# UNCONSCIONABLE:
# WHEN PROVIDERS DENY ABORTION CARE

INTERNATIONAL WOMEN'S HEALTH COALITION

POLICY BRIEF | JUNE 2018

## I. BACKGROUND

The global women's movement has fought for many years to affirm safe and legal abortion as a fundamental right, and the global trend has been toward the liberalization of abortion laws.[1] Despite this progress, persistent barriers prevent these laws and policies from expanding women's access to services.

One such obstacle is the growing use of religious or conscience claims by health care professionals to justify their refusal to provide abortion services. Mislabeled as "conscientious objection," a concept historically associated with the right to refuse to take part in military service on religious or moral grounds, the practice has been aggressively promoted by anti-choice movements.[2]

As a result, decision makers deliberately insert provisions into laws and policies to allow providers to refuse care, effectively negating the hard-fought right to abortion for many women. Although data are limited, in countries such as Italy and Uruguay, the percentage of health care professionals refusing to provide care can reach 80 percent, with dire consequences for women's health and lives.

## II. THE REFUSAL TO PROVIDE HEALTH SERVICES ON THE BASIS OF "CONSCIENCE" IS UNCONSCIONABLE

- **Providers denying lawful health care services are violating medical and professional ethics.** Claims of personal conscience to deny the provision of services have no place in health care. It is contrary to the ethical and professional obligations of health care providers, who must put the health and wellbeing of their patients first.[3] While primarily used to refuse provision of abortion care, conscience claims are increasingly used to deny other sexual and reproductive health services, such as contraception and infertility treatments, as well as services for lesbian, gay, bisexual, transgender, and queer (LGBTQ) persons and their families.[4]

  While health professionals are entitled to their religious beliefs, they must not prioritize their own beliefs over their duty to provide legal health care services when these services are part of that medical specialization or practice. Health professionals who practice obstetrics, gynecology, midwifery, pharmacy, or other fields that include the provision of sexual and reproductive health care should uphold their professional obligations to provide abortion, contraception, and other essential services, as their expertise permits.

  Nothing stops individuals who will not provide these essential services from joining the health profession as a whole. They should, however, specialize in a field where their ability to provide comprehensive services and uphold their professional duties and ethical obligations is not undermined by their personal beliefs.[5]

  The decision of health care organizations or the public sector to not employ individuals whose claims of conscience prevent them from performing their work duties does not constitute undue discrimination. Protecting the rights of patients to access legal health

care services without discrimination is of greater importance than protecting equality of opportunity for people whose personal beliefs prevent them from meeting the obligations of the profession they joined.

- **Denial of care harms those seeking essential health services.** In violation of the ethical principle of doing no harm, health care professionals' refusal to provide abortions, contraception, and other services hurts the individuals who are denied the care that they want and need. Because the denial of care forces patients to seek services elsewhere, to face delays, or even to forgo care, it particularly harms those who already face disadvantage and discrimination.

  Finding another provider can be costly in time and expense, and in some situations, may not be possible. A woman denied services might have no choice but to resort to a clandestine, unsafe abortion, with severe consequences for her health and life, or to continue an unwanted pregnancy. She might feel that she has nowhere to turn, contributing to feelings of stigmatization, isolation, and shame. All of these scenarios can cause mental anguish, trauma, and economic hardship.[6]

- **Refusal of care affects vulnerable patients more acutely.** Providers who refuse to deliver health care exacerbate existing inequalities. Health professionals, particularly physicians, are part of an elite and powerful profession in most societies. They often are more privileged than their patients, and physicians are often male. Their status and authority makes it hard for patients to challenge their decisions, or even ask questions.

  Furthermore, health professionals typically have a monopoly on the delivery of services. Asserting that their "right" to deny care, based on their personal beliefs, takes priority over patients' rights and health shifts even more power to them in an already unequal relationship. The more marginalized the person seeking services, the more likely they will face difficulty overcoming this power imbalance to demand the services they need.

- **Others pay the costs for health providers' denial of care.** Joining the health profession is voluntary, unlike conscripted military service. This is not the only significant difference between "conscientious objection" in health care and its exercise in the case of military service.[7] The military objector pays a price—typically undergoing a strict government vetting process, being required to justify the refusal, carrying out an obligatory alternative service, and frequently facing stigma and discrimination.[8]

  Health care providers do not pay a price for refusing to provide services based on conscience claims. The most severely affected is, of course, the person denied care, but others pay a price as well. Providers who uphold their professional obligations to provide comprehensive sexual and reproductive health services often face increased work burdens because of their colleagues' refusal. They also may experience increased stigma and discrimination in the workplace and in the community.

  Finally, making accommodations for those who refuse to provide care is costly. Doing so can distort resource allocation and create inefficiencies within health care facilities and systems that often are already strained.[9]

## III. INTERNATIONAL HUMAN RIGHTS BODIES DO NOT RECOGNIZE A RIGHT TO CONSCIENCE CLAIMS IN HEALTH CARE

International human rights bodies do not recognize a right to "conscientious objection" for health care providers. Nevertheless, some countries do allow providers to make such claims. In those cases, human rights treaty monitoring bodies have called for limitations on their use, in order to ensure that health providers' personal beliefs do not hinder access to services, and thus infringe on the rights of others.

Human rights treaty bodies have called out states' insufficient regulation of the use of "conscientious objection" and have directed them to take steps to guarantee access to health services. For example, the United Nations Committee on Economic, Social and Cultural Rights General Comment 22 on the right to sexual and reproductive health says:

> *Where health-care providers are allowed to invoke conscientious objection, States must appropriately regulate this practice to ensure that it does not inhibit anyone's access to sexual and reproductive health care, including by requiring referrals to an accessible provider capable of and willing to provide the services being sought, and that it does not inhibit the performance of services in urgent or emergency situations.*[10]

International human rights treaty monitoring bodies also affirm that organizations or institutions (such as hospitals) cannot make claims of "conscientious objection."

## IV. RECOMMENDATIONS

***For national policymakers:***

- **Policymakers should not include provisions in health care policies that allow providers to refuse services based on conscience claims.** Where decision makers are revising abortion policies, they should not refer to or make allowance for conscience claims by health professionals or institutions. Enshrining into law the notion that providers' personal beliefs are relevant to the provision of health care services and information opens the door to abuse, and legitimizes conscience claims.

  Allowing "exceptions" in the case of abortion and other sexual and reproductive health care services that enable women and/or LGBTQ people to make choices about their bodies, health, and lives, violates these individuals' rights to achieve the highest attainable standard of health and to access a full range of legal services. It also undermines the obligations of providers to uphold the law and perform their professional duties.

- **Where laws that permit refusals are in place, governments should strictly limit and regulate the use of conscience claims and enforce those regulations. Laws and policies should never allow institutions to refuse care. Policymakers should establish regulations that shift the burdens to those who deny care.**

Evidence and experience show that state regulation of conscience claims are rarely effective. Nevertheless, if it is not feasible to keep provisions for conscience claims out of the law, the law must require governments to strictly limit and regulate their use.

Regulations should require, at a minimum, that health care professionals refer patients to other professionals at a reasonable distance and in a timely manner. In the case of medical emergency or if another provider is not accessible, the provider *must* deliver needed care. Providers also must provide accurate information and unbiased counseling to their patients. Refusers should be required to provide written justification for their position. The exercise of conscience claims should be restricted to individuals directly involved in performing the procedure, and *never* allowed for institutions.

Governments must closely monitor and strictly enforce these regulations to ensure that all people have the ability to exercise their right to affordable, accessible, acceptable, and quality comprehensive care. Abortion and contraceptives should always be available in public health facilities without discrimination.

***For international and professional organizations:***

- **International agencies and professional organizations working in health should take a clear position that refusal of care based on personal beliefs is unacceptable.**

  Organizations such as the World Health Organization (WHO), the International Federation of Gynecology and Obstetrics (FIGO) and the International Confederation of Nurse Midwives should state that abortion is an essential aspect of sexual and reproductive health care and that abortion provision is an obligation of all professionals working in this area, regardless of personal beliefs.

  WHO should issue technical guidance that strongly discourages governments from formulating policies that allow providers to deny health care based on conscience claims. For countries where "conscientious objection" is already allowed, WHO should issue guidance on how to establish and enforce regulations that limit its use and impact.

- **Treaty monitoring bodies should further elaborate on how refusals to provide care specifically violate certain international human rights.** Regional human rights entities, in particular, should develop clear interpretations of human rights law on this matter, as well as on the obligations of health providers under international and regional human rights law.

***For those investing in or conducting medical education:***

- **Where the law is changing, health professionals need training and support to prepare to fulfill their professional duties.** In countries where the law has changed recently to decriminalize abortion in part or in full, the government and professional associations should educate health providers about the new law and their obligation to follow it. Professionals need support to examine their values and responsibilities in a

changing legal and policy environment. During this period of change, accommodations may need to be made for those health care professionals already working in reproductive health care who refuse to provide the legal services, while they transition to other specializations.

- **Provide on-going education for health professionals in bioethics and human rights, including values clarification on abortion**. Professional organizations and medical societies, medical and nursing schools, government agencies, and nongovernmental organizations can collaborate to educate current and future providers in all aspects of abortion care. Start educating early, during undergraduate education, and continue through professional development opportunities.

- **Create and institutionalize systems of accessible support networks for health care providers to combat stigma, isolation, stress, and burnout.** Develop ways to recognize and celebrate the hard work of health professionals providing abortion care. Health-related professional organizations and medical societies can play a leading role in motivating, renewing, and advancing the field.

- **Foster leadership within the profession**. Health care providers who feel able to do so should be encouraged to embrace an advocacy role within their institutions, professional communities, and among policymakers. They can talk about their work, the women they serve, the evidence on safe abortion, and the burden and consequences of the refusal of care for women and other providers.

***For those funding or conducting research:***

- **Collect more data on the prevalence and consequences of refusal of care due to conscience claims in reproductive health care.** While the existing evidence suggests widespread use of conscience claims in reproductive health care, there are not sufficient data to capture the breadth and depth of this phenomenon.

  A recommendation for advocates and researchers is to document the prevalence of refusal in a variety of contexts, as well as to link prevalence to studies of the effects, aiming to show the consequences of conscience claims—especially for individuals who are denied access to care. Centering on those affected, especially the most vulnerable, exposes the power imbalance inherent in this situation and highlights the ways that the refusal of care contributes to increasing inequities. Research also should be done on the consequences and costs for other providers and for the health system.

***For all those advocating for access to safe and legal abortion and other essential care:***

- **Build alliances across movements to share experience and develop strategies to combat the use of conscience claims to deny services.** The effects of the refusal of health care on grounds of conscience go beyond abortion access, also affecting those seeking contraception, infertility treatment, and sterilization services, as well as LGBTQ persons seeking health care generally, and those seeking aid-in-dying. Women's rights

activists should build alliances with other affected communities to combat the effects of such refusal of care.

- **Use courts and human rights treaty bodies to establish limits on providers' ability to refuse care based on claims of conscience.** Advocates can help shape the development and application of national and international law by engaging with courts and human rights bodies to challenge the use of so-called "conscientious objection" and to expose its implications for women's rights and health. National-level advocates should work to include the issue of refusals in official government and civil society shadow reports to international and regional human rights bodies and processes.

- **Reclaim "conscience" for those who follow theirs to affirm the right to health.** The term "conscientious objection" is a misnomer. Those that seek to deny people their right to health care have co-opted a term historically used in reference to a practice by people subjected to mandatory military service. Providers should not use it for a practice that subverts professional obligations and standards in health care and hurts patients. IWHC joins others who have called for finding terminology that more accurately reflects the action, such as "refusal of services" or "denial of services based on conscience claims." Health care providers and human rights and women's rights advocates must not cede the term "conscience" to those that misapply it to deny others health care.[11]

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[1] Katherine Mayall and Johanna B. Fine, "Abortion Worldwide: 20 Years of Reform" (Center for Reproductive Rights, 2014), https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/20Years_Reform_Report.pdf.
[2] United Nations Office of the High Commissioner on Human Rights, "Conscientious Objection to Military Service" (United Nations, 2012), http://www.ohchr.org/Documents/Publications/ConscientiousObjection_en.pdf; Catholics for Choice, "In Good Conscience—Respecting the Beliefs of Healthcare Providers and the Needs of Patients" (Catholics for Choice, 2010), http://www.catholicsforchoice.org/wp-content/uploads/2014/01/InGoodConscience2010.pdf; Douglas NeJaime and Reva Siegel, "Conscience Wars in Transnational Perspective: Religious Liberty, Third-Party Harm, and Pluralism," in *The Conscience Wars: Rethinking the Balance Between Religion, Identity, and Equality* (Cambridge: Cambridge University Press, 2018), https://ssrn.com/abstract=2714017.
[3] 2nd General Assembly of the World Medical Association, "WMA Declaration of Geneva" (World Medical Association, September 1948), https://www.wma.net/policies-post/wma-declaration-of-geneva/.
[4] NeJaime and Siegel, "Conscience Wars in Transnational Perspective: Religious Liberty, Third-Party Harm, and Pluralism."
[5] Udo Schuklenk, "Conscientious Objection in Medicine: Accommodation versus Professionalism and the Public Good," *British Medical Bulletin*, 2018, 1–10, https://doi.org/10.1093/bmb/ldy007.
[6] Rana E. Barar, "Best Practice for Abortion Policies: Listen to Women's Stories," *ResearchGate* (blog), September 8, 2015, https://www.researchgate.net/blog/post/best-practice-for-abortion-policies-listen-to-womens-stories; Diana Greene Foster, "Introduction to the Turnaway Study" (Advancing New Standards in Reproductive Health, February 2018), https://www.ansirh.org/sites/default/files/publications/files/turnaway-intro_2-20-2018.pdf.; Jane Harries et al., "An Exploratory Study of What Happens to Women Who Are Denied Abortions in Cape Town, South Africa," *Reproductive Health* 12, no. 21 (2015): 1–6.
[7] Schuklenk, "Conscientious Objection in Medicine: Accommodation versus Professionalism and the Public Good."
[8] United Nations Office of the High Commissioner on Human Rights, "Conscientious Objection to Military Service."
[9] For example, preliminary United States government estimates indicate that establishing mechanisms to conform to a new rule proposed in January 2018 that expands the right to refuse to provide patients reproductive and other health care will cost the health care system more than $300 million.
Ricardo Alonso-Zaldivar, "$300M Health Care System Cost to Protect Religious Rights," *The Associated Press*, February 5, 2018, sec. Health, https://www.apnews.com/1a1e49053509473b9c97578a0ee98636.
[10] Committee on Economic, Social and Cultural Rights, "General Comment No. 22 on the Right to Sexual and Reproductive Health" (United Nations Economic and Social Council, 2016), 22, http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=E%2fC.12%2fGC%2f22&Lang=en.
[11] Bernard M. Dickens and Rebecca J. Cook, "Conscientious Commitment to Women's Health," International Journal of Gynecology and Obstetrics 113 (2011): 163–66, https://doi.org/10.1016/j.ijgo.2011.02.002.

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