

Submission to the UK All-Party Parliamentary Group on Population, Development and Reproductive Health (APPG)

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From:

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“Conscientious Objection” Clause in 1967 Abortion Act is Obsolete

Thank you for the opportunity to make a submission. We would like to summarize the problems with allowing so-called “conscientious objection” (CO) and why it is harmful and inappropriate in health care, explain how CO was only included in the 1967 Abortion Act for pragmatic reasons to get the law passed, and argue that the clause allowing CO is obsolete and no longer needed.

CO is wrong and inappropriate in health care

The refusal by some HCPs to treat women with an unwanted pregnancy is misleadingly called “conscientious objection”. Individuals are being allowed to boycott a democratically decided law because of society’s deference to religious beliefs and traditional views that assign women to a childbearing role.

This points to an improper and unethical basis for CO in reproductive health care—one that has little in common with the military CO it is dishonestly named after. Objectors to military service must justify their stance, are often required to undergo a rigorous review process, and may be punished or required to complete an alternate service. In contrast, health care professionals

(HCPs) usually face no obligation to justify their refusals, rarely face any disciplinary measures, retain their positions, and even have their objection protected by law and policy. Further:

- Physicians have a monopoly on the practice of medicine, with patients completely reliant on them for essential health care. The medical profession fulfills a public trust, making doctors duty-bound to provide care without discrimination. CO allows health-care professionals to abuse their position of trust and authority by imposing their personal beliefs on patients.
- Doctors are in a privileged position. They chose and willingly trained for their profession, with the full understanding that it entails duties to patients and an obligation to provide safe and necessary medical care. The specialty of Obstetrics/Gynecology in particular carries with it the obligation to help women with unplanned pregnancies.
- It is not an issue of "competing rights" between the HCP and patient. There is no "balance" when an authority figure is allowed to impose their beliefs on a dependent person. Women's right to life and health has no moral equivalency with HCPs' supposed right to refuse them care.

Harms of “conscientious objection”

The exercise of so-called “conscientious objection” (CO) for abortion has been increasing around the world and has become a major impediment to the delivery of essential reproductive health care to women, especially in developing countries. Regardless of CO regulations in some countries (including the UK) that require objectors to provide referrals and/or emergency treatment, many objectors refuse to make referrals because they feel it makes them complicit, and pregnant women have suffered serious injury or been left to die by objectors who refuse to provide a life-saving abortion under the law.^{1, 2}

Because of these inescapable harms, an evidence-based approach should be adopted that disallows and imposes sanctions on the refusal to treat women with an unwanted pregnancy, in the same way that any other negligent action by a HCP would lead to censure and discipline.

This position is evidence-based and not uncommon – many others argue persuasively against the practice of CO not only in reproductive health care, but health care in general.^{3, 4, 5, 6} The refusal of care for personal reasons – when that care is legal and an expected part of the health care professional’s area of work – goes against medical ethics and professional obligations, and is therefore inappropriate in health care.

We have presented evidence for our views in several published papers, with excerpts below:

From the paper: ‘Dishonourable disobedience’ – Why refusal to treat in reproductive health care is not conscientious objection:⁷

Current laws and practices in various countries around CO in reproductive health care show that it is unworkable and frequently abused, with harmful impacts on women's health care and rights. CO in medicine is supposedly analogous to CO in the military, but in fact the two have little in common.

CO in reproductive health is not actually Conscientious Objection, but Dishonourable Disobedience to laws and ethical codes. Health care professionals who exercise CO are using their position of trust and authority to impose their personal beliefs on patients, who are completely dependent on them for essential health care. Health systems and institutions that prohibit staff from providing abortion or contraception services are being discriminatory by systematically denying health care services to a vulnerable population and disregarding conscience rights for abortion providers.

From the paper: *There Is No Defence for 'Conscientious Objection' in Reproductive Health Care:*⁸

A widespread assumption has taken hold in the field of medicine that we must allow health care professionals the right to refuse treatment under the guise of 'conscientious objection' (CO), in particular for women seeking abortions. At the same time, it is widely recognized that the refusal to treat creates harm and barriers for patients receiving reproductive health care. In response, many recommendations have been put forward as solutions to limit those harms.

'CO' in reproductive health care should not be considered a right, but an unethical refusal to treat. Supporters of CO have no real defense of their stance... Refusals to treat are based on non-verifiable personal beliefs, usually religious beliefs, but introducing religion into medicine undermines best practices that depend on scientific evidence and medical ethics. CO therefore represents an abandonment of professional obligations to patients. Countries should strive to reduce the number of objectors in reproductive health care as much as possible until CO can feasibly be prohibited.

From the article: *Yes we can! Successful examples of disallowing 'conscientious objection' in reproductive health care*⁹

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 laws and experiences of these countries 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.

Origin of CO in health care can be traced back to 1967 UK law

In our research on the origin of CO, we have found that CO in health care overall is a relatively new phenomenon that began only with the legalization of abortion in the UK (1967) and the US (1973)¹⁰.

The 1967 Abortion Act in the UK was the first law in the world that explicitly granted the right to CO in health care. Section 4 of the Act says:

4 (1) ...no person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorised by this Act to which he has a conscientious objection: Provided that in any legal proceedings the burden of proof of conscientious objection shall rest on the person claiming to rely on it.

4. (2) Nothing in subsection (1) of this section shall affect any duty to participate in treatment which is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman."

Mark Wicclair of the Center for Bioethics and Health Law in West Virginia is a recognized expert on CO. In his 2011 book *Conscientious Objection in Health Care: An Ethical Analysis*,¹⁰ he notes in the first chapter that he was unable to find any academic articles on the topic prior to the 1960's. Although his history focuses almost entirely on the U.S. in the 1970's and later, he recognized the UK 1967 abortion law as the first instance of officially-protected CO. (In the U.S., the first conscience clause law was 1973 U.S. federal legislation that was a reaction to *Roe v Wade*, the Supreme Court decision that legalized abortion in Jan 1973, as well as to a court decision requiring a Catholic hospital to allow a doctor to do a tubal ligation.)

According to the following anti-abortion source, it was doctors and their professional organizations who wanted the CO clause in the UK Abortion Act, based on their desire to protect their decision-making role and their unwillingness to accede to women's requests for abortion, as well as an aversion to act against their personal beliefs:¹¹

There were predictions that abortion on demand would inevitably follow. The BMA, Royal College of Obstetricians and Gynaecologists (RCOG) and other professional bodies were concerned that the doctor's role would shift from medical decision-maker to arbiter of social issues. It was suspected at the time that this would prove unworkable and the woman's attitude to pregnancy would be the ultimate determinant of whether she received an abortion. The bill's supporters rebuked these fears: 'it is only in extreme cases that a woman wants to terminate her pregnancy.'

This [CO clause] was not in the original bill, but was introduced in response to concerns that doctors would be under pressure to perform terminations against their beliefs. Interestingly, one amendment that didn't make the final Act proposed that, 'no person [shall be] deprived of, or be disqualified from, any promotion or other advantages by reason of the fact that he has such conscientious objection.'

...the conscientious objection clause was a concession that had to be made in order to get the legislation passed.

CO clause should be repealed

Fifty years after the UK introduced CO into health care, but only for abortion, the exercise of CO has been hugely expanded around the world and is *still* exercised almost entirely for abortion and other reproductive health care such as contraception and sterilization. (It's only recently that a few countries now allow CO for medical assistance in dying). In our article ***There Is No Defence for 'Conscientious Objection' in Reproductive Health Care***, we argue:⁸

It is likely that society has continued to accept CO because abortion still remains criminalized to some degree almost everywhere and is still highly stigmatized. Also, much of society retains traditional (sexist) beliefs about women and motherhood, and the Catholic Church is still powerful enough to enforce those beliefs. But why should society support CO at all in the 21st century? We now understand the necessity and value of access to safe and legal abortion for women, which means supporting CO just cedes ground to those who defend archaic social mores and traditional roles of women. As such, CO weakens the causes of reproductive rights and women's equality.

In the UK (except for Northern Ireland), doctors are allowed to object in the public system, but the National Health Service contracts out most abortion care to the private organizations British Pregnancy Advisory Service and Marie Stopes, who of course do not hire objectors. This means that CO is mainly a problem in public health facilities, and that granting HCPs the right to refuse part of their professional duties, while continuing to pay their salary, represents a misuse of public funding among other aspects. Privatizing abortion care in the UK minimizes the harms of CO because it results in far fewer objectors. But it also abdicates delivery of an essential health service to the private sector (even though funded by the NHS). Ideally, CO should not be allowed at all so that public hospitals can take on more responsibility to deliver abortion care. Public delivery would also help destigmatize abortion care. Other countries such as Portugal and Norway require all public hospitals to provide abortions.

Interestingly, England and Norway both have low numbers of objectors,¹² which may also relate to low levels of religiosity in both countries. However, the authors of the above cited paper (Chavkin et al.¹²) are wrong in asserting that CO regulation can accommodate objectors – in fact, the most successful CO regulations reduce the numbers of objectors to very low levels, which in itself is evidence that CO is inherently harmful and should be prohibited entirely, especially when low levels of objectors have been reached.

Conclusion

Given the evidence and arguments against the exercise of CO, we recommend that the CO clause in the 1967 Abortion Act be amended to ban CO entirely, and a monitoring and enforcement system be implemented against objectors.

Preferably, the entire 1967 law should be repealed since abortion does not need extra legislative control as proven by Canada's 29-year history of no abortion law.¹³ In this case, a positive (civil) law or policy could replace the current UK law, with the only goals to ensure and expand access to abortion, advance women's health and rights, and safeguard licensed providers from discrimination and prosecution. Such a law or policy should include a prohibition of CO as one of the measures to improve access.

The existing CO clause in the UK's 1967 Abortion Act may have been a necessary compromise to pass the law at the time, but it no longer serves any valid purpose. Allowing CO in health care is harmful, inappropriate, and outmoded. As the global initiator of CO laws, the UK can set a powerful example to the world by banning CO, thereby encouraging other countries to follow its example – in particular developing countries where restrictive laws combined with abortion stigma and rampant CO make access extremely difficult for women.

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1. Center for Reproductive Rights. *Abortion opponents undercut council of Europe resolution on conscientious objection*. 2010 (Oct 7). <http://reproductiverights.org/en/press-room/abortion-opponents-undercut-council-of-europe-resolution-on-conscientious-objection>
 2. Fiala, C. and Arthur J.H. *Victims of CO* (Conscientious Objection). 2016. <http://www.conscientious-objection.info/category/victims-of-co/>
 3. Stahl, R.Y., Emanuel, E.J. Physicians, Not Conscripts – Conscientious Objection in Health Care. *New England Journal of Medicine*. 2017; 376:14: 1380-1385. <https://cathmedflorida.org/wp-content/uploads/White.pdf>
 4. LaFollette H. / Munthe, C. et al. / Kennett J. (Three separate articles) My Conscience May Be My Guide, but You May Not Need to Honor It / The Legal Ethical Backbone of Conscientious Objection / The Cost of Conscience. *Cambridge Quarterly of Healthcare Ethics*. 2017; 26:1: 44-81. <https://www.cambridge.org/core/journals/cambridge-quarterly-of-health-care-ethics/issue/98F0F093F8904469C0A25D5DEACFA92A>
 5. Schuklenk, U., Smalling, R. Why medical professionals have no moral claim to conscientious objection accommodation in liberal democracies. *Journal of Medical Ethics*. 2016; 43:4: 234-240. <http://jme.bmj.com/content/early/2016/04/27/medethics-2016-103560>
 6. Giubilini, A. Objection to Conscience: An Argument Against Conscience Exemptions in Health care. *Bioethics*. 2016; 31:5. <https://www.ncbi.nlm.nih.gov/pubmed/28008640>
 7. Fiala, C., and Arthur J.H. "Dishonourable disobedience" – Why refusal to treat in reproductive health care is not conscientious objection. *Woman - Psychosomatic Gynaecology and Obstetrics*; 2014; 1: 12–23. <http://www.sciencedirect.com/science/article/pii/S2213560X14000034>
 8. Fiala, Christian, and Joyce H. Arthur. There is no defence for 'Conscientious objection' in reproductive health care. *European Journal of Obstetrics & Gynecology and Reproductive Biology*. July 2017. <http://www.sciencedirect.com/science/article/pii/S0301211517303573>

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- 9 Fiala, Christian, Kristina Gemzell Danielsson, Oskari Heikinheimo, Jens A. Guðmundsson, and Joyce Arthur. 2016. Yes we can! Successful examples of disallowing 'conscientious objection' in reproductive health care. *European Journal of Contraception & Reproductive Health Care*.
https://www.gynmed.at/sites/default/files/publications/yes_we_can_successful_examples_of_disallowing_conscientious_objection_in_reproductive_health_care.pdf
 - 10 Wicclair, Mark, 2011. *Conscientious Objection in Health Care: An Ethical Analysis*. Cambridge University Press.
 - 11 Engel, Jacky. Abortion Law Reform. *Nucleus*. 2004, 11-19. As cited by Christian Medical Fellowship:
<https://www.cmf.org.uk/resources/publications/content/?context=article&id=748>
 - 12 Chavkin, Wendy, Laurel Swerdlow, and Jocelyn Fifield. 2017. Regulation of Conscientious Objection to Abortion: An International Comparative Multiple-Case Study. *Health and Human Rights Journal*. Vol 19, No.1. <https://www.hhrjournal.org/2017/06/regulation-of-conscientious-objection-to-abortion-an-international-comparative-multiple-case-study/>
 - 13 Arthur, Joyce, and Jane Cawthorne. 2013. *The Benefits of Decriminalizing Abortion*. Abortion Rights Coalition of Canada. <http://www.morgentaler25years.ca/benefits-of-decriminalization/>