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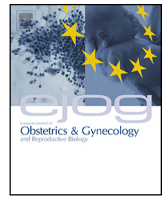

Review article

There is no defence for 'Conscientious objection' in reproductive health care

Christian Fiala[a], Joyce H. Arthur[b,*]

[a] Obstetrics and Gynecology Gynmed Clinic, Vienna, Austria[1]
[b] Abortion Rights Coalition of Canada, POB 2663, Station Main, Vancouver, BC, V6 B 3W3, Canada[2]

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ABSTRACT

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. Further, some researchers make a distinction between true CO and 'obstructionist CO', based on the motivations or actions of various objectors.

This paper argues that 'CO' in reproductive health care should not be considered a right, but an unethical refusal to treat. Supporters of CO have no real defence of their stance, other than the mistaken assumption that CO in reproductive health care is the same as CO in the military, when the two have nothing in common (for example, objecting doctors are rarely disciplined, while the patient pays the price). 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. Several Scandinavian countries already have a successful ban on CO.
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Introduction

In the past few years, there has been much concern and contention over the exercise of 'conscientious objection' in reproductive health care (CO), which is usually defined as the refusal by a health care professional (HCP) to provide a legal medical service or treatment for which they would normally be responsible, based on their objection to the treatment for personal or religious reasons.

* Corresponding author at: Department of Women's and Children's Health, Karolinska Institutet, Stockholm, Sweden.
E-mail addresses: christian.fiala@aon.at (C. Fiala), joyce@arcc-cdac.ca (J.H. Arthur).
[1] www.gynmed.at
[2] www.arcc-cdac.ca

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Two main aspects have emerged in the defence of CO: a widespread assumption that we must allow HCPs the right to refuse treatment, and a wave of recommendations that attempt to offer solutions to prevent the harms and barriers that CO creates, in particular for women seeking abortions.[3]

As demonstrated in a previous paper by the authors, so-called 'conscientious objection' (CO) as used in reproductive health care is a term falsely co-opted from military CO and has nothing in common with it [1]. For example, soldiers are drafted into compulsory service, are relatively powerless, and accept punishment or alternate service in exchange for exercising their CO; while doctors choose their profession, enjoy a position of power and authority, and rarely face discipline for exercising CO. Therefore, CO should more correctly be called 'dishonourable disobedience'[1] because it is a refusal to treat based on personal and non-verifiable beliefs, which is inappropriate and harmful in reproductive health care. It represents an abuse of medical ethics and professional obligations to patients.

Our position is not peculiar or uncommon – many others argue persuasively against the practice of CO not only in reproductive health care, but health care in general [2,3,4,5].

Is refusing patients a 'right'?

Remarkably, pro-choice researchers and ethicists who support CO in reproductive health care rarely try to defend the practice beyond a simple assertion that individual conscience is an important right. Certainly this is true for everybody in general, but in the field of reproductive health care, there has been little or no recognition of how CO unjustly privileges doctors' conscience over patients' conscience, not to mention their life and health [1]. The granting of CO also gives legitimacy to the religiously-based assumption that abortion is wrong – however, providing safe abortion is an ethical practice that has saved the lives and protected the rights of millions of women. Moreover, doctors have obligations to their patients and the public. They occupy a privileged position of trust and responsibility in our society, and profit from a monopoly on the practice of medicine.

CO in health care overall is a relatively new phenomenon that began only with the legalization of abortion in the UK (1967) [6] and the US (1973) [7]. Even today, almost all CO is exercised for abortion, as well as other reproductive health care such as contraception and sterilization. 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 21 st 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.

The problem with assuming CO as a right is exemplified by an article that objects to the 'Improper Use of Conscientious Objection in Bogotá, Colombia', by Vélez and Urbano [8]. This article in turn is a response to 'The Fetus Is My Patient, Too' [9], a study by Fink et al. about attitudes to abortion provision and referral by objecting doctors in Bogotá Colombia.

Vélez and Urbano's main criticism of the Fink et al. study is its division of objectors into 'extreme, moderate, and partial'. They claim that only some of these objectors are true objectors from conscience, while others are obstructing the service and disobeying the law, which is not conscientious objection and should not be called that. This misses the point of Fink et al.'s study, which was simply to categorize objectors' perspectives with the aim of finding possible interventions to reduce CO as a barrier to care. Instead, Vélez and Urbano draw a dividing line between the supposed true ethical use of CO and the false harmful kind.

In reality, there is only one kind of CO in reproductive health care: the refusal to provide a legal treatment that the patient requests and needs, based on the provider's subjective, personal belief that the treatment is immoral. Whether that belief is sincere or pretended, extreme or moderate, is irrelevant because CO is harmful in any case. It denies patients' right to health care and moral autonomy, and has negative consequences for them. The extent of harm of CO is on a continuum, and is often much worse than a short delay – women needing abortions have been left to suffer serious injury or even die [10,11]. But even if the harm seems minimal – i.e., the objector refers appropriately and the patient receives services promptly, refusals are still inherently wrong and harmful. The provider is deliberately refusing to do part of their job for personal reasons, thereby abandoning their fiduciary duty to patients, while still expecting payment and no negative consequences. It also discriminates based on gender and pregnancy because reproductive health care is largely provided to women. Finally, refusals demean a woman by undermining her dignity and autonomy, and sending a negative message that stigmatizes her and the health care she needs [12].

A telling point about the true nature and intention of CO was made in 2016 by Harris et al. [13], who support the right to exercise CO. They state that it is 'the only legal way to refuse to provide abortions that are permitted by law.' In effect, the state is allowing objectors to personally boycott democratically-decided laws, usually for religious reasons, without having to pay any price for it. But why should doctors be given a privileged exemption from otherwise valid laws, when similar actions by other workers who serve the public would be treated as illegal or discriminatory and result in punishment for the workers?

The largely religious and non-verifiable basis of CO makes the laws and policies that try to limit its exercise impossible to enforce. The inability to control CO has especially negative consequences in countries with a lot of objectors. In such countries (Italy [14] and South Africa [15] are just two of many examples), abuse of CO is rampant, with many objectors refusing to stay within the limits defined by law. This points to another fundamental contradiction of 'CO': it is impossible to reconcile faith-based medicine with evidence-based medicine. If we allow the former to exist, faith wins by default because we cannot argue rationally against it or control it.

Can we identify 'true CO'?

Vélez and Urbano imply that CO for reasons of true conscience can somehow be identified and protected, as opposed to obstructionist CO. But they fail to explain or give examples of how to do this.

Anti-choice HCPs might claim they are motivated by 'respect for unborn life' (for example). But that raises the issue of how we cannot rely on peoples' stated justifications since one's personal or religious beliefs cannot be verified or falsified on a rational basis, including how genuinely such beliefs are held. It is also

[3] We focus on the harms of CO for abortion care specifically, because the latter is our main interest. However, most of our arguments apply to other reproductive health care such as contraception, vasectomy, etc., as well as other contested areas of health care such as medical assistance in dying.

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