HHR Health and Human Rights Journal

LETTER TO THE EDITOR

Refusal to Treat Patients Does Not Work in Any Country—Even If Misleadingly Labeled "Conscientious Objection"

CHRISTIAN FIALA AND JOYCE H. ARTHUR

We would like to point out some serious problems and contradictions in the study "Regulation of Conscientious Objection to Abortion: An International Comparative Multiple-Case Study," by Wendy Chavkin, Laurel Swerdlow, and Jocelyn Fifield (*Health and Human Rights Journal*, vol. 19, no. 1, 2017).

The study purports to show that it is possible to accommodate health care providers' "conscientious objection" (CO) to legal abortion while assuring that women with an unwanted pregnancy have access to health care services. The researchers examined four countries—England, Italy, Portugal, and Norway—all Western democracies with laws that allow CO for abortion. They conclude that England, Norway, and Portugal are able to permit CO by law and still provide and fund abortion care. Italy is the major exception, where access to legal abortion is seriously compromised due to a very high number of objectors.

However, significant information is omitted from the study, the choice of countries and interviewed stakeholders are selective and unrepresentative, and the findings are interpreted in a biased way. The study does not lend weight to the acceptance of CO for abortion in any country, including the four studied. Instead, the results confirm that refusing to provide basic health care cannot and should not be "accommodated" with patient needs—not even if the treatment refusal is misleadingly called "conscientious objection."

In the introduction, the authors explain that CO was introduced into law "out of political compromise or pragmatic necessity," but they omit the obvious reasons for this unprecedented intrusion of personal beliefs into medical regulation. Individuals are allowed to boycott a democratically decided law because of society's deference to religious beliefs and traditional views that assign women to a childbearing role. This points to an inappropriate and unethical basis for CO in reproductive health care—one that has little in common with the military CO it is dishonestly named after. Indeed, many people have argued against the exercise of CO in health care, but the authors never mention this opposing view.[1]

The study's selection of four countries that allow CO is biased and rather puzzling. At least 22 countries allow CO through regulation, so why did the authors exclude most of them? They cite the four countries' ratification of various international human rights agreements as one apparent reason. However, ratified agreements are no guarantee of compliance and have limited relevance to the utility of CO regulation. They also state that the four countries meeting their requirements are those with CO clauses in statute, legal abortion, and funded health care, and are "all high-income Western European countries with liberal

Christian Fiala, MD, PhD, is a specialist in obstetrics and gynecology at Gynmed Clinic, Vienna, Austria, and a researcher in the Division of Obstetrics and Gynecology, Department of Women's and Children's Health at Karolinska Institutet, Stockholm, Sweden.

Joyce H. Arthur is executive director of the Abortion Rights Coalition of Canada.

Please address correspondence to Joyce Arthur. Email: joyce@arcc-cdac.ca.

Competing interests: None declared.

Copyright © 2017 Fiala and Arthur. This is an open access article distributed under the terms of the Creative Commons Attribution Non-Commercial License (http://creativecommons.org/licenses/by-nc/3.0/), which permits unrestricted noncommercial use, distribution, and reproduction in any medium, provided the original author and source are credited.

abortion regimes." However, CO regulations vary widely and are not directly comparable across the four selected countries.

Italy does not have a liberal abortion regime and has no legal limits on the exercise of CO. The 1978 Italian law that legalized abortion grudgingly allows it while trying to limit it as much as possible.[2] Nothing in the law requires doctors to provide abortions—it requires them only to *consider* whether to do so in each case, and gives them wide discretion to refuse. CO is now widespread in Italy, exercised among 82% to 91% of all gynecologists, according to the authors—even though gynecologists are the only health care professionals who can legally provide abortion care. Italian women cannot escape to private clinics as they can in England, because the Italian law limits abortion to public facilities—which are not obligated to provide the service. While some private clinics and "conscientious objectors" do provide abortions for profit in Italy, many women resort to illegal abortion or travel to other countries.[3] In Switzerland, 23% of all abortions in the border region of Tessin are done for women from Italy.[4]

Why did the authors not select one of the three countries (Sweden, Finland, and Iceland) that disallow any refusal to treat, including for abortion?[5] Without such an example, any comparison of the utility of "regulation of CO" will be incomplete and misleading. The authors briefly mention such countries but understate the situation by claiming that the absence of CO regulation has "been interpreted to mean that providers lack a legal right to object." In fact, CO is actively disallowed by policy in Sweden, Finland, and Iceland, as well as by court jurisprudence in Sweden.[6] The prohibition of CO has positive consequences—women have good access to abortion, and providers are held accountable for their professional obligations to patients.

The selective aspect of the four countries is also apparent with the inclusion of England. It cannot have escaped the authors' notice that England is not a country on its own and therefore not directly comparable to the other three. Did the authors select this part of the United Kingdom because CO is less of a problem in England compared to other parts of the country, such as Northern Ireland?

A major flaw is that the authors rely only on what the laws state and what their invited stakeholders said. The latter were arbitrarily selected for convenience, based on the researchers' ability to find them and conduct interviews. They included lawmakers, legal experts, health system officials, medical association representatives, reproductive health advocates, academics, bioethicists, anti-abortion advocates, and religious freedom advocates. Few of these people would have any knowledge of what is happening on the ground. CO regulations are poorly enforced in almost every country, and the study interviewees highlighted the "scant or spotty regional and national data on the prevalence and characteristics of objection" in their countries. Therefore, it is not possible to conclude that CO works well in some countries just by examining their laws and interviewing people who are not directly concerned and not even on the frontlines. They cannot know the extent to which CO laws are ignored or disobeyed by objectors, or how often women are denied services and treated unjustly.[7]

It is also difficult to understand why the authors would select stakeholders who are against abortion or who have only religious qualifications, while excluding the only persons affected by CO—pregnant women. Leaving out the real-life experience of women in a subject that affects them alone recalls the dark era of the paternalistic past and goes against all modern human rights values.

In the authors' case summaries of the four countries, it becomes clear why the negative consequences of CO appear to be reduced in Norway, England, and Portugal. First, all three countries "reserve certain positions for non-objectors." In other words, refusal to treat under CO is allowed only to a certain extent. Second, all hospitals in Norway and Portugal are obligated to provide abortions and are responsible for employing enough personnel to do so. Third, while doctors in England can object in the public system, the National Health Service contracts out most abortion care to private organizations like the British Pregnancy Advisory Service and Marie Stopes, who of course hire only non-ob-

jectors. This shows that CO can be minimized by imposing firm restrictions, because it results in fewer objectors. England and Norway both have low numbers of objectors, which may also relate to low levels of religiosity in both countries. Therefore, the authors are wrong in asserting that CO regulation can accommodate objectors—in fact, the most successful CO regulations reduce the numbers of objectors to very low levels, to the point that it should become feasible to prohibit CO entirely.

Portugal is deemed successful by the authors on the basis that it is small, so women can travel to find an abortion provider and even receive funds to do so. Also, all public hospitals are obligated to provide abortions. But little is known about the number of objectors in Portugal, whether hospitals and objectors are obeying the law, and what actually happens to women. As the authors admit, "Rigorous data on the prevalence of objection are not available." Also, few objectors are even aware of their legal duties to inform the national Order of Doctors and their patients about their objection. This reporting aspect of the CO law is not being followed because, apparently, "informal adjustments suffice."

The authors' study concedes that allowing CO makes access more difficult for women and increases the burden on health care systems to provide abortion, which they often fail to do. There are "varying degrees of implementation" of the laws, which generally require health care institutions to expend their own resources by hiring extra providers while paying objecting doctors to not do their job, or to contract out abortion care to private clinics. Further, health care personnel often have insufficient knowledge of the law, and Italy has a significant amount of "convenient objection" unrelated to conscience, as well as excessive workloads for abortion providers. None of that stops objectors in Italy and Portugal from complaining that attempts to hire non-objectors are discriminatory, even though hospitals must provide abortions by law.

Indeed, the authors note that "[a]ll interviewees opposed to abortion expressed discontent with any constraints on CO." This confirms that CO regulations are fatally flawed because of the assumption that objectors will follow them. The authors admit that all four countries have had clinicians who "illegally invoked CO to the provision of emergency contraception, intrauterine devices, and post-abortion care," as well as "uneven and incomplete monitoring of compliance." As we know, many anti-abortion doctors refuse to obey a requirement to refer, and some will even let a woman die rather than perform a life-saving abortion required by law.[8]

The study actually shows that CO regulations give a false sense of security to those who wish to "simultaneously" protect doctors' refusal to treat and patients' right to health. The conflict between these two objectives brings to mind the Enlightenment of the 18th century, when societies recognized the need to limit the power of religious beliefs and switch to evidence-based decision making. Why, in the 21st century, are we still debating whether this secular principle should apply to women with an unwanted pregnancy?

References

1. C. Fiala and J. H. Arthur, "'Dishonourable disobedience': Why refusal to treat in reproductive health care is not conscientious objection," *Woman – Psychosomatic Gynaecology and Obstetrics* 1 (2014), pp. 12–23; R. Y. Stahl and E. J. Emanuel, "Physicians, not conscripts: Conscientious objection in health care," *New England Journal of Medicine* 376/14 (2017), pp. 1380–1385; H. Lafollette, "My conscience may be my guide, but you may not need to honor it," *Cambridge Quarterly of Healthcare Ethics* 26/1 (2017), pp. 44–58; C. Munthe, M. Ebbe, and J. Nielsen, "The legal ethical backbone of conscientious objection," *Cambridge Quarterly of Healthcare Ethics* 26/1 (2017), pp. 59–68; J. Kennett, "The cost of conscience," *Cambridge Quarterly of Healthcare Ethics* 26/1 (2017), pp. 69–81; U. Schuklenk and R. Smalling, "Why medical professionals have no moral claim to conscientious objection accommodation in liberal democracies," *Journal of Medical Ethics* 43/4 (2016), pp. 234–240; A. Giubilini, "Objection to conscience: An argument against conscience exemptions in healthcare," *Bioethics* 31/5 (2016), pp. 400–408.
2. Columbia University, *The legalization of abortion: Law 194 of the Italian Republic, 1978*. Available at http://www.columbia.edu/itc/history/degrazia/courseworks/legge_194.pdf.
3. A. Giubilini, "Conscientious objection and medical tribunals," *Journal of Medical Ethics* 42/2 (2015), pp.

78–79; C. Torrisi, "Abortion in Italy: How widespread 'conscientious objection' threatens women's health and rights," *Open Democracy* (June 15, 2017). Available at https://www.opendemocracy.net/5050/claudia-torrisi/abortion-italy-conscientious-objection.

4. Swiss Federal Statistical Office, *Bestandesaufnahme der Schwangerschaftsabbrüche in der Schweiz, Bundesamt für Statistik* (Abortion statistics in Switzerland, National Statistical Office) (August 2015.) Available at https://www.bfs.admin.ch/bfsstatic/dam/assets/350139/master.

5. C. Fiala, K. Gemzell Danielsson, O. Heikinheimo, et al., "Yes we can! Successful examples of disallowing 'conscientious objection' in reproductive health care," *European Journal of Contraception and Reproductive Health Care* 21/3 (2015), pp. 201–206; E. Löfgren. "Anti-abortion midwife was not discriminated against, Swedish court rules," *The Local* (April 12, 2017). Available at https://www.thelocal.se/20170412/anti-abortion-midwife-was-not-discriminated-against-swedish-court-rules.

6. Fiala et al (see note 5); Löfgren (see note 5).

7. C. Fiala and J. Arthur, *Conscientious objection: Victims of CO* (2017). Available at http://www.conscientious-objection.info/category/victims-of-co.

8. Ibid.; L. R. Fink, K. K. Stanhope, R. W. Rochat, and O. A. Bernal, "'The fetus is my patient, too': Attitudes toward abortion and referral among physician conscientious objectors in Bogotá, Colombia," *International Perspectives on Sexual and Reproductive Health* 42/2 (2016), pp. 71–80; F. A. Curlin, R. E. Lawrence, M. H. Chin, and J. D. Lantos, "Religion, conscience, and controversial clinical practices," *New England Journal of Medicine* 356 (2007), pp. 593–600.