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CONSCIENTIOUS OBJECTION & CONSCIENTIOUS COMMITMENT

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Guest Editor: Dr. Connie Lu, Complex Family Planning Fellow, University of Illinois

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CONSCIENTIOUS OBJECTION & CONSCIENTIOUS COMMITMENT

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WHY THIS GAZETTE?

The Asia Safe Abortion Partnership is the only safe abortion rights advocacy network in Asia. Founded in 2008 it has members from over 20 countries across South Asia, South East Asia, South West Asia and the Oceania region.

As new members and partners join the safe abortion rights' movement we realized that there are hardly any collated or curated resources that they can engage with in order to gain a deeper understanding of some of the key issues or challenges in this work.

There are search engines and journals and many websites dedicated to safe abortion rights information and even services which people can access. However, there is no dedicated space where you can get a snapshot of a core topic within safe abortion rights that can offer someone the highlights of the scope of the issue and a range of perspectives that are relevant to us as a movement.

In order to address this gap, we have launched The Abortion Gazette.

This will be an immersive repository for a reader who would like to learn more on the landscape and depth of the issue in a relatable and practical way without having to search through pages and pages on the internet and sifting through multiple sources.

It will be a short quarterly publication and will include lead articles, clinical updates, thought pieces, interviews, statistics and of course links to other key articles, videos and other relevant material.

It will be published on the ASAP website as a pdf that can be downloaded and printed for use by anyone in the safe abortion rights movement. For those who would like to engage in deeper learning and a structured program, stay tuned for more updates!

Is it time for CIVIL DISOBEDIENCE?

Editorial by Suchitra Dalvie

From the Boston Tea Party to Mahatma Gandhi's Salt March, and from suffragists' illegally casting their ballots to whites-only lunch counter sit-ins, civil disobedience. has often played a crucial role in bending the proverbial arc of the moral universe toward justice.

So how is it different from other forms of political action?

Henry David Thoreau is widely credited with coining the term civil disobedience. For years, Thoreau refused to pay his state poll tax as a protest against the institution of slavery, the extermination of Native Americans, and the war against Mexico. Civil disobedience is the active, non-violent refusal to accept the dictates of governments. It informs them that unjust actions will be opposed and the people will act illegally if pushed to do so.

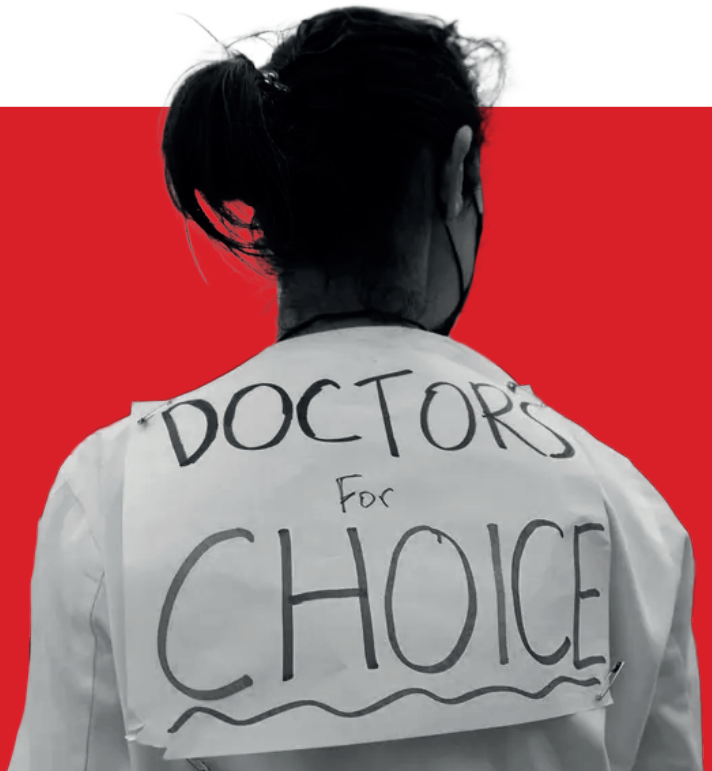
Civil disobedience causes disruption and focuses attention, while forcing debate with the aim of bringing about fundamental and progressive changes within our societies and our world.

You may wonder....how would this
be different from the actions of the anti-choice persons or those indulging in conscientious refusal or conscientious objection?

It may need more deliberation from us in the safe abortion rights movement but if civil disobedience is expected to bend the arc of the moral universe towards justice, then surely preventing deaths of pregnant persons by forcing them to have unsafe abortions, preventing damage to their mental health caused by forced births and ensuring that government policies and legal provisions protect those made vulnerable by an unwanted pregnancy would be a step in the right direction?

Self -managed abortions need to be included proactively within all service delivery system models. Including perhaps new research to find a way that molecules of Mifepristone and Misoprostol could be genetically modified to grow in kitchen plants so that women and pregnant persons could access directly without needing a service provider!

Just because you need a service provider to obtain an abortion does not mean they should have the power to decide whether you can actually obtain that service at the time and place of your choosing and your comfort and safety.



WHEN IS BREAKING THE LAW ILLEGAL AND WHEN IS IT CIVIL DISOBEDIENCE?

For a healthcare provider it should be rather simple. If the law is wrong and causing you to be involved in harming patients, it is in fact your professional obligation to ensure that your action or inaction will do no harm.

Here is news from Texas where the new legislation bans abortions from as early as six weeks into a pregnancy and gives any individual - from Texas or elsewhere - the right to sue doctors who perform an abortion past the six-week point. Dr. Alan Braid provided an abortion beyond 6 weeks and has been sued. Dr. Braid, who has been practising medicine for nearly 50 years wrote in an opinion column: "I acted because I had a duty of care to this patient, as I do for all patients, and because she has a fundamental right to receive this care. I fully understood that there could be legal consequences - but I wanted to make sure that Texas didn't get away with its bid to prevent this blatantly unconstitutional law from being tested," he wrote.

In India during the freedom struggle against the British colonizers in the 1940s, Mahatma Gandhi utilized the full power of civil disobedience and non-cooperation and also used a second level tactic called the Jail Bharo Andolan where protesters voluntarily let themselves get arrested in order to fill up the jails of the oppressive regime.

We may not be at that stage yet but it is certainly time for those of us who believe in autonomy, agency and the right to access safe abortions for an unwanted pregnancy to start actively bending the arc of the moral universe towards justice by speaking out and acting upon our beliefs!

It is time to bring back some civil disobedience!

World Health Organization

hrp

Preventing unsafe abortion

Evidence brief

Around 25 million unsafe abortion were estimated to have taken place worldwide each year, almost all in developing countries (1)

Key facts

- Between 2010–2014, on average, 56 million induced (safe and unsafe) abortions occurred worldwide each year.
- There were 35 induced abortions per 1000 women aged between 15–44 years.
- 25% of all pregnancies ended in an induced abortion.
- The rate of abortions was higher in developing regions than in developed regions.
- Among the 25 million unsafe abortions, 8 million were carried out in the least- safe or dangerous conditions.
- Over half of all estimated unsafe abortions globally were in Asia.
- 3 out of 4 abortions that occurred in Africa and Latin America were unsafe.
- The risk of dying from an unsafe abortion was the highest in Africa.
- Each year between 4.7% – 13.2% of maternal deaths can be attributed to unsafe abortion *(2)*.
- Around 7 million women are admitted to hospitals every year in developing countries, as a result of unsafe abortion *(3)*.
- The annual cost of treating major complications from unsafe abortion is estimated at US$ 553 million *(4)*.
- Safe abortion must be provided or supported by a trained person using World Health Organization (WHO) recommended methods appropriate for the pregnancy duration.
- Almost every abortion death and disability could be prevented through sexuality education, use of effective contraception, provision of safe, legal induced abortion, and timely care for complications

Full report linked here.

CONSCIENTIOUS PROVISION: a moral act of resistance

Lead Article by Dr. Connie Lu, Guest Editor

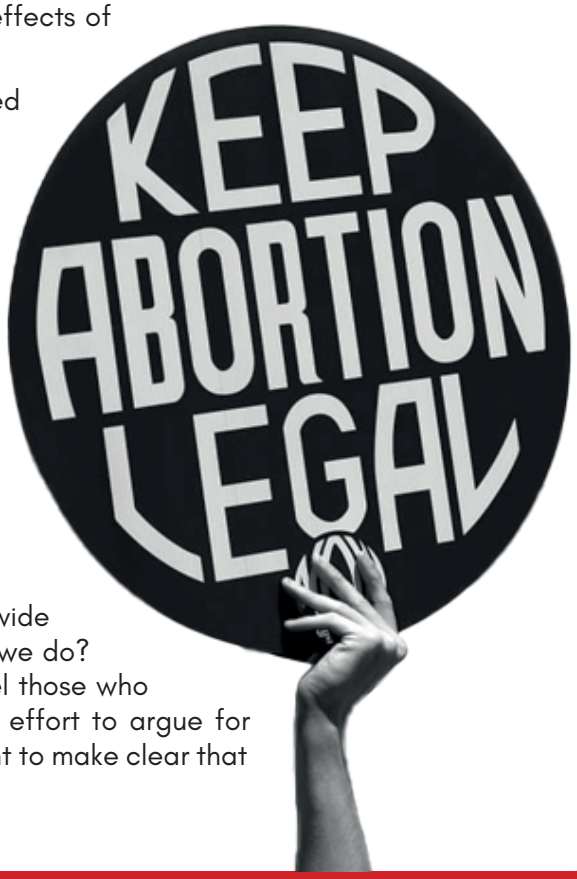
The following pages of this edition will center on conscientious objection – from its origin to its consequences to its resistance. Conscientious objection, the idea that providers can refuse care based on their conscience, refers to a number of scenarios; here, we focus on its cooptation within reproductive healthcare to decrease access to comprehensive contraceptive and abortion care, an impact that feels even more relevant now.

While we often talk about the "moral" line that must be crossed when an anti-choice provider encounters a patient needing abortion care, do we yield the same status to providers who feel a moral imperative to help patients receive essential healthcare? As an abortion provider myself, I hope to use these starting words to do just that – celebrate conscientious provision and those morally grounded providers who place patient autonomy and care above all else.

When describing abortion through the lens of conscientious objection, we start to insidiously equate the objection to abortion provision as morally "good" and the provision of abortion care as morally "bad." This is an almost natural association for our minds to make, as abortion care – and everything encompassed by it – is steeped in a history of stigmatization. Patients who have abortions are seen as deviant, pushing against ideals of innocent femininity and motherhood. Abortion providers have historically been painted as "dirty" and "illegitimate", qualities not often ascribed to the average physician. Especially relevant to the United States but applicable in a global context, the oppressive politics surrounding abortion fuel images of both patients and providers as criminals and felons.

Even at the level of medical education, we see the effects of abortion stigma.

Though multiple governing bodies have affirmed abortion as a fundamental component of essential reproductive healthcare, trainees in OBGYN are not receiving the education they need to feel competent in abortion care.



Abortion stigma has numerous disastrous downstream consequences, which could fill an entire gazette on its own. But, relevant to the topic of this issue, abortion stigma paves the path for conscientious objection to flourish, as it becomes seemingly obvious that healthcare providers, from pharmacists to physicians, would refuse to perform such an 'immoral' act despite the needs of their patients.

In the face of this hostility, abortion providers still provide – and, with pride. What drives us to provide the care we do? Is it not the same sense of morality and duty that fuel those who object? And while this analogy is often made in an effort to argue for protection of those who conscientiously provide, I want to make clear that the two are not morally equivalent.

Matthews writes on this moral asymmetry:

"Refusers often act against the interests, choices, and well-being of an oppressed population. Conscientious provisions seek to do the opposite. They promote patient autonomy by providing patients with healthcare that they desire and that is manifestly beneficial for them."

Negative claims of conscience have long been legally protected, but we often do not see the same fervor when it comes to provision. In the United States, this protection is now more important than ever. In June of 2022, the Dobbs v. Jackson Women's Health Organization Supreme Court decision took away constitutional protections for abortion and unleashed countless abortion bans across the country. In addition to the insurmountable barriers that obstruct patient care, providers are now in situations battling both their conscience and professional obligations against the legal landscape. Extreme political bans have resulted in extreme and heartbreaking stories; there are patients with ectopic pregnancies turned away without the appropriate treatment and those with previable premature rupture of membranes who await sepsis prior to getting their necessary procedure, to name a few. Two years later, these situations are no longer novel but still extremely dangerous. In this environment, conscientious provision is no longer a pro-choice perspective – it is vital to protect the lives of our patients and communities.

More than just a protection of abortion providers and their work, conscientious provision or commitment demands a complete cultural reframing of abortion care – as an act of good rather than something morally fraught. **Instead of protecting those who oppose abortion provision, how do we recenter our efforts on protecting those who provide?**

As we dive deeper into the scholarship surrounding conscientious objection, critically consider the mountains of energy that have been invested in protecting the refusal of services by healthcare providers. How do we, as a global community dedicated to advancing safe, accessible reproductive healthcare, instead push forward a narrative celebrating abortion as necessary, empowering, and life-changing?

"The simple act of caring is heroic."

- Edward Albert

How do we define CONSCIENTIOUS OBJECTION and CONSCIENTIOUS COMMITMENT?

CONSCIENTIOUS OBJECTION is when a registered healthcare practitioner refuses to provide, or participate in, a legal, legitimate treatment or procedure because it conflicts with their own personal beliefs, moral concerns and values.

Less attention has been given to positive claims of conscience in the form of **CONSCIENTIOUS COMMITMENT**. These are claims by professionals to provide services that are prohibited (either as a matter of law or policy), but that the professional conscientiously believes ought to be provided. While entailing the risk of severe legal consequences, conscientious commitment has historically been the start of legal challenges that paved the way to the decriminalization of abortion in countries such as the UK and Canada.

Dr. Halappanavar's death in 2012 at age 31 from septicemia set off outrage across Ireland and led to a referendum that changed the law. At 17 weeks pregnant, Dr. Savita Halappanavar went the hospital with back pain and was told she was having a miscarriage but that she could not be given an abortion since Ireland, she was told, is "a Catholic country," and it would be illegal to terminate the pregnancy while the fetus still had a heartbeat. After being repeatedly refused an abortion the contents of her womb were removed ten days later but she died of septicemia the following day.

Conscientious objection: A BARRIER TO CARE

Highlight Article | International Federation of Gynecology and Obstetrics, Ethical issues in obstetrics and gynecology (London: FIGO, 2012); World Health Organization, Safe abortion: Technical and policy guidance for health systems (Geneva: WHO, 2012)

We unequivocally recognise that the primary conscientious duty of health care providers at all times is to treat, provide benefit and prevent harm to the patients whose care they are responsible for.

Any conscientious objection to treating a patient is secondary to this primary duty; therefore, essential services cannot be denied.

All providers have a professional responsibility to ensure that every patient receives the clinical care they have authorised in the informed consent process.

Professional standards of care regarding conscientious objection to abortion

Providers have a right to conscientious objection and to not suffer discrimination on the basis of their beliefs.

The primary conscientious duty of health care providers is to treat (i.e., 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 to not misrepresent them on the basis of personal beliefs
- Patients have the right to be referred to practitioners who do not object to procedures medically indicated for their care
- Health care providers must provide patients with timely access to medical services, including giving information about the medically indicated options of procedures for care, even if they object to these options on the basis 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 beliefs.

Gerri Santoro's Tragedy: Fueling Generations of Activism and Resistance

Warning: this section features triggering and distrubing content and visuals

On June 8, 1964, the 28-year-old woman who was in an abusive marriage, checked in with her lover into a motel with a catheter and a textbook. Santoro, six and a half months pregnant, was prepared to let Dixon perform her illegal abortion—that is, until she started hemorrhaging during the process and Dixon panicked, abandoning Santoro to bleed to death on the motel floor.

In 2004, Joannie signed up for her first abortions rights rally with her daughter, channeling her anger into activism to ensure that no one else suffer the fate of her mother.

"Until a few years ago I would have said that the horrors of the past were just the scars of a hard won battle," she wrote. *"Now, as my daughters' freedoms slip away before my eyes and the horrors of my past become their reality, I realize I haven't done a damn thing to stop it. I don't know if I'll ever make a difference but I know it's time I started trying—before it's too late…I am Gerri Santoro's daughter and my daughters will not carry on her legacy."*

"There is only one cardinal rule: one must always listen to the patient."

- Oliver Sacks

From Conscientious Objection to Conscientious Commitment

By Dr. SP Choong, Founding Chair of the Asia Safe Abortion Partnership

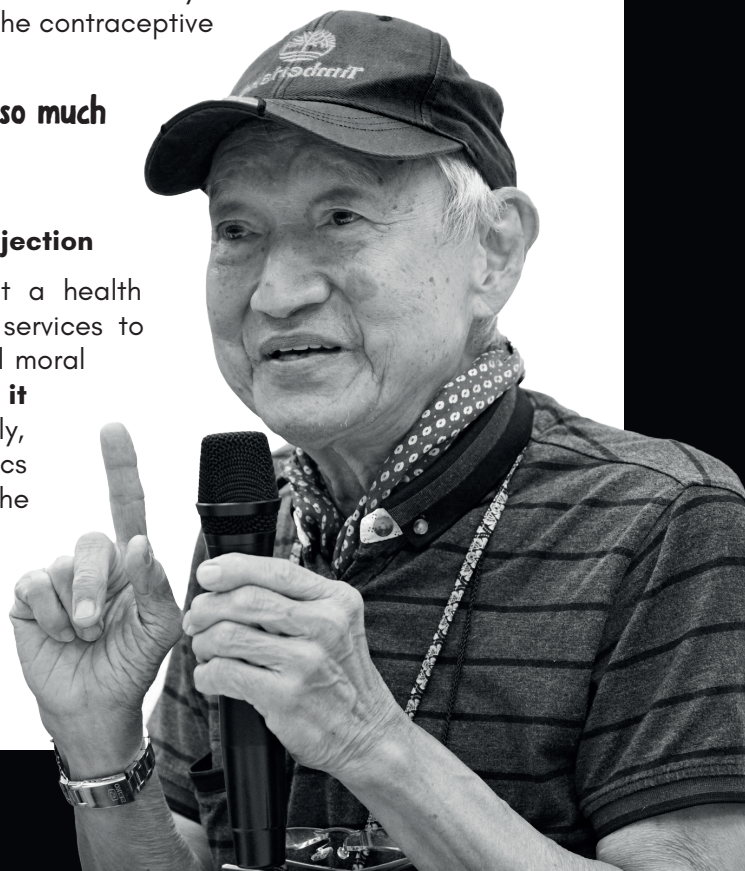
Background to Conscientious Objection

Historically, Conscientious Objection has always been applied to refusing military service, which is based on an individual's refusal to kill, a concept which is widely accepted. However, its application in relation to women's reproductive health is relatively new, becoming more prevalent since the attempts by religious groups to ban abortions have become increasingly militant. Their justification is to make the refusal to kill a foetus equal to that of a person. Gradually, it has been extended to other aspects of reproductive health such as contraception, IVF and even treatment for transgender. But mainly they were directed at preventing women's right to make their own decisions.

Aims of the so- called 'Pro-life' Movement.

The term 'Pro Life', has been used to mean protecting the life of the foetus and thus to justify their opposition to abortion. However, the reaction of the Catholics in the 1960s, with the popularity of the contraceptive pill leading to greater sexual freedom for women, showed their primary concern was over controlling women's sexual conduct. Their encyclical Humanae Vitae released in 1968 condemned both the contraceptive pill and abortion.

Clearly, it is not to the death of the foetus so much as imposing a sexual moral code for women.



Dangers of Excessive Power of Conscientious Objection

Conscientious Objection is the acceptance that a health provider has an absolute right to choose what services to provide a client in line with the providers personal moral principles. T**his cannot remain unchallenged as it clearly violates the client's autonomy.** Especially, being well aware of the unequal power dynamics between doctor and client, it is imperative for the doctor to avoid imposing his/her views on the client.

When Conscientious Objection used to withhold abortion services, it is not just a matter of

referring the client to another provider. They may not be available locally and there are many situations where any delays may increase risk of serious complications or death of the mother. Even in situations where the abortions are legal, widespread prevalence of Conscientious Objection amongst doctors continues to create barriers to easy access. An example being Ireland which just amended their abortion law after a referendum was largely due to the publicity over the tragic death of Dr Savita Halpannavar in 2012 who was refused any intervention in a case of sepsis in utero until foetal death was evident. However, Ireland is now faced with a dearth of providers.

The objectors are trying to extend the concept that Conscientious Objection should apply even to non-doctors including support personnel assisting in a procedure and other health professionals such as pharmacists, it will be more disruptive to the running of health services. There are now regulations in some Scandinavian countries where refusal to support abortions is a bar to employment in hospitals run by the state. But most countries where abortion is legal, still grapple with the problems of allowing hospital directors and staff to withhold treatment on the basis of Conscientious Objection.

Our Response

The pro-choice community including many leading academics have warned of this dangerous trend. Thus, we need to develop a counter narrative to stop this insidious move which violates the accepted respect for human rights as stated in the UDHR 1948 as well as using religion to withhold benefits of medical progress to women.

FIGO, in their Advocating Safe Abortion Project (ASAP 2021) has observed the negative impact on Women's Health with the growing acceptance of Conscientious Objection. It has therefore also called for all doctors to make a CONSCIENTIOUS COMMITMENT to counter threats of misuse of Conscientious Objection to undermine women's reproductive health needs.

In addition to CEDAW, and other UN Consensus statements after ICPD Cairo 1994 and Beijing Women's Conference 1995, member nations are supposedly committed to a) eliminate all forms of discrimination against women and b) to recognise women's reproductive autonomy as a key element to economic development and social progress.

Doctors are considered as belonging to a special professional CALLING with a unique trust and privileges accorded them by society. Therefore, they rightly owe certain obligations to society.

Regulations for Doctors

In using their right as Conscientious Objection to oppose Abortion, they are often disseminating misleading information to clients on legal status, on unfounded risks as well as denying them a proper referral for access to a safe provider. That should be a reason for a doctor to be deregistered. The unequal power dynamics between doctor and client makes it difficult for the latter to complain.

Public Opinion

Early claims of public opposition to abortion via opinion polls are often misleading. As prevailing moral environments prevent people from expressing an honest opinion, but over time, public support for Abortion Rights have clearly increased .Pressing for Legal change is a slow process but even if successful, can be frustrated by significant resistance from a conservative medical community, as in Ireland after their referendum and legal amendment. Shortage of service providers continues to be problematic.

Should doctors be allowed to have a conscience?

An interview with Dr. Amar Jesani, editor of the Indian Journal of Medical Ethics (www.ijme.in) (editor@ijme.in)

1. Should doctors be allowed to have a conscience? If yes, then should there be equal legal protections for doctors who express conscientious commitment?

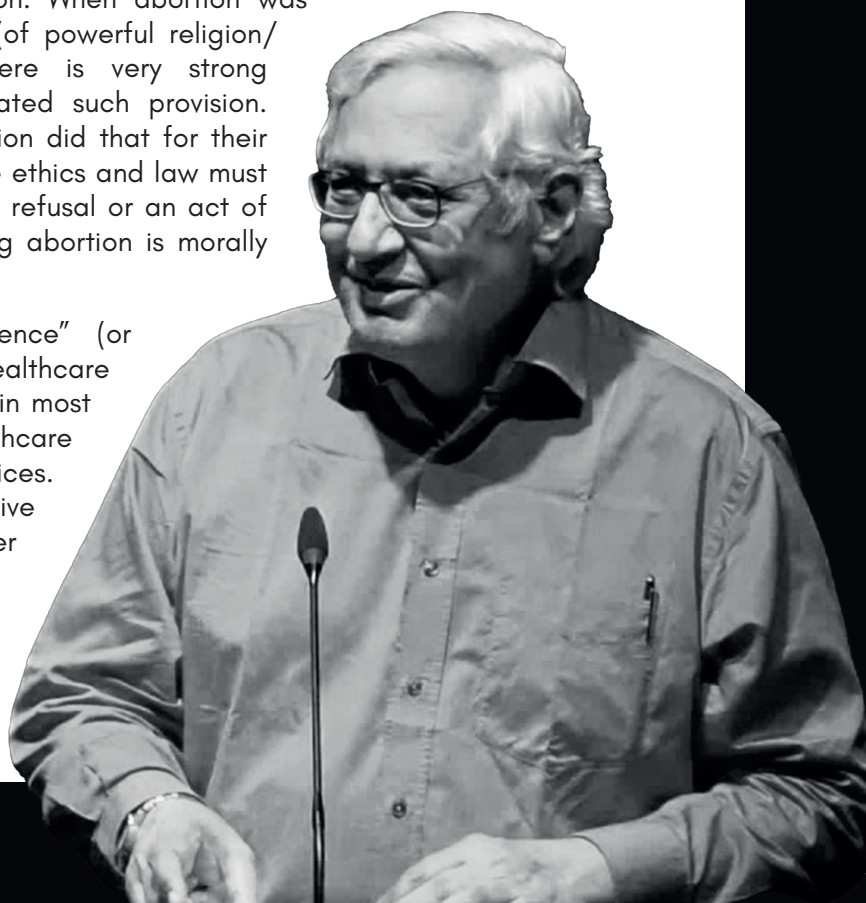
This question has multiple issues and is framed in legal terminology (allow/don't allow). We need to unpack those issues to understand them. Let us start with the term conscience, used and misused since ancient times. It is derived from Latin *con* (with) and *scientia* (knowledge). Although religion (Christianity) appropriated it first, it was also used by those who rebelled against it within the religion as well as by seculars against the religions in general. It is a capacious term.

Paul Strohm in his book (2011) Conscience: A very short introduction says *"Conscience refuses any settled or unvarying content. It can justify generous self-sacrifice, but selfish individualism as well. It can motivate an act of charity or an act of terror. The dictates of conscience can be Christian or pagan, divinely based or resolutely secular, selfishly nationalistic or generously international"*.

When one asserts that all humans have conscience, it means they are moral beings. Morality is used by those who believe in human rights (against oppression/exploitation) as well as those who do not (who oppress/exploit). I was first surprised by the title of Claudia Coontz's book (2003) Nazi Conscience, but on reading it I learnt that it is not an oxymoron term.

Now coming to the issue of abortion. When abortion was prohibited to assuage "conscience" (of powerful religion/rulers/Professional Associations), there is very strong evidence to show that women violated such provision. Those women and providers of abortion did that for their own "conscience". Thus, the normative ethics and law must decide, or choose, whether an act of refusal or an act of provision of service to women seeking abortion is morally good.

Law cannot prohibit bad "conscience" (or bad thought) but can prohibit healthcare professionals from acting on it. Laws in most countries confer monopoly to the healthcare professionals over provision of services. In that context, therefore, to deprive women of abortion service they consider essential for their health, cannot be allowed to be dictated by the providers' "conscience".



2. **What is the ethical perspective on non-doctors also exercising such Conscientious Objection eg. nurses, pharmacists, electricians, architects refusing to be involved in the provision of services against their conscience?**

Therefore, all recourse to "conscience" is not good, and we need to do ethics analysis or understand reasoning, motive and consequences of its use to differentiate good conscience from bad.

Healthcare provider is one who has knowledge and skill or whose assistance is essential in providing services. The doctor is only one of them. Thus, any ethical perspective on conscientious objection will be applicable to all healthcare providers.

The use of conscience objection to deny legitimate healthcare or deny beneficial care (e.g. abortion) cannot be ethically acceptable. However, its use for refusal to harm even when society or law demands (e.g. refusing to perform conversion therapy to LGBTQ community) is ethically acceptable.

3. **Is there a bioethical perspective on Conscientious Objection beyond abortion services for example euthanasia, lethal injection, fetal reduction in IVF and others?**

Yes, indeed. I just used an example other than abortion (refusal to provide conversion therapy). Similarly, the use of Conscientious Objection for refusal to participate in death penalty (by giving lethal injection) or in torture or aiding in torture as medical expert etc. are acceptable as the use is for the protection of rights and benefits of the person.

What is ethically acceptable or unacceptable conscience in healthcare needs to be judged by what it is being used for.

However, its use cannot be ethically justified for abortion, foetal reduction in IVF (a form of abortion) or in withdrawal of life support in brain dead or in the physician's assistance in death as they violate the rights and benefits of the persons.

4. **What is the ethical argument for Conscientious Commitment in this case?**

Those who use conscience to deny legitimate healthcare often do so by arguing that to force them to provide such healthcare would be against their "inner voice" or morals, and it will cause moral injury to them. But as I said, the conscience is used not only in refusal, but it is also used in assertion or in providing what is proscribed by societal morality or law. Thus, in the face of prohibition of abortion, those who provided it were also acting as per their "inner voice" or morals. Essentially, they are asserting their conscience to respect human rights of those who need beneficial healthcare with the use of their professional knowledge and skills.

Conscientious Commitment

Highlight Article by Bernard Dickens

Excerpt: In some regions of the world, hospital policy, negotiated with the health ministry and police, requires that a doctor who finds evidence of an unskilled abortion or abortion attempt should immediately inform police authorities and preserve the evidence. Elsewhere, religious leaders forbid male doctors from examining any part of a female patient's body other than that being directly complained about.

Can a doctor invoke a conscientious commitment to medically appropriate and timely diagnosis of care and refuse to comply with such directives?

Religion has no monopoly on conscience, however.

History, both distant and recent, shows how health-care providers and others, driven by conscientious concerns, can defy laws and religious opposition to provide care to vulnerable, dependent populations.

They might also defy the medical establishment.

Pioneers of the birth control movement were not doctors, and were opposed by medical, state, and religious establishments.

In 1915, Margaret Sanger, an American nurse who worked in the ghettos of New York and espoused the cause of birth control, fled prosecution to the UK, where she met and motivated an English botanist, Marie Stopes.

(Editor's note: It is important to note here that Sanger's commitment to contraception cannot be separated from her involvement in the eugenics movement.)

The momentum towards popular and political acceptance of family planning generated by these courageous pioneers, who defied the power of organised religion, conservative convention, and at first the medical establishment, rewarded their conscientious commitment.

In the 1930s Aleck Bourne, a consultant obstetrician at St Mary's Hospital, London, terminated the early pregnancy of a 14-year-old gang-rape victim and informed the Birkett Committee of the realities of conscientious abortion. He was subsequently prosecuted for criminal abortion at the Central Criminal Court in London, the Old Bailey, and the judgment resulting in his acquittal remains an influential landmark in Commonwealth jurisprudence establishing the legality of therapeutic abortion.

Conscientiously committed practitioners often need courage to act against prevailing legal, religious, and even medical orthodoxy, following the honourable medical ethic of placing patients' interests above their own.

"The purpose of a doctor or any human in general should not be to simply delay the death of the patient, but to increase the person's quality of life."

- Dr. Patch Adams

RECOMMENDED LITERATURE

Click on the box to follow each link!

HOW SPECIAL IS MEDICAL CONSCIENCE?

by David S Oderberg

The vigorous legal and ethical debates over conscientious objection have taken place largely within the domain of health care. Is this because conscience in medicine is of a special kind, or are there other reasons why it tends to dominate these debates?

CONSCIENTIOUS COMMITMENT, PROFESSIONAL OBLIGATIONS AND ABORTION PROVISION AFTER THE REVERSAL OF ROE V WADE

by Alberto Giubilini, Udo Schuklenk, Francesca Minerva, and Julian Savulescu

We argue that, in certain circumstances, doctors might be professionally justified to provide abortions even in those jurisdictions where abortion is illegal.

It is the responsibility of state authorities to enforce the law, but it is the responsibility of professional organisations to uphold the highest standards of medical ethics, even when they conflict with the law. Indeed, professional organisation should lobby to offer protection to such professionals.

PROFESSIONAL CIVIL DISOBEDIENCE: MEDICAL SOCIETY RESPONSIBILITIES AFTER *DOBBS*

by Matthew K. Wynia, M.D., M.P.H.

> *"In some cases, the law mandates conduct that is ethically unacceptable. When physicians believe a law violates ethical values or is unjust they should work to change the law. In exceptional circumstances of unjust laws, ethical responsibilities should supersede legal duties."*
>
> – Code of Medical Ethics of the American Medical Association (AMA)

What should medical professionals do when a law requires them to harm a patient?

This question has become a pressing one as physicians grapple with the implications of state laws banning abortion. When these laws directly and immediately threaten the health of patients, should physicians collectively disobey them — that is, should they engage in professional civil disobedience?

And the CEO of the American College of Obstetricians and Gynecologists called Dobbs "tragic" for patients, "the boldest act of legislative interference that we have seen in this country," and "an affront to all that drew my colleagues and me into medicine."

Medical organizations are rarely so united. Yet even many physicians who oppose abortion recognize that medically nuanced decisions are best left in the hands of individual patients and their physicians — not state lawmakers.

CONSCIENTIOUS COMMITMENT TO WOMEN'S HEALTH

by Bernard M. Dickens, Rebecca J. Cook

Conscientious commitment inspires healthcare providers to overcome barriers to delivery of reproductive services to protect and advance women's health. Providers' conscientious commitment is to deliver treatments directed to women's healthcare needs, giving priority to patient care over adherence to conservative religious doctrines or religious self-interest.

HOW A BIOETHICIST AND A DOCTOR SEES ABORTION

by Alvin Powell, Harvard Staff Writer

The Medical School's Louise King discusses how the potential Supreme Court ruling to overturn overturn Roe v. Wade might affect providers.

ON CONSCIENTIOUS OBJECTION TO ABORTION: QUESTIONING MANDATORY REFERRAL AS COMPROMISE IN THE INTERNATIONAL HUMAN RIGHTS FRAMEWORK

by Zoe L Tongue

This article examines how international human rights bodies address conscientious objection to abortion by mandating referral mechanisms in such cases. However, this approach falls short, as many objecting healthcare professionals also refuse referrals and exploit conscientious objection to block abortion access.

Attitudes, Practices, and Knowledge of Colombian Gynecologists Regarding VOLUNTARY TERMINATION OF PREGNANCY (VTP) and CONSCIENTIOUS OBJECTION: A Cross-Sectional Study, 2022

Highlight Article by **Laura Gil Urbano**, OB/GYN, Director of Global Doctors for Choice, Colombia; **Salomé Valencia-Aguirre**, MD, MPH, MS, PhD(c), Global Doctors for Choice, Colombia; **Ana Cristina González Vélez**, MD, PhD, Mesa por la Vida y la Salud de las Mujeres

Conscientious objection among healthcare professionals can limit access to medical services such as legal abortion. **Globally, between 14% and 80% of physicians refuse to provide abortion or contraception services.** In Colombia, abortion was partially decriminalized in 2006 under three circumstances: risk to the woman's life or health, rape or incest, and fetal malformation incompatible with life. In 2022, the Constitutional Court extended the decriminalization up to 24 weeks of pregnancy, but obstacles remain.

This study analyzes the perceptions of Colombian obstetrician-gynecologists regarding abortion, with an emphasis on Conscientious objection and total decriminalization. A cross-sectional study was conducted through a digital survey sent to 3,741 obstetrician-gynecologists, both affiliated and non-affiliated with the Colombian Federation of Obstetrics and Gynecology (FECOLSOG in Spanish).

A total of 246 responses were obtained, representing 6.57% of the population. Among the main findings, the demographic profile of the participants shows an equal gender participation, with 50% of participants being over 45 years old, 84% working in capital cities, and 77% identifying as Catholic.

Regarding the willingness to perform abortions, 50% of respondents would perform an abortion under any legal circumstance, while 22% would do so only in specific situations. The main reason for refusing to perform an abortion was advanced gestational age, cited by 42% of those who perform abortions under specific circumstances.

The most trained uterine evacuation technique was curettage (45%), although one in three professionals who perform abortions uses aspiration (MVA).

Regarding Conscientious Objection, 38% of respondents do not provide abortion services due to this. Meanwhile, 50% facilitate access to abortion, and 33% hinder it. More than 80% of respondents believe that those who declare Conscientious Objection should refer patients to another professional.

As for knowledge and agreement with the legal framework, 60% of respondents do not consider socioeconomic reasons as part of health, revealing a restrictive interpretation of the law. Additionally, 75% disagree with imprisonment for abortion, but only 57% support the elimination of abortion as a crime in Colombia.

Most consider that eliminating abortion as a crime could have positive effects.

The discrepancies between the responses regarding the elimination of the crime and imprisonment suggest that respondents do not always understand the practical implications of maintaining abortion as a crime, such as the possibility of imprisonment and stigmatization.

Regarding willingness towards abortion, it is noteworthy that advanced gestational age was the main reason for denying care, even though only 2% of abortions are requested after 20 weeks. This could indicate a lack of trained and available professionals, which may hinder access and increase the risk of complications. Some professionals refuse to provide services for personal reasons, conflicting with the legal framework that allows termination of pregnancy up to 24 weeks.

Finally, we recommend clarifying the differences between legitimate Conscientious objection and sanctionable practices, formulate regulations to avoid barriers, expand the availability of abortion services in rural areas, and strengthen training in modern techniques. It is also important to promote standardized academic training, provide comprehensive information from the first consultation on the available legal options, and identify and correct institutional practices that affect the free exercise of the profession, such as collective conscientious objection and restrictive interpretations of the grounds for abortion.

RIGHT TO CHOOSE:

The Powerof Professional Networks in Access to Abortion

Highlight article by Dra. Raquel I. Drovetta. Researcher at the National Council for Scientific and Technical Research (CONICET). Associate Professor, Academic and Pedagogical Institute of Social Sciences, National University of Villa María.

Conscientious objection allows healthcare professionals to refuse certain procedures, such as abortion, based on personal, religious, or ethical beliefs.

However, when widely exercised, it can significantly hinder women's access to safe and legal abortion services.

This issue is particularly complex in countries like Argentina, where the 2020 approval of the Voluntary Termination of Pregnancy Law (IVE) guarantees women's right to safe abortions but faces challenges in implementation due to the prevalence of conscientious objection.

Another important perspective is the concept of **conscientious commitment**, which refers to the ethical and professional responsibility of healthcare providers to ensure that individuals have access to necessary health services, including abortions, in a safe and respectful manner. This involves not only performing medical procedures but also actively advocating for reproductive rights and social justice, ensuring that no woman is denied medical care due to personal objections from healthcare providers.

In Argentina, I documented how participation in the **Network of Health Professionals for the Right to Decide** has proven to be an effective strategy to counter the challenges posed by conscientious objection. The Network has played a crucial role in supporting healthcare professionals, helping them confront the stigma associated with abortion and providing a safe and supportive space among peers. This interdisciplinary network, which includes gynecologists, general practitioners, psychologists, social workers, nurses, and others, has focused on providing comprehensive care to women seeking legal termination of pregnancy (ILE), especially within the public health sector.

The impact of the Network is significant in two key areas:

First, it has enabled healthcare professionals to change their perception of the stigma associated with abortion, which has strengthened their confidence and security in providing care in contexts where social disapproval is high. This transformation is largely due to the interaction and support among professionals with shared goals and values, which has reduced the

negative self-perception of their work and the fear of stigmatization.

Secondly, the Network has facilitated the referral of women and girls seeking safe abortions to professionals committed to the right to choose, thus overcoming the barriers imposed by conscientious objectors. This referral and support approach is a clear example of how conscientious commitment can be effectively articulated in practice, ensuring that the right to legal abortion is not merely a theoretical right but an accessible reality for all.

The work of the Network also highlights the **importance of alliances** between feminist organizations, activists, and healthcare professionals to promote access to safe abortion services and change social perceptions of abortion. While these coalitions do not completely solve the problem of clandestine abortion, they represent a crucial step toward cultural change and the normalization of access to abortion as a fundamental right.

In conclusion, while conscientious objection remains a significant challenge to abortion access, conscientious commitment and the creation of support networks, such as the "Network of Health Professionals for the Right to Decide," offer viable solutions to mitigate its effects.

Reducing the number of professionals exercising conscientious objection requires a **comprehensive approach** that includes education, effective public policies, and continuous support for networks of professionals committed to sexual and reproductive rights. This is an ongoing effort that must be reinforced and expanded to ensure that all women have access to safe and legal abortions in their contexts.

Unpacking the Legal and Strategic Positions Regarding Conscientious Objection

Click on the box to follow each link!

LEGAL BRIEFING: CONSCIENCE CLAUSES AND CONSCIENTIOUS REFUSAL

by Thaddeus Mason Pope

Over the past several months, conscientious refusal disputes have had an unusually high profile not only in courthouses, but also in legislative and regulatory halls across the United States. Healthcare providers' own moral beliefs have been obstructing and are expected to increasingly obstruct patients' access to medical services.

There are two fundamental types of conscientious objection laws.

First, there are laws that permit healthcare workers to refuse providing - on ethical, moral, or religious grounds healthcare services that they might otherwise have a legal or employer-mandated obligation to provide.

Second, there are laws directed at forcing healthcare workers to provide services to which they might have ethical, moral, or religious objections. Both types of laws are rarely comprehensive, but instead target:

1. certain types of healthcare providers,
2. specific categories of healthcare services,
3. specific patient circumstances, and
4. certain conditions under which a right or obligation is triggered.

YES WE CAN! SUCCESSFUL EXAMPLES OF DISALLOWING 'CONSCIENTIOUS OBJECTION' IN REPRODUCTIVE HEALTH CARE

by Christian Fiala, Kristina Gemzell Danielsson, Oskari Heikinheimo, Jens A Guđmundsson, Joyce Arthur

Reproductive health care is the only field in medicine where health care professionals (HCPs) are allowed to limit a patient's access to a legal medical treatment - usually abortion or contraception - by citing their 'freedom of conscience.' However, the authors' position is that 'conscientious objection' ('CO') in reproductive health care should be called dishonourable disobedience because it violates medical ethics and the right to lawful health care, and should therefore be disallowed.

Most notably, disallowing 'CO' protects women's basic human rights, avoiding both discrimination and harms to health. Finally, holding HCPs accountable for their professional obligations to patients does not result in negative impacts.

Almost all HCPs and medical students in Sweden, Finland, and Iceland who object to abortion or contraception are able to find work in another field of medicine. The key to successfully disallowing 'CO' is a country's strong prior acceptance of women's civil rights, including right to health care.

REFRAMING CONSCIENTIOUS CARE: PROVIDING ABORTION CARE WHEN LAW AND CONSCIENCE COLLIDE

by Mara Buchbinder, Dragana Lassiter, Rebecca Mercier, Amy Bryant, Anne Drapkin Lyerly

We challenge the dichotomy between conscientious refusal and morally compromised action, demonstrating how providers may work within the constraints of laws or institutional policies that raise moral challenges and act in accordance with conscience.

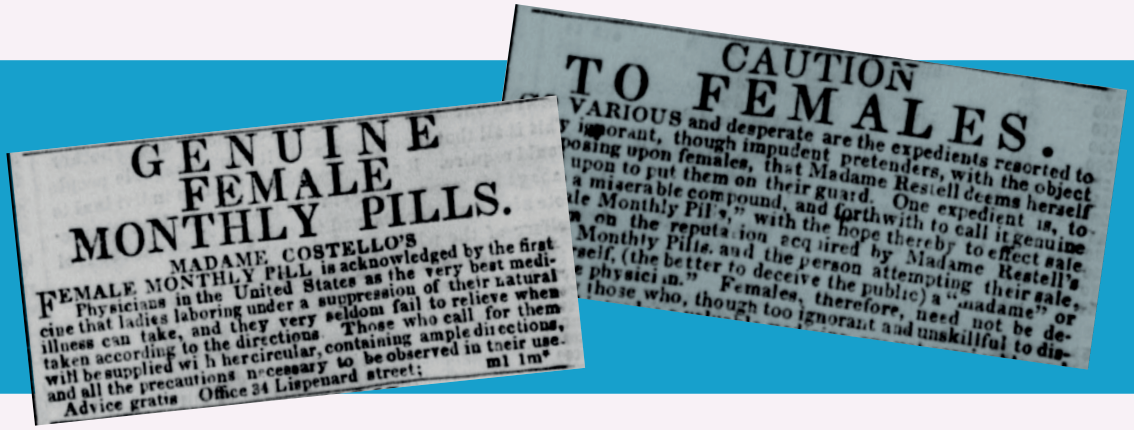
"*It's almost like putting salt in a wound, for this person who's already made a very difficult decision*," offered Dr. Meghan Patterson, a licensed obstetrician/gynecologist whom we interviewed in our qualitative study of the experiences of North Carolina abortion providers practicing under the 2011 "Woman's Right to Know" (WRTK) Act (HB 854).

THE HIGHLY COMPLEX ISSUE OF CONSCIENTIOUS OBJECTION TO ABORTION: CAN THE RECENT EUROPEAN COURT OF HUMAN RIGHTS RULING GRIMMARK V. SWEDEN REDEFINE THE NOTIONS OF CARE BEFORE FREEDOM OF CONSCIENCE?

by Simona Zaami, Raffaella Rinaldi, Gianluca Montanari Vergallo

The article aims to elaborate on two recent European Court of Human Rights (ECtHR) decisions which have rejected, on grounds of non-admissibility, the appeals by two Swedish midwives who refused to carry out abortion-related services, basing their refusal on conscientious objection, and to expound upon the legal and ethical underpinnings and core standards applied to the framing process of such a ECtHR decision.

In both decisions the European Court has asserted that the right to exercise conscientious objection must give way to the protection of the right to health of women seeking to have an abortion.



LEGAL AND ETHICAL STANDARDS FOR PROTECTING WOMEN'S HUMAN RIGHTS AND THE PRACTICE OF CONSCIENTIOUS OBJECTION IN REPRODUCTIVE HEALTHCARE SETTINGS by Christina Zampas

The practice of conscientious objection by healthcare workers is growing across the globe Few states adequately regulate the practice, leading to denial of access to lawful reproductive healthcare services and violations of fundamental human rights. International ethical, health, and human rights standards have recently attempted to address these challenges by harmonizing the practice of conscientious objection with women's right to sexual and reproductive health services.

THE NO CORRELATION ARGUMENT: CAN THE MORALITY OF CONSCIENTIOUS OBJECTION BE EMPIRICALLY SUPPORTED? THE ITALIAN CASE

by Marco Bo, Carla Maria Zotti, Lorena Charrier

The legitimacy of conscientious objection to abortion continues to fuel heated debate in Italy. In two recent decisions, the European Committee for Social Rights underlined that conscientious objection places safe, legal, and accessible care and services out of reach for most Italian women and that the measures that Italy has adopted to guarantee free access to abortion services are inadequate.

If new evidence would show that the increasing proportion of objectors does undermine the efficacy of the Italian law and the right of a woman to freely obtain a voluntary abortion, new ways will need to be found to address the conflict between moral principles and restrict the protection accorded to the principle of moral integrity.

CURRENT CHALLENGES FOR CONSCIENTIOUS OBJECTION BY PHYSICIANS IN SPAIN

by Borja Montero

The College of Physicians of Madrid organized an open debate on conscientious objection (CO) in the medical profession on September 14, 2022. We summarize here the main arguments discussed.

CO is defined as the right to raise exceptions to the performance of legal duties when they involve a contravention of personal convictions, whether religious, moral, or philosophical. It is not insubordination.

Health professionals are not blind instruments or mere "executors." The practice of medicine must follow the aim of the profession, namely the pursuit of the patient's good. Since then and particularly in light of the Nuremberg trials, most medical declarations have highlighted the duty of defending human life and the importance of CO.

Ultimately, CO is the tool that protects the freedom of the physician to refuse to perform actions that go against the values of medical ethics. With respect to the recent Spanish laws on abortion, euthanasia, and sex re-assignment of minors, if administrators want to know who is available for a health service that raises issues of conformity to medical ethics, requesting a list of volunteers is preferable to producing an objector list. Asking for registration of conscientious objectors goes against the right to privacy and is coercive, intrusive, and abusive.

"The human body experiences a powerful gravitational pull in the direction of hope. That is why the patient's hopes are the physician's secret weapon. They are the hidden ingredients in any prescription."

– Norman Cousins

How do we assess the Impact and Outcome of Conscientious Objection?

Click on the box to follow each link!

THE IMPACT OF 'CONSCIENTIOUS OBJECTION' ON ABORTION-RELATED OUTCOMES: A SYNTHESIS OF LEGAL AND HEALTH EVIDENCE

by Fiona de Londras, Amanda Cleeve, Maria I. Rodriguez, Alana Farrell, Magdalena Furgalska, Antonella F. Lavelanet

The World Health Organization (WHO) and international human rights bodies have long urged states to take steps to ensure that 'conscientious objection' does not undermine access to abortion in practice.

The evidence identified in this review suggests strongly that conscientious objection negatively affects the rights of abortion seekers and has negative implications for the rights of non-objecting health workers.

This is exacerbated in situations where an exercise of 'conscience' goes beyond 'opting out' of providing care and extends into seeking to prevent abortion through dissuasion, misinformation, misdirection, delay, and sometimes abuse.

CONSCIENTIOUS OBJECTION AS STRUCTURAL VIOLENCE IN THE VOLUNTARY TERMINATION OF PREGNANCY IN CHILE

by Adela Montero, Mirliana Ramirez-Pereira, Paz Robledo, Lidia Casas, Lieta Vivaldi, Daniela Gonzalez

After three decades of the absolute prohibition of abortion, Chile enacted Law 21,030, which decriminalizes voluntary pregnancy termination when the person is at vital risk, when the embryo or fetus suffers from a congenital or genetic lethal pathology, and in pregnancy due to rape. The law incorporates conscientious objection as a broad right at the individual and institutional levels.

Conscientious objection acts as structural violence by infringing the exercise of sexual and reproductive rights. The State must fulfill its role as guarantor in implementing public policies, preventing conscientious objection from becoming hegemonic and institutionalized violence.

IMPROPER USE OF CONSCIENTIOUS OBJECTION IN BOGOTÁ, COLOMBIA, PRESENTS A BARRIER TO SAFE, LEGAL ABORTION CARE

Article published by the Guttmacher Institute

Health care providers who invoke conscientious objection to providing or participating in abortion care in Bogotá, Colombia, can be categorized along a spectrum of objection—extreme, moderate and partial—finds a new study published in International Perspectives on Sexual and Reproductive Health.

The study, "**The Fetus Is My Patient, Too': Attitudes Toward Abortion and Referral Among Physician Conscientious Objectors in Bogotá, Colombia**," by Lauren Fink of Emory University, et al., seeks to understand conscientious objection from the perspective of objectors themselves in order to help identify potential interventions to ease the burden of conscientious objection as a barrier to care.

PROFESSIONAL RESPONSIBILITY, NURSES, AND CONSCIENTIOUS OBJECTION: A FRAMEWORK FOR ETHICAL EVALUATION

by Pamela J Grace, Elizabeth Peter Lucia D Wocial

Conscientious objections (CO) can be disruptive in a variety of ways and may disadvantage patients and colleagues who must step-in to assume care. Nevertheless, nurses have a right and responsibility to object to participation in interventions that would seriously harm their sense of integrity.

At its core, nursing, like other healthcare professions, has come into existence and persists as a function of an implicit social contract—privileges are accorded to professionals in exchange for services provided. Thus, there are ethical obligations to fulfill professional responsibilities.

People should be able to expect that the professional is working on their behalf and with their best interest at the forefront of decision-making and are not constricting or hiding available choices.

CONSCIENTIOUS OBJECTION IN THE HEALING PROFESSIONS: A READER'S GUIDE TO THE ETHICAL AND SOCIAL ISSUES

by Jere Odell, Rahul Abhyankar, Amber Malcolm, Avril Rua

Conflicts over conscientious objection in healthcare, particularly concerning abortion and contraception, stem from deeply held moral and religious beliefs. Many Christian healthcare professionals view abortion as murder, citing biblical teachings. Legal protections, such as the Coats Amendment and exemptions under the Affordable Care Act, safeguard these objections, but they also hinder access to time-sensitive services like emergency contraception, especially for sexual assault victims. While referral mechanisms exist to balance patient care with moral beliefs, they are often ineffective, leading to legal disputes and ongoing public debate.

THE CHALLENGES OF CONSCIENTIOUS OBJECTION IN HEALTH CARE

by Hasan Shanawani

While there may exist good reasons to accommodate COs of clinical providers, the exercise of rights and beliefs of the provider has an impact on a patient's health and/ or their access to care.

For this reason, it is incumbent on the provider with a CO to minimize or eliminate the impact of their CO both on the delivery of care to the patients they serve and on the medical system in which they serve patients.

CONSCIENTIOUS OBJECTION AND BARRIERS TO ABORTION WITHIN A SPECIFIC REGIONAL CONTEXT - AN EXPERT INTERVIEW STUDY

by Robin Krawutschke, Tania Pastrana & Dagmar Schmitz

Conscientious objection is regarded as an understudied phenomenon the effects of which have not yet been examined in Germany. Based on expert interviews, this study aims to exemplarily reconstruct the processes of abortion in a mid-sized city in Germany, and to identify potential effects of conscientious objection.

Our findings indicate that conscientious objection possibly imposes barriers to both early and late abortion provision and especially in the last procedural steps, which from an ethical point of view is especially problematic.

THE IMPACT OF GYNECOLOGISTS' CONSCIENTIOUS OBJECTION ON ABORTION ACCESS

by Tommaso Autorino, Francesco Mattioli, Letizia Mencarini

Although abortion in Italy is free of charge and legal in a broad set of circumstances, 71% of gynecologists are registered as conscientious objectors, i.e. they are exempted from performing abortions for reasons of religious or moral beliefs. Results, from both cross-regional panel data and microdata analysis, suggest that conscientious objection hampers abortion access at the local level, being a significant driver of a woman's decision of having an abortion out of the region of residence and leading to longer waiting times to have one.

CONSCIENTIOUS OBJECTION TO PROVISION OF LEGAL ABORTION CARE

by Brooke R. Johnson Jr a, Eszter Kismödi b, Monica V. Dragoman a, Marleen Temmerman

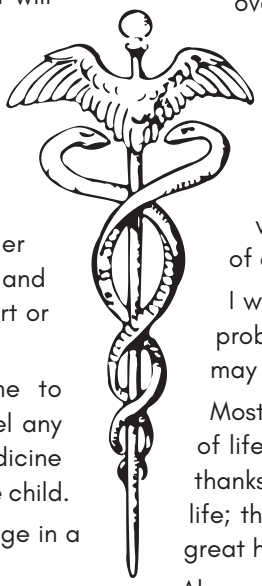
When conscientious objection to provision of abortion becomes one of these barriers, it can create risks to women's health and the enjoyment of their human rights. To eliminate this barrier, states should implement regulations for healthcare providers on how to invoke conscientious objection without jeopardizing women's access to safe, legal abortion services, especially with regard to timely referral for care and in emergency cases when referral is not possible. In addition, states should take all necessary measures to ensure that all women and adolescents have the means to prevent unintended pregnancies and to obtain safe abortion.

The Hippocratic Oath is the oldest and most widely known treatise on medical ethics. It requires new physicians to swear by numerous healing gods and dictates the duties and responsibilities of the physician while treating patients. There are two versions of the Hippocratic Oath: the original one and the modern one. The need for a revision was felt as drastic procedures like abortions & surgeries became commonplace and medically valid, questioning a physician's morals anew.

The Classic Hippocratic Oath

I swear by Apollo the physician, and Aesculapius the surgeon, likewise Hygeia and Panacea, and call all the gods and goddesses to witness, that I will observe and keep this underwritten oath, to the utmost of my power and judgment.

I will reverence my master who taught me the art. Equally with my parents, will I allow him things necessary for his support, and will consider his sons as brothers. I will teach them my art without reward or agreement; and I will impart all my acquirement, instructions, and whatever I know, to my master's children, as to my own; and likewise to all my pupils, who shall bind and tie themselves by a professional oath, but to none else.



With regard to healing the sick, I will devise and order for them the best diet, according to my judgment and means; and I will take care that they suffer no hurt or damage.

Nor shall any man's entreaty prevail upon me to administer poison to anyone; neither will I counsel any man to do so. Moreover, I will give no sort of medicine to any pregnant woman, with a view to destroy the child.

Further, I will comport myself and use my knowledge in a godly manner.

I will not cut for the stone, but will commit that affair entirely to the surgeons.

Whatsoever house I may enter, my visit shall be for the convenience and advantage of the patient; and I will willingly refrain from doing any injury or wrong from falsehood, and (in an especial manner) from acts of an amorous nature, whatever may be the rank of those who it may be my duty to cure, whether mistress or servant, bond or free.

Whatever, in the course of my practice, I may see or hear (even when not invited), whatever I may happen to obtain knowledge of, if it be not proper to repeat it, I will keep sacred and secret within my own breast.

If I faithfully observe this oath, may I thrive and prosper in my fortune and profession, and live in the estimation of posterity; or on breach thereof, may the reverse be my fate!"

This Hippocratic Oath has been modified and revised several times. The Oath was rewritten in 1964 by Dr. Louis Lasagna, Academic Dean at Tufts University School of Medicine and this revised form is widely accepted in today's medical schools.

The Revised Hippocratic Oath

I swear to fulfill, to the best of my ability and judgment, this covenant:

I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.

I will apply, for the benefit of the sick, all measures [that] are required, avoiding those twin traps of overtreatment and therapeutic nihilism.

I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.

I will not be ashamed to say "I know not," nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.

I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know.

Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty.

Above all, I must not play at God.

I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.

I will prevent disease whenever I can, for prevention is preferable to cure.

I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.

If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter.

May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help."

Thus, the classical Oath of Hippocratic involves the triad of the physician the patient and God, while the revised version involves only the physician and the patient, reliving the Gods of a few responsibilities.

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Sign up here for the **Global S.A.F.E Campaign**, a global movement advocating for safe abortion rights.

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BUILDING INCLUSIVE MOVEMENTS

Guest Editor: Nandini Mazumder