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PROJECT TEAM
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Rocco Mimmo, LLB, LLM
Ambrose Centre for Religious Liberty,
Sydney, Australia

Administrator
Sean Murphy

Submission to the Parliamentary Inquiry into Freedom of Conscience in Abortion Provision

11 July, 2016

Introduction:

The Protection of Conscience Project is a non-profit, non-denominational initiative that advocates for freedom of conscience in health care. The Project does not take a position on the morality or acceptability of morally contested procedures.

I am making this submission on behalf of the Project, using the template format provided. The eight questions of interest to the Inquiry are answered in the following pages. As requested, responses have been kept to fewer than 500 words.

The Project's submission may be made public by the Inquiry.

Sincerely,

Sean Murphy, Administrator
Protection of Conscience Project

Revision Date: 2016-07-29
(End note hyperlinks)

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

Yes.

Abortion has developed technologically and now includes medical and surgical methods, but, generally speaking, remains the deliberate killing of a developing human individual at some point between implantation in the uterus and birth, either directly or by premature delivery intended to cause death. The moral arguments against abortion have been refined and somewhat expanded since 1967, but their focus is substantially unchanged. The common moral argument against abortion is that killing a developing human individual is wrong, either in all situations, or in all situations except those in which an abortion is believed necessary to save the life of the mother.

Even physicians willing to provide abortions may, for similar reasons, decline to do so after a certain point in a pregnancy.[1] That abortion involves decisions about the life and death of a developing human individual was underscored when the British Medical Association recommended the development of policies to protect dozens of infants annually who survived late term abortions. [2, 3]

Either supporting abortion or opposing it inescapably entails moral judgement about killing human individuals, so it is not surprising that, almost fifty years after the *Abortion Act* received Royal Assent, abortion remains a morally contested procedure. While activists generally do not expect objecting physicians to provide abortions themselves, they often demand that objectors refer a patient to an abortion provider and otherwise collaborate in the provision of abortions.[4] Many objecting health care providers are unwilling to do this because they believe that they become morally complicate in abortion by facilitating it through referral or other means.

Hence, the most serious ongoing conflict with respect to freedom of conscience and religion in relation to abortion arises because of continuing attempts to force objecting physicians to refer patients to abortion providers. It is of grave concern that some activists, influential academics, powerful interests, state institutions and professional organizations have been working steadily to develop and entrench a 'duty to do what is wrong' in medical practice, frequently beginning with compulsory referral for abortion, but - as amply illustrated in Canada - applying the same principles and arguments to impose compulsory referral for euthanasia and assisted suicide.[5,6]

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?

No.

The courts in the United Kingdom have interpreted the term "participation" in the *Abortion Act* too narrowly. The leading case on this point, *R v Salford Health Authority, Ex p Janaway* [1989] AC 537, was not argued or decided on the basis of human rights legislation or jurisprudence because neither existed in the United Kingdom at the time. The arguments and the decision did not address freedom of conscience or religion. Instead, they addressed issues of criminal liability by an accessory, and the advisability of applying the criminal law on accessories to the meaning of "participation" in the *Abortion Act*. In *Doogan and Wood* [2014] UKSC 68 the Supreme Court of the United Kingdom explicitly set aside human rights law, including requirements to accommodate

freedom of conscience and religion. It confined itself strictly to determining the meaning of "participation" in the *Abortion Act*, and followed *Janaway* in its ruling.

That this definition is unacceptably narrow within the context of freedom of conscience is demonstrated by the review of a euthanasia bill by the House of Lords Select Committee on Assisted Dying for the Terminally Ill (2004-2005). The original bill included a requirement that objecting physicians refer patients for euthanasia. Numerous submissions protested this provision because it made objecting physicians a moral party to the procedure,[7] the same reason given by many objecting physicians who refuse to refer for abortion. The Joint Committee on Human Rights concluded that the demand was probably a violation of the *European Convention on Human Rights*.[8] The bill's sponsor, Lord Joffe, promised to delete the provision in his next draft of the bill.[9]

Despite the example provided by Lord Joffe's bill, in *Personal Beliefs and Medical Practice* (2013) the General Medical Council (GMC) adopted Janaway's narrow interpretation of "participation" with respect to abortion.[10] In addition, *Personal Beliefs and Medical Practice* requires objecting physicians to arrange for morally contested services like abortions in at least some circumstances.[11] The British Medical Association, based on *Janaway*, asserts it "would seem to support the view" that objecting physicians are obliged to refer.[12] The Royal College of General Practitioners asserts that objecting practitioners "must arrange to refer a woman requesting abortion to another doctor immediately and without delay."[13]

See also the response to Question 5.

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?

No.

See the response in (2) concerning *R v Salford Health Authority, Ex p Janaway* [1989] AC 537, *Doogan and Wood* [2014] UKSC 68 and Lord Joffe's euthanasia bill.

The Royal College of Midwives (RCM) intervened against the plaintiffs in the Doogan case at the Supreme Court. The College position statement on abortion not only adopts the narrow *Janaway* definition of "participation", but does not recognize any right to freedom of conscience with respect to abortion in Northern Ireland, and puts the organization in fundamental conflict with midwives who object to collaborating in the procedure.[14]

The Royal College of Nursing (RCN) adopts the narrow *Janaway* definition of "participation", and does not recognize any right to freedom of conscience with respect to abortion in Northern Ireland.[15]

The Nursing and Midwifery Council, following *Janaway* and *Doogan*, states that nurses "can only make a 'conscientious objection' in limited circumstances" and must find someone to provide the service to which they object.[16]

See also the response to Question 5.

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.

Yes.

A settlement reached in Ontario following a human rights complaint resulted in accommodation of objecting nurses formally set out in hospital policy:

- Markham Stoufville Hospital Policy: *Termination of Pregnancy- Religious Exemption* (April, 1999).[17]

A settlement in New Mexico to accommodate nurses who object to infant male circumcision demonstrates an approach that can be applied to abortion.

- St. Vincent Hospital, Santa Fe, New Mexico, *Memorandum of Understanding for Circumcision Procedure* (31 January, 1995)[18]

Note that both agreements distinguish between pre-operative and post-operative care. Objecting nurses are expected to provide the latter, not the former.

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.

Yes. The following examples are from the United Kingdom.

1) In 1973, Dr. Robert Walley, an obstetrician gynaecologist opposed to abortion, was told "there is no place for to practice within the National Health Service unless you are prepared to change your views or to re-specialise in another field." As a consequence, he emigrated from the United Kingdom to Canada.[19]

2) In 1989, during debate in the House of Commons, Member of Parliament Ken Hargreaves described the plight of health care workers who were the victims of discrimination, coercion and harassment because of their opposition to abortion. He provided several actual examples, noting that a number of victims were too frightened to exercise their legal right to refuse to participate and "too frightened to speak up for fear of losing their jobs."[20]

3) In 2000, Dr. T. Everett Julyan was denied a general practice rotation by North Glasgow University Hospitals NHS Trust because he would not perform abortions, nor prepare patients for abortions.[21,22]

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?

Yes.

Australia:

- State of Tasmania, *Reproductive Health (Access to Terminations) Act* (No. 72 of 2013) Section 7.[23]
- Australian Medical Association, *Conscientious Objection* (2013).[24]

- Australian Medical Association Tasmania Ltd., *Submission to the Tasmanian Government on the law governing termination of pregnancy*, 5 April, 2013.[25]

Canada:

- Canadian Medical Association, *Induced Abortion* (1988).[26]
- Canadian Medical Association, *Submission to the College of Physicians and Surgeons of Ontario, Consultation on CPSO Interim Guidance on Physician-Assisted Death* (13 January, 2016), addressing the issue of "effective referral" for morally contested services.[27]
- Canadian Medical Association, Canadian Healthcare Association, Canadian Nurses' Association, Catholic Health Association of Canada, *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999)[28]
- College of Physicians and Surgeons of Manitoba, *Conscience Based Objection* (2015)[29]

New Zealand:

- *Contraception, Sterilisation, and Abortion Act* (1977) Section 46.
- *Health Practitioners Competence Assurance Act* (2003) Section 174.[30]

United States:

- American Medical Association, *Code of Medical Ethics*, 1.1.7[31]
- American Medical Association, Council on Ethical and Judicial Affairs, *Letter to the College of Physicians and Surgeons of Ontario (18 February, 2015) Re: Professional Obligations and Human Rights*, addressing the issue of "effective referral" for morally contested services.[32]

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?

Yes.

However, it is important to note that what is proposed here presumes that freedom of conscience for health care providers and access to services by patients are not mutually exclusive goals. Both can by achieved by dialogue, prudent planning, and the exercise of tolerance, imagination and political will. The solutions have costs, to be sure, but in a country where £15 billion is spent annually on alcohol - about £30,000 per minute -[33] a proportionate investment in freedom of conscience for health care workers and access to services by patients is surely not an unreasonable expectation.

Legislation and regulations should include explicit and robust protection of conscience measures for all health care providers, and extend protection to students in health care programmes and applicants for health care employment or positions in health care educational programmes. This legislative framework should ensure that health care providers, students, etc. are not

a) intimidated or coerced for the purpose of compelling them to do or to collaborate in doing what they believe to be wrong; or

b) punished, disadvantaged or discriminated against for refusing to do or collaborate in doing what they believe to be wrong.

The Project's *Model Statute* illustrates the kind of protection needed.[34]

Subject to and consistent with this framework, access to services by patients can be ensured by professional standards, regulations, legislation, administrative policies, resource allocation, etc.

Three legislative approaches are possible: procedure specific, class specific, and generic.

The *Abortion Act* is an example of procedure specific legislation. The difficulty with this approach is that it must be replicated in different statutes, regulations or policies for every morally contested procedure. This piecemeal method is awkward, difficult to keep current with technological developments, and, having a narrow focus, may neglect general principles that ought to inform sound legislation and policy-making.

A class specific approach would ensure protection of conscience with respect to one or more classes of procedures likely to include or known to include morally contested services, such as, "procedures or services that cause death," "procedures or services involving reproductive technology" or "procedures and services associated with law enforcement, the administration of justice or national security."

A generic approach is preferable. It is directed to the accommodation of freedom of conscience and religion as a matter of principle and public policy rather than on moral controversies associated with the nature of specific procedures or classes of procedures. The College of Physicians and Surgeons of Manitoba standard *Conscience Based Objection* is an example of a generic regulation that can be applied to all morally contested procedures, including assisted suicide and euthanasia.[35]

8. Any other comments?

Suggested standards of practice for physicians who decline to provide a service or procedure for reasons of conscience or religion:

1) Physicians must provide patients with sufficient and timely information about relevant treatment options so that they can make informed decisions about accepting or refusing medical treatment and care, including diagnosis, prognosis and a balanced explanation of the benefits, burdens and risks associated with each option. Relevant treatment options include all legal and clinically appropriate procedures or services that may have a therapeutic benefit, including the option of no treatment or treatments not recommended by the physician.

2) The information provided must be responsive to the needs of the patient, and communicated respectfully and in a way likely to be understood by the patient. Physicians must answer a patient's questions to the best of their ability.

3) Physicians whose medical opinion concerning a treatment option is not consistent with the general view of the medical profession must disclose this to the patient.

4) Physicians must give reasonable notice to patients of beliefs or convictions that influence their recommendations or practice or prevent them from providing certain procedures or services. They must give reasonable notice to patients if their views change.

5) Notice is reasonable if it is given as soon as it would be apparent to a reasonable and prudent person that a conflict is likely to arise concerning treatments or services the physician declines to provide. In many cases - but not all - this may be prior to accepting someone as a patient, or when a patient is accepted.

6) Physicians should limit discussion related to their religious, ethical or moral convictions to what is relevant to the patient's care and treatment, reasonably necessary for providing an explanation, and responsive to the patient's questions and concerns.

7) Physicians who decline to recommend or provide services or procedures for reasons of conscience or religion must advise affected patients that they may seek the services elsewhere. Upon request, they must provide information about how to find other service providers, and transfer the care of the patient or patient records to the provider chosen by the patient.

8) Physicians must provide other treatment or care until a transfer of care is effected, unless the physician and patient agree to other arrangements.

9) Physicians unwilling or unable to comply with these requirements must promptly arrange for a patient to be seen by another physician or health care worker who can do so.

10) Physicians who provide medical services in a health care facility must give reasonable notice to a medical administrator of the facility if beliefs or convictions prevent them from providing certain procedures or services that are or are likely to be provided in the facility. In many cases - but not all - this may be when the physician begins to provide medical services at the facility.

11) Physicians must provide medical treatment that is within their competence when a patient is likely to die or suffer grave injury if the treatment is not immediately provided, or immediately arrange for the patient to be seen by someone competent to provide the necessary treatment.

Notes

1. The reluctance of Scots physicians to provide abortions after 15 weeks gestation resulted in women travelling to England for the procedure. "Ian Jones, chief executive of the BPAS . . . admitted that it could be difficult to find doctors and nurses, particularly in the west of Scotland, who were prepared to work at the clinic. He said the fact that so many women needed to travel to England for late abortions reflected the fact that medical staff in Scotland do not want to perform them." Templeton, Sarah Kate, "Private firm plans Scottish abortion clinic." *The Sunday Herald*, 19 January, 2003. (https://www.highbeam.com/doc/1P2-9994164.html) Accessed 2016-07-29.

2. British Medical Association, Annual Representative Meeting, 2004: "That this Meeting calls upon the MSC and BMA to work with the GMC, NHS and appropriate Royal Colleges to ensure that babies born alive as a result of termination of pregnancy procedures receive the same full neonatal care as that available to other babies." (http://www.bma.org.uk) Accessed 2006-06-13.

3. As many as 50 babies survive abortions each year in the United Kingdom. Rogers, Lois, "Fifty babies a year are alive after abortion." *The Sunday Times*, 27 November, 2005. (http://www.timesonline.co.uk/article/0,,2087-1892696,00.html) Accessed 2006-06-13

4. British Pregnancy Advisory Service, *Conscientious Objection*. (https://www.bpas.org/get-involved/advocacy/briefings/conscientious-objection/) Accessed 2016-07-11

5. Schuklenk U, van Delden J.J.M, Downie J, McLean S, Upshur R, Weinstock D. *Report of the Royal Society of Canada Expert Panel on End-of-Life Decision Making* (November, 2011) p. 62 (http://rsc-src.ca/sites/default/files/pdf/RSCEndofLifeReport2011_EN_Formatted_FINAL.pdf) Accessed 2014-02-23

6. College of Physicians and Surgeons of Ontario, Policy Statement 4-16, *Medical Assistance in Dying (June*, 2016). (http://www.cpso.on.ca/CPSO/media/documents/Policies/Policy-Items/medical-assistance-in-dying.pdf?ext=.pdf) Accessed 2016-07-11

7. United Kingdom Parliament, House of Lords Select Committee on Assisted Dying for the Terminally Ill Bill: Selections from the First Report (http://www.consciencelaws.org/law/commentary/legal027-001.aspx)

8. Joint Committee On Human Rights Twelfth Report: Assisted Dying for the Terminally Ill Bill, Para. 3.11 to 3.16. (http://www.publications.parliament.uk/pa/jt200304/jtselect/jtrights/93/9306.htm#a17) Accessed 2016-07-28.

9. Select Committee on Assisted Dying for the Terminally Ill Bill, *Minutes of Evidence: Examination of Witnesses* (Questions 70 - 79) , Thursday, 16 September, 2004, Q70. (http://www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/4091602.htm) Accessed 2016-07-28.

10. General Medical Council, *Personal Beliefs and Medical Practice* (2013), Legal Annex, p. 6. (http://www.gmc-uk.org/static/documents/content/Personal_beliefs-web.pdf) Accessed 2016-07-09

11. General Medical Council, *Personal Beliefs and Medical Practice* (2013), para. 13. (http://www.gmc-uk.org/static/documents/content/Personal_beliefs-web.pdf) Accessed 2016-07-09

12. British Medical Association Ethics Department, The Law and Ethics of Abortion: BMA Views (November, 2007), 1.31. (https://www.bma.org.uk/-/media/files/pdfs/practical%20advice%20at%20work/ethics/law_and_ethics_of_abortion_nov2014.pdf?la=en) Accessed 2016-07-09.

13. Royal College of General Practitioners, *RCGP Position Statement on Abortion* (2 April, 2012) (http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z-policy/RCGP_Position_Statement_on_Abortion.ashx) Accessed 2016-07-09.

14. Royal College of Midwives, *Position Statement - Abortion*. (https://www.rcm.org.uk/sites/default/files/RCM%20Abortion%20Statement.pdf) Accessed 2016-07-09

15. Royal College of Nursing, *Termination of Pregnancy: An RCN Nursing Framework*, p. 7. (https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2013/july/pub-004386.pdf) Accessed 2016-07-09.

16. Nursing and Midwifery Council, *The Code: Professional standards of practice and behaviour for nurses and midwives*, 4.4 (https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf) Accessed 2016-07-09; Conscientious objection by nurses and midwives (https://www.nmc.org.uk/standards/code/conscientious-objection-by-nurses-and-midwives/?_t_id=1B2M2Y8AsgTpgAmY7PhCfg%3d%3d&_t_q=conscientious+objection&_t_tags=language%3aen%2csiteid%3ad6891695-0234-463b-bf74-1bfb02644b38&_t_ip=50.92.93.30&_t_hit.id=NMC_Web_Models_Pages_ContentPage/_f9f2c003-6443-4336-86f6-a97573814140_en-GB&_t_hit.pos=1) Accessed 2016-07-09

17. Markham Stoufville Hospital Policy: *Termination of Pregnancy- Religious Exemption* (April, 1999) (http://www.consciencelaws.org/background/policy/institutions-002.aspx)

18. St. Vincent Hospital, Santa Fe, New Mexico, *Memorandum of Understanding for Circumcision Procedure* (31 January, 1995) (http://www.consciencelaws.org/background/policy/institutions-001.aspx)

19. Walley RL. "Question of Conscience." *THE FUTURE OF OBSTETRICS AND GYNAECOLOGY: The Fundamental Right To Practice and be Trained According to Conscience*: *An International Meeting of Catholic Obstetricians and Gynaecologists.* Organised by the World Federation of Catholic Medical Associations (FIAMC) and by MaterCare International (MCI). Sponsored by the Pontifical Council for the Health Pastoral Care ROME, June 17th-20th, 2001(http://www.consciencelaws.org/repression/repression027.aspx)

20. *Hansard*, 27 July, 1989, Vol. 157, cc 1371-90 (http://hansard.millbanksystems.com/commons/1989/jul/27/abortion-act-1967) Accessed 2016-07-10

21. Barratt H. "Conscientious Objection to Abortion." *Triple Helix*, Winter, 2001 (http://www.consciencelaws.org/background/procedures/abortion029.aspx)

22. Julyan TE. *Access to Appointments: The Effect of Discrimination on Careers.* THE FUTURE OF OBSTETRICS AND GYNAECOLOGY: The Fundamental Right To Practice and be Trained According to Conscience: *An International Meeting of Catholic Obstetricians and Gynaecologists.* Organised by the World Federation of Catholic Medical Associations (FIAMC) and by MaterCare International (MCI). Sponsored by the Pontifical Council for the Health Pastoral Care ROME, June 17th-20th, 2001(http://www.consciencelaws.org/repression/repression028.aspx)

23. Protection of Conscience Project, Existing Laws: Australia (http://www.consciencelaws.org/law/laws/australia003.aspx)

24. Australian Medical Association Position Statement, *Conscientious Objection* (2013) (https://ama.com.au/position-statement/conscientious-objection-2013**)** Accessed 2016-07-29.

25. Australian Medical Association Tasmania Ltd., *Submission to the Tasmanian Government on the law governing termination of pregnancy*, 5 April, 2013. (https://ama.com.au/sites/default/files/documents/AMA_Tasmania_Pregnancy_Termination_Submission_on_Draft_Legislation_April_2013_FINAL.pdf) Accessed 2016-07-29. Extracts re: freedom of conscience: (http://www.consciencelaws.org/law/commentary/legal053.aspx)

26. CMA Policy: *Induced Abortion* (1988). (https://www.cma.ca/Assets/assets-library/document/en/advocacy/CMA_induced_abortion_PD88-06-e.pdf#search=abortion) Accessed 2015-02-13

27. Canadian Medical Association, *Submission to the College of Physicians and Surgeons of Ontario, Consultation on CPSO Interim Guidance on Physician-Assisted Death* (13 January, 2016) (http://www.consciencelaws.org/background/policy/associations-013.aspx)

28. Canadian Medical Association, Canadian Healthcare Association, Canadian Nurses' Association, Catholic Health Association of Canada, *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) (http://www.consciencelaws.org/background/policy/associations-001.aspx)

29. College of Physicians and Surgeons of Manitoba, Section 17 to Bylaw 11, Standards of Practice of Medicine. (Effective December, 2015), Conscience Based Objection. (http://www.consciencelaws.org/background/policy/regulators-007.aspx)

30. Protection of Conscience Project, Existing Laws: *New Zealand* (http://www.consciencelaws.org/law/laws/new-zealand.aspx)

31. American Medical Association, *Code of Medical Ethics*, 1.1.7 (http://www.ama-assn.org/resources/doc/code-medical-ethics/x-pub/code-2016-ch1.pdf) Accessed 2016-07-10

32. American Medical Association, Council on Ethical and Judicial Affairs, *Letter to the College of Physicians and Surgeons of Ontario (18 February, 2015) Re: Professional Obligations and Human Rights* (http://policyconsult.cpso.on.ca/wp-content/uploads/2015/02/CEJA-to-CPSO_Redacted.pdf) Accessed 2016-07-10

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34. Protection of Conscience Project, *Model Statute: An Act to Ensure Protection of Conscience for Health Care Workers* (http://www.consciencelaws.org/model-statute.aspx)

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