Chilean Medical and Midwifery Faculty's Views on Conscientious Objection for Abortion Services

CONTEXT: *In 2017, Chile reformed its abortion law to allow the procedure under limited circumstances. Exploring the views of Chilean medical and midwifery faculty regarding abortion and the use of conscientious objection (CO) at the time of reform can inform how these topics are being taught to the country's future health care providers.*

METHODS: *Between March and September 2017, 30 medical and midwifery school faculty from universities in Santiago, Chile were interviewed; 20 of the faculty taught at secular universities and 10 taught at religiously affiliated universities. Faculty perspectives on CO and abortion, the scope of CO, and teaching about CO and abortion were analyzed using a grounded theory approach.*

RESULTS: *Most faculty at secular and religiously affiliated universities supported the rights of clinicians to refuse to provide abortion care. Secular-university faculty generally thought that CO should be limited to specific providers and rejected the idea of institutional CO, whereas religious-university faculty strongly supported the use of CO by a broad range of providers and at the institutional level. Only secular-university faculty endorsed the idea that CO should be regulated so that it does not hinder access to abortion care.*

CONCLUSIONS: *The broader support for CO in abortion among religious-university faculty raises concerns about whether students are being taught their ethical responsibility to put the needs of their patients above their own. Future research should monitor whether Chile's CO regulations and practices are guaranteeing people's access to abortion care.*

International Perspectives on Sexual and Reproductive Health, 2020, 46(Suppl. 1):25–34; doi: https://doi.org/10.1363/46e0620

By Lidia Casas, Lori Freedman, Alejandra Ramm, Sara Correa, C. Finley Baba and M. Antonia Biggs

Lidia Casas is director at Centro de Derechos Humanos, Facultad de Derecho, and Sara Correa is instructor and secretary of studies at Instituto de Investigación en Ciencias Sociales–both at Universidad Diego Portales, Santiago, Chile. C. Finley Baba is project manager, and Lori Freedman and M. Antonia Biggs are both associate professor–all at Advancing New Standards in Reproductive Health (ANSIRH), Bixby Center for Global Reproductive Health, University of California, San Francisco, Oakland, CA, USA. Alejandra Ramm is associate professor at Escuela de Sociología, Universidad de Valparaíso, Valparaíso, Chile.

The principle of conscientious objection (CO) originated as a way for individuals to refuse to participate in mandatory military service for moral or religious reasons,[1] but since has been applied in other contexts. In health care, CO describes providers' ability to refuse to participate in services—such as abortion—that they feel are incompatible with their beliefs.[2] Balancing the rights of patients to receive health care with those of clinicians to act according to their conscience has created a long-standing conflict.[3]

Some have argued that CO is used as a tool to limit abortion access,[4] or to avoid stigma or providing a service in which a clinician has limited training, or to reduce high workload.[3,5] Evidence suggests that CO refusals in abortion care can be misused and compromise patient care. A systematic review examining the views of nurses and midwives about CO in abortion care identified a range of positions on the subject, as well as conflict balancing the rights of patients and health professionals.[6] A survey in northern Ghana found that many clinicians trained to provide abortions objected to performing them, and that providers who would perform abortions experienced increased emotional and physical stress.[7] Interviews with abortion providers in Australia identified misuse of CO: Some respondents reported knowing providers who object for other than moral reasons and illegally refuse to provide referrals.[8] Similarly, a survey of obstetrician-gynecologists in Brazil found that many providers claimed CO when they were uncertain whether people seeking abortion as a result of rape were telling the truth.[9]

Human rights organizations have identified the use of CO for abortion as problematic; in response, they have called on countries to safeguard abortion access.[10,11] A 2016 legal ruling by the European Committee on Social and Economic Rights reaffirmed that CO should not pose a barrier to health care access; in other words, that an adequate number of providers should be available to ensure access to services.[12]

Abortion policies in Latin America are some of the most restrictive in the world. The few countries to have liberalized their laws in recent years have taken different paths with regard to CO. For example, Uruguay limits its use to personnel directly involved in the abortion procedure and does not allow CO for postabortion care (PAC). According to interviews with key stakeholders and experts, Uruguay's law decriminalizing abortion has resulted in high rates of CO, thereby limiting abortion access.[13,14] Colombia's law includes additional provisions that sanction providers who falsely claim CO or do not comply with the CO requirements.[15] In Argentina, in contrast, there are no legal consequences for not complying with CO regulations.[15]

In addition to allowing CO at the individual provider level, some countries permit CO at the institutional level—allowing an entire institution, such as a hospital or university, to refuse to provide abortion services. When institutions claim CO, health professionals employed by these institutions are not permitted to provide abortion care, whether or not the individuals personally object. Countries in the region have different laws regarding institutional CO for abortion: Colombia does not allow institutions to claim objector status,[15] while Mexico City and Uruguay allow only private institutions to claim it, and Argentina allows both private and public institutions to do so.[13,15]

Chile—the setting of this study—changed its abortion law in August 2017 from a complete ban to one permitting abortion when the woman's life is at risk, the fetus has a lethal anomaly or the pregnancy resulted from rape; at the time, public support for decriminalizing abortion in these circumstances was consistently high, ranging from 70% to 77%.[16–18] The initial law only permitted the physician performing the abortion to claim CO. However, soon after Chile's Congress approved the bill, the abortion reform bill was amended to allow institutions and a broader range of clinical and nonclinical health care personnel present during the abortion procedure—physicians, midwives, anesthetists and nurses—to claim CO.

The current regulations permit private institutions—including those that receive public funding—to claim CO, but prohibit public institutions from doing so. The law attempts to ensure that CO does not prevent abortion access entirely; for example, it may not be used to deny either preabortion (i.e., diagnosis of a fetal malformation or health condition affecting the pregnant person) or postabortion care. Objecting providers must register and notify the director of their institution of their objector status before making any CO claims, and objecting providers are required to refer all women seeking legal abortion to a nonobjecting provider.[4] In the event of a life-threatening emergency in which no nonobjecting provider is not available, an objecting provider is required to perform or assist in the abortion.

Since the law went into effect in September 2017, it is estimated that among obstetrician-gynecologists working in the 69 public hospitals in Chile designated to provide abortion services, 47% claimed CO status for cases involving rape, 27% for cases involving a fetal anomaly and 20% for cases in which the woman's life is at risk.[19] In some public hospitals, CO claims have reduced abortion access, especially those in which 100% of obstetrician-gynecologists refuse to perform abortions made legal by the 2017 measure.[19] Indeed, in the first abortion performed under the law, a girl younger than 12 seeking an abortion for a pregnancy that resulted from rape had to be transported 750 miles from her home to find a provider willing to participate in the procedure.[20]

The Pontificia Universidad Católica de Chile—a private religiously affiliated institution, and the highest-ranking university and medical school in the country[21]—was the first university in the country to claim CO at the institutional level. In response, its medical student organization conducted a university-wide poll of students that revealed substantial opposition to CO.[22] Fifty-five percent of students did not believe CO should be invoked in their educational institution, and 76% opposed the institution's ability to restrict their faculty from performing abortion in other health centers. Similarly, a survey of medical and midwifery students attending secular and religious universities in the Santiago metropolitan area conducted soon after abortion was decriminalized found that 97% of students supported the legal access to abortion in at least one circumstance, and 70–78% agreed that their university should train medical and midwifery students to provide abortion services.[23,24]

Because abortion was completely banned before reform, abortion training for providers in Chile was extremely limited in terms of both procedures and information. After decriminalization, the Ministry of Health began training practicing providers across the country in aspiration techniques and supplying public hospitals with the necessary equipment for these types of abortions. However, students who are becoming health care providers first receive abortion training from faculty. Thus, the views of medical and midwifery faculty on abortion provision and CO may affect students' knowledge, attitudes and training—and, in turn, patients' future access to abortion. Only physicians are legally allowed to provide an abortion, but midwives often provide abortion-related care. In addition, the law made the medication abortion drug mifepristone legal for the first time in Chile; physicians are the only providers allowed to write the prescription for mifepristone, but midwives are allowed to counsel the patient and give the prescription, and to report suspected cases of unlawful abortions to the police.[25]

This qualitative study is part of a larger project conducted to assess attitudes about decriminalization of abortion and legal reform—including CO—among medical and midwifery school faculty and students living in Santiago, Chile, during the months before and after legal reform. Here, we focus specifically on faculty's views about CO; to our knowledge, this is the first study to examine CO among medical or midwifery faculty in Chile. This research provides insight into the implementation of the new law by exploring faculty's views on the use of CO in reproductive health care. It is important to understand faculty's perspectives on CO because their views reflect what they might teach their students and give us insight into whether faculty are revising their curriculum to reflect the change in the legal status of abortion.

METHODS

Sample and Data Collection

After reviewing the Chilean Ministry of Education website, we identified 14 universities in Santiago that offer midwifery degrees or medical degrees with a specialization in obstetrics and gynecology. From those, we

identified seven universities to serve as recruitment sites; the selected schools included both public and private, secular and religiously affiliated (Catholic) universities. We estimate that the seven participating universities have more than 7,000 students seeking medical or midwifery degrees—representing 72% of medical and 38% of midwifery students in the Santiago metropolitan region.[26]

Faculty within the schools of medicine or midwifery who taught classes in obstetrics, gynecology or other related fields were eligible to participate. We used a purposive sampling approach in which we aimed to interview at least one faculty member from each medical or midwifery department within each university. We obtained faculty contact information from university websites and administrators, and invited 114 via email or phone to participate. We recontacted some nonresponders until we had reached our numeric goals, as well as thematic saturation and sufficient variation among participants with the same religious beliefs, or at the same types of institutions. A total of 30 faculty members were interviewed. Those who did not participate included one professor who was deemed ineligible because she no longer worked at the university; the remaining faculty did not respond to our email or phone invitations.

We conducted interviews from March to September 2017; this time frame overlapped with Chile's decriminalization of abortion in August 2017. All the interviews were conducted before the law was passed, except two that were conducted after the law was passed but before it was implemented. Two female, native-born Chileans—each with a master's degree in sociology, and trained in qualitative research methods and in-depth interviewing techniques—conducted the interviews in Spanish using a semistructured interview guide. They met with faculty in a private location of the participants' choice (e.g., university office, clinical office, cafe). Before the interviews, faculty read and signed a consent form, and gave their permission to be recorded. Interviews lasted approximately 45 minutes. Interviewees were not compensated for their participation. All interviews were audio-recorded and then transcribed in Spanish. As fieldwork was conducted, the two interviewers and the lead author met regularly to discuss progress, identify lines of inquiry and emerging themes.

Our study received human subjects' approval from the Committee of Ethics of the Institute of Social Science Research at the University of Diego Portales in Santiago, Chile.

Interview Guide

We developed a semistructured interview guide that included questions for faculty about their attitudes toward abortion and abortion provision; reporting and punishing people involved in unlawful abortions; and conscientious objection in health care and how they approach these topics in their classrooms. We also presented participants with scenarios—for example, a woman seeking PAC or a woman seeking information on how to self-manage an abortion—and asked them how they would instruct their students to approach these cases in their practice. We designed the interview guide to be free flowing, which allowed participants to introduce new ideas while also ensuring that we covered certain topic areas. The interview guide also collected demographic data, including education, teaching experience, gender, age, number of children, religion, political affiliation and region of residence. We conducted one pilot interview with a faculty member to test and finalize the guide.

Analysis

While most of the analysis was conducted in Spanish, a certified translator later translated all codes related to conscientious objection into English to aid in the final stage of analysis and summary of results, which was conducted in English. Four of the study authors are native-born Chileans and are fluent in Spanish, while two authors were born in the United States and have proficiency in Spanish; all authors are proficient in English.

We used a grounded theory approach to qualitative data analysis.[27] Two of the Chilean study authors, trained in sociology and with expertise in reproductive health and qualitative research, independently coded an initial set of interviews and discussed their respective lists of codes with the first author, a Chilean researcher trained in law. Together, they revised the code list iteratively after discussion and consensus, and applied the final list of codes to all interviews, using NVivo. A total of 27 codes were identified that reflected the main themes covered in the interviews. A fourth author, a sociologist and expert in qualitative research on reproductive health care, analyzed and summarized data relating to CO after it had been translated into English.

Our study focuses on faculty views on CO and abortion, the scope of CO (which employees should be allowed to object and the institution's obligations toward patients), and teaching about CO and abortion. We also sorted responses by whether respondents worked in a secular or Catholic university, as well as their background—either medicine or midwifery. This allowed us to get a more robust and insightful analysis that linked individual perspectives to a faculty member's training.

RESULTS

Of the 30 clinical teaching faculty interviewed, 17 were female and 13 were male (Table 1). Four of the faculty had been teaching for less than five years, 10 for 5–9 years, eight for 10–19 years, and seven for at least 20 years. In terms of their clinical background, 18 had medical degrees and 12 had midwifery degrees. The majority, 17, specialized in or focused on obstetrics-gynecology, while four faculty specialized in or focused on maternal-fetal medicine; no other category except for other had more than two. Eleven were faculty at public universities, nine at secular private universities and 10 at religious private universities. Eleven

of the faculty identified as practicing Catholic, eight as nonpracticing Catholic, six as having no religion and four as other.

Our analysis resulted in five main themes: faculty expressed strong support for the right of individual clinicians to conscientiously object to provide abortion care; they were divided over whether that right should be limited to specific providers because of the impact on patient access; only those working in religiously affiliated settings supported the unlimited extension of CO rights to institutions; the debate over CO highlighted the difficulty in balancing clinicians' rights with those of patients; and there was uncertainty about whether or how curricula should be changed as a result of the new law.

Widespread Support for CO to Abortion

While the vast majority of faculty described CO to participating in abortion care as both necessary and valid, their level of support for a person's right to abortion varied widely. Slightly more than half of faculty from secular universities supported the legal right to abortion in all circumstances, whereas more than half of religious-university faculty supported the right to abortion only to save a woman's life; three participants at religious universities and one at a secular university opposed abortion in all circumstances. Support for legal abortion also differed between midwifery and medical faculty: Most (nine of 12) midwifery faculty supported abortion in all circumstances, while most (16 of 18) physician faculty supported abortion in very limited circumstances.

Those opposed to abortion in all circumstances considered abortion to violate medical ethics; all faculty who expressed this opinion came from religiously affiliated universities. They said that CO allowed clinicians to work in accordance with the belief that the lives of the pregnant person and the fetus are valued equally. As one obstetrician-gynecologist put it, "It's not a conscientious objection for very personal reasons...abortion violates the principles of medicine, so we're never going to do anything that violates the principles and values of medicine." Faculty who expressed this view believed that abortion harmed one of two equally valued patients. As one faculty midwife explained, "I'm absolutely pro-women's rights, and the right of a woman to do what she wants with her body. But, to my mind, that little baby is not part of her body."

However, faculty who opposed abortion said that helping to terminate a pregnancy when the process has already started, as in the case of an incomplete abortion, or when the woman's life is at risk, was different. Most faculty who strongly opposed abortion still supported it in obstetric emergencies; some even said that individuals who are not comfortable with abortion while managing pregnancy complications should work in a different medical specialty or in a hospital where other doctors are willing to perform abortions. As one physician explained:

"If a woman is dying or her life is threatened, and I say, 'No, actually, I'm not going to interrupt the pregnancy because it goes against my principles...I think that person should find a different profession or be very careful where they work.... All of us who are against abortion understand that there are difficult situations in which you have to interrupt the pregnancy."–*Obstetrician-gynecologist, religious university*

Being religious did not necessarily mean that a faculty member opposed abortion or supported CO unconditionally. Of the participants who identified as practicing Catholics, one supported abortion in all circumstances, seven supported abortion to save a woman's life and only two opposed abortion in all circumstances. One maternal-fetal medicine physician—who worked at a secular university and was interviewed just before the abortion law was passed—had no problem providing abortion under the proposed law despite being religious, stating "My faith is

TABLE 1. Percentage distributions of medical and midwifery faculty study participants, Santiago, Chile, 2017

Characteristic	N	%
Gender		
Female	17	57
Male	13	43
Teaching experience (in yrs.)		
<5	4	14
5–9	10	34
10–19	8	28
≥20	7	24
Missing	1	3
Clinical degree		
Medicine	18	60
Midwifery	12	40
Specialty/focus area*		
Obstetrics-gynecology	17	57
Maternal-fetal	4	13
Infertility	2	7
Bioethics	2	7
Neonatology	2	7
Sexual health	2	7
Other	3	10
University type		
Public	11	37
Secular private	9	30
Religious private	10	33
Religion		
Practicing Catholic	11	38
Nonpracticing Catholic	8	28
None	6	21
Other	4	14
Missing	1	3
Has children		
Yes	23	77
No	7	23
Supports departmental changes**		
Content of current courses		
Yes	14	47
No	13	43
Missing	3	10
Types of courses required		
Yes	6	20
No	21	70
Missing	3	10
Total	30	100

*Some faculty reported more than one specialty. **Following decriminalization of abortion. *Notes*: Percentages may not add to 100% because of rounding.

strong, but it would not occur to me to make a conscientious objection in the face of an abortion in any of the three legal circumstances that are currently being considered...."

A few faculty explained how CO can ensure rights for both patients and physicians. As one maternal-fetal medicine physician at a secular university put it, "Just as a woman has the right or the freedom to abort a pregnancy, the physician also has every right to advise you if it is not appropriate for them to do it, given their ethical beliefs...."

Abortion Opponents Favor Expanded CO

Faculty who strongly believed that all employees involved in abortion care had the right to CO were almost entirely from religiously affiliated universities. For example, one physician described the range of professionals who should be allowed to claim CO:

"The abortion procedure itself is not something that the physician does alone, so probably he gets help from an anesthetist, a surgical assistant, a midwife, a medical assistant. I think it is totally logical to think that they could all have a conscientious objection...and have someone who's on the other side do it."—*Obstetrician-gynecologist, religious university*

Many faculty from religiously affiliated schools were inclined to prioritize the rights of a broad range of professionals to use CO to abortion over patients' rights to medical care. While these faculty did not explicitly state their position this way, many omitted any mention of patient rights when asked about balancing provider objection with a woman's right to receive care. For example, one physician said:

"The physician is not the patient's executioner. If a woman asks me to shoot her because she wants to die, my conscience tells me that I'm not acting in accordance with the goals of my chosen profession, which are to respect life, to heal whenever possible, to support in most cases." —*Physician, religiously affiliated university*

Most faculty from secular universities, but few from religiously affiliated universities, preferred to limit the right to CO to those with the greatest level of involvement and authority in the procedure. An obstetrician-gynecologist at a religiously affiliated university made this point:

"If I'm the orderly who takes the person to the operating room or something like that, it's hard for me to believe that they could conscientiously object, but I think the anesthesiologist and obviously the physician who's doing the abortion should."

One obstetrician-gynecologist at a secular university added that other clinicians should have the right if physicians are not on-site, stating "It has to be physicians [who can invoke CO], except in places where there are no physicians providing health care." One midwife at a secular university believed CO rights should be extended to those who provide information about and counseling for abortion: "I think those who intervene directly with the procedures, the consent process and informing the patients should have the right to conscientious objection."

Some faculty members made the explicit link between expanding CO rights and restricting abortion access. For this reason, this physician opposed an expansive approach to objection, as she believed it would create further barriers for women to get a lawful abortion:

"I think the ones who order treatment are the physicians; I think that it should go no further than that.... The midwife also has some influence, but I think not the pharmacist. No, I think there can be no more obstacles in the process; I think it is enough for the physician [to object to caring for] the poor woman for there to be even more obstacles."—*Physician, secular university*

Opinions Differ on Institutional CO

Only faculty working in religiously affiliated institutions said that they supported institutional CO. For example, one physician faculty member at a religiously affiliated university asserted that upholding institutional values was important to inspire those working within them, stating "more than a conscience, institutions have an ideology, a spirit; they have things that motivate them." Another physician said that private institutions should be allowed the right to CO, but questioned whether the same right applied to public institutions; this faculty member suggested that public institutions may even have an obligation to guarantee access to abortion care by ensuring that they have enough nonobjecting staff:

"I don't think a public hospital [should] be able to refuse...[but] every hospital should ensure that if it has conscientious objectors on staff, they also have others who are in agreement with the hospital's position."–*Obstetrician-gynecologist, religious university*

Another faculty member from a religious institution anticipated that his institution would never agree to perform abortions, thus ruling out the need to make any changes to their curricula or for providers to claim CO. When asked whether there was a reason to have CO, he responded:

"It doesn't make any sense to have a conscientious objection to an action [an abortion in a CO institution] that will always be illegal.... This hospital existed when there was an abortion law.... We didn't do abortions [then] and we never had any problems, so I don't see that there is any problem now." –*Gynecologist, religious university*

A secular university faculty member agreed that public hospitals should not have CO rights, and added that these hospitals should make sure they have enough staff willing to perform abortions:

"Conscientious objection is personal, not institutional, so the institution is the one that has to provide the service to the person who requests it.... I can't force a person to perform an abortion if their beliefs do not allow them to, but as an institution, there must be safeguards that allow the patient to receive care, and at every public institution there are people who are going to be for and others who object or don't object. So, managing that will not be a problem."–*Physician, secular university*

Finally, the idea of institutional CO was unacceptable to all faculty members at secular universities who were

asked the question. For example, one midwifery faculty member said that institutional CO deprives clinicians of their rights:

"I think conscientious objection is an individual issue, not an institutional one, and it seems to me that it's part of the rights all human beings have to want to participate or not in a certain activity...if I work at an institution where it's prohibited, I don't think that's right."–*Midwife, secular university*

Difficulty Balancing Clinicians' and Patients' Rights

For some faculty, all from secular universities, the debate over CO highlights the tension between a patient's right to health care and a clinician's right to do what she or he thinks is ethical. As one midwifery school faculty explained:

"If there is something I disagree with, I have to make sure that there is someone else who can do my job... because otherwise, the client's rights are completely null and void. So, I am protecting my right to conscientious objection and not the woman's right to receive care." –*Midwife, secular university*

A gynecologist similarly remarked:

"The woman's right takes precedence, not the conscience. If you're working somewhere as the only resident, for example, as is my case in [city], I can't provide or deny services to a patient based on my opinion. The patient's right prevails, always."–*Gynecologist, secular university*

Another physician placed the respect for individual religious liberties below the rights of a woman's access to care:

"Any individual [can object], I think, whose Christian faith could make them feel like their principles, beliefs, and values are being violated, as long as the patients' rights are safeguarded. So, I could have a conscientious objection and not resolve the woman's problem myself, but I am obligated to take her to another doctor who can." –*Physician, secular university*

Notably, those concerned with preserving abortion access all came from secular institutions. In contrast, faculty from religious universities—all of whom were opposed to abortion in most if not all circumstances—did not express concern about access.

Uncertainty in Teaching About Abortion and CO

When asked whether university curricula should be changed because of the legal reform, most faculty members from secular universities—but only one from a religious university—stated that their curriculum should be adapted to teach about the new law and its implications for CO. When asked how faculty currently teach about CO, a few described approaching it neutrally, like they would in any ethical case. As a maternal-fetal medicine physician from a religiously affiliated university described, "You approach [CO] as a discussion topic and as a case, but without giving a response, just the possible options." A few other faculty made it a point to teach students to withhold judgment of abortion or reasons for objecting when talking with their patients, and to claim CO only when there is another physician who can perform the abortion. As one faculty member explained:

"I have always told the kids [students] that personal judgment is not transmittable to the patient; we are there to provide a service.... [I tell them] you can only refuse if and when there is another colleague on shift in the same location with you.... Otherwise, you are up a creek, and you can't refuse to do it."–*Physician, secular university*

A faculty midwife from a secular university acknowledged that while "things come up with the students, and among us as academics, and there are issues that perhaps still aren't settled;" what they want to convey to the students is that people have "the right to health over and above conscientious objection, despite the recognition that all providers have a right to [CO]." A few faculty even taught students to tell patients that they do not have the skills necessary for abortion care, rather than telling them that they conscientiously object to protect the patient from feeling judged. One faculty midwife explained that her approach to CO is to teach students not to make it about themselves, but to approach it as "I'm not the best person to provide that service or information." She said, "I practice this with [my students], 'I feel like this colleague is better than me at this, so we're going to refer this woman to him/her.'"

One obstetrician-gynecologist from a religiously affiliated university felt that the law needed further clarification before they could teach their students about abortion, stating "It's an issue we still haven't dealt with, much less taught.... We're waiting a bit to see what is defined, what is legislated about the issue."

In general, faculty had not developed patterns of teaching, most likely because we conducted interviews just before and after the ban on abortion was lifted.

DISCUSSION

Our findings indicate widespread support for the right to CO in abortion care among our sample of medical and midwifery faculty from both religious and secular universities in Santiago, Chile. In general, faculty from religiously affiliated universities were more supportive of the use of CO by a broad range of individuals (e.g., physicians, midwives, pharmacists and administrators) and were less supportive of the provision of abortion services than their colleagues at secular universities. In turn, those from secular universities had more concerns about ensuring access to abortion through referral and transfer of care, while still generally supporting health care providers' rights to object.

Current CO regulations in Chile permit any health professional—even nonclinicians present during an abortion procedure—as well as private institutions to register as conscientious objectors; there is some indication that use of CO is limiting access to abortion.[19,28] Following the decriminalization of abortion in Mexico City, widespread use of CO by all types of health professionals—including nurses

and support staff–and concerns about a lack of providers willing to provide abortion care led Mexico City's Ministry of Health to restrict the use of CO to obstetrician-gynecologists and general surgeons; expand the range of providers legally allowed to provide abortions to mid-level practitioners, including midwives and nurses; and improve the provision of medication abortion in pharmacies.[29] Colombia has limited the use of CO to providers directly involved in providing abortion services.[15] Given that many faculty, particularly those at religious universities, did not express concern about the impact of CO on health care access, a similar step may be required in Chile to ensure that people eligible for a legal abortion are able to access timely and quality care.

Previous research has found that faculty at religious institutions do not necessarily share the same beliefs as those that govern their workplaces: For example, one study in the United States found that 52% of obstetrician-gynecologists at religious institutions expressed conflict with their patient-care policies.[17] In contrast, we generally observed a strong adherence to institutional mandates among faculty at Chilean religious universities. This might be because faculty, physicians and other staff working in Catholic-affiliated universities in Chile are often required to respect and share the Catholic values of the institution; indeed, in some Catholic-affiliated universities in Chile, it is explicitly stated that faculty must comply with the Catholic directives included in the university statutes and regulations.[18,19] These requirements result in cohesive opinions on abortion and other sexual and reproductive health issues among administrators and staff. However, while many religious university faculty in our study defended the right of private institutions to refuse to provide abortion care under the new law, their support for abortion in obstetric emergencies seemed to conflict with the fact that their institutions may claim institutional CO for all abortion care. These faculty seemed to fail to realize that the ability of religious universities to claim CO at the institutional level includes refusing to provide abortion care even in emergency cases.

Most faculty at religious institutions believed that the new law did not require changes to their current curricula or classroom discussions. Such opposition was based on the assumption that abortion procedures will never be permitted in their institutions. One faculty member wanted to refrain from discussing abortion until the recent legal change was further clarified; her comment suggests that lack of clarity about the new abortion law may affect classroom teaching. The lack of discussion about abortion within these religious institutions indicates a discordance between institutional policy and students' preferences to learn about abortion,[23] as well as an inability to consider the potential beneficial impacts of teaching about abortion on other aspects of obstetrics-gynecology and midwifery care, such as counseling, miscarriage management and PAC. Research from the United States found that health professionals who are trained in abortion care are more likely to offer patients counseling on pregnancy options and accurate medical information, and to have greater competency in postabortion and miscarriage management care.[30] Furthermore, students in Chile likely choose which medical or midwifery program to attend because of location and prestige, not because of religious practices. Catholic universities in Chile attract students who have differing personal or religious views. Findings from a recent survey of Chilean medical and midwifery students indicated that most–including those from religious institutions–want to be trained in abortion provision and believe that patient needs are more important than the beliefs of clinicians.[23] This apparent discordance between faculty and student views on this issue has implications for the quality of the training experience and student satisfaction with it.

Faculty views on abortion often conflicted with a provider's obligation to promote health.[31–33] Cook, Dickens and Fathalla argue that professionals in private health care contexts do not have the ethical obligation to care for all patients.[34] Faculty at religious institutions in our study expressed similar opinions, although some religious-university faculty recognized the limits of claiming CO when the life of a woman is at risk and no one else is available to provide care. Even some faculty opposed to abortion and working in religiously affiliated universities argued that health care providers not willing to perform an abortion in emergency situations should consider another profession. However, faculty perspectives were often at odds with their ethical responsibility to place the needs of a patient above their own, a concept endorsed by international codes of medical ethics, international human rights organizations and medical organizations.[32,33,35,36] This concept is included in the current Chilean law, in which providers have the legal and ethical obligations to ensure that CO does not hinder women's access to high-quality and nonjudgmental care.[4]

Faculty at secular universities–but not religious ones–expressed concern that CO may limit women's access to abortion, particularly when there is insufficient staff to do so. Yet, in the most recent assessment, which was conducted in 2018, as many as 5% of the 69 public hospitals designated to provide abortions in Chile had no obstetrician-gynecologists willing to perform an abortion to save a woman's life;[28] all of these hospitals serve low-income, marginalized communities, and in some cases are the only hospital nearby. In his analysis of CO in Mexico City, Ortíz-Millán argued that CO for abortion care must be regulated because its widespread use puts undue pressure on willing abortion providers and limits access for the lowest-income women in particular.[37] A similar negative impact of CO on abortion access has been documented in Italy, which was sanctioned by the European Committee on Social Rights in 2014 and 2016 for failing to guarantee people's access to abortion care.[38,39]

While clinicians can claim CO to abortion for reasons other than conscience (e.g., as a way to manage confusion

about the law, high workloads, low pay and stigma[40]), faculty in our study did not say that they would claim CO for these reasons. Now that the law has been in place for a few years, research is needed to examine whether these factors play a role in Chilean providers' refusals to perform abortions. One study comparing the experience of abortion stigma in Spain (which only allows abortion for medical reasons) to the experience in Italy (which allows abortions under more circumstances) found that clinicians in Spain were less likely to claim CO because they found providing abortion care for medical reasons was less stigmatizing.[41] In Chile, given the narrow circumstances—rape, women's health and fetal anomaly—in which abortion is legally permitted, abortion provision may not be as highly stigmatized.

Limitations and Strengths

Our study has several limitations. Its generalizability is limited to faculty teaching in the urban center of Santiago; while the majority of Chilean medical and midwifery schools are located there, faculty in Santiago may have different views about abortion than those working outside of the country's capital. Furthermore, while we captured a range of faculty perspectives working in both secular and religious universities, our sample may not be representative of all faculty working in these institutions, and people supportive of abortion may have been more likely to participate in our study. Also, we interviewed providers about CO as the new abortion law in Chile was being passed. As providers treat patients who need abortion under the current law, their support for CO may change. This study's principal strength is that we obtained perspectives from faculty at both secular and religious universities that represent a wide spectrum of universities in Santiago that offer degrees in medicine and midwifery.

Conclusions

Our findings have significant implications for medical and midwifery training programs in Chile, as well as other countries in Latin America. Adjustments to these programs may be required to ensure that future health professionals have a solid ethical foundation that informs them of their responsibility to prioritize their patients' health care needs, including timely, high-quality and nonjudgmental abortion services. These programs should focus on the ethical implications of denying people abortion care and assess whether providers might claim CO for reasons other than conscience, such as avoiding the stigma, harassment, burden and burnout that sometimes accompany abortion provision. Given the potential for CO to be used broadly under Chilean law, universities and their faculty should strengthen the training and support systems for potential future abortion providers so that more providers are willing to serve people in need of abortion services.

We found that clinical faculty, irrespective of their views about abortion, generally support the use of CO in abortion care, and that the concept of CO in abortion care is not yet developed enough to include concerns about access—nor is it even commonly taught in medical and midwifery curricula. The strong support among religious-university faculty for allowing all those involved in abortion care, including institutions, to claim objector status—even if that limits access to abortion—raises concerns about whether students in Chile are receiving adequate training to provide legal abortion care. Future research should closely monitor whether Chile's current CO practices and regulations are guaranteeing people's access to timely and safe abortion care.

REFERENCES

1. Moskos CC and Chambers JW, II, eds., *The New Conscientious Objection: from Sacred to Secular Resistance*, New York: Oxford University Press, 1993.

2. Wicclair MR, *Conscientious Objection in Health Care: an Ethical Analysis*, New York: Cambridge University Press, 2011.

3. Chavkin W, Leitman L and Polin K, for Global Doctors for Choice, Conscientious objection and refusal to provide reproductive healthcare: a White Paper examining prevalence, health consequences, and policy responses, *International Journal of Gynaecology & Obstetrics*, 2013, 123(Suppl. 3):S41–S56, http://dx.doi.org/10.1016/S0020-7292(13)60002-8.

4. Montero A and Villarroel R, A critical review of conscientious objection and decriminalisation of abortion in Chile, *Journal of Medical Ethics*, 2018, 44(4):279–283, http://dx.doi.org/10.1136/medethics-2017-104281.

5. Truong M and Wood S, *Unconscionable. When Providers Deny Abortion Services*, New York: International Women's Health Coalition and Mujer y Salud Uruguay, 2018.

6. Fleming V et al., Conscientious objection to participation in abortion by midwives and nurses: a systematic review of reasons, *BMC Medical Ethics*, 2018, 19(1):31, http://dx.doi.org/10.1186/s12910-018-0268-3.

7. Awoonor-Williams JK et al., Prevalence of conscientious objection to legal abortion among clinicians in northern Ghana, *International Journal of Gynaecology & Obstetrics*, 2018, 140(1):31–36, http://dx.doi.org/10.1002/ijgo.12328.

8. Keogh LA et al., Conscientious objection to abortion, the law and its implementation in Victoria, Australia: perspectives of abortion service providers, *BMC Medical Ethics*, 2019, 20(1):11, http://dx.doi.org/10.1186/s12910-019-0346-1.

9. Diniz D, Madeiro A and Rosas C, Conscientious objection, barriers, and abortion in the case of rape: a study among physicians in Brazil, *Reproductive Health Matters*, 2014, 22(43):141–148, http://dx.doi.org/10.1016/S0968-8080(14)43754-6.

10. United Nations Entity for Gender Equality and the Empowerment of Women, Committee on the Elimination of Discrimination Against Women, General recommendation 24: right to health, 1999, https://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm.

11. International Network for Economic, Social & Cultural Rights, General observation No. 22 (2016) on the right to sexual and reproductive health, 2016, https://www.escr-net.org/resources/general-comment-no-22-2016-right-sexual-and-reproductive-health.

12. Council of Europe, Processed complaints. No. 99/2013: Federation of Catholic family associations in Europe, (FAFCE) v. Sweden, 2015, https://www.coe.int/en/web/european-social-charter/processed-complaints/-/asset_publisher/5GEFkJmH2bYG/content/no-99-2013-federation-of-catholic-family-associations-in-europe-fafce-v-sweden?inheritRedirect=false.

13. Coppola F et al., Conscientious objection as a barrier for implementing voluntary termination of pregnancy in Uruguay: gynecologists' attitudes and behavior, *International Journal of*

Gynaecology & Obstetrics, 2016, 134(Suppl. 1):S16–S19, http://dx.doi.org/10.1016/j.ijgo.2016.06.005.

14. Stifani BM, Couto M and Lopez Gomez A, From harm reduction to legalization: the Uruguayan model for safe abortion, *International Journal of Gynaecology & Obstetrics*, 2018, 143(Suppl. 4):45–51, http://dx.doi.org/10.1002/ijgo.12677.

15. Cabal L, Olaya MA and Robledo VM, Striking a balance: conscientious objection and reproductive health care from the Colombian perspective, *Health and Human Rights*, 2014, 16(2):E73–E83, https://www.hhrjournal.org/2014/09/striking-a-balance-conscientious-objection-and-reproductive-health-care-from-the-colombian-perspective/.

16. CADEM Plaza Pública, Discusiones valóricas: grado de acuerdo con el aborto (Moral discussions: extent of agreement with abortion), Santiago, Chile, 2015.

17. Stulberg DB et al., Obstetrician-gynecologists, religious institutions, and conflicts regarding patient-care policies, *American Journal of Obstetrics and Gynecology*, 2012, 207(1):73e1–5, doi:10.1016/j.ajog.2012.04.023.

18. Radio Cooperativa and Universidad Central, Encuesta Cooperativa Imaginaccion Universidad Central 8 de Septiembre 2015 (Survey conducted by Central University Imagination and Radio Cooperativa, September 8, 2015), 2015, https://slideplayer.es/slide/7334868/.

19. Corporación Humanas, Realidad del aborto en Chile: revisión información estadística, agosto 2018 (The reality of abortion in Chile: a review of statistical information, August 2018), Santiago, Chile: Corporación Humanas, 2018.

20. El Mostrador, Hospital San José realiza primer aborto legal en Chile a menor de 12 años víctima de una violación (San Jose Hospital makes first legal abortion in Chile for youth younger than 12 years old who was the victim of rape), *El Mostrador*, Feb. 13, 2018.

21. Top Universities, Latin America rankings, 2018, 2019, https://www.topuniversities.com.

22. Leiva L, Estudiantes de la UC inician plebiscito para fijar postura frente a aborto en tres causales y objeción de conciencia institucional (UC students vote to establish a position on abortion for three causes and institutional conscientious objection), *La Tercera*, Sept. 11, 2017.

23. Biggs MA et al., Future health providers' willingness to provide abortion services following decriminalisation of abortion in Chile: a cross-sectional survey, *BMJ Open*, 2019, 9(10):e030797, http://dx.doi.org/10.1136/bmjopen-2019-030797.

24. Baba CF et al., Medical and midwifery student attitudes toward moral acceptability and legality of abortion, following decriminalization of abortion in Chile, *Sexual & Reproductive Healthcare*, 2020, 24:100502, http://dx.doi.org/10.1016/j.srhc.2020.100502.

25. Ramm A et al., "Obviously there is a conflict between confidentiality and what you are required to do by law": Chilean university faculty and student perspectives on reporting unlawful abortions, *Social Science & Medicine*, 2020, 261:113220, doi:10.1016/j.socscimed.2020.113220.

26. Conseulo Nacional de Educación, Indices base de datos: matrícula 2005–2018, 2019 (Indexes database: enrollment 2005–2018, 2019), https://www.cned.cl/bases-de-datos.

27. Glaser BG and Strauss AL, *The Discovery of Grounded Theory: Strategies for Qualitative Research*, New Brunswick, NJ, USA: Aldine Transaction, 2006.

28. Corporacion Humanas, Implementación de la ley No. 21.030 que regula la despenalización de la interrupción voluntaria del embarazo en tres causales (Implementation of law No. 21.030 that regulates the decriminalization of abortion in three circumstances), Corporacion Humanas: Santiago, Chile, 2018.

29. Díaz Olavarrieta C et al., Twelve years after abortion decriminalization in Mexico City: Can we still remain an island of liberties? *Best Practice & Research Clinical Obstetrics & Gynaecology*, 2020, 62:63–78, http://dx.doi.org/10.1016/j.bpobgyn.2019.07.009.

30. Steinauer J and Freedman L, Institutional religious policies that follow obstetricians and gynecologists into practice, *Journal of Graduate Medical Education*, 2017, 9(4):447–450, http://dx.doi.org/10.4300/JGME-D-17-00376.1.

31. Lamb C, Conscientious objection: understanding the right of conscience in health and healthcare practice, *New Bioethics*, 2016, 22(1):33–44, http://dx.doi.org/10.1080/20502877.2016.1151252.

32. International Confederation of Midwives, International code of ethics for midwives, 2008, https://www.internationalmidwives.org/our-work/policy-and-practice/international-code-of-ethics-for-midwives.html.

33. International Federation of Gynecology and Obstetrics (FIGO), Society of Obstetricians and Gynaecologists of Canada, International joint policy statement: FIGO professional and ethical responsibilities concerning sexual and reproductive rights, *Journal of Obstetrics and Gynaecology Canada*, 2004, 26(12):1097–1099, 1105–1107, http://dx.doi.org/10.1016/S1701-2163(16)30439-X.

34. Cook RJ, Dickens BM and Fathalla MF, *Reproductive Health and Human Rights: Integrating Medicine, Ethics, and Law*, Oxford, England: Clarendon Press, 2003.

35. FIGO Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health, *Ethical Issues in Obstetrics and Gynecology*, London: FIGO, 2012, https://www.glowm.com/pdf/English%20Ethical%20Issues%20in%20Obstetrics%20and%20Gynecology.pdf.

36. American Medical Association (AMA), Code of medical ethics overview, Chicago, IL, USA: AMA, 2012, https://www.ama-assn.org/delivering-care/ethics/code-medical-ethics-overview.

37. Ortiz-Millán G, Abortion and conscientious objection: rethinking conflicting rights in the Mexican context, *Global Bioethics*, 2017, 29(1):1–15, http://dx.doi.org/10.1080/11287462.2017.1411224.

38. Bo M, Zotti CM and Charrier L, Conscientious objection and waiting time for voluntary abortion in Italy, *European Journal of Contraception & Reproductive Health Care*, 2015, 20(4):272–282, http://dx.doi.org/10.3109/13625187.2014.990089.

39. Chavkin W, Swerdlow L and Fifield J, Regulation of conscientious objection to abortion: an international comparative multiple-case study, *Health and Human Rights*, 2017, 19(1):55–68.

40. Harris LF et al., Conscientious objection to abortion provision: why context matters, *Global Public Health*, 2018, 13(5):556–566, http://dx.doi.org/10.1080/17441692.2016.1229353.

41. De Zordo S, From women's 'irresponsibility' to foetal 'patienthood': obstetricians-gynaecologists' perspectives on abortion and its stigmatisation in Italy and Cataluña, *Global Public Health*, 2018, 13(6):711–723, http://dx.doi.org/10.1080/17441692.2017.1293707.

RESUMEN

Contexto: *En 2017, Chile reformó su ley de aborto para permitir el procedimiento bajo circunstancias limitadas. Explorar las opiniones del personal académico de medicina y partería en relación con el aborto y el uso de la objeción de conciencia (OC) en el momento de la reforma, puede informar sobre los temas que están siendo enseñados a los futuros prestadores de servicios de salud del país.*

Métodos: *Entre marzo y septiembre de 2017, fueron entrevistados 30 miembros del personal académico de las facultades de medicina y partería de universidades en Santiago, Chile. Veinte de ellos enseñaban en universidades laicas y diez en universidades con afiliación religiosa. Se analizaron las perspectivas del personal académico sobre la OC y el aborto, el alcance de la OC, y la enseñanza sobre OC y aborto, mediante el uso de un enfoque de teoría fundamentada.*

Resultados: *La mayoría del personal académico de las universidades laicas y de las de afiliación religiosa apoyó el derecho del personal clínico a rehusarse a proveer servicios de aborto. En general, el personal académico de las universidades laicas pensó que la OC debería limitarse a proveedores de servicios específicos y rechazó la idea de una OC institucional, mientras que el personal académico de las universidades con afiliación religiosa apoyó decididamente el uso de la OC por un amplio conjunto de proveedores y a nivel institucional. Solamente el personal académico de las universidades laicas avaló la idea de que la OC debería ser regulada de tal forma que no obstaculizara el acceso a los servicios de aborto.*

Conclusions: *El amplio apoyo a la OC en relación con el aborto en el personal académico de las universidades con afiliación religiosa genera preocupaciones sobre si se está enseñando a los estudiantes sobre su responsabilidad ética de poner las necesidades de sus pacientes por encima de las propias. Futuras investigaciones deben monitorear si las reglamentaciones y prácticas en materia de OC en Chile están garantizando el acceso de las personas a los servicios de aborto.*

RÉSUMÉ

Contexte: *En 2017, le Chili a réformé sa législation de l'avortement, autorisant l'intervention dans des circonstances limitées. L'étude de l'opinion du corps professoral des facultés de médecine et des écoles de sages-femmes concernant l'avortement et le recours à l'objection de conscience (OC) au moment de la réforme peut éclairer la manière dont ces sujets sont enseignés aux futurs prestataires de soins de santé du pays.*

Méthodes: *Entre mars et septembre 2017, 30 professeurs et enseignants de facultés et écoles de médecine et de sages-femmes à Santiago (Chili) ont été interviewés; 20 enseignaient dans des universités laïques et 10, dans des universités de confession religieuse. Leurs points de vue sur l'OC et l'avortement, la portée de l'OC et l'enseignement relatif à l'OC et à l'avortement ont été analysés selon l'approche de la théorie ancrée.*

Résultats: *Pour la plupart, le corps professoral des universités laïques et de confession religieuse reconnaissait le droit des cliniciens à refuser la prestation de soins d'avortement. Les professeurs d'universités laïques estimaient généralement que l'OC devrait être limitée à certains prestataires spécifiques et rejetaient la notion de l'OC institutionnelle, alors que ceux des facultés et écoles de confession religieuse soutenaient fermement le recours à l'OC par un large éventail de prestataires et au niveau institutionnel. Seul le corps professoral laïc souscrivait à l'idée que l'OC doit être réglementée de manière à ne pas entraver l'accès aux soins d'avortement.*

Conclusions: *Le soutien plus large de l'OC à l'avortement parmi le corps professoral d'universités de confession religieuse soulève des questions quant à savoir si les étudiants sont sensibilisés à leur responsabilité éthique de faire passer les besoins de leurs patientes avant les leurs. La recherche future devra surveiller si la réglementation et la pratique de l'OC au Chili garantissent l'accès aux soins d'avortement.*

Acknowledgments

This work was supported by a grant from the University of California, San Francisco, National Center of Excellence in Women's Health and an anonymous foundation. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the funders.

Author contact: *antonia.biggs@ucsf.edu*