

Re-thinking the Use of Conscientious Objection by Health Professionals:

A regulatory proposal based on legal abortion practices in Argentina

Executive Summary

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“Ninety percent of health-care practitioners will not perform abortions,” warned physicians in Chaco, a province in north-eastern Argentina, during the debate in Argentina’s Senate to extend the legalization of abortion in July 2018. Around this same time, in a nearby province, Misiones, every physician in one hospital declared that they would register as conscientious objectors should the legislation prove successful. Just a few days earlier, Argentina’s press reported that more than 200 girls had been raped and forced to give birth in Misiones, without access to legal abortion under the rape indication. In Argentina abortion is legally permitted in cases where a pregnancy presents a risk to the life or health of the pregnant woman or person and in cases of rape.

At the same time, many legal abortion providers experience stigma, work overload, and even professional and social marginalization. Some of them are labeled as “abortionists,” that is to say, “they do the dirty work.” It is not uncommon for chiefs of staff within health services and hospital directors to use their titles and authority to restrict young physicians’ freedom. There exists *“a kind of ‘forced obedience’; residents in certain facilities were afraid that, if they did not declare themselves objectors, they would be marginalized and would not have access to the positions or the training necessary for other services,”* as stated by a health-care manager interviewed for this research.

For all these reasons, when one seeks to lay the foundation for a public health policy that includes legal abortion, it is very difficult to avoid claims of *conscientious objection* (CO). It has become practically impossible to ensure access to legal abortion without responding to this phenomenon.

In our work to understand CO as it is applied to legal abortion services in Argentina and generally, we focused on two crucial and interdependent aspects of this problem: re-conceptualization of CO and a proposal for its regulation within the framework of a public health policy. Both are empirically informed. In addition to secondary sources, we assessed opinions and perceptions through a survey with 269 professionals working in public sector health services, about the manifestations, causes, and impact of CO, and conducted 11 semi-structured interviews with health-care managers and chiefs of staff at health facilities.

The framework we proposed brings into play regulatory gaps, concrete needs, and daily experiences both within health-care teams and among health authorities. This framework also seeks to account for the characteristics of medical training, the institutional context within health facilities, and the socio-political environment where CO is exercised.

We understand CO as a case of moral rejection, where health-care practitioners who are unable to resolve their internal dilemma recognize that, even though it is required by several principles of professional ethics, they will not be able to provide objective care to patients who request a legal abortion. Hence, they resort to this exception, transferring the case and workload to their colleagues. Thus, CO should be first and foremost an act of humility, rather than moral arrogance, much less religious fundamentalism or covert political pressure.

Nonetheless, we have found that CO is used as a tool to evade the costs associated with stigma, work overload, legal confusion, loss of professional prestige, and potential problems given the actions of conservative groups, prosecutors, and other authorities who abuse their power in hostile work, institutional, and even social environments.

Therefore, **CO functions as an individual and institutional form of evasion**, or an outlet, to avoid all costs generated by providing legal abortion care in this precarious

context. It is a mechanism used not only by providers, but also by entire teams and authorities, to avoid fulfilling their obligations to respect, protect, and uphold the right to a legal abortion, and to protect themselves in extremely hostile environments with respect to abortion. This is suggested by our survey, where for example 42% of providers thought that use of CO is partly due to fear of being stigmatized by other health-care providers.

Besides its distorted uses and the inevitable place, it occupies in the public debate on access to and expansion of reproductive rights, CO is especially relevant due to the magnitude and consequences of its exercise. **There is a correlation between the incidence of CO and problems related to health-care provision, including a lack of access and delays in care, patient mistreatment, and maternal morbidity and mortality, among others.** According to the respondents, the main problems caused CO are its impact on quality of care (62%), workload of health-care practitioners who provide legal abortions (58%), and tension among team members (57%). Only about 7% of those surveyed thought that CO does not generate problems within health-care teams.

In much of Argentina, **freedom of conscience among providers who treat women seeking a legal abortion is restricted.** For example, within health facilities, authorities abuse their power to limit health-care practitioners' individual decisions regarding the provision of legal abortion care. Most survey respondents (51%) believe that health facility authorities, including chiefs of staff, influence teams so that they will deny abortion care. According to one provincial sexual and reproductive health care coordinator, "in hospitals there are people who report that a catchphrase was "we must sign as objectors," a mandate that came from administrators at the health facility."

Even though providers who perform legal abortions work within the law and are motivated by their conscience, they face stigma, marginalization within their health

facilities and the professional community, harassment, and even threats of physical harm. In other words, they pay a very high price to exercise their freedom of conscience, unlike providers who deny this care. Accountability for providing care becomes distorted, as do the incentives and disincentives to fulfill one's professional and legal duties.

Besides being used as a way to avoid negative consequences for providing legal abortion care, CO is also used as a Trojan Horse; sheltered by the protection of individual freedom of conscience, it functions as a political tool to dismantle public policies regarding reproductive health. This is the case with regard to way the Catholic Church has encouraged the use of CO from its upper echelons, members of which who have urged their followers to use CO as a way to resist legal changes favorable to reproductive rights.

The distorted and political uses of CO have been promoted due to the lack of public policies that effectively include CO. Although Argentina's Supreme Court of Justice and health policy have recognized CO both legally and politically, beginning with the first national laws on reproductive rights passed in 2002, there's still no regulation that sufficiently address the matter of CO. The highest court, in its historical 2012 ruling on abortion, reaffirmed the need to regulate CO to ensure that its exercise does not hinder access to legal abortion. However, to this date, the national health policy has not dealt with the conditions for and limitations of CO, nor with its abuse nor the causes that drive providers to claim CO. This is in spite of the fact that providers' refusal to provide legal abortion care has translated into violation of patients' rights and lack of access to life-saving care, thus becoming the rule in several of the country's provinces.

This phenomenon is not exclusive to Argentina or the region. CO clauses accompanied the first wave of abortion legalization in European countries and in the United States, between 1970 and 1980, as a pragmatic need and also as legal reality stemming

from political negotiations that permitted the realization of abortion rights. Since then, they have proliferated somewhat mechanically, without attention to the inconsistencies of this extraordinary institution in the health context, as if there were no better ways to accommodate the interests at play.

Faced with this disturbing reality, aim to reflect upon and reconceptualize CO, to understand it not as the result of conflict between an internal moral belief and an external obligation, but as a complex moral conflict among several beliefs and principles that inform each provider's conscience. This conflict takes place deep within the conscience of each person, although it should consider the external impacts it generates. That is precisely why, when one claims conscientious objection so as to be considered exempt from fulfilling one's professional and legal duty, there is a costly moral dimension. Health providers' use of CO favors a given personal belief over, or place of, a set of moral principles, as well as legal and professional duties that are also part of the axiological substrate of that provider and, hence, are called upon to guide his or her behavior.

For all the aforementioned reasons, we propose a new name for this phenomenon, to understand it more precisely as: **“the denial to provide legal abortion care for moral or religious reasons.”** First, we believe that all health-care practitioners exercise their conscience. This is precisely one of the problems with the term CO: it grants monopoly over the term *conscience* to providers who, paradoxically, deny health care to a patient who is also exercising their conscience by requesting a legal abortion. A second problem is equating conscience with *not* providing abortions, which contributes to stigma toward those who do provide this service. A third problem with the term CO is that it creates an incomplete scenario. Providers who request to be exempt from fulfilling a legal duty are not only objecting, but also denying that care to someone. Conversely, speaking about *the refusal to provide legal abortion care for moral or religious reasons*, or for other similar reasons, presents a more complete picture of CO and synthesizes the behavior. For this reason, the

denial of legal abortion care for these reasons is a more accurate description of CO. Finally, it is problematic to continue using the term CO, which emerged as a result of mandatory military service, because it is very difficult to find similarities with the way in which the concept is applied in healthcare.

Understanding the refusal to provide legal abortion care for moral or religious reasons in the sense mentioned above, we proceed with a **regulatory proposal that inserts this concept in the framework of a public policy to uphold reproductive rights.**

The proposal includes a clause to be incorporated into the law to extend abortion rights and regulation of said clause as part of sexual and reproductive health policies, with the appropriate rationales.

The clause allows denial of care based on moral or religious reasons, with the following characteristics:

- i) **individual and not institutional**, given that conscience, and hence moral integrity, is individual and not collective;
- ii) **for health-care practitioners who practice abortions first-hand**, not for those who perform additional tasks, either before or after the procedure;
- iii) **only for moral or religious reasons, that do not constitute criteria for discrimination** against the persons requesting an abortion or against the other members of one's health-care team;
- iv) **this denial implies four duties**: claiming exemption from providing legal abortion care in all settings where one practices medicine; providing accurate, complete, and clear information to individuals who have the right to a legal

abortion, referring in good faith to another provider who is willing to provide this service, and making the necessary arrangements to re-distribute workloads within the care team, as established by the facility's Management or by the provider.

- v) **restrictions to exercising this exception:** *it cannot be exercised* in emergency cases, when there are no providers available to provide this service, or when the health professional occupies a managerial position. The last restriction is an important consideration given the need to prevent health-care practitioners in positions of authority from exercising undue influence and limiting the professional freedom of the team in charge.

The regulation we are proposing also establishes institutional responsibilities that correspond to each level of health-care management.

While this proposal was designed specifically for the Argentine context, we hope that it serves as a reference for other countries, primarily although not exclusively, in Latin America ■

Regulatory Proposal: Refusal to Provide Legal Abortion Services for Moral or Religious Reasons in Argentina*

Clause for inclusion in a law to legalize abortion in Argentina

Art. 1.- Health professionals who intervene directly in the abortion may refuse to provide the abortion for moral or religious reasons, by prior written notification addressed to the highest authority within the health facility where they work, accompanied by the reasons for their refusal.

All providers who refuse to provide abortion for moral or religious reasons must:

- a) maintain their refusal to provide abortion care in all public and private settings where they practice;
- b) provide truthful, adequate and clear information to the pregnant person;

- c) in good faith, refer the pregnant person to another provider available to perform the abortion, without causing undue burden on the person requesting the abortion.

Failure to comply with the above will prevent providers from exercising refusal to provide abortion care, and will lead to disciplinary, administrative, criminal, and civil sanctions, as appropriate.

Art. 2.- Health professionals may not refuse to provide legal abortion for moral or religious reasons:

- a) in emergencies or when there are no other providers available to provide this service at the health facility where the health professional works;
- b) when the provider holds the position of chief of staff or health team coordinator.

Regulation of Conscientious Objection to Abortion

Art. 1.- Health professionals who intervene directly in the abortion may refuse to provide the abortion for moral or religious reasons, as long as they fulfill, in all cases, the rest of their professional duties and legal obligations, and as long as their refusal does not hinder the rights of pregnant persons, especially their right to health, autonomy, and non-discrimination.

Reasons based on a lack of knowledge regarding validated scientific evidence or existing legal standards, or based on discriminatory beliefs or practices, will not be considered moral or religious reasons.

Art. 2.- All health-care practitioners who refuse to provide abortion for moral or religious reasons must:

- a) maintain their refusal in all public and private settings where they practice. Partial refusal to provide abortion limited by gestational age or by the abortion method will be accepted, as long as it refers to the provider's performance and not to the pregnant person's characteristics;
- b) provide truthful, sufficient, and clear information to the pregnant person, based on the pregnant person's capacities and conditions, respecting that person's right to participate and be heard during the care received;
- c) in good faith, refer the pregnant person to another provider, without disproportionate burden on the person seeking abortion care or delays in care;
- d) comply with alternate duties established by health authorities for redistribution of tasks within the facility;
- e) take all additional necessary steps to ensure access to abortion, in accordance with the current regulation aimed at that purpose.

Art. 3.- Health professionals may not refuse to provide abortion for moral or religious reasons:

- a) in emergency situations;
- b) when there are no other providers available to provide this service at the health facility where the health-care practitioner works, or when there is no previously established referral system;
- c) when the provider holds the position of chief of staff or health team coordinator, due to their role as institutional guarantor of access to this service.

Art. 4.- In order to exercise refusal to provide abortion for moral or religious reasons, providers must give prior written notification to the highest authority at the facility where they practice medicine, accompanied by the reasons for the refusal. Health professionals may withdraw their refusal at any time by written notification addressed to said authority.

Art. 5.- Failure to comply with the requirements described in articles 1, 2, 3, and 4 will prevent providers from exercising refusal to provide abortion for moral or religious reasons, and will lead to disciplinary, administrative, criminal, and civil sanctions, as appropriate.

Art. 6.- The highest authority within the health-care institution will be responsible for ensuring access to legal abortion and the management of providers' refusal to provide abortion for moral or religious reasons. To fulfill these obligations, the highest authority must:

- a) submit information about providers available to provide abortions to the health authority in their jurisdiction;
- b) develop and monitor adequate referral mechanisms, in case there are health-care practitioners who refuse to provide abortion for moral or religious reasons, to ensure access to abortion without undue delays;
- c) develop and monitor the implementation of mechanisms to incentivize legal abortion provision and for ensuring accountability regarding providers' refusal to provide this service. For this purpose, they may establish alternative duties for redistribution of workloads within health-care teams;
- d) promote ongoing training for health-care practitioners, with a gender and human rights perspective, in accordance with scientific and technological advances.

Art. 7.- Social security) entities providing prepaid medical care, and other health insurance agents must take the necessary steps to ensure that refusal to provide abortion for moral or religious reasons does not hinder access to this service provided by their affiliates.

Art. 8.- Each jurisdiction will have a guarantor body to ensure access to abortion, which will be responsible for coordinating and negotiating with the authority which oversees all health-care institutions, regarding adequate conditions for health team to ensure access to abortion and to exercise refusal to provide abortion care based on moral or religious reasons. With these objectives, the guarantor body ensuring access to abortion must:

- a) ensure that, in all health facilities where there are health-care practitioners who exercise refusal, several providers are available to provide the service contemplated within this law;
- b) specify suitable criteria for positions related to the provision of abortion to ensure the availability of active abortion providers established above;
- c) adopt the necessary measures and incentives to implement the provisions of this law, including reorganizing health services;
- d) promote ongoing training of health-care practitioners, with a gender and human rights perspective, in accordance with scientific and technological advances.

Art. 9.- In order to ensure access to abortion, the National Program of Sexual Health and Responsible Procreation must:

- a) develop, implement, and monitor a National Action Plan to ensure access to abortion, including financial and/or other types of incentive mechanisms, as well as mechanisms for ensuring accountability;
- b) support the work of local human rights bodies to uphold rights related to

the provision of abortion;

- c) negotiate actions with the public subsector, social security, and companies providing prepaid medical care for compliance with the law;
- d) develop technical assistance and training programs in jurisdictions in order to strengthen health teams' work to provide abortion care and ensure that the exercise of refusal to provide abortion care based on moral or religious reasons is not a barrier to health-care access for pregnant persons;
- e) develop, together with jurisdictions, the criteria, registration system, and basic indicators for the provision of abortion services, ensuring the confidentiality of the information provided by the pregnant persons who request this service;
- f) establish an accessible and confidential mechanism that will enable pregnant persons, health personnel, and civil society to report cases where health-care practitioners or health institutions obstruct access to abortion;
- g) collect information on jurisdictions, and develop an annual report on the status of access to abortion;
- h) promote, through the Federal Health Council (COFESA), the development of actions in coordination with provincial jurisdictions and the City of Buenos Aires to implement financial and other types of incentive mechanisms for abortion care provision, as well as mechanisms for ensuring vertical and horizontal accountability, with social participation, and to improve access to abortion.

* For more information on the rationale for each of the aforementioned articles, please see the full text of this publication in Spanish: “Una vuelta de tuerca a la objeción de conciencia: Una propuesta regulatoria de las prácticas del aborto legal en Argentina” which can be found at <http://www.redaas.org.ar/recurso.php?r=463>