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SOCIODEMOGRAPHIC ARTICLE

Yes we can! Successful examples of disallowing ‘conscientious objection’ in reproductive health care

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ABSTRACT

Reproductive health care is the only field in medicine where health care professionals (HCPs) are allowed to limit a patient’s access to a legal medical treatment – usually abortion or contraception – by citing their ‘freedom of conscience.’ However, the authors’ position is that ‘conscientious objection’ (‘CO’) in reproductive health care should be called *dishonourable disobedience* because it violates medical ethics and the right to lawful health care, and should therefore be disallowed. Three countries – Sweden, Finland, and Iceland – do not generally permit HCPs in the public health care system to refuse to perform a legal medical service for reasons of ‘CO’ when the service is part of their professional duties. The purpose of investigating the laws and experiences of these countries was to show that disallowing ‘CO’ is workable and beneficial. It facilitates good access to reproductive health services because it reduces barriers and delays. Other benefits include the prioritisation of evidence-based medicine, rational arguments, and democratic laws over faith-based refusals. Most notably, disallowing ‘CO’ protects women’s basic human rights, avoiding both discrimination and harms to health. Finally, holding HCPs accountable for their professional obligations to patients does not result in negative impacts. Almost all HCPs and medical students in Sweden, Finland, and Iceland who object to abortion or contraception are able to find work in another field of medicine. The key to successfully disallowing ‘CO’ is a country’s strong prior acceptance of women’s civil rights, including their right to health care.

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Introduction

Reproductive health care is the only field in medicine where societies accept the argument that the ‘freedom of conscience’ of health care professionals (HCPs) and institutions can limit a patient’s access to a legal medical treatment.

The authors’ position is that ‘conscientious objection’ (‘CO’) in reproductive health care is a misnomer, and has little to do with freedom of conscience. Instead, we argue it is an unethical refusal of care, and an abandonment of one’s professional obligations to patients. ‘CO’ in reproductive health care is more aptly called *dishonourable disobedience* (a term first coined by co-authors Fiala and Arthur in 2014,[1] because it violates medical ethics and the right to lawful health care.

Almost all western countries allow HCPs and even hospitals to exercise ‘CO’, which is usually regulated via law, policy, or a code of ethics. For example, 21 countries in the European Union grant ‘CO’ by law.[2] While countries generally regulate ‘CO’ themselves, some international organisations [3] have put forward a compromise approach. Typically, this compromise allows doctors to object to performing procedures, but requires them to make an effective referral to another doctor who will provide the care, as well as provide accurate information on all options, and provide or arrange for emergency care when required. However, there are virtually

no monitoring or enforcement processes in place to ensure this referral process is taking place or to prevent misuse. This is evident by a history of many objecting doctors – even those in liberal countries such as Italy [4] – refusing to refer and claiming it makes them ‘complicit.’ Therefore, abuse [5] of ‘CO’ is systemic [6] and mostly unsanctioned [7] across Europe and the rest of the world.

Only a handful of western countries [8] – including Sweden, Finland, and Iceland – do not permit HCPs in the public health care system to refuse to perform a legal medical service for reasons of ‘CO’ when the service is within their scope and professional duty. This article looks at the laws and positive experiences of these Nordic countries to show not only that ‘CO’ can be successfully disallowed, but that this is the only workable solution to avoid the many negative consequences of ‘CO’ on women’s health.

Sweden

The Swedish Abortion Act [9] (enacted in 1975) gives women the right to safe abortion on request without delay. It is a rights-based law (not in the criminal code) and women cannot be punished. Women do not need to state a reason and can self-refer until 18 weeks of pregnancy. Thereafter, they must apply for permission to the Board of Health and Welfare and an indication (reason) is required. After 18 weeks,

the law has no fixed upper limit or restrictions as to reason, but in practice, abortions are done for social indications up to 21 weeks and 6 days, with no gestational limit for pregnancies of non-viable fetuses or those that pose a risk to the woman's life.

All hospital obstetrical/gynaecological departments are obligated by law to perform abortions without delay up to 18 weeks on request and thereafter as soon as permission is granted. A central committee deals with the applications every week or earlier if needed. Less than 1% of abortions occur after 18 weeks and the majority are for serious foetal abnormalities.

Compared to most other western countries, access to abortion is arguably better in Sweden. Unlike in most countries, Swedish women do not need to travel for abortion, which shows that the law is meeting their needs. Hospitals are located throughout the country and all of them do abortions, along with some private clinics. Midwives can provide medical abortion, as well as contraceptive counselling, prescriptions, and aftercare. Abortion is viewed as emergency care and is therefore free for refugees. For Swedish women, the cost is the same as for all other public health care – about 20–30 Euros, which covers the abortion and all associated services, including contraceptive counselling and prescriptions. Women travelling from any other country must pay the full cost of the abortion, but it is done within the public system and not by private clinics who could profit from it. About 93% of abortions occur in the first trimester (up to 12 weeks), over 50% are done before 7 weeks, and medical abortions account for 90% of abortions before 9 weeks gestation.[10]

The political situation is generally supportive in regards to the liberal abortion law, and the population is largely in favour of it. The anti-choice movement is relatively small and has limited political influence, although a few smaller political parties and the growing Swedish Democratic Party are anti-choice.

The Abortion Act does not have any specific clauses related to 'CO', but not allowing 'CO' for abortion has become a stable policy in Sweden and has been confirmed by the courts (more below). Sweden's Prime Minister officially supports this ban on 'CO'. The Swedish Parliament has consistently rejected proposals [11] to enact a conscience clause for HCPs. Medical authorities have stated that those who object to performing abortions (or inserting intrauterine contraception) cannot become obstetricians/gynaecologists (Ob/Gyns) or midwives. Abortion care is included in the curricula for all medical students, and those who wish to become an Ob/Gyn or midwife must have mandatory training in abortion care. There is no way to opt-out.

The policy ban on 'CO' appears to work well, and is a contributing factor to the good accessibility of abortion in Sweden. Most anti-choice medical and nursing students are dissuaded from entering the specialties of obstetrics/gynaecology or midwifery, since they may not be able to obtain certification or employment without the ability and willingness to perform abortions. Problems sometimes occur with doctors or midwives trained abroad, who may not know how to perform abortions or have objections to it. However, the head of the clinic or Ob/Gyn department can refuse to employ a doctor or midwife who refuses to provide abortion or contraceptive counselling.

Occasionally, Sweden is targeted for anti-choice initiatives around 'CO', and abortion opponents have recently become more systematic and better organised in their attacks. Even so, all initiatives have failed so far. In June 2015, the European Committee of Social Rights (ECSR) rejected claims [12] by the Federation of Catholic Family Associations in Europe (FAFCE) that Swedish health care providers had a right to 'conscientious objection' and could refuse to provide abortion services under the European Social Charter:

Two other challenges to the ban on 'CO' are still pending but do not appear to pose much of a threat to the status quo. In 2013, a Swedish midwife's contract was rescinded [13] by a hospital because she refused to provide abortions (she was also against intrauterine contraception). She was later rejected from other hospitals where she applied because they required her to provide abortions. She filed a complaint, which was denied [14] by Sweden's Equality Ombudsman, and later in 2015 a district court in Sweden also ruled against her.[15] The public interest of having safe and accessible abortion care was deemed more important than her freedom of religion. Public sentiment also went against her, with most people questioning why she was engaged in a profession that required provision of abortion services if she was against it. However, the case is being carefully staged by the anti-choice movement, and in March 2015, the midwife appealed [16] to the United Nations Human Rights Council where the case is still pending.

In May 2015, the right-wing European Center for Law and Justice filed a complaint [11] at the United Nations on behalf of four Swedish midwives, three general practitioners, and two pediatricians. The complaint alleges a 'systemic violation of the freedom of conscience of medical staff in Sweden'. However, there is no mention of the right of patients to health care anywhere in the 11-page complaint, which could prove to be its downfall. The reason that challenges to the 'CO' ban have failed so far is because courts and tribunals have basically ruled that the right of women to reproductive health care outweighs the right of HCPs to refuse care on the basis of personal beliefs.

Finland

The Finnish Act on Termination of Pregnancy [17] (passed in 1970) allows abortion up to 20 weeks gestation, but one of the following reasons must be provided:

- Economic or social indications (continuation of pregnancy constitutes a significant burden).
- Age (<17 or ≥40 years of age when the pregnancy was conceived).
- Parity (the woman must have already delivered four or more children).
- Sexual violence.
- 'Disease or physical defect' in the woman that would interfere with her ability to care for the child or endanger her health if pregnancy continues.

A woman 'applies' for an abortion simply by attending a doctor's appointment and signing a form. The physician must consider her application and provide a referral as appropriate. For pregnancies up to 12 weeks where the woman is between 17 and 39 years, two physicians are required to approve the abortion – the primary care doctor who refers, and the hospital physician who performs the abortion. About

92% of abortions are performed in the first trimester, mostly for social reasons, such as a stressful life situation.

All abortions after 12 weeks require approval from the National Supervisory Authority for Welfare and Health. Between 12 and 20 weeks, abortions are similarly allowed for social, age, parity, or sexual violence indications, foetal indications, and in cases of 'disease or physical defect' in the woman. Abortion is also allowed up to 24 weeks in cases of serious and medically confirmed foetal anomaly.

All abortions must be done in approved 'abortion hospitals,' usually public hospitals with an Obstetrics/Gynaecology department, but also some private hospitals.

Medical students are given training to allow them to work as GPs (general practitioners) in primary health care, so they must be familiar with abortion legislation and care, and be able to act as the referring physician. Although some primary care doctors might be reluctant to care for women seeking abortion, patients are being directed to other physicians. Students entering the Ob/Gyn residency programs have mandatory training in abortion care. Thus, all Finland-trained specialists in obstetrics and gynaecology have participated in abortion care at some point in their career.

Refusal to participate in induced abortion by citing personal beliefs ('CO') does not occur [2] in the Finnish health care system. Under the Finnish law, no doctor in a public position – working for a community, public hospital, or the government – can refuse to consider an abortion application. They must either approve it or not, but refusals must be for a legitimate reason. In practice, refusals happen only occasionally, usually when the duration of gestation exceeds the legal limits. Further, all Ob/Gyns and other HCPs working in public gynaecological clinics and wards, including nurses, anaesthesiologists, and midwives, must participate in abortion care.

Although the abortion law is not as liberal as in other western countries, the current system works well. Women have good access to abortion care throughout the country, and care is provided according to comprehensive national guidelines.[18] More than 90% of abortions are performed medically [2] (rather than surgically). For medical abortion, only one visit to a hospital's outpatient clinic is needed, at a cost of 32€ (in 2015). Surgical abortions cost an additional 105€. However, if the woman cannot afford it, society pays the bill.

There is little political controversy over abortion in Finland, and high social acceptance. Although a few parliamentarians have periodically spoken out against abortion, the country has seen no significant political campaigns to restrict abortion since 1970.

There have only been a few reported cases at public hospitals [19] where health care workers have tried to refuse to provide abortion care. Some objecting doctors have had to leave public hospitals because of the requirement to provide urgent medical care in case of pregnancy or abortion complications. Similarly, some midwives have sought alternative jobs or further training voluntarily, while others decided against continuing. The Finnish Medical Association took a firm stand on the issue and said it was unfair to leave tasks for others to perform.

In 2013, Nieminen et al. [2] examined attitudes about 'CO' amongst medical students and HCPs in Finland. The authors found that the wish to personally exercise 'CO' for induced abortion was relatively low: 3.5% for nursing students and 14.1% for medical students – although the willingness to

allow 'CO' was higher: 10.6% for nursing students and 34.2% for medical professionals.

A 2014 citizens' initiative called for the right of HCPs to refuse to participate in performing abortions on the grounds of personal or religious convictions. By November 2014, the initiative had gathered 50,000 signatures,[20] and it was presented to the Finnish parliament in the fall of 2015 for discussion. It proceeded to the parliamentary committee on social affairs and health for further discussion and work and returned to Parliament for a final debate, where it was rejected in December 2015. Throughout the process, the Finnish Society of Obstetrics and Gynaecology and the Finnish Medical Society opposed the initiative.

Iceland

The first laws on family planning and legal abortion in Iceland (passed in 1935) allowed abortion for medical reasons but also permitted socioeconomic reasons to be taken into account. The practice of abortion, especially for socioeconomic reasons, was quite conservative until 1975. However, doctors could perform abortion on the woman's request by using a medical diagnosis such as 'reactive depression'. This particular diagnosis became more and more common up until 1975, indicating that abortion on request was being performed before the law was reformed in 1975. Even then, a proposed clause to allow free abortion on a woman's request did not pass, while a rule requiring signed authorisation by two HCPs was kept.[21]

The present law allows termination of pregnancy for medical reasons (physical or mental health of the woman or her partner; foetal abnormality or disease), as well as due to rape or criminal activity, and on the following socioeconomic grounds as per Section 9 of the law [22]:

- (1) The woman has had many children at short intervals and recently gave birth.
- (2) The woman lives in disadvantaged or unhealthy conditions.
- (3) Young age and immaturity would prevent the woman from taking adequate care of a child.
- (4) Other reasons that are comparable to the above.

The woman must make a written request and provide reasons. The request must be signed by two doctors, or a hospital doctor and an authorised social worker. A refusal can be appealed to a standing referral committee (three persons including a gynaecologist, a social worker, and a lawyer) under the supervision of the Directorate of Health. Abortions are allowed up to 16 weeks and must be performed in hospitals, but they are covered by national insurance. After 16 weeks, abortions can be performed for serious medical reasons and foetal abnormality, with written permission from the committee.

The interpretation of Section 9.d was brought to the High Court of Iceland in 1997 [23] after a woman in her 14th week of pregnancy was refused an abortion at Landspítali University Hospital. The referral committee confirmed the doctor's refusal. The woman was not prevented by law from applying again at a different hospital, but after she received permission and had the abortion at a nearby rural hospital, the committee accused the performing doctor of an illegal abortion. The doctor was acquitted, and upon appeal the High Court stated that no-one but the woman herself could

decide her reasons for an abortion. As a result, abortion in Iceland is practically allowed on request, but only up to 16 weeks of pregnancy and two signatures of HCPs are still required.

The 1975 Icelandic law does not include any clauses on 'CO' and this issue has not been an issue in the media. The law requires that information and services be made available for women seeking abortion, including medical advice, pregnancy tests, counselling and support, social assistance, and assistance with the application and referral to a hospital. Information and guidance must be provided impartially by HCPs.[22] Training in abortion is also mandatory for Ob/Gyns, although not for midwives or other HCPs.

A handful of HCPs (gynaecologists and midwives) working in the few Icelandic hospitals that provide abortion services have been allowed to avoid direct participation in the services on religious or moral grounds. This does not seem to impact care as almost all HCPs who would normally be involved in abortion care do so. No objectors have been disciplined.

Legal abortion and current abortion practice are generally well-accepted by the majority of Icelandic citizens. At least 70% belong to the Icelandic National Church, but relatively few people are devout and religious arguments are seldom used in the abortion debate. Religious leaders such as the bishop of the Icelandic National Church have criticised the 'high' number of abortions in Iceland (rates have declined substantially despite population increases since the late 1990s) but these religious authorities exhibit a relatively liberal standpoint: they respect the law and the individual's conscience, including women's freedom of choice on abortion.[24] Smaller religious communities are generally more anti-choice, however. A tiny anti-choice movement advocates the banning of abortion using religious arguments but their influence is negligible. On a few occasions since 1975, anti-choice advocates have persuaded several conservative members of Parliament to propose a more restrictive abortion law, but the bills never proceeded through the legislature.[25]

What the countries with no 'CO' have in common

Sweden, Finland, and Iceland are known as countries with high levels of gender equality with a strong social safety net, as well as limited religious influence. Birth rates remain somewhat higher than in most other western countries, especially for Iceland, and most women are employed despite having children. Teenage birth rates are among the lowest globally and education is generally of a high standard. Access to abortion ranges from good to excellent and services are high-quality and well-organised, at least in part because abortion care is recognised as basic medical care for women. It is a funded part of the public service in all three countries, and is provided in every region in all hospitals. This helps reduce access barriers due to geographic challenges in the north of Sweden and Finland and in rural areas of Iceland, where there may be long distances to health facilities and extreme weather conditions.

Conversely, we know that the harmful impacts [1] of 'CO' seen in countries that allow it, including disrespect for women, reduced access to health care services, and accompanying risks to their health and lives, are absent in these

Nordic countries. All three nations rank in the top five in the world when it comes to the well-being of mothers and children, showing that excellent maternal health outcomes are closely correlated with a lack of 'CO'. [26]

A key feature common to the three countries is the mandatory training in abortion care for Ob/Gyns (and midwives in Sweden). This aspect has a significantly positive effect for everyone involved:

- For women: It guarantees that all Ob/Gyns can and will perform abortions under the legal framework, ensuring quick and non-judgmental access.
- For colleagues: It means that the workload will be shared fairly, and no-one can opt out of part of their professional duties or be judged because of providing abortion care.
- For objectors: They are informed in advance of the incompatibility between their beliefs and the professional duties of an Ob/Gyn, and can choose another speciality in time.
- For society: There is no negative impact on women or HCPs from 'CO' and nothing to regulate.

Anti-choice objections do not align with human rights

Anti-choice campaigners involved in the Sweden and Finland initiatives to allow 'CO' have cited the Council of Europe's ruling in 2010 [27] that all member states of the European Union must guarantee the freedom of conscience to refuse to take part in performing abortions. Unfortunately, the process leading up to the Council of Europe's decision was hijacked [28] by anti-choice members. The original pro-choice resolution was completely gutted, and even hospitals were given the 'right' of conscience. But of course, only individuals can have a conscience, never institutions.

The campaigners also cited the fact that almost all other European countries allow 'CO'. However, this cannot serve as evidence for the necessity or justice of 'CO'. As detailed in the paper on 'dishonourable disobedience'[1], allowing any degree of 'CO' is unworkable and damaging, violates the rights of patients, and amounts to a breach of professional and public duties. The anti-choice initiatives to introduce conscience clauses in Sweden and Finland are driven by anti-choice politics, sexism, and the entitlement that some HCPs think they deserve – not by evidence, patient safety, or human rights.

'Conscientious objection' in reproductive healthcare amounts to a capitulation to anti-choice views without any benefit to women or society. It can be seen as an objection to the legality of abortion, and a backdoor attempt to limit the accessibility of safe abortion. In that sense, 'CO' tries to turn back the clock to the days when women died from unsafe, illegal abortion. A woman in Poland died [28] in 2010 after being refused a legal abortion by objectors. But women have also died or were seriously injured after being refused an abortion because it was against the law, as per recent reports from Ireland,[29] Nicaragua,[30] and El Salvador.[31] Abortion is still illegal in large parts of Africa, Asia, and Latin America, and a few countries in Europe. An estimated 47,000 women [32] die every year and almost 7 million [33] are injured from unsafe, usually illegal abortion.

The difference between an abortion refusal because of the law or because of 'CO' is only a matter of degree. For too many women, the experience is the same – disrespect, suffering, and even death.

Lessons from the Nordic countries

What lessons could other countries learn from the examples of Sweden, Finland, and Iceland? First, we can see that it's not at all necessary to accept the refusal to treat under the guise of 'CO'. The experiences of the Nordic countries confirm that it's possible to prioritise evidence-based medicine, rational arguments, and democratic laws over faith-based refusals to treat. The absence of 'CO' does not reflect a problem that needs to be fixed – on the contrary, the fact that women have good access to abortion is due in part to the lack of 'CO'. Disallowing 'CO' is therefore not only a sensible and workable approach, but a generally positive one.

Second, there is nothing wrong with holding HCPs accountable for their professional obligations to patients, and no negative impact. Almost all HCPs and medical students in Sweden, Finland, and Iceland who object to abortion or contraception can find work in another field of medicine. Only a tiny number of HCPs still want to work in the field they have some objections to, primarily those with another cultural background or who trained abroad.

Third, disallowing 'CO' aligns with the advancement of human rights over the last few centuries, including the establishment of democratic societies, racial and gender equality, the abolition of slavery, and other human rights advances.

Conclusion

The key to disallowing 'CO' and maintaining that ban despite challenges requires a strong prior acceptance of women's civil rights on the part of government and society, including their right to comprehensive health care. While religious beliefs of HCPs should be respected on an individual level, in the same way as anyone else's personal beliefs, HCPs have a public obligation to not impose their beliefs onto patients.

The examples of Sweden, Finland, and Iceland should be taken up by other countries and promoted by professional medical bodies so that we can reach the positive goals of eventually disallowing 'CO' entirely in reproductive health care, and eradicating the stigma still associated with abortion, one of the most common medical procedures.

Disclosure statement

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

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