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UNEXPECTED USES OF AND RESPONSES TO CONSCIENTIOUS OBJECTION TO LEGAL ABORTION

Agustina Ramón Michel &
Sonia Ariza Navarrete

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Based on a survey answered by more than 260 healthcare providers in Argentina and on what we know occurs at healthcare facilities, legal termination of pregnancy (LTP) is, by far, the most objected healthcare practice (Ariza Navarrete & Ramón Michel, 2018).

Conscientious objection (CO) is an exceptional legal concept. As a general principle, the legal system requires and seeks compliance with regulations by everyone who has the legal duty to do so. CO is a curious case where the State allows an individual to be exempted from a legal duty on moral grounds, provided they meet the requirements and the procedures set forth, and that they do not affect the rights of third parties. Originally, CO was meant to protect religious or cultural minorities, usually ignored by legal provisions.

There are healthcare providers who, after weighing their moral principles and beliefs and their legal duties, request to be exempted from providing LTP services, as performing an LTP would severely damage their integrity. They somehow recognize their failure to resolve their moral conflict in a way that is more beneficial to their patients, their colleagues, and the health system. Thus framed, CO appears as an act of humility, not of pride or moral refusal (Maglio, 2009).

However, as we well know, many cases of CO to LTP distance themselves from this liberal use, from that ethical image embodied in bioethics and law, and appear more like reactionary acts, including religious fundamentalism and political pressure, which often translate into illicit acts that harm those whom they supposedly should accompany, assist, and care for. Some providers claim conscientious objection as part of activism against reproductive rights, particularly abortion rights. Other providers resort to CO for fear of being stigmatized in extremely hostile environments, for unfounded fears resulting from ignorance or lack of institutional support, or to avoid standing out from their superiors and paying the price for that distancing. These are motivations and situations that are very different from each other, equivocally encompassed by the term CO but requiring different approaches and responses.

Thus, there is currently immense dissonance between that set forth in legal instruments and practice: the version of CO as a thoughtful, sincere, and humble act by someone who is part of a minority has yielded to other uses that are much more problematic and much less ethical.

1. USES OF CONSCIENTIOUS OBJECTION

Liberalism justifies CO as a way of protecting freedom of conscience and the individual moral integrity of minority groups. **Within this expected liberal use,** providers may deny a legal health service, which they have the duty to provide, because providing said service would irreparably affect their moral or religious beliefs. It is a civil guarantee, with no political aspirations or resistance against majority democratic decisions.

In practice, CO is being used in ways beyond those originally imagined. We have long seen **conservative political uses** of CO to counteract progress toward full realization of sexual and reproductive rights (SRR) in Argentina. CO is claimed and used to pursue goals associated with the defense of sexuality, gender roles, and traditional family structures that objecting providers deem under attack due to recent legal and cultural achievements.

CO has been used by some health professionals as a "Trojan horse" to derail Argentina's progress on SRR. The Catholic Church has promoted this use of CO, urging their followers to use it in diverse scenarios. Perhaps the most explicit statement from a church leader was the encyclical *Evangelium vitae* by Pope John Paul II (El País, 1995). *In its Instruction on Respect for Human Life*, the Congregation for the Doctrine of the Faith (1987, section III) states:

The civil legislation of many states confers an undue legitimation upon certain practices in the eyes of many today (…) All men of good will must commit themselves, particularly within their professional field and in the exercise of their civil rights, to ensure the reform of morally unacceptable civil laws and the correction of illicit practices. In addition,"conscientious objection"vis-à-vis such laws must be supported and recognized.

There are providers who refuse to provide LTP services on religious or moral grounds, even when they are not religious fundamentalists or political conservatives; they use the only mechanism available to them to avoid what they perceive as a situation that will only bring them serious problems.

In addition, hospital authorities have used CO as an instrument to establish an ideological approach. A provincial sexual and reproductive health (SRH) coordinator (Ariza Navarrete & Ramón Michel, 2018) stated:

In hospitals, you find people saying that the instructions were "The CO must be signed,' and those orders came from department heads.

But besides being almost always acts that are more or less collective, which pursue the political objective of changing the legal status of abortion by promoting absolute inaccessibility, these uses of CO evidently show that currently CO is not so much a mechanism to which minorities marginalized by laws resort, but rather a mechanism accessed by majorities, elites or privileged sectors in order to resist social and legal changes (and political and legal successes, many of them weak) (Deza, 2014; Siegel & NeJaime, 2015)

These behaviors, due to their nature (propaganda, goal of joining others, etc.) are more like civil disobedience, which is not legally endorsed (Alegre, 2009). On the contrary, whoever practices civil disobedience should face the appropriate legal sanctions (this is the most evident difference between civil disobedience and CO). Moreover, at times these conservative political uses of CO exceed the protection granted by law and constitute illicit actions that have harmful consequences on patients (denials or obstacles in the provision of information; deliberate delays to go beyond the time during which the abortion can be performed; ill-treatment; obstetric violence; injuries, etc.).

However, our research also points to other uses of CO that are less obvious but equally harmful to health policies, to the healthcare system, and especially to those who require an LTP; we refer to those uses as defensive CO uses (many of which are involuntarily harmful), including healthcare providers who resort to CO even when not driven by moral reasons, or when not against caring for women who require a pregnancy termination, or when not seeking to advance a conservative political agenda—but rather to avoid the stigma associated with performing abortions in extremely hostile environments or to avoid a heavy workload due to the lack of practitioners available to provide abortion services.

CO is also used as protection in cases of legal uncertainty and fear of potential legal problems usually driven by conservative groups or even by prosecutors or judges who abuse their institutional power (Clarín, 2019; Niehans & Varcoe-Wolfson, 2018).

2. EFFECTS OF AND RESPONSES TO CO

Each one of these uses of CO (liberal, conservative political and defensive) needs different responses, hence the importance of distinguishing them.

2.1. Liberal use: conscientious denial

The most extensive conceptualization of CO does not describe it adequately.

Firstly, traditional definitions of CO assume incorrectly that providers who seek to be exempted from performing LTPs have in their conscience *only one moral principle,* associated with the sacredness of intrauterine life. However, this affirmation is a caricature of conscience, and not conscience. Individuals and their conscience are morally complex and nurture themselves with experiences; conscience is neither static nor formed from only one belief (Ramón Michel & Cavallo, 2014).

Therefore, providers who have a particular moral belief with respect to the sacredness of human life from the moment of fertilization, for example, **do not have only that belief in relation to their duty to provide LTP services, but rather their conscience is also shaped by several ethical principles,** including their duty to respect patients' autonomy or beneficence (Sepper, 2002).

When providers object, they pay a high price in the moral dimension, as they prioritize a particular belief above a set of moral principles, and above legal and professional duties that are called on to guide professional behavior.

In that light, the first conflict experienced by those providers will be internal, hence they should reflect on what belief or principle to prioritize and which to put aside, or on how to combine them. Providers who object prioritize one principle above others; they choose a way of understanding their moral integrity that does not give priority to their patient's care (Ramón Michel & Cavallo, 2014). This idea appears to be shared by 55.7% of healthcare providers who believe that CO involves the breach of professional duties (Ariza Navarrete & Ramón Michel, 2018).

Secondly, *the prevailing view of CO does not capture successfully all the ethical dimensions of medical practices.* Formal training usually allows providers to resolve a good deal of their daily practices, but occasionally dilemmas arise, when ethical duties and legal obligations conflict and deeper reflection is necessary (Sepper, 2002). To decide what to do, providers do not resort to only one moral principle, but rather to those principles, beliefs, and experiences that shape their conscience and who they are.

In these more complex situations, it is challenging to preserve a “moral purity” (Ramón Michel & Cavallo, 2014). Claiming and prioritizing a personal belief as a reason to be exempted from a legal duty and to deny care to those who request an LTP implies standing by and not becoming involved, under the rationale that moral conflict is supposedly unsolvable (Van Bogaert, 2002). **This purity claim can lead to a mediocre, even incorrect, practice of medical care** (by excluding the considerations of others, of patients, providers can miss out on considering important information needed to provide appropriate care) and, paradoxically, involves the exercise of ethical violence: I believe this and only this, and I close myself to the other person; I refuse to listen to that person and to establish a relationship.

We (…) have all seen a woman die from an unsafe abortion; we know the patients, what their lives are like when they become pregnant and have children within contexts of violence and poverty. No objector can say that those things do not touch them, but they don’t take charge. (Ariza Navarrete & Ramón Michel, 2018)

2.2. Unexpected uses of CO: understanding the problems to develop appropriate responses

There are multiple conditions that encourage the use of CO as a mechanism to avoid problems. Moreover, there are institutional conditions and those related to the medical culture that incentivize healthcare providers to shun LTP services, often claiming reasons of conscience.

Many healthcare providers who work in hostile environments do not speak openly about their work. **This silence, part of the stigma,** creates a vicious cycle: when providers do not disclose their role as LTP providers, their silence perpetuates stereotypes that portray LTP services as deviant or unusual. This contributes to the perception that "serious" providers do not become involved in these situations. One of the interviewees describes the situation as follows:

Other [providers] do so [provide LTP] keeping a ‘low profile’, or they do nothing for fear of repercussions and recrimination, like most people. (Ariza Navarrete & Ramón Michel, 2018)

In many regions diverse **mechanisms are used to informally punish LTP providers.** CO is used by physicians to avoid this potential harassment and the damages they (and at times even their families) might suffer; under other conditions, those same physicians would possibly be willing to provide LTP services. There are countless examples of harassment. In 2018 a physician in Tucuman who performed an LTP on an 11-year-old girl received all types of threats and was even harassed at work (Perfil, 2018; page 12, 2018a). In January 2019, a young female provider who performed

an LTP on a 12-year-old girl from Jujuy was discredited during sensationalism of the case (La Nación, 2019). Likewise, officials like the almost famous prosecutor in Tucumán, who use their institutional authority to prevent LTPs, and the ongoing presence of conservative groups in hospital facilities, are ways to intimidate patients and healthcare teams (Perfil, 2018; El Diario de la República, 2019; Domínguez, 2019).

These informal mechanisms to punish or at least to torment health professionals who provide LTP services, are activated more strongly in provinces with conservative hegemonic preferences, where there may be **an adaptation for professional and social survival.** In Misiones, the entire medical staff at the Maternal Neonatal Hospital stated that they would object to providing LTPs (Azarkevich, 2018; page 12, 2018b). It is hard to believe that in cases as brutal as those of girls whose pregnancy is the result of rape, all those physicians are genuinely willing on "moral or religious grounds" to deny them a safe and legal abortion, but rather that they do not provide LTPs to avoid the costs of being singled out in societies that are hardly pluralist and that have state apathy towards LTP.

In fact, many of the practices to intimidate LTP providers and harm their freedom of conscience are possible due to precarious institutional conditions, including **misinterpretation of accountability.** There are no incentives to provide LTP service, while accountability mechanisms for those who abuse their power to prevent access to LTP are scarce.

In fact, there is a status **quo of impunity**[1] regarding the breach of professional duties, which support the abuse of CO, as one of the respondents states:

At this facility, there is a pharmacist who refuses to order contraceptives bimonthly and distribute them... Regarding LTP, the same person tried to hinder that practice and convince other providers that it is wrong. All these attitudes are supported by the director of the facility, as she does not want to 'create conflict.' (Ariza Navarrete & Ramón Michel, 2018)

This state of things enables **abuses by those who hold positions of authority;** there are no clear regulations or an institutional culture that prevent a department head who is opposed to LTP from defining the internal policy at that facility; therefore, even if that policy is not explicit, many residents and other professionals would rather call themselves objectors than conflict with their boss. Twenty-six percent of survey respondents believe that healthcare authorities influence the use of CO among health teams at the time of denying LTP services and that the lack of leadership in health facilities boosts the use of CO (24.5%) (Ariza Navarrete & Ramón Michel, 2018).

[1] This is slowly being modified. See Carbajal (2014), Pausa Periódico Digital (2017) and the case of Ana María Acevedo.

This situation is aggravated by i**naction, ambiguous behavior, and the lack of responsibility of political leaders.** For example, it is known that Tucumán's health authority does not approve an LTP protocol; allows, possibly by default, the legal area of the public health system, SIPROSA, to issue confusing messages regarding the legal status of abortion in Article 86 of the Penal Code and in the FAL court ruling; and continues delaying training on professional secrecy ordered by a provincial court, but responded to a case that attracted attention nationwide as follows: The health system never hindered the pregnancy termination process and never delayed such situation (TN, 2019; La Izquierda Diario, 2019).

As a result of all this, **the perception prevails that providing LTP services is not a professional duty** but rather discretionary:

A 'friendly' physician who had training and experience providing LTPs refused to provide the service because the governor of the province had spoken out against LTP in the debate for abortion legalization. He did not perform an LTP on a patient who requested it for a health indication. (Ariza Navarrete & Ramón Michel, 2018)

Finally, there are providers who use CO unscrupulously **to avoid more work:**

It is rather about "not providing the service to avoid complicating one's professional life," which implies a position of not recognizing that the medical role involves ensuring people's rights. It is not so much an active resistance process, but rather a passive one. (Ariza Navarrete & Ramón Michel, 2018)

2.3. Public policy responses

These defensive uses of CO detract from its original rationale, but the way to address this is neither to simply allow these individuals to continue these uses nor to group them with others who use CO as an opposition instrument. As expressed by one of the respondents:

CO should be taken seriously with all it entails as a barrier and comfort zone, and with all that it implies as a challenge for health policy to exercise coordination, control, governance, standardization, legitimization—in sum, everything a health policy should do. (Ariza Navarrete & Ramón Michel, 2018)

Key recommendations to address these unexpected uses of CO, based on the insights and perceptions collected (Ariza Navarrete & Ramón Michel, 2018) and on our experience and understanding:

1. Focus on improving access to LTP, and not place CO at the center of our actions.

2. Form teams and add new healthcare providers to reduce opportunities for informal punishment, fear, isolation, and harassment that force individuals to use CO.

3. Continue nurturing professional networks, as an antidote to stigma and isolation.

4. Demand and take more concrete measures, such as making training available, promoting spaces for reflection against disinformation, ignorance, or medical biases, which also promote the use of CO.

5. Show the harmful effects of denying services and cite, when appropriate, behaviors by those, allegedly objectors, who commit illicit acts: CO is not an impunity pass.

6. Insist on the State's obligation to take measures to uphold, protect, and ensure freedom of conscience of LTP providers or of those who would be willing to provide LTPs.

7. Implement mechanisms (economic and non-economic) to incentivize the provision of LTPs.

8. Strengthen vertical and horizontal accountability mechanisms (judicial and non-judicial).

9. Legally define CO's reach, limitations, and conditions in health care.

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SOBRE LAS AUTORAS

Agustina Ramón Michel is an adjunct researcher at CEDES and profesor at the University of Palermo Law School.
rmichelagus@yahoo.com.ar

Sonia Ariza Navarrete eis a lawyer and external researcher for CEDES and member of REDAAS.
sonia.ariza@EUI.eu

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