

Professional conscience



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Obstetrics is second only to cosmetic surgery for the proportion of legal claims made against it and obstetrics is the specialty most exposed to large claims.¹ Obstetricians are not likely to be more prone to negligence than any other medical specialty, so one can assume that the risk is related to the nature of the work itself.

Obstetrics and gynaecology is more likely than most specialties to involve differences of opinion about the morality of some of the procedures involved. It often finds itself in controversy. That may be partly due to the intrinsic nature of a profession that often deals with two patients simultaneously. While what is good for mother is most often good for baby, there are circumstances in which the interests do not so exactly coincide and dilemmas arise. Partly, the controversy may be due to the different values our pluralist society attaches to the importance of fertility and sexuality.

No one in obstetrics and gynaecology is immune from having to make ethical decisions and thus having to take a stand on their own values with respect to what they are prepared to do.

Those decisions are in large part made according to the perception that the individual practitioner has a vocational role in medicine. The decision about who a doctor is, what the aims of the work are and what makes a good doctor, shape the conscientious application of medical science. Science does not shape conscience. The evidence does not determine the vocation, but rather the vocation guides action in response to the evidence. Science cannot tell us what to do.

In the drafting of ethical guidelines, it has become the practice for the National Health and Medical Research Council (NHMRC) to first identify the ethical values and principles to be applied. This is not thought to be determined by science, but by the moral sense of the community. The function of the Australian Health Ethics Committee, with its diverse membership, is to try to identify a consensus on those values.

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A major value identified is respect for human beings, which is a recognition of their intrinsic value. In human research, this recognition includes abiding by the values of research merit and integrity, justice and beneficence. Respect also requires having due regard for the welfare, beliefs, perceptions, customs and cultural heritage, both individual and collective, of those involved in research.²

However, some see medicine as being less a professional vocation and more as an expertise, a morally neutral servant to the autonomy of the patient. The values to be applied are the patient's values.

The doctor's values do not enter into it. That perception is a sad one, because it diminishes the dignity and integrity of the individual professional. 'Professional' comes to mean the application of technical expertise, rather than professional judgement.

In this context of 'deprofessionalising' the medical profession, there has been a push for what is called reproductive rights, the right to insist that a doctor provide reproductive medical services regardless of the doctor's own personal views about the procedures involved. Against such claims, in 2004, the NHMRC promulgated 'Ethical guidelines on the use of assisted reproductive technology in clinical practice and research'. The guidelines were re-issued in 2007 with changes to accommodate the cloning legislation. Compliance by Australian IVF teams with the guidelines is secured by the terms of the funding agreements with the Commonwealth and by the administration of standards by the Reproductive Technology Accreditation Committee (RTAC).

The guidelines require that pre-implantation genetic diagnosis of embryos (PGD) must not be used for:

- Prevention of conditions that do not seriously harm the person to be born;
- Selection of the sex of an embryo except to reduce the risk of transmission of a serious genetic condition; or
- Selection in favour of a genetic defect or disability in the person to be born.

This restriction may challenge those who uphold the notions of reproductive rights and reproductive freedom, especially those who are of the view that it is their right to choose the sex or other genetic features of their child.

IVF practitioners also raise questions about whether they can withhold IVF from a person who is, for instance, a convicted paedophile or a patient who already has other children who have been taken into care.

The overall rationale adopted by the NHMRC for restricting choice in the use of reproductive technology is that: 'Clinical decisions must respect, primarily, the interests and welfare of the persons who may be born, as well as the long-term health and psychosocial welfare of all participants, including gamete donors.'³

The jurisprudential dialogue about reproductive rights occurs against the background of the legal tradition that the interests of the child are paramount. This principle found expression in the United Nations Convention on the Rights of the Child, which recognises, amongst other matters, the rights of the child to an identity, a nationality, family relations, and, to personal relations and direct contact with both parents. In this respect too, family law has been based on the notion that the interests of the child are paramount. Family law restricts parental choices and resolves conflicts in favour of the welfare of children.

The fact that there are conscientious decisions to be made by those who practise obstetrics and gynaecology raises questions about what happens when practitioners disagree on what is the right ethical decision.

The NHMRC, in several recent sets of guidelines, has indicated the need to respect conscientious objection. For instance, the guidelines on use of foetal tissue in research state:

'Those who conscientiously object to being involved in conducting research with separated fetuses or foetal tissue should not be compelled to participate, nor should they be put at a disadvantage because of their objection.'⁴

Similarly, 'no disadvantage' clauses can be found in guidelines on organ donation and brain death, assisted reproductive technology (ART), the use of stem cells and medical research.

Finding oneself in a position in which one's own ethical values conflict with what is expected is not easy. Conscientious objection needs to be exercised responsibly so as not to put the patient in danger and in a spirit of mutual respect for the consciences of others. The NHMRC notes that a person who exercises conscientious objection to participate in an activity ought not to undertake activities within the institution or directly involving the institution that might undermine confidence in other professionals within the institution.⁵

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The exercise of conscientious objection also needs to be open to discussion so that others can at least see that there is a rationale for the view, even if they disagree. Part of the function of conscientious objection is to give witness to what one believes. That is an important part of what very often is a situation in which one is cooperating with others and that cooperation may be morally compromised if it implies an acceptance of unethical practices. The explanation is needed for the sake of the person who wishes to withdraw and for the sake of others who need to understand that that is the case.

The idea of 'secular neutrality' puts a person with ethical scruples at some kind of disadvantage. Their freedom to act rationally, sensibly and according to the evidence may be thought to be impeded by their ethical values.

The judgement that we live in a secular society may reflect an historical aberration, a modern phenomenon and largely an exclusively Western phenomenon, the recent judicial difficulties of Turkey's ruling AK Party notwithstanding.

The philosopher Charles Taylor, in his recent book, *A Secular Age*⁶, suggests that a secular society may be one in which one can engage fully in politics without ever encountering God. Apart from some vestigial prayers on such an occasion as the opening of Parliament, now to be preceded by a welcome from the original owners of our land, (or an occasional speech from a member of a minority religious party who became elected through the vagaries of the system for electing upper chambers and inter-party dealing on preferences), Australian politics are basically secular according to Taylor's characterisation.

In another sense though, Australia is even more secular than our American counterpart. In 2005, only 40 per cent of Australian marriages took place in the presence of a minister of religion.⁷ America, despite a rigorous separation of Church and State, is the Western society with the highest statistics for religious belief and practice. Religious practice in Australia is in decline. Therefore, a secular society may mean a society in which people are predominantly not religious by belief or practice. In that case,

though constitutionally secular, one would not describe Turkey as secular, given the vast majority of the population is Muslim, with 95 per cent declaring their belief in a God.⁸

Taylor however identifies a third sense of secularism, by which he means to refer to the rise of the alternative of secularism as a form of belief.

A society may be secular in the first sense of religion not being a part of public life, the so-called separation of Church and State. It may be secular in the second sense of declining religious belief and practice. Finally, it may be secular in the sense of secularism emerging as an alternative belief form.

It seems to me that it is the latter we are witnessing in Australia and it appears as a very aggressive, exclusionist form of secularism which views personal ethical values, particularly religious values, with arrogant intolerance and dismissiveness. This kind of secularist belief is characterised by attempts to exclude contributions to public discussion on the basis of a kind of bigotry that classifies the contributions of persons who have ethical scruples or who are religious in a nominalist way. Perhaps even more significantly, this kind of secularism is a claim that undermines all those in the health professions who see themselves as more than just technical experts, those who see themselves as having a vocation to serve the human good.

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