Consequences for patients of health care professionals' conscientious actions: the ban on abortions in South Australia

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Author's abstract

The legitimacy of the refusal of South Australian nurses to care for second trimester abortion patients on grounds of conscience is examined as a test case for a theory of permissible limits on the autonomy of health care professionals. In cases of health care professional (HCP) conscientious refusal, it is argued that a balance be struck between the HCPs' claims to autonomous action and the consequences to them of having their autonomous action restricted, and the entitlement of patients to care and the consequences for them of being refused such care. Conscientious action that results in the disruption or termination of health care services, however, is always impermissible on two grounds. Firstly, because it is at this point that the action '... invades a patient's autonomy, puts a patient at serious risk ... [and] treats a patient unjustly' (1) Secondly, because the consequences of such refusals turn them into political acts – acts of civil disobedience. It is arguable that in order for acts of civil disobedience to be legitimate, certain obligations are required of the dissenter by the community. It is concluded that the actions of the South Australian nurses, which have over the last few years both terminated and disrupted second trimester services, are morally impermissible.

1. The case

In the state of South Australia, between the years 1988 and 1990 it was nearly impossible for a woman to obtain a second trimester abortion for social reasons in an SA hospital, hospitals being the only place in the state where such services are available (2). In SA, legislation provides for legal abortions to protect the woman's physical and mental health and on eugenic grounds, within 28 weeks of conception.

From 1988 to 1990, only one private practitioner in the entire state provided a mid-trimester service. Thus, the vast majority of women who needed such services (approximately 10 per cent of abortions take place in the second trimester (3)),

were forced to travel by bus, at state government expense, to Sydney or Melbourne, journeys of 22 and 11 hours respectively from SA's capital, Adelaide. The cause of this two-year disruption of late abortion services was the mass refusal by SA nurses, on grounds of conscience, to participate in abortions for social reasons beyond the twelfth week (4).

In this paper, I will be using the SA case as a test case, against which I will be applying a theory that seeks a balance between HCPs' autonomy-based rights and their corresponding obligations to patient care. I believe there will be relevant similarities between this case and others, whether in Australia or abroad, where HCP rights and obligations collide over morally charged medical issues.

2. Argument summary

I will argue in this paper that conscientious action by HCPs is impermissible in cases where such action results in the disruption or termination of health care services. My claim is that HCP obligations to patient care can be derived from the set of obligations that rightfully flow out of the professional-client relationship. Although there are a significant number of instances where HCP conscientious action should be respected, once the disruption or termination of health care service is the result, such action becomes impermissible for two reasons. Firstly, because it is at this point that the conscientious action illegitimately '... invades a patient's autonomy, puts a patient at serious risk ... [and] treats a patient unjustly' (1). Secondly, because it is at this point that the nurses' actions become political in nature, and are thus properly understood as acts of civil disobedience, not acts of conscience. When a person exercises her autonomy-based rights to civilly disobey, she must also accept the obligations that this right entails. Thus, in the SA case, the nurses' actions were morally impermissible for two reasons. Firstly, because the risk to which they subjected abortion patients outweighed the benefits to those patients of the nurses exercising their autonomy-based right to act on conscience.

Key words

Conscientious action; conscientious objection; abortion; professional ethics; nursing ethics.

Secondly, because the nurses failed to fulfil the obligations that were incumbent upon them as civil dissenters. In the final section of the paper, I will address myself to what I believe is the most likely objection to the account presented; an objection on grounds of fairness.

3. Professional obligations/patient claims

When considering the morality of the conscientious action of the SA nurses, one must consider the claims for care that the second trimester abortion patients had on the nurses. My contention is that the abortion patients do have a claim for care on the nurses, one that can be derived from the nurses' professional training and responsibilities.

Michael Bayles (5) says that professions are almost always characterized by the following three features:

1. A professional undergoes extensive training.
2. The training involves a substantial intellectual component.
3. A professional's service is valued by society.

Commonly, professions are also associated with:

4. Licensing or certification requirement.
5. A professional organization.
6. Exercise of autonomy and discretion at work.

While the career of nursing can clearly be characterized by features 1–5, Bayles allows that '... nurses are often thought to have equivocal status as professionals simply because their superiors can overrule their judgements about specific aspects of their work (6). He concludes, however, that nursing is a profession firstly because an '... element of autonomy remains ...' in nursing work, and secondly because while autonomy is clearly a '... common and partially defining feature of a profession ...' it may not be a '... necessary one' (7). Certainly, nurses consider themselves to be professionals, as shown by any number of books, reports or periodicals in the nursing field which refer to the occupation of nursing as a profession (8).

If we are now confident that nurses are professionals, we must then ask about the nature of the obligations that professionals have to their clients. There are a number of characteristics of the role of the professional from which we may derive the responsibilities of HCPs' to patient care. These are that the role of the professional is:

- (a) Important
- (b) Monopolistic
- (c) Reciprocal
- (d) Contractual
- (e) Circumstantial

Let us look at these more closely.

(a) Important: That the service provided by the HCP is important suggests that it is not a dispensable service. While not all patient-care claims are urgent in nature, relatively few patients can wait for care for weeks on end. And even in those cases where patients do wait many months for treatment, this period is characterized for most by worry, inconvenience, discomfort and an increased health risk (9). However, just because the service provided by the HCP is important does not establish any patient claim to this service. What it does do, however, is explain why society (which we might think of as mostly comprised of past and future patients) has an interest in setting up a situation where patients can rightfully make claims on HCPs for care.

(b) Monopolistic and (c) Reciprocal: HCPs have exclusive possession and exercise of skills that are crucial to the health of individuals and thus so important to society. Silver points out that this monopoly is a valuable one, giving HCPs immense social and, in the case of doctors, economic power (10). The substantial education required to educate an HCP costs society significantly, and thus engenders in the recipient an obligation from reciprocity to attend to society's health care needs. However, here again, no obligation is established between a specific HCP and any individual or class of patients. Monopoly and reciprocity do, however, mean that an HCP cannot simply refuse to treat or care for a class of patients for any reason she devises, however arbitrary or trivial. Obligations from monopoly and reciprocity mean that, all things being equal, HCPs have an obligation to treat all patients. Thus, if the HCP wants to refuse treatment to any patient or group of patients, it is her responsibility to provide an adequate justification for her actions.

(d) Contractual: Silver points to HCP ethical codes as forms of explicit promises from physicians to treat patients. But here again, none of these codes explicitly requires HCPs to care for all patients (11). Moreover, Silver points out that 'occupational roles are especially good at creating obligations ...' (12). By this, two things can be understood. Firstly, that in accepting the job, HCPs have implicitly contracted to sacrifice some of their autonomy in order to further the autonomy of others. Secondly, in accepting the job, Silver argues that HCPs implicitly agree to '... a job description that includes a relatively high degree of danger' (12). Although Silver advances this argument in response to prudential reasons that HCPs offer for refusal to treat, the argument also holds for moral reasons that HCPs advance for refusing to treat. The crucial part of Silver's argument is about what it is reasonable to expect an HCP to know about the issues that will arise in the course of practising her profession before she actually decides to train for and accept the job. It

seems as reasonable to expect that HCPs know there will be health risks in their job as it is to expect that they know that moral conflict will arise in their work.

(e) Circumstantial: It may be said of characteristics 1–4 that none of the claims flowing from them obligate *specific* HCPs to treat all patients who are entitled to care. However, if an HCP finds herself in an emergency, where a refusal to treat could result in the death of, or serious damage to a patient, a specific claim for care does exist upon that HCP. In an emergency, where the life or health of the patient is at risk, the consequences of the HCP refusing to treat are serious enough to outweigh, in every conceivable circumstance, any objection which that HCP has to treating the patient (let's say an objection to treating patients who have not tested negative for the presence of HIV antibodies).

What has been shown in this section is that there exists a *prima facie* claim for care by all patients on all HCPs, a claim derived from the important, monopolistic, reciprocal, and contractual nature of the HCP-patient relationship. The *prima facie* obligations of HCPs, while not establishing an HCP obligation to treat any specific patient, do mean that the onus is on the HCP refusing to treat to justify this refusal. It has also been shown that claims of care deriving from circumstance do obligate specific HCPs to care for specific patients in urgent and medically serious situations. However, because the majority of HCP-patient relationships are characterized by the first four criteria rather than the last criterion of circumstance, we must turn to the question of what constitutes an adequate justification for an HCP's refusal to treat. However, if we accept that justifications on grounds of conscience are acceptable ones for HCPs refusing to care for a specific patient or patients, do we accept this reason in all circumstances?

4. Conscientious action and permissible limits

Beauchamp and Childress state that: 'The right to have one's autonomy respected – or the right of self-determination – entails the right of conscientious action' (1). HCPs are individuals and as such, have the same moral claim as other individuals to having their autonomy respected. Conscientious action is a person's legitimate exercise of his or her autonomy. Further, we are morally obligated to respect a professional's autonomy because of our recognition that autonomy and discretion are one of the partially defining features of a profession. In fact, as Bayles notes: 'If professionals did not exercise their judgement ... people would have little reason to hire them' (5).

But the principle of autonomy has only *prima facie* standing, it does not legitimize conscientious action purchased at the cost of the rights of others. In answer to the question 'does the principle of autonomy legitimize all conscientious action', Beauchamp and Childress have this to say:

'The rules for justified interferences with autonomous actions are equally applicable to conscientious action. It is therefore possible to justify overriding a person's conscientious action if that action imposes serious risks on others, invades the autonomy of others, or treats others unjustly' (13).

Beauchamp and Childress ground these restrictions in the principles of autonomy, beneficence, non-maleficence and justice, which in turn can be defended by both a Rule Utilitarian or Kantian ethical theory. Thus, not all conscientious actions are legitimate, their justification depending on the action not unduly compromising the other *prima facie* principles of equal standing, to which individuals have a right. The application of Beauchamp and Childress's rules assist us to curtail the right to conscientious action by forcing us to assess the consequences of an HCP's conscientious action on patients. In addition, the legitimacy of a decision to restrict an HCP's conscientious action can be to assess how 'deeply held' the belief motivating the HCP's conscientious act is. It is to these two types of justifications for restricting HCP autonomy that I now turn my attention.

5. Justified limits to conscientious action – consequences for the patient and the HCP

The consequences of HCP conscientious action on patients differ from one case to another. What needs to be assessed in each instance is whether the action has put patients at risk, invaded their autonomy or treated them unjustly. Applying this criteria to actual cases, however, is not a simple process because in most cases, the rights of patients will be invaded to some extent. Thus, we must apply the rules with precision to each case in question, in order to be able to assess the extent to which a patient's autonomy is invaded, the extent to which she is placed at risk and the extent to which she is treated unjustly. But how much is too much? Such a line cannot be absolutely demarcated. Rather, the detriment to the patient must be weighed, along with the weight of the patient's claim for care, against the importance of the conscientious action for the professional and the weight of her claim to act autonomously without interference. Such a scale is not equally weighted at the outset, however, because the HCP's professional obligations mean that there is a presumption that patients have a right to care unless the HCP presents a justifiable reason for refusing such care. In order to assess the importance of the conscientious action for

HCPs, and the weight of their claim to act autonomously without interference, it is necessary to understand the consequences for HCPs of having their conscientious action restricted.

To thwart an HCP's conscientious action may cause that person, in some instances, considerable stress. If the action to which the HCP objects holds a central place in her belief system, being compelled to perform the act will result in what could be described as the internal disharmony of the self. In some instances, the disharmony suffered by the HCP would outweigh the harm done to the patient by the HCP's refusal to treat.

To assess the weight that should be accorded to an HCP's act of conscience, we must know how central to the HCP is the belief that prompted the action. How can the centrality of a belief be measured? One way might be to seek to discover from the HCP the position of the belief in her belief system. The other would be to determine the length of time and/or the strength with which the belief is held.

A truly central belief is one upon which a person's self-definition is based. The literature on the experience of adoption people shows that when a person suddenly discovers she is adopted, she experiences a blow to her sense of self. This is because one of the central ways in which most of us define ourselves is relationally. We are Jake's father, and Kathy and Mark's son. Such knowledge forms the bedrock upon which all our other knowledge has accumulated. To destroy that knowledge upends the entire structure of knowledge that has grown upon it. To curtail an HCP from acting on a belief so centrally positioned in her belief system would exact a heavy toll on such a person. The centrality of a belief can also be assessed by measuring the length of time it has been held. But time, while often a good indicator of centrality, will not always be an accurate gauge. This is because it is possible for a belief that is newly acquired to be of great importance to a person. Religious conversion is a good example of this phenomenon.

The validity of the reasons of the objecting HCP are also important in determining the weight that should be given to the objection. If, in other words, the factual basis for the belief is erroneous, we may believe less weight should be given to the HCP's desire to act upon it, no matter how central the fallacious belief is to her belief system. If the validity of the HCP's reasons for refusing treatment becomes questionable, it would be unlikely that she could make a strong enough claim of professional autonomy to justify overriding the patient's entitlement to care.

6. Conscientious action, individual political action and civil disobedience

However, regardless of how accurate and central the HCP's beliefs are, a conscientious action that results

in the discontinuation of patient services is still morally impermissible. To understand why this is so we must understand the differences between conscientious action, what I will call individual political action, and civil disobedience.

Conscientious action is, as we have already seen, properly used to absent oneself from participating in a process which would cause considerable 'internal disharmony'. According to Hannah Arendt, conscientious action is:

'not primarily interested in the world where the wrong is committed or in the consequences that the wrong will have for the future course of the world' (14).

In other words, conscientious action is essentially an unpolitical act, one that does *not* have as its consequence the termination of the activity from which the actor wishes to absent herself.

What I have dubbed individual political action differs from conscientious action in its consequences. Like the conscientious actor, the individual political actor grounds her refusal to participate in the claims of conscience. However, the individual political actor also has political objectives. An example of this is a war protester who refuses to fight on grounds of conscience, but hopes that the publicity generated by her actions will spur a reconsideration of the government's commitment to war. What is important here is that the consequence of the actions of individual political actors is not the *enforced* disruption or termination of the policy to which she is individually opposed. The electorate is free either to ignore the action of the individual political actor, or to act in such a way as to bring the issue back to lawmakers.

If the disruption or termination of power is enforced, it is an illegitimate use of power. One example of this sort of illegitimate use of power is the use of 'ecotage' by radical environmentalists. Ecotage consists of '... secret acts of destruction aimed at stopping or slowing down processes judged as harmful to the environment' (15). While it is difficult not to empathize with the frustration of such protesters, tactics such as the clandestine destruction of logging equipment can only be understood as blatant abuses of power. When the law is broken by an individual or a group, and the outcome forcibly affects others who have legitimate claims to what was provided by the law, that act is political in nature – it is an act of civil disobedience. And in order for an actor to exercise her right to disobey, she is morally obliged publicly to acknowledge the act, and to accept the obligations that accompany such rights.

The civil dissenter has two essential obligations. Firstly, an act of civil disobedience must be a public act. Secondly, acts of civil disobedience must '... be done in a situation where arrest and punishment are

expected and accepted without resistance' (16). Such costly obligations from the dissenter are required for three reasons. Firstly, because the dissenter's willingness to accept them convinces the majority that the dissenter's acts are sincere. The acceptance of a dissenter of the loss of her job or even jail surely demonstrates the seriousness with which the dissenter holds her views. Accepting punishment also acts as compensation to the community, which is being forced to bear the costs of the dissenter's actions without having had any input into the process by which those actions were brought about. Thirdly, the dissenter's willingness to accept punishment indicates the dissenter's commitment to and faith in the underlying system to which she is appealing for justice.

7. A return to the case in South Australia

Did the nurses' conscientious action, resulting in the termination of second trimester abortion services in SA invade the autonomy of their patients, impose a serious risk on their patients, or treat their patients unjustly to an unacceptable extent? Were, in other words, the patients' autonomy and their claims from the principles of beneficence, non-maleficence and justice unacceptably compromised in order to allow the nurses to exercise their autonomy? It is not necessary successfully to show that each of these conditions was satisfied to have argued successfully for the immorality of the SA nurses' actions. If the actions of the nurses unduly compromised the set of entitlements flowing to patients from just one principle, then this would weight against the permissibility of the HCPs' refusal to treat.

Thus, although I believe sufficient argument can be mustered to support each of these claims, for the sake of brevity I will argue here only that the nurses' actions did impose a serious risk on the abortion patients at the point where abortion services were terminated. On the other side of the scale, I will also consider the validity of the nurses' reasons for refusing to treat. Although it is difficult to know in this case how central the beliefs motivating the nurses' actions are, the validity of these beliefs is problematic on two separate counts. However, even if the nurses' beliefs were found to be both central and valid, the fact that their action resulted in the termination of services means that before their refusal to treat can be considered morally permissible, they must fulfil the obligations of the conscientious objector.

Did the nurses' conscientious action impose a serious risk on their patients? I believe that it did at the point where abortion services in South Australia were terminated as a result of the nurses' actions. Penelope Debelle's account of the incident tells how women and girls who were more than three months' pregnant '... travelled ... to Melbourne or Sydney for abortions. They went by bus but were allowed to

fly home. The experience was traumatic for some, particularly if it was their first trip out of the State' (17).

Debelle's account of the SA incident suggests that the patients underwent emotional and possibly physical risks from being forced to obtain their abortions interstate. Second term abortions are not simple procedures, requiring at least an overnight stay in hospital. Complications of the various methods, which include inducement, dilation and evacuation and hysterotomy, vary, but include: hypervolaemia, coagulopathy, cervical fistula or cervical laceration, nausea, vomiting, uterine perforation, convulsions, infection, haemorrhage (requiring transfusion) and incomplete abortion requiring curettage (18), in addition to the general risks associated with anaesthesia. A woman who undergoes any of these procedures would be physically exhausted afterwards, and in need of bed rest and at least a few days of 'taking it easy'. The fact that a woman is allowed to fly back from an abortion signals the state's recognition of the physical hardship of second trimester abortion procedures. However, whether a plane trip immediately after induced labour or surgery is actually good for a woman, or whether it is simply a better alternative than putting her back on a bus, is debatable. The question of physical risk says nothing about the emotional costs of abortion, which for many women are quite high. A large percentage of women who seek second trimester abortions '... are young, poor or women of color' (18). Younger women will sometimes deny their pregnancy, or choose to put off coping with it until after an exam period while poor women are often unable to get the necessary money together in time to have the abortion in the first trimester. Errors in pregnancy detection, or diagnosis of fetal abnormality through amniocentesis are also the cause of many second trimester abortions. Given these types of experiences, '... a woman may come to the experience of a later abortion already emotionally exhausted' (18). To force women to procure abortions interstate, without the comfort of family, friends and familiar surroundings undoubtedly exacts a substantial cost on the emotional well-being of many of them.

In the SA case, it is difficult to assess either the centrality of the beliefs upon which nurses based their refusal to treat or the factual validity of these beliefs. This is because the majority of media coverage of the event did not delve very deeply into the issue. Penelope Debelle's account, however, does report that the nurses recognised:

'Two sorts of clients ...: the "deserving" and the "undeserving". In the first category were women seeking abortion because of medical complications, foetal abnormality or failed contraception ... In the "undeserving" fell the rest, women seeking abortions

primarily for social or economic reasons ... it is not the abortion [at any stage], per se, but the reasons which affect people's willingness to participate. And this distinction, becomes more important as an unwanted pregnancy, for whatever reason, is allowed to progress' (19).

What conclusions can we draw from DeBelle's account? First, it might be noted that there would be a significant amount of room for nurses to err in their evaluation of the pregnant woman's reasons for aborting. If DeBelle is right that the nurses' evaluation of the immorality of the abortion turns on the pregnant woman's reasons, then any nurse objecting to caring for an abortion patient on the grounds of her reasons for aborting *who turns out to be mistaken*, could not expect her refusal to be given much moral weight. Because the validity of the distinctions the nurses made between deserving and undeserving women cannot be known from the available information, this issue will have to be put to one side.

But if DeBelle is right that the nurses' objection to treating abortion patients is based on the reasons the woman has for aborting, this would suggest that the nurses would not have refused to treat all second term abortion patients. Those considered 'deserving' would still, using the nurses' criterion, be entitled to care. However, because of the shutdown of services, even those whom the nurses believed to be 'deserving' were forced to go interstate for their abortions. Thus, the outcome of the SA nurses' conscientious action was not the result of distinguishing between abortion patients on the basis of their reasons. Rather, it was an action similar to one we would expect to result from HCP refusals to treat based on an objection to treating *all* second trimester abortion patients. Thus, we must first wonder whether the 'deserving/undeserving' criteria is an adequate justification of the nurses' refusal to treat abortion patients. Then we must wonder whether the refusal to treat abortion patients on the basis of their reasons was based on correct information about those reasons.

Therefore, even if we accept that it is permissible for a nurse to refuse treatment to an 'undeserving' woman, we might still argue that the SA nurses' conscientious action was morally impermissible because it affected women outside of the range of women that they had stated opposition to treating. Only after we have accepted that the deserving/undeserving criteria is valid in theory, and that the nurses have fairly carried out this distinction in practice, can we weight the cost to the nurses of having their conscientious action restricted against the cost to the abortion patients of being refused care. But because the nurses' actions resulted in the termination of services, a precondition for this weighting would be the fulfilment by the nurses of the obligations of the civil disobedient.

Once services were terminated, the actions of the SA nurses were also impermissible because they could no longer be properly viewed as the acts of conscientious objectors, but rather had to be seen as the political acts of civil dissenters. The termination of abortion services must be seen as political. The nurses' actions terminated second trimester abortion services, services guaranteed by law to SA women. This consequence came at considerable personal cost to both the community of women seeking second trimester abortions and to the South Australian community as a whole. The former were denied medical services to which they had a right, without due process, and were forced to undergo the emotional and physical strain of travelling interstate. The SA community, which had decided through the representative democratic process to provide second trimester services to Australian women, also had its will thwarted by the nurses' actions. However, the nurses were not dismissed from their jobs, nor were they at risk of going to jail as punishment for their disobedience. Thus, the nurses were able to abuse their power by thwarting the representative system without fairly compensating, through an acceptance of punishment, those who bore the consequences for their action.

8. Possible objections

The major objection to which I believe my account is open is that of fairness. Such an objection would be Kantian in nature in its contention that if a conscientious action is legitimate, then it should be legitimate regardless of how many people decide to engage in that action. If, for instance, the only abortion service in South Australia can cope with three nurses opting out of caring for patients, but the fourth nurse's departure terminates the service, this account holds that the action of the fourth nurse is morally impermissible, but the actions of the three nurses before her were permissible. How can this be understood?

Firstly, by understanding that the action of the first, second, and third nurse are not the same as that of the fourth. The actions differ because their consequences differ, thereby changing the nature of the act. The fourth nurse's action is a political act, unlike those of the previous nurses, because it results in political consequences for the unrepresented community. And as a political act of law-breaking – an act of civil disobedience – the fourth nurse's act is permissible if the obligations incumbent upon a civil dissenter are accepted. Thus, it is fair to restrict the fourth nurse from carrying out her action as one of conscience, though it would be unfair to restrict her if she labelled her action as one of civil disobedience and accepted the obligations that flowed from this exercise of autonomy.

Sister Regis Dunne argues that autonomy is not an unqualified good:

'... that ... persons ... are ... exercising their liberty does not take into account whether in the overall public good they are entitled to do this, as the consequences of their action will not be contained with them, nor does it address the moral question of whether they ought to do this' (20).

It seems to me that Dunne's point, and her approach, is characterised by a healthy scepticism for a respect for autonomy that allows individuals to exercise their liberty completely without restriction at the expense of others who are '... affected by their autonomous choice' (20). Thus, in order to have acted morally the SA nurses should not only have considered their rights to act in the way they desired, but also the obligations they had to others unavoidably affected by their exercise of personal freedom. Common sense morality admonishes us to refrain from acting without considering the interests of others. Those who do not are labelled 'inconsiderate', 'self-absorbed' and plain old 'selfish', and are certainly not considered to be acting morally, even if their actions can be seen technically to conform to a narrow set of prescribed rights. A balance must be struck between the right of the HCP to act autonomously and the HCP's obligations to patients and society as a whole.

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References and notes

- (1) Beauchamp T, Childress J. *Principles of biomedical ethics* (3rd ed). New York: Oxford University Press: 1983: 390.
- (2) In 1994, the situation in South Australia while not still one of crisis, has still not returned to 'normal'. Many nurses and doctors continue to refuse to participate in late abortions with the consequence that a stream of women continue to be sent interstate for services. However, the setting up of special centres for abortion, affiliated but not directly connected to hospitals, and staffed by those who have chosen involvement in this sort of work, has ameliorated the situation.
- (3) Available abortion statistics for South Australia show the South Australian experience roughly paralleling this general trend. In SA between 1980 and 1984, 19,714 terminations were performed. Of those, 1,538 or 7.8 per cent, were done after 12 weeks of pregnancy with 18,176 or 92.2 per cent done before 12 weeks. Only 0.4 per cent of the total number of abortions in this period were performed after the nineteenth week. See: Hart G, Macharper T. *Medical termination of pregnancy in South Australia, 1970-1984*. Technical report number 1, Pregnancy Outcome Unit, Epidemiology Branch, Public Health Service, South Australian Health Commission.
- (4) Case extracted from DeBelle P. 'Ethics in embryo' *Good weekend, The Age* magazine, 1991 Jan 9: 18-24. See also Gay R, Krutli D. *Women and surgery 1990 conference proceedings*, 'Mid trimester abortion in South Australia' and 'Mid trimester abortion service within a public hospital: 318 Little Bourke Street, Melbourne: Health Sharing Women, 1990. It should be noted that different accounts of the reasons nurses had for refusing participation in second trimester psycho-social abortions exist. My characterisation of the refusals as grounded in reasons of conscience relies both on journalist Penelope DeBelle's coverage of the story for *The Age* newspaper, and on a paper presented by Di Krutli, a Clinical Nurse Consultant in Gynaecology in South Australia, at the Women in Surgery Conference. In both these sources, reasons of conscience are cited for the nurses' refusal, though Krutli's paper also points to the difficulty of clinical practices and the lack of support for nurses involved with abortions, as contributing factors. The Australian Federation of Nurses, on the other hand, cites only these latter concerns, plus worries about anti-abortion lobbyists, as the primary reasons for the nurses' refusal (personal correspondence).
- (5) Bayles M D. The professions. In Callahan J C, ed. *Ethical issues in professional life*. Oxford: OUP, 1988: 7-11.
- (6) See reference (5): 28.
- (7) See reference (5): 29.
- (8) See for example: Thompson I E, Melia K M, Boyd K M. *Nursing ethics* (2nd ed). Edinburgh, New York: Churchill Livingstone, 1988: 52, or The National Health and Medical Research Council. *The role of the nurse in Australia*. Canberra: Australian Government Publishing Service, 1991.
- (9) An arguable exception to this is most patients awaiting voluntary cosmetic surgery, where the discomfort and increasing health risk encountered by patients could be expected to be quite minimal.
- (10) Silver M. The morality of refusing to treat HIV positive patients. *Journal of applied philosophy* 1989; 6: 2: 149-157.
- (11) See reference (10): 150.
- (12) See reference (10): 153.
- (13) See reference (1).
- (14) Arendt H. *Crisis of the republic*. New York: Harcourt Brace Jovanovich, 1969: 60.
- (15) Chandler J. Green Guerillas. *The Age*: Saturday extra 1992 Jan 18: 1, 6.
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- (17) See reference (4): DeBelle P.
- (18) The Boston Women's Health Collective. Abortion. In: *The new our bodies, ourselves*. New York: Simon & Schuster, 1984: 303.
- (19) See reference (4): DeBelle P: 22.
- (20) Dunne R M. Dissenting view 1. The National Bioethics Consultative Committee on Surrogacy. *Report 1*. Commonwealth of Australia, 1990: 47-55.