European Journal of Obstetrics & Gynecology and Reproductive Biology 216 (2017) 254–258

Contents lists available at ScienceDirect

European Journal of Obstetrics & Gynecology and Reproductive Biology

journal homepage: www.elsevier.com/locate/ejogrb

Review article

There is no defence for 'Conscientious objection' in reproductive health care

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ARTICLE INFO

Article history:
Received 15 June 2017
Received in revised form 9 July 2017
Accepted 17 July 2017

Keywords:
Conscientious objection
Reproductive health care
Conscience refusals
Dishonourable disobedience
Abortion

ABSTRACT

A widespread assumption has taken hold in the field of medicine that we must allow health care professionals the right to refuse treatment under the guise of 'conscientious objection' (CO), in particular for women seeking abortions. At the same time, it is widely recognized that the refusal to treat creates harm and barriers for patients receiving reproductive health care. In response, many recommendations have been put forward as solutions to limit those harms. Further, some researchers make a distinction between true CO and 'obstructionist CO', based on the motivations or actions of various objectors.

This paper argues that 'CO' in reproductive health care should not be considered a right, but an unethical refusal to treat. Supporters of CO have no real defence of their stance, other than the mistaken assumption that CO in reproductive health care is the same as CO in the military, when the two have nothing in common (for example, objecting doctors are rarely disciplined, while the patient pays the price). Refusals to treat are based on non-verifiable personal beliefs, usually religious beliefs, but introducing religion into medicine undermines best practices that depend on scientific evidence and medical ethics. CO therefore represents an abandonment of professional obligations to patients. Countries should strive to reduce the number of objectors in reproductive health care as much as possible until CO can feasibly be prohibited. Several Scandinavian countries already have a successful ban on CO.

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Introduction

In the past few years, there has been much concern and contention over the exercise of 'conscientious objection' in reproductive health care (CO), which is usually defined as the refusal by a health care professional (HCP) to provide a legal medical service or treatment for which they would normally be responsible, based on their objection to the treatment for personal or religious reasons.

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http://dx.doi.org/10.1016/j.ejogrb.2017.07.023

Two main aspects have emerged in the defence of CO: a widespread assumption that we must allow HCPs the right to refuse treatment, and a wave of recommendations that attempt to offer solutions to prevent the harms and barriers that CO creates, in particular for women seeking abortions.[3]

As demonstrated in a previous paper by the authors, so-called 'conscientious objection' (CO) as used in reproductive health care is a term falsely co-opted from military CO and has nothing in common with it [1]. For example, soldiers are drafted into compulsory service, are relatively powerless, and accept punishment or alternate service in exchange for exercising their CO; while doctors choose their profession, enjoy a position of power and authority, and rarely face discipline for exercising CO. Therefore, CO should more correctly be called 'dishonourable disobedience'[1] because it is a refusal to treat based on personal and non-verifiable beliefs, which is inappropriate and harmful in reproductive health care. It represents an abuse of medical ethics and professional obligations to patients.

Our position is not peculiar or uncommon – many others argue persuasively against the practice of CO not only in reproductive health care, but health care in general [2,3,4,5].

Is refusing patients a 'right'?

Remarkably, pro-choice researchers and ethicists who support CO in reproductive health care rarely try to defend the practice beyond a simple assertion that individual conscience is an important right. Certainly this is true for everybody in general, but in the field of reproductive health care, there has been little or no recognition of how CO unjustly privileges doctors' conscience over patients' conscience, not to mention their life and health [1]. The granting of CO also gives legitimacy to the religiously-based assumption that abortion is wrong – however, providing safe abortion is an ethical practice that has saved the lives and protected the rights of millions of women. Moreover, doctors have obligations to their patients and the public. They occupy a privileged position of trust and responsibility in our society, and profit from a monopoly on the practice of medicine.

CO in health care overall is a relatively new phenomenon that began only with the legalization of abortion in the UK (1967) [6] and the US (1973) [7]. Even today, almost all CO is exercised for abortion, as well as other reproductive health care such as contraception and sterilization. It is likely that society has continued to accept CO because abortion still remains criminalized to some degree almost everywhere and is still highly stigmatized. Also, much of society retains traditional (sexist) beliefs about women and motherhood, and the Catholic Church is still powerful enough to enforce those beliefs. But why should society support CO at all in the 21 st century? We now understand the necessity and value of access to safe and legal abortion for women, which means supporting CO just cedes ground to those who defend archaic social mores and traditional roles of women. As such, CO weakens the causes of reproductive rights and women's equality.

The problem with assuming CO as a right is exemplified by an article that objects to the 'Improper Use of Conscientious Objection in Bogotá, Colombia', by Vélez and Urbano [8]. This article in turn is a response to 'The Fetus Is My Patient, Too' [9], a study by Fink et al. about attitudes to abortion provision and referral by objecting doctors in Bogotá Colombia.

Vélez and Urbano's main criticism of the Fink et al. study is its division of objectors into 'extreme, moderate, and partial'. They claim that only some of these objectors are true objectors from conscience, while others are obstructing the service and disobeying the law, which is not conscientious objection and should not be called that. This misses the point of Fink et al.'s study, which was simply to categorize objectors' perspectives with the aim of finding possible interventions to reduce CO as a barrier to care. Instead, Vélez and Urbano draw a dividing line between the supposed true ethical use of CO and the false harmful kind.

In reality, there is only one kind of CO in reproductive health care: the refusal to provide a legal treatment that the patient requests and needs, based on the provider's subjective, personal belief that the treatment is immoral. Whether that belief is sincere or pretended, extreme or moderate, is irrelevant because CO is harmful in any case. It denies patients' right to health care and moral autonomy, and has negative consequences for them. The extent of harm of CO is on a continuum, and is often much worse than a short delay – women needing abortions have been left to suffer serious injury or even die [10,11]. But even if the harm seems minimal – i.e., the objector refers appropriately and the patient receives services promptly, refusals are still inherently wrong and harmful. The provider is deliberately refusing to do part of their job for personal reasons, thereby abandoning their fiduciary duty to patients, while still expecting payment and no negative consequences. It also discriminates based on gender and pregnancy because reproductive health care is largely provided to women. Finally, refusals demean a woman by undermining her dignity and autonomy, and sending a negative message that stigmatizes her and the health care she needs [12].

A telling point about the true nature and intention of CO was made in 2016 by Harris et al. [13], who support the right to exercise CO. They state that it is 'the only legal way to refuse to provide abortions that are permitted by law.' In effect, the state is allowing objectors to personally boycott democratically-decided laws, usually for religious reasons, without having to pay any price for it. But why should doctors be given a privileged exemption from otherwise valid laws, when similar actions by other workers who serve the public would be treated as illegal or discriminatory and result in punishment for the workers?

The largely religious and non-verifiable basis of CO makes the laws and policies that try to limit its exercise impossible to enforce. The inability to control CO has especially negative consequences in countries with a lot of objectors. In such countries (Italy [14] and South Africa [15] are just two of many examples), abuse of CO is rampant, with many objectors refusing to stay within the limits defined by law. This points to another fundamental contradiction of 'CO': it is impossible to reconcile faith-based medicine with evidence-based medicine. If we allow the former to exist, faith wins by default because we cannot argue rationally against it or control it.

Can we identify 'true CO'?

Vélez and Urbano imply that CO for reasons of true conscience can somehow be identified and protected, as opposed to obstructionist CO. But they fail to explain or give examples of how to do this.

Anti-choice HCPs might claim they are motivated by 'respect for unborn life' (for example). But that raises the issue of how we cannot rely on peoples' stated justifications since one's personal or religious beliefs cannot be verified or falsified on a rational basis, including how genuinely such beliefs are held. It is also

[3] We focus on the harms of CO for abortion care specifically, because the latter is our main interest. However, most of our arguments apply to other reproductive health care such as contraception, vasectomy, etc., as well as other contested areas of health care such as medical assistance in dying.

inappropriate and impossible for courts or governments to 'decide' whether someone's religious beliefs are valid or sincere. That is because there is no evidence – we can only trust a person's word, which is not good enough. Allowing CO is a bad idea is because it leaves us unable to challenge peoples' justifications – we have to accept them at face value regardless of the harms they may cause to patients.

An article by two ethicists (Savulescu and Schuklenk) [16] also addresses this aspect:

> . . . individual moral judgments about the rights and wrongs of particular medical practices are by necessity partly arbitrary. They are arbitrary in the sense that their moral basis cannot be conclusively evaluated for soundness (an impossibility when it comes to religious convictions, for instance.) In some of these cases, there can be reasonable disagreement about whether the practice is right or wrong. As a result of this, pretty much any conscience view that is the result of some deliberation and is claimed to be held deeply and sincerely 'counts'.

Since it is impossible to determine whether an objector's motivations are genuine, or even to question them, there is no rational evidence-based argument for allowing CO. Laws and policies trying to control and limit CO cannot be effectively applied because consciences are private, subjective things that differ for each individual. It is simply not possible to have any criteria for CO, let alone enforce them. Anyone can cite CO and lie or exaggerate. Or be sincere. Who knows? The only way we can judge is in rare evidence-based situations, such as when doctors in Italy and Poland are caught exercising 'CO' in public hospitals while doing abortions for profit in private clinics [17,18].

The debate about where to draw the line between 'true and false' CO is an illogical attempt to distinguish between true and false religious beliefs, similar to counting how many angels can dance on the head of a pin. It is unresolvable. When we allow religious beliefs to dictate medical decisions, we fail patients and we fail society, because we have surrendered evidence-based medicine to irrationality.

Does CO have any place at all in health care?

HCPs should conscientiously refuse treatment based on the principle of 'beneficence' or 'non-maleficence' to ensure the patient is helped or at least not harmed. For example, this may become necessary if a patient requests a risky experimental treatment, or a mentally disturbed patient wants an unnecessary procedure such as an amputation.

However, such refusals should be rightly seen as an obligation of doctors to their patients and to their professional ethics [19]. They are not due to an individual doctor's subjective personal or religious beliefs, and therefore do not fit the definition of conscientious objection.

Likewise, HCPs should refuse to perform illegal or quasi-legal activities that are not requested by the patient and may injure people and violate their rights, such as torture or genital mutilation of children. Such practices are not legitimate medical treatments and do not have patient consent, which means that HCPs have a professional ethical obligation to refuse to provide them. Since these refusals are not grounded on the individual personal beliefs of HCPs, they do not qualify as CO.

Therefore, personal conscientious objection to a treatment that a patient requests has no valid place in health care. Treatment decisions by HCPs must be patient-directed, not self-directed, and must be based on evidence, medical ethics, and professional obligations. If the treatment is legal, within the HCP's qualifications, requested by a mentally healthy patient, and primarily beneficial (which abortion is), there is simply no excuse to refuse.

Can we rescue CO while protecting patients' right?

Over the last few years, many researchers and ethicists have tried to develop recommendations aimed at reducing the harms and barriers caused by CO in reproductive health care. These include: Harris et al. [13], Lertxundi et al. [20], Minerva [14], Cabal et al. [21], Downie et al. [22], Zampas and Andión-Ibañez [23], Cavallo and Michel [24], and contributors to a medical journal's supplementary issue on CO [25].

In the example from Harris et al., the authors claim that it is not CO itself that is the inherent problem. Rather, they argue that the political, economic, and social contexts in which objection occurs are responsible for the inadequacy of CO laws and regulations, their poor implementation and enforcement, the obstructionism of many objectors, and the stigma against abortion. The premise is: If we can address these external problems, then it would be possible to protect providers' claimed right to refuse to treat patients and patients' right to health care at the same time.

Those two goals are inherently contradictory on their face, and it remains unclear whether their proponents realize this on some level. The pattern that emerges from all these recommendations is a clear aim to curtail and control CO as much as possible – as if it is a bad thing, and not a right. Some fixes require extraordinary or long-term social/institutional changes such as significant reduction of abortion stigma, extensive awareness campaigns, or the decriminalization of abortion. Others are attempts to reduce the number of objectors or the extent of their CO, such as limiting its exercise to individuals involved in direct care, implementing monitoring and compliance measures, imposing disincentives on objectors, expanding abortion provision to GPs and midlevel HCPs, educating objectors on their duties, and offering values clarification workshops.

Common recommendations such as the requirements to refer and to provide emergency abortions, limit CO to the extent that conscience is no longer sufficiently protected or hardly at all, from the perspective of many objectors at least. Indeed, how can someone's true conscience be 'limited'? Who decides and on what basis? We are back to the impossible task of judging the integrity and depth of someone else's religious beliefs. Besides, asking doctors to compromise their beliefs is often futile. Large numbers of anti-choice doctors will never obey a requirement to refer [9,26], and some will let a woman die rather than perform a life-saving abortion required by law [11].

These attempts to mitigate the situation are a tacit admission that CO itself is fundamentally unworkable, ethically wrong, dangerous for women, and incompatible with reproductive health care and human rights [1]. Many are also based on wishful thinking, a hopeful pipe dream about how things should be. The inherent contradiction becomes apparent by the fact that no-one can cite a single example of 'successful' CO practice anywhere in the world – unless the measure of success is reducing the number of objectors to a tiny number, such as in Norway [27]. Indeed, only one approach has proved successful in eliminating the negative consequences of CO – prohibiting it.

Sweden, Finland, and Iceland do not allow doctors to exercise CO for abortion in public hospitals [28]. Denmark and Norway require every hospital to provide abortions without delay, although individual doctors retain a right to CO. Scandinavian countries are further ahead in gender equality compared to other countries, and since CO is largely a reflection of sexism [1], Nordic nations likely had a low number of objectors to begin with and were able to largely ban CO.

Therefore, as a first step towards mitigating the harms of CO, countries could at least require all publicly-funded hospitals to provide abortions, like Portugal [29] has also done. Enforcing such a ban would further serve to discourage potential objectors from entering any field or speciality that involves abortion care, thereby reducing the number of objectors even more over time, until it becomes feasible to ban CO entirely. This does not interfere with the conscience of individual HCPs, because if someone objects to doing abortions, the only *true* way to exercise freedom of conscience is to not enter the speciality of Obstetrics/Gynecology in the first place (or family medicine, midwifery, etc.), just as any true objector to killing in war should not voluntarily enter the military.

Of course, the more objectors a country has, the more difficult it is to assure services for women, especially in strongly-Catholic countries. This is the case even if they make efforts to limit CO through regulation, such as in some Latin American countries [30] as well as Portugal [31]. Unfortunately, it may not be possible to fix this situation until organized religion loses much of its influence, and paternalistic attitudes about women subside.

Colombia is actually a good example of how the attempt to regulate conscience generally falls far short of its goals. In 2014, Cabal et al. [21] promoted Colombia's CO principles that became law during 2006 to 2009 as 'strong guidance' for other countries, because they offer an 'informed and balanced approach to the protection of the freedom of conscience with women's reproductive rights, specifically the right to an abortion.' Yet, in 2016, we discover from Fink et al. [9] that implementation of the CO regulations in Colombia has been 'challenging and contentious' and 'inconsistent', with many hospitals setting their own policies that openly flout the law, and abortion opponents and some objectors adopting restrictive interpretations of the law or just ignoring it completely. In a separate 2016 paper, Uberoi and Galli [30] say that despite extensive regulation of CO in several Latin American countries to protect patients, 'doctors have still sought to abuse their rights' (Colombia); 'medical providers consistently refuse to perform essential services for women' (Argentina); and 'doctors have refused to provide [abortion] services' (Brazil).

Conclusion

Those who want to preserve 'conscientious objection' (CO) as a right in reproductive healthcare seem to treat it like a sacred cow, a religious belief that cannot be questioned. But mixing religion with evidence-based medicine does not work and has negative consequences.

Societies should still work to implement recommendations to mitigate CO and its harms, and robustly enforce existing CO regulations. Such measures are essential and will hopefully have positive effects over time. But the primary, transparent objective of these efforts should be to steadily reduce the number of objectors and eventually *abolish CO, not save it*. That should include the repeal of discriminatory policies and laws[4] that mistakenly treat CO as a 'right' of health care professionals. Instead, CO should be recognized as fundamentally unethical. It is 'dishonourable disobedience' and has no place in reproductive health care.

Conflict of interest

None.

[4] A leading example is Section 4 of the UK's 1967 Abortion Act, the first law in the world to allow CO in health care. However, this clause appears to violate the UK's 2010 Equality Act, which prohibits discrimination on the basis of sex or pregnancy.

Acknowledgment

None. Also, no sources of funding.

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