Parliamentary Assembly
Assemblée parlementaire
http://assembly.coe.int

COUNCIL OF EUROPE CONSEIL DE L'EUROPE

Doc. 12347
20 July 2010

Women's access to lawful medical care: the problem of unregulated use of conscientious objection

Report[1]
Social, Health and Family Affairs Committee
Rapporteur: Ms Christine McCAFFERTY, United Kingdom, Socialist Group

Summary

The practice of conscientious objection arises in the field of health care when healthcare providers refuse to provide certain health services based on religious, moral or philosophical objections. While recognising the right of an individual to conscientiously object to performing a certain medical procedure, the Social, Health and Family Affairs Committee is deeply concerned about the increasing and largely unregulated occurrence of this practice, especially in the field of reproductive health care, in many Council of Europe member states.

There is a need to balance the right of conscientious objection of an individual not to perform a certain medical procedure with the responsibility of the profession and the right of each patient to access lawful medical care in a timely manner.

The Parliamentary Assembly should thus invite member states to develop comprehensive and clear regulations that define and regulate conscientious objection with regard to health and medical services, including reproductive health services, as well as to provide oversight and monitoring, including an effective complaint mechanism, of the practice of conscientious objection.

The Assembly should also recommend that the Committee of Ministers instruct the competent Steering Committees and/or other competent Council of Europe bodies to assist member states in the development of such regulations and the setting up of such oversight and monitoring mechanisms.

[1] Reference to committee: Doc. 11757, Reference 3516 of 26 January 2009.

A. Draft resolution[2]

1. The practice of conscientious objection arises in the field of health care when healthcare providers refuse to provide certain health services based on religious, moral or philosophical objections. While recognising the right of an individual to conscientiously object to performing a certain medical procedure, the Parliamentary Assembly is deeply concerned about the increasing and largely unregulated occurrence of this practice, especially in the field of reproductive health care, in many Council of Europe member states.

2. The Assembly emphasises the need to balance the right of conscientious objection of an individual not to perform a certain medical procedure with the responsibility of the profession and the right of each patient to access lawful medical care in a timely manner. The Assembly is concerned that the unregulated use of conscientious objection disproportionately affects women, notably those having low incomes or living in rural areas.

3. In the majority of Council of Europe member states, the practice of conscientious objection is inadequately regulated or largely unregulated. A comprehensive and clear legal and policy framework governing the practice of conscientious objection by healthcare providers, coupled with an effective oversight and complaint mechanism, would have the potential to ensure that the interests and rights of both healthcare providers and individuals seeking legal medical services are respected, protected, and fulfilled.

4. In view of member states' obligation to ensure access to lawful medical care and to protect the right to health, as well as the obligation to ensure respect for the right of freedom of thought, conscience and religion of individual healthcare providers, the Assembly invites member states to:

4.1. develop comprehensive and clear regulations that define and regulate conscientious objection with regard to health and medical services, including reproductive health services, which:

4.1.1. guarantee the right to conscientious objection only to individual healthcare providers directly involved in the performance of the procedure in question, and not to public or state institutions such as public hospitals and clinics as a whole;

4.1.2. oblige the healthcare provider to:

4.1.2.1. provide information to patients about all treatment options available (regardless of whether such information may induce the patient to pursue treatment to which the healthcare provider objects);

4.1.2.2. inform patients in a timely manner of any conscientious objection to a procedure, and to refer patients to another healthcare provider in that case;

4.1.2.3. ensure that patients receive appropriate treatment from the healthcare provider to whom they have been referred;

4.1.3. oblige the healthcare provider to provide the desired treatment to which the patient is legally entitled despite his or her conscientious objection in cases of emergency (notably danger to the patient's health or life), or when referral to another healthcare provider is not possible (in particular when there is no equivalent practitioner within reasonable distance);

4.2. provide oversight and monitoring, including an effective complaint mechanism, of the practice of conscientious objection so as to ensure that everyone, but particularly women, have access to an effective and timely remedy, and to guarantee the effective implementation and enforcement of these regulations within member states' respective health services.

[2] Draft resolution adopted by the committee on 22 June 2010.

B. Draft recommendation[3]

1. The Parliamentary Assembly refers to its Resolution … (2010) on women's access to lawful medical care: the problem of unregulated use of conscientious objection and Resolution 1607 (2008) on access to safe and legal abortion in Europe.

2. The Assembly is deeply concerned about the increasing and largely unregulated occurrence of conscientious objection, especially in the field of reproductive health care, which poses an obstacle to women's access to lawful medical care in many Council of Europe member states.

3. The Assembly believes that the right of conscientious objection of an individual not to perform a certain medical procedure must be balanced with the responsibility of the profession and the right of each patient to access lawful medical care in a timely manner.

4. Thus, the Assembly recommends that the Committee of Ministers:

4.1. invite member states to develop comprehensive and clear regulations that define and regulate conscientious objection with regard to health and medical services, including reproductive health services, as well as to provide oversight and monitoring, as outlined in Resolution … (2010);

4.2. instruct the competent Steering Committees and/or other competent Council of Europe bodies to assist member states in the development of such regulations and the setting up of such oversight and monitoring mechanisms.

[3] Draft recommendation adopted by the committee on 22 June 2010.

C. Explanatory memorandum by Ms McCafferty, rapporteur

Contents

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1. Introduction

1. On 14 October 2010, Ms Hägg (Sweden, Socialist Group) and a number of her colleagues tabled a motion for a resolution entitled "Women's access to lawful medical care: the problem of unregulated use of conscientious objection" (Doc. 11757). This motion pointed out that, in the majority of the member states of the Council of Europe, the practice of conscientious objection in the medical field is inadequately or largely unregulated. The absence of a comprehensive and effective legal and policy framework governing the practice of conscientious objection by healthcare providers may severely affect individuals' health and lives in a number of Council of Europe member states. The signatories of the motion were particularly concerned about the way in which the unregulated occurrence of this practice disproportionately affects women, notably those having low incomes or living in rural areas.

2. The motion was referred to this committee for report (which appointed me rapporteur), and to the Committee on Equal Opportunities for Women and Men for opinion (which appointed Ms Circene, Latvia, EPP/CD, rapporteur for opinion). The Social, Health and Family Affairs Committee organised an exchange of views with two experts on this issue[4] at its meeting in Paris on 13 November 2009, and held a further exchange of views with two experts in Paris on 4 June 2010.[5] This report also draws on my fact-finding visit to Austria and the Czech Republic in June 2009, as well as on the expertise of Ms Christina Zampas, whom I would like to thank for her contribution to this report.

3. Based on the facts, and after proposing a brief definition of the phenomena, I wish to examine international and European human rights law and international medical standards on this issue. I will then address various facets of the issue, illustrating them through the practice of conscientious objection in different member states and set forth examples of the impact that non-regulation can have on individuals' health and lives. Lastly, I would like to propose lines of action to be followed at the national and European levels.

[4] Dr Christian Fiala, President of the International Federation of Professional Abortion and Contraception Associates, Austria, and Ms Christina Zampas, Senior Regional Manager and Legal Adviser for Europe of the Center for Reproductive Rights (New York/Stockholm).

[5] Ms Eugenia Roccella, Undersecretary of State, Ministry of Labour, Health and Social Policies (Italy), and Ms Joanna Mishtal, Ph.D., Assistant Professor, Department of Anthropology, University of Central Florida (United States of America).

2. Conscientious objection in its various aspects

4. Conscientious objection in the medical field is generally based on personal convictions and ethical values of medical professionals of various professional categories (healthcare providers). Their convictions, very often linked to religion, can stand against their readiness to provide certain medical information and services. These consist, for example, of certain family planning services and reproductive technologies, safe abortion services where legal, and pain-relief by life-shortening means for terminally ill patients. [6]

5. The phenomenon of conscientious objection in the medical field is highly controversial and its appraisal depends on various legal and social factors in a given national context. The debate on the issue is motivated by the wish to balance doctors' rights not to act contrary to their beliefs on the one hand, and patients' rights to access lawful medical procedures on the other.

6. Those who are against the idea of conscientious objection argue that a medical professional's conscience has little place in the delivery of modern medical care. Some even believe that if healthcare providers are not prepared to offer legal, efficient and beneficial care to a patient because it conflicts with their values, they should not practise medicine or related professions. In line with this attitude, the door to "value-driven medicine" is often seen as a door to a Pandora's box of idiosyncratic, bigoted and discriminatory medicine. The partisans of such attitudes quite frequently support the idea that doctors who compromise the delivery of medical services to patients on grounds of conscience should be punished through the removal of their license to practise and other legal mechanisms.

7. The argument in favour of allowing conscientious objection is that to fail to do so harms the healthcare providers and constrains their autonomy. Regardless of the position taken towards the issue as a whole, there is wide-spread belief that healthcare providers who have a conscientious objection to certain medical interventions should not be marginalised professionally.[7] In order to ensure patients' access to lawful medical services, however, healthcare providers should be obliged, also by law, to refer patients to other colleagues willing to provide the service in question. The fact that this does not occur very often is of particular concern.

8. In the context of this report, it is important to note that most of the examples given are in the context of reproductive health, as this is the field in which the practice of conscientious objection most often arises, and most concerns women. However, the standards of access to medical care which are illustrated through the examples given are applicable in any situation where there is an objection by a healthcare provider.

3. Conscientious objection in international and European human rights law and medical standards

9. International and European human rights law recognises an individual's right to freedom of religion, conscience and thought as well as a state's obligations to respect that right. States also have an obligation to ensure access to lawful medical services, including reproductive healthcare services. Where these come into conflict, states should ensure that a healthcare service provider's refusal to provide medical care or deliver health-related products, does not unduly disadvantage or deny access to healthcare services which patients are legally entitled to receive.[8]

10. International human rights treaty monitoring bodies, such as the United Nations Committee on the Elimination of Discrimination Against Women, which monitors states' compliance with the Convention on the Elimination of All Forms of Discrimination Against Women ("CEDAW Convention"), have repeatedly affirmed that states have a positive obligation to regulate the invocation of conscientious objection by health professionals so as to ensure that women's access to health and reproductive health is not limited.[9] Overall, the regulation of the right to conscientious objection should implement "the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law.[10]

[6] Bernard Dickens: The art of medicine. Conscientious commitment. www.thelancet.com, vol. 371, 12 April 2008.
[7] Conscientious objection and doctors' personal beliefs, British Medical Association (BMA), 2007.
[8] See: Universal Declaration of Human Rights; International Covenant on Civil and Political Rights (ICCPR); International Covenant on Economic, Social and Cultural Rights (ICESCR) and Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).
[9] Report of the United Nations CEDAW Committee, (2008).
[10] Report of the International Conference on Population and Development.

11. At European level, Article 9 of the European Convention on Human Rights guarantees the right to freedom of thought, conscience and religion and provides that this right is "subject to such limitations as are prescribed by law and as are necessary in a democratic society in the interests of public safety, for the protection of public … health, or the protection of the rights and freedoms of others". This limitation on an individual's right to conscientiously object was explicitly recognised by the European Court of Human Rights in the context of access to contraceptives.[11]

12. Under international human rights law, states have a duty to ensure that healthcare providers' exercise of conscientious objection does not harm the health and rights of their patients. This means that regulation of the right to conscientious objection should ensure the functioning of administrative procedures that provide immediate alternatives to women when conscientious objection would otherwise deny the women access to a legal procedure.[12]

13. International medical ethical standards, such as those established by the World Health Organization (WHO) and the International Federation of Gynaecology and Obstetrics (FIGO) provide further guidance on regulating the right to conscientious objection. The WHO and FIGO both direct that physicians who conscientiously object to performing a procedure have a duty to refer the patient to another provider who does not object. Such physicians also have a duty to treat an individual whose life or health is immediately at risk, and to provide timely care when referral to other practitioners or delay would jeopardise the patient's health and well-being.

14. As regards hospitals and indirect service providers, the WHO makes it clear that hospital managers should ensure that trained staff, whatever their perspective, "are available at all times" to assist in cases of abortion complications,[13] and that a public hospital, clinic or health centre cannot endanger women's lives or health by refusing services allowed by law.[14] Lastly, FIGO affirms that physicians have "an ethical obligation, at all times, to provide benefit and prevent harm".[15]

4. Regulation and practice in Council of Europe member states

15. Many member states have enacted laws, ethical codes and occasionally regulations or guidelines, guaranteeing the right to conscientious objection in healthcare settings, and the national courts of some countries have developed jurisprudence on this topic. However, many countries facing problems in the area of conscientious objection in healthcare settings lack a comprehensive and effective legal and policy framework, as well as oversight mechanisms to govern the practice of conscientious objection by healthcare providers.

16. Some member states have constitutional protections for freedom of conscience, but have not elaborated on this right, and others only recognise the right to conscientious objection in the context of a specific medical procedure. Some countries do not regulate this practice at all,[16] while others inadequately implement the regulatory framework in respect of conscientious objection.[17]

17. Healthcare providers who invoke conscientious objection have certain legal and ethical duties that aim to protect the patient. States should ensure that regulations on conscientious objection clearly specify these duties. The absence of effective legal and policy frameworks in some member states means that individuals are unable to access the healthcare services that they are entitled to receive, undermining, *inter alia*, their rights to healthcare services and to privacy, and potentially constituting a breach of the duty of care and abandonment of patients.[18]

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[11] See *Pichon and Sajous v. France*, European Court of Human Rights, Application No. 49853/99 (admissibility decision), and Adriana Lamacková, Conscientious Objection in Reproductive Healthcare: Analysis of *Pichon and Sajous v. France, European Journal of Health Law 15* (2008).

[12] See CEDAW General Recommendation on Women and Health, No. 24 (1999), paragraph 11.

[13] WHO, Department of Reproductive Health and Research, Technical and Managerial Guidelines for Prevention and Treatment of Abortion Complications (1995).

[14] See WHO, Safe Abortion Guidance (2003).

[15] FIGO: Resolution on Conscientious Objection, 2006.

[16] Andorra, Latvia, Malta, Montenegro, "the former Yugoslav Republic of Macedonia" and Sweden do not regulate conscientious objection. In the case of Sweden, healthcare providers are accommodated and there appears to be few problems in balancing the rights of healthcare providers with the rights of women.

[17] Relevant evidence is known for Poland, Slovakia and Italy, for example.

[18] See, generally, Rebecca J. Cook, Monica Arango Olaya, Bernard M. Dickens, Healthcare Responsibilities and Conscientious Objection, 104, International Journal of Gynecology and Obstetrics (2009) (hereinafter Cook et al., Healthcare Responsibilities).

4.1. Obligation to ensure availability and accessibility of lawful healthcare services through adequate personnel

18. According to international human rights law and medical standards, countries have an obligation to ensure the adequate availability and accessibility of quality sexual and reproductive healthcare services by, *inter alia*, employing staff who are available and willing to competently deliver services in a timely manner and within a convenient distance.[19]

19. Regulations on conscientious objection should establish clear procedures within healthcare facilities for medical personnel to report in advance their refusal to provide certain services, including the establishment of a register of objecting providers, and should clearly establish the duties of objecting healthcare providers (see sub-sections below on specific duties). Objecting healthcare providers have the burden of proving that their objection is grounded in their conscience or religious beliefs and that the refusal is in good faith.[20]

20. Many countries regulate conscientious objection only, or primarily, in the abortion context, recognising that this is one of the most common medical procedures that healthcare providers may conscientiously object to. Hence, the examples given and many of the issues that arise do so in the abortion context. For example, in Croatia, it has been reported that some doctors will say they object to providing an abortion, but then offer the patient an abortion in a private setting, for financial gain. In Norway, regulations on conscientious objection require healthcare providers to give written notice to their employing hospital if they refuse to assist with abortions, and those hospitals, in turn, have to report it to government authorities. In Slovenia, the Health Services Act allows for conscientious objection in accordance with international rules on the practice. It requires healthcare workers to report their conscientious objection to their employing institution, and the institution to ensure that patients' rights to healthcare are accessible "without disruption". This enables member states to ensure that medical professionals willing to perform healthcare services are available.

21. Some countries have organised their healthcare system and personnel recruitment in such a way as to ensure that there are doctors willing and able to provide services. For example, guidelines on the appointment of doctors to hospital posts issued by the United Kingdom National Health Service recommend that termination of pregnancy duties should be a feature of the job when adequate services for termination of pregnancy "would not otherwise be available", that the job description should be explicit about termination of pregnancy duties, and that applicants should be "prepared to carry out the full range of duties which they might be required to perform if appointed", including duties related to termination of pregnancy.[21]

22. Other contexts where the issue of conscientious objection can be of relevance are "end of life situations" and the field of assisted reproduction. As far as the former is concerned, doctors are generally expected to treat patients in their best interest and notably to provide treatment if there are chances of recovery for the patient. Euthanasia is forbidden by law in many Council of Europe member states, such as in Austria, which is examined for the purpose of this report. The professional rules generally impose on medical professionals the duty to provide pain relief. The absence of a clear legislative framework, however, makes relevant decisions difficult for medical professionals. The healthcare providers' fear of litigation and challenge often leads to life-prolonging measures. Regarding this issue, reference must be made to the Parliamentary Assembly's Resolution 1649 (2009) on palliative care, based on a report prepared by Wolfgang Wodarg (Germany, SOC), which stated that that "liberal constitutional states cannot leave ethical questions concerning the life and death of individuals unanswered".

23. According to the Austrian Law on Living Wills of 2006, patients can refuse treatment in end of life situations in advance. This is an ideal precondition to avoid demands for euthanasia legislation and has also made it easier for medical staff to deal with conflicting opinions of family members. It also creates better conditions for people who want to be able to die with dignity. Related to this issue and as a follow-up to Resolution 1649 (2009), the Committee is currently working on a report on "Living wills and the protection of health and human rights".

[19] See ICCPR, CEDAW and WHO.
[20] European Union Network of Independent Experts on Fundamental Rights, *The right to conscientious objection and the conclusion by EU Member States of concordats with the Holy See* (2005).
[21] United Kingdom, NHS Guidelines, Appointment of doctors to hospital posts, NHS Executive HSG(94)39, 14 September 1994.

24. The field of assisted reproduction has been regulated by a number of member states. Relevant laws were, for example, introduced in the Czech Republic recently. Assisted reproduction is allowed for heterosexual couples with prior consent of the donors. Three cycles would generally be covered by the health insurance, so that even poor people can receive treatment and be fully reimbursed. Anonymous donors are allowed but are not paid. Surrogacy is not allowed at all. The issue of individual conscientious objection is, however, less problematic in this field, given the fact that only specialised centres offer such treatments anyway. The main issue arising here is one of (collective) ethics and the way it is expressed by the legal limits set in specific situations (homosexual couples, anonymous donors, surrogacy, etc.).

4.2. Conscientious objection applies to individuals, not institutions

25. According to international human rights law, the right to freedom of thought, conscience and religion is an individual right and, therefore, institutions such as hospitals cannot claim this right. Healthcare institutions, as state entities, have a duty to provide legal health services to the public.

26. In France, a Constitutional Council decision recognised that conscientious objection is a right afforded to individuals, not institutions, and upheld the repeal of paragraphs in the Code of Public Health, removing the possibility for department heads of public health establishments to refuse to allow the provision of abortion services in their departments. The Constitutional Council clarified that freedom of conscience is individual, not institutional or departmental.

27. In Germany, the Federal Administrative Court, in upholding the decision of the Bavarian Higher Administrative Court, indicated that public hospitals must provide abortions, enabling women to realise their entitlement to abortion under the law.

4.3. Duties of healthcare providers

28. Regulations on conscientious objection in healthcare settings recognise the right of healthcare providers to object to certain healthcare procedures, but also impose certain obligations on providers to ensure that patients receive the medical care they need and are legally entitled to receive. These obligations include the duty to provide information to patients about all the treatment options available, regardless of whether such information would induce the patient to pursue treatment to which the healthcare provider objects.

29. Healthcare providers also have a duty to inform patients in good time of any conscientious objection to a procedure, and in these circumstances to refer patients to another healthcare provider. Furthermore, the conscientious objector has a duty to ensure that any patient whom she or he refers receives quality treatment from the new healthcare provider. Additionally, in situations in which a referral to another healthcare provider is not possible, or in cases of emergency, the conscientious objector must provide the desired treatment to which the patient is legally entitled.

Patients' right to information

30. Conscientious objection regulations apply only to medical services; a healthcare provider cannot invoke the right to conscientious objection in relation to the provision of information. Even if they object to providing certain services, healthcare providers have the duty to offer accurate and non-biased information about all the medical procedures legally available, including the risks, benefits and alternatives to treatment, so that the patient can make an informed choice about the treatment to pursue. In order to enable the patient to make informed decisions about her or his healthcare, healthcare providers must provide diagnostic care services, such as prenatal examinations to detect foetal impairment, to all patients, whether or not the results of such care may lead to an objectionable act by the patient.

31. Additionally, in the United Kingdom, the General Medical Council Guidelines indicate that in a situation in which a doctor conscientiously objects to the provision of certain services, she or he must ensure that the patient has sufficient information about the available treatment options. The doctor must discuss with the patient the information that she or he has and that the patient might need. Furthermore, the doctor has an obligation to personally meet with such a patient and provide him or her with printed materials about any treatments or procedures which the doctor chooses not to provide him- or herself because of a conscientious objection.[22]

[22] United Kingdom General Medical Council, "Personal Beliefs and Medical Practice".

Timely notice to patients and duty to refer

32. Conscientious objectors also have a duty to inform the patient in a timely manner of their conscientious objections to a specific procedure, and similarly, to refer such patient, in a timely manner, to a healthcare provider who is willing and able to perform the healthcare procedure or treatment and who is conveniently accessible.[23] This requirement for timely notice and referral should apply from the moment the patient first requests medical intervention from a healthcare provider.

33. For example, Portugal's Medical Association Code of Ethics mandates that a physician "immediately communicate" to patients his or her objection, while Law 16/2007 requires that physicians communicate their objections to patients in a "timely fashion". In France, doctors who conscientiously object also have a legal duty to a woman seeking an abortion to give her the name of experts to perform the procedure. In Poland, Croatia and Hungary, laws require physicians to inform patients of any conscientious objection to a procedure and refer such patients to other doctors, but they do not have an oversight mechanism to ensure that this happens, leaving many patients without a referral.

34. In the United Kingdom, guidelines issued by the British Medical Association (BMA)[24] and the Royal College of Obstetricians and Gynaecologists (RCOG), which have informed the implementation and judicial interpretation of the conscientious objection provisions of the 1967 Abortion Act, oblige physicians who conscientiously object to providing abortion services to take preparatory steps to arrange for an abortion and provide referrals to another doctor without delay. The BMA guidelines explicitly provide that "[i]t is not sufficient simply to tell the patient to seek a view elsewhere since other doctors may not agree to see her without appropriate referral". The RCOG has issued recommended referral times for abortion services.[25]

35. In addition, the United Kingdom National Health Service guidelines, which are issued to provide guidance to practitioners, note that all doctors who conscientiously object to "recommending termination should quickly refer a woman who seeks their advice about a termination to a different [general practitioner]. … If doctors fail to do so, they could be alleged to be in breach of their terms of service".[26] Similarly, in the Netherlands and France, laws place a legal obligation on healthcare professionals and physicians, respectively, to immediately communicate to a pregnant woman their refusal to perform an abortion.

Duty to treat if referral is not possible

36. In situations in which the healthcare provider is unable to guarantee that women will receive quality treatment elsewhere, that healthcare provider must provide treatment to the patient, regardless of whether it conflicts with her or his conscience.[27] In Norway, for example, a physician may not refuse to treat a patient unless the patient has reasonable access to another doctor who can provide the treatment. In San Marino, a physician who conscientiously objects to the performance of a procedure must refer the patient to another medical professional who can provide adequate treatment, and the physician must ensure that the patient continues to receive care during the transition period.

4.4. Conscientious objection applies to healthcare professionals directly performing medical treatment or procedures

37. While all countries that recognise conscientious objection in the healthcare context or in relation to a specific medical procedure extend such right to physicians, the application of this right to other healthcare personnel is often unclear and therefore problematic for defining the scope of the right. Conscientious objection should only be invoked by the personnel who are directly involved in the medical procedure and not by those who are involved indirectly, such as hospital administrators, nurses, etc. The resulting lack of clarity with regard to whom such a right extends may delay women's access to reproductive health services.[28]

38. Norway's abortion regulations, for instance, establish that the right to refuse to participate in an abortion can only be claimed by those who are performing or assisting with the performance of the procedure and not by staff providing care or treatment to the woman before or after the procedure. Similarly, Italy's abortion law does not exempt healthcare personnel from providing pre- and post-abortion care.

[23] CEDAW.
[24] BMA's Handbook of Ethics and Law.
[25] BMA's Handbook of Ethics and Law; RCOG Guidelines.
[26] United Kingdom NHS Guidelines, HSG(95)37, July 1995.
[27] See FIGO, 2006 Resolution on Conscientious Objection; CEDAW.
[28] This is particularly problematic in the case of emergency contraception (the "morning after pill") if there is no pharmacist in the vicinity willing to sell the medication, since it needs to be taken within a certain number of hours.

39. The case of *Pichon and Sajous v. France*, in the European Court of Human Rights, illustrates how accommodations to conscientious objection are not unlimited. The Court held that pharmacists who refused to sell contraceptives cannot impose their religious beliefs on others. The Court explained that the right to freedom of religion, as a matter of individual conscience, does not always guarantee the right to behave in public in a manner governed by that belief. The Court stated that "as long as the sale of contraceptives is legal and occurs on medical prescription nowhere other than in a pharmacy, the applicants cannot give precedence to their religious beliefs and impose them on others as justification for their refusal to sell such products".[29]

4.5. Exceptions to the invocation of a conscientious objection

40. Surveys show that only a limited number of Council of Europe member states expressly prohibit the invocation of conscientious objection in the case of emergency or risk of death as well as danger to the patient's health.[30] This is an area that should generally be regulated in order to clarify the rights of both healthcare providers and their patients.

4.6. Accountability and complaint mechanisms

41. Member states have an obligation to put in place effective monitoring and accountability mechanisms to ensure that conscientious objection clauses do not, in practice, unduly disadvantage patients or deny them access to lawful healthcare services. Many countries have a general healthcare complaint mechanism as recourse for patients who believe their rights have been violated, through which illegal exercise of the right to conscientious objection can presumably be addressed. While a separate complaint mechanism may not be necessary for the issue of conscientious objection, laws and regulations that grant a right to conscientious objection should clarify that the exercise of this right in violation of the law will be subject to such member state's general complaints procedure and that individuals have a right to an effective remedy in a timely manner.

42. Every member state should have a complaint mechanism with a clear procedure available to individuals against a healthcare professional or institution who allegedly acts in violation of the law while providing medical services. All responses to complaints should be issued in a well-justified written decision available to all parties.

43. In the Czech Republic, for example, in the context of abortion, the law provides for a complaint mechanism with a timely appeals process, for when a gynaecologist denies a patient an abortion. While this mechanism does not explicitly make reference to conscientious objection, the time guidelines in this law are extremely important in ensuring that a woman is not denied access to abortion because of administrative delays that could be caused solely by a health professional's personal objections to the procedure. In cases in which a woman's right to access lawful health services is violated, legislation should establish appropriate sanctions and remedies.

5. The impact on women's access to lawful medical care

44. In practice, various factors can lead to situations where women's access to lawful medical care is affected. The most widely observed reasons are the lack of oversight mechanisms ensuring the implementation of existing legal provisions and policies, the non-respect of legal duties with regard to the information of patients, the absence of regulations requiring or facilitating timely action (notification of conscientious objection, appeals processes, etc.) as well as the lack of regulation regarding the scope of conscientious objection provisions.

5.1. Lack of oversight mechanisms

45. A recent report by Italy's Ministry of Health demonstrates the impact of the lack of oversight mechanisms that ensure the availability and accessibility of healthcare providers in the context of abortion. The report shows that nearly 70% of gynaecologists in Italy refuse to perform abortions on moral grounds, despite a strong legal framework in this area. The report found that between 2003 and 2007, the number of gynaecologists invoking conscientious objection in their refusal to perform an abortion rose from 58.7 to

[29] *Pichon and Sajous v. France* (admissibility decision), see footnote 11.
[30] Bosnia and Herzegovina, Croatia, Czech Republic, Hungary (risk of death applies only to abortion), Italy, Lithuania, Poland, Portugal, San Marino, Slovak Republic and the United Kingdom (abortion only).

69.2%. The percentage of anaesthetists who refused to assist in an abortion rose from 45.7 to 50.4%. In the southern parts of the country, the numbers are even higher.[31]

46. According to the International Planned Parenthood Federation (IPPF), in Austria, a woman faces a number of challenges in obtaining an abortion, even though the country expressly recognises a right to abortion, because healthcare professionals frequently conscientiously object to performing this procedure. There are no specific legal guidelines regarding conscientious objection in Austria, but in practice, doctors can refrain from abortion if the only reason for the intervention is unwanted pregnancy, although no objection is possible if the mother's life is in danger. It has been reported that there is a difference of practice between the eastern and the western part of Austria (abortion being less accessible in the latter) and that few doctors are willing to perform abortions in rural areas of the country. As a result, women must travel to another region of Austria or even another country to obtain an abortion.[32] In any case, the women concerned would have to pay themselves for medical services linked to abortion.

47. The ability of public institutions to conscientiously object to healthcare services impedes women's ability to exercise their right to legal sexual and reproductive health services, and oversight mechanisms are crucial in ensuring that this practice does not occur. For example, in Slovakia and Poland,[33] conscientious objection is often abused by the top management of hospitals, who frequently have an unwritten policy banning some interventions (usually abortions or sterilisations) throughout their hospital, regardless of the opinion of the healthcare staff. In Poland, many institutions do not have a formal policy of conscientious objection and, in many instances, individual providers do not formally invoke their right or express it in terms of conscientious objection. In the capital city of Slovakia, Bratislava, for instance, one of the public hospitals does not perform abortions. In the large regional capital of Trnava, no hospitals perform abortions.[34]

5.2. Non-respect of legal duties with regard to information of patients

48. Breaches of the duties that conscientious objectors owe to their patients may also have dire consequences for women. For instance, if healthcare providers do not provide information to their patients about various treatment options, including diagnostic care, they deprive them of the opportunity to make informed decisions about the healthcare procedures that are in their best interest. Healthcare providers should not be allowed to invoke conscientious objection with regard to healthcare information, including diagnostic care that may or may not lead to objectionable treatment. Regarding yet an earlier 'stage' of information, it has been observed that the number of abortions decreases with the availability of contraception. Accordingly, the Ministry of Health of the Czech Republic has, until very recently, observed a significant long-term trend of decrease in abortions. This shows the importance of timely educational measures for the prevention of medical situations (such as abortion) where the issue of conscientious objection might arise.

49. A 2003 United Kingdom High Court judgment sheds some light on the potential unlawfulness of such acts. It found a doctor negligent for failing to properly counsel – in part because of his religious beliefs – his patient about her increased risk of giving birth to a baby with Down's syndrome and the availability of prenatal screenings for such abnormalities. The doctor, a devout Catholic, noted that he did not routinely and explicitly discuss screening for abnormalities with every pregnant woman. He testified that he thought pregnancy was a happy event and would want to "soothe, not alarm patients", but that he expected he would have told someone of the plaintiff's age that she was "at a slightly raised risk" for foetal abnormalities. The court noted that "[o]n his own account [the physician's] approach to the subject [of informing patients about screening for abnormalities] was coloured by his belief in Roman Catholic doctrine". The court ultimately found that if the doctor had used the phrase "slightly raised risk," as he testified, "it would have been seriously misleading"; considering that experts testified that the risk of foetal abnormalities increases significantly at the plaintiff's age.[35] As a result of the doctor's failure to provide such information, the patient could not make an informed choice about whether or not to carry her pregnancy to term, given the risk that her child could have Down's syndrome.

[31] Republic of Italy, Ministry of Health, Report of the Ministry of Health on the Performance of the Law Containing Rules for the Social Care of Maternity and Voluntary Interruption of Pregnancy: 2007-2008.
[32] International Planned Parenthood Federation European Network, *Abortion Legislation in Europe*.
[33] *Reproductive Rights in Poland, the effects of the anti-abortion law*, Federation for Woman and Family Planning, edited by Wanda Nowicka (2008).
[34] Information provided by the Slovak Family Planning Association, 2010.
[35] *Enright and another v. Kwun and another*, 2003, High Court of England and Wales.

5.3. Absence of regulations requiring or facilitating timely action

50. In the absence of regulations requiring timely notification of a healthcare provider's conscientious objection to a specific procedure, accompanied by a timely referral to another provider, women may be unable to locate another healthcare provider to perform such procedure in a timely manner, which prevents them from accessing the healthcare services to which they are legally entitled.

51. For example, in Denmark, in response to a situation in which a woman who scheduled an appointment at a clinic to undergo an abortion, but was not informed by the doctor of his/her conscientious objection to the performance of abortions, nor was the patient provided with a timely referral, a representative of the Danish National Board of Health commented that doctors must immediately inform the patient of any conscientious objection. The failure to do so or to provide a referral could delay the time period within which a woman can legally exercise her right to a voluntary termination of pregnancy. Such a delay could cause the woman to exhaust the 12-week period during which she may legally procure an abortion, and thereby cause her to unwillingly forego her right to this procedure.[36]

52. In addition, the necessity for a timely appeals process cannot be overstated, since reproductive health issues can easily be rendered moot by a slow encumbered system, with devastating results such as death or permanent health disability. For example, in the case of *Tysiac v. Poland*, the European Court of Human Rights stated that states must ensure access to lawful healthcare services and set up appeal mechanisms for women who are denied such services.[37] In that case, doctors refused to issue a certificate granting an abortion, despite serious health risks of delivery, and the woman's eyesight seriously deteriorated as a result of the childbirth; with a timely appeals process the woman would have been able to challenge the doctors' refusal to grant an abortion in time to obtain treatment that would have saved her from a permanent disability.

5.4. Lack of regulation regarding the scope of conscientious objection provisions

53. Furthermore, the lack of regulation in regard to whom and in respect of which services conscientious objection provisions apply prevent women from accessing the healthcare to which they are legally entitled. Legal 'loopholes' might possibly allow ancillary healthcare providers to object to the provision of subsidiary services, which may then delay or obstruct women's access to reproductive healthcare.

54. For example, the scope of the conscientious objection clause in the United Kingdom's abortion law was clarified by a 1988 House of Lords decision, which made clear that the clause applies only to participation in treatment. The case involved a doctor's secretary who objected to signing an abortion referral letter on grounds of conscience. The House of Lords held that such an act did not constitute part of the treatment for abortion and, thus, was not covered by the conscientious objection clause of the abortion law. The decision supports the proposition that doctors cannot claim exemption from giving advice or performing the preparatory steps to arrange an abortion if the request for abortion meets legal requirements.[38]

6. Conclusions

55. Member states should enact comprehensive and clear regulations that balance the right of the healthcare provider to conscientiously object to the performance of a procedure, and ensure that patients can exercise their right to access lawful health services. In situations in which such regulations exist, many member states lack oversight and monitoring mechanisms to ensure that healthcare providers act in accordance with them. Such regulations should establish mechanisms to ensure the accessibility and availability of healthcare providers when other healthcare providers may conscientiously object, and mandate the creation of a registry of conscientious objectors.

56. National regulations should recognise that the right to conscientious objection extends only to individuals, not to public or state institutions. Additional safeguards should delineate the duties of healthcare providers to their patients in the context of conscientious objection, which include a duty to:

- provide information to patients about all treatment options;
- inform patients of any conscientious objection and provide a referral to another healthcare provider, in a timely manner;

[36] "Ethical issues regarding abortion: How far does the right go?" (Etisk forbehold ved abort: Hvor langt rækker retten?), Ugeskrift for Læger, 2007.
[37] *Tysiac v. Poland*, European Court of Human Rights (2007).
[38] BMA's *Handbook of Ethics and Law.*

- ensure that the healthcare providers to which patients are referred will provide quality treatment, or in the absence of an appropriate referral or in emergency situations, require the conscientious objector to provide the necessary care.

57. National policies should define the scope of the right to conscientious objection in respect of the type of services and healthcare professionals to whom it applies, and carve out appropriate exceptions for emergency situations.

58. Lastly, all national regulations should establish effective complaint mechanisms that can address abuses of the right to conscientious objection and provide women with an effective and timely remedy.

59. The enactment by member states of regulations which include these principles will ensure that the interests and rights of both healthcare providers and individuals seeking legal healthcare are respected, protected and fulfilled.