

THE RIGHT TO CONSCIENCE

An Annotated Bibliography

by the International Reproductive and Sexual Health Law Program,
Faculty of Law, University of Toronto

[Program website](#) [Reprohealthlaw Blog](#) [@Reprohealthlaw](#) reprohealth.law@utoronto.ca

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Domestic Court Decisions
Canada (Ontario)

Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario, 2019 ONCA 393, Doc. no. C65397, Decision of May 15, 2019. (Canada: Ontario Court of Appeal) [Decision online](#). [Case summary by Bernard M. Dickens](#):

The Ontario Court of Appeal unanimously upheld the lower court ruling that the Policies of the College requiring physicians who invoke rights of conscientious objection in order not to participate in procedures that violate their religious beliefs must provide a patient seeking such a procedure with an “effective referral.” Objected procedures included abortion, contraception (including emergency contraception, tubal ligation and vasectomy), infertility treatment for heterosexual and homosexual patients, prescription of erectile dysfunction medication, gender re-assignment surgery and medical assistance in dying. The Policies defined effective referral as “a referral made in good faith, to a non-objecting, available, and accessible physician, other health-care professional, or agency.”

The objectors complained that such referral constitutes complicity, which is as wrongful as direct participation, in the procedures which violate their religious beliefs. The Policies were therefore claimed to be in breach of the complainants’ right to “freedom of conscience and religion”, protected under section 2(a) of the Canadian Charter of Rights and Freedoms, under which CPSO is bound by discharging functions delegated by government. Charter section 1 guarantees rights and freedoms subject to reasonable limits that “can be demonstrably justified in a free and democratic society”.

The Court accepted the complainants’ evidence that effective referral offends their religious convictions, and (without addressing secular conscience) found that the Policies restrict their Charter right to freedom of religion. Restriction was found demonstrably justified under section 1, however, because the purpose of medical services is to serve patients’ access to medical care. The Court endorsed the lower court’s observation that “[a]s members of a regulated and publicly-funded profession, they [the complainants] are subject to requirements that focus on the public interest, rather than their own interests. In fact, the fiduciary nature of the physician-patient relationship requires physicians to act at all times in their patients’ best interests, and to avoid conflicts between their own interests and their patients’ interests” (para. 187). The Court supported this finding by noting patients’ vulnerability regarding access to medical services of personal sensitivity, and dependence on medical professionals to guide them through otherwise obscure or obstructed pathways to other professionals who will provide the effective care patients seek.

Effective referral preserves a proportionate balance between professionals’ rights of conscientious objection to conduct procedures and patients’ rights of timely access to appropriate health services.

Chile

Tribunal Constitucional de Chile, (Constitutional Court) Sentencia Rol N° 5572-18- CDS/5650-18-CDS (acumuladas), 18 de enero de 2019. [Spanish Decision](#). [Backup copy](#).

[This decision upheld the 2017 unconstitutionality claim against new regulations governing institutional conscientious objection.]

“... the current Constitution does not give the State a ‘preferent’ role in the provision of health care services, but entrusts this operation to ‘public and private institutions’ ” (internal quotations in the original). The Court quoted the records of the advisory commission that drafted the Constitution and stated that “in this field the principle of the subsidiarity of the State also applies” (cited from Undurraga and Sadler, see below, first and second pages)

Tribunal Constitucional (Constitutional Court) 2017, STC Rol N° 3729(3751)-17 CPT [English Decision](#) with Synthesis and Table of Contents for both English and Spanish editions, Unofficial translation.

[Synthesis in English](#) (unofficial translation). (allows institutional conscientious objection) [Spanish Decision](#). [Accompanying documents](#). [Other Submissions](#). [Síntesis en Español](#).

Chapter Two of the Supreme Court’s decision discusses the topic of conscientious objection in relation to Chile’s newly legalized grounds for abortion (i.e. rape, risk to mother’s health, and fatal fetal anomaly). The majority ruled that not only are natural persons granted an exemption from the performance of abortion in accordance with the law, but that the conscientious objection provision extends to institutions as well. It was decided that institutions are legal persons entitled to freedom of conscience and religion, and that it is arbitrary to make a distinction otherwise. The court went on to further state conscientious objection applies to institutions and individuals beyond the sphere of healthcare professionals acting in abortion care, including religious, educational, and other private associations.

Bernard Dickens, amicus curiae brief on conscientious objection submitted to the Tribunal Constitucional of Chile, August 10, 2017 [English PDF](#)

This amicus curiae brief was submitted by Bernard Dickens to Chile’s Constitutional Court regarding the provision on conscientious objection in the newly enacted legislation on legal abortion. Dickens argues that conscientious objection to direct participation in termination of pregnancy is properly accommodated in Art.119 (the impugned provision), and objection is properly disallowed to referral of patients to non-objecting practitioners, to disclosure of

lawful treatment options in which a practitioner objects to participate, and to discharge of management, administrative or supervisory functions. He also says Art. 119 properly makes conscientious objection available only to human individuals, not to institutions. Further, the duty of referral that is part of the legal duty of care practitioners owe their patients is not applicable between practitioners and non-patients of theirs, such as individuals seeking to become their patients. That is, the duty of referral for services practitioners decline to undertake on grounds of conscientious objection applies only where a physician-patient relationship exists. Within this framework, Dickens argues, Art. 119 conforms to laws widely applicable that provide for lawful interruption of pregnancy.

Colombia

Colombian decision T-388/09 Corte Constitucional [Constitutional Court] 2009, [Decision in Spanish](#). (allows conscientious objection)

The petitioner requested the authorization from the Municipal Court for termination of pregnancy involving severe fetal malformations, but the judge claimed the right of conscientious objection and refused to admit the case, as his moral and religious beliefs would prevent him from being objective and impartial. Upon appeal, the judge's decision was overturned and the health care provider company, SaludCoop, was ordered to perform the procedure within 48 hours. On review, the Constitutional Court held that health providers could only claim conscientious objection and avoid performing the requested procedure if there was another health provider available that could perform the procedure without delay, as well as if denying that procedure did not put the woman's life or physical integrity at risk. Further, it was held that judicial authorities could not claim the right of conscientious objection to excuse themselves from adjudication or to deny the appeal.

Corte Constitucional [Constitutional Court] 2008, Sentencia T-209/08, [Decision in Spanish](#). (institutional conscientious objection not allowed)

A 13-year old girl became pregnant as a result of rape and her health care company refused to perform an abortion claiming conscientious objection on the part of all of its physicians. The company then referred her to the Erasmo Meoz de Cúcuta University Hospital, which also invoked conscientious objection to the procedure on the part of its entire medical staff. The Court held that conscientious objection is not a right to which institutions or the State is entitled and that only natural persons can exercise that right.

France

Conseil Constitutionnel [Constitutional Court] June 27, 2001, Decision No. 2001-446 DC. [Decision in French](#). [Official English translation](#). (departmental heads of public health facilities cannot refuse to allow abortions on premises but can refuse participation in an individual procedure.

The Court upheld the removal of a provision that would have allowed heads of department in public health establishments to refuse to allow terminations of pregnancy to be practiced in their department. Although the head of a department cannot oppose pregnancies being terminated in their own department, the Code of Public Health still respects the freedom of that individual (or any other healthcare professional) to refuse to perform the termination themselves, thereby upholding the freedom of personal conscience.

New Zealand

Hallagan and Anor v Medical Council of New Zealand, HC WN CIV-2010-485-222 [2 December 2010]

At issue in this case were proposed guidelines on beliefs and medical practices set out by the defendant, which required conscientious objectors to abortion to refer their patients to another unobjecting medical practitioner. The plaintiff medical practitioners sought judicial review of these guidelines, contending that they went beyond what the Council may lawfully require of medical practitioners, as legislation only says they must “arrange for the case to be considered and dealt with”. Justice MacKenzie held that the doctor does not have to provide a referral upon conscientious objection, but that “the health practitioner must inform the person who requests the service that he or she can obtain the service from another health practitioner or from a family planning clinic.” Further, the Council's proposed guidelines were held to “overstate the duty of a doctor with a conscientious objection, by failing to give adequate recognition to the ability of that doctor to decline to provide the service requested”. The court held that the guidelines must be amended to recognize the ability of health practitioners to refuse to refer a woman for an abortion by instead informing her that the service is available from another health practitioner or from a family planning clinic.

Norway

I. Sauherad municipality (Counsel Frode Lauareid) v. A, Norges Kristelige Legeförening (intervener) (Counsel Håkon H. Bleken), II. A, Norges Kristelige Legeförening (intervener) (Counsel Håkon H. Bleken) v. Sauherad municipality (Counsel Frode Lauareid), HR-2018-1958-A (case no. 2018/199), 11 October 2018, (Supreme Court of Norway) [Judgment online in English – official translation](#)

(Official summary) A physician [Dr Katarzyna Jachimowicz] was dismissed from her job as a regular general practitioner (RGP) in a municipality because she, for reasons of conscience, **refused to insert IUDs**. The Supreme Court found that a binding oral agreement had been entered into between the doctor and the municipality under which

<https://www.law.utoronto.ca/sites/default/files/documents/reprohealth/conscientiousobjection.pdf>

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her right of reservation for reasons of conscience had been recognised. The state of the law with regard to RGPs' right of reservation was unclear when the agreement was entered into, so the oral agreement was not contrary to applicable law at the time of employment. Since the physician was dismissed for breaching her duties under the RGP agreement, the grounds were unreasonable, and the termination was declared unlawful. The Supreme Court also commented on the application of Article 9 of the European Convention on Human Rights to situations where a RGP, for reasons of conscience, refuses to insert IUDs. The municipality was held strictly liable. The Supreme Court pointed out that the dismissal took place in a contractual relationship where the individual party carries the risk of any mistake of law, the physician had lost her job as a RGP, and the notice of termination was worded in a sanction-like manner.

Spain

Spain: Tribunal Constitucional, *Sentencia S.T.C. 145/2015*, 25 de junio de 2015, 2015–182 BOE 66654. [Spanish judgment now online, including dissenting opinions.](#) [Published decision.](#) [English newspaper report.](#) [Summary by Women's Link Worldwide](#)

Seville pharmacy had been fined €3,000 in 2008 for refusing to sell emergency contraceptive, but Spanish constitutional court overturns decision on appeal.

Zurich Insurance PLC, Sucursal en España v. Doña Encarnacion y don César y Servicio Galego de Saude, Sentencia 00392/2017, Apelación 43/17 (High Court of Galicia at Coruña, Spain). [Decision in Spanish.](#)

The Health Service of Galicia in Spain was found guilty of intentionally concealing from a pregnant mother the fact that her child was suffering from severe life-limiting anomalies. During the High Court proceedings, it emerged that her doctors had deliberately delayed the protocolled prenatal diagnostic testing. Once she had a proper diagnosis, following a consultation with a private geneticist, the gynaecologist in the regional health service then delayed authorization for an abortion, maintaining that it was necessary to carry out further diagnostic tests. However, an expert witness testified that the tests were by no means urgent, especially in a case of advanced gestation that required immediate termination. The High Court's ruling made it clear that what had occurred was a "severe failure of the health system." The president of the regional government, Albert Nuñez Feijoo, resolved not to appeal the initial decision of the county court and apologized for what had happened, attributing blame to the fact that a very high proportion of doctors in the region are "conscientious objectors" to medical abortions.

Sweden

Grimmark v. Landstinget i Jönköpings Län, [2015-11-12] Jönköping District Court. [Decision online in Swedish.](#)

Grimmark was a Swedish midwife who was successively denied employment as a result of her conscientious objection to the performance of abortions due to her Christian faith.

She brought a suit against the local municipality in the District Court, claiming discrimination on the basis of religious belief, as well as to her lack of recognition as a conscientious objector. She also claimed that the state violated Article 9 of the European Convention. The three judges of the District Court ruled against Grimmark on the grounds that the region has an obligation to provide guaranteed access to abortion and that carrying out abortions was a necessary part of Swedish midwives' duties. Thus the hospitals' grounds for refusing employment were legitimate and Grimmark could not have suffered discrimination. Grimmark was later denied leave to appeal. See Fleming et al, "[Freedom of conscience in Europe? An analysis of three cases of midwives with conscientious objection to abortion](#)" (abstracted below) for a discussion of the case (p.106).

United Kingdom

Barr v. Matthews, (1999) 52 B.M.L.R. 217 (High Court of England and Wales, Queen's Bench Division). (conscientious objector has a duty to refer immediately)

The Court ruled that once a termination of pregnancy is recognized as an option, the doctor invoking the conscientious objection clause should immediately refer the patient to a colleague.

Greater Glasgow Health Board v Doogan & Anor decision of December 17, 2014. [2014] UKSC 68, [2015] SLT 25. [Decision online](#).

The petitioners are practicing Roman Catholics and experienced midwives who were employed as Labour Ward Co-ordinators. They raised a grievance regarding the lack of accommodations for their religious objections to being involved with abortion procedures in an administrative capacity. The UK Supreme Court rejected their and reversed the expansive scope of the Scottish appeal court's decision, ruling instead that s.4(1) of the Abortion Act 1967 (right to conscientious objection) should be interpreted narrowly to allow conscientious objection only to direct participation in procedures. This can be understood practically as the "whole course of medical treatment bringing about the termination of the pregnancy" The Court further reiterated that any conscientious objector is under an obligation to refer the issue to a professional who does not share their objections.

Janaway v Salford Area Health Authority [1988] 3 All ER 1079 (House of Lords). [Decision Online](#).

An administrative assistant refused to type a doctor's letter of referral for an abortion on the ground of conscientious objection. She was dismissed from employment and brought an action challenging the dismissal. Section 4(1) of the 1967 Act permitted the right to conscientious objection. It provided that no person shall be under any duty "to participate in any treatment authorized by this Act to which he has a conscientious objection." The court held that the right to conscientious objection did not apply to an administrative assistant, who on religious grounds, refused to type a letter of referral for abortion under

the Abortion Act of 1967. Typing a referral letter was marginal to the actual procedure of abortion. The court found that the conscience clause of the 1967 Act does not apply to “any” procedures that associated with abortion but only procedures that are directly or closely connected with the actual performance of abortion procedures.

R. (on the application of Smeaton) v. Secretary of State for Health, [2002] E.W.H.C. 610 (Admin) (High Court of England and Wales). [Decision online](#). (Dickens p.218 morning after pill not abortifacient, judge says individual beliefs not business of government or secular courts)

The claimant had brought suit to enjoin pharmacists from selling emergency contraception to women over the age of sixteen without a prescription. The organization argued that the morning-after pill is an abortifacient agent and that Parliament had intended, in the 1861 Offences Against the Person Act, to prevent interference with implantation by criminalizing miscarriage. The court held that the 1861 Act left the word 'miscarriage' undefined, and that the word is to be interpreted as only referring to the disruption of pregnancies after implantation. At para 398, Justice Munby goes on to state that “Decisions on such intensely private and personal matters as whether or not to use contraceptives, or particular types of contraceptives, are surely matters which ought to be left to the free choice of the individual”.

United States of America

Brownfield v. Daniel Freeman Marina Hospital, 208 Cal. App. 3d 405, 256 Cal. Rptr. 240 (1989) (California Second District, Court of Appeal). [Decision online](#). (patient request for emergency contraception after rape must prevail over Catholic hospital conscience. (see: Dickens, “The Right to Conscience” pp. 217-18)

Brownfield sought a declaration that a Catholic hospital's failure to provide her with estrogen pregnancy prophylaxis treatment constituted failure to provide optimal emergency treatment to rape victims. Brownfield also sought an injunction ordering the hospital to provide this treatment. While ultimately ruling that no cause of action could be allowed because the treatment was neither fraudulent nor deceptive, the court reaffirmed that “no nonprofit hospital or clinic which is organized or operated by a religious corporation or other religious organization or its administrative officers, employees, agents, or members of its governing board shall be liable, individually or collectively, for failure or refusal to perform or to permit the performance of an abortion in such facility or clinic or to provide abortion services” (para 7a); however, the treatment consisted of “prevention” rather than “termination” in this case, so this principle did not apply.

Rodriguez v. City of Chicago, 156 F. 3rd 771 (1998) (Seventh Circuit Court of Appeals). [Decision online](#). (Public officers must serve public neutrally, cannot invoke freedom of conscience when assigned to protect abortion clinic from protestors’ violence and assaults)

Chicago police officer, Rodriguez, stated his religious objection to abortion to his superiors. He asked not to be assigned to help protect abortion clinics except in case of

emergency. His supervisors attempted to comply with his request until one day a personnel shortage caused him to be assigned to a clinic, an assignment he accepted under protest. He filed suit against the city for religious discrimination. The suit was dismissed as the court held that the city had "a responsibility to make a reasonable accommodation of Rodriguez's religious belief or to show that any accommodation would result in undue hardship" – an obligation the city met by allowing an officer to request a transfer to another district with no loss of pay or seniority.

Uruguay

Alonso Justo y otros contra Poder Ejecutivo, Ficha No. 430/13 (2015) (Court of Administrative Litigation). [Decision in Spanish](#).

Uruguay's Court of Administrative Litigation held that the ability to claim conscientious objection extends to those who work at any stage of the abortion process, including preparatory actions. The Court interpreted conscientious objection to mean an individual's refusal, for reasons of conscience, to engage in conduct which would be otherwise legally compulsory, whether the objection derives from a norm, contract, judicial mandate or administrative resolution. Before the Court's decision, both physicians and healthcare personnel were required to assist in all stages of the abortion process and only doctors who directly participated in the actual abortion procedure were allowed to invoke conscientious objections; the decision allows both doctors and healthcare personnel to raise conscientious objections to taking part in any process that contributes to an abortion being performed.

Treaty Resources: Regional and International Treaty Bodies - Decisions, Comments and Observations

Regional

African Commission on Human and Peoples' Rights

General Comment No. 2 on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, para 26. [General Comment 2 online](#).

This General Comment provides interpretive guidance to the implementation of the Article 14 of the "Maputo Protocol" (i.e. Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa), which calls for the right to safe abortion in cases of risks to the life of the fetus, among other enshrinements of reproductive rights. This Comment addresses the invocation of conscientious objection at para 26. It states that state parties must ensure that the necessary infrastructure is set up to enable women to be knowledgeable and referred to other health care providers on time upon conscientious objection. In addition, State parties must ensure that only the health personnel directly involved in the provision of contraception/family planning services enjoys the right to conscientious objection and that it is not so for the institutions.

Further, it states that the right to conscientious objection cannot be invoked in the case of a woman whose health is in a serious risk, and whose condition requires emergency care or treatment.

European Court of Human Rights

Ahmad v. United Kingdom (1981), 4 Eur. H.R. Rep. 126, at para. 11 (limitations on freedom of religion, depending on the situation of the person claiming that freedom}. (see Dickens, “The Right to Conscience, p.232)

The ECHR held that Freedom of religion is not absolute and 'it may as regards the modality of a particular religious manifestation, be influenced by the situation of the person claiming that freedom' (para 11).

Grimmark v. Sweden, App. No. 43726/17, Eur. Ct. H.R. (2020) [Decision online](#). [Backup copy](#).

The ECHR dismissed the application of a nurse, re-trained as a midwife, who was denied jobs in Sweden because of her refusal to perform abortions due to her Christian faith. (See case summary under “Sweden” above)

Pichon and Sajous v. France, Case No. 49853/99, Eur. Ct. H.R. (2001) [Decision in English](#). [Decision in French](#). (Pharmacists)

Three women had been refused the supply of contraceptives prescribed for them by their doctors by the claimant pharmacists, who were later found to have infringed their duties of supply. The claimants had argued that they had the right to apply their ethical or religious principles, but the court found that the contraceptives were not abortifacients allowing any such exemption. The court ruled that as long as the sale of contraceptives is legal and occurs on medical prescription nowhere other than in a pharmacy, the applicants cannot give precedence to their religious beliefs and impose them on others as justification for their refusal to sell such products, since they can manifest those beliefs in many ways outside the professional sphere.

P. and S. v. Poland, App. No. 57375/08, Eur. Ct. H.R. (2012) [Decision online](#). At paras 78-112

P was 14 years old in 2008 when she was raped and became pregnant as a result. She had a right to legal abortion under Polish law; however, her access to abortion was severely obstructed. Among other obstacles, doctors invoked conscientious objection without referring P to another provider or hospital. The Court reaffirmed its statement from *R.R.*, that states are obliged to organize their health systems in a way that reconciles the freedom of conscience of health professionals with patients' rights to lawful services. Health providers in Poland have a legal obligation to make their refusals to provide abortion services in writing and to refer patients to non-objecting providers, but these procedural requirements were not complied with. The Court concluded the medical staff involved did not consider themselves obliged to carry out the medical services in

question. These procedural requirements may be considered to be minimum safeguards in order to protect patients' rights under Article 8.

R.R. v. Poland, Application No. 27617/04, Eur. Ct. H.R. (2011) [Decision online](#).at para. 206. (“States must organize health services to ensure health professionals’ freedom of conscience.” Cited in Dickens, *The Right to Conscience*, p. 213)

This case represents the first time the Court addressed States’ obligation to adequately regulate the practice of conscientious objection in the reproductive health sphere. Under the ECHR, States are obliged to “organise the health services system in such a way as to ensure that an effective exercise of the freedom of conscience of health professionals in the professional context does not prevent patients from obtaining access to services to which they are entitled under the applicable legislation”(para 206). Thus, the possibility for individual doctors to refuse services on grounds of conscience did not absolve the Polish State from its positive obligation to provide RR with the services to which she was legally entitled.

European Committee of Social Rights

Confederazione Generale Italiana del Lavoro (CGIL) v. Italy, Complaint no. 91/2013, Decision on admissibility and the merits, April 11, 2016 [Download decision](#)

The complaint was filed by one of Italy’s largest trade unions. There was concrete evidence of the professional disadvantages for non-objecting medical professionals whose workload became dominated by the performance of abortions, restricting other career prospects. The Committee re-affirmed the judgment in *International Planned Parenthood Federation* (see below), and also found a violation of the right to work (paras 214-246), and the right to dignity in work (paras 282-298), because the state had failed to adequately address the burdensome workload on non-objecting doctors caused by the high percentage of objecting doctors in some areas of Italy. This decision broke new ground in finding a violation of the right to work and the right to work in dignity of non-objecting providers.

International Planned Parenthood Federation – European Network (IPPF EN) v. Italy, Complaint No. 87/2012, Decision on the Merits, March 10, 2014 [Download decision](#)

Section 9 of the Italian Act No. 194/78 allows medical practitioners and other health personnel to exempt themselves from assisting abortion procedures in cases provided for in law if they raise a conscientious objection beforehand. Paragraph 4 of Section 9 of the Italian Act, central to the plaintiff’s complaint, provides that, in any case, hospitals and authorized nursing homes are required to ensure that women have access to abortion procedures in accordance with law. The Committee concluded that the Italian law violated Article 11 of the Charter (right to health) alone and read in conjunction with Article E (non-discrimination clause). It found that in light of the evidence put before it “shortcomings exist in the provision of abortion services”, and that they “appear to be the result of an ineffective implementation” of the impugned Act. Moreover, the Committee

found that discriminatory treatment existed on the ground of socio-economic and territorial status, health status and gender, and that it constituted an instance of ‘overlapping’, ‘intersectional’ and ‘multiple’ discriminations.

International

CEDAW Committee, *General Recommendation No. 24: Women and Health*, U.N. Doc. A/54/38/Rev.1 (1999), para. 11. [Online](#).

“It is discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women. For instance, if health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers.”

Policy Guidance

Domestic

United Kingdom

General Medical Council, *Personal Beliefs and Medical Practice* (25 March 2013), pp. 2-3. [Online](#).

In these guidelines, the GMC provides guidance to physicians on how to implement the principles of “good medical practice”. On the topic of conscientious objection, guidance includes (para 12-13): telling the patient of their objection; telling the patient of their right to discuss treatment with another doctor; and making sure the patient has enough information to arrange to see another doctor. Further, if it is not practical for the patient to make the arrangement, these guidelines state that the doctor must make sure that arrangements are made – without delay – for another suitably qualified colleague to advise, treat or refer the patient. In the case of emergencies, doctors may not refuse treatment because it conflicts with personal beliefs.

Royal College of Obstetricians and Gynecologists, *The Care of Women Requesting Induced Abortion: Evidence-based Clinical Guideline Number 7*. London: Royal College of Obstetricians and Gynaecologists (2011), pp. 20-21. [Online](#).

Section 3.3 of these guidelines deal with healthcare professionals’ right to conscientious objection to abortion. It describes the scope of the clause in the Abortion Act which permits doctors (and nurses) to refuse to participate in any treatment authorised by the Act if it conflicts with their religious or moral beliefs. This clause does not apply where it is necessary to save life or prevent grave permanent injury to the woman’s physical or mental health. Doctors who have a conscientious objection to abortion must tell women of their right to see another doctor. NHS GPs who have contracted to provide contraceptive services and who have a conscientious objection to the abortion must, where appropriate, refer women promptly to another doctor. Hospital managers have

been asked to apply the principles as described above, at their discretion, to those ancillary staff involved in handling fetuses and fetal tissue

International

International Federation of Gynecology and Obstetrics (FIGO)

“Ethical Guidelines on Conscientious Objection,” FIGO (International Federation of Gynecology and Obstetrics) in *Reproductive Health Matters* 14.27 (May 2006):148–149.

Also in: [FIGO Ethical Issues in Obstetrics and Gynecology](#), 2015 pp. 37-39

French “Directives éthiques sur l’objection de conscience” pp 220-222.

Spanish “Directrices éticas sobre la objeción de conciencia” pp. 416-418

Approved in 2006, this FIGO official guideline states that the primary conscientious duty of health practitioners is to treat their patients, with any conscientious objection remaining a secondary concern. This entails providing timely access to medical services, which includes giving information to patients regarding the procedures to which the practitioner is objecting to. Further, patients are entitled to a good faith referral after conscientious objection on the part of their practitioner, as well as timely care when referral is not possible or in emergency situations, regardless of the practitioners’ personal objections. Finally, the guidelines affirm the right of practitioners to conscientiously object in the delivery of lawful procedures and to not face discrimination; however, this requires respecting the patient’s choice in the care they wish to receive.

“Ethical Guidelines on Conscientious Objection in Training” (2014) pp 172- 274 in:

[FIGO Ethical Issues in Obstetrics and Gynecology](#), 2015

French “Pratiques d’éthique sur l’objection de conscience lors de la formation,” pp. 367-369.

Spanish “Objeción de conciencia durante el entrenamiento, pp. 564-566.

These guidelines reiterate the above-mentioned Ethical Guidelines on Conscientious Objection and apply the same principles in the context of students and trainees in the healthcare field. See above for details regarding the guidelines. Important to note is that “trainees cannot decline training in procedures being performed for medically indicated purposes to which they cannot or do not object, even though the same procedures can be used for medical indications to which they object.”

American College of Obstetricians and Gynecologists (ACOG)

American College of Obstetricians and Gynecologists Committee on Ethics, “The Limits of Conscientious Refusal in Reproductive Medicine, ACOG Committee Opinion No. 385,” *Obstetrics & Gynecology* 110 (2007): 1203-8. [Online](#).

In this opinion, the ACOG Committee on Ethics considers the issues raised by conscientious refusals in reproductive medicine and outlines a framework for defining the ethically appropriate limits of conscientious refusal in reproductive health contexts. The committee begins by offering a definition of conscience and describing what might

constitute an authentic claim of conscience. Next, it discusses the limits of conscientious refusals, describing how claims of conscience should be weighed in the context of other values critical to the ethical provision of health care. It then outlines options for public policy regarding conscientious refusals in reproductive medicine. Finally, the committee proposes a series of recommendations that maximize accommodation of an individual's religious or moral beliefs while avoiding imposition of these beliefs on others or interfering with the safe, timely, and financially feasible access to reproductive health care that all women deserve.

World Health Organization (WHO)

World Health Organization, *Safe Abortion: Technical and Policy Guidance for Health systems*, 2nd ed (Geneva: WHO, 2012) p.69, 96 [WHO Technical Guidelines](#).

These guidelines suggest that individual health-care providers have a right to conscientious objection to providing abortion, but that right does not entitle them to impede or deny access to lawful abortion services because it delays care for women, putting their health and life at risk (p. 69). It is recommended that health-care providers must refer the woman to a willing and trained provider in the same, or another easily accessible health-care facility, in accordance with national law. Where referral is not possible, the health-care professional who objects, must provide safe abortion to save the woman's life and to prevent serious injury to her health. On the topic of religious freedoms and freedom of conscience, the WHO states that international human rights law stipulates that these might be subject to limitations necessary to protect the fundamental human rights of others (p.96). Therefore, it is recommended that health services be organized in such a way as to ensure that an effective exercise of the freedom of conscience of health professionals in the professional context does not prevent patients from obtaining access to services to which they are entitled under the applicable legislation.

Publications

Articles and Book Chapters

Amado, Eduardo Díaz et al., "Obstacles and challenges following the partial decriminalisation of abortion in Colombia," *Reproductive Health Matters* 18.36 (Nov 2010): 118–126, online: <[https://www.tandfonline.com/doi/full/10.1016/S0968-8080\(10\)36531-1](https://www.tandfonline.com/doi/full/10.1016/S0968-8080(10)36531-1)>.

This article analyzes 36 cases of women who in 2006–08 were denied the right to a lawful termination of pregnancy, or had unjustified obstacles put in their path which delayed the termination, in the wake of the partial decriminalization of abortion in Colombia. In four cases, institutional conscientious objection was given as a reason for refusal by health professionals. The authors argue that Doctors must not be allowed to use conscientious objection as an excuse to evade their professional duties. Preventing someone from accessing a health care service to which they are entitled constitutes

ethical and legal misconduct. It is concluded that the meaning and limitations of conscience objection and interpretation of the health exception require more public debate and ownership.

Anderson, Richard M., “Pharmacists and Conscientious Objection Scope Note 46,” *Kennedy Institute of Ethics Journal* 16.4 (December 2006): 379-396. [Scope Note](#).

Focusing mainly on the situation in the US and Canada, this scope note provides short summaries of the position statements and codes of the professional organizations, journal articles, and online resources devoted to the issue of conscientious objection in the health care context that have been published over the last few years. The Note is divided into three main parts: (1) official position statements and codes; (2) general literature, and (3) legal perspectives and cases. In each of the parts, the summaries provide the arguments related to the accommodation of conscientious refusals by health professionals, especially pharmacists. In general, most of the summaries seem to suggest a balancing approach to accommodate some health care providers' conscientious objections in a way that does not compromise women's timely access to lawful reproductive health care services.

Ariza Navarrete, Sonia & Ramón Michel, Agustina. Una vuelta de tuerca a la objeción de conciencia: Una propuesta regulatoria a partir de las prácticas del aborto legal en Argentina. CEDES e IPAS, Buenos Aires, 2019. <https://www.ipas.org/resource/una-vuelta-de-tuerca-a-la-objecion-de-conciencia/>

Bribosia, Emmanuelle, Ivana Isailovic and Isabelle Rorive, “Objection ladies! Taking IPPF-EN v. Italy one step further,” in: *Integrated Human Rights in Practice: Rewriting Human Rights Decisions*, ed. Eva Brems and Ellen Desmet (Cheltenham, UK: Elgar, 2018). [Abstract and previous version](#).

This paper proposes to reconsider the decision of the European Committee of Social Rights in *International Planned Parenthood Federation European Network (IPPF-EN) v. Italy* which addresses the regulation of the practice of the conscientious objection, using an integrated approach to human rights. More specifically, it argues that the use of different human rights instruments – broadly defined -- could have led the Committee to adopt a gendered approach to the legal questions it had to tackle. By adopting this approach, we intend to challenge Committee’s reasoning on two fronts: first, we argue that its interpretation of the right to health fails to account for the specific violation of women’s right to access to health services. Second, we show how this gendered approach could have modified Committee’s approach to discrimination raised by the plaintiff.
[from working paper]

Bribosia, Emmanuelle and Isabelle Rorive, “Seeking to square the circle: Conscientious objection in Reproductive Healthcare,” Chapter 15 in: *The Conscience Wars: Rethinking the Balance between Religion, Identity, and Equality*, ed. Susanna Mancini and Michel Rosenfeld

(Cambridge, UK: Cambridge University Press, 2018) pp. 392-413. [Institutional Access](#).
[Abstract and previous version](#)

[In this chapter, the authors] focus on the practical and conceptual difficulties in reconciling the reproductive rights of women with the conscience claims of individual health care providers. From a practical standpoint, drawing on national, international, and European measures, cases, and policy papers, they demonstrate that even the most balanced regulatory framework of conscientious objection fails to overcome the strength of the web of religious and patriarchal structures of society, in which women are still caught. This results in a distortion of religious exemption clauses to the detriment of women's rights. From a conceptual standpoint, Bribosia and Rorive, like Melling, maintain that conscience clauses involve not only direct harm to women who wish to access abortion services but also dignitary and symbolic harm. In this light, conscientious objection places the medical doctor in the position of exercising personal power over the patient by imposing his or her beliefs, and that per se constitutes a violation of women's dignity and equality. In the end, according to Bribosia and Rorive, access to abortion is not enough to protect women from discrimination: what is required is access to health care on an equal footing, without any moral judgment by an authority.
[From Book Introduction]

Campbell, Mark, "Conscientious Objection, Health Care and Article 9 of the European Convention on Human Rights," *Medical Law International* 11 (2011): 284-304. [Available here](#).

In this article it is argued that the interpretation of Article 9 of the European Convention on Human Rights in the context of guaranteeing a right to conscientious objection in health is nuanced and complex. Moreover, given the nature of the subject matter, national authorities should be afforded a significant margin of appreciation in the way that they protect and regulate conscientious objection. By way of illustration, there is a discussion of the ways in which Article 9 might affect conscientious objection in health care under English law. The final part of the article considers the conceptual limitations of Article 9 in thinking about conscientious objection in health care; in particular, the claim that the extent to which Article 9 of the Convention provides protection for a conscientious objection in the health care context is a different question from whether conscientious objection by doctors and other health care practitioners is justified in principle.

Card, Robert F., "Is there no alternative? Conscientious objection by medical students" *Journal of Medical Ethics* 38 (2012): 602-604. [Available online](#).

After presenting some background on promulgated US conscience protections and reflecting on their significance for conscience objections by medical students, this paper observes that the dominant approach (following the American Medical Association's conscience clause) is to allow exempted students to instead be evaluated on the basis of alternative curricular activities to learn the associated underlying content. It is argued, that there is difficulty in a conscience clause that resolves the dilemma by granting reasonable exemptions in the form of participation in alternative curricular activities:

there are cases where one must perform the ‘objectionable’ activity itself in order to learn the necessary content and underlying principles. Specific reference to abortion is made in the article.

Casas, Lidia, “Invoking conscientious objection in reproductive health care: evolving issues in Peru, Mexico and Chile, in *Reproductive Health Matters* 17.34 (Nov 2009): 78–87, online: <[https://www.tandfonline.com/doi/full/10.1016/S0968-8080\(09\)34473-0](https://www.tandfonline.com/doi/full/10.1016/S0968-8080(09)34473-0)>.

This paper provides an analysis of law and policy on conscientious objection in Peru, Mexico and Chile to show that it is being used to erode women's rights, especially where it is construed to have no limits, as in Peru. The author argues that conscientious objection must be distinguished from politically-motivated attempts to undermine the law; otherwise, the still fragile re-democratization processes underway in Latin America may be placed at risk. It is asserted that true conscientious objection requires that a balance be struck between the rights of the objector and the health rights of patients, in this case women. The author argues that health care providers are entitled to their beliefs and to have those beliefs accommodated, but it is neither viable nor ethically acceptable for conscientious objectors to exercise this right without regard for the right to health care of others, or for policy and services to be rendered ineffectual because of individual objectors.

Casas, Lidia, "Invoking Conscientious Objection in Reproductive Health Care: Evolving Issues in Latin America" LL.M. thesis, University of Toronto, 2005. Abstract online at: <https://www.law.utoronto.ca/programs-centres/programs/irshl-reproductive-and-sexual-health-law/irshl-thesis-abstracts#casas>, #16.

This investigation explores conscientious objection in reproductive health care in Latin America and how this issue could become an obstacle to women's right to health -and even jeopardize their safety and lives.

Charo, R. Alta, “The Celestial Fire of Conscience – Refusing to Deliver Medical Care,” *New England Journal of Medicine* 352 (2005): 2471-3, online: <<https://www.nejm.org/doi/full/10.1056/NEJMp058112>>.

In this perspective piece, Charo describes how physicians, nurses, and pharmacists are increasingly claiming a right to the autonomy not only to refuse to provide services they find objectionable, but even to refuse to refer patients to another provider and, more recently, to inform them of the existence of legal options for care.

Chavkin, Wendy, Liddy Leitman, and Kate Polin, "Conscientious objection and refusal to provide reproductive healthcare: A White Paper examining prevalence, health consequences, and policy responses." *International Journal of Gynecology & Obstetrics* 123 (2013): S41-S56. [Available online](#).

This White Paper examines the prevalence and impact of the conscience-based refusal of reproductive healthcare and reviews policy efforts to balance individual conscience,

autonomy in reproductive decision making, safeguards for health, and professional medical integrity. The White Paper draws on medical, public health, legal, ethical, and social science literature published between 1998 and 2013 in English, French, German, Italian, Portuguese, and Spanish. The White Paper reviews these data and offers logical frameworks to represent the possible health and health system consequences of conscience-based refusal to provide abortion, among other care. It concludes by categorizing legal, regulatory, and other policy responses to the practice. Ultimately, the authors conclude that with dual commitments toward their own conscience and their obligations to patients' health and rights, providers and professional medical/public health societies must lead attempts to respond to conscience-based refusal and to safeguard reproductive health, medical integrity, and women's lives.

Chavkin, Wendy, Laurel Swerdlow, and Jocelyn Fifield. "Regulation of Conscientious Objection to Abortion: An International Comparative Multiple-Case Study," *Health and Human Rights Journal* 19.1 (2017): 55-68 [Article online](#)

This is a comparative multiple-case study, which triangulates multiple data sources, including interviews with key stakeholders from all sides of the debate in England, Italy, Norway, and Portugal. While the laws in all four countries have similarities, we found that implementation varied. In this sample, the ingredients that appear necessary for a functional health system that guarantees access to abortion while still permitting CO include clarity about who can object and to which components of care; ready access by mandating referral or establishing direct entry; and assurance of a functioning abortion service through direct provision or by contracting services. Social attitudes toward both objection and abortion, and the prevalence of CO, additionally influence the degree to which CO policies are effectively implemented in these cases. England, Norway, and Portugal illustrate that it is possible to accommodate individuals who object to providing abortion, while still assuring that women have access to legal health care services.

Cloatre, Emilie and Máiréad Enright, "McGee v. Attorney General" in *Northern/Irish Feminist Judgments: Judges' Troubles and the Gendered Politics of Identity*, Máiréad Enright, Julie McCandless and Aoife O'Donoghue eds. (Oxford: Hart, 2017), 95-115 ([available here](#))

This book is the most recent of a series of studies on re-imagining court decisions from feminist perspectives. It includes rewrites of *McGee v. Attorney General*, [1974] I.R. 284 (Supreme Court of Ireland), which had overturned a criminal ban on the importation of contraceptives into Ireland. [Actual decision online](#). This chapter explores the ways that Enright J. acknowledged Mrs. McGee's experiences in trying to access effective contraception to enable her to plan her family in ways that did not seriously risk her life. Of particular note is the way in which Enright J. elaborated how Mrs. McGee's right to freedom of conscience was a basis for overturning the importation ban: "There can be no clearer example, in my view, of the exercise of constitutionally protected conscience than Mrs. McGee's deliberate breach of a provision of the criminal law that imposes a particular set of moral principles on the citizenry."

Cook, Rebecca, "Sir Nigel Rodley's Insights on the Feminist Transformation of the Right of Conscience," *Human Rights Quarterly* 40.2 (May 2018): 255-259. [Online through Project Muse.](#)

The author examines Sir Nigel Rodley's concurring judgment in the case of *Mellet v. Ireland* and explores how he may have provided a feminist perspective in finding a violation of the right of conscience, had that right been argued in the Mellet case. Cook ultimately concludes that given Nigel's spirited concurring judgment in the Mellet case, his life's work with prisoners of conscience, and his recognition that women's rights are part of the human rights imperative, he would have been well on his way to finding a violation of the right of conscience of Amanda Mellet, had it been argued.

Cook, Rebecca and Bernard Dickens, Letter in Response to a Letter to the Editor, (2004) 26(2) *Journal of Obstetrics and Gynaecology of Canada* 112. (clarifies conscientious objection by healthcare professionals). [PDF Online.](#)

This letter is in response to Dr. Bright's letter regarding the article "Access to Emergency Contraception" (see below). The authors maintain that despite there being no requirement in the Canadian Medical Association's Code of Ethics Courts for physicians to refer patients upon conscientious objection, the Courts continue to insist that they refer those patients to other physicians who are not so constrained. Similarly, physicians must also serve their patients' conscientious convictions when they require accommodation of their own. It is asserted that "physicians who feel entitled to subordinate their patients' desire for well-being to the service of their own personal morality or conscience should not practise clinical medicine".

Cook, Rebecca and Bernard Dickens, "Access to Emergency Contraception" (2003) 25(11) *Journal of Obstetrics and Gynaecology of Canada* 914-916 (addresses conscientious objection by healthcare professionals on pages 915-916). PDF online: [https://www.jogc.com/article/S1701-2163\(16\)30238-9/pdf](https://www.jogc.com/article/S1701-2163(16)30238-9/pdf).

The authors contend that physicians who propose to apply non-medical criteria, and use religious objections to abortion to deny prescription of emergency contraception (EC), must publicize their opposition in advance, so that women may seek assistance elsewhere. Further, it is argued that when objecting practitioners, or facilities, become responsible for women for whom EC is indicated, such as rape victims, they are bound ethically and legally to refer them to reasonably accessible non-objecting sources of care.

Cook, Rebecca, Bernard Dickens and Mahmoud Fathalla, *Reproductive Health and Human Rights: Integrating Medicine, Ethics and Law* (Oxford: Oxford University Press, 2003) online: http://www.law.utoronto.ca/faculty_content.asp?itemPath=1/3/4/0/0&contentId=1105

This book is an introduction to and defence of the concept of reproductive health. Chapters integrate related disciplines to provide a comprehensive picture. They analyze fifteen cases from different countries and cultures and explore options for resolution. The aim is to equip readers to fashion solutions in their own health care circumstances,

compatibly with ethical, legal and human rights principles. The index section includes an entry on conscientious objection, as the topic is touched upon throughout the book.

Cook, Rebecca, Monica Arango Olaya and Bernard M. Dickens, "Healthcare Responsibilities and Conscientious Objection" *International Journal of Gynecology and Obstetrics* 104 (March 2009) 249-252. http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1337165

This article examines the Constitutional Court of Colombia's decision in 2006 that clarified the legal duties of providers, hospitals, and healthcare systems when conscientious objection is made to conducting lawful abortion. The decision establishes objecting providers' duties to refer patients to non-objecting providers, and that hospitals, clinics, and other institutions have no rights of conscientious objection. The authors argue that the case shows how powerful health facility administrators and physicians who enjoy a monopoly of service delivery can violate their ethical duties by the abuse of vulnerable, dependent patients in denying them their legal rights. The case exposes the paradox of unscrupulous resort to conscience, and the injustice of its excesses that, unlike in these cases, often go without remedy.

Cook, Rebecca and Susannah Howard, "Accommodating Women's Differences under the Women's Anti-Discrimination Convention," *Emory Law Journal* 56 (2007): 1039-1092, especially 1085-1087. http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1029375

The purpose of this article is to explore how the Convention on the Elimination of All Forms of Discrimination Against Women can be more effectively applied in the abortion context. Conscientious objection is discussed at p.1085-1087, where the authors claim that it is a fundamental challenge to health care professionalism.

Deans, Zuzana, "Conscientious Objections in Pharmacy Practice in Great Britain," *Bioethics* 27 (2013): 48-57. [Available for purchase online.](#)

The author proposes propose that the pharmacy profession's policy on conscientious objections should be altered slightly. Building on the work of Brock and Wicclair, Deans argues that conscientious refusals should be acceptable provided that the patient is informed of the service, the patient is redirected to an alternative source, the refusal does not cause an unreasonable burden to the patient, and the reasons for the refusal are based on the core values of the profession. Finally, it is argued that a principled categorical refusal by an individual pharmacist is not morally permissible. The author claims that, contrary to current practice, a pharmacist cannot legitimately claim universal exemption from providing a standard service, even if that service is available elsewhere. This discussion uses high-profile cases in Great Britain concerning the refusal to supply emergency hormonal contraception (viewed as abortifacient) as an example.

Dickens, Bernard M., “The Right to Conscience,” in *Abortion Law in Transnational Perspective: Cases and Controversies*, ed. Rebecca J. Cook, Joanna N. Erdman and Bernard M. Dickens (University of Pennsylvania Press, 2014), 210-238. [Book in English](#) [Book in Spanish](#). [Abstract in English](#). [Resumen en Espanol](#).

In this chapter, Dickens explores variants of the human right to freedom of conscience in abortion debates. The aim of this chapter is to release “conscience” from capture by those who object to participation in induced abortion. It argues that, while opponents of induced abortion are properly entitled to invoke conscientious objections to participation, others are equally entitled conscientiously to participate in such lawful procedures, to advise patients about the option, and to refer patients to where appropriate services are available. This includes taking such actions in institutions that, for religious or other reasons, oppose such procedures on principle. It is argued that religiously inspired health facilities must accommodate providers’ rights of conscientious commitment to undertake or make provision for services, and women’s conscientious rights to receive them, just as secular health facilities do.

Dickens, Bernard M., “The Ethical Responsibilities of Conscience” *IPPF Medical Bulletin* 43.4(Dec 2009): 3-4. https://issuu.com/ippfresources/docs/medical_bulletin_december09

This brief article provides a legal and ethical perspective on conscientious objection in the medical context. There is a section on the protection of conscience as a right and freedom; professional ethics and conscience; conflicts of interest and the exercise of freedom of conscience; the scope of the right to conscientious objection; and, the abuse of conscientious objection through misguided policies, legislation and provisions.

Dickens, Bernard M., “Unethical Protection of Conscience: Defending the Powerful against the Weak.” *Virtual Mentor* 2009; 11:725-729, online: <<https://journalofethics.ama-assn.org/article/unethical-protection-conscience-defending-powerful-against-weak/2009-09>>.

This op-ed piece argues that in protecting and privileging health care professionals who withhold information that their patients depend upon, the U.S. federal provisions on protection of conscience reduce health care professionals to the status of “self-serving traders in an unequal market who may take advantage of those obliged or unwise enough to trust them and rely on their integrity”. Further, this piece contends that allowing physicians to deny or frustrate a patient’s rights of conscience by enforcing their own through nonreferral, as the new regulations do, is unethical.

Dickens, Bernard M., “Conscientious Objection and Professionalism,” Editorial in *Expert Review Obstetrics and Gynecology* 4(2), 97-100 (2009), online: <http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1372865>

This editorial outlines the principle of protection of health service providers' personal conscience, and the limit necessary to protect the health and freedom of their patients' rights of access to lawful health services. It is explained that the balance protecting both providers' rights of conscience and patients' rights of care is the providers' duty to refer

their patients to other providers who are suitable, available and prepared to offer the services to which the initial providers object. The author argues that referral is an ethical and often a legal duty that does not constitute complicity in the services the providers to whom reference is made may undertake. Objection is protected to lawful participation in procedures, but there is no right to object to administration of providers who undertake procedures administrators would object to provide to their own patients. Dickens suggests that institutions and professional associations may assist clinical providers by keeping lists of other providers prepared to deliver services to which clinical providers object.

Dickens, Bernard M., "Legal Protection and Limits of Conscientious Objection: When Conscientious Objection is Unethical" *Medicine and Law* (2009) 28:337-347, online: <<http://ssrn.com/abstract=1483363>>

This article contends that the reconciliation of patients' rights to care and providers' rights of conscientious objection is in the duty of objectors in good faith to refer their patients to reasonably accessible providers who are known not to object. Ultimately, it is argued that conscientious objection is unethical when healthcare practitioners treat patients only as a means to their own spiritual ends. Practitioners who would place their own spiritual or other interests above their patients' healthcare interests have a conflict of interest, which is unethical if not appropriately declared.

Dickens, Bernard M., "Conscientious Commitment" *The Lancet* 371 (April 12, 2008): 1240-41. (PDF)

This perspective piece examines the history and development of conscientious commitment: the opposite of conscientious objection, where health care providers strive to defy laws and religious opposition to provide care to vulnerable patients. Examples from all over the world are cited.

Dickens, Bernard M., "Conscientious Objection: A Shield or a Sword?" in S.A.M. McLean, ed. *First Do No Harm: Law, Ethics and Healthcare* (Aldershot, UK: Ashgate, 2006) 337-351. (PDF). [Google Books free preview](#).

This essay discusses the boundaries between legitimate conscientious objection and an indiscriminate appeal to conscience in violation of law and of others' rights. The author examines the tension between individuals' right to manifest their religious faith and convictions, and others' rights to health, liberty and equal rights of conscience. In the context of reproductive health and abortion, this is of particular concern.

Dickens, Bernard M., "Ethical misconduct by abuse of conscientious objection laws" *Medicine & Law* 25 (2006): 513-522 (PDF)

This article addresses laws and practices urged by conservative religious organizations that invoke conscientious objection in order to deny patients access to lawful procedures. Religious institutions that historically served a mission to provide healthcare are now

perverting this commitment in order to deny care. Dickens asserts that the shield tolerant societies allowed to protect religious conscience is abused by religiously-influenced agencies that beat it into a sword to compel patients, particularly women, to comply with religious values they do not share. It is argued that this is unethical unless accompanied by objectors' duty of referral to non-objecting practitioners, and governmental responsibility to ensure supply of and patients' access to such practitioners.

Dickens, Bernard M., "Reproductive Health Services and the Law and Ethics of Conscientious Objection," *Medicine and Law* 20 (2001), pp. 283-293. (PDF)

Spanish translation Servicios de Salud Reproductiva y el derecho y etica de la objeccion de consciencia, *Revista Argentina de Teoria Juridica* 13 (2009).

http://www.utdt.edu//ver_contenido.php?id_contenido=2455&id_item_menu=4082

This article addresses limits to conscientious objection to participation in reproductive health services, and conditions to which rights of objection may be subject. Dickens argues that individuals have human rights to freedom of religious conscience, but institutions, as artificial legal persons, may not claim this right.

Dickens, Bernard M. & Rebecca J. Cook, "Conscientious Commitment to Women's Health." *International Journal of Gynecology and Obstetrics* 113.2 (2011): 163-166

<http://papers.ssrn.com/abstract=1832549>

This article discusses the development of conscientious commitment, the reverse of conscientious objection, which inspires healthcare providers to overcome barriers to delivery of reproductive services to protect and advance women's health. This is challenged by religious doctrines that view treatment of ectopic pregnancy, spontaneous miscarriage and emergency contraception not by reference to women's healthcare needs, but through the lens of abortion. The authors argue that modern legal systems increasingly reject this myopic approach. Providers' conscientious commitment is to deliver treatments directed to women's healthcare needs, giving priority to patient care over adherence to conservative religious doctrines or religious self-interest. The authors further point to the development of in vitro fertilization to address childlessness as illustrating the inspiration of conscientious commitment over conservative objections.

Dickens, Bernard M. and Rebecca J. Cook, "The Scope and Limits of Conscientious Objection," *International Journal of Gynecology and Obstetrics* 71(2000), pp. 71-77.

http://papers.ssrn.com/sol3/papers.cfm?abstract_id=946461

This article argues that physicians who refuse to perform procedures on religious grounds must refer their patients to non-objecting practitioners. Further, the authors contend that when physicians refuse to accept applicants as patients for procedures to which they object, governmental healthcare administrators must ensure that non-objecting providers are reasonably accessible. This paper makes several other contentions. One, nurses' conscientious objections to participate directly in procedures they find religiously

offensive should be accommodated, but nurses cannot object to giving patients indirect aid. Two, medical and nursing students cannot object to be educated about procedures in which they would not participate, but may object to having to perform them under supervision. Finally, hospitals cannot usually claim an institutional conscientious objection, nor discriminate against potential staff applicants who would not object to participation in particular procedures.

Dickens, Bernard M., R.J. Cook and E. Kismodi, *Reproductive Health: Case Studies with Ethical Commentary*. (Haifa: UNESCO Chair for Bioethics, 2006)

<http://medlaw.haifa.ac.il/index/main/4/ReproductiveHealth.pdf>

pp 15-17 (image 25ff in the PDF) and pp 59-60 (image 69ff in the PDF)

This document, commissioned by the UNESCO Chair for Bioethics, contains various case studies relating to reproductive health with responses by the authors on the appropriate ethical course of action. Case study 6 (p.15) is regarding access to emergency contraception for a rape victim and the lone physician from a remote village conscientiously objecting to providing the appropriate care. Case study 27 (p.59) is regarding the conscientious objection of a pharmacist and access to emergency contraception, where the hospital executive agrees to stocking the approved drugs but three individual pharmacists exercise their right to conscientious objection on the grounds that they are abortifacient.

Diniz, Debora, Alberto Madeiro and Cristião Rosas, "Conscientious objection, barriers, and abortion in the case of rape: a study among physicians in Brazil," *Reproductive Health Matters* 22.43 (May 2014): 141-148, online: <[https://www.tandfonline.com/doi/full/10.1016/S0968-8080\(14\)43754-6](https://www.tandfonline.com/doi/full/10.1016/S0968-8080(14)43754-6)>.

The aim of this study was to understand the practice and opinions about providing abortion in the case of rape among obstetricians-gynecologists (OBGYNs) in Brazil. A mixed-method study was conducted from April to July 2012 with 1,690 OBGYNs who responded to a structured, electronic, self-completed questionnaire. In-depth telephone interviews with 50 of these physicians showed that they frequently tested women's rape claim by making them repeat their story to several health professionals; 43.5% of these claimed conscientious objection when they were uncertain whether the woman was telling the truth. The data suggest that women's access to legal abortion is being blocked by these barriers in spite of the law. The authors recommend that FEBRASGO and the Ministry of Health work together to clarify to physicians that a woman's statement that rape occurred should allow her to access a legal abortion.

Enright, Máiréad. *McGee v Attorney General-Judgment*, in *Northern/Irish Feminist Judgments*, Máiréad Enright, Julie McCandless and Aoife O'Donoghue (eds.), *Northern/Irish Feminist Judgments* (Oxford: Hart, 2017) 107-112.

This rewrite of the Irish *McGee* decision recognizes Mrs. McGee's right of conscience. The author addressed Article 44 of the Irish Constitution on the freedom of conscience

and explained: “The protections of Article 44 cannot logically be confined to those faithful whose lives conform in every aspect to the orthodoxy of their religious community. Freedom is always the freedom of dissenters, those whose life projects might upend the preferences of the majority.... We must be entitled to call our souls our own. If it were otherwise, and the disobedient citizen cannot invoke the right of conscience, then the fundamental rights protected under Article 44 are not those of individuals but those of powerful religious institutions.”

Faúndes, Anibal, Graciana Alves Duarte, and Maria José Duarte Osis. "Conscientious objection or fear of social stigma and unawareness of ethical obligations." *International Journal of Gynecology & Obstetrics* 123.S3 (2013) S57-S59. [Available online](#).

This article explores the problem of physicians who camouflage under the guise of conscientious objection their fear of experiencing discrimination and social stigma if they perform legal abortions. It asserts that these physicians seem to ignore the ethical principle that the primary conscientious duty of OB/GYNs is to treat, or provide benefit and prevent harm to, the patients for whose care they are responsible. Any conscientious objection to treating a patient is secondary to this primary duty. Writing on behalf of the FIGO Working Group for the Prevention of Unsafe Abortion, the authors explain that it is their job to change this paradigm and make physicians proud of providing legal abortion services that protect women's life and health, and concerned about disrespecting the human rights of women and professional ethical principles.

Fleming, Valeria, Beate Ramsayer, Teja Škodič Zakšek, “Freedom of conscience in Europe? An analysis of three cases of midwives with conscientious objection to abortion,” *Journal of Medical Ethics* (2018) 44: 104-108 [Article online](#).

This article provides a documentary analysis of three examples of conscientious objection on religious grounds to performing abortion-related care by midwives in different Member States of the European Union, two of which have resulted in legal action. These examples show that as well as the laws of the respective countries and the European Union, professional and church law each played a part in the decisions made. However, support from both professional and religious sources was inconsistent both within and between the examples. The authors conclude that there is a need for clear guidelines at both local and pan-European level for health professionals and recommend a European-wide forum to develop and test them.

Fletcher, Ruth, “Conscientious Objection, Harm Reduction and Abortion Care”, in Mary Donnelly and Claire Murray eds. *Ethical and legal debates in Irish healthcare: Confronting complexities* Manchester: Manchester University Press, 2016, ISBN: 978-0-7190-9946-5, [details here](#). A post-print version is available [here](#).

This chapter argues for a harm reduction approach to conscientious objection. It is explained that those who wish to refuse provision of healthcare in spite of a legal obligation, and those who wish to provide healthcare in spite of a legal prohibition, may be harmed by having to act against their most intimate convictions. Moreover, public

reasoning about the proper scope of healthcare provision could be disadvantaged by a failure to recognize a space for critical consciousness. The need to reduce the risk of harm to women, whose lawful entitlement to access abortion has been hard-won, also animates the justification for legal limits on conscientious objection. In arguing for a harm reduction approach, the account offered here draws on but distinguishes itself from those who have relied on public obligations to refute conscientious objection and those who have relied on an individual right to moral integrity to ground conscientious objection.

Harris, Lisa, "Divisions, New and Old — Conscience and Religious Freedom at HHS" *New England Journal of Medicine* 378.15 (April 12, 2018) 1369-71. [Institutional access](#).

This article describes the author's analysis of the Conscience and Religious Freedom Division created by the US Department of Health and Human Services in January 2018. The decision is said to "more vigorously and effectively enforce existing laws protecting the rights of conscience and religious freedom" and will ensure that "no one is coerced into participating in activities that would violate their consciences, such as abortion, sterilization or assisted suicide." The author argues for a nuanced and collaborative approach to bridging the ideological divide.

Harris, Lisa, "Recognizing Conscience in Abortion Provision," *New England Journal of Medicine* 367 (Sept 13 2012): 981-983. [Online](#).

The author of this perspective piece argues that the provision of abortion can also be based on strong moral convictions and that conscience legislation need not be refusal based. It is argued that abortion care providers have a legitimate claim that they act in good conscience just as their counterparts who refuse to provide abortion care. The author explains that nearly all bioethicists have focused on conditions for which conscientious refusals are acceptable, but that few ethicists have focused on the moral case for protecting the conscientious provision of abortion care. Although opponents of abortion argue that abortion providers are motivated by political beliefs not conscience, this argument can be used against them by proponents of abortion care.

Johnson, Brooke R., et al. "Conscientious objection to provision of legal abortion care." *International Journal of Gynecology & Obstetrics* 123.S3 (2013) 60-62. [Available online](#).

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

Lamackova, Adriana, "Conscientious Objection in Reproductive Health Care: Analysis of Pichon and Sajous v. France." *European Journal of Health Law*, 15.1(2008): 7-43. Abstracted online at: <https://www.ncbi.nlm.nih.gov/pubmed/18630725>

This article explores the issue of conscientious objection invoked by health professionals in the reproductive and sexual health care context and its impact on women's ability to access health services. When the exercise of conscientious objection conflicts with other human rights and fundamental freedoms, a balance must be struck between the right to conscientious objection and other affected rights such as the right to respect for private life, the right to equality and non-discrimination, and the right to receive and impart information. This article analyses the European Court of Human Rights' decision on admissibility in *Pichon and Sajous v. France* (2001) and argues that a balancing approach should be applied in cases of conscientious objection in the sexual and reproductive health care context.

Lynch, Holly Fernandez. *Conflicts of Conscience in Health Care: an Institutional Compromise*. (MIT Press, 2010).

This book addresses the issue of conscience clauses in healthcare by proposing a compromise that protects both a patient's access to care and a physician's ability to refuse. Lynch argues that doctor-patient matching on the basis of personal moral values would eliminate, or at least minimize, many conflicts of conscience, and suggests that state licensing boards facilitate this goal. Licensing boards would be responsible for balancing the interests of doctors and patients by ensuring a sufficient number of willing physicians such that no physician's refusal leaves a patient entirely without access to desired medical services. This proposed solution, Lynch argues, accommodates patients' freedoms while leaving important room in the profession for individuals who find some of the capabilities of medical technology to be ethically objectionable.

Mancini, Susanna and Michel Rosenfeld, eds. *The Conscience Wars: Rethinking the Balance between Religion, Identity, and Equality*, (Cambridge University Press, 2018). [More information.](#)

[Publisher's summary] ...Analysis on the greater demand for religions exemptions to government mandates. Traditional religious conscientious objection cases, such as refusal to salute the flag or to serve in the military during war, had a diffused effect throughout society. In sharp contrast, these authors argue that today's most notorious objections impinge on the rights of others, targeting practices like abortion, LGTBQ adoption, and same-sex marriage. The dramatic expansion of conscientious objection claims have revolutionized the battle between religious traditionalists and secular civil libertarians, raising novel political, legal, constitutional and philosophical challenges. Highlighting the intersection between conscientious objections, religious liberty, and the equality of women and sexual minorities, this volume showcases this political debate and the principal jurisprudence from different parts of the world and emphasizes the little known international social movements that compete globally to alter the debate's terms.

Melling, Louise, “Religious Refusals and Reproductive Rights,” chapter 14 in: *The Conscience Wars: Rethinking the Balance between Religion, Identity, and Equality*, ed. Susanna Mancini and Michel Rosenfeld (Cambridge, UK: Cambridge University Press, 2018) pp. 375-391.

[Institutional Access](#).

[This chapter] critically addresses the different popular reactions to, and conceptualization of, refusals based on religious beliefs to serve LGBT people versus refusals to serve women seeking reproductive health services. Melling focuses specifically on the refusals of institutions – stores, pharmacies, and hospitals, among others – to provide such services, as this has greater implications for third parties than refusals by individuals. Melling argues that in the current US debate, denial of service to LGBT individuals is understood as having a discriminatory effect on the ground of sexual orientation, thus causing stigma and dignitarian harms. To the contrary, the latter harms and shaming of women resulting from denying them reproductive services is neither discussed in the broad cultural debates, nor properly addressed by the courts.

The reason for this difference in treatment is twofold. In the first place, refusals of institutions to allow access to abortions or contraception are cast as being about the service, not about women. In the second place, Melling argues that the legacy of legal and cultural discrimination against women is at play in the treatment of conscientious objection in the field of reproductive rights. In this light, refusals to serve women seeking to control their fertility are not conceptualized as discriminatory on the ground of gender, because reproductive rights challenge the stereotype of women as committed to embracing their traditional role as mothers. However, Melling argues, the refusals involved stigmatize women and deprive them of equality just as similar refusals do in the case of LGBT individuals. [from book introduction]

Montero, Adela and Raúl Villarroel, “A critical review of conscientious objection and decriminalisation of abortion in Chile,” *Journal of Medical Ethics*, online: <https://jme.bmj.com/content/44/4/279>.

This article offers a critical review of the emergence of conscientious objection and its likely policy and ethical implications through the lens of the recently enacted legislation decriminalizing abortion in Chile. It posits the need to regulate conscientious objection through checks and balances designed to keep it from being turned into an ideological barrier meant to hinder women’s access to critical healthcare.

NeJaime, Douglas 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*, ed. Susanna Mancini & Michel Rosenfeld (Cambridge Univ. Press, 2018), pp. 187-219. [Online at SSRN](#).

This essay examines the spread of opponents of contraception and abortion (as well as same-sex relationships) seeking religious exemptions from laws protecting these practices in the United States and across borders. After surveying the spread of these new religious liberty claims, and sampling the laws’ nascent response, the authors offer a pluralism-respecting framework for engaging with claims of this kind.

NeJaime, Douglas, and Reva Siegel, “Conscience Wars in the Americas,” *Latin American Law Review* 5 (2020): 1-26, [English and Spanish on web](#). [Download English PDF](#) [Spanish PDF](#).

Across the globe, public and private actors are now invoking conscience as a ground for objecting to laws or judicial decisions that confer on citizens reproductive and LGBT rights. Conscience claims in culture-war conflicts over reproduction and sexuality differ from paradigmatic religious accommodation claims, where an individual from a minority faith seeks to engage in ritual observance or religiously-motivated dress that runs afoul of generally applicable laws. Accommodation of culture-war conscience claims may inflict significant harms on other citizens and impose older, traditional views on citizens whose rights the law only recently has come to protect. Our intervention is practical and critical. We offer guidance on accommodation, showing how government might promote pluralism by accommodating objectors while protecting citizens who may be affected. We suggest that when government accommodates conscience in a framework that does not preserve the other citizens’ rights, government may be employing accommodation to create a de facto public order favoring objectors’ beliefs.

Ngwena, Charles G., “Conscientious Objection to Abortion and Accommodating Women's Reproductive Health Rights: Reflections on a Decision of the Constitutional Court of Colombia from an African Regional Human Rights Perspective,” *Journal of African Law* 58.2 (October 2014) 183 - 209 [online here](#).

This article reflects on one of the Columbian Constitutional Court’s decisions regarding the right to conscientious objection and draws lessons for the African region. In recent years, the Court has been giving a judicial lead on the development of a right to conscientious objection that accommodates women’s fundamental rights. The author argues that a transformative understanding of human rights requires that the right to conscientious objection to abortion be construed in a manner that is subject to the correlative duties which are imposed on the conscientious objector, as well as the state, in order to accommodate women’s reproductive health rights.

Perdomo, Mendoza and Juan Francisco, “Criminal Scopes of the Doctor Conscientious Objection in the Cases of Lawful Abortion in Colombia; Alcances penales de la objeción de conciencia del médico en el aborto lícito en Colombia; Âmbitos penales da objeção de consciência em o médico, *IUSTA* 2:37 (2012) doctoral research, [Summary in Spanish, English and Portuguese](#)

The article analyzes Colombian Constitutional Court judgment which partially decriminalized abortion and delineated specific grounds for legal abortion, as well as the explores the reasons that caused its constitutional approval. The authors also review the concept of conscientious objection through the lens of criminal law, in order to determine the criminal legal scope of objection in medical abortion practice, proposing the foundation and configuration that this exemption must follow in resolving cases.

Ramón Michel, Agustina, Stephanie Kung, Alyse López-Salm, and Sonia Ariza Navarrete, "Regulating Conscientious Objection to Legal Abortion in Argentina: Taking into Consideration Its Uses and Consequences", *Health and Human Right Journal* Volume 22/2, December 2020, pp 271 – 384 [Abstract and Article, English](#). [Study paper in Spanish](#).

Claims of conscientious objection (CO) have expanded in the health care field, particularly in relation to abortion services. In practice, CO is being used in ways beyond those originally imagined by liberalism, creating a number of barriers to abortion access. In Argentina, current CO regulation is lacking and insufficient. This issue was especially evident in the country's 2018 legislative debate on abortion law reform, during which CO took center stage. This paper presents a mixed-method study conducted in Argentina on the uses of CO in health facilities providing legal abortion services, with the goal of proposing specific regulatory language to address CO based not only on legal standards but also on empirical findings regarding CO in everyday reproductive health services. The research includes a review of literature and comparative law, a survey answered by 269 health professionals, and 11 in-depth interviews with stakeholders. The results from our survey and interviews indicate that Argentine health professionals who use CO to deny abortion are motivated by a combination of political, social, and personal factors, including a fear of stigmatization and potential legal issues. Furthermore, we find that the preeminent consequences of CO are delays in abortion services and conflicts within the health care team. The findings of this research allowed us to propose specific regulatory recommendations on CO, including limits and obligations, and suggestions for government and health system leaders.

Sepper, Elizabeth, "Not Only the Doctor's Dilemma: The Complexity of Conscience in Medicine," *Faulkner Law Review*, 2013. [Online here](#).

Sepper argues that the word conscience does not simply stand in for refusal to deliver abortions or contraception or to remove or withhold life support. First, medical decisions — especially those involving questions of life and death — inspire divergent moral convictions. Second, medical decisions do not simply implicate conscience for the provider. They should be thought of instead as involving, at minimum, three parties: patients, providers, and institutions. The author contends that in responding to conflicts over medical decisions, lawmakers have overlooked their complexity. As a result, existing legislation undermines conscience, risks harm to patients, and destabilizes ethical decision-making within medicine itself.

Sepper, Elizabeth, "Taking Conscience Seriously," *Virginia Law Review* 98 (2012):1501-1575 [Online](#).

This article aims to reframe the conscientious objection debate by taking conscience seriously. Through engagement with the moral philosophical literature, it makes two inter-related arguments. First, conscience equally may compel a doctor or nurse to deliver a controversial treatment to a patient in need. Yet existing legislation meant to protect conscience, paradoxically, has undermined the consciences of these doctors and nurses. Second, endowing healthcare institutions with conscience via legislation is theoretically

and practically problematic. By privileging the institutions' rights to refuse to provide certain treatments, legislation impinges on the rights of individual providers to provide care they feel obligated by conscience to deliver. The author argues that ultimately, if legislation is to protect conscience, it must negotiate between competing claims of conscience of health providers and the facilities in which they work — regardless of whether they refuse or are willing to provide controversial care. This article introduces a new framework for achieving a better balance between the interests of institutions, individual doctors and nurses, and the patients who depend on them for care.

Sifris, Ronli, "Tasmania's Reproductive Health (Access to Terminations) Act 2013: An analysis of conscientious objection to abortion and the 'obligation to refer'", *Journal of Law and Medicine* 22(2015): 900-914, online: http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2595467.

This article focuses on Tasmania's Reproductive Health (Access to Terminations) Act 2013, which decriminalises abortion in that State. Part I of this article provides an overview of the Tasmanian legislation, comparing it with Victoria's Abortion Law Reform Act 2008. Part II then shifts its focus to a more in-depth analysis of a doctor's right to "conscientious objection" and the requirement in both Acts of an "obligation to refer". The article concludes that ultimately, as a democratic society it is important that we respect both a woman's right to terminate a pregnancy and a doctor's right to freedom of conscience. Where these rights conflict, as is the case when a doctor with a conscientious objection to abortion is confronted with a patient who seeks information about abortion, they must be balanced. The Victorian and Tasmanian Acts represent a considered and reasonable approach to balancing the rights at issue.

Sterling, Steph and Jessica L. Waters, "Beyond Religious Refusals: The Case for Protecting Health Care Workers' Provision of Abortion Care," *Harvard Journal of Law & Gender* 34 (2011): 463-502. [Available through Research Gate](#).

This article seeks to explore the question of whether and to what extent conscience-based employment protections available to those medical professionals opposed to the provision of abortion care should also be available to health care professionals who seek, based on their religious or moral beliefs, to affirmatively provide abortion care at religiously affiliated medical facilities. Part I examines the prevalence of religiously affiliated medical institutions that refuse to provide abortion care and the ways in which these prohibitions violate the consciences of some health care professionals who seek, as a matter of religious or moral conviction, to provide abortion care to their patients. Part II examines whether existing employee legal protections such as Title VII of the 1964 Civil Rights Act or the Church Amendment, both of which prohibit various forms of employment "discrimination" based on moral, ethical, or religious beliefs, can be used to protect health care providers' affirmative right to provide, as a matter of conscience, abortion care. While both laws have been used to protect employees' conscience-based refusals to provide reproductive health care, Part II explores whether and to what extent these same laws could also provide meaningful remedies for medical professionals who seek to provide conscience-based abortion care. Recognizing that existing employment

conscience protections for employees seeking to provide abortion care are in some ways limited, Part III briefly concludes that policymakers and courts must begin to recognize that the conscience-based provision of abortion care can be rooted in beliefs held with a strength equal to the beliefs underlying the conscience-based refusal of such care, and as such must craft and enforce existing laws to provide parallel protection for both.

Schwartzman, Micah, Nelson Tebbe, and Richard Schragger, “The Costs of Conscience,” (March 2018) *Virginia Public Law and Legal Theory Research Paper No. 2018-14*. [Abstract and article](#).

This article discusses the third-party harm doctrine – the principle that when the government enacts laws or regulations that accommodate religious believers, it may not impose significant costs on identifiable third parties. Critics of this doctrine have raised a diversity of objections to it. They have argued that it (1) lacks normative foundations, (2) is not grounded in constitutional sources, (3) assumes an incorrect baseline for determining when third parties are harmed, and (4) cannot be applied without eliminating all, or nearly all, religious accommodations. Critics have also argued (5) that the doctrine does not apply when the government provides legal exemptions for both religious and secular claims of conscience, and (6) that religious freedom is like other fundamental rights that impose harms on others. The authors argue that none of these objections is persuasive. Responding to them provides an opportunity to develop the third-party harm doctrine in ways that illuminate the limits of religious liberty, freedom of conscience, and other constitutional rights.

Uberoi, Diya & Beatriz Galli, “Refusing Reproductive Health Services on Grounds of Conscience in Latin America: Challenging policies and practises based on human rights standards” in *SUR International Journal on Human Rights*, issue 24 (Dec 2016) [special issue on “Women: Movements, Successes and Obstacles ([Overview](#))] online: [English edition](#) [Spanish edition](#). [Portuguese edition](#)

This article provides an overview of policies regulating conscientious objection in Latin America. It considers the regulation of conscientious objection under both international law and under various state laws within the region. It suggests that if women’s reproductive rights are to become a reality, then there is a real need that states as well as international and regional human rights bodies continue to find ways to clarify frameworks around conscientious objection, so that grounds of conscience do not become an excuse to deny women realisation of their fundamental rights.

Undurraga, Verónica & Michelle Sadler, “The misrepresentation of conscientious objection as a new strategy of resistance to abortion decriminalisation,” *Sexual and Reproductive Health Matters* 27.2 (2019):17-19. [Article online](#).

The implementation of abortion laws around the world is suffering setbacks due to these ways of interpreting the work of health professionals. What happens in Chile is likely to influence sexual and reproductive health policies in the rest of Latin America. Although the arguments we criticise in this paper may seem unsound, we should not underestimate

their impact within political, medical and legal circuits and their capacity to propagate throughout the Region, especially at a time when right-wing, conservative governments that promote the privatisation of healthcare and religious privileges are gaining ground.

Zampas, Christina, “Legal and ethical standards for protecting women’s human rights and the practice of conscientious objection in reproductive healthcare settings,” in special issue “Conscientious Objection to the provision of reproductive healthcare, *International Journal of Gynaecology and Obstetrics*, vol 123, Supp. 3 (Dec. 2013) [online in this special issue](#).

This article sets forth existing ethical and human rights standards on the issue of conscientious objection in the reproductive health context – including abortion - and illustrates the need for further development and clarity on balancing these rights and interests.

Zampas, Christina and Ximena Andión-Ibañez, "Conscientious Objection to Sexual and Reproductive Health Services: International Human Rights Standards and European Law and Practice," *European Journal of Health Law* 19 (2012) 231-256. [Online here](#).

This article outlines the international and regional human rights obligations and medical standards on the issue of conscientious objection in Europe in the field of health care, including abortion, and highlights some of the main gaps in these standards. It illustrates how European countries regulate or fail to regulate conscientious objection and how these regulations are working in practice, including examples of jurisprudence from national level courts and cases before the European Court of Human Rights. Finally, the article provides recommendations to national governments as well as to international and regional bodies on how to regulate conscientious objection so as to both respect the practice of conscientious objection while protecting individual’s right to reproductive health care.

[Spanish/Portuguese Articles and Books](#)

Dickens, Bernard M., “Objeción de conciencia y compromiso en conciencia,” in *Bioética, reproducción y familia*, ed. Fernando Zegers H. & Sofía P. Salas, (Santiago: Ediciones Universidad Diego Portales, 2014), 145-182.

Dickens, Bernard M., "[Objeción de Conciencia](#)," *Discusiones sobre Genero, Sexualidad y Derecho: Taller 2010*, ed. Alejandro Madrazo, Estefanía Vela, y Cecilia Garibi. (Mexico D.F.: Fontamara, 2013) 135-154.

Perdomo, Mendoza and Juan Francisco, “Criminal Scopes of the Doctor Conscientious Objection in the Cases of Lawful Abortion in Colombia; Alcances penales de la objeción de conciencia del médico en el aborto lícito en Colombia; Âmbitos penales da objeção de consciência em o médico, *IUSTA* 2:37 (2012) doctoral research, [Summary in Spanish, English and Portuguese](#)

Uberoi, Diya & Beatriz Galli, “Refusing Reproductive Health Services on Grounds of Conscience in Latin America: Challenging policies and practises based on human rights standards” in *SUR International Journal on Human Rights*, issue 24 (Dec 2016) [special issue on “Women: Movements, Successes and Obstacles ([Overview](#))] online:
[English edition](#) [Spanish edition](#). [Portuguese edition](#)

Reports and Resources

Inter-Governmental Bodies

Council of Europe, Jim Murdoch, *Protecting the Right to Freedom of Thought, Conscience and Religion under the European Convention on Human Rights* (Strasbourg Cedex: Council of Europe, 2012). [93-page handbook](#).

This handbook examines the scope and content of freedom of thought, conscience and religion as guaranteed in particular by Article 9 of the European Convention on Human Rights and as interpreted by the case-law of the European Court of Human Rights and by the former European Commission on Human Rights. There is no particular reference to conscientious objection in the reproductive health context.

EU Network of Independent Experts on Fundamental Rights, Opinion N° 4-2005, *The right to conscientious objection and the conclusion by EU member states of concordats with the Holy See*, 14 December 2005. [41-page report](#).

The E.U. Network of Independent Experts on Fundamental Rights (“the EU Experts”) is a body set up by the European Commission at the request of the European Parliament. They prepared an opinion on the Right to Conscientious Objection (outside conscription) and an EU Member State entering into a Concordat with the Holy See, as requested by the European Commission in July 2005. It was initiated due to concerns raised by a number of Slovak and international NGOs in relation to Slovakia’s initiative to sign the historically first concordat with the Holy See in (“the Draft Treaty”) on the Protection of the Right to Conscientious Objection for Roman Catholics. The EU experts have examined the Draft Treaty from a perspective of human rights standards, as set out in the EU Charter of Fundamental Freedoms, the ECHR, ICCPR and CEDAW. They have observed that none of the existing concordats between EU member states and the Holy See provides protection of conscientious objection in such a degree as this Draft Treaty.

The EU experts found that the right to object, even if not expressly protected, may be in some instances understood as a manifestation of one’s conscience or belief protected in international human rights law. However, the right to manifest conscience, including the right to object, is not absolute. An adequate balance must be struck between the right to object and the rights of others.

Non-Governmental Organizations

Abortion Rights Coalition of Canada, *The Refusal to Provide Health Care in Canada A Look at “Conscientious Objection” Policies in Canadian Health Care*. Position Paper #95 (Vancouver: ARCC, 2018). [Online](#). Also see the [Appendix](#).

This position paper examines conscientious objection in Canada and argues that it is unethical. Suggestions are made on how to stop the refusal to treat. The appendix describes and critiques the policies of the Canadian Medical Association (CMA) and each College of Physicians and Surgeons across Canada as they relate to the refusal to treat and obligation to refer², in particular for abortion care, but also medical assistance in dying (MAiD).

Catholics for Choice, *In Good Conscience: Conscience Clauses and Reproductive Rights in Europe – Who Decides?* (Washington DC: Catholics for Choice, 2017). [24-page report](#).

This pamphlet gives a brief overview of some of the key themes in the debate on conscience clauses in a European context—how conscience clauses have evolved and what Catholic teachings on conscience really are—especially within the context of reproductive health and rights. There is an expanding use of refusal clauses (also known as exemption clauses or conscience clauses) under the guise of protecting healthcare providers who have a religious or moral objection to providing some or all reproductive health services. This pamphlet explains in reality, antichoice activists are not concerned with an individual’s conscience—they want to end access to abortion and contraception. The Catholic hierarchy—through the Holy See and bishops in many countries—has promoted this trend by claiming that the consciences of medical professionals are routinely violated and by seeking to expand the number of services covered by these exemptions.

Catholics for Choice, *In Good Conscience: Respecting the Beliefs of Health-Care Providers and the Needs of Patients* (Washington D.C.: Catholics for a Free Choice, 2010). [16-page report](#).

This pamphlet was written to give a brief overview of some of the key themes in the debate on conscience clauses in health care—how conscience clauses evolved, Catholic teachings on conscience and how the concept of conscience has been manipulated, especially within the context of reproductive health and rights. One of the more recent tactics involves significantly expanding the concept of refusal clauses (also known as exemption clauses or conscience clauses) beyond protecting the religious and moral beliefs of healthcare providers and, in effect, acting as a means to refuse some treatments and medications to all comers. Under the guise of protecting religious freedom, antichoice activists—with the backing of some members of the Catholic hierarchy—have aggressively used the political process to allow healthcare professionals, including doctors, nurses and pharmacists, to opt out of providing essential reproductive healthcare services and medications. This pamphlet explains how the Catholic hierarchy—through the United States Conference of Catholic Bishops and the Catholic Health Association of the United States—has collaborated with antichoice organizations across the country both to suggest that the consciences of medical professionals are routinely violated and to expand the number of services that are considered to be subject to such an exemption.

Center for Reproductive Rights, *Addressing Medical Professionals' Refusals to Provide Abortion Care on Grounds of Conscience or Religion: European Human Rights Jurisprudence on State Obligations to Guarantee Women's Access to Legal Reproductive Health Care*. (New York: CRR, 2018) Fact sheet. <https://www.reproductiverights.org/document/medical-professional-refusal-to-provide-abortion-care-on-grounds-of-conscience-or-religion>

This fact sheet clarifies and summarizes state obligations in Europe to guarantee women's access to legal reproductive health care and presents an overview of European human rights jurisprudence related to medical professionals' refusals to provide abortion care and other forms of reproductive health care on grounds of conscience or religion.

International Network of Civil Liberties Organizations, *Drawing the Line: Tackling tensions between religious freedom and equality*, 2015. [56-page report](#).

This report discusses the topic of religious freedom and reproductive rights (p.24). The cases presented in this section address three principal ways in which the tensions between claims of religious freedom and reproductive rights have arisen: where institutions such as hospitals have claimed a right to an exemption from an existing mandate because of faith; where health care professionals assert a right to refuse to provide a service, whether abortions or contraception, because of faith; and where individuals assert a right to be exempt from any task they believe facilitates health care to which they object.

INCLO identifies several principles that in their view should guide future cases. First, institutions such as hospitals should not be afforded exemptions, just as the businesses and other organisations addressed in the previous section should not. Second, at minimum, individuals who object to providing reproductive health care should not be accommodated where the accommodation would result in harm to life or health. Third, exemptions are not appropriate where individuals object to performing tasks they believe facilitate an abortion, contraception, or access to either. The conduct is too attenuated, the theory too expansive, and the harm too great. Parts I through III discuss case law developments in these three areas, highlighting the reasoning they think instructive. Part IV offers a conclusion and recommendations for advocates and policymakers considering similar claims. The recommendations derive from the central principle that religious freedom does not include the right to infringe the rights of others.

International Planned Parenthood Federation (IPPF), "On conscientious objection: refusal of care and professional conduct of reproductive health services in the context of legal restrictions" IMAP Statement (December 2016). [6-page statement](#).

This Statement is prepared by the International Medical Advisory Panel (IMAP). The purpose of this Statement is to familiarize IPPF Member Associations and relevant partners with the concept of 'conscientious objection' and its application in service delivery settings, with particular emphasis on its implications for the provision or denial of sexual and reproductive health services, including abortion services provided by IPPF.

It is also a call for action to develop guidance on how Member Associations should address this issue in both public policy and practice in a range of service settings.

International Women’s Health Coalition, Michelle Truong and Susan Y. Wood, *Unconscionable: When Providers Deny Abortion Care.*, 2018. [48-page report](#).

The International Women’s Health Coalition (IWHC) and Mujer y Salud en Uruguay (MYSU) co-organized the Convening on Conscientious Objection: Strategies to Counter the Effects, in August 2017. Over three days, participants discussed the consequences of the refusal of care by health care providers claiming a moral or religious objection, possible legal and policy responses to arrest this trend, and the need to reframe the way so-called “conscientious objection” is understood in the context of healthcare. This report is the result of those discussions. Experts from 22 countries agree that denial of health care services based on personal belief is a violation of human rights. Further, a person’s need for evidence-based, medically sound, legal health care services should take precedence over a provider’s religious or personal beliefs. Among the recommendations are that policymakers should never allow institutions to refuse care based on religious belief and that advocates should reclaim “conscience” for those who follow theirs to affirm the right to health.

Ipas and CEDES, “Re-thinking the Use of Conscientious Objection by Health Professionals: A regulatory proposal based on legal abortion practices in Argentina, 2019 [Executive Summary](#).

In this executive summary,” developed by Ipas and the Center for Studies of State and Society (CEDES), we propose language for the regulation of conscientious objection within public policy. This proposal is empirically informed, as it is based on a review of comparative legal studies and a conceptual framework that considers regulatory needs, gaps in public policy and the everyday experiences of women, health-care teams and health authorities. Though this document focuses on the Argentine context, we believe it will be of interest and use in other countries confronted with the need to address providers’ refusal to provide abortion services on religious or moral grounds.

Ipas, Patty Skuster, “When a Health Professional Refuses: Legal and regulatory limits on conscientious objection to provision of abortion care” 2012, Chapel Hill, NC. [16-page Ipas report](#).

This resource contains recommendations for enacting laws and regulations¹ that safeguard women’s access to services while still protecting providers’ rights of conscience. It also provides information on human rights standards that address provider refusal and includes a list of further resources.

Ipas, National Health Law Program, Tracy A. Weitz, *Health Care Refusals: Undermining Quality Care for Women.*, USA, 2010, [84-page report](#).

This report addresses health care refusals and denials of care rooted in political ideology or institutional or personal religious objections and evaluates their potential impact on

access to care. It explains how health care refusals and denials of care are proliferating in the U.S. based on ideological and political justifications that have nothing to do with scientific evidence, good medical practice, or patient needs. The author argues that these refusals and denials of care should be scrutinized to assess their impact on quality health care and redressed when they fall below the standard of care. Chapter 2 discusses refusals on emergency contraception at p.40-45. Chapter 3 address abortion (p.46-59).

Women’s Link Worldwide and The O’Neill Institute for National and Global Health, Bernard M. Dickens, “Jurisprudence from the Constitutional Court of Colombia on Conscientious Objection” in *T-388/2009. Conscientious Objection and Abortion: A Global Perspective on the Colombian Experience*, ed. (2014) 67-85. [Online in English](#) and [Spanish](#).

In this article published in a report by Women’s Link Worldwide and the O’Neill Institute for National and Global Health, Dickens describes the decision in T-388/2009 and points out compatibilities between this ruling and standards set by international human rights treaties, particularly the International Covenant on Civil and Political Rights. He goes on to note similar language in existing or developing regulations in other countries, as well as certain differences, in an analysis in which the Colombian standards come out ahead. Dickens reviews in detail who would be precluded from claiming conscientious objection because of the restriction establishing that only those practitioners who are directly involved in the termination of pregnancy procedure may claim it, and how this provision will apply to abortions induced by medications—two issues that the Constitutional Court’s ruling is silent on. The author notes that certain European standards could be adapted to Colombia, particularly those that preclude pharmacists from claiming conscientious objection to filling prescriptions for contraceptives.

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