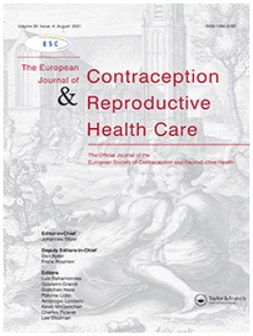

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REVIEW ARTICLE

The highly complex issue of conscientious objection to abortion: can the recent European Court of Human Rights ruling Grimmark v. Sweden redefine the notions of care before freedom of conscience?

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ABSTRACT

Purpose: The article aims to elaborate on two recent European Court of Human Rights (ECtHR) decisions which have rejected, on grounds of non-admissibility, the appeals by two Swedish midwives who refused to carry out abortion-related services, basing their refusal on conscientious objection, and to expound upon the legal and ethical underpinnings and core standards applied to the framing process of such a ECtHR decision.

Materials and Methods: By drawing upon relevant recommendations from international institutions, the authors have aimed to assess how the ECtHR rationale could affect the balance between CO and patient rights; searches have been conducted up until December 2020.

Results: In both decisions the European Court has asserted that the right to exercise conscientious objection must give way to the protection of the right to health of women seeking to have an abortion.

Conclusions: ECtHR judges concluded that the failure to provide for a right to conscientious objection does not constitute, in fact, a violation of the more general right to freedom of thought, conscience and religion, if provided for by a state law to protect the right to health. The legal ethical and social ramifications of such a decision are of enormous magnitude.

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Introduction

Conscientious objection (CO) in health care entails practitioners not providing certain treatments to their patients on grounds of 'morality' or 'conscience'. CO generally entails the rejection or refusal on the part of a provider to engage in a given procedure or action, primarily because the action would run afoul of deeply held moral or ethical values having to do with the notions of what is right and wrong, whether rooted in religious beliefs or not [1]. The exercise of CO among health care professionals is a multifaceted, complex issue, which lawmakers in most countries have to reconcile with patient rights and the need to ensure access to care for all. Although valid and sensible reasons may be found to accommodate CO among clinical professionals, the exercise of such rights and convictions could have an impact on the patients' access to care and consequently, on their health [2]. For this reason, it would be advisable for objecting professionals to contribute and play a role in minimising the impact of their refusal to participate on the access to, and delivery of, care and on the health care system as a whole [3]. First and foremost, however, lawmakers and governmental institutions have a duty, under international law, to enforce and uphold their citizens' inalienable human rights, which of course include reproductive rights as well. National authorities must therefore ensure at all times that abortion providers do not infringe upon reproductive rights, while guaranteeing safe access to legal abortion for those who choose to end their pregnancies. In addition, family planning services and broad-ranging information campaigns need to be prioritised, in order to foster free reproductive choices [4,5]. To complicate things further, many countries currently rely on the provision of health care services and benefits by private entities with public funding. That dynamic however may result in a blurring of the lines between the public sector, where similar rights and responsibilities should apply to all stakeholders and entities, and private facilities, where personal beliefs and restrictions are generally granted a higher degree of tolerance, although targeted hiring of non-objecting professionals is easier in the latter. In light of all of the above, the significant exercise of CO is certainly liable to have an impact on large segments of the population. Ultimately, CO in health care, and how to strike a tenable balance between the rights of objecting professionals and those of patients seeking care or the prescription of medication, are daunting challenges with legal ethical and social ramifications of enormous magnitude.

The inherent complexities at the core of the competing interests at play have not been solved through a universally-acknowledged set of standards or regulations [6]; consequently, inconsistencies in how the rights of objectors are pitted against those of patients have engendered

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lingering controversies, particularly in nations where the right to receive care is universally guaranteed.

Ethical complexities of conscientious objection to abortion

From a regulatory standpoint, conscientious objection to abortion is legally recognised in 24 member states of the European Union, in addition to the United Kingdom, Norway and some cantons of Switzerland. Only Sweden, Finland and Bulgaria do not acknowledge the right to refuse participation on conscience grounds [7]. In its 2015 guideline titled 'Health worker roles in providing safe abortion care and post-abortion contraception', the World Health Organisation (WHO) specifically mentioned midwives, including them among the key professional figures for the safe and timely provision of abortion procedures [8], with a thorough analysis of their role in each abortion-related procedure. That has been deemed a significant expansion of their traditional roles and tasks [9]; midwives have been largely underestimated within the academic discussion, although they certainly provide valuable care and support for patients undergoing abortions [10]. Counselling, for instance, is undoubtedly a core competency for midwives and that certainly constitutes an integral part of both abortion and post-abortion care. Although the key role of midwives in termination of pregnancy care is acknowledged in the above-mentioned WHO guideline, no in-depth analysis is laid out as to the issue of conscientious objection among midwives, other than remarking that conscientious objection in health care, where allowed, should be regulated while guaranteeing access to alternate care for all patients [3]. That is obviously reflected in most national legislative frameworks that codify a 'duty to refer' patients to other non-objecting professionals, so that they can receive the care they seek [11,12]; that obligation is also controversial, with some arguing against it, on grounds that no professional should ever be forced to get involved in any kind of activity or procedure that they deem to be morally wrong [13]. It is however quite difficult, and subjective, to figure out where a line should be drawn between an 'acceptable' degree of participation and one that each objecting professional feels intolerable [14]. Moreover, although referral to another service provider may be relatively easy and timely,at least for doctors and pharmacists, in high-income countries with reliable health care systems, that may not be the case in developing countries, where the referral process could be difficult or even unfeasible; hence, the patient seeking to terminate her pregnancy is liable to be deprived of her ability to exercise her reproductive rights and choices [15,16].

The International Confederation of Midwives' Code of Ethics openly upholds the rights of objecting midwives, arguing that midwives should be entitled to deny their participation in activities to which they are opposed on moral grounds, although such an option may be quite theoretical rather than practically viable. The Code however does not go as far as prescribing how the necessary care ought to be provided, other than remarking that respect for the health professionals' deeply-held values and conscience should not deprive patients of essential health services [17].

Swedish employment laws, and the margin of appreciation granted to member states, played a key role

The right of member states to enact legislation that limit the right to conscientious objection to abortion was upheld by the European Court of Human Rights on Thursday 12 March 2020; in a double decision (Grimmark [18] and Steen [19] v. Sweden), three judges of the European Court of Human Rights (ECtHR) have cast a doubt on the guarantees and safeguards normally enjoyed by conscientious objectors operating in health care who decide to opt out of abortion procedures. Because of her religious convictions, Ms. Grimmark refused to perform medical (i.e., non-surgical) abortions, but was still willing to care for women requesting the procedure. In seeking employment, she disclosed her CO, which she claimed had resulted in duties and positions being withheld or withdrawn from her, in violation of her right to freedom of thought, conscience and religion under Article 9(1) of the European Convention on Human Rights [20]. Article 9(2) of this Convention sets limits on manifestation of religion or belief when the exercise of one's right to object conflicts with the rights and freedoms of others.

While broadly speaking employment laws may require employers to seek the reasonable accommodation of employees' CO, Swedish law allows employers to require employees to perform all tasks naturally falling within the scope of their employment [21]. This includes requiring midwives to perform medical abortions. Exemption for one midwife, according to supporters of said legislation, would unfairly burden another, although that conclusion is far from fully borne out by scientific evidence [22]. The ECtHR itself noted that Sweden provides accessible abortion services nationwide [23]. Under Swedish law, employers define the duties of their employees, including objecting ones, and plan their assignments based on specific skills. If a healthcare professional asks to be exempted from carrying out, or participating in, a voluntary termination of pregnancy on grounds of conscience, the hospital director or the head of the ward are required to make determinations on a case-by-case basis, prioritising the efficiency of the health service and the quality of the working environment while making such decisions [21]. Therefore, employers can reassign or transfer objectors. If, however, they decide to dismiss them, objectors cannot claim any rights, because, according to Swedish law, workers are not entitled to be reassigned or exempted from their duties [23]. Before filing her application to the ECtHR, Grimmark had in fact turned to the Swedish Discrimination Ombudsman, to no avail. As she argued, her choice to become a midwife stemmed from her determination to help bring life into this world. That powerful underlying motive, in her view, made her professionally fit, and she cannot be disqualified by her deeply-held moral beliefs, which in her view, must be accommodated by the Swedish government. In her last resort, the national Labour Court, a thorough assessment was made of the Swedish legislation upholding the right to have an abortion in a safe and timely fashion. In light of that legislative principle, the Labour Court came to conclude that healthcare for women choosing to terminate their pregnancies must be deemed an objectively justifiable goal. Hence, clinics that provide such services need to be

articulated and function based on the principle that all healthcare staff partake in each and every procedure lawfully performed therein, not unlike different moving parts within a multi-layered, unfolding process. Given that abortion services are indisputably included among the procedures legally carried out in women's clinics throughout the country, every healthcare staff member, including of course midwives, are expected to make themselves available to fulfil all their duties, including abortion procedures. That employment standard, the Labour Court further argued, is as reasonable as it is necessary, for the ultimate purpose of ensuring all women who made a choice to end their pregnancies can do so swiftly and with as few adverse repercussions as possible. As for the denial of the right to CO, it does not represent any form of discrimination against Christians or other religious groups whatsoever, the Court went on to remark; allowing CO-based refusals can in fact jeopardise the free exercise of the right to abortion. Therefore, it was deemed unreasonable to require employers in charge of running the organisation of a complex healthcare facility to allow their employees to opt out of performing their duties based on private moral or religious convictions, however deeply-held [24].

Grimmark and Steen v. Sweden: on what grounds was the decision arrived at?

The Court's reasoning and language was similar to the rationale followed in another case, R.R. v. Poland (2011), which held that a state is obliged 'to organize its health system in a way as to ensure that the effective exercise of freedom of conscience by health professionals in the professional context does not prevent the provision of such services' [25]. The Court accordingly found that any infringement of the claimant's freedom of religion did not violate Article 9 of the European Convention on Human Rights. What remains to be seen is whether that same rationale may apply to the medical profession as a whole, and to other ethically-complex issues that entail the introduction of new rights in terms of treatment options [26,27], such as end-of-life care [28,29], genome editing [30,31] and prenatal diagnostic testing [32], emergency contraception [33], or even assisted reproductive technologies, which have been regulated with varying degrees of restrictions [34,35]; in fact, all said techniques undoubtedly pose considerable quandaries as to whether, and to what extent, objecting professionals should be legally entitled to opt out of performing or participating in such procedures [36]. The Strasbourg-based ECtHR, which hears only 6 percent of cases brought before it, rules on cases in which there is an alleged violation of the European Convention on Human Rights. The Court's decisions can affect more than 820 million Europeans across the 47 Council of Europe Member States.

The ECtHR judges based their ruling on the argument that abortion constitutes an ordinary medical act, and that guaranteeing access to abortion for all who legally seek it outweighs respect for the personal freedom of conscience of health care professionals. In Sweden, abortion is available up to 18 weeks, and ends one pregnancy out of five [37]. In 2013, the Federation of Catholic Families in Europe (FAFCE) filed an appeal against Sweden to the Council of Europe's European Committee of Social Rights for failing to regulate CO for Swedish healthcare workers [38], claiming such a failure constituted a violation of article 11 of the European Social Charter [39]. The Committee rejected the appeal, stressing that Article 11 does not bind States to recognise and uphold a right to CO for health professionals, but rather it aims to guarantee pregnant women adequate access to care.

By a similar rationale, the ECtHR committee sided with the Swedish authorities in Grimmark vs Sweden, ruling that the obligation to perform abortion serves 'the legitimate aim of protecting the health of women seeking an abortion'. They also saw fit to mandate that the plaintiffs do participate in abortion procedures, since only an obligation can ensure the practice is available throughout the country. Lastly, the court argued that the plaintiffs had voluntarily chosen to become midwives and apply for vacant posts, while knowing that this would also entail involvement in abortion cases.

Critics denounce decision on flimsy grounds

Freedom of conscience supporters pointed out alleged flaws in the court's make-up as well as the reasoning based on which the decision was issued. It is highly unusual for such a relevant decision to be made by a committee of only three judges, rather than by a seven judge-chamber, or a Grand Chamber made up of 17 judges.

Smaller judicial committees usually handle routine cases through established case law. More complex or new cases, as this one was according to critics of the decision, ought to be heard in a chamber or a Grand Chamber. It should also be pointed out that these three judges did not issue their ruling in the form of a judgement, subject to appeal, but rather a simple and final 'decision of inadmissibility'. Thus, a decision of exceptional relevance such as this was arrived at in a small judicial committee and 'through the back door', according to critics.

A campaign aimed at delegitimizing abortion, they argue, can be seen today in France in the attempt to remove the conscience clause introduced by the Veil law [40,41]. In 2010, it was against this campaign that a resolution reaffirming 'The right to CO in lawful medical care' was adopted by the Parliamentary Assembly of the Council of Europe [42]. The resolution appears to strike a reasonable balance between ensuring respect for the right of freedom of thought, conscience and religion of health-care providers and the need of patients to be informed of any CO and referred to another health-care provider in a timely fashion. Following this vote, the Swedish Parliament adopted a resolution committing its government to take international action against CO.

Conflicting views linger

A radically different school of thought from the one espused by CO advocates holds that invoking CO and refusing to partake in any lawful medical service and procedure is in itself intolerable, and should never be countenanced, under any circumstances.

As mentioned earlier, three EU countries, Sweden, Finland and Bulgaria, do not acknowledge the right of

health professionals to CO, when the service or procedure which they refuse to perform is part of their duties [43]. According to adamant CO opponents, there is an array of advantages in banning CO altogether. Firstly, it does away with hurdles and delays which may arise even when a duty to refer is in place [44]. In addition, it is argued, allowing faith-based refusals or personal moral convictions to outweigh rational arguments and democratically enacted legislation is unacceptable and dangerous [45]. It is essential, according to that rationale, to acknowledge the different roles played by values and conscience in public or private life: belief systems should mould and steer policy discussions as to what kind of health system to build, but they should never affect what kind of care individual physicians provide to their patients, lest the door be opened to 'value-driven medicine' and unscientific, discriminatory dynamics [46]. Outlawing CO-based refusals is also presumably effective in upholding the patients' human rights; to buttress their argument, opponents point to developed countries such as Italy, when CO is so widespread as to make access to abortion extremely difficult, particularly in southern regions, which could entail both discrimination and prejudice to the patients' health [47,48]. In that regard, it is noteworthy that the European Committee of Social Rights (ECSR), the Council of Europe body which oversees compliance with the European Social Charter (ESC), found two instances in which Italy had violated ESC precepts in 2014 and 2016, namely the right to health (enshrined in ESC Article 11), in light of the inability of women to carry out voluntary terminations of pregnancy due to extremely high CO rates [49,50].

While international law clearly provides protections for the right to freedom of conscience, it is not deemed an absolute right. When the exercise of CO comes into conflict with other fundamental rights and freedoms such as the right to respect for private life, the right to equality and non-discrimination, a balance must be struck in order to uphold conflicting beliefs [51]. It is therefore up to legislators to define the scope and limits of the objection, so as to ensure that it is exercised without prejudice to the proper functioning of organisational structures [52]. Specifically, the ECtHR conclusions may be summed up as follows: the Swedish legislation codifying an 'interference' in and prejudice to CO rights was warranted, since according to that very legislation, 'an employee is under a duty to perform all work duties given to him or her'. ECtHR magistrates found that such a limitation was necessary and reasonably enforced in a democratic society, in light of the fact that Sweden provides nationwide abortion services, hence it has a positive duty to organise its healthcare system so that any CO exercise by health professionals within the system itself 'does not prevent the provision of such services' [53].

Ultimately, middle-of-the-road moderate positions are largely prevalent. Code of Ethics and guidelines as a beacon towards a balanced approach

It behoves us to point out, for the sake of clarity and thoroughness, that CO clauses, enforced in the vast majority of European countries, are mostly interpreted in a rather moderate manner, thus ensuring, for the most part, that the rights of all parties involved are upheld. Firstly, conscience clauses only cover refusal to be actively involved in abortions: differentiating, from a legal perspective, between direct and indirect participation in a given health care procedure is certainly relevant to assessing the legitimacy of a claim to invoke CO. Case law shows how indirect participants have frequently been barred from invoking CO on grounds that any participation in something they find morally objectionable has to be direct [54]. The British Medical Association [55] and the Royal College of Obstetricians and Gynaecologists [56] have effectively elaborated on such a stance, by setting fundamental core principles for a sensible approach, in the best interest of all those involved:

- Objecting professionals are anyway bound to provide emergency care, when the patient's life or well-being may be at risk
- Objectors may not impose their views upon their patients, but may discuss and clarify their beliefs to them if asked
- Objectors may not deny their participation in administrative procedures linked to abortion; such a broad interpretation of CO rights oversteps the boundaries of CO clauses
- Professionals cannot invoke CO to opt out of providing advice or helping through the preparatory phases leading up to the abortion procedure itself; such steps may comprise the duty to refer patients to other non-objecting doctors, should the need arise
- Medical students are also entitled to invoke CO, if they wish to avoid witnessing abortion procedures

The International Federation of Gynaecology and Obstetrics has largely espoused such principles at least since 2006, adding the crucial point that health care professionals must abide by scientifically acknowledged definitions of reproductive health services, and should never misconstrue or distort them based on personal religious, moral or ethical beliefs [57,58].

Specifically, as also pointed out by the National Institute for Health and Care Excellence (NICE) [59] and the Royal College of Nursing [60], CO clauses protect the right to opt out of performing abortions but not the right to opt out of providing access to abortion services.

Laws binding objecting professionals to refer patients to non-objecting providers may in our view reasonably be deemed to fall under the rubric of the duty to care. In order to facilitate such a transition, objectors should provide public notice of professional services which they refuse to provide on CO grounds, with adequate notice so that the patient's prospects of getting the care she needs are not endangered. Furthermore, as the American College of Obstetricians and Gynaecologists has laid out in a 2007 opinion, reaffirmed in 2016, resource-poor areas stand to be damaged in terms of access to safe and legal reproductive services. In such settings, CO is liable to undermine patient autonomy, freedom of choice, and even their health. A possible solution to such potentially dangerous developments could be to frame policies requiring, or at least encouraging, providers with moral or religious objections to practice in proximity to individuals who do not

share their views in terms of CO to abortion or other controversial services, in addition to optimising the way in which referral processes are discharged [61]. On the other hand, the European Council of Medical Orders, in its 1995 Principles of European Medical Ethics, does not appear to go far enough, in terms of specificity and clarity as to how CO rights and patient well-being ought to be reconciled [62]. That only underscores how essential it is to rely on updated guidance, in the form of sets of guidelines framed by multidisciplary pools of experts, on such sensitive, fast-evolving ethical quandaries.

Conclusions

There is no denying that Western societies have become increasingly diverse and heterogeneous from the standpoint of ethical, social and religious beliefs, with inevitable reverberations on peoples lifestyles and interrelationships; such an ongoing transition is likely to result in an ever higher degree of heterogeneity among patients, providers, and institutions, whose interests and priorities may often come to conflict with one another. In such a burgeoning climate of diversity and plurality among multiple, and possibly opposing, notions as to the concept of what is 'desirable', 'acceptable' and 'good,' the provision of medical care within the mosaic of ethical diversity arguably constitutes a remarkably daunting challenge that needs to addressed and coped with by contemporary science, and medicine in particular [63]. That being said, it is worth bearing in mind that clinicians hold a potentially coercive power over their patients, based on exclusive prerogatives, knowledge, skills and resources. In an effort to countervail that power, medical societies and health care institutions have attempted to dictate norms of professional behaviour: most agree that protecting the moral integrity of physicians and providers may be important, but that is outweighed by the patients' need to promptly access care. The right to conscience-based refusal is a fundamental individual right because it is an integral part of the broader right to freedom of thought, conscience and religion. The decisions of the European Court herein examined establish that the dismissal of two objecting Swedish midwives who refused to carry out interventions in relation to abortion has not violated any right related to freedom of thought and expression, and therefore constituted no discrimination in any shape or form. In order to solve such a potential conflict, health care professionals and institutions ought to strive to accommodate COs as much as practically possible, while prioritising actions and initiatives meant to best ensure patients can rely on high-quality medical care delivered in a timely fashion. However challenging, reconciling those two key aspects by accommodating COs without penalising patients in need of care is worthy of attention.

Ultimately, CO in health care, and how to strike a tenable balance between the rights of objecting professionals and those of patients seeking care or the prescription of medication, are daunting challenges with legal ethical and social ramifications of enormous magnitude.

The inherent complexities at the core of the competing interests at play have not been solved through a universally-acknowledged set of standards or regulations [64,65]; consequently, inconsistencies in how the rights of objectors are pitted against those of patients have engendered lingering controversies in many nations where the right to receive care is universally guaranteed. To balance these differences, non-binding codes of ethics can provide valuable guidance in bridging the gap and meeting the challenges posed by a morally pluralistic state of healthcare practice, as can the universal notion of common good.

Disclosure statement

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