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''Dishonourable disobedience'' — Why refusal to treat in reproductive healthcare is not conscientious objection

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Summary In medicine, the vast majority of conscientious objection (CO) is exercised within the reproductive healthcare field — particularly for abortion and contraception. Current laws and practices in various countries around CO in reproductive healthcare show that it is unworkable and frequently abused, with harmful impacts on women's healthcare and rights. CO in medicine is supposedly analogous to CO in the military, but in fact the two have little in common.

This paper argues that CO in reproductive health is not actually *Conscientious Objection*, but *Dishonourable Disobedience* (DD) to laws and ethical codes. Healthcare professionals who exercise CO are using their position of trust and authority to impose their personal beliefs on patients, who are completely dependent on them for essential healthcare. Health systems and institutions that prohibit staff from providing abortion or contraception services are being discriminatory by systematically denying healthcare services to a vulnerable population and disregarding conscience rights for abortion providers.

CO in reproductive healthcare should be dealt with like any other failure to perform one's professional duty, through enforcement and disciplinary measures. Counteracting institutional CO may require governmental or even international intervention.

1. Origin and meaning of ''conscientious objection''

Conscientious objection (CO) in the West originates in Christianity in the form of pacifism — the belief that taking human life under any circumstances is evil (Moskos and Whiteclay Chambers, 1993). Although all conscientious objectors take

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their position on the basis of conscience, they may have varying religious, philosophical, or political reasons for their beliefs.

The original expression of conscientious objection was the refusal to perform mandatory military service because of personal or religious moral objections to killing. However, in recent years, the concept has been used by some in the medical profession to refuse to provide services with which they personally disagree, such as euthanasia, abortion, contraception, sterilization, assisted reproduction, and other health services — even when these services are legal and within the scope of their qualifications and practice. In particular, the Catholic Church and the anti-choice movement have co-opted the term ''conscientious objection'' to include the refusal by medical personnel to provide or refer for abortion (and increasingly, contraception), on the grounds that abortion is murder and that actions to oppose it are imperative. As the late Pope John Paul II said (Pope John Paul II, 1995):

> *Abortion and euthanasia are thus crimes which no human law can claim to legitimize. There is no obligation in conscience to obey such laws; instead there is a grave and clear obligation to oppose them by conscientious objection.*

Reproductive health is the only field in medicine where societies worldwide accept freedom of conscience as an argument to limit a patient's right to a legal medical treatment. However, CO in medicine is still largely unregulated across Europe (as in the rest of the world) and abuses remain systemic (Center for Reproductive Rights, 2010).

2. Current CO policies and laws

Most western countries allow healthcare professionals some degree of CO through medical policies or codes of ethics — often called ''refusal clauses'' or ''conscience clauses''. Typically, healthcare personnel can opt out of providing non-emergency care, but only if they promptly refer the patient to someone else who can help them. The Code of Ethics of FIGO (International Federation of Gynecology and Obstetrics) states (FIGO):

> *Assure that a physician's right to preserve his/her own moral or religious values does not result in the imposition of those personal values on women. Under such circumstances, they should be referred to another suitable health care provider. Conscientious objection to procedures does not absolve physicians from taking immediate steps in an emergency to ensure that the necessary treatment is given without delay.*

Many countries have enshrined CO into law (Heino et al., 2013):

- Austrian law states: *No one may be in any way disadvantaged ... because he or she has refused to perform or take part in such an abortion.* (Government of Austria, 1975)
- France's law says: *A doctor is never required to perform an abortion but must inform, without delay, his/her refusal and provide immediately the name of practitioners who may perform this procedure... No midwife, no nurse, no paramedic, whatever is required to contribute to an abortion. ... A private health establishment may refuse to have abortions performed on its premises.* (Government of France, 2001)
- Even though the Australian state of Victoria decriminalized abortion in 2008, the new law retains a CO clause: *If a woman requests a registered health practitioner to advise on a proposed abortion, or to perform, direct, authorise or supervise an abortion for that woman, and the practitioner has a conscientious objection to abortion, the practitioner must refer the woman to another registered health practitioner [who] does not have a conscientious objection to abortion.* (Australasian Legal Information Institute, 2010)
- In the United States, almost every state has passed refusal clauses allowing physicians to opt out of providing abortions and other services. In addition, federal law protects doctors and nurses who do not want to perform abortions or sterilizations, and allows health workers to file complaints if they feel discriminated against (Huffington Post, 2011).

3. Abuse of CO

Once the basic principle of CO is accepted in reproductive healthcare, it becomes impossible to control or limit. Who will be in charge of deciding? Where does it stop? What criteria will determine the limits? Who will enforce it? And what are the sanctions? Currently, legal provisions for CO are routinely abused by anti-choice healthcare personnel (Cook and Dickens, 2006; Dickens, 2006), who are usually not disciplined for it.

Most CO laws and policies require doctors to refer appropriately to another doctor who will provide the service — what we call ''limited CO'' — but this often does not happen because many anti-choice healthcare workers believe that even giving information or a referral violates their conscience. Such workers will sometimes break the law or even commit malpractice — they may refuse outright to refer, make an inappropriate referral to an anti-choice ''counselling'' agency, treat the patient disrespectfully, fail to disclose the services they will not provide or why, refuse to give any information on options, provide misinformation on options, or delay a referral until it is too late for an abortion (CARAL, 2003). For example:

- In Wisconsin, ''...a married woman with 4 children sought the morning-after pill at a local pharmacy. Not only did the pharmacist refuse to fill the prescription, he refused to transfer it to another pharmacist or to return the original prescription to the patient.'' (Grady, 2006a)
- In Poland, women who qualify for a legal abortion are entitled to a certificate that they must present to get an abortion, but doctors will often refuse to provide one when they should, or improperly declare a certificate ''invalid'' when one is presented to them (Reuters, 2007).
- In a Canadian survey (CARAL, 2003): ''Anti-choice doctors were noted for lying about abortion services, claiming that there was not enough time to do the abortion, or that a hospital might not provide services after eight weeks''.

Not only did many anti-choice doctors flatly refuse to refer women to an abortion provider, they ''sometimes delayed appointments for tests until the pregnancy was too advanced to be eligible for the procedure''. In one instance, a physician told his regular patient that he ''would no longer provide medical care in the future should [she] proceed with an abortion''.

- In Idaho, an anti-choice pharmacist abused the state's conscience law by refusing to dispense Methergine, a non-abortifacient drug that prevents or controls bleeding, because the pharmacist suspected that the woman may have had an abortion. In addition, the pharmacist rudely refused to refer the woman to another pharmacy (Miller, 2011).

Allowing limited CO rests on the misconception that objecting healthcare personnel will make the required compromises, including referring for abortion or providing accurate information on the procedure. But this relies on trusting people to set aside deeply held beliefs that have already been deemed strong enough to invoke CO, making any compromise far less likely. In fact, objectors often see no moral difference between doing an act and allowing it (Card, 2007). As stated by one anti-choice writer (McGovern, 2009):

> *From the perspective of a doctor with a conscientious objection to abortion, referral to another practitioner is like saying, 'I can't rob the bank for you myself. But I know someone down the road who can.' In other words, referral involves becoming complicit in the abortion. It is therefore something that healthcare practitioners with an objection to abortion rightly refuse to do.*

Similar convictions were stated by a Canadian anti-choice pharmacist who refuses to make referrals for emergency contraception prescriptions: ''I will not direct people to a source of life-taking medicine. I cannot collaborate in the modern Holocaust.'' (Grady, 2006b) Since objectors often view a referral as equivalent to doing the procedure themselves, limited CO is inherently contradictory and therefore unworkable. In effect, a referral requirement tries to mitigate the harm of CO but permits that harm to occur.

CO regulations also require objectors to provide emergency care, but some doctors will risk a woman's death rather than perform an abortion. In Poland, even though abortion is legal to save a woman's life, doctors let a woman die out of concern that treating her for her colon disease might harm the foetus (Center for Reproductive Rights, 2010). In a highly publicized 2012 case, Savita Halappanavar died of sepsis in an Irish hospital three days after doctors refused to end her doomed pregnancy because her foetus still had a heartbeat (Berer, 2013).

In any case, the legal requirement to provide a service in a life-threatening situation is unworkable by definition. It is usually impossible to determine with certainty whether any medical case is truly life-endangering and to what degree — until the patient actually dies. Differing medical opinions on the risk of death means that some will advise a ''wait and see'' approach until it is too late. When it comes to abortion, the loudest voices urging a delay are often guided by personal beliefs, not medical knowledge and skills, especially in restrictive social environments hostile to abortion rights.

Granting the basic right to CO sets a precedent that can lead to dramatic extensions of CO to other areas, as well as confusion on where to draw the line. The George W. Bush administration tried to expand the legal right of CO to any public healthcare worker in the U.S. for almost any reason. Although the regulation was mostly rescinded by President Obama in 2011, it represented a serious abuse of CO because of the potential for inflicting increased harms on ever-larger numbers of patients. Further, when the U.S. government included a provision requiring full coverage of contraception in its landmark healthcare legislation enacted in 2012, it triggered many lawsuits from religious organizations and private companies, claiming that paying for their employees' birth control would violate their faith. The issue will likely end up at the Supreme Court because of ''strong disagreements'' at lower court levels (Bronner, 2013), potentially leaving millions of women at the mercy of their employers' religious beliefs.

In an article on refusal clauses, the radical American group ''Priests for Life'' hopes to expand the right of CO to everyone (Pavone, 2002):

> *There is certainly a strong defense here for those who are opposed to abortion to refuse to service abortion facilities. Let this witness begin, from plumbers, electricians, office supply companies, delivery services, printing companies, lawn and garden companies, snow removal services, computer consultants, office machine repair services, sanitation workers, roofing companies, taxi drivers, security companies, lock and key companies, cleaning and maintenance services, sign and fence companies, food services, exterminators, and every other conceivable service*!

A 2010 report on CO presented at the Council of Europe (Council of Europe Parliamentary Assembly, 2010) explains CO abuses by highlighting problems at the health system level, specifically, the omission of mechanisms to ensure access to abortion:

> *In practice, various factors can lead to situations where women's access to lawful medical care is affected. The mostly widely observed reasons are the lack of oversight mechanisms ensuring the implementation of existing legal provisions and policies, the non-respect of legal duties with regard to the information of patients, the absence of regulations requiring or facilitating timely action (notification of conscientious objection, appeals processes, etc.), as well as the lack of regulation regarding the scope of conscientious objection provisions.*

Perhaps defining and enforcing CO regulations more consistently could mitigate the abuse of CO and help more patients access services they are entitled to. However, we argue that the systemic abuse of CO is not a mere sign of an imperfect world; rather, it indicates that such abuse is inherent in the very acceptance of CO, making laws and policies on limited CO essentially unenforceable. Endorsing CO means endorsing the principle that individual beliefs trump the health and lives of people who need a medical service.

4. CO in military service vs reproductive healthcare

The ethical obligation to serve the public is integral to the practice of medicine, the legal profession, and the military. Those who enter these ''helping professions'' are expected to subordinate their own interests and beliefs in order to serve others, even those they dislike or disagree with (Dickens, 2009). For example, doctors risk infection to treat others, lawyers defend heinous criminals, and soldiers risk death and must kill others when they go to war.

The refusal to kill in a war may well be morally defensible, but as an act that compromises a country's objectives in war (such as self-defense), it is also considered socially irresponsible and unacceptable. Historically, military objectors have been harshly penalized, often with imprisonment or even execution. Most western countries today protect CO for military service, but objectors must still justify their stance, are often required to undergo a rigorous review process, and are frequently punished (National Peace Museum, 2006). At the least, they are required to assume other burdens to compensate for their refusal.

In contrast, the ''right'' to CO in reproductive healthcare is widely accepted, even though refusing to provide an abortion for a woman in the difficult situation of an unwanted pregnancy has adverse consequences for her, not the objector. Not only does it negate a woman's self-determination, it could harm her health and can result in unwanted children. Yet healthcare professionals usually face no obligation to justify their refusals, rarely face any disciplinary measures, retain their positions, and even have their objection protected by law. Health systems that refuse to provide abortion services similarly face no national or international sanctions, even though that refusal contributes to significant maternal mortality and morbidity in many parts of the world (World Health Organization, 2011; Council of Europe Parliamentary Assembly, 2008a).

Some argue that abortion is a type of killing (of the foetus or embryo) and therefore CO is just as relevant in medicine as in the military. However, killing a living person in war cannot be equated with stopping the development of a gestational sac or foetus. The latter has only the potential to become a person — it is still an inseparable and fully dependent part of a woman's body and not an individual human being. Embryos and foetuses are rarely given the same legal status as a born person, except in a handful of countries like Poland and Nicaragua where the Catholic Church hierarchy imposes its doctrines on the legal system. Further, the alleged parallel in terms of refraining from killing is turned upside down for CO in reproductive healthcare. Abortion and contraception preserve the health and lives of women, while those practicing CO put women's lives at risk and sometimes even sacrifice them (Attie & Goldwater Productions, 2005).

CO in a military context is generally only invoked when military service is compelled via a draft, by ordinary citizens who have no power over others. In contrast, healthcare professionals are not forced into being a doctor, nurse, or pharmacist, and doctors are not compelled to be gynaecologists. They enter such careers of their own free will after successfully competing for training and positions, knowing in advance the full range of duties they will be expected to perform and their responsibility to patients who depend on them. This power imbalance between healthcare professionals and patients is a reversal of that between foot soldiers and their commanders. The legitimate exercise of CO can only be by the powerless against the powers-that-be — not by the privileged against regular people who rely on them for essential services.

5. Impacts of CO on women's healthcare

Because reproductive healthcare is largely delivered to women, CO in this field has implications for women's human rights and constitutes discrimination. Women are often expected to fulfil a motherhood role, so they frequently face ignorance, disapproval, or even hostility when requesting abortion. In these circumstances, the exercise of CO becomes a paternalistic initiative to compel women to give birth.

Refusals to provide emergency contraception also force women to risk unwanted pregnancy, while referrals to other pharmacies can cause delays that reduce the effectiveness of the medication. Prescriptions for birth control or emergency contraception have been refused by anti-choice pharmacists in the U.S. (Planned Parenthood (Affiliates of New Jersey), 2005) and occasionally in other countries such as the U.K. (Brooke, 2010) and New Zealand (Sparrow, 2012). At least six U.S. states explicitly allow pharmacists to refuse to dispense contraception (Guttmacher Institute, 2013a). As with abortion, refusals to dispense contraception are not a mere inconvenience to women, but cause genuine harm to their reproductive autonomy, their sense of security, and their moral identity as people who deserve to be treated respectfully when requesting sexual and reproductive health services (McLeod, 2010). Public confrontations with objecting pharmacists compromise patient confidentiality and can shame or humiliate women.

The presumption that only a small minority of healthcare professionals will exercise CO and that others will be available to perform the medical service places limited CO on a foundation of shifting sand, further revealing its contradictory and dangerous nature. Indeed, CO can become quite widespread, leaving women without access to services across entire regions. In Italy, 69% of all gynaecologists refuse to perform abortions, with the figure rising to over 80% in some regions (Italy Ministry of Health, 2007—2008). In Austria, abortion providers must travel from Vienna to Salzburg once a week to do abortions at one public hospital, because gynaecologists in the region invoked CO after intense pressure from the Catholic Church and anti-choice groups. Abortion is unavailable elsewhere in Salzburg or the surrounding county (Fiala, 2013).

The example of South Africa is an important lesson in the anti-democratic nature of CO and the negative impact it can have on women. Abortion was illegal during Apartheid, and one of the first actions of the newly elected democratic government was to legalize abortion to improve women's health (in 1996). But religious groups mounted campaigns against abortion that significantly reduced the number of willing providers. As a result, most of the healthcare professionals who should be responsible for performing abortions refuse to participate. Because of the latitude given to CO in

South Africa, almost a third of South African women believe abortion is still banned, illegal abortions appear to be more common than legal ones (van Bogaert, 2002), and women who show up at public hospitals with complications are often mistreated and shamed (SANGONeT, 2012).

In countries with a minority of anti-choice doctors, women may suffer worse hardship than a short delay and a minor inconvenience, even if the doctor makes a referral. Women may be burdened with additional costs, such as for travel or daycare, and may need to take more time off work — if they can find and get to another doctor or clinic. Delayed access to abortion can also result in significant morbidity. Waiting extra weeks or even months for the procedure increases the medical risk of abortion and may require a more complicated method (for example, D&C instead of vacuum aspiration) (Cheng, 2008). Further, the delay may lead to debilitating symptoms such as severe nausea and psychological distress from a developing pregnancy they want to terminate. They may also need to hide the pregnancy from employers, friends, and family members.

Low-income and rural women are hurt the most by the exercise of CO, because such women may not have the resources to seek services elsewhere. It also disproportionately affects women from ethnic minorities, and women who experience intimate partner violence or sexual violation, who are twice as likely to need abortion services than women who don't experience such violence (World Health Organization, 2013).

Finally, allowing CO for abortion ignores the realities of poor abortion access and the negative impact of allowing CO in that environment. Abortion is probably the most heavily restricted medical procedure in the world, despite it being one of the most common — and one that only women need, often desperately. In such a context, governments and health systems have an even greater obligation to ensure that abortion care is fully available and accessible. Instead, abortion is frequently singled out as the main or only target for CO in many countries, reducing access even further.

6. Impacts of CO on women's autonomy and human rights

Abortion is a necessary health intervention, as well as highly ethical. Women with wanted pregnancies can experience serious medical or fetal complications to the point where abortion becomes the ''standard of care'' — a medically required, evidence-based service that any practitioner should be expected to provide. CO undermines the standard of care by preventing patients from receiving accurate and unbiased information about their treatment options, and by inhibiting their ability to access such care (Weitz and Berke Fogel, 2010).

Termination of unwanted pregnancy is ethical because women do so only if they don't see any responsible way to care for that potential child. It protects their families and their future, since women may have existing children that they can barely afford to care for, or they may want to delay their first child until they finish school (Finer et al., 2008). Their decision is well-thought out and based on personal circumstances that only they can fully appreciate. Once the decision to terminate is made, most women will go to great lengths to carry it out, regardless of the law or the risk to their safety. Globally, 40% of all pregnancies are unintended (Guttmacher Institute, 2011). Over a quarter of all pregnant women will have either an abortion or an unwanted birth (Koyama and Williams, 2005), but 49% of the 43.8 million abortions that take place every year are unsafe and mostly illegal (Sedgh et al., 2012). An estimated 47,000 women die annually from unsafe abortion (Shah and Ahman, 2010) and 8.5 million are injured (Guttmacher Institute, 2010). This is why legalizing abortion has a dramatic impact on saving women's lives and improving their health, a phenomenon that has been demonstrated in dozens of countries over the last few decades. Internationally, women have established human rights and constitutional equality in most western countries, and the exercise of CO infringes those rights. Access to abortion (and contraception) frees women to pursue an education and career and to participate fully in public life, thereby advancing their equality, liberty, and other human rights. It allows women to better plan and provide for their families (well over half of all women requesting an abortion already have at least one child (Guttmacher Institute, 2013b)), which also benefits the entire community and society. Births of unwanted children can be detrimental to women who were denied abortion (and to their families), leading to a higher risk of poverty, health complications, and domestic violence (Foster et al., 2012). Unwanted children themselves are at higher risk for lifelong dysfunction, including child abuse or neglect, emotional handicaps, and stunted intellectual and educational development (Arthur, 1999; David, 2011).

Further, the decision to have an abortion is closely linked to social and economic circumstances, and the support or sanction of the societies that women live in. Women are much more likely to experience unintended pregnancy and seek abortion if they are adolescents, live in poverty, have chaotic lives or an abusive partner, or have poor access to contraception (Major et al., 2009).

Historically, one of the prime objectives of past governments was to increase their population, with little if any consideration for the quality of life of women and their children. Former monarchies, dictatorships, and war-leading countries wanted soldiers to increase their empires and serve as cannon fodder (Museum of Contraception and Abortion, 1916). This fundamental conflict between the state and the individual resulted in laws in almost every country that essentially forced women to have more children than they wanted. Much progress has been made over the last century, with many countries liberalizing their abortion laws. In 2010, the United Nations Special Rapporteur on the Right to Health called for immediate decriminalization of abortion around the world because legal restrictions had discriminatory and stigmatizing effects and violated the right to health by leading to preventable deaths and injuries (United Nations General Assembly, 2011). Canada already struck down its law entirely in 1988 and never replaced it, proving that criminal abortion laws are unnecessary and counter-productive. The Supreme Court of Canada said: ''Forcing a woman, by threat of criminal sanction, to carry a fetus to term unless she meets certain criteria unrelated to her own priorities and aspirations, is a profound interference with a woman's body and thus a violation of her security of the person.'' (Abortion Rights Coalition of Canada, 2013)

In western countries today, the anti-choice movement wants women to bear children to reverse declining population levels and mitigate the effects of an ageing demographic. Invoking CO is one strategy to achieve this goal. But history provides ample evidence of the ineffectiveness of such restrictive strategies and the catastrophic consequences they lead to. Perhaps the most well-known ''social experiment'' took place in Romania between 1966 and 1990. Former dictator Nicolae Ceausescu decided to increase the population by criminalizing contraception and abortion. Women were even subjected to regular gynaecological examinations to detect any pregnancy. But underground abortion networks mushroomed (as they do in any society where abortion is banned), and over the course of 20 years, an estimated 10,000 women died needlessly from illegal abortions alone. As a consequence of many unwanted pregnancies carried to term, state orphanages were overwhelmed with tens of thousands of children abandoned every year, most of whom ended up living on the street (U.S. Embassy, 2001; Westend Film+TV Produktion, 2004).

Anti-choice objections to providing abortions are based on a denial of this evidence and historical experience. The provision of safe, legal abortion is a vital public interest that negates any grounds for CO.

7. Impacts of CO on abortion provision

The exercise of CO can exacerbate the lack of access to abortion care by further reducing the pool of providers. Even pro-choice doctors may decline to or be unable to provide abortion care for a variety of other reasons besides CO, most of which are unique to abortion because of its politicized nature.

The stigma and misconceptions around abortion turn CO into an attractive solution for individual healthcare providers (ironically reinforcing those negative attitudes and beliefs). Allowing CO also encourages opportunistic refusals — doctors who are ambivalent about abortion may begin to adopt CO when given that option, making it very difficult to stop its growth (Millward, 2010). The refusal to perform or assist with abortion is often not even related to personal beliefs. Most pro-choice doctors who should or could perform abortions (obstetricians/gynaecologists and general practitioners) never do them, frequently because they fear that their reputation or livelihood will suffer because of social stigma. In North America, the atmosphere of fear and intimidation created by anti-choice extremists has worsened the provider shortage. The well-publicized violence against providers gives doctors ample reason to back away from performing abortions, irrespective of their personal beliefs.

Doctors who invoke CO to not perform abortions can benefit professionally by spending more of their time delivering more ''reputable'' or higher status treatments compared to their abortion-providing colleagues. As a result, they can escape stigma and boost their careers, reputations, and salaries.

Doctors who nevertheless want to provide abortion care may be prevented from doing so by their healthcare institution or employer for a variety of reasons, or by a lack of support from their collegial and social networks (Joffe, 2009). Physicians cite obstacles such as an anti-choice climate in their workplace, and widespread ''no-abortion policies'' that exist in many hospitals and private practices (Coletti, 2011), which may threaten health care providers with instant dismissal if they provide any banned treatment. Further, many doctors are simply unable to find work or training opportunities in an environment where abortion is legally restricted and stigmatized.

Lack of training and expertise is a common reason for not doing abortions, even though early abortion is a simple procedure and doctors routinely treat miscarriage using the same techniques as for surgical abortion. In general though, specific medical school training in common abortion techniques such as vacuum aspiration is often inadequate or non-existent, even in many western countries (Koyama and Williams, 2005).

When access to abortion care is reduced, restricted, and stigmatized in so many ways, allowing any degree of CO adds further to the already serious abrogation of patients' rights and medical ethics.

8. Institutional CO and violation of pro-choice right to conscience

Most CO laws and policies shield only healthcare professionals who refuse to participate in a given medical service like abortion, but fail to protect those who are ready to perform such interventions. Bioethicist Bernard Dickens refers to the stance of pro-choice healthcare workers as ''conscientious commitment,'' pointing out that ''religion has no monopoly on conscience''. For example, many doctors and healthcare personnel working in illegal settings around the world have provided safe abortions to women in desperate need. ''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.'' (Dickens, 2008) Such practitioners deserve legal and institutional protection for their commitment to their patients. Physician Lisa H. Harris has also recognized that caregivers may be compelled by conscience to provide abortion services, noting that the one-sided ''equation of conscience with non-provision of abortion contributes to the stigmatization of abortion providers,'' leading to provider shortages and even harassment and violence (Harris, 2012).

A prime example of negating a pro-choice right to conscience is when health systems such as Catholic hospitals claim the right to exercise their ''conscience'' by refusing to perform some reproductive health services, and then imposing that on all their staff and patients regardless of differing personal beliefs. Such policies may even be unwritten because they are based on the personal religious beliefs of hospital administrators (Nowicka, 2008). In Austria, almost all hospitals, both Catholic and public, refuse to provide legal abortions (Wimmer-Puchinger, 1995), and the director of a Catholic hospital even admitted in a media interview that a doctor would be fired for performing an abortion (Pongauer Nachrichten, 2004).

However, many Catholic healthcare personnel believe they are helping women and saving lives by providing abortions, and that being prohibited from doing so — even to

save a woman's life — would be a violation of their own religious beliefs, as well as medical ethics and the directive to ''do no harm''. Indeed, 37% of obstetricians/gynaecologists who practice in religiously affiliated institutions have had a conflict with their institution over its doctrinal-based policies (not just abortion), including 52% of Ob/Gyns in Catholic institutions (Stulberg et al., 2012).

At a Catholic hospital in Arizona, a nun in charge of the hospital's ethics committee was ''automatically excommunicated'' and ''reassigned'' after she decided to save a woman's life by providing an emergency abortion. As further punishment, the local bishop even revoked the hospital's Catholic designation (Associated Press, 2010). In Germany, two separate Catholic hospitals refused to give a raped woman a gynaecological examination to preserve evidence, or even any counseling or support. Staff had been threatened with dismissal for treating her, because the hospitals wanted to avoid having to offer advice on abortion or emergency contraception (The Local (Germany), 2013).

American women experiencing an ectopic pregnancy or miscarriage have been denied emergency life-saving treatment by religiously affiliated hospitals, in violation of accepted medical standards and federal laws (National Women's Law Center, 2011). Ectopic pregnancies, in which the embryo implants outside the uterus, are life-threatening to women. The pregnancy cannot be saved under any circumstance, so the standard of care is to immediately administer the drug methotrexate or to surgically remove the pregnancy. But because methotrexate is also used for abortion, Catholic hospitals refuse to provide it. Instead, they frequently force women to wait until their fallopian tube ruptures, increasing the woman's suffering and putting her life and future fertility at serious risk.

When CO is invoked by a health system on behalf of all its employees, it will likely impede women's access to sexual and reproductive health services far more than CO by individual doctors. In smaller communities, religiously based hospitals are often the only facility around, which reduces or eliminates access to a range of reproductive health services (female sterilization, emergency contraception, abortion etc.) for the entire region. This abandons local women to risk needless suffering or even death if they require essential reproductive healthcare (Berer, 2013; Catholics for a Free Choice, 2003). The woman's religion or beliefs are disregarded by the institution, even though Catholic women in the U.S. have abortions at the same rates as non-Catholics, and 98% have used a form of contraception banned by their Church (Catholics for Choice, 2011). Further, institutional CO sanctions only one sectarian religious view among many, since most organized religions, including Catholicism, have liberal streams of thought that support the right to abortion in some or most cases (Maguire Daniel, 2001). Despite this, most religiously affiliated institutions that exercise CO are publicly funded and serve entire communities with diverse views. In effect, female citizens of countries with government-funded healthcare are paying taxes to support a discriminatory system that denies them essential care based on their child-bearing capacity.

An amended resolution allowing institutional CO was forced through by anti-choice voting members in October 2010 at the Council of Europe, via a series of political tactics that subverted a democratic vote. The original resolution would have provided the first-ever official recommendations on how governments could ''balance'' women's right to required healthcare with healthcare workers' claim of CO. The corrupted resolution elevated a foetus over a woman's life, even the life of her family and other children, and essentially gave hospitals in Europe an escape clause from being held responsible or financially liable for neglect or harm inflicted onto patients (Council of Europe Parliamentary Assembly, 2010). The resolution still stands, although later decisions by the European Court of Human Rights in abortion-related cases (R.R. v. Poland; P. and S. v. Poland) tried to redress the situation with this oxymoronic ruling: ''States are obliged to organize their health service system...to ensure that the effective exercise of freedom of conscience by health professionals...does not prevent patents from obtaining access to services to which they are entitled...'' (European Court of Human Rights, 2012)

International human rights frameworks confirm that the right to freedom of thought, conscience, and religion is a right that only individual human beings can enjoy. In the words of Christine McCafferty, the Rapporteur for the committee that produced the Council of Europe report: ''...only individuals can have a soul or a conscience... Institutions such as hospitals cannot, by definition, have a conscience.'' (Council of Europe Parliamentary Assembly, 2010)

9. CO as dishonourable disobedience

As shown above, CO in reproductive healthcare is largely unworkable and inappropriate, and arguably unethical and unprofessional as well. As a ''refusal to treat,'' CO should more aptly be called dishonourable disobedience, because it violates women's fundamental right to lawful healthcare and places the entire burden of consequences, including risks to health and life, on the shoulders of women.

The accommodation of CO in reproductive healthcare is actually surprising. Why should a doctor's private beliefs trump the medical needs of an individual? No other sector of medicine or other kind of service delivery would allow a service refusal with so little resistance. Perhaps it arises from society's reluctance to allow women the freedom to make their own reproductive decisions, and the perception that women need guidance or even some moral persuasion to carry an unwanted pregnancy to term.

However, most women have already decided to have an abortion before they speak to any healthcare professional. They go to a doctor only because abortion is a medical service they need but cannot perform themselves in a safe way. The reliance on a doctor to protect one's life and health makes any right to CO in medicine unethical — and downright dangerous in light of the fact that women often resort to unsafe do-it-yourself abortions when they are unable to access medical care. If peoples' right to life means anything, they must be able to access necessary healthcare, which should supersede the conscience rights of others.

CO gives a person a pretext not to do their job, even though they were specifically hired to do that job and are being paid for it. Indeed, if you can opt out of part of your work without being punished, why wouldn't you? CO is a shield to protect employees from liability for their own negligence, while placing unfair burdens on colleagues and

employers. They are like employees who arrive late for work every day, forcing more dependable employees to cover for them. The unfair effects of allowing CO can be seen at the University of Medicine and Dentistry of New Jersey, which had to hire additional staff to make up for the refusal by 12 nurses to have any contact whatsoever with patients having an abortion — even routine tasks like taking a temperature, filling out paperwork, or walking a patient to the door after recovery. These nurses, who had essentially abandoned their professional duties and discriminated against patients, even filed a lawsuit against the hospital for ''forcing'' them to assist in abortion care against their religious objections (Giambusso, 2011).

The principle of public accommodation requires the discounting of individual conscience within a profession. Everyone's conscience is different and cannot be coerced, which is why a free democratic society places a high value on tolerance and equal respect for all citizens. However, if individuals are permitted to exercise their conscience *when serving the public*, it gives social sanction to the practice of intolerance. CO invites discrimination against people needing the services being refused, and infringes *their* freedom of conscience. This is why the American *Civil Rights Act* prohibited discrimination by facilities that serve the general public — a racist waiter working in a restaurant cannot refuse service to a black person. As one writer stated about an Iowa bill that would have allowed any business or organization to refuse to recognize gay marriage: ''It uses a word we associate with compassion — conscience — for the sole purpose of discriminating.'' (Basu, 2011) Similarly, CO in medicine contravenes the ethical obligation to serve the public, which is why it is dishonourable disobedience.

A healthcare provider's personal right of conscience can and should be limited to protect the rights of others, including their safety and health. As stated in the United Nations' International Covenant on Civil and Political Rights, Article 18(3) (Office of the United Nations High Commissioner for Human Rights, 1976):

> *Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety order, health or morals, or the fundamental rights and freedoms of others.*

CO violates medical ethics because doctors agree to assume professional obligations to patients when they join the profession. Patients cannot obtain services elsewhere because doctors enjoy a legal monopoly on provision of medical services, with their profession and medical knowledge fulfilling a public trust. Doctors are bound by laws on negligence and by ''fiduciary duty'' — a legal or ethical relationship of confidence or trust between two or more parties (Based on British common law, 2014). When doctors cite CO as a reason to refuse healthcare to a patient, they renege on their professional and public duties and their legal responsibilities. As such, CO should require a greater sacrifice on the part of the refuser, including a willingness to resign their position or even to go to prison (Cannold, 2010).

CO also clashes with the recent revolution in healthcare in western countries, where a new paradigm of patient-centred care, together with evidence-based medicine and a commitment to prevention, has been accepted (Weitz and Berke Fogel, 2010). One such example is in the UK, with its new Patient Choice framework adopted by the National Health Service (Department of Health, 2013). When patients take a more pro-active role in managing their own health and treatments, it leads to significantly better health outcomes. But CO reinforces the stereotype of the ''all-knowing'' doctor who dictates what is best for patients, with little regard for their individual needs or even the evidence. The exercise of CO becomes an excuse for the doctor to exert personal power over the patient by imposing their own views. In practical terms, time pressures and the unequal power dynamic between a patient and a doctor mean there may be no time or opportunity to negotiate, anyway. As Dr. Julie Cantor states: ''There is little recourse when care is obstructed — patients have no notice, no process, and no advocate to whom they can turn.'' (Cantor, 2009)

Most countries still enforce abortion laws that originated in the 18th and 19th centuries, reflecting the knowledge and social mores of those times. The spirit of those laws is still alive in countries where abortion is legal but access is restricted by political measures that have nothing to do with protecting women's health, such as obligatory counseling, waiting periods, and doctors' signatures to confirm the woman's mental distress. Laws that accommodate CO are even more inappropriate for less developed countries. Anthropologist and bioethicist Debora Diniz points out that developing countries tend to have greater anti-choice sentiment, a less secular culture, more dominance by the Catholic Church, and less access to abortion because of fewer facilities and providers and poor healthcare infrastructure. Such factors led Diniz to conclude that ''conscientious objection in developing countries should not be seen only as an issue of accommodation, but as a constitutional offense against the stability of the secular state.'' (Diniz, 2010)

10. Eliminating CO in reproductive healthcare

The unregulated practice of CO in reproductive healthcare has become entrenched in many countries and health systems, resulting in widespread negative consequences for the women concerned and violations of their rights (Council of Europe Parliamentary Assembly, 2010). Even where a law or policy allows limited CO, abuse of that right is common. This implies that objecting personnel cannot be trusted to exercise the right responsibly, and that those who abuse CO are not qualified to be healthcare workers. Even doctors who exercise CO within the law are arguably unsuited for their position because they are demonstrating an inability to perform their job — that is, they are allowing religious beliefs or some other personal issue to interfere with their job performance to the extent of negating their professional duty to patients.

Abortion is the most frequently performed surgical intervention in the obstetrics/gynecology specialty (although it is also performed by many general practitioners). Becoming an Ob/Gyn engenders a special responsibility towards female patients, since a significant number of them will experience an unwanted pregnancy leading them to request abortions. Ob/Gyns have serious ethical obligations to those patients.

We argue that healthcare personnel should respect the accepted ethical standard of a non-judgmental approach towards their patients for all essential healthcare, with no exceptions. Consequently, we propose that healthcare providers be prohibited from a blanket right to refuse to perform or refer for abortion or dispense contraception for personal or religious reasons. Our recommended prohibition is specific to abortion and contraception because these two medical services are both essential and common, but are overwhelmingly the ones that objectors refuse to deliver.

Further, we propose the following specific remedies to reduce and eventually eliminate CO in reproductive healthcare. Everyone aspiring to enter health professions that involve reproductive healthcare should be required to declare that they will not allow their personal beliefs to interfere with their management of patients to the point of discrimination. Medical students entering the Ob/Gyn specialty should be informed about the full scope of the specialty, including treating women with unwanted pregnancies. Students should be rejected if they do not wish to learn and prescribe contraception or perform abortions for CO reasons. All Ob/Gyns should be required to dispense birth control and perform abortions as part of their practice (unless there is a legitimate medical or professional reason not to). General practitioners should be expected to dispense contraception if requested, and perform abortions if they have the skills and capacity, or else refer appropriately. Pharmacists should be compelled to dispense all lawfully prescribed drugs without exceptions. Institutional CO should be completely prohibited for health systems and businesses that serve the general public.

Monitoring and enforcement measures should be put into place to ensure that prohibitions on CO are followed. After all, CO is a form of resistance to rules or laws, so those who exercise CO must be prepared to accept punishment for their disobedience, just as in any other profession. Doctors should be sanctioned when they violate laws or codes of ethics that prohibit CO. Disciplinary measures could include a review process, an official reprimand and order to correct, and could escalate to loss of medical license, dismissal, or even criminal charges. In addition, any costs involved in the exercise of CO should be borne by the health professional or institution, who must be held liable for any health risks and negative consequences of their refusal. Patients should be legally entitled to sue and to claim compensation for any physical or mental harm, and for additional costs resulting from the refusal to treat.

Over time, such measures should result in a reduction in the number of anti-choice healthcare workers in the field of reproductive healthcare who refuse to deliver patient-centered care. Those who decide to remain and provide abortions and contraception could adopt an attitude of ''professional distance'' in order to separate their personal beliefs from their work duties. They could derive satisfaction from obeying laws and codes of ethics, respecting patient needs and autonomy, keeping their jobs or licenses, and furthering workplace harmony (McLeod, 2008) Outside their work lives, they are free to express their beliefs in many other ways.

Implementing such measures may seem like a daunting task given the ongoing stigma against abortion and the strength of the anti-choice movement. But with political will, much could be done at local, national, and international levels to ensure that contraception and abortion services are widely available and accessible to all who need them. For example, governments could regulate public health systems to guarantee abortion provision, and provide financial aid to hospitals to recruit abortion providers. Other needed measures include compulsory training in contraception provision and abortion techniques at medical schools, security measures to protect doctors and patients such as clinic buffer zones, full funding of contraception and abortion through government health insurance, public education to reduce abortion stigma, and other initiatives. The Council of Europe has already recommended that States should ''guarantee women's effective exercise of their right of access to a safe and legal abortion;. . .lift restrictions which hinder. . .access to safe abortion, and. . .offer suitable financial cover.'' (Council of Europe Parliamentary Assembly, 2008b)

11. Conclusions

Allowing CO in reproductive healthcare, even to a limited extent, creates a fundamental contradiction and injustice. The patient's rights to life and bodily security surely outweigh the healthcare worker's right to conscience, whose first obligation is to their patients, not themselves. The exercise of CO allows medical professionals in a position of authority to abandon dependent patients whom they are duty-bound to serve. Health systems that prohibit staff from providing abortion or contraception services are being allowed to systematically deny healthcare services to a vulnerable population and disregard conscience rights for abortion providers, as well as patients. Since women are the vast majority of patients in reproductive healthcare, CO rises to the level of gender discrimination.

The systemic abuse of CO will inevitably occur as long as CO in reproductive healthcare continues to be tolerated. Further expansions of CO cannot even be opposed with evidence-based arguments, because the provision of healthcare has become contingent on religious or personal beliefs.

Healthcare workers' refusal to participate in reproductive care such as contraception and abortion is not a ''conscientious objection;'' rather, it is a refusal to treat that should be seen as unprofessional. A just society and an evidence-based medical system should deem it as ''dishonourable disobedience,'' an ethical breach that should be handled in the same way as any other professional negligence or malpractice, or a mental incapacity to perform one's duties. Unless workers are able to adopt an attitude of professional distance that would allow them to deliver necessary healthcare with which they personally disagree, they should quit the field of reproductive healthcare, or not get involved in it at all. In fact, those two options represent the only honest exercise of CO in medicine.

The state's acceptance of CO in reproductive health contravenes women's legal right to access health services. As such, CO can be seen as an attempt to claw back the legality of abortion (and contraception) and return women to their traditional duty of producing soldiers and citizens for the state. By manipulating women into continuing an unwanted

pregnancy against their best interests, the exercise of CO undermines women's self-determination and liberty and risks their health and lives. As such, it has no place in a democratic society.

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