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CONSCIENTIOUS OBJECTION

Legal and ethical standards for protecting women's human rights and the practice of conscientious objection in reproductive healthcare settings

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ABSTRACT

The practice of conscientious objection by healthcare workers is growing across the globe. It is most common in reproductive healthcare settings because of the religious or moral values placed on beliefs as to when life begins. It is often invoked in the context of abortion and contraceptive services, including the provision of information related to such services. 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. FIGO ethical standards have had an important role in influencing human rights development in this area. They consider regulation of the unfettered use of conscientious objection essential to the realization of sexual and reproductive rights. Under international human rights law, states have a positive obligation to act in this regard. While ethical and human rights standards regarding this issue are growing, they do not yet exhaustively cover all the situations in which women's health and human rights are in jeopardy because of the practice. The present article sets forth existing ethical and human rights standards on the issue and illustrates the need for further development and clarity on balancing these rights and interests.

1. Introduction

Ethical, health, and human rights standards have attempted to harmonize the practice of conscientious objection with women's right to sexual and reproductive health services. They consider regulation of the unfettered use of conscientious objection essential to the realization of sexual and reproductive rights. Under international human rights law, states have a positive obligation to act in this regard. These standards and recommendations should be universally adopted and applied. While ethical and human rights standards on this issue are growing, they do not yet exhaustively cover all the situations in which women's health and human rights are in jeopardy because of the practice. The present article sets forth existing ethical and human rights standards on the issue and illustrates the need for further development and clarity on balancing these rights and interests.

The practice of conscientious objection by healthcare workers is growing across the globe. It is most common in reproductive healthcare settings because of the religious or moral values placed on beliefs as to when life begins. It is often invoked in the context of abortion and contraceptive services, including the provision of information related to such services. Frequently, such invocation is not transparent and women are neither directly told of providers' beliefs nor referred to another provider. Instead, they are subjected to attempts to sway them away from undergoing abortion. While OB/GYNs may most often be the healthcare workers claiming conscientious objection, pharmacists, nurses, anesthesiologists, and cleaning staff have been reported to refuse to fill their job duties in connection to acts they consider objectionable. In addition, public healthcare institutions are informally refusing to provide certain reproductive health services, often owing to beliefs of individual hospital administrators [1].

The practice arises in countries with relatively liberal abortion laws, such as the USA, Slovakia, and South Africa, as well as in countries with more restrictive laws, such as most Latin American and certain African countries [2,3]. The implications for women's health and lives can be grave in both contexts and urgent questions arise as to how to effectively reconcile respect for the practice of conscientious objection with the right of women to have access to lawful reproductive healthcare services.

Ethical standards in this area can provide some answers. In fact, ethical standards have not only helped shape the development of national law but also recently influenced the development of international human rights law in this area. While these are welcome developments, many gaps remain both in ethics and in law.

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2. International human rights law

The right to access to reproductive healthcare is grounded in numerous human rights, including the rights to life, to health, to non-discrimination, to privacy, and to be free from inhuman and degrading treatment, as explicitly articulated by UN and regional human rights bodies. Such rights place obligations on states to ensure transparent access to legally entitled reproductive health services and to remove barriers limiting women's access to such services [4,5]. Such barriers include conscientious objection. UN bodies monitoring state compliance with international human rights treaties have raised concern about the insufficient regulation by states of the practice of conscientious objection to abortion. They have consistently recommended that states ensure that the practice is well defined and well regulated in order to avoid limiting women's access to reproductive healthcare. They encourage, for example, implementing a mechanism for timely and systematic referrals, and ensuring that the practice of conscientious objection is an individual, personal decision and not that of an institution as a whole [1,6–8].

The UN Special Rapporteur on the Right to the Highest Attainable Standard of Health issued a groundbreaking report in 2011 on the negative impact that the criminalization of abortion has had on women's health and lives, and specifically articulated state obligations to remove barriers—including some laws and practices on conscientious objection—that interfere with individual decision making on abortion. The report notes that such laws and their use create barriers to access by permitting healthcare providers and ancillary personnel to refuse to provide abortion services, information about procedures, and referrals to alternative facilities and providers. These and other laws make safe abortions unavailable, especially to poor, displaced, and young women. The report notes that such restrictive regimes serve to reinforce the stigma of abortion being an objectionable practice. The Rapporteur recommended that, in order to fulfill their obligations under the right to health, states should "[E]nsure that conscientious objection exemptions are well-defined in scope and well-regulated in use and that referrals and alternative services are available in cases where the objection is raised by a service provider" [9].

Conscientious objection is grounded in the right to freedom of religion, conscience, and thought—recognized in many international and regional human rights treaties, as well as in national constitutions. Under international and regional human rights law, the freedom to manifest one's religion or beliefs can be limited for the protection of the rights of others, including reproductive rights [8,10–12].

The Human Rights Committee, which monitors state compliance with the International Covenant on Civil and Political Rights (one of the major UN human rights treaties), has recognized that religious attitudes can limit women's rights and called on states to "… ensure that traditional, historical, religious or cultural attitudes are not used to justify violations of women's right to equality before the law and to equal enjoyment of all Covenant rights" [13].

Two recent decisions of the European Court of Human Rights shed light on the meaning of such limitations in the context of conscientious objection to abortion-related reproductive health services. In these separate cases against Poland, an adolescent and a woman have complained that access to lawful abortion and prenatal diagnostic services was hindered, in part, by the unregulated practice of conscientious objection. While Poland has one of the most restrictive abortion laws in Europe, the law does allow for abortion in cases of threat to a pregnant woman's health or life, and in cases of rape and cases of fetal abnormality. It also entitles women to receive genetic prenatal examinations in this context. In *R.R. v. Poland* (2011), the applicant was repeatedly denied prenatal genetic testing after her doctor discovered fetal abnormalities during a sonogram [14]. The exam results would have informed *R.R.*'s decision on whether to terminate her pregnancy, yet doctors, hospitals, and administrators repeatedly denied her information and diagnostic tests until the pregnancy was too advanced for abortion to be a legal option [14]. In a case decided a year later, *P. and S. v. Poland* (2012), a 14-year-old who became pregnant as a result of rape faced numerous barriers and delays in obtaining a lawful abortion, including coercive and biased counseling by a priest; divulgence of confidential information about her pregnancy to the press and others; removal from the custody of her mother, who supported her decision to undergo an abortion; and the unregulated practice of conscientious objection [15]. The procedure eventually took place but in a clandestine-like manner and without proper postabortion care [15].

In both cases, the Court found violations of Articles 3 (right to be free from inhuman and degrading treatment) and 8 (right to private life) of the European Convention on Human Rights for obstructing access to lawful reproductive healthcare information and services [16]. With regard to conscientious objection, it held that the Convention does not protect every act motivated or inspired by religion: "… States are obliged to organise the health services system in such a way as to ensure that an effective exercise of the freedom of conscience of health professionals in the professional context does not prevent patients from obtaining access to services to which they are entitled under the applicable legislation" [14,15].

It also noted problems with lack of implementation and respect for the existing law governing this practice, and specified that reconciliation of conscientious objection with the patient's interests makes it mandatory for such refusals to be made in writing and included in the patient's medical record, mandating that the objecting doctor refer the patient to another physician competent and willing to carry out the same service [15].

These cases are groundbreaking for numerous reasons, but for the purposes of the present article I will focus on 2 reasons. First, it is the first time any international or regional human rights body in *an individual complaint* has articulated states' *positive* obligations to regulate the practice of conscientious objection in relation to abortion and to prenatal diagnostic services. These cases required an international human rights tribunal to take a look at abuse of the practice in a specific situation and the experiences of the women subject to the practice. The Court's finding in the case related to prenatal diagnostic care is groundbreaking because it is the first time a human rights body has addressed objection to providing information to a patient about her health. While the Court's judgments provide minimal guidance, it is developing its standards in this area.

The second reason is that, for the first time, the Court directly relied on FIGO's ethical standards/guidelines and resolution on the issue of conscientious objection to support its decision [14,17].

3. Ethical and health standards

The FIGO Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health submitted an amicus brief in the case of *R.R. v. Poland*, presenting its resolution and ethical guidelines on conscientious objection to the Court [18]. In articulating state obligations to regulate the practice, the Court directly relied on the information provided by FIGO to support its judgment, citing the material provided in FIGO's amicus brief as a source of relevant law and practice [14]. FIGO's ethical guidelines and resolution on the subject have, thus, directly influenced the emerging human rights standards regarding conscientious objection to reproductive health services. This is a rare example of how ethical standards can shape the development of international human rights law and reflects the critical importance that ethical standards can have in protecting and promoting human rights.

In fact, FIGO has the most comprehensive ethical guidelines on conscientious objection of any international medical professional organization. The ethical guidelines note that any conscientious objection to treating a patient is secondary to the primary duty—which is to treat, provide benefit, and do no harm, and includes provision of accurate information and referral/obligatory provision of care when referral is not possible or need is urgent [17]. A resolution mirroring these guidelines was adopted a year later by the FIGO General Assembly [19]. The resolution also recognized the duty of practitioners as professionals to abide by scientifically and professionally determined definitions of reproductive health services and not to mischaracterize them on the basis of personal beliefs [18].

WHO has also recognized that, as a barrier to lawful abortion services, conscientious objection can impede women from reaching the services for which they are eligible, potentially contributing to unsafe abortion. In its recent edition of guidelines on safe abortion, WHO notes that health services should be organized in such a way as to ensure that an effective exercise of the freedom of conscience of health professionals does not prevent patients from obtaining access to services to which they are entitled under the applicable legislation. It recommends the establishment of national standards and guidelines facilitating access to and provision of safe abortion care, including the management of conscientious objection [18,20,21].

While these health and ethical standards provide some guidance for regulating the practice of conscientious objection and have an important role in influencing the development of the nascent human rights standards on the topic, many issues that arise in this context are not fully addressed by international legal, health, or ethical standards.

4. Conclusion

International ethical and health bodies, and international and regional human rights mechanisms are well positioned to fill in the gaps in guidance. Such standards can help in the development of national laws and regulations on the subject and can be used to hold states accountable when associated violations of human rights occur. The standards should cover the numerous systemic and individual barriers leading to denial of services. Such guidance should clearly establish that only individuals, not institutions, can have a conscience and that only those involved in the direct provision of services should be allowed to invoke conscientious objection. Medical students, for example, cannot object to learning to perform a service that they may need to provide in case of emergency. They should also establish under which circumstances individuals can and cannot object. For example, the practice should be prohibited when a patient's life or physical/mental health is in danger. In addition, the types of services for which objection is impermissible should be specified, such as providing referrals, information, and diagnostic services. Standards should also clearly articulate state obligations to guarantee that the practice of conscientious objection does not hinder the availability and accessibility of providers, including by employing sufficient staff who are available and willing to deliver services competently; by ensuring oversight and monitoring of the practice; and by holding to account those in violation [1,6,12,22].

Moreover, as in all circumstances, healthcare systems should be transparent. and services should respect women's dignity and autonomy in decision making. In other words, *women's* conscience should be fully respected [23].

Conflict of interest

The author has no conflicts of interest.

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