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## ETHICAL AND LEGAL ISSUES IN REPRODUCTIVE HEALTH

## Healthcare responsibilities and conscientious objection

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## ABSTRACT

The Constitutional Court of Colombia has issued a decision of international significance clarifying 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. Their professional and legal duties are to ensure that patients receive timely services. Hospitals and other administrators cannot object, because they do not participate in the procedures they are obliged to arrange. Objecting providers, and hospitals, must maintain knowledge of non-objecting providers to whom their patients must be referred. Accordingly, medical schools must adequately train, and licensing authorities approve, non-objecting providers. Where they are unavailable, midwives and perhaps nurse practitioners may be trained, equipped, and approved for appropriate service delivery. The Court's decision has widespread implications for how healthcare systems must accommodate conscientious objection and patients' legal rights.

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## 1. Introduction

Over the last four decades, at an increasing rate, laws against abortion have been progressively liberalized, by many democratically-accountable legislatures and many countries' superior courts that have responded to evolving legal protections of human rights [1]. The movement is not universal, and indeed some legislatures and courts have approved more restrictive measures, but the general trend has been toward relaxation of historically prohibitive or restrictive laws. This is particularly evident in western-style democracies, but paradoxically, many countries that have emerged to independence from colonial domination to achieve their political and economic self-determination retain restrictive abortion laws, imposed by western former-colonial powers that have since liberalized their own abortion laws, in conformity with human rights principles respectful of women's human rights to life, health, and reproductive self-determination [2].

Challenges against liberalizing reproductive health laws, brought or sponsored by conservative religious institutions before national and international tribunals, have almost invariably failed. Reactionary strategy has become directed to resistance through invocation of human rights to religious conscience. Implementing the Universal Declaration of Human Rights of 1948, the UN International Covenant

on Civil and Political Rights (ICCPR), which came into force in 1976, provides in Article 18 (1) that:

Everyone shall have the right to freedom of thought, conscience and religion... [and] to manifest his religion or belief in worship, observance, practice and teaching.

On this foundation, claims are made of conscientious objection to contribute particularly to abortion procedures which, for instance, some Christian denominations regard as a mortal sin, meaning a sin endangering eternal life of the soul. The right of conscience is not absolute, however, since the Covenant limits conscience where others' health is concerned, such as where therapeutic abortion is indicated. Article 18(3) provides that:

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

Limitations on the power of conscientious objection were addressed in a case resulting in an important judgment of the Constitutional Court of Colombia in February 2008 [3], which is of considerable significance and instruction nationally, regionally, and internationally.

## 2. The Case

The pitiable facts of the case are sadly familiar. A 13-year-old Colombian rape victim became pregnant, and, complying with

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requirements set by the Constitutional Court in 2006 for lawful abortion [4], requested through her mother that the governmental health authority responsible for her care schedule the procedure. Its hospital declined, and she was referred successively to four further healthcare facilities, each of which declined on the ground that none of its gynecologists would undertake abortion. One hospital added that no legal obligation existed, because the girl's life was not at risk, although on diagnosis of pregnancy and venereal infection she had attempted suicide.

Denial of abortion services to which women are legally entitled, such as in Mexico for rape [5] and in Peru for danger to mental health, for instance when an adolescent was required to carry to term and then breast feed an anencephalic fetus [6], is becoming a pattern in Latin America abusive of women's human rights. Leading courts in Argentina and Brazil are addressing women's rights to legal abortion following prenatal diagnosis of anencephaly [7]. In Europe, Poland was condemned by the European Court of Human Rights for denial of legal abortion to a mother of young children whose compelled childbirth predictably brought her close to blindness [8]. The Supreme Court of Poland has ordered compensation to parents against a physician whose denial of medically-indicated prenatal genetic diagnosis resulted in birth of a predictably severely disabled child [9].

The Colombian judgment followed a legal proceeding under a Constitutional provision for protection of fundamental rights, in this case to compel access to abortion. The case began in a trial court, where the judge denied constitutionality of the claim, expressing doubts whether the pregnancy was due to rape, although the 2006 Constitutional Court ruling observed that pregnancy in a girl aged under 14 years was presumed to be by rape [10]. In some jurisdictions where enacted law provides that a girl below a given age is incapable of giving legally effective consent to intercourse, this is described as "statutory rape." When the appeal was heard from the trial court, the appeal court confirmed the lower court's decision, and the girl was compelled to complete her pregnancy. By Article 86 of the Constitution, all court decisions on fundamental rights under the Constitution go automatically to the Constitutional Court, which decides whether to review them and confirm or overturn the lower courts' rulings.

### 3. The Constitutional Court decision

The Constitutional Court found that the lower courts had decided incorrectly, since the young girl's fundamental constitutional rights had been violated by denial of lawful abortion, and ordered the governmental health authority to pay compensation [3]. In reaching its decision, the Court made legal rulings affecting how healthcare systems should accommodate both conscientious objection and patients' rights to lawful care. These rulings provide valuable instruction in themselves, and also bear wider implications. The Court's principal legal rulings were that:

- (a) The human right to respect for conscience is a right enjoyed by natural human beings, but not by institutions such as hospitals. The Court found that, by allowing their gynecologists' conscientious objections to limit their services, hospitals were unlawfully asserting conscientious objections of their own.
- (b) Hospitals whose physicians object to undertaking procedures on grounds of conscience must have, on staff or by other means, available physicians to whom patients have convenient, timely access who do not object.
- (c) Physicians who invoke rights of conscientious objection may do so on grounds only of their own religious convictions, which they must explain individually in writing.
- (d) Conscientious objection cannot be invoked with the effect of violating women's fundamental rights to lawful healthcare. Women denied abortion services on grounds of conscience must be referred to physicians willing and able to provide such

services. Individual objecting physicians have a duty of immediate referral, and institutions must maintain information of non-objecting physicians to whom patients can promptly be referred.

- (e) A claim of conscientious objection will be reviewed by a medical professional or another governmentally designated committee, to ensure that the objection is legitimately founded on well-based convictions such as the teachings of an acknowledged religion.
- (f) The governmental system responsible for healthcare security is obliged to ensure an adequate supply of abortion service providers.
- (g) The health authority liable to pay compensation is entitled to recover contributions from the physicians who, in failing to refer the patient to other practitioners who would undertake the procedure, violated her legal rights and rules on conscientious objection set under authority of the Court [4,11].
- (h) The lower court judges who denied a remedy to enforce the applicant's legal right should be investigated under rules of professional discipline for disregard of the Criminal Code, the Constitution, and the 2006 decision of the Constitutional Court.
- (i) The appropriate Ministry of Health and Office of Health Supervision should investigate the offending hospitals in light of the regulations established for legal termination of pregnancy, and impose sanctions where they were violated or disregarded.

These principal rulings fit within the wider framework of national law. For instance, Article 2 of the 1991 Constitution requires the state to guarantee the effectiveness of rights enshrined in the Constitution. Similarly, Article 229 secures individuals' judicial protection of their lives, health, and fundamental rights. An existing decree allows individuals to invoke conscientious objection to their direct participation in surgical and closely proximate procedures they find offensive to their religious convictions, but healthcare administrative personnel, who would not directly participate in medical procedures, cannot [11]. The 2008 judgment addresses the rights and duties of physicians, but the decree and Article 18(1) of the ICCPR, would extend conscientious objection to operating room nurses and, for instance, anesthesiologists. However, reflecting Article 18(3), the 2008 judgment acknowledges that conscientious objection is not an absolute right, and that a practitioner who is the only person capable of performing a timely termination procedure to protect a woman's life or health, and cannot effectively refer her to another provider, is required to perform the procedure to protect the woman's fundamental rights to life and health.

### 4. Implications - direct

The Constitutional Court's requirement that hospitals have means to accommodate lawful abortion challenges hospitals whose administrative officers claim adherence to religious convictions opposed to abortion. They may properly object in their private or personal lives, but not project their personal faith onto the hospital, which, unlike a human being, cannot claim a soul that must remain intact against mortal sin. The distinction between manifesting one's religion in one's personal life and one's secular obligations in one's professional or business life was drawn by the European Court of Human Rights, which ruled that pharmacists could manifest their religious conviction in ways other than refusing to fill prescriptions for contraceptive products [12].

The ruling that administrative officers cannot invoke conscientious objection to accommodating abortion confirms that the claim that this amounts to complicity in abortion has no legal substance. Objection is allowed to direct participation, such as by conducting surgery or writing a prescription for medication abortion, or rendering for instance nursing

or anesthetic assistance during surgery, but not for more remote acts of administration or service, such as postoperative care. Some US legislatures have enacted widely-drawn immunities for those who claim opposition to abortion, such as hospital admission staff and ambulance attendants, but these laws, designed to prevent abortion, abuse defense of religion in order to restrict human rights to healthcare, particularly of women [13].

The standard ethical rule that physicians invoking conscientious objection immediately refer their patients to non-objecting providers of the service [14] is given legal force in this ruling, and applied similarly to hospitals. They are required to maintain, on their staff or through outside providers, knowledge of physicians prepared to provide lawful services to which others object. Discharge of the duty of referral in good faith cannot be legally denied on grounds of complicity. The duty of physicians and hospitals to have timely access to non-objecting providers of abortion services requires such providers to be trained, and licensed.

Medical schools, like hospitals, cannot invoke an institutional conscientious objection, in order to decline to offer instruction in safe abortion procedures. In the same way that they provide training in other gynecological and obstetric procedures, such as the removal of a dead fetus, they must provide conscientious instruction in lawful abortion procedures. Similarly, medical licensing authorities must ensure that licensed practitioners are appropriately trained. To accommodate those who state their objection to training and participation in abortion, licensing authorities may grant specially designated licenses. For instance, they may grant category A licenses to those untrained in abortion procedures, and category B licenses to those trained in conduct of procedures and management of pre- and postoperative counseling, including conscientious disclosure for informed consent, and any special confidentiality or recording requirements. Hospitals could ensure recruitment of adequate numbers of license B holders.

Even without a differential licensing system, providers who object to undertake procedures associated with their specialty, particularly gynecologist-obstetricians, should disclose this to potential patients, and to administrators of facilities liable to engage their services. This saves patients the inconvenience and delay of requesting services that would be denied, saves the providers from receiving requests they find offensive, and allows hospitals, clinics, and comparable facilities to ensure an adequate complement of providers of patient services.

Hospitals, clinics and the like cannot discriminate against potential recruits, such as physicians and nurses, on the basis of their religious or other convictions, since this would violate principles of human rights. However, when objections of existing providers create the risk of leaving abortion services for patients understaffed or delayed, non-objection to participation would be a bona fide condition of engagement, and not discriminatory. The contracts of any engaged to participate who subsequently claimed conscientious objection could be terminated, either for misrepresentation, or through them having frustrated their contracts by subsequent conversion to beliefs that render them incapable of fulfilling contractual conditions.

The Constitutional Court's requirement that providers who invoke conscientious objection do so in writing, and be subject to review, requires officers of governmental agencies or professional licensing authorities to have review procedures. These need not be applied to every instance, but might be, for instance, by random sampling. Review would focus on whether objection was founded on demonstrated observance of the teachings of a recognized religion, and not selective on discriminatory grounds, such as patients' racial or ethnic origins or marital or socioeconomic status. Objectors would be reviewed to see if their objections were, for instance, in public hospitals but not in private clinics or offices, inconsistent over time, or perhaps not in their personal relationships or families, although this level of investigation might be excessive.

The willingness of conscientious objectors to abortion in principle to terminate pregnancies when continuation endangers pregnant

women's lives is not necessarily inconsistent with sincere objection. Under the philosophical concept of "double effect", incorporated into doctrine of, for instance, the Roman Catholic church [15], termination would be regarded as a justified life-preserving procedure on behalf of the endangered women [16], distinguishable from any primary intention to terminate fetal life [17].

## 5. Implications - indirect

The requirement that hospitals amass names of physicians willing to undertake abortion may be difficult to satisfy where religious sentiment is strong and the grounds for legal abortion are wide. This raises the question of whether providers other than physicians should be allowed to undertake abortion services. In South Africa, for instance, registered midwives are legally allowed to perform first trimester abortion procedures [18], under appropriate training and conditions. Where a simple vacuum suction procedure is appropriate, early in pregnancy, when a menstrual period has been missed and pregnancy has not been diagnosed, and when a rape victim is receiving care, nurse practitioners may be appropriate to perform menstrual extraction, ending an early pregnancy if it exists. Both midwives and appropriately-trained nurses may also be empowered to prescribe medication abortion for early pregnancies, and be responsible and equipped to manage necessary follow-up care.

In such cases, there may still be a need for postprocedure medical care, by a gynecologist or other appropriately skilled physician, raising the question of whether a physician with conscientious objections to abortion is legally and/or ethically required to treat a woman who needs care. If such a woman is already under the care of a physician such as a family doctor, a duty exists to render medically indicated care, or refer her to a specialist as would be the case if she suffered an accident or an unlawful abortion. If no prior professional relationship exists, physicians are still obliged to provide indicated care. This will not implicate them in any intervention that occurred before the women come to them, perhaps in hospital emergency departments.

In hospital settings, physicians may have legal duties to care for presenting women, and even without legal obligations they may have professional ethical duties. The British Medical Association ethical guidance provides that physicians who object to undertake abortion procedures remain under a duty of care "which obliges them to provide necessary treatment in an emergency when the woman's life may be jeopardized" [19]. Any lack of personal sympathy between women seeking postabortion care and physicians responsible for treating them should not affect the professional quality of care provided. For instance, under the Geneva Conventions applicable under a state of war, captured enemy combatants must be provided with indicated medical care. Article 15 provides that "The Power detaining prisoners of war shall be bound to provide... for the medical attention required by their state of health" [20]. However opposed to abortion providers may be, it seems that they should treat women who require care following a procedure with no lesser regard.

The Constitutional Court ruling denies hospitals, clinics, and comparable institutions a claim of conscience, and requires facilities to negotiate referral of patients whose physicians object to provide them with abortion services to providers who do not object. That is, the facilities must respect providers' rights both of conscientious objection and of conscientious commitment to give treatment for termination of pregnancy [21]. In many countries, however, hospitals and other healthcare facilities are established under religious inspiration, funding, and authority. In westernized countries, many bear the names of Christian saints. Those who manage the administration of hospitals dedicated to a religious mission hostile to abortion may decline to maintain them under a legal regime that requires accommodation of that procedure. The issue therefore arises, where such hospitals are the only accessible facilities on which local populations depend, of whether they should be taken over by secular state authorities, in a form of

nationalization, or by, for instance, regional or municipal government authorities.

## 6. The ethical context

The Colombian judgment reflects an authoritative pronouncement on conscience of Pope John Paul II in 1991, addressing conditions for preservation of peace in society [22]. He observed that:

Freedom of conscience does not confer a right to indiscriminate recourse to conscientious objection. When an asserted freedom turns into license or becomes an excuse for limiting the rights of others, the State is obliged to protect, also by legal means, the inalienable rights of its citizens against such abuses.

The Constitutional Court was the instrument of the state to provide this protection. The papal pronouncement does not contradict the expectation that church members will refuse to participate in abortion in their personal capacities, but embodies the expectation that they will show the same respect for others' conscience that they require for their own. Their religion has no monopoly on conscience. The 1991 pronouncement opens with the observation that "people must not attempt to impose their own 'truth' on others" [23] and requires that differences be resolved peaceably, not by violence, force or compulsion, except the necessary enforcement of just law.

History unfortunately shows that opponents of abortion rights have had resort to force, violence, and even murder [24]. This raises ethical concerns about how publicly providers willing to serve such rights are identified. The Court's judgment requires hospitals and similar facilities to keep records of providers to whom to refer patients for abortion that other providers object to undertake, and that individual objecting practitioners refer their patients to non-objecting providers. This information should be treated as confidential, analogous to the confidential nature of information about patients. Similarly, patients should be requested to observe the same confidentiality of their providers' identities as they require for their own.

Practitioners do not owe the same legal and ethical duty of referral to those who are not their patients as they owe to those who are. They may decline to accept to enter into professional relationships with new applicants for their care without referring them to other providers [25]. Where hospitals on which populations depend for care receive applicants for their services, whether in emergency or specialty departments, they do have duties to provide personnel able and willing to deliver the services the patients need. As the Constitutional Court made clear, they cannot claim that anyone's conscientious objection absolves the hospitals from discharge of their duty, which the Court confirmed is a legal as well as an ethical duty. Equally clear is the duty of referral owed by an individual practitioner, working within a hospital system or independently [26].

The case that resulted in the seminal judgment of the Constitutional Court of Colombia 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, and the comparable cases from Mexico [5], Peru [6] and, for example, Poland [8], expose the paradox of unscrupulous resort to conscience, and the injustice of its excesses that, unlike in these cases, often go without remedy.

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