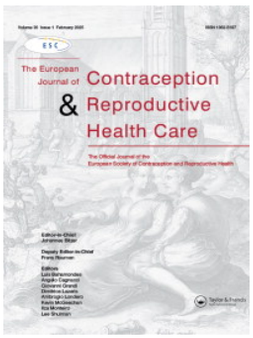

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COMMENT

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How to discourage belief-based denial of abortion care

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ABSTRACT

The exercise of so-called 'conscientious objection' in reproductive healthcare is unchecked and subject to widespread abuse. A growing body of evidence shows that the practice creates significant harms for patients needing abortions by delaying their care or depriving them of care, sometimes even costing their lives. We have coined the more accurate term 'belief-based care denial' as the phrase 'conscientious objection' was inappropriately co-opted from military conscientious objection, with which it has nothing in common. In this article, we note the evidence against belief-based care denial, refute fallacies in the views that support the practice, and recommend measures to reduce the number of care deniers over time, with the prospect of an eventual return to the ethical standard that obligates healthcare professionals to provide medical care.

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In July 2024, the United Nations Working Group on Discrimination Against Women and Girls found that the exercise of so-called 'conscientious objection' in reproductive healthcare is unchecked and subject to widespread abuse [1]. A growing body of evidence shows that the practice creates significant harms for patients needing abortions by delaying their care [2] or depriving them of care, sometimes even costing their lives [3].

We have coined the more accurate term 'belief-based care denial'[1] to emphasise that the practice is ideological and negatively impacts patients. The phrase 'conscientious objection' was inappropriately co-opted from military conscientious objection, with which it has nothing in common.[2]

In this article, we note the evidence against belief-based care denial and refute fallacies in the views that support the practice. We recommend measures to reduce the number of care deniers over time, with the prospect of an eventual return to the ethical standard that obligates healthcare professionals to provide medical care, and a consensus that belief-based care denial is as unethical and unacceptable in abortion care as it is in medicine generally.

Questionable origins and ethics of belief-based care denial

The United Kingdom was the first country in the world to codify belief-based care denial into healthcare, when it passed the *Abortion Act* in 1967 [4]. Jonathan Montgomery stated in 2015:

> …'conscientious objection' as set out in section 4 of the 1967 *Abortion Act* needs to be understood as an act of heresy, a departure from the orthodox professional identity. … In a twenty-first century context, once the historical contingencies of the Abortion Act's conscience clauses are recognised, the case for a specific exemption is dramatically reduced. It is no longer necessary for such a clause to be in place to secure collective medical support for abortion services. [5]

We have argued elsewhere [6,7],[3] along with many other researchers [8], that belief-based care denial violates medical ethics, constitutes a misuse of physician authority, undermines gender equality, harms patients, and violates their rights. The practice is unethical in both its consequences and its nature because it reverses the prime ethical directive in medicine of putting patients first [9], and vacates a doctor's fiduciary duty [10] to patients.

While some countries impose limits on the exercise of belief-based care denial – such as a requirement to refer – these are rarely monitored or enforced, allowing abuse and expansion of the practice. Moreover, it appears that belief-based care denial cannot be effectively accommodated by any of the regulatory models commonly offered.[4] Many have proposed or support a system that would allow belief-based care denial while also ensuring patients' access to care – however, these two aims stand in contradiction and imply that a healthcare professional's (HCP) interest in refusing care is morally equivalent to the patient's need for healthcare.

For example, Rodgers and Blackshaw [11] recognise that large numbers of objectors in a health system pose a significant barrier to abortion care. They recommend a quota system to limit the number of medical trainees in specialties where they would deny care. The authors note the challenges in effectively implementing such a system, but offer as a defence that belief-based care denial has 'considerable value' and a quota system 'is certainly preferable to the risk of conscientious objection provisions being removed'. Those opinions are not explained further.

Indeed, two common elements across much of the literature on belief-based care denial for abortion are: (1)

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treating the practice as a recognised right that requires no explicit defense, and (2) tacit acceptance of the belief that abortion is unethical.

Harms of belief-based care denial

Supporting care denials for abortion means overlooking how the practice reinforces stigma and increases barriers to abortion access. For example, de Londras et al. found that the practice is associated with 'increased workload, stigmatisation, and personal ethical challenges' for HCPs, and 'stigma, judgement, refusal, inaccessibility, and unforeseeability about the availability of care' for the patient.[5] According to the authors, belief-based care denial 'goes beyond 'opting out' of providing care and extends into seeking to prevent abortion through dissuasion, misinformation, misdirection, delay, and sometimes abuse'. Further, they pointed to a study showing that the practice contributes to increased abortion-related morbidity and mortality in Africa, and to four studies indicating that belief-based care denial increases 'broad health system and social costs'.[6]

Krawutschke et al. found that belief-based care denial can impose 'barriers to both early and late abortion provision and especially in the last procedural steps' [12]. One major effect was to reduce the number of abortion providers and assisting personnel – in one mid-sized city in Germany, only 4 of 58 gynaecologists provided abortion, with personal moral beliefs playing an important role [12, pg 4]. In Italy, 71% of gynaecologists are registered as so-called 'conscientious objectors', resulting in reduced abortion access at the local level and longer waiting times [13].

Comprehensive abortion care is an essential health service according to the World Health Organisation [14]. The WHO notes that inaccessibility of safe abortion care can violate a range of human rights of women and girls, not least of which are substantial risks to life and health, as between 4.7% and 13% of maternal deaths are linked to unsafe abortion [14]. Indeed, countries that maintain restrictive laws have significantly higher mortality rates [15], while countries that legalise abortion see mortality rates plummet. Romania [16] and the United States [17] are well-studied examples.

When patients attempt to access care in a world where abortion is still stigmatised and legally restricted almost everywhere, belief-based care denial serves as a political tool to erect even more barriers to access, putting patients' lives in danger, and in effect contributing to ongoing gender oppression (as only women and some transgender people need access to abortion). The provision of safe, legal abortion is therefore a vital public interest that saves health and lives and empowers women. In this light, belief-based care denial should be seen as unethical and unsupportable.

Rebutting the defences of belief-based care denial

Many have offered defences of belief-based care denial, which we list and rebut as follows:

- Equating it with the right of conscience itself, or assuming that it naturally flows from the right of conscience.[7] But international human rights agreements do not recognise belief-based care denial as a right [19]. Further, this notion depends on the parallel with the misappropriated term 'conscientious objection'.
- Asserting that the rights of HCPs and patients should be 'balanced' [20]. This disregards that providers are in a position of power and patients are dependent on them. HCPs rarely face repercussions for care denial while patients largely bear the burden, including violations of their rights to life and health, bodily autonomy, liberty, equal protection, gender equality, privacy, dignity, and conscience.
- Ignoring or misrepresenting[8] the success of Sweden and Finland in not allowing care denials for abortion [22,23]. The impacts in these two countries have been positive, as potential care deniers can find work in other fields, and reproductive health services are accessible across the country in all public hospitals and some private clinics.
- Expecting that care deniers will adhere to the limits placed on them in the exercise of belief-based care denial. However, referral requirements are frequently if not usually disregarded [24],[9] while some HCPs have let women die rather than provide emergency abortion care [25]. Further, HCPs are often unfamiliar with the regulations around belief-based care denial [26].
- Proposing that care deniers must demonstrate that their care denial comes from a sincere or genuine belief [27], even though it is improper to interrogate someone's religious beliefs, as well as impossible to verify their authenticity.
- Asserting that HCPs will experience 'moral distress' [28] or risk their 'moral integrity' [29] if expected to provide services like abortion. This disregards the distress inflicted onto patients and the power imbalance between HCPs and vulnerable patients.
- Recommending that health authorities accommodate care deniers by ensuring that enough hospitals and HCPs are available to provide abortion care [30], despite the additional systems costs and the unfair burdens placed on abortion providers, including heavier workloads and stigmatisation.[10]

A roadmap for discouraging belief-based care denial

The following are suggested measures[11] for reducing belief-based care denials in reproductive health care over time. These actions do not involve forcing doctors to do abortions and instead involve disincentives that aim to decrease the number of care deniers in an ethical and fair manner. While some measures may be more challenging to implement than others, they do not depend on each other and can be individually taken up, in no particular order, with each measure having the potential to bring benefits by itself. Further, the suggestions should not be taken as proscriptive, but as an aspirational roadmap to spark action.

What medical schools could do

1. Inform students intending to enter training programs for Obstetrics/Gynecology or family practice that these fields require provision of reproductive

health care, including abortion and contraception, and that belief-based care denials are discouraged or may not be allowed, and could limit their career opportunities.
2. Offer guidance and assistance to students who would deny care by helping them consider a career in acceptable fields or specialties where their personal beliefs will not conflict with their duty and ethical obligation to provide care.
3. For all students on placements in family medicine, provide comprehensive and mandatory training in contraception provision and medication abortion.
4. For all students on placement in Obstetrics/Gynecology, provide comprehensive and mandatory training in contraception provision, medication abortion, procedural abortion, and sterilisation methods.

What employers/hospitals could do

5. Include the requirement to participate in abortion provision in HCP job descriptions at the point of hiring, or in contracts or agreements as applicable.
6. Implement a rating system that prioritises the recruitment of HCPs who will not deny necessary care to patients.
7. Before recruiting a care denier, inform them that their work environments and opportunities may be limited.
8. Impose a reduction in salary for care deniers that is equivalent to the reduced scope of their job description, or a percent reduction in reimbursed Medicare fees where care is government-funded.
9. Do not allow care deniers to work alone, such as being the only doctor on the Obstetrics ward during a shift, or in a small community where they are the only physician.
10. Require care deniers to enrol in Continuing Education courses or Values Clarification workshops on the need for reproductive health care services and why patients request abortions. This may decrease their numbers because some may be misinformed, uncertain, or using the excuse of 'conscience' for the wrong reasons. For example:
    - Expose them to patients requesting the services.
    - Explain the negative effects of care denials on patients, and the benefits of abortion care for patients.
    - Provide a clear understanding of their fiduciary duty to patients.
11. For remaining care deniers, develop a monitoring and disciplinary policy. For example:
    - Register the HCPs so they can be monitored.
    - Request that HCPs file a report each time they deny care.
    - Follow up on all reports of care denial.
    - Carry out occasional reviews or audits of care deniers.
    - Consider disciplinary measures against those who frequently violate the policy.
    - Ensure that care deniers bear at least some liability for any harms done to patients (e.g., if a patient or their family sues).

What medical organizations/associations could do

12. Review any policies or statements on belief-based care denial and amend them as needed. For example, phrasing that refers to 'conscience' or 'conscientious objection' should be reframed as belief-based care denial and not referred to as a 'right'.
13. Educate members on their fiduciary duty to patients and the unacceptability of care denials based on personal beliefs.
14. If belief-based care denials are allowed by policy, implement monitoring and enforcement mechanisms (similar to #11 above). The goal of the policy should be to discourage care denials and prioritise the patient's health and interests.
15. Make the complaint process easier for patients, such as preventing the care-denying HCP from learning the complainant's identity.
16. Engage in public advocacy about a patient's right to complain when doctors deny care or referrals. For example, organisations could require HCPs to provide a brochure to patients or post a prominent notice in their offices and on their websites.
17. Take seriously instances of belief-based care denial by recognising their potential for grave patient harm and discriminatory effects, and holding doctors accountable.

What governments/health authorities could do

18. Inform the public and medical professions, such as via fact sheets or published articles, about the widespread negative consequences of belief-based care denial on women's survival and human rights and on the health care system itself over the past half-century.
19. Regulate public health systems to guarantee abortion provision, such as by requiring all public hospitals to provide abortions.
20. Provide financial aid to hospitals to recruit abortion providers, and ensure that recruitment processes do not favour care deniers.
21. Work with medical associations to encourage and incentivise new providers, especially outside major cities, such as by offering additional pay and benefits.
22. Implement safe access zones outside abortion-providing facilities to protect HCPs and patients from anti-abortion protesters, and to increase the number of providers (who need safety assurances when entering the field).
23. Set up a central referring agency that patients can call to be referred to a provider in their area, and maintain a list of doctors who provide this care. This can circumvent care deniers.
24. Review any laws and regulations allowing belief-based care denial, and repeal or amend them. For example,

referrals to HCPs who can provide abortion should be obligatory, not just recommended.

25. Ensure that any law that limits belief-based care denial is enforced and that those who violate the law face justice, especially when patients are harmed.

Conclusion

Belief-based denial of abortion care has resulted in serious harms for patients seeking abortion and the providers who help them. Common defences for belief-based care denial do not stand up to scrutiny because they ignore the contradictions and mistreatments that arise when healthcare professionals suspend their fiduciary duty to patients by denying essential care on the basis of personal moral disagreement.

We hope that advocates and policy-makers will learn about the dishonourable origin of so-called 'conscientious objection' in healthcare, and understand the injustices that followed and multiplied across the world. Given the conflicts between medical ethics and belief-based care denial, we encourage everyone to create change.

Notes

1. We define belief-based care denial as the refusal by a healthcare professional to provide a legal, patient-requested medical service or treatment that falls within the scope and qualifications for their field, based on their personal or religious beliefs against the treatment. We distinguish this practice from its opposite, conscientious commitment (aka conscientious provision) which we define as the provision of necessary or beneficial health care to patients in need despite stigma, unjust laws, or oppressive systems.
2. See Fiala, *supra* [3].
3. See Arthur and Fiala, *supra* [4].
4. See Fiala, *supra* [6].
5. See de Landras, *supra* [2], pg 9.
6. Ibid, pg 10.
7. Berlinger [18] observes that 'For too long, bioethics has followed law in reducing "conscience" to "conscientious objection," in other words, to laws and policies permitting and protecting refusal'.
8. For example, a lengthy report defending the workability of belief-based care denial has only this brief statement: 'However, a few countries, primarily in Scandinavia and Eastern Europe, do not discuss CO in their abortion laws, which has been interpreted to mean that providers lack a legal right to object'. Chavkin et al. [21].
9. See de Londras, *supra* [2], pg 7.
10. Ibid., pg 7–9.
11. Further recommendations can be found in an NGO report of a meeting in Uruguay where experts concluded that healthcare policies should not allow for belief-based care denial, and that the term 'conscience' should not be ceded to HCPs who misapply it by denying abortion care. International Women's Health Coalition and Mujer y Salud en Uruguay [31].

Ethical approval

The article is an opinion, not a study, so did not require any ethics approval. There was no Ethics Committee involved.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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Data availability statement

Data sharing is not applicable to this article as no new data were created or analysed in this study.

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