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Article *in* Global Public Health · September 2016

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Conscientious Objection to Abortion Provision: Why Context Matters

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Acknowledgments

Sarah Baum, Clare Cameron, Kelly Knight, and Melissa Murray gave valuable feedback on drafts of this paper. Conversations with members of the UC Berkeley-UCSF Joint Medical Program, Seth Holmes, Lori Freedman, and members of Global Doctors for Choice helped provide background for the paper. A grant from a family endowment, the Schoeneman fund, supported Laura Harris's time writing this manuscript.

Conscientious Objection to Abortion Provision: Why Context Matters

Conscientious objection to abortion – a clinician's refusal to perform abortions because of moral or religious beliefs – is a limited right, intended to protect clinicians' convictions while maintaining abortion access. This paper argues that conscientious objection policies and debates around the world generally don't take into account the social, political and economic pressures that profoundly influence clinicians who must decide whether to claim objector status. Lack of clarity about abortion policies, high workload, low pay, and social and workplace stigma towards abortion providers can discourage abortion provision. As the only legal way to refuse to provide abortions that are permitted by law, conscientious objection can become a safety valve for clinicians under pressure and may be claimed by clinicians who don't have moral or religious objections. Social factors including stigma also shape how stakeholders and policymakers approach conscientious objection. To appropriately limit the scope of conscientious objection and make protection of conscience more meaningful, more information is needed about how conscientious objection is practiced. Additionally, abortion trainings should include information about conscientious objection and its limits, reproductive rights, and how to create an enabling environment for abortion provision. Policymakers and all stakeholders should also focus on creating an enabling environment and reducing stigma.

Keywords: abortion; conscientious objection; conscience-based refusal; stigma; enabling environment

Introduction

Conscientious objection to abortion provision is defined as a clinician's refusal to perform abortions because of religious or moral beliefs (Charo, 2015; Wicclair, 2011). Ethicists, legal scholars and policymakers delineate the scope of conscientious objection in differing ways depending on how they balance reproductive rights and health with clinicians' convictions (Charo, 2005; Chavkin et al., 2013; Cook & Dickens, 2006; Dickens & Cook, 2000; Faúndes Duarte, & Osis, 2013; Fiala &Arthur, 2014; Kantymir et al., 2014). Yet perhaps more significant – and less well understood – are the differences between, on the one hand, how policies in

various countries around the world define conscientious objection, and on the other, how health administrators and clinicians in those countries actually comprehend and practice it. Policies seldom take into account how the context in which reproductive healthcare is delivered will affect the practice of conscientious objection. Yet claims of conscience can be rooted in and mask economic, social and political pressures for providers. In part because of these contextual factors, conscientious objection can function as a barrier to abortion access, leading to an increased risk of morbidity and death for those who seek abortions outside the legal system (Chavkin et al., 2013). Women with the fewest resources are likely the most affected by provider objection, which increases inequities in reproductive health and choice (Chavkin et al., 2013).

Because of the potential of conscientious objection to endanger reproductive rights and health, it is imperative to understand how clinicians understand and practice it. In this paper, we define clinicians as members of health care cadres that are directly involved with providing abortions; depending on context, this may mean doctors, midwives, nurses with special training, or others. Other health workers who do not provide abortions - for example, medical receptionists, charge nurses - may attempt to invoke conscientious objection, but most policies do not permit indirectly associated health workers to claim objector status, and these other health workers are not the focus of this paper. This paper adds to the literature by attempting to situate conscientious objection in social, political, and economic contexts. It describes ways that contextual factors – from clinicians' compensation to social stigma – can affect the understanding and practice of conscientious objection; and it calls on researchers, reproductive health advocates and policymakers to take a broader view of the phenomenon. Accounting for context in this case improves understanding of conscientious objection, and provides the basis

for interventions that may protect both reproductive rights and clinicians' beliefs more effectively.

Conscientious objection policies

Conscience is considered worth protecting because forcing an individual to act against her conscience compromises that individual's identity and integrity (Wicclair, 2011). Conscientious objection, like civil disobedience, is rooted in moral conviction. However, while civil disobedience goes against a law, occurs publicly, and seeks to create wider change, conscientious objection occurs within the law, usually privately, and does not involve changing a broader system (Childress, 1985). The concept of conscientious objection to military service has existed since at least the Middle Ages, and has spread to healthcare as recently as the 1960s and 70s, largely in response to the liberalization of abortion during this time (Wicclair, 2011).

The ethical justification for conscientious objection presumes that it will not impinge on others' rights, in this case access to legal abortion. When objection makes accessing abortion more difficult, it stigmatizes patients, and contributes to the 44,000 deaths and even greater morbidity toll from unsafe abortion each year (Kassebaum et al., 2014). The impact for patients is particularly concerning from an equity perspective. The more vulnerable are overrepresented among those who seek abortions, as many have poor access to contraception or lack control over their reproductive lives (Finer & Zolna, 2011). Provider objection poses a barrier particularly for those who are already the most vulnerable, and who have the fewest resources – those who may not be able to take time off work or afford transportation for a second appointment, or are already dealing with too many burdens to find another provider, to overcome administrative barriers, or to find their own referrals as is often the case.

Thus, conscientious objection is a limited right: the ability to object should exist because clinicians are moral agents, but its practice should be limited because clinicians are also professionals with duties to their patients, who are entitled to legal health services (Wicclair, 2011). The International Federation of Gynaecology and Obstetrics (FIGO) and other professional societies take this approach, as do most countries around the world (Chavkin et al., 2013). Indeed, nearly all conscientious objection policies include limits on conscientious objection that are intended to help patients gain access to abortion services in a timely manner, such as referring patients who seek abortion to other providers (Beca et al., 2015; Chavkin et al., 2013; Instituto Borja de Bioética, 2012; McCafferty, 2010; Sepper, 2012). Some policies specify further limits, for example requiring that clinicians inform patients in advance of their objector status; that patients with unwanted pregnancies be informed of all legal options, including abortion; that health insurance plans are responsible for ensuring access to abortion despite conscientious objection; or that health facilities cannot claim conscientious objection (because only individuals and not institutions have moral agency) (Beca et al., 2015; Cabal et al., 2014; Chavkin et al., 2013; Instituto Borja de Bioética, 2012). Other conscience policies, however, state that health facilities can refuse to provide abortions at an institutional level (Wicclair, 2011). In sum, conscience should be meaningfully protected, but the ability to object on grounds of conscience should be limited.

Conscientious objection in practice

In contrast to the substantial bioethical and legal literature about conscientious objection, relatively little is known from a public health or medical perspective (Chavkin et al., 2013). There are far too few studies of the prevalence of objecting clinicians, and of how conscientious objection is understood and practiced (Chavkin et al., 2013). There are no systematic

investigations of conscientious objection's effects on patients, clinicians, or health systems (Chavkin et al., 2013). What is known about the practice of conscientious objection complicates the picture significantly.

The handful of studies available about the prevalence of conscientious objection in different countries has found that the percentage of clinicians who refuse to perform legal abortions ranges between 14% and 80%, depending on the country (Chavkin et al., 2013). One can imagine that when a majority of clinicians object, a seemingly simple task such as referral becomes difficult to implement. Patients may need to travel great distances to reach a willing clinician, if one can be found at all, and the few available abortion providers may be heavily overworked. Burdens of great distance may prevent women from obtaining abortions, and should be considered unacceptable (Zampas, 2013). Facilities should also guarantee continuity of care to women who receive abortions (i.e. a provider must continue an abortion procedure started on a prior shift) (Zampas, 2013). However, given the paucity of prevalence studies, most policies are made in the absence of prevalence data, and may not include sufficient measures to ensure access to abortion services.

Conscientious objection policies should also be considered in the light of other abortion policies in the country. In countries with restrictive abortion laws, which already have many barriers to abortion access, the barriers added by conscientious objection may be particularly burdensome on women seeking abortion - although conscientious objection can cause significant barriers in more liberal abortion policy contexts as well (Chavkin et al., 2013).

Further, in many contexts, clinicians and administrators are not familiar with relevant national policies about abortion and conscientious objection (Aniteye & Mayhew, 2013; Harries, Cooper, Strebel, & Colvin, 2014), and health facilities may not have clear protocols for how to

object (Harries et al., 2014). This lack of clarity might make some clinicians reluctant to participate in abortion services, or might result in clinicians overstepping the limits set in conscientious objection policies – for example, they may not know that they need to refer patients to another provider when they object. The confusion can be exacerbated by clinical instructors who are unsure or unaware of these laws themselves, or who are reluctant to teach about abortion care because it contradicts their own religious beliefs (Voetagbe et al., 2010). Lack of clarity can be further exacerbated by a general lack of clinician education about human rights and patient autonomy – principles that form the basis for limiting the practice of conscientious objection (Chavkin et al., 2013).

Some clinicians may claim conscientious objection in ways that do not reflect its purpose of protecting conscience. For example, articles from different countries have suggested that some clinicians may invoke conscientious objection as a strategy to disengage with a morally contentious issue: if they say they are objectors, they do not need to provide abortions (De Zordo & Mishtal, 2011; Dresser, 2005; Faúndes et al., 2013; Harries et al., 2014; Millward, 2010; Minerva, 2015; Mishtal, 2006; Sepper, 2012). Ironically, in this way conscientious objection may actually serve as an excuse for some clinicians to avoid grappling with difficult questions of conscience rather than as an affirmation of the importance of conscience (Sepper, 2012). Beyond using objection as a shield from a contentious issue, some providers may use it to alleviate stressful workloads or for other practical reasons. For example, one qualitative study described how some South African clinicians who self-identified as conscientious objectors became willing to provide abortions when financial incentives were given, suggesting that these clinicians' initial refusal to provide was driven at least in part by financial considerations (Harries et al., 2014). All of this suggests that the practice of conscientious objection may not always be a true

expression of conscience, but rather can sometimes be understood as an option providers have to respond to various stresses and incentives in their distinct social contexts.

A contextual perspective on conscientious objection

If we understand conscientious objection to be an exercise of moral agency by isolated individuals in environments that are morally neutral towards abortion, the differences between policy and practice may seem puzzling. They become easier to understand when we acknowledge that conscientious objection is a social act that takes place in an environment fraught with political, economic and social pressures. Conscientious objection appears to serve as a pressure valve: as the only legally permitted reason for objecting to providing a legal healthcare service (e.g., abortions that are legal and meet applicable administrative requirements), it can serve as a final common pathway for all the reasons that clinicians might not want to or feel able to provide this service.

For example, one could imagine that in the context of improved pay and workload, objection might not be as prevalent. Clinicians working in poor countries are often woefully overworked and underpaid, and health facilities – especially public sector health facilities – often lack basic resources (Astor et al., 2005). Hypothetically, in this economic context, it might be tempting to refuse to provide any service. The ability to object might even make some clinicians view abortion differently – as an 'optional' service. Unfortunately, these economic issues would emerge most strongly in the public sector, when public-sector clinicians are the ones charged with delivering the full range of health services as part of the right to health, and public health services are the only feasible option for patients with the least resources, those who most need to have that right protected by external forces. These hypothetical arguments should not be taken to imply that clinicians are indolent or unprincipled; on the contrary, we view most clinicians as

hardworking, highly principled, and motivated to serve their patients. However, they are subject to constraints on medical practice that may take their toll, much as context affects us all.

Abortion stigma only compounds these issues (De Zordo & Mishtal, 2011, Diniz, 2011; Faúndes et al., 2013; Hessini, 2014). Public knowledge of a clinician's willingness to provide abortions can come with a high price of social discrimination and even threats of violence in many societies (Hessini, 2014). The pressures can also be institutional. In Colombia, the *procurador* – the official in charge of making sure that public servants comply with laws – is strongly anti-choice; health administrators and activists report that complaints about abuse of conscientious objection are unheeded and some clinicians do not provide abortions because of fear of retaliation (personal communication with Colombian health administrator and activist, 2014). In Central and Eastern Europe, churches have pressured clinicians to publicly declare themselves to be conscientious objectors, threatening social and religious sanction if they do not comply (Fiala & Arthur, 2014). This is a particularly blatant example of social institutions (such as churches) actively and explicitly using conscientious objection as a tool to achieve ends that may not have anything to do with an individual clinician's conscience. However, similar but more implicit pressures may exist from a variety of social structures – whether from religious institutions, other organized groups, or from family or friends. In a recent article, Faúndes et al. (2013) have called on clinicians to stop hiding 'their fear of stigma [of abortion providers] under the guise of conscientious objection'.

Some clinicians identify as conscientious objectors in public facilities yet provide abortions in their private practice for a fee (Fiala & Arthur, 2014; Mishtal, 2006). In these cases, clinicians may be using conscientious objection in multiple ways: to refuse extra workload in their already busy public practice, to gain extra income, and to avoid stigma in their public

workplace. In some countries with restrictive laws, private offices are not authorized to provide abortions; if some providers prefer to perform abortions in their private offices rather than in the authorized public facilities, their patients face the added burden of having an illegal abortion when a legal one should have been available to them.

Conscientious objection is at its core a social phenomenon: objections to providing a healthcare service only become acceptable when this service is widely understood as morally controversial. For example, it is unlikely that physicians would be permitted to conscientiously refuse to prescribe pain medication even if they argued it went against their conscience. Pain medication is widely considered to be a central, un-controversial tool in allopathic medical practice; a physician who is morally opposed to medicating pain would depart from the socially understood physician's role.

The social, political and economic context also shapes broader attitudes about gender and reproductive health, which in turn affects the perceived legitimacy of abortion and of conscientious objection. Implicit beliefs about women, sexuality and reproduction play an influential role in shaping the boundaries of what options acceptable in the first place. Some feminist thinkers argue that the intertwining of religious morality and women's reproductive needs is inherently problematic. For example, Christian ethicist Beverly Wildung Harrison notes, 'much discussion of abortion betrays the heavy hand of misogyny, the hatred of women… [T]he Christian ethos is the generating source of the current moral crusade' (1983). Implicit political and economic assumptions also shape what we think of as a fair balance between patients' rights and clinicians' duties (Nader, 1997). Social forces thus complicate and problematize the meaning of conscientious objection even as they shape it.

Further, it is important to recognize that policies about abortion and conscientious objection are created in the same context that shapes the practice and public understanding of conscientious objection. In a telling discrepancy, most conscience policies only protect conscience-based *refusal* to provide abortions. Yet, in hospitals that do not provide abortion care, clinicians who feel a conscience-based duty to provide abortions – for example, in miscarriages where there is still a heartbeat but no chance of foetal survival – are not protected by most conscience policies, and must abide by hospitals' restrictive policies (Harris, Cooper, Rasinski, Curlin, & Lyerly, 2011; Sepper, 2012). In addition, several US laws about conscientious objection do not require clinicians to counsel patients on all of their options, or to refer patients (Sepper, 2012). Patient rights include the right to information (Cabal et al., 2014; Westeson, 2013); this abrogation of clinician responsibility to inform suggests that such laws are being used to further restrict abortion (Sepper, 2012).

The vision of a provider making an independent decision about objection based solely on their core moral or religious beliefs is, therefore, unrealistic. In light of this, how should we understand the clinician who decides to identify as a conscientious objector in part because the policies for abortion provision are unclear, and she doesn't want to put herself at risk of prosecution for her clinical actions? (For example, in restrictive contexts, a provider may invoke conscientious objection in order to avoid having to determine whether or not an abortion is legal.) Or the clinician who cannot perform abortions because he has not received adequate training, which may in part be due to administrators and/or educators' moral opposition to abortion (De Zordo & Mishtal, 2011; Voetagbe et al., 2010)? Can clinicians – whatever their beliefs – truly be considered conscientious objectors in a healthcare institution that already prohibits abortion care, such as a Catholic hospital? What about in a public hospital with an anti-

choice administrator? In short, what does conscientious objection mean in healthcare systems that in so many ways have already 'objected' to abortions? The focus of conscientious objection on individual decisions omits this larger picture and can cause us to neglect the ways that social, political, and economic factors shape abortion access. This process of misrecognition – viewing complex social processes as resulting only or primarily from individual behaviour – has been described in various arenas (e.g. Bourdieu & Wacquant, 2003).

Pathways forward

In their 2014 article, Fiala and Arthur discuss many of the issues that we have addressed – lack of clarity in policies, misuse of objection in practice – and conclude that conscientious objection is inherently, irredeemably flawed. They advocate for abolishing conscientious objection, and changing the term to 'dishonourable disobedience' to emphasize that objection is an inappropriate abdication of responsibility by clinicians. While their observations regarding the abuses and misuses of conscientious objection are apt, the argument that such misuses are inherent to conscientious objection as a construct is more challenging to prove. Indeed, it is more likely that such misuses are encouraged by the specific ways that laws are formulated and regulated, as well as the political, economic social contexts in which the objection occurs. A contextual perspective not only helps make sense of how conscientious objection is currently practiced; it can provide insight into ways to reduce abuses.

As a first step towards reduction of abuses of conscientious objection, more information about how objection is practiced is sorely needed. Policymakers, public health planners, and other stakeholders have far too little data on conscientious objection and its effects. Collecting reliable data about the prevalence of conscientious objectors in specific countries of interest will help shed light on the magnitude of the issue. Given the complexities of the practice of

conscientious objection, research should assess not only whether a clinician self-identifies as a conscientious objector, but also their knowledge, actions and beliefs related to conscientious objection and to abortion more broadly. Research should also investigate how clinicians and administrators view conscientious objection, how it operates within a social context, and its effects on patients as well as clinicians. Importantly, the practice of conscientious objection may operate quite differently in different countries, cultures, and contexts, and it may be more germane to some contexts than it is to others. More research about conscientious objection will help uncover variations, and answer questions about how to define it and whether it can or should be understood as a singular, translatable concept.

In addition to more research, clearer policies and regulations that respond to contextual factors are needed. Importantly, these regulations should not focus on punishing clinicians, and should not make clinicians choose whether they identify as objectors without also ensuring that these clinicians have proper knowledge, training and facility-level support for abortion provision. In fact, policies in the absence of clearly communicated guidance and support have the potential to dramatically reduce access to abortion provision, by forcing some clinicians who may provide some abortions (i.e. abortions that conform to their context-specific beliefs of what they should or should not provide), to instead provide none. Instead, regulations should aim to create more feasible opportunities to provide abortions for those who want to do so – for example, by addressing basic working conditions and by reducing abortion stigma. Equally important, policies should encourage and enable clinicians who are morally opposed to abortions to practice conscientious objection and not obstruction. This involves not only making the regulations themselves clearer (i.e. specifying that unbiased counselling on all pregnancy options is

mandatory) and encouraging protocols at facilities to help implement these policies, but by pursuing complementary strategies to address the environment of stigma as a whole.

One of these complementary strategies would be to include trainings on abortion and conscientious objection in pre-clinical education and in-service training for appropriate clinicians (doctors, midwives, and some nurses, depending on context) that robustly prepare these clinicians to perform abortions. Clinicians are much more likely to provide abortions if they feel confident in their technical skills with the procedure (Sundaram, Juarez, Ahiadeke, Bankole, & Blades, 2014), and even conscientious objectors should be able to provide abortions in emergency situations. Importantly, abortion trainings should also include sessions on human rights, medical ethics, and clinician duties, as well as personal opportunities for values clarification. Reproductive rights and patient autonomy are the driving force that limit the scope of conscientious objection; clinicians' decisions about whether to provide abortions should occur with their robust understanding of patient rights as elaborated by the national health system and international professional and human rights bodies. Such international bodies - for example, the International Federation of Gynecology and Obstetrics (FIGO) and the European Court of Human Rights - have affirmed that conscientious objection must be limited by duties to patients, including providing information, referring or providing service in urgent cases or when referral is unavailable (Zampas, 2013; Zampas & Andión-Ibañez, 2012). Abortion trainings at the facility level could work towards creating an enabling facility environment by training administrators as well as clinicians in the scope and limits of conscientious objection, and by including time to brainstorm ways that units can support clinicians who provide abortions and support patients who seek abortions.

Clinicians and administrators must be supported in creating an enabling environment; policymakers and all stakeholders around the world must also work to create an environment that is more supportive of abortion provision. Unfortunately, this environment is the most feasible to achieve in settings that already have the least stigma and opposition to abortion provision. Part of addressing conscientious objection is to work towards reducing stigma at social, institutional, and clinician levels, and improving clinicians' working conditions. These are challenging tasks to be sure, but their benefits go far beyond improving the practice of conscientious objection.

Conclusion

Bioethics literature often describes conscientious objection as a balance between a clinician's status as a moral agent, with responsibility to her or his own integrity, and the clinician's status as a professional agent, with responsibilities to patients. This calculus misses a third consideration, that the clinician is also a social, economic and political agent, responding to, and exerting, social and political pressures. Indeed, misapplications of conscientious objection are best understood not only in terms of individual clinician behaviour, but also as a function of the broader political and social dynamics related to abortion and healthcare provision. Policies about conscientious objection usually fail to take these pressures into account, and are themselves created in the context of similar pressures. In practice, divergences from these policies by clinicians and health administrators have significant consequences for the wellbeing of patients and their clinicians. Because the poorest are the least likely to have the time or money to search for another abortion provider, abuses of conscientious objection increase inequity in reproductive health. Further, abuses undermine the legitimacy of conscience as worth protecting. Conscience is worth protecting, but its protection can only be meaningful in an environment that enables abortion provision.

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