MARTINUS NIJHOFF PUBLISHERS

European Journal of Health Law 19 (2012) 231-256

European Journal of Health Law

brill.nl/ejhl

Conscientious Objection to Sexual and Reproductive Health Services: International Human Rights Standards and European Law and Practice

Christina Zampas[a), *] **and Ximena Andión-Ibañez**[b)]

[a)] Lecturer and Practitioner-in-Residence, University of Miami Law School, Human Rights Clinic, Miami, FL, USA

[b)] Co-founder and President, EQUIS: Justice for Women and Director of Strategic Development, Grupo de Información en Reproducción Elegida (GIRE), Mexico

Abstract

The practice of conscientious objection often arises in the area of individuals refusing to fulfil compulsory military service requirements and is based on the right to freedom of thought, conscience and religion as protected by national, international and regional human rights law. The practice of conscientious objection also arises in the field of health care, when individual health care providers or institutions refuse to provide certain health services based on religious, moral or philosophical objections. The use of conscientious objection by health care providers to reproductive health care services, including abortion, contraceptive prescriptions, and prenatal tests, among other services is a growing phenomena throughout Europe. However, despite recent progress from the European Court of Human Rights on this issue (*RR v. Poland*, 2011), countries and international and regional bodies generally have failed to comprehensively and effectively regulate this practice, denying many women reproductive health care services they are legally entitled to receive. The Italian Ministry of Health reported that in 2008 nearly 70% of gynaecologists in Italy refuse to perform abortions on moral grounds. It found that between 2003 and 2007 the number of gynaecologists invoking conscientious objection in their refusal to perform an abortion rose from 58.7 percent to 69.2 percent. Italy is not alone in Europe, for example, the practice is prevalent in Poland, Slovakia, and is growing in the United Kingdom. This article outlines the international and regional human rights obligations and medical standards on this issue, and highlights some of the main gaps in these standards. It illustrates how European countries regulate or fail to regulate conscientious objection and how these regulations are working in practice, including examples of jurisprudence from national level courts and cases before the European Court of Human Rights. Finally, the article will provide recommendations to national governments as well as to international and regional bodies on how to regulate conscientious objection so as to both respect the practice of conscientious objection while protecting individual's right to reproductive health care.

Keywords

reproductive health; conscientious objection; human rights; right to health care; European Court of Human Rights; sexual and reproductive rights

[*)] This article builds on research, advocacy and litigation undertaken in the International Legal Program of the Center for Reproductive Rights since 2004.

DOI: 10.1163/157180912X639116

1. Introduction

Conscientious objection is the refusal to participate in an activity that an individual considers incompatible with his/her religious, moral, philosophical or ethical beliefs. The practice of conscientious objection has historically arisen in the context of opposition to mandatory military service,[1] but is increasingly being raised in the context of objection to engaging in certain medical procedures, particularly in the area of sexual and reproductive health.[2] While standards regulating the practice of conscientious objection to military service are generally well-developed, legal standards governing the practice in health care settings are often inadequate to address the multiple scenarios in which the practice arises. The law and practice in European countries is peppered with differences, indicating a great need to develop comprehensive standards in this area.

A large number of States worldwide have conscientious objection clauses in laws and/or medical ethical standards that are applicable to sexual and reproductive health care services. These clauses are usually included in deontology (ethics) codes,[3] or in general health care laws and/or in laws that regulate a specific reproductive health care service such as abortion or sterilization.[4] The scope of conscientious objection clauses and the legal rights and obligations of patient and provider that they create vary from country to country.

According to established international human rights and medical standards, states should regulate conscientious objection to both accommodate health care providers' beliefs and also ensure women's access to adequate and timely sexual and reproductive health care services. Regulations should thus, for example, ensure an adequate number of providers willing and able to perform lawful health services, clearly establish the types of health services and circumstances in which conscientious objection can be invoked, and establish legal and ethical duties of

---

1) The concept of a conscientious objector emerged at the beginning of the 20th Century when some people refused to fight in World War I, and it gained international recognition in 1989 when the United Nations Commission on Human Rights adopted the resolution "Conscientious objection to military service". UN Commission on Human Rights, *Conscientious objection to military service*, U.N. Doc. E/CN.4/1989/L.19/Add.15 (9 Mar. 1989). For more, *see generally*, Rachel Brett, Quaker United Nations Office, International Standards on Conscientious Objection to Military Service (2008), *available at* http://www.quno.org/geneva/pdf/humanrights/CO/COintlStds200811-English.pdf.

2) *See* Judith Bueno de Mesquita and Louise Finer, University of Essex Human Rights Centre, Conscientious Objection: Protecting Sexual and Reproductive Health Rights (2008) available at http://www.essex.ac.uk/human_rights_centre/research/rth/docs/Conscientious_objection_final.pdf; *see also* Rebecca Cook, Bernard Dickens and Mahmoud Fatallah, *Reproductive Health and Human Rights: Integrating Medicine, Ethics And Law* (2003).

3) Deontology or medical ethics codes, while not legally binding, are a highly persuasive authority since the development of deontology codes is mandated by public health laws. Often times they are used by national courts as persuasive authority.

4) *See* Center for Reproductive Rights' Third Party Intervention to the European Court of Human Rights in the case of *Tysiąc* v. *Poland*, App. No. 5410/03, Eur. Ct. H.R. para. 21 (filed 21 Sept. 2005), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/Tysiac%20Amicus%20AS%20SENT%20TO%20ECHR%209%2020%2005.pdf.

health care providers who invoke conscientious objection, such as timely referral of patients to providers willing and able to provide services.[5] Such regulations should also establish oversight mechanisms, penalties for healthcare providers who do not comply with their duties and effective appeal mechanisms for women who are denied services.[6] Moreover, in cases where women's right to health services are violated, legislation should establish appropriate remedies.[7]

This article examines the law and practice of conscientious objection to sexual and reproductive health services in Europe. It first outlines the international (UN) and European human rights standards as well as the medical and ethical standards regarding the regulation of conscientious objection in reproductive health care settings. It then examines national European laws and jurisprudence on the practice, offering a more detailed articulation of the issues and concerns, and providing guidance on the regulation of the practice. The article shows that often in European countries conscientious objection clauses are being applied too broadly and sometimes even abused. The lack of adequate legal and policy framework to regulate the practice and prevent abuse results in serious violations of women's right to access quality sexual and reproductive health services with potentially detrimental impact on their health and lives.

2. International (UN) Standards on Conscientious Objection to Sexual and Reproductive Health Care Services

The Programme of Action of the International Conference on Population and Development (ICPD), agreed to by governments around the globe, recognised that reproductive rights are human rights:

> Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other relevant UN consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes

---

5) *See* Eur. Parl. Assemb., Social, Health & Family Affairs Comm., *Explanatory memorandum — Women's access to lawful medical care: the problem of unregulated use of conscientious objection*, Doc. 12347 (2010) [hereinafter Eur. Parl. Assemb., *Explanatory Memorandum — Unregulated use of conscientious objection*].

6) *See* Judgment, *Tysiąc* v. *Poland*, App. No. 5410/03, Eur. Ct. H.R. paras. 116-17 (2007).

7) The right to an effective remedy is a fundamental right recognised in most international and regional human rights treaties. *See, e.g.*, International Covenant on Civil and Political Rights, adopted 16 Dec. 1966, Art. 2, para. 3, G.A. Res. 2200A (XXI), UN GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (entered into force 23 Mar. 1976) [hereinafter ICCPR]; *see also* Convention for the Protection of Human Rights and Fundamental Freedoms, adopted 4 Nov. 1950, Art. 13, 213 U.N.T.S. 222, Europ. T.S. No. 5 (entered into force 3 Sept. 1953) [hereinafter European Convention on Human Rights].

> their right to make decisions regarding reproduction free of discrimination, coercion and violence, as expressed in human rights documents.[8]

The content and scope of these internationally recognised human rights have been developed and interpreted by UN and regional human rights bodies for decades. For instance, the U.N. treaty monitoring bodies (UNTMBs) which monitor states compliance with the major international human rights treaties and provide interpretation of those treaties, have articulated protection for reproductive rights including in the areas of abortion, family planning, female genital mutilation, gender-based violence, sexuality education and maternal mortality, among others.[9] Their recognition is grounded in the fundamental rights to life, to be free from inhumane and degrading treatment, health, non-discrimination and equality, self-determination and access to information. At the regional level, the European Convention on Human Rights also protects women's reproductive rights.[10]

Conscientious objection is grounded in the right to freedom of religion, conscience and thought, recognised in many international and regional human rights treaties as well as national constitutions.[11] Under international and regional human rights law, the freedom to manifest one's religion or beliefs can be limited for the protection of the rights of others, including women's sexual and reproductive rights.[12] Human rights bodies have established standards for state regulation of conscientious objection clauses, including the legal obligation of health care providers to ensure that patients are not denied access to health care services.[13]

---

8) *Programme of Action of the International Conference on Population and Development*, Cairo, Egypt, 5-13 Sept. 1994, at 7.3, U.N. Doc. A/CONF.171/13/Rev.1 (1995).

9) *See generally Center for Reproductive Rights, Bringing Rights to Bear* (2008), *available at* http://reproductiverights.org/en/resources/publications/briefing-papers.

10) *See, e.g.*, Judgment, *Tysiąc v. Poland, supra* note 6. The Court has noted that "legislation regulating the interruption of pregnancy touches upon the sphere of private life, since whenever a woman is pregnant her private life becomes closely connected with the developing foetus." Eur. Comm. HR, *Brüggemann and Scheuten v. The Federal Republic of Germany*, App. No. 6959/75, 10 Eur. H.R. Rep. (1977) (Commission Report).

11) *See, e.g.*, Human Rights Committee, *General Comment No. 22: The Right to freedom of thought, conscience and religion*, (48th Sess., 1993), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies (Vol. I), at 204, para. 11, U.N. Doc. HRI/GEN/1/Rev.9 (2008) (recognizing that the right to conscientious objection can be derived from the right to freedom of thought, conscience and religion as guaranteed in the International Covenant on Civil and Political Rights); *see also* European Convention on Human Rights, *supra* note 7, Art. 9; EU Network of Independent Experts on Fundamental Rights, The right to conscientious objection and the conclusion by EU Member States of concordats with the Holy See, Eur. Comm'n., Opinion No. 4-2005, at 9-12 (14 Dec. 2005), available at http://158.109.131.198/catedra/images/experts/CONSCIENTIOUS%20OBJECTION%20%2810%29.pdf [hereinafter EU Network of Independent Experts].

12) *See, e.g.*, ICCPR, *supra* note 7, Art. 18, para. 3; *see also* European Convention on Human Rights, *supra* note 7, Art. 9, para. 2.

13) *See, e.g.*, Human Rights Committee, *Concluding Observations: Poland*, para. 12, U.N. Doc. CCPR/C/POL/CO/6 (2010) [hereinafter HRC, *Poland* (2010)]; Committee on Economic, Social and Cultural Rights, *Concluding Observations: Poland*, para. 28, U.N. Doc. E/C.12/POL/CO/5 (2009) [hereinafter

UNTMBs which interpret and monitor state compliance with UN human rights treaties, have specifically recognised that conscientious objection is a potential barrier to access reproductive health services[14] and have stated that governments have a positive obligation to ensure that the application of conscientious objection clauses does not violate women's right to access to quality, affordable and acceptable sexual and reproductive health care services.[15]

The CEDAW Committee, which interprets and monitors state compliance with the Convention on the Elimination of All Forms of Discrimination against Women, has recognised that: "It is discriminatory for a State party to refuse to legally provide for the performance of certain reproductive health services for women. For instance, if health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers."[16] In the context of abortion, it specifically noted that provisions allowing conscientious objection without ensuring alternate means of accessing abortion violate women's reproductive rights and that measures should be introduced to guarantee the referral to alternative health care providers.[17] This Committee has expressed concern to countries over the lack of access to abortion services due to the practice of conscientious objection by hospital personnel[18] and has also recommended that states parties ensure access to abortion in public health services.[19]

The Human Rights Committee, which interprets and monitors state compliance with the International Covenant on Civil and Political Rights (ICCPR),

---

ESCR Committee, *Poland* (2009)] (calling on the state to take all effective measures to ensure that women enjoy their right to sexual and reproductive health, including by "enforcing the legislation on abortion and implementing a mechanism of timely and systematic referral in the event of conscientious objection"); *see also* EU Network of Independent Experts, *supra* note 11, at 20.

14) *See, e.g.*, Committee on the Elimination of Discrimination against Women, *Concluding Observations: Croatia*, para. 109, U.N. Doc. A/53/38 (1998) [hereinafter CEDAW Committee, *Croatia* (1998)]; *Concluding Observations: Italy*, para. 353, U.N. Doc. A/52/38 Rev.1 (1997) [hereinafter CEDAW Committee, *Italy* (1997)]; *Concluding Observations: Poland*, para. 25, U.N. Doc. CEDAW/C/POL/CO/6 (2007) [hereinafter CEDAW Committee, *Poland* (2007)]; Human Rights Committee, *Concluding Observations: Poland*, para. 8, U.N. Doc. CCPR/CO/82/POL (2004) [hereinafter HRC, *Poland* (2004)]; ESCR Committee, *Poland* (2009), *supra* note 13, para. 28.

15) *See, e.g.*, Committee on the Elimination of Discrimination against Women, *Concluding Observations: Slovakia*, paras. 42-43, U.N. Doc. A/63/38 (2008) [hereinafter CEDAW Committee, *Slovakia* (2008)]; HRC, *Poland* (2004), *supra* note 13, para. 8.

16) Committee on the Elimination of Discrimination against Women, *General Recommendation No. 24: Article 12 (women and health),* (20th Sess., 1999), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies (Vol. II), at 358, para. 11, U.N. Doc. A HRI/GEN/1/Rev.9 (2008).

17) *See, e.g.*, CEDAW Committee, *Slovakia* (2008), *supra* note 15, para. 43.

18) *See, e.g.*, CEDAW Committee, *Croatia* (1998), *supra* note 14, para. 109; *Italy* (1997), *supra* note 14, para. 353; *Poland* (2007), *supra* note 14, para. 25.

19) *See, e.g.*, Committee on the Elimination of Discrimination against Women, *Concluding Observations: Colombia*, para. 23, U.N. Doc. CEDAW/C/COL/CO/6 (2007); *Croatia* (1998), *supra* note 14, para. 117; *Italy* (1997), *supra* note 14, para. 360.

established that states parties have an obligation, under the right to life, to ensure women's access to abortion, by removing barriers to the procedure, and has raised concerns over the practice of conscientious objection and the obstacles it poses to women's access to lawful abortion.[20]

In its General Comment 14, the Committee on Economic, Social and Cultural Rights (ESCR Committee) established that the right to the highest attainable standard of health entails "not only to timely and appropriate health care but also to the underlying determinants of health, such as . . . access to health-related education and information, including on sexual and reproductive health."[21] The Committee stressed that States should "refrain from . . . censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information."[22] This Committee has expressed concern at the refusal of physicians and clinics to perform legal abortions on the basis of conscientious objection and has recommended States to "take all effective measures to ensure that women enjoy their right to sexual and reproductive health, including by enforcing the legislation on abortion and implementing a mechanism of timely and systematic referral in the event of conscientious objection."[23]

Concern over the lack of availability of reproductive health care services due to laws and practices concerning conscientious objection in Europe has been specifically raised by UN TMBs when reviewing European countries compliance with their treaty obligations, such as Croatia,[24] Italy,[25] Poland[26] and Slovakia.[27] These bodies have called on state parties to adequately regulate the practice and ensure that effective referral mechanisms are in place.

In 2010, the Human Rights Committee in monitoring Poland's compliance with the ICCPR, raised concerns 'that, in practice, many women are denied access to reproductive health services, including contraception counselling, prenatal testing and lawful interruption of pregnancy' . . . and recommended that Poland to be in compliance with its obligations to respect, protect and fulfil its obligations under the right to life '. . . introduce regulations to prohibit the improper use and performance of the "conscience clause" by the medical profession.'[28] Similarly, the ESCR Committee expressed concern over the high

---

20) *See* HRC, *Poland* (2010), *supra* note 13, para. 12; *Poland* (2004), *supra* note 13, para. 8 (in both sets of concluding observations, the Committee references ICCPR article 6, on the right to life, in the context of expressing concern that women in Poland are denied access to legal abortions in part due to inappropriate application of Poland's conscientious objection clause).

21) *See* Committee on Economic, Social and Cultural Rights, *General Comment 14: The Right to the Highest Attainable Standard of Health (Art. 12)*, para. 11, U.N. Doc. E/C.12/2000/4 (2000).

22) *Ibid.*, para. 34.

23) ESCR Committee, *Poland* (2009), *supra* note 13, para. 28.

24) CEDAW Committee, *Croatia* (1998), *supra* note 14, para. 109.

25) CEDAW Committee, *Italy* (1997), *supra* note 14, para. 353.

26) HRC, *Poland* (2010), *supra* note 13, para. 12; *Poland* (2004), *supra* note 13, para. 8; ESCR Committee, *Poland* (2009), *supra* note 13, para. 28.

27) CEDAW Committee, *Slovakia* (2008), *supra* note 15, para. 43.

28) HRC, *Poland* (2010), *supra* note 13, para. 12.

number of clandestine abortions in Poland and the fact that women often resort to these procedures "because of refusal of physicians and clinics to perform the legal operations on the basis of conscientious objection."[29] It recommended Poland to "take all effective measures to ensure that women enjoy their right to sexual and reproductive health, including by enforcing the legislation on abortion and implementing a mechanism of timely and systematic referral in cases of conscientious objection."[30]

In 2008, the CEDAW Committee in its Concluding Observations to Slovakia noted that it "… is deeply concerned about the insufficient regulation of the exercise of conscientious objection by health professionals with regard to sexual and reproductive health"[31] and recommended that Slovakia "… adequately regulate the invocation of conscientious objection by health professionals so as to ensure that women's access to health and reproductive health is not limited."[32] The Committee recalled its "general recommendation No. 24, which states that it is discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women" and recommended "… that, if health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers."[33]

The UN Special Rapporteur on the Right to the Highest Attainable Standard of Health, issued a groundbreaking report in 2011 on the devastating impact the criminalization of abortion has on women's health and lives and specifically articulated state obligations to remove barriers, including laws and practices on conscientious objection which interfere with individual decision-making on abortion.[34] The report notes that such laws and their use create barriers to access by permitting health care providers and ancillary personnel, such as receptionists and pharmacists, to refuse to provide abortion services, information about procedures, and referrals to alternative facilities and providers. He noted that these and other laws make safe

---

29) ESCR Committee, *Poland* (2009), *supra* note 13, para. 28.

30) *Ibid.*; see also Anand Grover, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health: Mission to Poland, para. 53*, U.N. Doc. A/HRC/14/20/Add.3 (2010)*, para. 50* [hereinafter Special Rapporteur on the right to health — Poland 2010] ("Health systems should have procedures, such as administrative procedures to provide immediate alternatives to healthcare users when conscientious objection would otherwise lead to a denial of services, and effective remedies, in place to ensure that in practice, legitimate conscientious objection does not obstruct the enjoyment by women and men of their sexual and reproductive health rights. States should also monitor the exercise of conscientious objection with a view to ensuring that all services are available and accessible in practice. In short, health service providers who conscientiously object to a procedure have the responsibility to treat an individual whose life or health is immediately affected, and otherwise to refer the patient to another provider who will perform the required procedure.").

31) CEDAW Committee, *Slovakia* (2008), *supra* note 15, para. 42.

32) *Ibid.* para. 43.

33) *Ibid.*

34) Anand Grover, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Interim report*, A/66/254 (2011) [hereinafter Special Rapporteur on the right to health — Criminalisation of abortion 2011].

abortions unavailable, especially to poor, displaced and young women and noted that such restrictive regimes serve to reinforce the stigma that abortion is an objectionable practice. He recommended that states, in order to fulfil their obligations under the right to health should "[E]nsure that conscientious objection exemptions are well-defined in scope and well-regulated in use and that referrals and alternative services are available in cases where the objection is raised by a service provider."[35]

3. European Regional Human Rights Standards

The Council of Europe and other European regional bodies have issued numerous reports, recommendations and resolutions on the practice of conscientious objection in the military.[36] They have stressed the need for member states to enact legislation to regulate the right to conscientious objection[37] and that there should be a procedure for the examination of applications for conscientious objector status.[38] However, few such standards exist on the regulation of the practice of conscientious objection in health care settings. Below is a review of the few existing standards from Council of Europe and European Union bodies.

3.1. *The European Union*

The European Union Network of Experts Opinion on the Right to Conscientious Objection[39]

The European Union Network of Experts on Fundamental Rights has addressed the concern over the law and practice of conscientious objection in relation to access to various health services, including abortion. In 2005, it issued an opinion

---

35) *Ibid.*

36) *See, e.g., Resolution 337 on the right of conscientious objection*, Eur. Parl. Assemb. (1967); *see also Recommendation 816 on the right of conscientious objection to military service*, Eur. Parl. Assemb. (1977) [hereinafter *Eur. Parl. Assemb., Recommendation 816*]; *Recommendation 1518 on exercise of the right of conscientious objection to military service in Council of Europe member states*, Eur. Parl. Assemb. (2001); *Resolution on conscientious objection and alternative civilian service*, Eur. Parl. Doc. A3-15/89 (1989); Council of Eur., *Recommendation No. R(87)8 of the Committee of Ministers to member states regarding conscientious objection to compulsory military service* (1987) [hereinafter *Council of Eur., Recommendation No. R(87)8]; Directorate General of Hum. Rts., Council of Eur., Conscientious objection to compulsory military service* (2002), available at http://www.coe.int/t/e/human_rights/cddh/2._activities/Conscientious Objection_en.pdf.

37) *See, e.g., Recommendation 478 (1967) on the right of conscientious objection*, Eur. Parl. Assemb. (1967); *see also Eur. Parl. Assemb., Recommendation 816, supra* note 36.

38) *See, e.g., Council of Eur., Recommendation No. R(87)8, supra* note 36, sec. B, paras. 2-8.

39) The E.U. Network of Independent Experts on Fundamental Rights was set up by the European Commission upon the request of the European Parliament. It monitors the situation of fundamental rights in the Member States and in the Union, on the basis of the Charter of Fundamental Rights. It issued reports on the situation of fundamental rights in the Member States and in the Union, as well as opinions on specific issues related to the protection of fundamental rights in the Union. In 2007, the Network's mandate was merged with the newly formed European Union Fundamental Rights Agency.

on the conformity of a draft treaty on conscientious objection between the Holy See and Slovakia with the European Union Charter on Fundamental Rights, which guarantees both the right to respect for private life (Article 7) and freedom of thought, conscience and religion (Article 10). The draft treaty essentially allowed for the unlimited exercise of conscientious objection in a wide range of areas, including health care, education and legal services. If accepted, it would have been one of the broadest and most encompassing treaties between the Holy See and a state on conscientious objection. The Network recognised that while conscientious objection can be considered a part of the freedom of thought, conscience and religion, when it conflicts with other rights and freedoms, it is necessary to restrict its exercise by means of creating adequate balance between conflicting rights and freedoms.[40] The opinion notes that "this right [to conscientious objection] should be regulated in order to ensure that, in circumstances where abortion is legal, no woman shall be deprived from having effective access to the medical service of abortion."[41] In addition, they noted that denying a woman the effective possibility to terminate the pregnancy in circumstances where abortion is lawful may "amount to the infliction of an inhuman and degrading treatment…"[42]

3.1.1. *The European Parliament*

In 2002, the European Parliament passed a resolution recognizing the disparities in Europe in the area of sexual and reproductive health and rights, including access to contraception, unwanted pregnancies and abortion, as well as adolescent sexual and reproductive health, including sexuality education.[43] The resolution identified barriers to exercising sexual and reproductive rights, including the practice of conscientious objection, and made recommendations to Member States and Accession Countries of the European Union on how to address the situation. It recommended, for example that states develop a national policy on sexual and reproductive health, in cooperation with civil society organizations, which ensures the provision of comprehensive information concerning effective and responsible methods of family planning as well as equal access to a range of high quality contraceptive methods.[44] It further recommended states to ensure the provision of unbiased, scientific and clearly understandable information and counselling on sexual and reproductive health, including the prevention of unwanted pregnancies and the risks involved in unsafe abortions carried out under unsuitable conditions.[45] Finally, it reinforced the importance of safeguarding

---

40) EU Network of Independent Experts, *supra* note 11, at 16.
41) *Ibid.* at 20.
42) *Ibid.* at 19. This opinion played a role in the treaty not being adopted by the government.
43) *Resolution on sexual and reproductive health and rights, Eur. Parl. Assemb*. 2001/2128(INI) (2002).
44) *Ibid.*, para. 2.
45) *Ibid.*, para. 10.

women's reproductive health and rights by making abortion legal, safe and accessible to all[46] and that in case of legitimate conscientious objection of the provider, referral to other service providers that can perform the service should be required.[47]

3.2. *The Council of Europe*

3.2.1. *European Convention on Human Rights*

The European Court of Human Rights has addressed the issue of conscientious objection in health related settings in only two cases. First, in an Article 9 admissibility decision concerning pharmacists refusal to fill prescriptions for contraceptives[48] and most recently in *RR v. Poland* (2011), a case concerning denial of a prenatal genetic examination due, in part, to the practice of conscientious objection.[49] The latter being the first time ever an international or regional human rights tribunal has articulated that states have a *positive* obligation to regulate the practice of conscientious objection in a reproductive health care setting.

In *R.R v. Poland*, the Court noted that R.R.'s access to genetic testing "was marred by procrastination, confusion and lack of proper counselling and information given to [her]" . . . and that ultimately she obtained admission to a hospital where the genetic tests were conducted "by means of subterfuge." The Court found that this 'shabby treatment' and the 'acute anguish' it caused her violated her right to be free from inhumane and degrading treatment (article 3).[50] This is the first time the Court ever found a violation of Article 3 in a reproductive rights case. The Court also made clear that access to diagnostic services was decisive for the "possibility of exercising her right to take an informed decision as to whether to seek an abortion or not."[51] The Court noted the crucial importance of timely access to information on one's health condition by stating that, "in the context of pregnancy, the effective access to relevant information on the mother's and foetus' health, where legislation allows for abortion in certain situations, is directly relevant for the exercise of personal autonomy."[52] It noted that effective implementation of abortion laws is important for ensuring a right to lawful abortion and found Poland's failure to do so also a violation of Poland's positive obligations to respect private life (Article 8).[53]

---

46) *Ibid.*, para. 12.
47) *Ibid.*, para. 11.
48) *Pichon and Sajous v. France*, 2001-X Eur. Ct. H.R.
49) Judgement, *R.R. v. Poland*, App. No. 27617/04, Eur. Ct. H.R. (26 May 2011).
50) *Ibid.*, paras. 15 and 159-162.
51) *Ibid.*, para. 208.
52) *Ibid.*, para. 197.
53) *Ibid.*, paras. 213-214. The Court also found a violation of Article 3, the right to be free from inhumane and degrading treatment.

The Court added that freedom of conscience does not protect "each and every act or form of behaviour motivated or inspired by a religion or a belief,"[54] and made clear that states have an obligation "to organise the health services system in such a way as to ensure that an effective exercise of the freedom of conscience of health professionals in the professional context does not prevent patients from obtaining access to services to which they are entitled under the applicable legislation."[55]

In 2001, The European Court of Human Rights while considering the admissibility of a complaint regarding a French court's decision that ethical or religious principles are not legitimate grounds to refuse to sell a contraceptive by pharmacists, recognised the limitations of conscientious objection when a person is completely reliant on a certain profession to obtain legally authorised health care services.[56] The Court noted that "as long as the sale of contraceptives is legal and occurs on medical prescription nowhere other than in a pharmacy, the applicants cannot give precedence to their religious beliefs and impose them on others as justification for their refusal to sell such products, since they can manifest those beliefs in many ways outside the professional sphere."[57] The Court explained that Article 9 of the European Convention on Human Rights, which guarantees the right to freedom of thought, conscience and religion, protects acts closely linked to personal convictions and religious beliefs, such as acts of worship, teaching, practice, and observance. However, it noted that Article 9 does not always guarantee the right to behave in public in a manner governed by that belief. The Court said that Article 9(1) does not protect "each and every act or form of behaviour motivated or inspired by a religion or a belief."[58]

In another admissibility decision unrelated to access to health care, but useful nonetheless given the growing practice of public health care *institutions* not providing certain lawful health care services on grounds of conscience, the European Commission of Human Rights noted that the right to freedom of conscience is by its very nature an individual right and therefore it cannot be exercised by an institution.[59] In finding so, the Commission made a distinction between exercise of religious freedom and exercise of conscience, the former being applicable to institutions, such as churches, the latter solely an individual right.[60]

---

54) *Ibid.*, para. 206.
55) *Ibid.*
56) *Pichon and Sajous v. France*, *supra* note 48.
57) *Ibid.*, at 4.
58) *Ibid.* For a detailed analysis of the *Pichon and Sajous* decision, see Adriana Lamačková, 'Conscientious Objection in Reproductive Health Care: Analysis of *Pichon and Sajous v. France*', *European Journal of Health Law 15* (2008) 7-43.
59) *Kontakt-information-Therapie and Hagen v. Austria*, 57 Eur. Ct. H.R. 81 (1988) ("Moreover, the rights primarily invoked, i.e. the right to freedom of conscience under Article 9 (Art. 9) of the Convention and the right not to be subjected to degrading treatment or punishment (Article 3) (Art. 3), are by their very nature not susceptible of being exercised by a legal person such as a private association").
60) *Ibid.*

3.2.2. *Commissioner for Human Rights*

In 2007, the Council of Europe Commissioner for Human Rights recognised the concerns raised by Polish civil society that "Doctors often refuse to issue a certificate required for termination of pregnancy (relying on the 'conscience clause'). Even when they do issue a certificate, the doctor who performs the termination can question the certificate's validity and refuse the service."[61] In his report to the Polish government he stressed "that access to legal abortion . . . in Poland is frequently hindered" and urged the "government to ensure that women falling within the categories foreseen by the law are allowed, in practice, to terminate their pregnancy without additional hindrance or reproach."[62]

3.2.3. *Parliamentary Assembly of the Council of Europe (PACE)*[63]

PACE has recently passed two resolutions that address the practice of conscientious objection in Council of Europe Member States. The first resolution passed in 2008 concerns women's right to abortion. Entitled *Access to Safe and Legal Abortion in Europe*,[64] this resolution calls upon member states to decriminalise abortion, guarantee women's effective exercise of their right to safe and legal abortion, remove restrictions that hinder *de jure* and *de facto* access to abortion, and adopt evidence-based sexual and reproductive health strategies and policies, such as access to contraception at a reasonable cost and of suitable nature, and compulsory age appropriate and gender-sensitive sex and relationship education for young people. The adoption of this resolution is particularly significant as it recognises that in many member states there are conditions which hinder effective access to legal abortion, including, "the lack of doctors willing to carry out abortions . . . [which has] the potential to make access to safe affordable, acceptable and appropriate abortion services more difficult, or even impossible in practice."[65] PACE affirmed the right of all women to respect for their physical integrity and to freedom to control their own bodies and in this context recognised that the ". . . ultimate decision on whether or not to have an abortion should be a matter for the woman concerned, who should have the means of exercising this right in an effective way."[66] In addition, PACE recognises the need to prevent unwanted

---

61) Council of Europe, Commissioner for Human Rights, *Memorandum to the Polish Government: Assessment of the Progress Made in Implementing the 2002 Recommendations of the Council of Europe Commissioner for Human Rights*, para. 95, CommDH(2007)13 (2007).

62) *Ibid.*, para. 98.

63) The parliamentary body of the Council of Europe is made up of parliamentarians who come from the national parliaments of the organization's 47 member states. They meet four times a year to discuss topical issues relating to democacy, human rights and the rule of law and ask European governments to undertake initiatives and report back on their progress.

64) *Resolution 1607 (2008) Access to safe and legal abortion in Europe*, Eur. Parl. Assemb. (2008).

65) *Ibid.*, para. 3.

66) *Ibid.*, para. 6.

pregnancies[67] and to address barriers that affect women's access to contraceptives,[68] which would include pharmacists refusing to fill prescriptions for contraceptives on grounds of conscience. While not legally binding, this resolution is the most progressive pronouncement on the right to abortion by any international or regional human rights system and was PACE's first recognition of the growing unregulated practice of conscientious objection to reproductive health care services in Europe.

Recognising the need to elaborate on the standards regarding conscientious refusal to provide services and the growing problem in Europe, two years later, a resolution was introduced and overwhelmingly passed by PACE's Committee on Family and Social Affairs. This resolution titled 'Women's Access to Lawful Medical Care: the problem of unregulated use of conscientious objection', set forth comprehensive recommendations to member states on regulating the practice of conscientious objection in health care settings, including reproductive healthcare.[69] The resolution called on member states to recognise that the exercise of conscientious objection belongs to an individual and not to institutions and applies only to those directly involved in the performance of the procedure.[70] It also called on member states to oblige health care providers to: inform patients about all treatment options; inform and refer patients on their refusal; and perform services regardless of conscience in cases of emergency or when referral is not possible.[71] Finally, the resolution called on member states to provide oversight and monitoring mechanisms and effective complaints mechanisms.[72]

However, when the resolution was up for vote in plenary amendments were introduced by anti-abortion parliamentarians that resulted in the original resolution being undercut and undermined the original proposal and diminished the seriousness of the problem.[73] For example, the resolution includes a clause contradicting the decision of the European Court in *Tysiąc v. Poland* that recognised

---

67) *Ibid.*, paras. 1, 7.7.

68) *Ibid.*, paras. 7.5-7.6.

69) Draft Resolution, *Women's access to lawful medical care: the problem of unregulated conscientious objection*, *Eur. Parl. Assemb. Doc.* 12347 (2010).

70) *Ibid.*, para. 4.1.1.

71) *Ibid.*, para. 4.1.2.

72) *Ibid.*, para. 4.2.

73) *Resolution 1763 (2010) The right to conscientious objection in lawful medical care*, Eur. Parl. Assemb. (2010), *available at* http://assembly.coe.int/ASP/APFeaturesManager/defaultArtSiteView.asp?ID=950 [hereinafter *Eur. Parl. Assemb., Resolution 1763*]. The amendments were passed by a slight majority (56 to 51 with 4 abstentions. For example, the resolution now recognises that providers and health care institutions can refuse to provide women care in emergency situations, which violates basic medical ethics, World Health Organization standards, human rights standards and laws in many member states. Moreover, the amendments contradict universally recognised fundamental human rights and rule of law principles by removing from liability any person or institution for their conduct, even if the exercise of conscientious objection was unlawful and led to serious harm. This contradicts basic concepts of lawfulness and the rule of law in a democratic society that require that persons who have been harmed have a right to have access to review procedures before an independent body. *See, e.g., Rotaru v. Romania*,

that a state has a positive obligation to *prevent* harm that could arise from a dispute between a patient and her doctor when a doctor refuses to perform an abortion. It noted that "[O]nce the legislature decides to allow abortion, it must not structure its legal framework in a way which would limit real possibilities to obtain it" and found Poland in violation of Article 8 of the ECHR which protects the right to private life, for failing to have in place a mechanism to resolve disputes between a patient and her doctor.[74]

Nevertheless, the operative paragraph of the non-binding resolution asks member states to develop comprehensive and clear regulations to ensure patients' appropriate treatment, particularly in cases of emergency.[75] This operative paragraph is in line with UN standards, its own earlier resolution, and supported by growing evidence in this field as reflected in the resolution's own explanatory memorandum.[76]

4. Non-binding International Medical and Ethical Standards

International medical and ethical regulations have also recognised that conscientious objection should be regulated and that health care providers have a primary duty to treat their patients and prevent any harm. Standards issued by international medical bodies stress the importance of timely referrals especially with respect to reproductive healthcare services, ensuring availability of providers willing to perform abortions and prohibiting the exercise of conscientious objection in emergency situations.

The World Health Organization (WHO) has recognised the problem of lack of access to abortion services even where women are legally entitled to have the procedure, and the resulting increased risk of unsafe abortion.[77] In its safe abortion guidelines for national health systems, the WHO recommends that govern-

---

2000-V Eur. Ct. H.R. paras. 55-63; *see also AGOSI v. United Kingdom*, 180 Eur. Ct. H.R. (ser. A) para. 55 (1986); *Jokela v. Finland*, 2002-IV Eur. Ct. H.R. para. 45.

74) Judgment, *Tysiąc v. Poland*, *supra* note 6, para. 116.

75) *Eur. Parl. Assemb., Resolution 1763*, *supra* note 73, para. 4.

76) Eur. Parl. Assemb., *Explanatory memorandum — Unregulated use of conscientious objection, supra* note 5, para. 15 ("…many [European] countries facing problems in the area of conscientious objection in healthcare settings lack a comprehensive and effective legal and policy framework, as well as oversight mechanisms to govern the practice of conscientious objection by healthcare providers").

77) *World Health Organization, Safe Abortion: Technical and Policy Guidance for Health Systems* 82 (2003). The problem of access helps explain the fact that unsafe abortion is a leading cause of maternal mortality and morbidity worldwide, despite the fact that abortion is legal for at least some reasons in most countries. Lack of access to safe abortion services is due to a range of health systems problems and broader policy and social factors, including lack of trained providers or their concentration in urban areas; negative provider attitudes; use of inappropriate or outdated methods of inducing abortion; lack of knowledge of the law and women's rights under the law by providers and the public, or lack of application of the law by providers; stigmatization and fears about privacy and confidentiality; and the perceived quality of care provided. *Ibid.*, at 14-15.

ments establish policies that ensure access to quality abortion services where abortion is legal.[78] The guidelines urge ministries of health to clarify legal requirements for abortion and remove common barriers that constrain access to services allowed by law.[79] In the context of the exercise of conscientious objection, WHO notes that providers have 'an ethical obligation to follow professional ethical codes, which usually require health professionals to refer women to skilled colleagues who are not, in principle, opposed to termination of pregnancy allowed by law.'[80] According to general WHO guidelines, a well-functioning referral system is critical to the provision of safe abortion services and all health personnel should be able to direct women to appropriate services if they are unavailable on site.[81] The guidelines further establish that '[t]raining and equipping health professionals at the primary level to provide early abortion services and to make appropriate referrals may thus be one of the most important investments to consider.'[82] In addition, the WHO has stated that regardless of the personal perspectives of health care personnel, the managers should ensure the availability of trained health care providers to provide care for abortion complications.[83]

The International Federation of Gynecology and Obstetrics (FIGO) has affirmed that: "The primary conscientious duty of obstetrician-gynaecologists [...] is at all times to treat, or provide benefit and prevent harm to, the patients for whose care they are responsible. Any conscientious objection to treating a patient is secondary to this primary duty."[84] In its Code of Ethics, FIGO stated that while health care providers have the right to preserve their moral or religious values, this should not result in the imposition of such values on others.[85] The World Medical Association has also echoed this position stating that while health

---

78) *Ibid.*, at 82. The guidelines recognise that health professionals themselves have ethical and legal obligations to respect women's rights, and appeal to such individuals to "understand and apply their national law related to abortion, and contribute to the development of regulations, policies and protocols to ensure access to quality services to the extent permitted by law and respecting women's rights to humane and confidential treatment." *Ibid.*, at 15.

79) *Ibid.*, at 90.

80) *Ibid.*, at 66.

81) *Ibid.*, at 64.

82) *Ibid.*, at 59.

83) *World Health Organization, Complications of Abortion: Technical and Managerial Guidelines for Prevention and Treatment 95* (1995), *available at* http://whqlibdoc.who.int/publications/1995/9241544694.pdf.

84) *Ethical Guidelines on Conscientious Objection*, in *International Federation of Gynecology and Obstetrics (FIGO), Comm. for the Study of the Ethical Aspects of Human Reproduction and Women's Health, Ethical Issues in Obstetrics and Gynecology* 25, 26 (2009). (The International Federation of Gynecology and Obstetrics (FIGO) is the only worldwide organisation that groups obstetricians and gynecologists. It has member associations in 124 countries/territories. Its Secretariat is based in London, the UK. FIGO's mission is to promote the wellbeing of women and to raise the standards of practice in obstetrics and gynecology.)

85) International Federation of Gynecology and Obstetrics (FIGO), *Code of Ethics: Professional and Ethical Responsibilities Concerning Sexual and Reproductive Rights*, at A(5), adopted Nov. 2003, available at http://www.figo.org/Codeofethics (last visited 19 Dec. 2011).

care providers should act on their conscience, they must always act in the best interest of the patient to guarantee her/his "autonomy and justice".[86] Hence, FIGO's resolution on conscientious objection establishes that in emergency situations health care providers should "provide care regardless of practitioners' personal objections."[87]

5. The Law and Practice in Europe

There is a growing body of domestic standards that lay out state obligations and duties of health care providers that should guide the legal and policy frameworks on conscientious objection to sexual and reproductive health services and related ethical and legal standards and practice in European countries. These standards are rooted in international and regional human rights standards (see above) and have been articulated and defined in European domestic legislation and jurisprudence. They are guided by the principle that states and public institutions have a positive obligation to ensure that women are able to access sexual and reproductive health care services provided for by law.[88] These standards, set forth below, are followed by examples of European law, including jurisprudence, governing the issue.

5.1. *General State Obligations: Establish Adequate and Effective Legal and Policy Frameworks to Ensure that Conscientious Objection Clauses Do not Prevent Women from Accessing the Services They Are Legally Entitled to Receive*

5.1.1. *Ensure Adequate Availability of Healthcare Providers for Sexual and Reproductive Health Services*

The availability of providers for sexual and reproductive health services, especially abortion, is specifically impacted by the practice of conscientious objection. While many countries in Europe exempt health care providers from performing procedures to which they conscientiously object, including abortion, only a few have regulated the practice by requiring notification of their objecting status to authorities and organizing the health care system and job recruitment to ensure that there are doctors willing, trained and able to provide services. As illustrated

---

86) World Medical Association, *Declaration on the Rights of the Patient, adopted* Oct. 1981, *available at* http://www.wma.net/en/30publications/10policies/l4/index.html (last visited 26 Feb. 2011).

87) International Federation of Gynecology and Obstetrics (FIGO), *Resolution on "Conscientious Objection"*, adopted Nov. 2006, available at http://www.figo.org/projects/conscientious (last visited 26 Feb. 2011) [hereinafter FIGO, *Resolution on Conscientious Objection*].

88) *See* Rebecca J. Cook and Bernard M. Dickens, *World Health Organization, Considerations for Formulating Reproductive Health Laws* 34 (Doc. WHO/RHR/00.1, 2nd ed. 2000), *available at* http://whqlibdoc.who.int/hq/2000/WHO_RHR_00.1.pdf; *see also* Rebecca J. Cook, Monica Arango Olaya and Bernard M. Dickens, 'Healthcare responsibilities and conscientious objection,' 104 *Int'l J. Gyn. & Obst*. 249-252 (2009); Bueno de Mesquita and Finer, *supra* note 2.

in the case of Italy, below, the rising number of objectors is a worrisome trend that will test health systems approach to balancing interests of the provider with the rights of women.

Norway is one of the few countries in Europe with a comprehensive regulatory and oversight framework on conscientious objection to abortion that includes ensuring the availability of providers willing and able to perform abortions. Norway's abortion law guarantees that a woman can obtain an abortion at anytime by requiring that medical services are organised to take into account health personnel who conscientiously object to abortion.[89] Regulations on conscientious objection require healthcare providers to give written notice to their employer hospital if they refuse to assist with an abortion and those hospitals, in turn, to report to government authorities.[90] If requested, persons applying for hospital employment must give notice of their conscientious objection to performing or assisting in abortion procedures.[91] Furthermore, in employment advertisements, hospitals may require as a condition for employment that hired health-care personnel be willing to perform or assist in abortion procedures.[92] As the regulations state, these provisions are in place to ensure the availability of an adequate number of providers so that women are able to exercise their right to abortion.[93]

In Germany, a 1990 decision by the Bavarian High Administrative Court,[94] which was upheld by the Federal Administrative Court of Germany,[95] ruled that a municipality's job advertisement for a chief physician in a women's hospital, which included a requirement that the physician be willing to perform abortions, was not in violation of a law providing that no one is obligated to perform abortions. The court referred the need to provide abortions in public hospitals and took into consideration that private hospitals may not be willing to provide abortions due to religious or moral reasons. It emphasized that public hospitals must enable women to realize their entitlement to abortion under the law and, thus, the criteria for the job was deemed permissible.[96]

---

89) The Act dated 13 June 1995 no. 50 concerning Termination of Pregnancy, with Amendments in the Act dated 16 June 1978 no. 5, at 14 (Nor.).

90) Regulations for the Implementation of the Act dated 13 June 1995 no. 50 concerning Termination of Pregnancy, with Amendments in the Act dated 16 June 1978, no. 66, § 20 (Nor.) [hereinafter Norway Regulations for Implementation of Abortion Act]. Slovenia's Health Services Act contains similar provisions, which require healthcare workers to report their conscientious objection to their employer institution, and the institution to ensure that patients' rights to health care are accessible "without disruption." Health Services Act [*Zakon o zdravstveni dejavnosti*], Art. 56, Official Gazette of the Rep. of Slovenia [*Uradni list Republike Slovenije*], No. 9, enacted 1992.

91) Norway Regulations for Implementation of Abortion Act, *supra* note 90, at 20.

92) *Ibid.*

93) *Ibid.*

94) *Judgment of the Bavarian Higher Administrative Court of 03/07/1990*, BayVGH DVB1. 1990, 880-82 (F.R.G.).

95) *Judgment of the Federal Administrative Court of 12/13/1991*, BVerwGE 89, 260-70 (F.R.G.).

96) *Judgment of the Bavarian Higher Administrative Court, supra* note 105, at 880-82.

Guidelines on the appointment of doctors to hospital posts issued by the United Kingdom National Health Service recommend that termination of pregnancy duties should be a feature of the job when adequate services for termination of pregnancy "would not otherwise be available," the job description should be explicit about termination of pregnancy duties, and applicants should be "prepared to carry out the full range of duties which they might be required to perform if appointed," including duties related to termination of pregnancy.[97] The British Medical Association (BMA) has recommended that conscientious objectors' position be disclosed to supervisors, managers or partners at as early a stage in employment as possible to ensure the availability of an adequate number of providers to perform abortions.[98]

Italy's abortion law requires healthcare institutions to ensure that women have access to abortion.[99] Specifically, regional health care bodies are required to supervise and ensure such access, which may include transfer of health care personnel.[100] In accordance with this requirement, the law mandates health care personnel to submit a written declaration of their conscientious objection to abortion to the medical director of their employer healthcare institution and to the regional medical officer.[101] However, a recent report by Italy's Ministry of Health indicates potential problems in implementation of the law due to growing numbers of conscientious objectors. The report shows that nearly 70 percent of gynaecologists in Italy refuse to perform abortions on moral grounds.[102] It noted that between 2003 and 2007 the number of gynaecologists invoking conscientious objection in their refusal to perform an abortion rose from 58.7 percent to 69.2 percent,[103] and that the percentage of anaesthesiologists who refused to help in an abortion rose from 45.7 percent to 50.4 percent.[104] In the southern parts of the country, the numbers are higher.[105]

---

97) National Health Service Guidelines, Appointment of doctors to hospital posts: termination of pregnancy, NHS Executive HSG (94)39 (1994) (U.K.).

98) British Medical Association, 'Contraception, abortion, and birth', in *Medical Ethics Today: The BMA's Handbook of Ethics and Law* 248-50 (2d ed., 2004) [hereinafter *BMA's Handbook of Ethics and Law*].

99) Law No. 194 of 22 May 1978 on the social protection of motherhood and the voluntary termination of pregnancy, Gazz. Uff., Part I, 22 May 1978, No. 140, 3642-46 (Italy) [hereinafter *Italy Voluntary Termination of Pregnancy Act*].

100) *Ibid.*, § 9.

101) *Ibid.*

102) *Republic of Italy, Ministry of Health, Report of the Ministry of Health on the Performance of the Law Containing Rules for the Social Care of Maternity and Voluntary Interruption of Pregnancy:* 2006-2007 4 (2008).

103) *Ibid.*

104) *Ibid.*

105) *Ibid.*

5.1.2. *Regulate the Unlawful Practice of Institutional Conscientious Objection*
The refusal of public health care *institutions* to provide certain services on grounds of conscientious objection is a growing problem in some countries in Europe. As discussed above, it's an individual that can hold a conscience, not an institution. Health care facilities, as state entities, have a duty to ensure that legal health services are available and accessible to the public. However, laws in Europe generally do not explicitly prohibit this practice and there is little, if any, oversight and monitoring. Women in these countries are often turned away and denied the health care services they need because of a decision by management not to perform abortions. In addition, travel to another health facility that does perform abortions may be burdensome, especially to low income. In addition, women may be unable to access services outside the geographical range of their insurance plans.

For example, in Slovakia and Poland, conscientious objection is sometimes abused by top management of hospitals, who have an unwritten policy banning performance of some lawful interventions (usually abortions) throughout the hospital, regardless of the opinion of the healthcare staff.[106] In Slovakia's capital, Bratislava, it has been reported that one of the public hospitals does not perform abortions and in the regional capital of Trnava, no hospitals perform abortions[107] and the state has not taken any steps to address this growing problem. In a case against Poland pending before the European Court of Human Rights, a woman with a wanted pregnancy was denied health services in numerous hospitals in part on grounds of conscience. Unable to get the diagnostic and medical treatment she needed, she developed sepsis, which led to a miscarriage and then to her death.[108]

A 2001 decision of the French Constitutional Court recognised the principle that conscientious objection is a right afforded to individuals, not institutions, and upheld the repeal of paragraphs in the Code of Public Health, removing the possibility that department heads of public health establishments could refuse to allow the provision of abortion services in their departments.[109] The case was brought by senators who claimed, in part, that the repeal of these provisions violated the principle of freedom of conscience protected by the Constitution.[110] While the Constitutional Council recognised the fundamental nature of the freedom of conscience, it also clarified that such freedom was that of *individual*, not

---

106) Eur. Parl. Assemb., *Explanatory Memorandum — Unregulated use of conscientious objection*, *supra* note 5, para. 47.
107) Information provided by the Slovak Family Planning Association, 2010.
108) *Z. v. Poland*, App. No. 46123/08, Eur. Ct. H.R. (filed 16 Sept. 2008) (on file with the Center for Reproductive Rights and the Federation for Women and Family Planning in Poland).
109) *CC decision no. 2001-446DC*, June 27, 2001, Rec. 74, paras. 11-17 (Fr.), available at http://www.conseilconstitutionnel. fr/conseil-constitutionnel/root/bank_mm/anglais/a2001446dc.pdf.
110) *Ibid.*, para. 12.

institutional or departmental, conscience "…which cannot be exerted at the expense of that of other doctors and medical staff working in his service."[111] The Council also provided that "…these provisions [of the Health Code] contribute in addition to respect for the constitutional principle of the equality of users before the law and before the public service."[112]

5.1.3. *Ensure that Conscientious Objection Is only Exercised in Direct Performance of Treatment Services*

Many legal frameworks are unclear about who can conscientiously object and for what services. Some conscientious objection clauses in Europe, however, state either explicitly that they apply only to healthcare personnel involved in the *actual performance* of procedures or have been interpreted as such. For example, Norway's regulation implementing the abortion law expressly provides that the right to refuse to assist in an abortion belongs only to personnel who perform or assist the actual procedure, not to staff providing services, care or treatment to the woman before or after the procedure.[113] Italy's abortion law does not exempt health-care personnel from providing pre and post-abortion care.[114]

The scope of the conscientious objection clause in the United Kingdom's abortion law was articulated by House of Lords decision in 1988, which made clear that the clause applies only to participation in treatment.[115] The case involved a doctor's secretary who objected to signing an abortion referral letter on grounds of conscience. The House of Lords held that such an act did not constitute part of the treatment for abortion and, thus, was not covered by the conscience clause of the abortion law.[116] The decision supports the proposition that doctors cannot claim exemption from giving advice or performing the preparatory steps to arrange an abortion if the request for abortion meets legal requirements.

In a recent 2011 decision, a judge in Málaga, Spain, declared that a family doctor from a public medical centre could not object to give referrals to pregnant women seeking terminations.[117] In this decision, which comes soon after the liberalization of the abortion law in Spain, the judge established that as a public employee, his "duty to provide adequate health care prevailed over that of conscience". The decision reaffirms that the conscientious clause in the abortion law, allowing providers to refuse to provide services, applies only to the performance

111) *Ibid.*, para. 15.
112) *Ibid.*
113) Norway Regulations for Implementation of Abortion Act, *supra* note 90, § 20.
114) Italy Voluntary Termination of Pregnancy Act, *supra* note 99, § 9.
115) *Janaway v. Salford Health Authority*, 3 All E.R. 1079 (H.L. 1988).
116) *Ibid.*
117) *Auto del Juzgado Contencioso-Administrativo No. 3 de Málaga*, Pieza separada medidas provisionales nº 12.1/2011, Pmto. Especial protección derechos fundamentales nº 39/2011. 29 March, 2011.

of a termination of pregnancy and not to the provision of information and referrals to non-objecting providers.[118]

5.2. *State Regulation of Duties of Healthcare Providers*

5.2.1. *Duty to Provide Accurate and Non-biased Information about Patients' Health Status and Available Procedures*

Health care providers have the duty to offer accurate and non-biased information about all legally available medical procedures, treatment options and products to the patient, even if they object to providing the services themselves. Failure to do so denies women the ability and the right to make free and informed health care decisions. For example, the European Court of Human Rights recently found Poland in violation of the European Convention, in part, because it did not fulfil its duty to regulated conscientious objection. The case, as referred to above, regarded a woman who was repeatedly denied diagnostic genetic prenatal examinations because doctors argued that the results could lead to a termination of pregnancy, in contravention of their conscience. While the Court's judgment did not provide detailed reasoning, it implied that healthcare providers should not be allowed to invoke conscientious objection with regards to healthcare information, including *diagnostic* care that may or may not lead to an objectionable act.[119]

A 2003 United Kingdom High Court of Justice Queens Bench Division judgment sheds further light on the unlawfulness of such acts. It found a doctor negligent for failing to properly counsel — in part because of his religious beliefs — his patient about her increased risk of giving birth to a baby with Down's syndrome and the availability of prenatal screenings for such abnormalities.[120] The woman was denied a chance to make an informed decision regarding her pregnancy, and gave birth to a child with Down's syndrome. The doctor, a devout Catholic, noted that he did not routinely and explicitly discuss screening for abnormalities with every pregnant woman. He testified that he thought pregnancy was a happy event and would want to "soothe, not alarm patients," but that he expected he would have told someone of the plaintiff's age that she was "at a slightly raised risk" for foetal abnormalities.[121] The court noted that "[o]n his own account Dr. Kwun's approach to the subject [of informing patients about screening for abnormalities] was coloured by his belief in Roman Catholic doctrine."[122] The court ultimately found that if the doctor had used the phrase "slightly raised risk," as the doctor testified, "it would have been seriously misleading," considering that experts

---

118) *Ibid.*

119) Judgement, *R.R. v. Poland, supra* note 49; *see also* Center for Reproductive Rights, *R.R. v. Poland*, http://reproductiverights.org/en/feature/poland-a-victory-of-firsts.

120) *Enright and Another v. Kwun and Another*, [2003] E.W.H.C. 1000 (Q.B.).

121) *Ibid.*, paras. 29, 55.

122) *Ibid.*, para. 30.

testified that the risk for foetal abnormalities increases significantly at the plaintiff's age.[123] As a result of the doctor's failure to provide such information, the patient could not make an informed choice about whether or not to carry her pregnancy to term, given the risk that her child would have Down's syndrome.

5.2.2. *Duty to Refer Patients and to Maintain Quality of Care*

The duty that is reflected in most laws and ethical codes across Europe and in international human rights standards is the duty to refer patients to non-objecting providers. Almost all countries in Europe require this.[124] Some countries also explicitly add that the referral should be done in a timely manner and should apply from the moment the patient first requests medical intervention from a healthcare provider. In addition, the duty implies quality referral; ensuring women can receive quality treatment. In its Declaration on Therapeutic Abortion, the World Medical Association established that "If the physician's convictions do not allow him or her to advise or perform an abortion, he or she may withdraw while ensuring the continuity of medical care by a qualified colleague."[125]

In the Netherlands and France, for example, laws place a legal obligation on healthcare professionals and physicians to immediately communicate to a pregnant woman their refusal to perform an abortion.[126] Similarly, Portugal's Medical Association Code of Ethics mandates that a physician immediately communicate his or her objection to patients,[127] while the law requires that physicians communicate their objections to patients in a "timely fashion."[128] In France, doctors who

---

123) *Ibid.*, para. 56. *See also Barr v. Matthews*, 52 BMLR 217 (Q.B. 1999). In 1999, the UK Queen's Bench Division held that plaintiff's medical negligence claim against defendant for failure to provide medical advice on termination of pregnancy because of defendant being "philosophically opposed to abortion, [and] unwilling to facilitate one," thus *resulting in the birth of a child suffering from cerebral palsy,* was not successful. The court did emphasise that "once a termination of pregnancy is recognised as an option, the doctor invoking the conscientious objection clause should refer the patient to a colleague at once."

124) *See, e.g., BMA's Handbook of Ethics and Law, supra* note 98, at 16-17 (U.K.); National Health Service Guidelines, Guidance on fundholder purchase of terminations of pregnancy, HSG (95)37, para. 6 (1995) (U.K.) [hereinafter *NHS Guidelines* HSG (95)37]; Code de la Sante Publique, arts. L2212-8, R4127-18 (Fr.); Zakon o liječništvu (Zl) [Law of Doctoring], Art. 20 (2003) (Croat.) [hereinafter Croatia Law of Doctoring]; Kodeks medicinske etike i deontologije [Code of Medical Ethics and Deontology] Art. 2, para. 15 (Croat.) [hereinafter Croatia Code of Medical Ethics]; Act No. 154 of 1997: Health Care (1997. évi CLIV. törvény az egészségügyről) §§ 125-37 (Croat.) [hereinafter Croatia Act No. 154]; Ministry of Health Decree No. 30/2007: The Code of Ethics of Health Care Service Providers [30/2007. (VI. 22.) EüM rendelet az egészségügyi dolgozók rendtartásáról] § II (Hung.) [hereinafter Hungary Ministry of Health Decree No. 30/2007]; Codigo Deontologico da Ordem dos Medicos (2008), Art. 37 (Port.); Lei No. 16/2007 de 17 de abril, Exclusão da ilicitude nos casos de interrupção voluntária da gravidez (Port.).

125) World Medical Association, *Declaration on Therapeutic Abortion*, adopted Aug. 1970, available at http://www.wma.net/en/30publications/10policies/a1/index.html (last visited Dec. 19. 2011).

126) *See* Code de la Sante Publique (Fr.), *supra* note 124, arts. L2212-8, R4127-18; *see also* Law of 1 May 1981 (Stb. 257) prescribing rules concerning the termination of pregnancy, § 20 (2) (Neth.).

127) Codigo Deontologico da Ordem dos Medicos (Port.), *supra* note 124, Art. 37(2).

128) Lei No. 16/2007 (Port.), *supra* note 124, § 4.

conscientiously object also have a legal duty to the woman seeking abortion to "give her the name of experts to perform the procedure."[129] In Poland, Croatia and Hungary, laws require physicians to inform patients of their objection to a procedure and to provide a referral to such patients, but they do not have an oversight mechanism to ensure that this occurs, leaving many women without a referral.[130]

In the United Kingdom, guidelines issued by the British Medical Association (the "BMA") and the Royal College of Obstetricians and Gynaecologists (RCOG),[131] two of Britain's leading medical associations, have informed the implementation and judicial interpretation[132] of the conscientious objection provisions of the 1967 Abortion Act, and obligate physicians who conscientiously object to providing abortion services to take preparatory steps to arrange for an abortion and provide referrals to another doctor without delay.[133] The BMA guidelines explicitly provide that "[i]t is not sufficient simply to tell the patient to seek a view elsewhere since other doctors may not agree to see her without appropriate referral."[134] RCOG has issued recommended referral times for abortion services.[135] In addition, the UK National Health Service guidelines, which are issued to provide guidance to practitioners, note that all doctors who conscientiously object to "recommending termination should quickly refer a woman who seeks their advice about a termination to a different [general practitioner]... If doctors fail to do so, they could be alleged to be in breach of their terms of service."[136]

In the absence of regulations requiring timely notification of a healthcare provider's objection, accompanied by a timely referral, women may be unable to locate another provider to perform such procedure in a timely manner, foregoing their right to an abortion. For example, in Denmark, a woman who scheduled an appointment at a clinic to undergo an abortion was not informed by the doctor of such doctor's conscientious objection to the performance of abortions, nor was

---

129) Code de la Sante Publique (Fr.), *supra* note 124, Art. L2212-8.

130) *See* Act of 5 December 1996 on the Medical Profession [Dz. U. z 2002 r. Nr 21 poz. 204 z po˚n. zm.], Art. 39 (Pol.); *see also* Croatia Law of Doctoring, *supra* note 124, Art. 20; Croatia Code of Medical Ethics, *supra* note 124, Art. 2, para. 15; Croatia Act No. 154, *supra* note 124, §§ 125-37; Hungary Ministry of Health Decree No. 30/2007, *supra* note 124, § II.9.

131) *Royal College of Obstetricians & Gynaecologists, The Care of Women Requesting Induced Abortion* 2004 [hereinafter *RCOG Guidelines*].

132) *See, e.g., Family Planning Ass'n of Northern Ireland v. Minister for Health, Soc. Serv. and Pub. Safety*, 2004 NICA 39 (Transcript) (Q.B.).

133) *BMA's Handbook of Ethics and Law*, *supra* note 98, at 249; RCOG Guidelines, *supra* note 143, at 16-17.

134) *BMA's Handbook of Ethics and Law*, *ibid.*, at 249.

135) *RCOG Guidelines*, *supra* note 131, at 23-24.

136) *NHS Guidelines HSG* (95)37, *supra* note 124, para. 6.

she provided a timely referral.[137] A member of the Danish Board of Health and legal commentator, in reviewing this case noted the impact this could have on the exercise of her right to an abortion, 'the failure to immediately inform the patient of a conscientious objection to abortion and to provide a referral could delay the time period within which a woman can legally exercise her right to a voluntary termination of pregnancy. Such delay could cause the woman to exhaust the 12-week period during which she may legally procure an abortion, and thereby cause her to unwillingly forego her right to this procedure.'[138]

A corollary to such duty is that in situations in which the healthcare provider is unable to guarantee that women will receive quality treatment, such healthcare provider must provide treatment to the patient, regardless of whether it conflicts with her or his conscience.[139] For example, in Norway, a physician may not refuse to treat a patient unless the patient has reasonable access to another doctor who can provide treatment.[140] Additionally, in San Marino, a physician that conscientiously objects to the performance of a procedure must refer the patient to another medical professional who can provide adequate treatment, and the physician must ensure that the patient continues to receive care during the transition period.[141]

5.2.3. *Duty to Provide Care in Emergency Situations*

International and regional medical and human rights standards establish that conscientious objection cannot be invoked in emergency situations when life-saving treatment is needed.[142] While most countries impose a general duty on

---

[137] *Doctor refuses to refer pregnant women to abortion* (Læge nægter at henvise gravide til abort), Tv2Lorry, July 10, 2007, http://ekstrabladet.dk/nyheder/samfund/article94950.ece (last visited 19 Dec. 2011).

[138] *Ibid.*,; see also Janne Rothmar Hermann, 'Ethical issues regarding abortion: How far does the right go?' (*Etisk forbehold ved abort: Hvor langt rækker retten?*), 169 *Ugeskrift for Læger (Journal of the Danish Medical Association)* (2007) 4488.

[139] *See* FIGO, *Resolution on Conscientious Objection*, *supra* note 87 ("FIGO affirms that to behave ethically, practitioners shall . . . Provide timely care to their patients when referral to other practitioners is not possible and delay would jeopardise patients' health and well-being").

[140] Code of Ethics for Doctors [*Den Norske Legeforening*], § 6 (Nor.).

[141] Code and Rules of Ethics for the Medical Profession, Art. 16 (San Marino).

[142] *See, e.g.*, FIGO Ethical Guidelines, *supra* note 84, para. 8; Committee on the Elimination of Discrimination against Women, *Concluding Observations: Morocco*, para. 78, U.N. Doc. A/52/38/Rev.1 (1997); *Concluding Observations: Pakistan*, para. 41, U.N. Doc. CEDAW/C/PAK/CO/3 (2007); *Concluding Observations: Peru*, para. 340, U.N. Doc. A/53/38/Rev.1 (1998); *see also* Human Rights Committee, *Concluding Observations: Mali*, para. 14, U.N. Doc. CCPR/CO/77/MLI (2003). Various UN Treaty Monitoring Bodies have reaffirmed the need to guarantee women's access to emergency care services in order to ensure their health and prevent maternal mortality and morbidity. *See e.g.*, Committee on Economic, Social and Cultural Rights, *General Comment 14: The Right to the Highest Attainable Standard of Health (Art. 12)* (22nd Sess., 2000), *in* Compilation of General Comments and General Recommendations by Human Rights Treaty Bodies, at 90, ¶ 14, U.N. Doc. HRI/GEN/1/Rev.7 (2004). The UN Committee on the Elimination of Discrimination Against Women recently issued a decision against Brazil for the State's failure to provide quality medical emergency care to a pregnant woman. Decision *Alyne vs Brazil*, CEDAW/C/49/D/17/2008, Communication No. 17/2008 (10 August 2011).

health care providers to provide care in emergency situations,[143] only eleven European countries expressly prohibit the invocation of conscientious objection in the case of emergency or risk of death as well as danger to patient's health.[144] Some countries do not explicitly provide any exceptions to the right to conscientious objection.[145] This is an area of law and policy that must be clarified in order to guarantee access to emergency healthcare services. For example, under the United Kingdom Abortion Act, doctors have a right to opt out of participating in abortion but are obliged to provide necessary treatment in emergencies. If a woman's life or long-term health care is at stake, doctors who hold a conscientious objection to terminating a pregnancy are obliged to provide necessary care.

6. Conclusion

Despite the progress achieved in the last fifteen years on expanding the recognition and enjoyment of women's rights to sexual and reproductive healthcare services, the unregulated practice of conscientious objection is increasingly restricting women's access to a wide range of legal health services, including abortion and contraception. In many European countries, the practice of conscientious objection is largely unregulated. The absence of a comprehensive and effective legal and policy frameworks governing the practice is putting women's health and lives at risk and violating their human rights.

While existing international and regional human rights, medical and ethical standards as well as national laws and jurisprudence, provide some guidance on how to adequately regulate the practice, further guidance is needed. International and regional human rights bodies are well-positioned to provide such guidance. These bodies should monitor state compliance with their obligations to ensure timely and adequate sexual and reproductive health services and hold governments accountable when violations of such rights occur. In addition, medical and ethical bodies should also uphold women's reproductive rights and promote the regulation of conscientious objection.

In order to guarantee access to health care services provided by law and to uphold their international human rights commitments, European states should develop comprehensive laws and policies that define and regulate the practice of

---

143) *See* Eur. Parl. Assemb., *Explanatory Memorandum — Unregulated use of conscientious objection, supra* note 5, at 10.

144) Bosnia & Herzegovina; Croatia; Czech Republic; Hungary (risk of death applies only to abortion); Italy; Lithuania; Poland; Portugal; San Marino; Slovakia; and the United Kingdom (abortion only).

145) In Denmark, there are no explicit exceptions to the right to conscientious objection; however, the Danish Constitution only protects religious belief to the extent that it does not provide "reasons [to] evade compliance with any common civic duty." Danmarks Riges Grundlov, § 70 (1953) (Den.), *available at* http://www.grundloven.dk/. In the Netherlands, legislation, regulations and codes do not provide any clear exceptions to the right to conscientious objection.

conscientious objection. The regulations should clearly establish who can object, under which circumstances and to which services. They should also establish the duties of health care providers and set up oversight mechanisms to ensure that these duties are fulfilled and that redress is provided when those duties are violated.

Basic principles, derived from medical and international and regional human rights standards, governing the regulation of conscientious objection should ensure the following:

- Availability and accessibility of reproductive health care providers, including by employing adequate staff available and willing to competently deliver services.
- Availability of timely services within a convenient distance for the patient.
- A duty on providers to ensure timely notice to patients that they are conscientious objectors.
- A duty on providers to refer the patient, to another provider willing and able to perform the health care procedure/treatment. Such a provider must be conveniently accessible and the referral should be done in a timely manner.
- Conscientious objection cannot be invoked in emergency situations when the life or health of the patient is at risk. Health care providers should be trained in performing all legal reproductive health care services, irrespective if objectionable. This will ensure access to health care services in emergency and other situations where conscientious objection is not applicable.
- Conscientious objection applies only to direct health care treatment/procedures, not diagnostic care that may or may not lead to an objectionable act by the patient.
- Conscientious objection should not apply to staff in performing general care functions, such as preparing operating rooms, making appointments, issuing referral notices, etc.
- Conscientious objection cannot be invoked in information services; patients must be informed of their health status and all risks, benefits and alternatives to treatment/procedures.
- Conscientious objection can only be invoked by individuals; it cannot be invoked by institutions.
- Oversight and monitoring of the practice of conscientious objection so as to ensure women are able to access the timely medical services they need and are legally entitled to receive.
- Legal remedies be available when harm results from the practice of conscientious objection.