Conscientious objection to abortion and reproductive healthcare: a review of recent literature and implications for adolescents

Kathleen M. Morrell[a] *and Wendy Chavkin*[b]

Purpose of review
Conscientious objection to reproductive healthcare (refusal to perform abortion, assisted reproductive technologies, prenatal diagnosis, contraception, including emergency contraception and sterilization, etc.) has become a widespread global phenomenon and constitutes a barrier to these services for many women. Adolescents are a particularly vulnerable group because some providers object to specific aspects of their reproductive healthcare because of their status as minors.

Recent findings
Recent peer-reviewed publications concerning conscientious objection address provider attitudes to abortion and emergency contraception, ethical arguments against conscientious objection, calls for clarification of the current laws regarding conscientious objection, legal case commentaries, and descriptions of the country-specific impact of policies in Russia and Italy.

Summary
Conscientious objection is understudied, complicated, and appears to constitute a barrier to care, especially for certain subgroups, although the degree to which conscientious objection has compromised sexual and reproductive healthcare for adolescents is unknown. Physicians are well positioned to support individual conscience while honoring their obligations to patients and to medical evidence.

Keywords
abortion, conscientious objection, contraception, reproductive health

INTRODUCTION

Conscientious objection is defined as the objection to participate in an activity on ethical or moral grounds. Conscientious objection to reproductive healthcare (refusal to perform abortion, assisted reproductive technologies, prenatal diagnosis, contraception, including emergency contraception and sterilization, etc.) has become a widespread global phenomenon and constitutes a barrier to these services for many women. Adolescents are a particularly vulnerable group because some providers object to specific aspects of their reproductive healthcare because of their status as minors.

TEXT OF REVIEW

The consensus of the international human rights community (the UN Committee on Economic, Social and Cultural Rights, the UN Committee on the Elimination of Discrimination against Women, and the UN Human Rights Committee, the European Court of Human Rights) and the medical and public health community (FIGO, ACOG, WHO, etc.) is that the rights of the provider need to be balanced with the rights of the patient to have access to healthcare [1] (Fig. 1). There must also be safeguards to ensure patients receive accurate information and timely care through referral. In emergency situations, a patient's needs should trump the provider's beliefs and objectors must provide necessary care. International and regional human rights bodies, governments, courts, and health professional associations have developed different guidelines with regards to conscientious

[a]Physicians for Reproductive Health and [b]Mailman School of Public Health, Columbia University, New York, New York, USA

Correspondence to Kathleen M. Morrell, MD, MPH, 55 W 39th St, Suite 1001, New York, NY 10018, USA. Tel: +1 646 649 9919; e-mail: kmorrell.obgyn@gmail.com

Curr Opin Obstet Gynecol 2015, 27:333–338
DOI:10.1097/GCO.0000000000000196

KEY POINTS

- Conscientious objection to reproductive healthcare has become a widespread global phenomenon and constitutes a barrier to these services for many women including adolescents.
- Conscientious objection is understudied, complicated, and appears to constitute a barrier to care, especially for certain subgroups.
- The degree to which conscientious objection has compromised sexual and reproductive healthcare for adolescents is unknown.
- International consensus on conscientious objection affirms that providers have a right to conscientious objection, but that right should be secondary to their primary conscientious duty as healthcare providers to provide benefit and prevent harm to patients.

objection, but all based on these generally accepted principles.

Previous research about conscientious objection has been mostly qualitative and/or of methodological limitations. A recent review of extensive research of medical, public health, legal, ethical, and social science examined the prevalence, character, and impact of conscience-based refusal, and reviewed policy efforts to balance individual conscience, autonomy in reproductive decision-making, safeguards for health, and professional medical integrity [1]. This White Paper concluded that prevalence of conscientious objection is difficult to measure, as there is no consensus about criteria for what it means to be an objector and no standard definition of the practice. Nonetheless, consistent trends indicate that the array of objectors includes pharmacists who object to dispensing both medication abortion and contraception (including emergency contraception), GPs who object to referring patients to abortion providers, and providers who object to performing an abortion for a minor without parental consent even when the law allows it. The literature has shown that some clinicians purport to be objectors when in fact they are uncomfortable with specific patient characteristics or circumstances, rather than because of deeply held religious or ethical convictions. Examples include some doctors in Brazil who described themselves as objectors but were willing to provide abortions for family members [2], and Polish physicians who objected to providing abortion in their public sector jobs but provided abortions in their fee-paying private practices [3]. Others suggest some providers object in order to avoid stigmatized work rather than for reasons of conscience [4].

Although no specific studies in the last 18 months tackled conscientious objection to abortion care pertaining to adolescents, peer-reviewed publications address provider attitudes to abortion and emergency contraception, ethical arguments against conscientious objection, calls for clarification of the current laws regarding conscientious objection, legal case commentaries, and descriptions of the country-specific impact of policies in Russia and Italy.

Recently published work investigating providers' attitudes regarding conscientious objection

International Consensus:

- Providers have a right to conscientious objection and not to suffer discrimination on the basis of their beliefs.
- The primary conscientious duty of healthcare providers is to treat, or provide benefit and prevent harm to patients; conscientious objection is secondary to this primary duty.

Moreover, the following safeguards must be in place in order to ensure access to services without discrimination or undue delays:

- Providers have a professional duty to follow scientifically and professionally determined definitions of reproductive health services, and not to misrepresent them on the basis of personal beliefs.
- Patients have the right to be referred to practitioners who do not object for procedures medically indicated for their care.
- Healthcare providers must provide patients with timely access to medical services, including giving information about the medically indicated options of procedures for care, including those that providers object to on grounds of conscience.
- Providers must provide timely care to their patients when referral to other providers is not possible and delay would jeopardize patients' health.
- In emergency situations, providers must provide the medically indicated care, regardless of their own personal objections.

FIGURE 1. Principles related to the management of conscientious objection to reproductive healthcare provision.

has focused on physicians who object to providing referrals for abortion. Norway has more extensive regulation of conscientious objection than most: healthcare providers must provide written notice of conscientious objection, hospitals are required to report those individuals to government agencies, and a 2011 law explicitly prohibits conscientious objection by GPs for referral to abortion. Referral for abortion by a GP is a necessary step for women in Norway to obtain abortions in their healthcare system. One small qualitative Norwegian study of seven GPs who objected to referring was conducted in 2012–2013 when this law was being contested in the legislature [5▪▪]. These general practitioners perceived referral for an abortion as contributing to the abortion process in a way that they found to be morally problematic. They did, however, emphasize that they would give information on how patients could obtain referrals so as not to obstruct patients' legal right to abortion. Most of these GPs also stipulated that their refusal was not absolute; all but one would refer in cases of rape or incest, when the mother's life was in danger, and sometimes in other cases depending on the circumstances.

A survey of senior medical students in Norway revealed that 5% of respondents would object to referring for abortion and 15% of the total would object to performing a first-trimester abortion [6▪▪]. Consistent with the Norwegian social norms found in the qualitative interviews with GPs, 92% of the students felt that first-trimester abortion should remain legal and accessible. A total of 58% of the surveyed students said they support conscientious objection to performing or assisting with abortion, but only 10% support objection to referrals.

In Brazil, abortion is highly restricted but legal in the case of rape, requiring only the woman's consent to be permissible. In a recent mixed-methods study of 1690 Brazilian obstetrician–gynecologists who responded to an electronic, self-completed questionnaire, 82% said they request at least one physical document not required by law before agreeing to perform an abortion [7▪▪].

Nurses and midwives assist with abortion procedures in different ways depending on the setting. A qualitative study of 17 Italian midwives investigated their experiences taking care of women during second-trimester abortions in a hospital setting [8▪]. These midwives all struggled with the balance between empathy and their own personal belief, but firmly believed that caring for these women was part of their professional duty and that a woman should never be judged for her choices. A British nurse encouraged clinicians to thoroughly explore their own beliefs as a form of self-care, and also suggested that team leaders survey individuals' beliefs [9▪]. She explicitly asserts that conscientious objection during care for an emergency abortion is 'not valid'. Two Scottish midwife supervisors recently brought their conscientious objection case to court because they did not want to delegate or provide supervision or support at any stage of the abortion process [10▪]. They lost this case in the UK Supreme Court because the deputy president of the court Lady Hale concluded that their tasks did not constitute direct provision of the abortion. '"'Participate' in my view means taking part in a 'hands-on' capacity,'' she argued [11]. In a qualitative study in Senegal where abortion is highly restricted but post-abortion care is supposed to be readily provided, several providers reported that they would withhold care from women who came to the hospital bleeding until the women admit to having induced abortion [12▪]. None of these providers actually were observed to withhold treatment in the study, but indicated that they would inform police or obscure the induced abortion by reporting it as a spontaneous miscarriage in the medical records.

Pharmacists also assert conscientious objection status and have refused to dispense different contraceptive methods or medication abortion. Medication abortion has been covered by Australia's national healthcare system since 2013, but pharmacists are legally able to object to dispensing. They must, however, facilitate continuity of care for the patient according to the Pharmaceutical Society of Australia's Code of Ethics. Yet, in a recent qualitative study, 41 randomly selected pharmacists in Australia were interviewed regarding their attitudes and knowledge around medication abortion [13▪]. Half of the pharmacists objected to providing medication abortion and some refused to refer patients to another willing pharmacist.

Recently published authors on conscientious objection argue that the autonomy of the provider should be a secondary consideration, as the needs of the patient should be considered paramount. Giubilini [14▪] contends that it is not possible to defend conscientious objection in healthcare because of the potentially negative consequences of the objection. In the specific case of abortion, he asserts that referrals from an objecting provider can cause a woman psychological distress, and that objection may limit a woman's access as there may be few other available providers. Diniz [15] maintains that the private realm of religious beliefs should not interfere with public healthcare policy.

Others argue that existing laws need to be clarified and that more regulation is needed to protect the rights of women. The White Paper's authors call on medical organizations to recognize

their obligations to patients, as well as personal integrity, and therefore call for regulations that will balance these competing claims [1]. Zampas [16] points to the International Federation of Gynecology and Obstetrics' ethical guidelines on conscientious objection, the WHO Safe Abortion Guidelines, the UN Special Rapporteur on the Right to the Highest Attainable Standard of Health, and two recent decisions of the European Court of Human Rights as references for ethical and human rights standards. She illustrates the need for clear directives in order to balance the rights of women and the practice of conscientious objection. Johnson *et al.* [17] highlight the WHO Safe Abortion Guidelines and argue that countries should do more to ensure abortion access for women and ensure that conscientious objection is not abused. They stress that regulation of conscientious objection will help protect women's access to safe abortion. They also outline other health system interventions to increase abortion access: make effective contraception widely accessible, train midlevel clinicians in order to increase the number of abortion providers, provide abortion in the outpatient setting, and allow home use of medication abortion. Westeson [18] also references European Court of Human Rights decisions involving conscientious objection and explains why different country-level laws lead to varied outcomes for women. She implores medical professional societies to put forth guidelines, which can influence human rights courts. Heino *et al.* [19] explain the laws across Europe and again argue that the lack of current protection for women prevents some from gaining access to services, particularly in places where the prevalence of conscientious objection is high.

Shaw and Downie [20▪▪] underscore the confusion resulting from unclear policies regarding conscientious objection and the resultant obstruction to care in Canada, specifically in the northern territories. In Latin America where abortion laws are often restrictive, the prevalence of conscientious objection is highly problematic in those limited cases in which abortion is legally permitted. Russia passed a law in 2012 that allows physicians to conscientiously object to abortion by putting their objection in writing [21].

Faúndes *et al.* [22] explore the reasons behind conscientious objection, the consequences for women, and propose next steps for the FIGO Working Group for the Prevention of Unsafe Abortion. These include dispelling the myth that improved access increases the abortion rate, and promoting and normalizing the ethical principles that the primary duty of a physician is to provide benefit and prevent harm in an effort to break the stigma around abortion.

In Italy the prevalence of conscientious objection to abortion is high and prevalence of objection has been increasing for more than a decade [23▪▪]. Almost 70% of gynecologists, who are the sole legal providers of abortion, have registered as objectors. However, the criminal prosecution of almost 200 gynecologists is currently underway for claiming conscientious objection in their public sector jobs, but then performing unauthorized abortions in their private practices. One study analyzed Ministry of Health data in Italy and showed that the high prevalence of conscientious objection is leading to longer waits for abortion [24▪▪].

Kantymir and McLeod [25▪] propose a regulatory model wherein objectors are required to defend their objection and ensure that their patients receive timely care. The authors feel this requirement will help expose 'morally weak or corrupt norms in healthcare' with regards to conscientious objection [25▪]. Gallagher *et al.* [26] examine the dilemmas for pharmacists who object to emergency contraception, given the complexity of current regulations. They argue that guidelines should be consistent and restricted to the following two options: pharmacists should be compelled to dispense, or they can refuse to dispense or refer, and must accept the consequences.

DISCUSSION

As highlighted in this recent literature, the exercise of conscientious objection by clinicians occurs in many different aspects of reproductive healthcare. Conscientious objection appears to be inconsistently practiced by individual providers, witness the Norwegian GPs whose objection varied according to the reason for abortion and the Brazilian obstetrician–gynecologists whose objection varied according to patient characteristics [7▪▪]. This complexity illuminates the difficulty in defining conscientious objection and illustrates the need to disentangle prejudice from a consistently helpful moral position.

Another example of physicians who framed their bias as conscientious objection are the Brazilian physicians who interrogated rape victims and required unnecessary documentation of rape, and thus created obstacles for these women to abortion care. These providers knew such documentation was not required by law but defended their behavior claiming that it served to verify the truth of the rape allegation. The authors speculate that a physician's religious objection to abortion could cause them to have heightened suspicion of the truth of the rape allegation [7▪▪].

Italy is a country where physician behavior now constitutes a barrier to legal abortion care.

Conscientious objection has become the norm, with a resultant lack of providers, and therefore access for Italian women seeking abortion.

Norway serves as a counter example as abortion care has been normalized; abortion is less controversial than euthanasia and circumcision [6▪▪]. Wide ranging variation in beliefs about conscientious objection in Norway illustrates the importance of context and normative values within that context.

Both authors writing about nurses and midwives who assist in abortion care emphasized the importance of respecting the personal decision and rights of the patients [8▪,9▪]. International agreements uphold respect for the moral integrity of individual clinicians but concur that patient care must take priority and that the health system is obligated to assure that all patients have access to legal care.

CONCLUSION

Conscientious objection is understudied, complicated, and appears to constitute a barrier to care, especially for certain subgroups. Clinicians treating adolescents who seek abortion may conflate conscientious objection with disapproval of parentally unsanctioned premarital sexual activity. The international community has stated, 'Governments should ensure the protection and promotion of the rights of adolescents, including married adolescent girls, to reproductive health education, information and care' [27]. Adolescents are a vulnerable group and need protection of their basic human rights and their access to comprehensive reproductive healthcare. The degree to which conscientious objection has compromised sexual and reproductive healthcare for adolescents is unknown.

Yet although physicians care about their own individual ethics, they also care about their obligations to patients and to the highest standards of evidence-based care. They are thus well positioned to help society negotiate the tensions between honoring the rights of objectors, limiting their impact on others, and honoring the rights of patients and those of willing providers. Physicians can contribute this multiangled perspective to balancing these competing interests, advancing medical integrity and reproductive health.

Acknowledgements

None.

Financial support and sponsorship

None.

Conflicts of interest

There are no conflicts of interest.

REFERENCES AND RECOMMENDED READING

Papers of particular interest, published within the annual period of review, have been highlighted as:

- ▪ of special interest
- ▪▪ of outstanding interest

1. Chavkin W, Leitman L, Polin K. Conscientious objection and refusal to provide reproductive healthcare: a White Paper examining prevalence, health consequences, and policy responses. Int J Gynaecol Obstet 2013; 123:S41–S56.
2. Faúndes A, Duarte GA, Neto JA, de Sousa MH. The closer you are, the better you understand: the reaction of Brazilian obstetrician-gynaecologists to unwanted pregnancy. Reprod Health Matters 2004; 12:47–56.
3. Mishtal JZ (2006). Contradictions in democratization: the politics of reproductive rights and policies in postsocialist Poland [dissertation]. Boulder (CO): University of Colorado. http://www.federa.org.pl/dokumenty_pdf/prawareprodukcyjne/Mishtal%20dissertation.pdf. [Accessed 13 April 2015]
4. De Zordo S, Mishtal J. Physicians and abortion: provision, political participation and conflicts on the ground – the cases of Brazil and Poland. Womens Health Issues 2011; 21:S32–S36.
5. ▪▪ Nordberg EM, Skirbekk H, Magelssen M. Conscientious objection to referrals for abortion: pragmatic solution or threat to women's rights? BMC Med Ethics 2014; 15:15.

This qualitative study explores conscientious objection by Norwegian general practitioners to referrals for abortion.

6. ▪▪ Nordstrand SJ, Nordstrand MA, Nortvedt P, Magelssen M. Medical students' attitudes towards conscientious objection: a survey. J Med Ethics 2014; 40:609–612.

This study examines attitudes of Norwegian medical students toward conscientious objection to different aspects of medical care.

7. ▪▪ Diniz D, Madeiro A, Rosas C. Conscientious objection, barriers, and abortion in the case of rape: a study among physicians in Brazil. Reprod Health Matters 2014; 22:141–148.

This mixed-methods study explores the physician perspective about abortion in cases of rape in Brazil. It highlights that providers have become an additional barrier to care for women in Brazil.

8. ▪ Mauri PA, Ceriotti E, Soldi M, Guerrini Contini NN. Italian midwives' experiences of late termination of pregnancy. A phenomenological-hermeneutic study. Nurs Health Sci 2015; 17:243–249.

This qualitative study examines experiences of midwives caring for women and the complexities of their feelings.

9. ▪ Murray H. A reflective study on abortions in theatre. J Periop Pract 2014; 24:147–150.

This article puts forth recommendations for nurses on how to exercise conscientious objection without negatively affecting patient care.

10. ▪ Neal M. The scope of the conscience-based exemption in Section 4(1) of the Abortion Act of 1967: Doogan and Wood v NHS Greater Glasgow Health Board [2013] CSIH 36. Med Law Rev 2014; 22:409–421.

This article provides an in-depth analysis of this specific court case involving conscientious objection and discusses the potential implications going forward.

11. Brooks L. Catholic midwives' abortion ruling overturned by Supreme Court. The Guardian 17 December 2014. http://www.theguardian.com/world/2014/dec/17/catholic-midwives-abortion-ruling-overturned. [Accessed 10 April 2015]
12. ▪ Suh S; Rewriting abortion. Deploying medical records in jurisdictional negotiation over a forbidden practice in Senegal. Soc Sci Med 2014; 108:20–33.

This qualitative study from Senegal describes how providers treat women who they suspect have had an abortion.

13. ▪ Lee RY, Moles R, Chaar B. Mifepristone (RU486) in Australian pharmacies: the ethical and practical challenges. Contraception 2015; 91:25–30.

This qualitative study explores the attitudes of pharmacists in Australia to providing medication abortion.

14. ▪ Giubilini A. The paradox of conscientious objection and the anemic concept of 'conscience': downplaying the role of moral integrity in healthcare. Kennedy Inst Ethics J 2014; 24:159–185.

This article outlines one ethicist's argument that conscientious objection should not exist in healthcare.

15. Diniz D. Secular state, conscientious objection and public health policies. Cad Saude Publica 2013; 29:1704–1706.
16. Zampas C. Legal and ethical standards for protecting women's human rights and the practice of conscientious objection in reproductive healthcare settings. Int J Gynaecol Obstet 2013; 123 (Suppl 3):S63–S65.
17. Johnson BR Jr, Kismödi E, Dragoman MV, Temmerman M. Conscientious objection to provision of legal abortion care. Int J Gynaecol Obstet 2013; 123 (Suppl 3):S60–S62.
18. Westeson J. Reproductive health information and abortion services: standards developed by the European Court of Human Rights. Int J Gynaecol Obstet 2013; 122:173–176.
19. Heino A, Gissler M, Apter D, Fiala C. Conscientious objection and induced abortion in Europe. Eur J Contracept Reprod Healthcare 2013; 18:231–233.

20. Shaw J, Downie J. Welcome to the wild, wild North: conscientious objection ■■ policies governing Canada's medical, nursing, pharmacy, and dental professions. Bioethics 2014; 28:33–46.
This article provides a thorough examination of Canada's conscientious objection policies and puts forth recommendations for policy reform.
21. Erofeeva LV. Traditional Christian values and women's reproductive rights in modern Russia: is a consensus ever possible? Am J Public Health 2013; 103:1931–1934.
22. Faúndes A, Duarte GA, Osis MJ. Conscientious objection or fear of social stigma and unawareness of ethical obligations. Int J Gynaecol Obstet 2013; 123 (Suppl 3):S57–S59.
23. Minerva F. Conscientious objection in Italy. J Med Ethics 2015; 41:170–173. ■■
This article highlights the high prevalence of conscientious objection in Italy including cases wherein providers register as conscientious objectors, but perform abortions in their private practices.
24. Bo M, Zotti CM, Charrier L. Conscientious objection and waiting time for ■■ voluntary abortion in Italy. Eur J Contracept Reprod Healthcare 2015; 16:1–11.
This study analyzes Ministry of Health data and reveals that Italian women appear to wait for abortions because of the high rate of conscientious objection by providers.
25. Kantymir L, McLeod C. Justification for conscience exemptions in healthcare. ■ Bioethics 2014; 28:16–23.
This article proposes a regulatory model wherein objectors are required to defend their position and ensure that their patients receive timely care.
26. Gallagher CT, Holton A, McDonald LJ, Gallagher PJ. The fox and the grapes: an Anglo-Irish perspective on conscientious objection to the supply of emergency hormonal contraception without prescription. J Med Ethics 2013; 39:638–642.
27. United Nations Population Fund. Key actions for the further implementation of the program of action. 1999. http://www.unfpa.org/sites/default/files/resource-pdf/key_actions.pdf. [Accessed 23 April 2015]