

On conscientious objection to abortion: Questioning mandatory referral as compromise in the international human rights framework

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Abstract

This article explores the approach of international human rights bodies to conscientious objection to abortion, by requiring states to implement mandatory referral mechanisms where conscientious objection is permitted. This, however, represents an inadequate compromise position as many objecting healthcare professionals also object to referral and circumvent those requirements. Furthermore, referral cannot address the broader issues with the overuse and misuse of conscientious objection provisions which obstructs access to abortion services. After considering the harms caused by conscientious objection and suggestions for alternative regulatory responses, this article proposes that the international human rights framework should aim to strike a contextual balance between freedom of conscience and ensuring access to abortion. This new approach should place clearer obligations on states to properly regulate conscientious objection, including obligations to address socio-cultural stereotypes around motherhood and the foetus, which result in widespread conscientious objection.

Keywords

Abortion, conscientious objection, European Convention on Human Rights, international human rights, reproductive rights

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Introduction

There are significant barriers to accessing abortion services, even where abortion has been legalized. One of these barriers is conscientious objection to the provision of abortion by healthcare professionals, which can obstruct access and, in some contexts, seriously limit the availability of abortion services.¹ This is a complex issue to address, and there is an expanse of literature considering the appropriate means of protecting freedom of conscience while ensuring access to abortion services at the same time. This article will address a gap in this literature, in terms of how the international human rights framework responds to conscientious objection. International human rights actors rely on mandatory referral mechanisms, where objecting healthcare professionals must formally refer a pregnant person to a non-objecting professional for abortion care.² This purported compromise position is intended to uphold human rights standards on abortion while offering protection for healthcare professionals opposed to providing those services.³ In practice, however, mandatory referral mechanisms are limited in efficacy due to the reluctance of anti-abortion healthcare professionals to refer patients and the broader issues with conscientious objection.

In this article, I will therefore argue that reliance on mandatory referral mechanisms by international human rights bodies strikes an inadequate balance between freedom of conscience and access to abortion. The first section will set out international human rights standards on abortion and the approach of human rights bodies to conscientious objection in this context. In the second section, I will highlight why mandatory referral mechanisms will often fail to ensure access to abortion. I argue that mandatory referral cannot be taken to be compromise position by either side, as objecting healthcare professionals are opposed to any involvement in the abortion process and may avoid complying with such requirements. I then highlight the further issues with widespread conscientious objection, considering the contexts of Poland and Italy where this is a particular issue, and the broader misuse of conscientious objection provisions which render mandatory referral mechanisms wholly ineffective. The third section identifies the spectrum of harms resulting from conscientious objection to abortion and considers proposals from other scholars as to how these harms might be addressed or mitigated. Finally, in the last section, I will make suggestions as to how the international human rights framework should appropriately respond to the issues associated with permitting conscientious objection. I argue that human rights bodies must strike a contextual balance, recognizing the problems with widespread conscientious objection in some

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1. See, for example, W. Chavin, L. Swerdlow and J. Fifield, 'Regulation of Conscientious Objection to Abortion: An International Comparative Multiple-Case Study', *Health and Human Rights Journal* 19 (2017), pp. 55–68.
 2. I use the terms 'pregnant person' or 'pregnant people' to be inclusive of all people with the capacity to become pregnant, but I refer to women where I am discussing the gender stereotypes around motherhood which are specifically imposed on cisgender women.
 3. See, for example, Anand Grover, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Mental and Physical Health', (2011), UN Doc. A/66/254, para 65(m).

countries and how this has a particularly severe impact where abortion is legally restricted. I conclude that it is necessary to place obligations on states to tackle gender-based stereotypes around motherhood and anti-abortion attitudes if the harms resulting from conscientious objection are to be fully addressed.

The international human rights approach to abortion and conscientious objection

There is no legally recognized human right to abortion in the international system, but UN treaty bodies, such as the Human Rights Committee (HRC), Committee on the Elimination of Discrimination against Women (CEDAW), and Committee on Economic, Social, and Cultural Rights (CESCR), require that states legalize abortion in some circumstances. These bodies have recognized that restrictions on abortion can violate a number of other rights, so that states have an obligation to provide abortion services where there is a risk to the life or health of the pregnant person, where the pregnancy resulted from rape, and for fatal foetal impairments.⁴ More recently, these human rights bodies have indicated that states must also decriminalize abortion to prevent unsafe abortions and abortion-related mortality.⁵ Beyond this, the comments of CESCR and CEDAW indicate a procedural right to access abortion services on the grounds already legalized by the state.⁶ Barriers to the timely access of reproductive health services must be addressed by states, and such barriers include conscientious objection as pregnant people must seek abortion services from a non-objecting healthcare professional after a conscientious refusal, causing delays.⁷

Conscientious objection is afforded protection under the right to freedom of thought, conscience, and religion contained in Article 18 of the International Covenant on Civil and Political Rights.⁸ Historically, conscientious objection referred to the moral objection to military service, and in particular, refusals to participate in compulsory military service. Conscience-based exemptions are now also used by healthcare professionals, often in relation to sexual and reproductive health services, such as abortion, contraception, and assisted reproductive technologies. While protection for conscientious objection under Article 18 has not been explicitly extended to the medical sphere, international

4. See, for example, HRC, 'General Comment No. 36: Article 6 (Right to Life)', (2019), UN Doc. CCPR/C/GC/36, para 8; CEDAW, 'Inquiry Concerning the United Kingdom of Great Britain and Northern Ireland under Article 8 of the Optional Protocol to CEDAW', (2018), UN Doc. CEDAW/C/OP.8/GBR/1, para 83.

5. HRC, 'General Comment 36', para 8; CEDAW, 'Northern Ireland Inquiry', para 83; CESCR, 'General Comment No. 22 on the Right to Sexual and Reproductive Health (Article 12 of the ICESCR)', (2016), UN Doc. E/C.12/GC/22, para 34.

6. CEDAW, 'General Recommendation No.24: Article 12 of the Convention (Women and Health)', (1999), UN Doc. A/54/38/Rev.1, paras 21, 23; CESCR, 'General Comment 22', para 16.

7. Op. cit.

8. HRC, 'General Comment No. 22 on Article 18 of the ICCPR', (1993), UN Doc. CCPR/21/Rev.1/Add.4, para 11.

human rights bodies have not indicated that conscientious objection, where appropriately regulated, violates human rights standards on sexual and reproductive health.

Instead, the approach of these bodies suggests that conscientious objection to sexual and reproductive health services is permissible, provided states strike a balance between allowing conscientious objection and ensuring the availability of those services. The HRC, CESCR, and CEDAW have all expressed concerns over the use of conscientious objection in states, such as Colombia, Poland, and Romania, where conscientious objection provisions are relied on excessively or are unregulated to the point of obstructing access to abortion services.⁹ However, in response to this issue, none of these bodies have recommended that balancing conscientious objection with access to abortion services may require that conscientious objection be restricted. Rather, they recommend that states implement mechanisms for mandatory referrals and ensure that there are effective procedures in place for contesting refusals.¹⁰ In its 2015 Concluding Observations on Slovakia, for example, CEDAW explicitly noted that such a referral mechanism should be implemented in a manner that also respects individual conscientious objectors.¹¹ The Special Rapporteur on the right to the highest attainable standard of physical and mental health, Anand Grover, expanded on conscientious objection in his 2011 report on sexual and reproductive health, recommending that conscience-based exemptions be 'well-defined in scope and well-regulated in use'.¹² Grover also relied upon referrals as a method of regulation, recommending that states ensure the availability of alternative services where a doctor objects.¹³

The current international human rights approach to conscientious objection is an attempt to take a compromise position, where mandatory referrals are taken as a balance between sexual and reproductive rights, and the right to freedom of conscience. By requiring the objecting healthcare professional to refer the patient for an abortion, their right not to participate in an abortion procedure is upheld, while also ensuring that the pregnant person is still able to obtain an abortion. However, in practice, mandatory referral mechanisms are unlikely to achieve this compromise in many contexts. The effectiveness of this approach rests on the assumption that objecting healthcare professionals will not also object to referral and will therefore comply with referral requirements. Furthermore, mandatory referral requirements cannot address the impact of widespread conscientious objection, as this requires regulation beyond that aimed at individual healthcare professionals.

9. HRC, 'Concluding Observations on the Seventh Periodic Report of Colombia', (2016), UN Doc. CCPR/C/COL/CO/7, paras 20–21; CESCR, 'Concluding Observations on the Sixth Periodic Report of Poland', (26 October 2016), UN Doc. E/C.12/POL/CO/6, paras 46–47; CEDAW, 'Concluding Observations on the Combined Seventh and Eighth Periodic Report of Poland', (2014), UN Doc. CEDAW/C/POL/CO/7-8, paras 36–37; CEDAW, 'Concluding Observations on the Combined Seventh and Eighth Periodic Reports of Romania', (2017), UN Doc. CEDAW/C/ROU/CO/7-8, paras 32–33.

10. *Op. cit.*

11. CEDAW, 'Concluding Observations on the Combined Fifth and Sixth Periodic Reports of Slovakia' (2015), UN Doc. CEDAW/C/SVK/CO/5-6, para 31(d).

12. Anand Grover, 'Report of the Special Rapporteur', para 65(m).

13. *Op. cit.*

Where mandatory referral is ineffective

For healthcare professionals who strongly object to abortion, referral amounts to involvement, albeit indirectly, in an abortion going ahead. Fovargue and Neal highlight that objecting healthcare professionals view referral requirements as entailing complicity in the objected practice.¹⁴ For an anti-abortion healthcare professional, any involvement in the abortion procedure will be seen as unacceptable. McLeod therefore argues that for objecting healthcare professionals, who believe that the foetus has a right to life and that abortion is murder, referral requirements can never amount to a true compromise.¹⁵ That mandatory referral is not an acceptable compromise from the perspective of conscientious objectors is a concern that has also been raised in relation to the international human rights approach. Fischer argues that the recommendations to implement mandatory referral requirements afford ‘more weight to the woman’s right to health than to the healthcare provider’s right to freedom of conscience’.¹⁶ From this perspective, referral requirements infringe the right to freedom of conscience.

For those concerned with ensuring access to abortion services, referral requirements may appear to be an attractive means of regulating conscientious objection. Feminist scholars have reluctantly accepted that conscientious objection should be afforded some (limited) protection, on the basis that although conscience-based exemptions will inevitably have some impact on abortion service delivery, this can be minimized through referral requirements.¹⁷ Referral requirements are a compromise from this position, through the accommodating of the right to conscientiously object despite the potential impact on access to abortion.¹⁸ In viewing referral in this way, its proponents reject the argument that referral amounts to involvement. For example, Dickens argues that referral gives the pregnant person the opportunity to choose from a range of options concerning their pregnancy, of which abortion is merely one of; referral does not always result in an abortion.¹⁹ In relation to a decision by the Colombian Constitutional Court on the

14. S. Fovargue and M. Neal, ‘“In Good Conscience”: Conscience-Based Exemptions and Proper Medical Treatment’, *Medical Law Review* 23 (2015), pp. 221–241, at 241.

15. C. McLeod, ‘Referral in the Wake of Conscientious Objection to Abortion’, *Hypatia* 23 (2008), pp. 30–47, at 34–35.

16. M. Grizzle Fischer, ‘The United Nations and the Right to Conscientious Objection in the Health-Care Field’, *Texas Review of Law & Politics* 21 (2016), pp. 187–219, at 216.

17. See, for example, S. Sheldon, *Beyond Control* (London: Pluto Press, 1997), p. 61; S. Zaami, R. Rinaldi and G. Montanari Vergallo, ‘The Highly Complex Issue of Conscientious Objection: Can the Recent European Court of Human Rights Ruling *Grimmark v. Sweden* Redefine the Notions of Care before Freedom of Conscience’, *The European Journal of Contraception & Reproductive Healthcare* 26 (2021), pp. 349–355, at 350; R. Fletcher, ‘Conscientious Objection, Harm Reduction and Abortion Care’, in Mary Donnelly and Claire Murray, eds., *Ethical and Legal Debates in Irish Healthcare* (Manchester: Manchester University Press, 2016), pp. 24–40.

18. McLeod, ‘Referral’, p. 35.

19. B.M. Dickens, ‘The Right to Conscience’, in Rebecca J. Cook, Joanna N. Erdman and Bernard M. Dickens, eds., *Abortion Law in Transnational Perspective* (Philadelphia, PA: University of Pennsylvania Press, 2014), p. 230.

accommodation of conscientious objection to abortion, Cook, Arango Olaya, and Dickens highlight that the duty on healthcare professional to refer a pregnant person in good faith cannot be *legally* denied on the grounds of complicity with abortion.²⁰ However, taking referral to be an adequate compromise dismisses the strength of anti-abortion values, and fails to account for healthcare professionals who do object to referral and will therefore evade or refuse to follow mandatory referral requirements.

Prior to 2015, conscientiously objecting healthcare professionals in Poland had an obligation to refer pregnant people seeking an abortion.²¹ However, this requirement was largely unenforced. In *R.R. v Poland*, a pregnant woman and her doctors suspected a severe foetal impairment, but the doctors refused to provide prenatal diagnosis until the gestational time limit for a legal abortion on the grounds of foetal impairment had passed.²² In *P and S v Poland*, a 14-year-old who had become pregnant as a result of rape was hindered from accessing legal abortion services by doctors who were opposed to abortion.²³ In both cases, the European Court of Human Rights (ECtHR) criticized the lack of procedural mechanisms in place to ensure that conscientious objection did not interfere with the patient's interest, which enabled doctors to obstruct access to prenatal diagnostic and legal abortion services.²⁴ The European Court, in *P and S*, highlighted the State's failure to enforce its own laws around the regulation of conscientious objection.²⁵ In the context of Norway, a study of healthcare professionals refusing to refer patients for abortion indicated a spectrum of co-operation.²⁶ Some doctors were willing to engage in a more informal process of referral, by passing the patient on to a colleague who would then refer them, whereas others were not transparent about their objection.²⁷

The latter experience supports concerns that pregnant people may mistake their doctor's refusal as an indicator that they are not eligible for an abortion where there is a lack of transparency around conscientious objection.²⁸ *Tysi c v Poland* demonstrates how Polish doctors also evaded referral requirements by refusing to provide abortion services without invoking the conscientious objection provision.²⁹ The applicant, Alicja Tysi c, had a visual impairment which doctors concluded would likely worsen, possibly leaving

20. R.J. Cook, M. Arango Olaya and B.M. Dickens, 'Healthcare Responsibilities and Conscientious Objection', *International Journal of Gynecology and Obstetrics* 104 (2009), pp. 249–252, at 251.

21. In 2015, the Polish Constitutional Tribunal held this requirement to be an unconstitutional limit on freedom of conscience. See: Polish Constitutional Tribunal Case K 12/14 (7 October 2015).

22. *R.R. v Poland* App no. 27617/04 (ECHR, 26 May 2011).

23. *P and S v Poland* App no. 57375/08 (ECHR, 30 October 2012).

24. *R.R.*, paras. 174–176; *P and S*, paras 92–93, 106, 107.

25. *P and S*, paras 81, 107.

26. E.M. Kibsgaard Nordberg, H. Skirbekk and M. Magelssen, 'Conscientious Objection to Referrals for Abortion: Pragmatic Solution or Threat to Women's Rights?', *BMC Medical Ethics* 15 (2014), pp. 1–9.

27. *Op. cit.*

28. E. Jackson, *Regulating Reproduction* (Oxford: Hart, 2001), pp. 85–86.

29. *Tysi c v Poland* App no. 5410/03 (ECHR 20 March 2007).

her blind, following the delivery of the foetus she was carrying.³⁰ They recommended sterilization after the birth, due to the risk that pregnancy would have on her eyesight, but refused to certify for an abortion in relation to her present pregnancy, despite her condition meeting the legal criteria for therapeutic abortion.³¹ The doctors did not invoke the conscientious objection provision in making such a refusal, thus avoiding the obligation to refer Alicja Tysi c to a doctor willing to provide an abortion. Instances of evading referral requirements may not always be as extreme as in this case, but doctors can nonetheless take advantage of the space for uncertainty around conscientious objection. In *Saxby v Morgan*, it was claimed that a Scottish doctor had told a pregnant woman that at 18- to 19-week gestation she was ‘too far gone’ for an abortion, despite falling within the gestational time limit set out in the Abortion Act 1967.³²

Thus, referral requirements do not represent, in practice, an adequate compromise to objecting healthcare professionals or from the perspective of ensuring access to abortion services. Objecting healthcare professionals who view referral for abortion as participation in the objected practice are likely to circumvent these requirements, and they are difficult to enforce – particularly in contexts where refusal to refer is a widespread issue. As a result, referral requirements do not protect a pregnant person’s ability to access abortion services. The reliance on mandatory referral mechanisms at the international human rights level therefore fails to strike an adequate compromise between freedom of conscience and access to abortion.

Conscientious objection obstructing access to abortion

The reliance on mandatory referral requirements also fails to account for contexts where there is a significant volume of healthcare professionals objecting to the provision of abortion services. Referral requirements are simply ineffective where there are too few non-objecting healthcare professionals to refer patients to. Italy has a relatively liberal abortion law, permitting abortion within the first 90 days of pregnancy (around 12 weeks) for health, socio-economic, or family reasons, and after this point where the pregnant person’s life or health is at risk and in cases of foetal impairment.³³ However, abortion provision in Italy suffers considerably as a result of conscientious objection. In 2019, 67% of Italian gynaecologists were recorded as conscientiously objecting to the provision of abortion services.³⁴ Many hospitals are staffed only by objecting healthcare professionals, making abortion services entirely unavailable in those institutions.³⁵ This has

30. Op. cit., paras 8–10.

31. Op. cit.

32. *Saxby v Morgan* [1997] P.I.Q.R. P53; S.D. Patinson, *Medical Law and Ethics*, 6th ed. (London: Sweet & Maxwell, 2020), p. 260.

33. Law 194 of the Italian Republic 1978, Articles 4 and 6.

34. Ministero della Salute, *Relazione del Ministro della Salute sulla attuazione della legge contenente norme per la tutela sociale della maternit  e per l’interruzione volontaria di gravidanza (legge 194/78) – dati definitivi 2019*, p. 56. Available at: https://www.salute.gov.it/imgs/C_17_pubblicazioni_3103_allegato.pdf (accessed 28 February 2022).

35. Chavin et al., ‘Regulation of Conscientious Objection’, p. 59.

a particular impact in public hospitals, as many are affiliated with the Catholic Church. Furthermore, in Catholic hospitals, or hospitals where the senior directors object to abortion, institutional conscientious objection policies – where the institution objects to the provision of abortion services on behalf of all staff members – mean that abortion services are unavailable even where individual doctors are willing to provide them.³⁶ Although hospitals and regional health departments are required by law to implement mechanisms to guarantee timely access to abortion services, the number of objecting healthcare professionals makes it difficult to organize personnel to ensure that abortion is always available.³⁷

Objecting healthcare professionals in Italy are not currently required to refer the pregnant person to another doctor for an abortion.³⁸ However, given this context, it seems unlikely that mandatory referral requirements would mitigate the impact of such a high percentage of conscientious objection. With more than half of all gynaecologists in Italy conscientiously objecting, this leaves an insufficient number of non-objecting gynaecologists left for pregnant people to be referred to, particularly in rural regions with fewer healthcare facilities. Caruso highlights, for example, that a number of regions have just one doctor willing to provide abortions services, while others have none at all.³⁹ In one reported case, a pregnant woman was rejected for an abortion by 23 different public hospitals on the basis of conscientious objection or administrative issues before she was eventually able to access abortion services.⁴⁰ Though the pregnant woman in this particular situation was not delayed beyond the 90-day threshold for an abortion, conscientious objection on this scale risks pushing people beyond the gestational time limit.

In countries with more restrictive abortion regimes than this, the result of widespread conscientious objection is to render abortion almost entirely unavailable. In Poland, abortion is only legal where the pregnant person's life or health is at risk, or in cases of rape.⁴¹ However, in practice, the prevalence of conscientious objection makes it difficult to access abortion on either ground. As the *Tysiacy* case highlights, doctors will object to performing abortions even on therapeutic grounds. Institutional conscientious objection is also common in Poland, as senior doctors will object on behalf of all staff to prevent

36. Op. cit., pp. 59–60.

37. Law 194, Article 9; Chavin et al., 'Regulation of Conscientious Objection', p. 59; F. Minerva, 'Conscientious Objection in Italy', *Journal of Medical Ethics* 41 (2015), pp. 170–173, at 171.

38. E. Caruso, 'The Ambivalence of Law: Some Observations on the Denial of Access to Abortion Services in Italy', *Feminist Review* 124 (2020), pp. 183–191, at 186.

39. E. Caruso, 'Abortion in Italy: Forty Years On', *Feminist Legal Studies* 28 (2020), pp. 87–96, at 91–92.

40. Op. cit., p. 92; La Repubblica, 'Aborto, denuncia Cgil: "Donna respinta da 23 ospedali, soluzione solo dopo nostro intervento"', *La Repubblica Online*, 1 March 2017. Available at: https://www.repubblica.it/cronaca/2017/03/01/news/padova_aborto_respinta_23_ospedali-159526952/ (accessed 28 February 2022).

41. The Family Planning, Human Embryo Protection and Conditions of Permissibility of Abortion Act of 7 January 1993, Article 4a. The ground for foetal impairment was declared unconstitutional in Polish Constitutional Tribunal Case K 1/20 (22 October 2020).

any abortions being carried out in their facility.⁴² The result of this has been the near-complete removal of abortion services from public hospitals, as doctors who do want to provide abortion services tend to do so only in private practices where institutional conscientious objection policies can be avoided.⁴³ The result of widespread conscientious objection in contexts, such as Italy and Poland is the obstruction of access to abortion services, which requires conscientious objection to be regulated to a greater extent than implementing mandatory referral.

Broader issues with conscientious objection misuse

There are also broader issues surrounding the use of conscientious objection that mandatory referral mechanisms cannot address. First, conscientious objection provisions are often invoked for non-conscientious reasons. As Smith argues, objections are only conscientious if they are based on moral values, rather than values in general.⁴⁴ Healthcare professionals may wish to avoid the potential career disadvantages associated with providing abortion services, particularly in staunchly anti-abortion contexts; this is a value, but it is not a moral value, and so does not amount to a conscience-based objection. Yet, in some contexts, healthcare professionals may be able to rely on legal provisions for conscientious objection for these non-moral reasons. Ramón Michel et al. refer to this as a ‘defensive use’ of conscientious objection, as the provisions are invoked by healthcare professionals to protect themselves from this personal disadvantage.⁴⁵

In Poland, the stigmatization and criminalization of abortion encourages the defensive use of conscientious objection. Doctors often refuse to provide abortion services out of fear of harassment by the Church or of damaging their careers if they are situated in an anti-abortion workplace.⁴⁶ Furthermore, the European Court has also identified how the criminalization of people providing illegal abortions has a chilling effect on doctors, who have to decide whether the requirements for a legal abortion have been met in each individual case.⁴⁷ In Britain, the Abortion Act 1967 provides protection for doctors as abortion is legal where the two doctors are of the good-faith opinion that a legal ground has been met.⁴⁸ However, in Poland, the criminalization of doctors performing abortions outside of the narrow legal grounds alongside the requirement that doctors determine

42. S. De Zordo and J. Mishtal, ‘Physicians and Abortion: Provision, Political Participation and Conflicts on the Ground – The Cases of Brazil and Poland’, *Women’s Health Issues* 21 (2011), pp. 32–36, at 34; *P and S*, para 59.

43. A. Chelstowska, ‘Stigmatisation and Commercialisation of Abortion Services in Poland: Turning Sin into Gold’, *Reproductive Health Matters* 19 (2011), pp. 98–106, at 98–99.

44. S.W. Smith, ‘Individualised Claims of Conscience, Clinical Judgement and Best Interests’, *Health Care Analysis* 26 (2018), pp. 81–93, at 83.

45. A. Ramón Michel, S. Kung, A. López-Salm and S. A. Navarrete, ‘Regulating Conscientious Objection to Legal Abortion in Argentina: Taking into Consideration Its Uses and Consequences’, *Health and Human Rights Journal* 22 (2020), pp. 271–384, at 274.

46. De Zordo and Mishtal, ‘Physicians and Abortion’, pp. 33–34.

47. *R.R.*, paras 192–193.

48. Abortion Act 1967, s.1.

whether a case falls within one of those grounds creates uncertainty. Thus, even where the legal grounds for an abortion have been met, a doctor's belief that an abortion is legal can be challenged – and this threat that any abortion they provide could be challenged imposes a burden on doctors, which leads to the defensive use of conscientious objection. Instead of explicitly invoking conscientious objection, doctors may also defensively refuse to provide an abortion by simply stating that the legal grounds have not been met.

In the Italian context, non-objecting healthcare professionals, who represent a minority of gynaecologists, are thus required to perform most abortions.⁴⁹ In institutions where there are very few other non-objecting healthcare professionals, this results in an increased workload and conscientious objection provisions are thus invoked to avoid this.⁵⁰ The defensive use of conscientious objection provisions has also been identified as a problem in numerous other countries, including Australia, Argentina, Bolivia, Croatia, Mexico, and Zambia.⁵¹ The problem of conscientious objection misuse in this way is worsened where healthcare professionals lack comprehensive understanding of their state's abortion laws and regulations, or where resource constraints also incentivize the use of conscientious objection provisions.⁵² Access to abortion is further limited where healthcare professionals who do not have a moral or religious objection to abortion nonetheless refuse to provide abortion services, and regulation beyond mandatory referral mechanisms is required to address this problem.

Second, objecting healthcare professionals may actively attempt to obstruct access to abortion through measures beyond refusing to refer or avoiding invoking conscientious objection provisions. Smith argues that genuine conscientious objections must be for inward-facing rather than outward-facing reasons, for example, refusing to perform an abortion because it would be against the healthcare professional's conscience to

49. Chavin et al., 'Regulation of Conscientious Objection', p. 60; T. Autorino, F. Mattioli and L. Mencarini, 'The Impact of Gynecologists' Conscientious Objection on Abortion Access', *Social Science Research* 87 (2020), pp. 1–16, at 6.

50. Op. cit.

51. See, for example, L.A. Keogh, L. Gillam, M. Bismark, K. McNamee, A. Webster, C. Bayly and D. Newton, 'Conscientious Objection to Abortion, the Law and Its Implementation in Victoria, Australia: Perspectives of Abortion Service Providers', *BMC Medical Ethics* 20 (2019), pp. 1–10, at 6; Ramón Michel et al., 'Regulating Conscientious Objection', p. 274; D.I.G. Håkansson, P. Ouis and M. Ekstrand Ragnar, 'Navigating the Minefield: Women's Experiences of Abortion in a Country with a Conscience Clause – The Case of Croatia', *Journal of International Women's Studies* 22 (2021), pp. 166–180, at 174–175; S.A. Küng, J.D. Wilkins, F.D. de León, F. Huaraz and E. Pearson, "'We Don't Want Problems": Reasons for Denial of Legal Abortion based on Conscientious Objection in Mexico and Bolivia', *Reproductive Health* 18 (2021), pp. 1–11, at 2; E. Freeman and E. Coast, 'Conscientious Objection to Abortion: Zambian Healthcare Practitioners' Beliefs and Practices', *Social Science & Medicine* 221 (2019), pp. 106–114, at 112.

52. De Zordo and Mishtal, 'Physicians and Abortion', p. 35; J. Harries, D. Cooper, A. Strelbel and C.J. Colvin, 'Conscientious Objection and Its Impact on Abortion Service Provision in South Africa: A Qualitative Study', *Reproductive Health* 11 (2014), pp. 1–7, at 4; L.F. Harris, J. Halpern, N. Prata, W. Chavkin and C. Gerds, 'Conscientious Objection to Abortion Provision: Why Context Matters', *Global Public Health* 13 (2018), pp. 556–566, at 560.

participate in that action, not because it would be against the healthcare professional's conscience for the pregnant person to obtain an abortion.⁵³ However, some healthcare professionals invoke conscientious objection provisions for outward-facing reasons.⁵⁴ Fink et al. identify 'extreme' objectors as those that not only refuse to provide abortion services, but also give legally or medically inaccurate information to prevent patients from accessing legal abortions.⁵⁵ Poland represents an example of widespread extreme objection, as conscientious objection is misused by anti-abortion healthcare professionals to intentionally deter or obstruct pregnant people from seeking abortions. CEDAW has highlighted the abuse of conscientious objection in Poland, and the three European Court cases mentioned above also highlight instances of extreme objection.⁵⁶ For example, in *P and S*, the doctors had taken a minor who had become pregnant as a result of rape and was requesting an abortion to see a priest, without consent and while her mother was absent, who tried to convince her to go through with the pregnancy.⁵⁷

Selective objection, where healthcare professionals refuse to provide abortion services in some cases but not others, operates in a similar way in obstructing access to abortion for specific reasons. For example, healthcare professionals in Brazil will often invoke conscientious objection for abortion on the grounds of rape where they do not feel that enough proof has been given.⁵⁸ A study in Mexico and Bolivia also revealed gestational time limits, where they are not set by law, to be key reasons for conscientious objection.⁵⁹ Not all selective objections will amount to a misuse of conscientious objection. Smith argues that individualized, context-based objections can be genuinely conscientious in the same way as generalized objections where they appeal to inward-facing reasons.⁶⁰ However, Smith gives the refusal to perform a particular abortion based on the pregnant person's lifestyle choices as an example.⁶¹ While all conscientious objection to abortion may be viewed as appealing to outward-facing reasons to some extent, selective objections appeal to outward-facing reasons to a greater extent than generalized objections as the healthcare professional is imposing their moral values in relation to a *particular* pregnant person's situation. In addition, while a generalized objection to abortion may be based on anti-abortion values, the refusal to provide abortion services where the

53. Smith, 'Individual Claims', p. 83.

54. This distinction is not a clear-cut one, as objections may entail both inward- and outward-facing reasons. The extent to which the objection is outward-facing is what is important here.

55. L.R. Fink, K.K. Stanhope, R.W. Roach and O.A. Bernal, "'The Fetus Is My Patient, Too': Attitudes toward Abortion and Referral among Physician Conscientious Objectors in Bogotá, Colombia', *International Perspectives on Sexual and Reproductive Health* 42 (2016), pp. 71–80, at 74–75.

56. CEDAW, 'Concluding Observations on Poland', para 37(b); *P and S*; *R.R*; *Tysiqc*.

57. *P and S*, paras 16–19.

58. D. Diniz, A. Madeiro and C. Rosas, 'Conscientious Objection, Barriers, and Abortion in the Case of Rape: A Study among Physicians in Brazil', *Reproductive Health Matters* 22 (2014), pp. 141–148, at 146–147.

59. Küng et al., 'Denial of Legal Abortion', p. 6.

60. Smith, 'Individual Claims', p. 85.

61. Op. cit., pp. 83–84.

healthcare professional is not an extreme objector primarily serves the inward-facing function of protecting their own conscience.

With selective objection, the lines between inward- and outward-facing reasons become blurred. The refusal to perform an abortion based on the lifestyle choices of the pregnant person may serve the function of protecting the healthcare professional's conscience, but it is also informed by a moral judgement made towards the pregnant person. This is most obvious in cases where a selective objection relates to gender stereotypes around how pregnant people and people capable of becoming pregnant should behave. Selective objection can reinforce traditional sexual and gender roles and reinforce stigmatizing attitudes around unwanted pregnancies, such as through invoking conscientious objection where the pregnant person did not use contraception.⁶² Selective objections which amount to the imposition of the healthcare professional's moral values onto the patient should not be treated as a genuine conscientious refusal but a misuse of conscientious objection provisions. Both extreme and selective conscientious objection, then, can amount to an attempt by healthcare professionals to impose their personal beliefs on their patients and circumvent the legalization of abortion in all or specific circumstances.⁶³ The misuse of conscientious objection provisions – where conscientious objection provisions are invoked based on non-moral values or to impose moral values upon the pregnant person – must be addressed within the state regulation of conscientious objection, requiring measures beyond mandatory referrals.

Preventing the harms associated with conscientious objection

Mandatory referrals are taken to be a compromise position by international human rights bodies, but as I have argued thus far, this cannot be viewed as an adequate compromise from either side, and mandatory referral mechanisms are wholly ineffective in addressing the broader issues with conscientious objection. The rights to freedom of conscience and access to abortion must be appropriately balanced; protection for, or restrictions on, conscientious objection must be proportionate to the potential harms caused for each side. Restricting conscientious objection in the healthcare sphere would cause psychological harm to those required to act against their moral values. However, where it is widespread or inadequately regulated, conscientious objection can significantly harm people requiring abortion services.

The most serious harm caused by conscientious objection is the total prevention of access to abortion. Where conscientious objection is widespread or misused in the ways explored above, pregnant people may be left without any access to legal abortion

62. Ramón Michel et al., 'Regulating Conscientious Objection', p. 274; Freeman and Coast, 'Zambian Healthcare Professionals', p. 107.

63. A.C. González Vélez and L. Gil Urbano, 'Improper Use of Conscientious Objection to Abortion/Authors' Response', *International Perspectives on Sexual and Reproductive Health* 42 (2016), pp. 221–223; V. Undurraga and M. Sadler, 'The Misrepresentation of Conscientious Objection as a New Strategy of Resistance to Abortion Decriminalisation', *Reproductive Health Matters* 27 (2019), pp. 17–19.

services. In Italy, the fact that some regions have no healthcare professionals willing to provide abortion services means that pregnant people must travel to another region to find a non-objecting doctor, a disparity which adds an additional obstacle for socio-economically disadvantaged people.⁶⁴ Having to travel to access abortion services can have a number of consequences, the worst of them felt by people unable to travel due to the geographical distance and financial cost. In a study of the impacts of travelling for abortion in two US states, Jerman et al. found three key outcomes: abortions obtained at a later gestational age, negative mental health outcomes, and attempts by pregnant people to end their own pregnancies through medication, home remedies, or physical trauma.⁶⁵ If pregnant people are unable to access alternative means of abortion, such as through travelling or obtaining abortion medication online, they may have no choice but to continue an unwanted pregnancy or engage in unsafe abortion practices, risking their health and criminalization where abortion is an offence.⁶⁶

Furthermore, in Poland, the near-total exclusion of abortion from public hospitals means that people unable to pay for private healthcare may be left without access to abortion even where it is necessary to prevent risk to the pregnant person's life.⁶⁷ Thus, in *Tysiąc*, the outcome of being refused an abortion was that the applicant was left almost blind after giving birth.⁶⁸ There have also been cases in Italy where doctors have conscientiously objected to providing abortions in emergency situations, resulting in the death of a pregnant woman from sepsis in 2016.⁶⁹ In contexts where conscientious objection acts as a significant barrier to access to abortion services, this has serious consequences for the bodily autonomy and health of pregnant people, in violation of the international human rights standards requiring states to guarantee the accessibility of legal abortion services and prevent unsafe abortion.

However, conscientious objection can perpetuate harms even where a pregnant person is subsequently able to access legal abortion services. Fiala and Arthur identify a continuum of harm associated with conscientious objection, which includes the harm

64. Caruso, 'Abortion in Italy', p. 93.

65. J. Jerman, L.F. Frohwirth, M.L. Kavanaugh and N. Blades, 'Barriers to Abortion Care and Their Consequences for Patients Traveling for Services: Qualitative Findings from Two States', *Perspectives on Sexual and Reproductive Health* 49 (2017), pp. 95–102, at 98.

66. Telemedical abortion services, where consultation for an abortion is done remotely and abortion medication is sent to the pregnant person's home, can mitigate many of these socio-economic and geographic barriers as non-objecting healthcare professionals are able to distribute abortion pills across the country. However, full telemedicine for early medical abortion is not yet available in many countries. For more on telemedical abortion, see: J. Parsons and E.C. Romanis, *Early Medical Abortion, Equality of Access, and the Telemedical Imperative* (Oxford: Oxford University Press, 2021).

67. Chelstowska, 'Turning Sin into Gold'.

68. *Tysiąc*, paras 16–18.

69. Caruso, 'Ambivalence of Law', p. 183; S. Kirchaessner, 'Police Launch Inquiry into Death of Woman 'Refused' an Abortion by Silician Doctors', *The Guardian*, 23 October 2016. Available at: <https://www.theguardian.com/world/2016/oct/22/italy-death-miscarriage-abortion-doctors-refuse-procedure> (accessed 28 February 2022).

caused by delays and the stigmatizing of those seeking abortion services.⁷⁰ Delays can make the process of obtaining an abortion more stressful and burdensome and can create additional difficulties in relation to gestational time limits for abortion. Delays can cause or exacerbate psychological distress around an unwanted pregnancy, and people in situations of vulnerability – such as adolescents and people facing intimate partner violence – may find it difficult to overcome the additional obstacles created by conscientious objection.⁷¹ Furthermore, delays will be particularly psychologically distressing to people who have become pregnant as a result of rape or those carrying a foetus with a fatal impairment. The ECtHR and HRC have found in previous cases that prohibitions on or obstacles to accessing abortion in these situations amounted to cruel, inhuman, and degrading treatment.⁷² Even where delays or barriers to access do not cause this level of harm, they may still infringe human rights requirements that states guarantee timely access to services. Delays to accessing abortion services as a result of conscientious objection can therefore cause harm, in varying degrees of severity, amounting to a violation of human rights standards.

Furthermore, as conscientious objection in the healthcare sphere is largely practised in relation to reproductive health services, such as abortion and contraception, these refusals can perpetuate gender stereotypes around motherhood and pregnancy. As Ngwena identifies, conscientious objection can become a ‘Trojan horse for popular patriarchal and religious prejudices that deny women’s reproductive agency’.⁷³ This is particularly the case with selective objections based upon outward-facing reasons, as discussed above, such as the pregnant person’s contraceptive use or lifestyle choices. Conscientious objection to abortion is premised on the belief that abortion – either generally or in a specific instance – is wrong, which can reinforce patriarchal beliefs that abortion is selfish and a deviation from women’s biological duty to become mothers.⁷⁴ Adenitire argues, in relation to conscientious objection by commercial service-providers

70. C. Fiala and J.H. Arthur, ‘There Is No Defence for ‘Conscientious Objection’ in Reproductive Health Care’, *European Journal of Obstetrics & Gynecology and Reproductive Biology* 216 (2017), pp. 254–258, at 255.

71. In relation to the psychological distress caused by being denied an abortion or delayed in accessing an abortion, see: D.G. Foster, *The Turnaway Study* (New York: Scribner Book Company, 2020); S. Hovarth and C.A. Schreiber, ‘Unintended Pregnancy, Induced Abortion, and Mental Health’, *Current Psychiatry Reports* 19 (2017), pp. 1–6; U. Kumar, P. Baraitser, S. Morton and H. Massil, ‘Decision Making and Referral Prior to Abortion: A Qualitative Study of Women’s Experiences’, *BMJ Sexual and Reproductive Health* 30 (2004), pp. 51–54.

72. *P and S; Mellet v Ireland* (2016) UN Doc. CCPR/C/116/D/2324/2013; *Whelan v Ireland* (2017) UN Doc. CCPR/C/119/D/2425/2014.

73. C.G. Ngwena, ‘Conscientious Objection to Abortion and Accommodation Women’s Reproductive Health Rights: Reflection on a Decision of the Constitutional Court of Colombia from an African Regional Human Rights Perspective’, *Journal of African Law* 58 (2014), pp. 183–209, at 209.

74. M. Boyle, *Re-Thinking Abortion* (Abingdon: Routledge, 1997), p. 28; Sheldon, *Beyond Control*, p. 36; E. Miller, *Happy Abortions* (London: Zed, 2017), p. 5; J.M.J. Mavuso, ‘Understanding the Violation of Directive Anti-Abortion Counselling [and Cisnormativity]: Obstruction to Access or Reproductive Violence?’, *Agenda* 35 (2021), pp. 69–81, at 70.

and sexual orientation discrimination, that the denial of services (such as providing flowers for a gay wedding) represents an unjustifiable dignitary harm by treating lesbian, gay, and bisexual people as second-class citizens.⁷⁵ Dignitary harm is not merely offence or humiliation, but also differential treatment in the context of historically discriminatory laws and continuing homophobia in the present day, which represents a social harm.⁷⁶ Inadequately regulated conscientious objection to abortion can also amount to an unjustifiable dignitary harm against people capable of becoming pregnant in the context of the historical marginalization of women as a gendered class.

In the context of conscientious objection to emergency contraception, McLeod therefore argues that the harm caused is never just mere inconvenience because of how objection to reproductive healthcare is interlinked with these gendered norms.⁷⁷ Although not all instances of conscientious objection by individual healthcare professionals will be explicitly based on these gendered norms, conscientious objection to abortion, when considered at a structural rather than individual level, perpetuates gender-based harm as restrictions on abortion have historically been tied to these gendered stereotypes. CEDAW requires states to

modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes *or on stereotyped roles for men and women*.⁷⁸

This obligation on states to address gender stereotypes has been explicitly extended to norms that place the protection of the foetus above that of the pregnant person.⁷⁹ Thus, insofar as conscientious objection to abortion perpetuates gender stereotypes around pregnancy, states have an obligation to respond to this harm.

Regulating conscientious objection

As highlighted in the above sections, conscientious objection, where insufficiently regulated, can significantly obstruct access to abortion services in violation of international human rights standards on abortion and causes harm to pregnant people. Mandatory referral mechanisms are unable to adequately address these issues, particularly in contexts with widespread and extreme conscientious objection, and thus fail to achieve the compromise position sought by human rights treaty bodies. However, despite the recognition that the regulation of conscientious objection is a significant and complex challenge, numerous scholars concerned with ensuring access to abortion still present referral mechanisms as the best way of striking a balance between freedom

75. J. Adenitire, *A General Right to Conscientious Exemption: Beyond Religious Privilege* (Cambridge: Cambridge University Press, 2020), pp. 279–283.

76. Op. cit.

77. C. McLeod, 'Harm or Mere Inconvenience? Denying Women Emergency Contraception', *Hypatia* 25 (2010), pp. 11–30, at 18–19.

78. CEDAW Article 5(a) [emphasis added].

79. *L.C. v Peru* (2011) UN Doc. CEDAW/C/50/D/22/2009, para 8.15.

of conscience and reproductive rights.⁸⁰ Zaami, Rinaldi, and Montanari Vergallo acknowledge the shortcomings of referral mechanisms, but they limit this to low-income countries by arguing that

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 [. . .]⁸¹

These limitations are not confined to low-income countries as the referral process can be just as difficult or unfeasible in high-income countries, with Italy presenting an obvious example. Rather, whether referral mechanisms are feasible or not will depend on a range of contextual variables, such as the prevalence of anti-abortion attitudes, the legalization or criminalization of abortion, and the organization of healthcare systems, personnel, and resources, issues which are not specific to low-income countries.

From both the sides of protecting conscientious objection and the side of ensuring access to abortion, there appears to be an impossibility of reaching a satisfactory position. This can be demonstrated by the position of conscientious objection in Britain, which has been critiqued for both not doing enough to ensure that pregnant people are not prevented from accessing abortion services and for failing to sufficiently protect conscience. In Britain, the Abortion Act 1967 allows doctors to conscientiously object to participation in an abortion procedure, except where the abortion is necessary to save the life of or prevent grave permanent injury to the pregnant person.⁸² The Supreme Court confirmed in *Doogan* that only those healthcare professionals who would be directly involved in the abortion procedure can conscientiously object, so that, two Catholic midwives could not conscientiously object to performing administrative and supervisory tasks relating to patients who had abortions.⁸³

Ó Néill argues that the Abortion Act and the Supreme Court in *Doogan* struck a sufficient compromise between the rights of objecting healthcare professionals and pregnant people seeking abortions.⁸⁴ However, the Abortion Act's position has been criticized by both feminist scholars and those concerned with protecting conscience. Feminist scholars have pointed out the potential for regional and socio-economic variations in the availability of abortion services across Britain as a result of conscientious objection.⁸⁵ Furthermore, Harmon argues that the Supreme Court in *Doogan* failed to offer any insight into conscientious objection as properly balanced against access to abortion as

80. See, for example: Dickens, 'The Right to Conscience'; McLeod, 'Referral'; Zaami et al., 'Care before Freedom of Conscience', p. 350.

81. Zaami et al., 'Care before freedom of conscience', p. 350.

82. Abortion Act 1967 s.4.

83. *Glasgow Health Board v Doogan and others* [2014] UKSC 68.

84. C. Ó Néill, *Religion, Medicine and the Law* (Abingdon: Routledge, 2019), pp. 185–186; C. Ó Néill, 'Conscientious Objection in *Greater Glasgow Health Board v. Doogan and others* [2014] UKSC 68', *Medical Law International* 15 (2015), pp. 246–254, at 254.

85. Jackson, *Regulating Reproduction*, p. 86; Sheldon, *Beyond Control*, p. 56.

anti-choice advocates adopt conscientious objection to undermine timely access to abortion.⁸⁶ From this perspective, the regulation of conscientious objection in Britain affords insufficient weight to ensuring that access to abortion services is not impeded.

Neal, however, critiques *Doogan* for its narrow reading, as healthcare professionals and other staff members who have an indirect role in the context of abortion treatment are still, in their view, participating in an act which goes against their own conscience.⁸⁷ Neal thus sees the limiting of conscientious objection to those directly involved as offering insufficient protection to freedom of conscience, as this entails a 'logically indefensible' complicity with abortion.⁸⁸ Allowing staff members who are indirectly involved to conscientiously object and having no duty to inform or refer would result in a relatively liberal approach to freedom of conscience with limited regulation. Yet, this approach is contingent on limited impact on access to abortion. Indeed, Neal comments that if the Abortion Act did cover all staff members directly and indirectly involved in abortion provision, there would be little chance of conscientious objection becoming so widespread as to threaten access to abortion.⁸⁹ As indicated above, feminist scholars have expressed concerns over the potential impact of conscientious objection on access to abortion, and Harmon comments that the number of doctors trained in abortion care and those with anti-abortion views threatens abortion care.⁹⁰ However, there is a lack of recent evidence to suggest that abortion services in Britain have been threatened by conscientious objection. Abortion service provision in Britain is largely organized through dedicated abortion providers, such as the British Pregnancy Advisory Service and Marie Stopes International, whose staff members are highly unlikely to conscientiously object to abortion otherwise they would not be working for an abortion clinic.⁹¹

In the British context, there is still the potential for harm to be caused in individual cases, where conscientious objection results in delays or perpetuates stigma against the pregnant person seeking an abortion, which could justify some restrictions on conscientious objection. As conscientious objection does not have a significant impact upon the availability of abortion services beyond this, Neal's liberal approach to conscientious objection would nonetheless be very much limited to the British context. This approach cannot be applied in other contexts, such as Poland and Italy, where conscientious objection is so widespread that greater regulation is necessary to strike an appropriate balance between access to abortion and freedom of conscience. The same limitation applies to the suggestions of other scholars to take a 'reasonable accommodation' approach to

86. S.H.E. Harmon, 'Abortion and Conscientious Objection: *Doogan* – A Missed Opportunity for an Instructive Rights-Based Analysis', *Medical Law International* 16 (2016), pp. 143–173, at 160.

87. M. Neal, 'Commentary: The Scope of the Conscience-Based Exemption in Section 4(1) of the Abortion Act 1967: *Doogan and Wood v NHS Greater Glasgow Health Board* [2013] CSIH 36', *Medical Law Review* 22 (2014), pp. 409–421, at 417.

88. Fovargue and Neal, 'In Good Conscience', p. 241.

89. Neal, '*Doogan*', p. 420.

90. Harmon, '*Doogan*', pp. 160–161.

91. Many thanks to the anonymous reviewer who highlighted this point.

conscientious objection.⁹² Where there is widespread anti-abortion sentiment among doctors, accommodation for conscientious objection will result in the lack of availability of abortion services.

Preventing conscientious objection

Several scholars suggest that conscientious objection should not be tolerated at all, taking the view that conscientious objection has been too freely accommodated, and that those objecting to abortion should not enter those fields as a healthcare professional's conscience has no place in modern healthcare.⁹³ Conscientious objection has been described by others as 'an act of heresy' and 'dishonourable disobedience' as it is at odds with professional values.⁹⁴ For Smalling and Schuklenk, the easiest way of ensuring efficient access to healthcare is to prevent healthcare professionals from conscientiously objecting to the provision of services, such as abortion, as a 'society that grants medical professionals a conscientious objection-based opt-out will have to accept suboptimal health outcomes'.⁹⁵ This would not mean that objecting healthcare professionals would be forced to provide abortion services, but instead they argue that healthcare professionals who object to abortion should not be allowed to enter fields, such as gynaecology and obstetrics.⁹⁶ This is already the policy in Sweden, where healthcare professionals are unlikely to be employed in fields, such as gynaecology, obstetrics, and midwifery if they are unwilling to certify that they will provide abortions and contraception.⁹⁷

As explored above, there is a continuum of harm associated with conscientious objection. The international human rights response to conscientious objection must be

92. See, for suggestions of reasonable accommodation, M.R. Wicclair, 'Preventing Conscientious Objection in Medicine from Running Amok: A Defense of Reasonable Accommodation', *Theoretical Medicine and Bioethics* 40 (2019), pp. 539–564; M.R. Wicclair, *Conscientious Objection in Health Care* (Cambridge: Cambridge University Press, 2011); H. Fernandez Lynch, *Conflicts of Conscience in Health Care: An Institutional Compromise* (Cambridge, MA: MIT Press, 2008).

93. J. Savulescu, 'Conscientious Objection in Medicine', *BMJ* 332 (2006), pp. 294–297; J. Savulescu and U. Schuklenk, 'Doctors Have No Right to Refuse Medical Assistance in Dying, Abortion or Contraception', *Bioethics* 31 (2017), pp. 162–170, at 168–169; R. Smalling and U. Schuklenk, 'Against the Accommodation of Subjective Healthcare Provider Beliefs in Medicine: Counteracting Supporters of Conscientious Objector Accommodation Arguments', *Journal of Medical Ethics* 43 (2017), pp. 253–256.

94. J. Montgomery, 'Conscientious Objection: Personal and Professional Ethics in the Public Square', *Medical Law Review* 23 (2015), pp. 200–220, at 211; Fiala and Arthur, 'Dishonourable Disobedience'.

95. Smalling and Schuklenk, 'No Right to Refuse', p. 256; U. Schuklenk and R. Smalling, 'Why Medical Professionals Have No Moral Claim to Conscientious Objection Accommodation in Liberal Democracies', *Journal of Medical Ethics* 43 (2017), pp. 234–240, at 237.

96. Schuklenk and Smalling, 'No Right to Refuse', p. 239.

97. C. Fiala, K.G. Danielsson, O. Heikinheimo, J.A. Guðmundsson and J. Arthur, 'Yes We Can! Successful Examples of Disallowing "Conscientious Objection" in Reproductive Health Care', *The European Journal of Contraception & Reproductive Health Care* 21 (2016), pp. 201–206, at 202.

proportionate to the harm caused; where conscientious objection has the effect of completely or near-completely obstructing access to abortion, thus risking the health and lives of pregnant people, it may be proportionate to increasingly regulate healthcare professionals' ability to refuse to provide abortion services. However, in other contexts, such as Britain where conscientious objection does not operate as a significant barrier to accessing abortion, increasing regulation would unjustifiably infringe the right to freedom of conscience. Alternative suggestions include setting quotas for new medical trainees entering fields, such as obstetrics and gynaecology to ensure that a certain percentage of healthcare professionals are able and willing to provide abortion services, or setting up review panels to oversee the invoking of conscientious objection provisions to ensure that they are not misused.⁹⁸ There may be administrative or resource-based burdens associated with putting in place these kinds of regulatory systems, and neither would be effective where there are insufficient numbers of non-objecting healthcare professionals. In relation to the defensive use of conscientious objection provision, measures, such as financial incentives and comprehensive training on abortion law and provision may be effective at improving timely access to abortion services. This will also require improving the allocation of resources to reproductive healthcare services, ensuring that healthcare professionals are informed of the relevant regulations, and ensuring that abortion providers have the support of their colleagues and adequate working conditions.⁹⁹ As the effectiveness of these different types of regulation will be context-dependent, and will have legal, moral, and practical implications, their appropriateness must be assessed at the domestic level. Yet, while these regulatory responses may alleviate the impact conscientious objection has on abortion service delivery, they cannot address the gender-based harms resulting from conscientious objection to abortion.

How the international human rights framework should respond to conscientious objection

At the international human rights level, mandatory referral mechanisms do not operate as a workable compromise due to the complex and contextual nature of conscientious objection to abortion worldwide, which often obstructs access to abortion and perpetuates additional harms against pregnant people. Zampas highlights that while there have been growing human rights standards on ensuring access to reproductive health services and the removal of barriers, including the unfettered use of conscientious objection, these standards do not cover all situations in which conscientious objection places human rights in jeopardy.¹⁰⁰ Zampas and Andión-Ibañez thus argue that more guidance on the regulation of conscientious objection is needed from international and regional human

98. Op. cit.; L. Kantymir and C. McLeod, 'Justification for Conscience Exemptions in Health Care', *Bioethics* 28 (2014), pp. 16–23, at 22.

99. Harris et al., 'Why Context Matters', p. 562.

100. C. Zampas, 'Legal and Ethical Standards for Protecting Women's Human Rights and the Practice of Conscientious Objection in Reproductive Healthcare Settings', *International Journal of Gynecology and Obstetrics* 123 (2013), pp. 63–65, at 63–64.

rights bodies.¹⁰¹ The remainder of this article will set out how the international human rights framework should offer guidance on conscientious objection.

The ECtHR appears to limit the right to conscientious objection in relation to reproductive healthcare. In *Pichon and Sajous v France*, the owners of a pharmacy, who had been fined after refusing to provide contraceptives to three women, argued that this penalty was an interference with the Article 9 right to freedom of religion contained in the European Convention on Human Rights.¹⁰² The ECtHR declared the application to be inadmissible as the penalty did not interfere with the rights guaranteed by Article 9, and was thus manifestly ill-founded.¹⁰³ In 2020, the ECtHR issued decisions in two cases concerning Swedish midwives who had been refused employment in women's clinics after informing their prospective employers of their objection to provide abortions.¹⁰⁴ The ECtHR again rejected the applications on the basis that they were manifestly ill-founded, noting that there is no guaranteed right to occupy a post in the civil service.¹⁰⁵ Domenici has expressed concerns over the ECtHR accepting the de facto exclusion of Catholics from the midwifery profession in these two cases without properly assessing the proportionality of this exclusion.¹⁰⁶

However, the ECtHR's decisions indicating that Article 9 does not contain a right to conscientiously object to providing reproductive healthcare are in line with its approach to abortion, which is left within the margin of appreciation of each Member State. In the three Polish cases discussed above, violations of Convention rights were found because the applicants were all denied access to abortion services in circumstances where they met the criteria for a legal abortion in domestic law.¹⁰⁷ In *A, B, and C v Ireland*, the ECtHR did not accept that the Article 8 right to private life conferred a right to abortion and a violation was found only in relation to one of the three applicants, on the basis that they were legally entitled to a therapeutic abortion in Ireland.¹⁰⁸ The ECtHR thus takes a procedural approach to abortion, leaving an assessment of the competing rights or values within the abortion context to individual Member States.¹⁰⁹ There is no right to conscientious objection just as there is no right to abortion, with the ECtHR accepting in the Swedish cases that protecting access to abortion is a legitimate aim in restricting

101. C. Zampas and X. Andi3n-Iba3ez, 'Conscientious Objection to Sexual and Reproductive Health Services: International Human Rights Standards and European Law and Practice', *European Journal of Health Law* 19 (2012), pp. 231–256, at 255.

102. *Pichon and Sajous v France* App no. 49853/99 (ECHR, 2 October 2001).

103. Op. cit.

104. *Grimmark v Sweden* App no. 43726/17 (ECHR, 11 February 2020); *Steen v Sweden* App no. 62309/17 (ECHR 11 February 2020).

105. *Grimmark*, para 22; *Steen*, para 17.

106. I. Domenici, 'Antigone Betrayed? The European Court of Human Rights' Decisions on Conscientious Objection to Abortion in the Cases of *Grimmark v. Sweden* and *Steen v. Sweden*', *European Journal of Health Law* 28 (2021), pp. 26–47, at 47.

107. R.R; P and S; Tysia3.

108. *A, B, and C v Ireland* App no. 25579/05 (ECHR, 16 December 2010), paras 240–242, 267.

109. D. Fenwick, 'The Modern Abortion Jurisprudence under Article 8 of the European Convention on Human Rights', *Medical Law International* 12 (2013), pp. 249–276, at 274.

conscientious objection and in *A, B, and C* that the State's interest in protecting the life of the foetus is a legitimate aim in restricting access to abortion.¹¹⁰ As Campbell identifies, the ECtHR is unlikely to make a definitive statement on conscientious objection and the above cases should not be interpreted as such.¹¹¹ A deferential approach is not uncommon for international bodies; the World Health Organization contains a qualifier in its list of essential medicines to note that mifepristone and misoprostol should be provided where it is culturally acceptable.¹¹² However, in applying the margin of appreciation, the ECtHR is reluctant to set any concrete standards on abortion provision.

While there is therefore a limited opportunity for expansion on the balancing between conscientious objection and access to abortion at the European level, it is both possible and important for international human rights bodies to offer further guidance. Although there is also no right to abortion recognized in the international human rights framework, legal restrictions on abortion and barriers to access violate a number of rights in certain circumstances. Thus, there is more scope for international human rights bodies to require states to properly regulate conscientious objection in support of these existing standards on abortion. The current reliance on mandatory referral mechanisms is ineffective, and where conscientious objection obstructs access to abortion, this approach undermines these existing standards.

However, this approach should not be replaced with a similarly standardized recommendation. The international human rights approach must account for the socio-economic and political pressures of different contexts, primarily in relation to the worldwide variation in prohibitions on and socio-cultural attitudes towards abortion, the current regulation and use of conscientious objection, and broader issues with reproductive healthcare delivery. Harris et al. argue that conscientious objection policies seldom take into account the context of reproductive healthcare delivery and how this leads to conscientious objection acting as a barrier to abortion access.¹¹³ Reliance on generalized measures, such as mandatory referral mechanisms, will fail to adequately respond to these different contexts. The international human rights framework must therefore adopt recommendations aimed at achieving this contextual balance.

First, this requires recognition of the continuum of harms caused by conscientious objection. As highlighted above, conscientious objection obstructs access to abortion services which can delay an abortion, force pregnant people to travel for an abortion or access clandestine abortion services, or where this is not possible, continue an unwanted pregnancy to term. At worst, healthcare professionals conscientiously objecting to therapeutic abortions can have potentially devastating consequences. The European Committee of Social Rights, the regional human rights body monitoring the implementation of the European Social Charter, has found in relation to Italy that widespread conscientious

110. *Grimmark*, para 10; *Steen*, para 20; *A, B, and C*, para 227.

111. M. Campbell, 'Conscientious Objection, Health Care and Article 9 of the European Convention on Human Rights', *Medical Law International* 11 (2011), pp. 284–304, at 290, 303.

112. World Health Organization, 22nd List of Essential Medicines (2021), at 50; Parsons and Romanis, 'Early Medical Abortion', p. 12.

113. Harris et al., 'Why Context Matters', p. 557.

objection amounts to a violation of the right to health in conjunction with the right to non-discrimination.¹¹⁴ Even where the pregnant person is eventually able to access abortion services, the initial refusal is nevertheless stigmatizing and can perpetuate harmful gender-based stereotypes around pregnancy. International human rights bodies should highlight how conscientious objection can violate various human rights, including gender-based rights, and has the potential to undermine existing human rights standards on abortion.

To minimize the harms caused by conscientious objection, international human rights bodies should place clearer obligations on states to implement a comprehensive regulatory response to ensure that access to abortion services is not obstructed. As the adoption of a blanket policy, such as mandatory referral, cannot address the problems associated with conscientious objection in different contexts, the specific details of this response should be left to individual states. Individual states are better placed to determine a feasible and effective measure of addressing conscientious objection, guided by the obligations placed on them regarding access to abortion. However, in states where the use of conscientious objection is widespread or extreme, and therefore creates a significant barrier to accessing abortion services, human rights standards must require states to further restrict the use of conscientious objection by healthcare professionals. In addition, Ó Néill argues that the breadth of defensible conscientious objection is connected to the breadth of abortion provision, so greater restrictions on conscientious objection can be justified where there are greater restrictions on abortion provision.¹¹⁵ Thus, where states have failed to meet existing human rights standards on ensuring access to abortion, international human rights bodies should also require those states to further restrict conscientious objection than in states with more progressive abortion regimes.

The regulation of conscientious objection will not address the gender-based harms resulting from refusals, as these issues will likely be present wherever conscientious objection to abortion is practised. The key issue is that healthcare professionals hold a moral objection to healthcare services that are necessary for reproductive autonomy and gender equality, which requires tackling abortion stigma in healthcare settings as well as comprehensive abortion training emphasizing why access to abortion is morally important.¹¹⁶ As conscientious objection poses less of a problem for abortion service delivery where only a small minority of healthcare professionals object to providing abortions, steps must be taken to change stereotypical socio-cultural attitudes towards women's reproductive roles and lessen the impact of anti-abortion views. International human rights bodies, particularly CEDAW, could address this as an issue of non-discrimination and gender equality. As States are already required by CEDAW to modify socio-cultural stereotypes, this obligation could be expanded to cover anti-abortion attitudes, to fully address the gender-based harm caused by conscientious objection. Conscientious objection must be understood not only as a procedural barrier to accessing abortion services

114. *International Planned Parenthood Federation – European Network (IPPF EN) v Italy* (10 September 2013) Complaint No. 87/2012; *Confederazione Generale Italiana del Lavoro (CGIL) v Italy* (12 October 2015) Complaint No. 91/2013.

115. Ó Néill, *Religion*, p. 186.

116. Harris et al., 'Why Context Matters', p. 562; McLeod, 'Referral', p. 42.

but also as an issue of gender inequality, which states must actively take steps to challenge. It is only through recognizing conscientious objection as an issue of gender inequality that the international human rights framework can fully uphold its existing standards on access to abortion.

Conclusion

The reliance on referral mechanisms by international human rights bodies fails to strike an adequate balance between freedom of conscience and ensuring access to abortion, thus undermining existing human rights standards on abortion. The insufficient regulation of conscientious objection has the potential to significantly obstruct access to abortion services, particularly where this objection is widespread and healthcare services cannot be organized in a way which minimizes its impact. The spectrum of harm resulting from conscientious objection to abortion must be addressed through a range of measures, depending on the specific context of individual states. In this article, I have argued that international human rights bodies should place clear obligations on states to regulate conscientious objection to guarantee access to abortion. While the specific details of this regulation should be left to individual states, it would be appropriate for human rights bodies to require the restrictive regulation of conscientious objection in states where abortion is largely restricted. Finally, fully addressing the harms of conscientious objection requires acknowledgement of the gender stereotypes reinforced by objecting healthcare professionals. States must therefore tackle these stereotypes, and anti-abortion values, which result in and are perpetuated by widespread conscientious objection.

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