upon an aborted but still living baby who would otherwise be resuscitated? Should that practitioner reject the practice of his faith which would insist on action?

Perhaps it is hard in these post-modern days in which truth is deconstructed, for authors of legislation to understand that others may be bound by a meta-narrative that life should be preserved: that history reveals human nature has not earned the right to decide who lives or dies. Conversely, perhaps the authors are well aware that some are bound by ‘eternal truths’ whose ‘observance, practice and teaching’ needs to be contained by legislative measures. If so, the Commonwealth is requested to provide leadership against discrimination.

Allied to the concept of ‘teaching’ is open discussion on such matters as abortion, euthanasia and gender with patients, families, medical students, other practitioners and staff. Essential to the concept of autonomy, which is fundamental to medical ethics, is the obligation for full disclosure of all aspects of medical care. With regard to abortion this would include the possibility of alternatives such as adoption, including of handicapped children, issues related to future procreation, foetal pain, the actual mechanism of abortion, the intended management of those born alive, and the possibility of psychological effects of regret.

Article 41 of the intended Act does not assure that full autonomy will be ensured. It declares in Subsection (1) ‘a statement of (religious) belief does not constitute discrimination...’ However, such statements would be considered discriminatory according to Subsection (2) if they were deemed to be ‘malicious’, or ‘likely to harass, vilify or incite hatred or violence against another person or group of persons’.

Definition of the word ‘vilify’ is not precise and can be used to stifle legitimate discussion on the procedures and risks of abortion. No Christian would tolerate harassment of a woman seeking an abortion, let alone inciting hatred or violence against her. But compassionate discussion, and reasoned explanation to students and the public could be claimed to be ‘vilification’ given the imprecision of the term and the determination of some to stifle all debate. The word ‘vilification’ should be removed from the Bill. It is too inflammatory.

Perhaps some legislators have forgotten that members of the early Church distinguished themselves and their commitment to Life by rescuing abandoned babies from the fields of Rome, contrary to social practice and in the likelihood of persecution. Has it been forgotten that the spirit of agape love...self sacrificial, non-judgemental, persistent commitment to the ‘widows and fatherless’, regardless of wealth, race and creed...inspired our forefathers to institute hospices, centres of medical learning, hospitals and orphanages throughout the world, and are still doing it, despite hardships and danger. This commitment is inspired by the Belief that life is invaluable and humans have no right to kill. It appears fashionable to deny the contribution of Christianity to past and present medical care but that contribution is real, if not fundamental, and continues. It is historically unfair to discriminate against the Faith that has contributed so much, to so many.

The commitment to the ‘widows and fatherless’ is an Old Testament commandment, rejuvenated in the New. Of course, it means all mothers, all women and all children, including those not yet born, and those with disabilities. Does the Federal government wish to stifle such agape commitment? And, if so, what then?

Does Federal parliament really want a medical profession with deconstructed ethics? One whose ethics are ‘institutionalised’ to prevailing opinions? Would it not prefer practitioners to be inspired, though human themselves, with concepts of unchanging truths? Is it not safer for everyone to have a profession committed to the simple commandment ‘thou shalt not kill’?

The issue of conscience is not confined to abortion but extends, of course, to euthanasia and other social experimentation. It also extends beyond medical practitioners to, in our case, medical students, but even more broadly to staff in all employments that could be caught up in the process of medical killing, from administration to cleaning.

We should not overlook the ward clerk who fills in the forms, or the porter who transports the corpse to the mortuary because, for example, Queensland Health, declares ‘Conscientious objection only applies to individual health care providers working in a facility and not to the whole facilities.’ In answer to the question ‘When does conscientious objection not apply?’ Queensland Health emphasises ‘The conscientious objection provision...does not extend to administrative,
The broader intention of the Queensland Act is to bring ‘the whole facilities’ into line with practices that permit the taking of human life. This will disrupt ‘faith based institutions’ that have been providing services to the public for many years. Will the public be served if faith based maternity hospitals are forced to close on the issue of abortion? Let alone the injustice involved in closing these facilities which have contributed so much for so long, CMDFA is concerned about the capacity of the public system to digest the added burden. Ironically, the well-being of many mothers and babies will be challenged in the name of the right to take human life.

To ensure the subjugation of the institution and its members, Queensland Health insists ‘All health care facilities must have in place clearly defined and communicated processes that will facilitate awareness and understanding of Conscientious Objection’. This may include the establishment of ‘champions who will ensure...the understanding)... ‘rights and obligations’ of the Act, ‘support...(practitioners)...‘formally document their objection’ and record information on ‘the number of referrals of women to other services because of Conscientious Objection.’

Reference to an earlier Germany can be over-wrought but the institutions of that country, once celebrated for its human progresses, were one way or another recruited to a national programme of the ending of lives. Ethics were fragmented: People coerced to report or refer; While ‘champions’ ensured obedience and kept immaculate records.

In summary, CMDFA requests the Federal Government to give special attention to the following points.

(1) CMDFA requests the Commonwealth to demonstrate leadership in the protection of Conscientious Objection. As medical registration is now a federal issue under the Australian Health Practitioners’ Regulatory Authority, protection should be elevated to national from state authority. Practitioners should be protected from the vagaries of states with regard to discrimination on the grounds of religion, should religion be the reason for objection to the taking of life. Only the Commonwealth can ensure consistency of protection.

(2) Practitioners should not be obliged to transfer care for procedures that confront their consciences. There is sufficient information available at all levels for a patient to identify resources of their own choice. The current legal obligation appears to be of no greater purpose than that of intimidation for obedience by the practitioner. It is discriminatory against those, on religious grounds, who are objecting to the taking of life.

(3) Similarly, the creation of ‘champions’ to monitor the activities of doctors appears to have no practical role than intimidation. The Federal government should intervene to promote cohesion of staff, avoiding inevitable divisions that will reduce the capacity for patient care.

(4) Medical students should not be obliged to witness or take any part in procedures that confront their consciences. Does the Commonwealth want to nurture a generation of practitioners who are afraid to act on their ethical convictions?

(5) The right of conscientious should be extended to all people in a public institution. Not to do so is to discriminate on the grounds of employment. The religious sensibilities of a porter are as worthy of protection as those of medical practitioner. They, too, would benefit from Commonwealth leadership.

(6) The imprecise word ‘vilification’ should be removed because of its possibility of abuse.

CMDFA acknowledges the freedoms of Australia and has some understanding of the pressures of government. It does understand the obligation to care for the ‘widows and the fatherless’, and assures the Federal government of its commitment to continue the relentless application of, as the Bible teaches, agape love.

CMDFA confesses, however, that its members are but human. It requests the Federal government to protect its members from undue intimidation, and the inner stress of serving both Caesar and God. We wish to be able to serve Caesar but our inner conviction with regard to the taking of life is for God and, what we believe is inherent in His Love for mankind: our commitment to human life.

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