The Right to Conscience
Abortion Law in Transnational Perspective: Cases and Controversies

Bernard Dickens, R.J. Cook & J.N. Erdman

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Chapter 10

The Right to Conscience

Bernard M. Dickens

The aim of this chapter is to release “conscience” from capture by those who object to participation in induced abortion. It argues that, while opponents of induced abortion are properly entitled to invoke conscientious objections to participation, others are equally entitled conscientiously to participate in such lawful procedures, to advise patients about the option, and to refer patients to where appropriate services are available. This includes taking such actions in institutions that, for religious or other reasons, oppose such procedures on principle. The human right to act lawfully according to one’s individual conscience is not a monopoly of abortion opponents. As a legally protected human right, however, the right to conscience may be considered an entitlement primarily of human individuals, and available to corporate or other institutions on only a limited basis. Individuals may accordingly invoke conscientious reasons to participate, or not to participate, in abortion procedures, and to offer advice and referral without suffering sanctions or discrimination on grounds of their religious or philosophical convictions.

The origins of conscientious objection in health care precede the legalization of abortion. In England, for instance, legislation of mandatory vaccination of children against smallpox in 1867 triggered violent objections to vaccination. Among medical practitioners, historical conservative attitudes rooted in different religions, religious denominations, and laws influenced practitioners conscientiously to object to advise and assist artificial contraception, contraceptive sterilization, artificial insemination, and abortion. The transition to legality of these procedures was traced in 1966 by two
gynecologists regarding artificial insemination when they observed, “Any change in custom or practice in this emotionally charged area has always elicited a response from established custom and law of horrified negation at first; then negation without horror; then slow and gradual curiosity, study, evaluation, and finally a very slow but steady acceptance.” It was growing legalization of abortion, however, from the late 1960s in Europe and beyond, that made this procedure the prime center of health service providers’ claims to object to participation in lawful medical care on grounds of conscience.

An important factor easing enactment of the U.K. Abortion Act, 1967, for instance, was inclusion of section 4(1), which provides that “no person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorised by this Act to which he has a conscientious objection.” Section 4(2) provides the exception, however, of: “any duty to participate in treatment which is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman.”

The section is consistent with the Universal Declaration of Human Rights, of 1948, which provides in Article 18 that: “Everyone has the right to freedom of thought, conscience and religion; this right includes freedom . . . to manifest his religion or belief in teaching, practice, worship and observance.” When legal effect was given to this right, however, in the International Covenant on Civil and Political Rights, it was made clear that the right is not absolute. Article 18(1) repeats that everyone “shall have the right to freedom of thought, conscience and religion,” but 18(3) provides that: “Freedom to manifest one’s religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others.”

The protection under human rights of “conscience and religion” shows that conscience is separate from religion. Religious convictions may well shape individuals’ conscience, but religion has no monopoly on conscience and is indeed subject to scrutiny and evaluation on grounds of conscience. Conscience may be shaped by social, philosophical, political, professional, and other convictions apart from those founded on religious faith. Religious institutions and hierarchies that, for instance, do not include women, and that expressly exclude women from positions of doctrinal authority, may be considered conscientiously flawed, and to lack relevance in their pronouncements, particularly on a matter such as abortion, in which women’s health and interests are centrally involved.
Religious convictions may inspire individuals to enter the health care professions, for instance as doctors or nurses. This conforms to a long, honourable tradition of religious commitment to care for the sick and for disabled individuals. When health care practitioners would place their personal conscience above serving their dependent patients’ health needs, however, they risk violation of their duties of conscientious professionalism, with legal implications, which this chapter addresses, and ethical implications.5

The four historic reputable professions, namely religious ministry, the profession of arms, medicine, and the law, are founded on a calling to self-sacrifice. In times of plague, for instance, ministers of religions tended to the sick and dying at the risk of contracting infections and sharing the fate of those they comforted. The status of mercenary soldiers is now discredited, but volunteers and conscripts who serve their nations have paid, and still pay, with their health and very lives. Doctors who treated infectious patients have faced risks of contracting their infection in past and present times. For instance, Dr. Carlo Urbani, who in 2003 discovered and named the severe acute respiratory syndrome (SARS), died of contracting that viral infection. Lawyers may be obliged to defend those accused, and guilty, of atrocious crimes, and to advance the purposes of clients, including governments, whose motivations they deplore, with professional detachment and disregard for their own interests. Against this background of self-sacrifice, health care professionals who will serve their own religious or other interests by sacrificing the interests of their dependent patients, by reliance on the claim of conscientious objection, are in a conflict of interest, with legal and ethical accountability, and risk committing a travesty of professionalism.

The challenge in law is to address how health care providers conscientiously opposed to abortion and comparable procedures that serve their patients’ wishes and interests should conduct themselves. A related challenge is how health care institutions founded on religious traditions opposed to such procedures should accommodate health care providers who are conscientiously committed to delivering such services when, in their clinical judgment, the providers consider the procedures to best serve their patients’ wishes and health interests.

The latter challenge bears attention, since in the abortion context the focus in the literature, legislation, and jurisprudence has been on conscientious objection, and accommodation of objectors’ human rights of conscience. Respect for and accommodation of conscience should in justice be symmetrical, however. Institutions with no policy opposing particular
medical procedures such as forms of reproductive health care, and end-of-life care, should accommodate practitioners who object to participation in them on grounds of conscience, without censure or discrimination, and institutions whose leadership is opposed should accommodate practitioners conscientiously committed to deliver care to patients for whom such procedures appear medically indicated, equally without censure or discrimination.\textsuperscript{6}

States must protect practitioners’ conscientious commitment to undertake abortion care, so that states are able to discharge their legal responsibilities to patients. The European Court of Human Rights has observed, regarding abortion services, that “States are obliged to organise the health services system in such a way as to ensure that an effective exercise of the freedom of conscience of health professionals in the professional context does not prevent patients from obtaining access to services to which they are entitled under the applicable legislation.”\textsuperscript{7}

Laws designed to restrict access to abortion services may violate human rights, of both women and service providers, and justify challenge. Deliberate defiance of laws, amounting to civil disobedience, has been advocated by opponents of abortion restriction who assert the superiority of human rights, and by religious advocates of abortion restriction who claim the superiority of divine law.\textsuperscript{8} However, this chapter lacks space to address arguments for legal accommodation of noncompliance with states’ abortion laws.

**The Nature and Scope of Conscience**

The foundation of rights to conscience in leading international human rights instruments, reflected in the constitutional laws and human rights codes and provisions of many countries, confirms the importance of these rights to human dignity and identity. Although rights to conscience are formally distinguishable from rights to religion in Article 18(1) of the International Covenant on Civil and Political Rights (CCPR), Article 18(3) addresses limits on the freedom “to manifest one’s religion or beliefs,” indicating that freedom of belief is allied with religious freedom. This is of particular significance in some sectors of the Roman Catholic tradition regarding induced abortion, where this is considered a mortal sin, constituting death of the soul and a risk of forfeiture of eternal life in heaven after the end of one’s life on Earth. To those who have faith in this or a comparable belief system, the risk of committing this sin is too fearful to take. Their spiritual anguish can deny them
their physical, mental, and/or social well-being; that is, what the World Health Organization considers their “health.”

Conscientious objection based on religious beliefs must accordingly be accommodated to the fullest extent consistent with, in the language of CCPR Article 18(3), “the fundamental rights and freedoms of others.” No less worthy of profound respect than religiously guided conscience is conscience based on secular convictions, such as philosophical, social, political, professional, or other beliefs. If individuals are to be free to be true to themselves, the diversity of their rights to conscience must be accommodated as a key human right. In international human rights law, three “generations” of human rights have been identified, the first being civil and political rights, the second equality or socioeconomic rights, and the third collective or solidarity rights.

Collective rights may be possessed by members of social or communal groups of individuals, and by private or public corporate bodies recognized by law to have artificial personality as an administrative or commercial convenience, including, for instance, rights of property ownership and to commercial speech. They can also bear responsibility for violation of individuals’ rights, such as to nondiscrimination in recruitment for employment. Jurisprudence, for instance under Article 9 of the European Convention on Human Rights, recognizes rights of religious institutions such as churches and mosques to invoke human rights in their own name, acting as representatives of their members, for instance to resist state intervention in their internal affairs and denial of their rights. However, a legal entity such as a hospital corporation, as a civic, nonecclesiastical institution, cannot claim a right to religious conscience.

In a 2008 judgment of international significance, for instance, the Constitutional Court of Colombia ruled that a hospital corporation could not claim a right of conscientious objection on its own behalf to justify denial of a medically indicated abortion procedure. The Court held that the human right to respect for conscience is enjoyed only by natural human beings. By requiring and allowing its gynecologists’ conscientious objections to limit its services, the hospital was unlawfully asserting a conscientious objection of its own. The hospital’s legal duty is to have physicians available to conduct timely procedures for patients’ care in which others may object to participate on grounds of conscience.

The Court recognized individuals’ right to object to direct participation in abortion but ruled that hospital administrative officers responsible for such tasks as admitting patients and booking operating theaters, and, for
instance, those conducting routine nursing procedures such as for postoperative care, do not attract the protection of conscientious objection. This ruling is consistent with a body of jurisprudence holding that, in the absence of specifically directed legislation, administrative personnel in health facilities where abortions are conducted, who are not directly clinically engaged in such procedures, cannot invoke conscientious objection to refuse to discharge their routine responsibilities. The Constitutional Court indicated that religious objections to complicity in sin have no legal substance when such objections would deny “the fundamental rights and freedoms of others” to receive medically indicated lawful treatment.

The Court required that patients for whose care abortion is indicated, and who request the procedure, have to be promptly referred by, or on behalf of, those who have conscientious objections to physicians who would conduct the procedure. This touches on an area of professional sensitivity, since it is known in many countries, but rarely reflected in their jurisprudence, that some gynecologists who invoke conscientious objection to participate in abortions in public hospitals perform the procedure for fee-paying patients in their private clinics. Physician self-referral, meaning referral by physicians of their public hospital patients to be treated in their private practices, usually as fee-paying clients, raises legal and ethical concerns regarding conflict of interest. Gynecologists may want to maintain a public appearance of opposing abortion, thereby avoiding stigma and risk of condemnation for being “abortionists,” and to offer patients the greater confidentiality of private care, where pregnancy termination can be recorded by medical euphemisms unrelated to abortion.

That conscientious objection may be publicly invoked insincerely and unconscionably stands in contrast to the moral worthiness of practitioners whose objections are authentic, uniform, and sincere. Their discharge of a religious duty to tend to the sick and needy, but within a framework of serving their own spiritual salvation, explains why they are prepared to place their own spiritual interests above the interests their patients intend to pursue by obtaining indicated health care. In a sense, they may be using their dependent patients instrumentally, as a means to achieving their own spiritual ends, even though they may self-servingly rationalize their conduct as protecting the unborn or, more paternalistically, as protecting the patients themselves. This would violate the Kantian ethic that people should treat others as ends in themselves, and not purely as means or objects through which to serve their own ends.
Conscientious objection to abortion raises concerns about medical education and training for medical students of gynecology, for medical schools, and for medical licensing authorities. It is common that medical students and qualified doctors do not make efforts to learn the types of skills that they do not intend to practice. For instance, intended pediatricians do not seek the skills of geriatricians, nor vice versa. However, those who intend careers in gynecology are expected to learn the skills of that specialty even if they intend not to induce abortions. They may be called on, for instance, to treat patients suffering threatened spontaneous miscarriage, and to remove a dead fetus from the uterus according to professional techniques and standards, even if those skills may be applied in other circumstances in termination of pregnancy. A student’s refusal to learn these procedures, a medical school’s acceptance not to teach them to prospective gynecologists, and a medical licensing authority’s grant of an unrestricted licence to a specialist who is incompletely trained, all raise legal questions of holding out to the public that qualified gynecologists are fit to practice who may be unable to provide adequately trained care.

Gynecologists should disclose the limits of their training to the agencies interested to engage their services, and the areas of practice expected of gynecologists to which they object. Similarly, as will be addressed below, their patients and prospective patients should be informed of what services patients may reasonably expect from practitioners in their specialty that they are not able or willing to undertake.

The same applies to midlevel providers of gynecological services, such as nurse practitioners, who can be trained for competent discharge of selected services where fully qualified gynecologists are not available. Women should not be denied care because gynecologists trained and qualified to the highest levels are unavailable. If such personnel would decline to undertake services reasonably expected of them on grounds of conscientious objection, however, this should be appropriately disclosed to agencies liable to recruit them.

An approach to encourage medical and related students who conscientiously object to inducing abortion to learn to assist women with threatened loss of pregnancy may be through use of appropriate language. The use of language in the sensitive area of abortion is notoriously euphemistic, imprecise, or casual. If “abortion” is taken to refer to deliberately induced abortion, however, while spontaneous loss of pregnancy, whether before or after fetal viability, is described as “miscarriage,” gynecologists who object to participation in abortion procedures may be trained and willing to assist women
who suffer spontaneous threatened or actual miscarriage. That is, the legitimate scope of their objection may be narrowed to its conscientious focus.

A less tractable definitional concern is the status of emergency contraception. The medical evidence is that the emergency contraceptive pill levonorgestrel is not abortifacient, since it will not affect an actual pregnancy, but may prevent pregnancy. This reasoning is based on the definition of pregnancy applied by the International Federation of Gynecology and Obstetrics (FIGO), the only organization that brings together professional societies of gynecologists on a global basis, which is that “pregnancy . . . commences with the implantation of the conceptus in a woman, and ends with either the birth of an infant or an abortion.” Implantation is usually completed in the lining of the uterus. A conceptus is an ovum that has become fertilized by a sperm. The view that there cannot be abortion until pregnancy, and that before completion of implantation there is no pregnancy, has been endorsed at a governmental level, for instance in the U.K., where the Attorney-General explained that disposal of unimplanted embryos following in vitro fertilization (IVF) is not governed by the abortion law.

Underlying this issue is contention about when protected human life commences. Scientific approaches vary, as do religious traditions, and legal judgments. Many religious denominations accept the medical view that prevention of implantation constitutes contraception, and not abortion. Doctrine in the Roman Catholic denomination of Christianity has varied historically on when human life warrants protection, but in 1869 Pope Pius IX fixed this time as “conception.” The words “fertilization” and “conception” were synonymous at that time, since the only evidence of fertilization of an ovum, and of conception by implantation of the fertilized ovum in the uterus, was that a woman had become pregnant. The development of IVF, however, showed fertilization to occur before conception and pregnancy, and even when there would be no conception or pregnancy. Roman Catholic doctrine, which condemns IVF, was then interpreted to equate deliberate wastage of unimplanted human embryos with abortion.

Those who for religious reasons conscientiously object to abortion may therefore equally object to deliberate wastage of embryos, should they exist, in emergency contraception, since an embryo will be prevented from survival, which depends on completion of uterine implantation. Indeed, their approach may consider the distinction between abortion and routine or emergency contraception inconsequential, since they are as much opposed to any form of artificial contraception as to abortion. For instance, many
pharmacists who object to filling prescriptions for emergency contraception also object to delivering prescribed contraceptive products.

The distinction between abortion and emergency contraception remains significant, however, in law, since what constitutes abortion is a legal as well as a religious matter. A rape victim treated in the emergency department of a Roman Catholic hospital in California once complained of violation of her constitutional and civil rights because she was not offered nor informed of her option of using emergency contraception, which she described as “the morning-after pill” and the court as “estrogen pregnancy prophylaxis.” The hospital invoked its statutory protection against any obligation to perform or to permit abortion. The California Court of Appeal ruled, however, that prevention of pregnancy by emergency contraception is different from abortion, and that the rape victim’s rights had been violated. The Court accepted the victim’s claim that her “right to control her treatment must prevail over [the hospital] respondent’s moral and religious convictions,” to the extent of being informed of her right to emergency contraception, and of means to acquire that treatment within seventy-two hours of the assault.

In requiring hospital emergency or gynecological staff to provide information of emergency contraception, and to supply it or refer the patient, in a timely manner, to where she could avail herself of it, notwithstanding their personal conscientious objections, the Court was not denigrating or dismissing the significance of religious convictions, but acting as a secular court does. When the English Court of Appeal (Administrative Court) in 2002 similarly ruled that the morning-after pill was not abortifacient, and that in using it, “hundreds of thousands, indeed millions, of ordinary men and women” in England and Wales were not causing (arguably illegal) abortions, Mr. Justice Munby (as he then was) observed, “I sit as a secular judge serving a multi-cultural community of many faiths in which all of us can now take pride, sworn to do justice ‘to all manner of people.’ Religion—whatever the particular believer’s faith—is no doubt something to be encouraged but it is not the business of government or of the secular courts. So the starting point of the law is an essentially agnostic view of religious beliefs and a tolerant indulgence to religious and cultural diversity.”

In contrast, courts in several Latin American countries have applied legislation, including their national constitution, that provides that human life is afforded protection “from conception,” to find emergency contraception unlawful. In Peru in 2009, for instance, the Constitutional Court required the Ministry of Health not to distribute emergency contraception, which
remained accessible in the private sector.\textsuperscript{24} This prohibition followed a 2002 decision of the Supreme Court of Argentina,\textsuperscript{25} which prohibited production, distribution, and sale of an emergency contraceptive product, and a similar decision of the Constitutional Court of Ecuador in 2006.\textsuperscript{26} Some conscientious objectors, fearful of excommunication from the Catholic Church, suspected scientific assurances that abortion is not implicated in emergency contraception, and their doubts were echoed by courts that found the scientific evidence inconclusive. The Constitutional Courts of Chile\textsuperscript{27} and Peru\textsuperscript{28} resolved the uncertainty in favor of a potential for human life and upheld prohibition of emergency contraception.

The Latin American jurisprudence may be superseded, however, by the 2012 ruling of the Inter-American Court of Human Rights, that an embryo, prior to implantation, has no legal right to life.\textsuperscript{29} The Court’s ruling that any wastage of surplus embryos from in vitro fertilization does not justify prohibition of that reproductive means supports the legal conclusion that emergency contraception, preventing possible implantation, is not abortifacient.

For the same reason, menstrual extraction, for instance following a woman being late in her menstrual period, cannot be equated with abortion. This simple vacuum suction technique removes menstrual blood and other products from the uterus and restores the woman’s menstrual cycle. Menstruation may be delayed for a variety of reasons, but the procedure is not preceded by a pregnancy test. In contrast is restoration of regular menstruation by manual vacuum aspiration, which is a clinic or hospital procedure that requires dilation of the cervix, may require use of a vacuum machine, and must be preceded by a positive pregnancy test. The latter procedure is clearly intended to terminate pregnancy, justifying conscientious objection.

Patients’/Women’s Conscience

The preamble to the U.N. Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) notes that the U.N. Charter “reaffirms faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women.” It further notes that the Universal Declaration of Human Rights promotes equality in dignity and rights of all human beings “without distinction . . . based on sex,” and that states must “secure the equal rights of men and women to enjoy all economic, social,
cultural, civil and political rights.” Article 12 of CEDAW addresses equal access to health care services, including family planning.

Adopted in 1979 and in force since 1981, CEDAW remains unratified by, among others, the United States and the Holy See. Identifying U.N. declarations requiring the equality of women and men, the preamble expresses concerns that “despite these various instruments extensive discrimination against women continues to exist.” These concerns remain pertinent today, particularly regarding women’s unimpaired access to abortion services that they conscientiously consider in the best interests of their families and themselves. A continuing concern, for instance, is that “in situations of poverty women have the least access to food, health, education [and] training.” These are interactive concerns regarding pregnancy, since malnutrition leading to anemia and related ill-health, as well as illiteracy, dependency on others for sustenance, and lack of means to cope with family and related responsibilities, can combine to make continuation of pregnancy medically contraindicated, and contraindicated on wider grounds of “health,” described by the WHO as a state of “physical, mental and social well-being.”

Even the most culturally, socially, and economically advanced of countries have not shed the legacy of denying women’s moral agency as conscientious decision makers, for their societies, families, and even their own bodies. Male-led institutions in which women are underrepresented, not included, or deliberately excluded, such as legislatures, government ministries, judicial benches, religious hierarchies, and medical professional associations, often consider themselves better capable of serving women’s health care and other interests than are women themselves. Insensitive to or unaware of the particular circumstances of individual women, they stereotype women through often crude characterizations, for instance as impetuously, or in panic, making hurried decisions to abort, uninformed of the implications of abortion procedures.

Both religious and secular intruders into pregnant women’s choices are often more preoccupied with protection of unborn human life than with protection of women’s health and the welfare of their families, including their dependent children. Rejecting pre-natal baptism and so requiring live birth as the precondition to achieving a child’s spiritual salvation, they fear that, without their intervention, the unborn child will lose not only its life, but its heavenly afterlife too. Opposing abortion through denial or obstruction of procedures is seen as merciful rescue, and a legitimate, necessary initiative, whether or not in conformity with human laws.
The woman who proposes to terminate her pregnancy is myopically viewed in relation only to her embryo or fetus. This is especially so in religious environments conditioned by celibate priesthhoods whose members exist outside the lived experience of family life, with its trade-offs of interests, its difficult judgments on whose interests to privilege, postpone, or subordinate, and its assessments of how the interests of past and future generations should weigh in the balance. For instance, a woman aged thirty with two young children, a husband who requires her assistance in his small business that supports the family, elderly dependent parents and/or parents-in-law, and commitments to other family members, may conscientiously judge that these competing interests weigh against continuation of a pregnancy. The welfare of the parents for the foreseeable future, and the well-being of her young children and their rearing, depend on her availability, which she sees being jeopardized by birth and caring for a newborn, if she survives childbirth and maintains her health. Depending on the health care and other resources to which she has access, none of these outcomes may be assured.

It is arrogant and impertinent for strangers to this woman’s circumstances, whether they have the power of legislators, the authority of judges, the piety of ministers of religion, or the learning and experience of doctors, to believe that their conscientious resolutions of this woman’s competing family interests are superior to hers. Her health, meaning her physical, mental, and social well-being, is denied security by the claims of third parties, perhaps empowered by law, to impose their preferences in decision making over hers. This is the basis on which the Chief Justice of Canada, in a landmark ruling in 1988 declaring the restrictive national criminal law on abortion unconstitutional, observed: “Forcing a woman, by threat of criminal sanction, to carry a foetus to term unless she meets certain criteria unrelated to her own priorities and aspirations, is a profound interference with a woman’s body and thus a violation of security of the person.”

The previous law made abortion dependent on decisions of committees no agency was legally required to establish, that many medical institutions were ineligible to establish, and that could ignore an applicant’s “own priorities and aspirations.” Their purpose was to ensure compliance with statutory criteria, although evidence showed that they often added their own arbitrary, idiosyncratic conditions. In many countries, access to professional care for abortion has been made dependent on compliance with patronizing conditions that infantilize women applicants, and with others designed to dissuade or deter women from pursuing their intentions.
For instance “reflection delay” laws, initiated in France, require women requesting abortion to reflect for a time, measured in hours or days, before their consent is legally effective. These laws presuppose that women request abortions without prior reflection. The stereotype this demonstrates of women as impulsive, and unreflective unless made to be so by legislatures, is profoundly disrespectful of the conscientious, sometimes agonizing but responsible thought that usually precedes an abortion request. Such a legal provision approaches pregnant women as immaturesly incapable of personal, social, or moral reflection without legal compulsion. No other medical procedure, however invasive or long-lasting its effect, attracts this type of discriminatory statutory requirement. Doctors are required to ensure, as far as they reasonably can, that patients understand the information they are given for their consent to proposed treatment to be adequately informed, and will recommend counseling when desirable, but patients who are resolved in their choices may waive these opportunities and consent when they want to.

Similarly, laws such as introduced in Germany that make documented receipt of dissuasive counseling by governmentally approved non-physician counselors a precondition to lawful abortion subordinate the moral agency of women to perceived state duties to the unborn. Laws of this nature further compromise women’s access to care since eligible counselors may arbitrarily decline to meet with women.

Several U.S. state legislatures under control of anti-abortion politicians have abused informed consent laws to compel doctors to recite, and women to hear, “information” that the legislators have scripted. Some, such as Texas, go further, and require women to see ultrasound pictures of their fetuses, including real time images of their pulsating hearts. In regular law, to obtain adequately informed consent to proposed treatment, doctors must offer to provide material information, and give it to patients who want to receive it, without statutory compulsion. There is no obligation on the part of patients, however, to receive it. The aim of these clinically unnecessary, often cynical laws is to deter women from having abortions, and to punish those who have them by implanting memories for guilt and remorse. The role of U.S. state legislatures in inducing abortion-based regret has attracted academic analysis (see below).

Women’s capacities for conscientious judgment on abortion may be denied concerning their own bodies, and also concerning their capacities and duties as mothers of their daughters. When young or adolescent girls are victims of sexual abuse and become pregnant, their mothers often initiate
abortion requests on their behalf. This is liable to bring them into contact, and in some countries not uncommonly into conflict, with hospital administrations, government health care agencies, criminal law enforcement agencies, hospital chaplains, and senior clerics. An incident that generated public reaction occurred in Recife, Brazil, in 2009 when a nine-year-old girl, whose stepfather reportedly admitted sexually abusing her, was found to have a life-endangering twin pregnancy. In Brazil, abortion is lawful when pregnancy is due to rape. Local doctors accepted the mother’s abortion request, but Archbishop Sobrinho of Olinda and Recife condemned the mother and doctors, declaring their excommunication from the Catholic Church. In an unusual reaction, another archbishop wrote to the Vatican’s newspaper that this approach to the girl’s plight “hurts the credibility of our teaching, which appears in the eyes of many as insensitive, incomprehensible and lacking mercy.” Perhaps embarrassed at public condemnation of Archbishop Sobrinho and support for the girl’s mother and doctors, the diocese later advanced a more compassionate explanation in accordance with Catholic teaching.

The incident reflects a disdain for mothers’ conscientious judgments made in their daughters’ best interests. In a 2012 case, the European Court of Human Rights held Poland in violation of the European Convention for the Protection of Human Rights and Fundamental Freedoms when the mother of a fourteen-year-old pregnant rape victim seeking abortion was asked to sign a statement including that “this procedure could lead to my daughter’s death,” was told by a priest brought into the case in breach of confidentiality that she was a bad mother, and later was subjected to proceedings in the Lublin Family and Custody Court to terminate her parental rights regarding her daughter. The Family Court initially divested the mother of her legal status, but quashed that decision on a re-hearing of the case. The doctor at the hospital to which the girl was first taken offered to adopt the girl’s baby, and the girl herself, showing how women’s status in relationship to their pregnant daughters can be minimized and denied when they conscientiously request abortion. The European Court found violations of the mother’s and daughter’s rights to respect for their private lives by the doctors’ and hospital’s intervention between them, and by breach of medical confidentiality affecting them both.
The right to act or to refrain in accordance with one's conscience, whether based on religious, philosophical, or other convictions, is a central human right protected by leading international and national legal instruments such as treaties and constitutions. As such, conscientious objection warrants maximum protection. Laws may require, as for instance in Poland, that objection be made in writing and included in the individual patient's medical record, with referral to another physician competent to perform the same service. The burden of proof of conscientious objection usually falls on the person who claims the right. In Scotland, for instance, a statement made on oath or affirmation is sufficient proof, with legal liability for speaking falsely.

Like other human rights, the right of conscientious objection is not absolute. It must yield, as CCPR Article 18(3) provides, to legal “limitations . . . necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others.” There is a nice point of interpretation regarding whether “public” qualifies only “safety,” to contrast public with private safety, or whether it provides protection only for public order, comparable to the French ordre public which underpins operation of the state's legal system, public health and public morals. If the disallowance of exercise of rights of conscience applies only for protection of public health but not of private or clinical health, then abortion to protect or promote individual health will need to be defended under the CCPR as a “fundamental” right and freedom.

Such right or freedom may be recognized for medically necessary procedures, but not elective procedures. For instance, the U.K. Abortion Act, 1967, section 4(2), excludes rights of conscientious objection only from “any duty to participate in treatment which is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman.” This may appear to allow conscientious objection to participation in abortion procedures for lesser health risks. However, mental health may be permanently and gravely impaired if a woman is compelled to gestate and deliver an unwanted child, and to feel responsible for its welfare for the rest of her life. This is particularly so where, as section 1(1) (d) of the Act provides, “if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.” Conscientious objection to abortion that would leave the applicant with grave permanent injury to her mental health, and perhaps, by psychosomatic causation, similar injury to her physical health,
would fall within the scope of section 4(2), so that the immunity for conscientious objection provided by section 4(1) would be inapplicable.

Subject to section 4(2), conscientious objection is available to a person who would otherwise be “under any duty . . . to participate in any treatment authorised by this Act.” This seems to preclude hospitals and comparable institutions as such from claims to conscientious objection, since, while as corporate bodies they may facilitate procedures, they do not participate in them. This is consistent with the 2008 decision of the Constitutional Court of Colombia. However, corporate bodies such as hospitals must accommodate the objections of health care providers they engage, without censure or discrimination, while also ensuring patients’ access to lawful treatment, including abortion as allowed by prevailing law.

What extent of immunity or protection is afforded conscientious objectors varies among jurisdictions. In the U.S., for example, at least forty-five states have so-called conscience clauses in laws to allow objection to participation in health care procedures. Some, such as California, permit objection to abortion, but not other services. Others allow objection to sterilization, contraceptive, and, for instance, medically assisted fertility or reproduction services, and to forms of end-of-life care, and some define “participation” expansively to cover indirect services such as those of pharmacists, ambulance drivers, medical instructors, and students. Most if not all of these laws were enacted in the aftermath of the U.S. Supreme Court 1973 decision recognizing the legality of abortion in Roe v. Wade, to accommodate an expanding anti-abortion backlash.

An instance of this type of law is the Mississippi Health Care Rights of Conscience Act, which was initially directed only to abortion, but was expanded comprehensively to accommodate the full agenda of the right-to-life movement. This covers any broadly defined “health care service,” including “patient referral, counseling, therapy, diagnosis or prognosis . . . prescribing, dispensing or administering any device, drug, or medication, surgery, or any other care or treatment rendered by health care providers or health care institutions.” Protection of conscience is available to a “health care provider,” defined as “any individual who may be asked to participate in any way in a health care service, including . . . any professional, paraprofessional, or any other person who furnishes, or assists in the furnishing of, a health care procedure.”

The Act does not recognize patients’ rights of conscience but grants such rights to a “health care institution,” defined as “any public or private
organization . . . that is involved in providing health care services, including . . . institutions or locations where health care procedures are provided to any person. The Act similarly grants rights of conscientious objection to any entity or employer that pays for health care services. It addresses the right not to “participate” in health care services, meaning “to counsel, advise, provide, perform, assist in, refer for, admit for purposes of providing, or participate in providing, any health care service or any form of such service.”

A key provision is the underlying protection of “conscience,” which is explained as “the religious, moral or ethical principles held by a health care provider, the health care institution or health care payer.” Conscience shall be determined by reference to “existing or proposed religious, moral or ethical guidelines, mission statement, constitution, bylaws, articles of incorporation, regulations, or other relevant documents.” However, institutions’ accommodation of refusals of care does not allow refusal of care “because of the patient’s race, color, national origin, ethnicity, sex, religion, creed or sexual orientation.” Similarly, while “no health care provider shall be civilly, criminally, or administratively liable for declining to participate in a health care service that violates his or her conscience,” there is no such exemption when refusal is because of the patient’s race or other characteristic identified in the Act.

Health care providers, institutions, officials, and others are fully protected against suffering discrimination for invoking rights of conscience covered by the Act, which provides that it shall be unlawful “to discriminate against any health care provider in any manner based on his or her declining to participate in a health care service that violates his or her conscience.” Discrimination includes termination, transfer, refusal of staff privileges, refusal of board certification, adverse administrative action, demotion, loss of career specialty, reassignment to a different shift, reduction of wages or benefits, refusal to award any grant, contract, or other program, refusal to provide residency training, or any other penalty, disciplinary, or retaliatory action. Comparable protections are enacted for health care institutions and payers for services.

The Act is enforceable by a civil action for treble damages and/or injunction, and no defense is allowed that violation of the Act “was necessary to prevent additional burden or expense on any other health care provider, health care institution, individual or patient.” This means that violations of the Act are not defensible on the ground that conformity would impose significant additional burdens or expenses on health care institutions, or patients.
It is not clear whether legislation of this nature entitles gynecologists or obstetricians to refuse to inform prospective patients that they will not participate in particular services that fall within the usual range of services that members of the public reasonably expect of practitioners in this medical specialty, such as prescribing contraceptive products, offering contraceptive sterilization, or abortion. The legislation protects refusals to render treatments, but disclosure of treatments that will and will not be rendered is not itself treatment. Before any treatment is begun, prospective patients legally should know of any deviations from services that patients reasonably expect to receive. These include any proposed treatment that is experimental or unproven, and any usual service within the specialty of obstetrics and gynecology that is not provided. This serves patients’ legal option to forgo that service, or change to another practitioner. Some private health insurance policies cover treatments only through designated providers, which makes it important for prospective patients to know whether such providers will refuse to render services within their specialty on grounds of personal conscience.

In many circumstances, prospective patients do not enjoy a choice of practitioners but receive care from whichever practitioner is available to them from the hospital, clinic, or comparable facility to which they have access. It is important that facility administrators know what services potential providers are able and willing to offer, and in particular what services within their specialty they refuse to provide. For patient care, administrators must ensure that they can direct personnel to render necessary care, and can adequately cover those who object to provide care by recruiting others who do not object. They must therefore enquire if potential recruits object to provide any services within their medical or other specialty.

Potential recruits are usually protected against discriminatory hiring practices, but it is not discriminatory to decline to hire them if they do not meet the reasonable employment requirements of positions for which they apply. If a hospital where many gynecologists object to participate in abortion procedures wants to recruit one who does not object, willingness to participate is an explicit, essential bona fide condition of recruitment. Those not willing to participate make themselves ineligible for appointment. The requirement must be central to the proposed employment, however, and not be a cover for unlawful discrimination.

Refusals of health care services related to abortion have been reviewed in the United States in the National Health Law Program (NHHeLP) 2010 report, showing how appropriate health care for women has been denied,
postponed, and undermined. An instance is recorded of a patient nineteen weeks pregnant when her membranes ruptured. The fetus was not viable, and the patient was septic. Her doctor considered termination of pregnancy necessary, but the hospital administration refused to allow this because a fetal heartbeat was recorded. The patient spent ten days in intensive care and nearly died. The fetus died in utero, the woman surviving but with substantial internal bleeding and pulmonary disease resulting in lifelong oxygen dependency.64

The report identifies how claims of conscientious objection and related administrative barriers to care that is required according to medical professional guidelines, such as provided by the American College of Obstetricians and Gynecologists,65 jeopardize pregnant women’s health. In addition to delayed care on premature rupture of membranes, treatment of preeclampsia and eclampsia by medically indicated delivery of the fetus may be postponed to increase the chance of fetal viability. Medically indicated care may be postponed or denied when a fetal heartbeat exists in cases of anencephaly, in which the fetus, lacking an upper brain, is not viable, and when comparable conditions exist that are dangerous to women’s health. Some therapeutic drugs may be withheld from pregnant patients lest fetal health be compromised, and from women affected by health- and life-endangering cardiovascular conditions that make continuation of pregnancy contraindicated. Such health conditions affecting pregnant patients may be left inadequately treated for fear of religiously construed liability for causing abortion.

Of special note is delay in treating tubal or ectopic pregnancy, a life-threatening condition occurring when an embryo implants outside the uterus, most commonly in the fallopian tube. There are surgical and nonsurgical means to remove the embryo before it causes the fallopian tube to rupture, risking permanent damage to the woman’s future fertility, morbidity, and even death. However, on grounds of conscientious objection to deliberately inducing what some Catholic theologians rule is abortion, practitioners may wait until the fallopian tube ruptures or is close to rupturing before undertaking an emergency, life-saving intervention. In all of the circumstances outlined above, the Ethical and Religious Directives for Catholic Health Care Services (“the Directives”) applied in Roman Catholic associated health care facilities, and by Catholic health care providers engaged outside such facilities, give priority to survival of embryos and fetuses, and subordinate regard to preservation of women’s health and fertility.66

Institutions and individual practitioners intending to apply priorities of
this nature and effect, without regard to their patients’ wishes, should provide potential and actual patients with timely information of that intention. Patients who have been induced to rely on their health care institutions and providers for medically indicated care, in accordance with professional standards, should not suddenly be confronted, perhaps in moments of crisis, with denial of indicated care based on personal claims to conscientious objection.

The inclusion in conscientious objection immunity laws, such as in Mississippi, of protection of objecting health care providers who do not refer patients whom they refuse to treat to nonobjecting providers confirms that, in the absence of such laws, objecting doctors have a duty to refer their patients, in good faith, to providers of such care. As an English High Court judge ruled in 1999, “once a termination of pregnancy is recognised as an option, the doctor invoking the conscientious objection clause should refer the patient to a colleague at once.” Failure to refer violates professional standards of care, exposing a defaulting practitioner to professional discipline. Some jurisdictions in the Common law tradition consider the unequal doctor-patient relationship to be fiduciary, so that the doctor, with the power of professional knowledge, is under a fiduciary duty to assist the patient, who is dependent on the conscientious application of that knowledge to serve his or her interests. Further, conformity to professional standards may be an implied term of a doctor-patient contract.

A distinction must be drawn between duties owed to patients and those owed to other people requesting to become patients. A doctor can decline to treat an applicant for care, on such grounds as inability to accept any additional patients, but not on discriminatory grounds such as race or religion. The doctor has no duty to refer the applicant for care to another provider. When a doctor-patient relationship exists, however, following from a past association or, for instance, because the doctor is appointed to care for the patient by the hospital the patient attends, the doctor owes duties to the person who has thereby become the doctor’s patient, particularly duties of nonabandonment. The doctor cannot withdraw from care, such as on grounds of conscientious objection, without first ensuring the patient’s continuous access to appropriate care.

The doctor cannot legally claim, unless supported by legislation as expansive as that in Mississippi, that there is an additional right of conscientious objection to referral. That claim is often founded on complicity, that is, that it is as wrong or sinful to be complicit in another’s wrongdoing as it is directly to perpetrate the wrong oneself. This misconstrues the purpose of abortion
referral, however, which is not simply for abortion but for consideration of a range of legitimate options, of which abortion is one. Not infrequently, referral does not lead to abortion.

Conscientious objection is accommodated so that the objector does not have to participate directly in abortion. However, referral for consideration of a treatment does not constitute participation in it. For instance, the referring doctor does not share any fee the doctor to whom referral is made may earn, is not party to any negligence the other doctor may commit, and does not share in any criminal liability that doctor may incur. The duty to refer may be discharged by referring the patient, in good faith, to another practitioner or agent known not to object. In New Zealand, for instance, the Health Practitioners Competence Assurance Act of 2003 provides that, when a health practitioner conscientiously objects to providing a reproductive health service, “the health practitioner must inform the person who requests the service that he or she can obtain the service from another health practitioner or from a family planning clinic.”

One author has built on this model to propose mediation between the practitioner who objects to referral and the patient requesting a service in which the practitioner refuses to participate. She advances the concept that the medical profession itself, through specialist and/or local associations, can maintain lists of practitioners who are prepared to undertake procedures to which others conscientiously object. Objecting practitioners unwilling or unable to refer their patients to others who will undertake such procedures may then refer their patients to the associations. This would be a service both to maintain the objecting practitioner’s sense of integrity, and to provide patients with the referral to which they are entitled.

Manifesting Conscience

While Article 18(1) of the International Covenant on Civil and Political Rights (CCPR) protects freedom “of thought, conscience and religion,” limitations under Article 18(3) may reduce freedom “to manifest one’s religion or beliefs” in order to protect “health . . . or the fundamental rights and freedoms of others.” Individuals are free passively to reach judgments based on their ideas, conscience, and/or religion, perhaps as an aspect of their privacy protected under Article 17, and to express their convictions as protected under Article 19, but they may be subject to limitations on how they actively manifest their religious or other beliefs.
National courts have addressed whether limitations on the right to manifest one's religion can be imposed to protect one's own health, for instance whether to prohibit Jehovah's Witnesses from refusing blood transfusions. International tribunals have not elaborated on the application of Article 18 in a substantive way, but its equivalent in the European human rights system has founded a sophisticated jurisprudence in the European Commission and the European Court of Human Rights, and in domestic courts of states that are parties to the European Convention for the Protection of Human Rights and Fundamental Freedoms.

Article 9(1) of the European Convention echoes Article 18(1) of the CCPR on freedom of thought, conscience, and religion, and Article 9(2) similarly provides that: “Freedom to manifest one's religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society . . . for the protection of the rights and freedoms of others.” The contrast between subsections (1) and (2) was crisply summarized in a Scottish court in the judicial observation that “Article 9 encapsulates a duality of rights, namely the freedom to hold a belief and freedom to ‘manifest’ it. The former is absolute. The latter is qualified.” While freedom of religious or other beliefs cannot be contained, limits may legally be set upon, or result from, how individuals may manifest such beliefs. For instance, the Constitutional Council in France has upheld legislation providing that departmental heads of public health facilities cannot refuse to allow conduct of lawful abortions on grounds of their personal conscience, although they may refuse direct participation in an individual procedure.

The European Court of Human Rights addressed Article 9 in the Pichon case. Two French pharmacists operating the only pharmacy in a remote area refused to sell contraceptives to women presenting valid prescriptions, on grounds of their religious beliefs. French courts upheld their criminal convictions for breach of the national Consumer Code by refusal to supply services without a legitimate reason. Health service providers are allowed nonparticipation in abortion-related services, but by law other religious or moral beliefs do not provide legitimate reasons for breach of the Consumer Code. The pharmacists appealed to the European Court of Human Rights alleging violation of their rights to conscientious objection, protected under Article 9(1). The Court found the claim inadmissible, however, on the ground that the appellants’ freedom of religious belief had not been violated.

The finding was more procedural than substantive, not expanding on the scope of Article 9(2), but observed that “the applicants cannot give
precedence to their religious beliefs and impose them on others . . . since they can manifest those beliefs in many ways outside the professional sphere.” Alternative means to express beliefs may set a limit to undertaking employment with responsibilities from which the employee seeks legal exemption on grounds of conscientious objection. The European Commission of Human Rights ruled in 1981 that: “The freedom of religion, as guaranteed by Article 9 is not absolute, but subject to the limitations set out in Article 9(2). Moreover, it may, as regards the modality of a particular religious manifestation, be influenced by the situation of the person claiming that freedom.”

This ruling was cited by a Scottish judge in a 2012 decision concerning two midwives employed as labor ward coordinators in a hospital where abortions were performed. They had accepted employment requiring them to supervise midwives, without themselves directly treating patients, but claimed rights of conscientious objection to supervising participants in abortion procedures. They petitioned for reversal of dismissal of their employment grievance actions, and for declarations that they were not required to delegate, supervise, and/or support staff in the conduct of induced abortions. They invoked rights of conscientious objection under section 4(1) of the U.K. Abortion Act, 1967, and Article 9 of the European Convention.

The trial judge rejected the claim brought under section 4(1) of the 1967 Act, which affords rights of conscientious objection regarding “any duty . . . to participate in any treatment” authorized by the Act, because the petitioners were not direct participants in such treatment. Regarding Article 9, the judge observed that “the European Court of Human Rights has been reluctant to impose obligations on employers to take positive steps to accommodate an employee’s wishes to manifest his religious beliefs in a particular manner.” She also cited the highest U.K. court, now named the U.K. Supreme Court, in which it was observed that “Article 9 does not require that one should be allowed to manifest one’s religion at any time and place of one’s choosing.” However, citing the practical difficulty of knowing what part of “treatment” is direct participation and which is not, the appeal court reversed the trial decision. Its expansive ruling that rights of objection “should extend to any involvement in the process of treatment, the object of which is to terminate a pregnancy” unfortunately creates serious doubts about patients’ rights to indicated, dignified care, for instance from nursing and administrative staff, and ignores limits under Article 9(2) of the European Convention binding on the U.K. This wide ruling is being further appealed to the U.K. Supreme Court, whose decision may conceivably be yet
further appealed to the European Court of Human Rights for application of the European Convention.

Conscientious Commitment

In contrast to practitioners whose personal conscience compels them to refuse participation in abortion procedures is the half-century and longer history of practitioners whose conscience commits or allows them to advise, offer and/or provide abortion. Most conscientious commitment to undertake abortion is derived from secular and professional convictions. One is that, since doctors enjoy a state-granted monopoly over the practice of medicine, and therefore over lawful abortion procedures, they would abuse that monopoly were they to refuse to undertake such procedures, on patients’ requests, so widely as to deny patients effective means of access. This is reinforced by experience of how women denied the lawful, safe procedures to which they are entitled may resort to unsafe interventions, including medically unsupervised, self-induced abortions, with high resulting rates of mortality and morbidity.

A related ground of conscientious commitment is that doctors publicly licensed to practice, particularly though not only in public hospitals and facilities, and whether or not educated at public expense, are public officers, who must accordingly serve the public neutrally, without favor or disfavor on religious or other personal grounds. This principle was supported by Chief Judge Posner, of the United States Court of Appeals for the Seventh Circuit, in 1998. The case concerned a Chicago police officer assigned to protect an abortion clinic against protesters’ violence and assaults. As a devout Roman Catholic, he considered this assignment to facilitate abortion, and to violate his freedom of conscience. Judge Posner observed, however, that as an agent serving a public function, the police officer was not free to choose which premises he would protect and which not, like a firefighter cannot choose which buildings to protect and which to let burn. By analogy, doctors should not deny lawful procedures that patients want when they are the only ones trained, qualified, and available to undertake them, on the basis of their personal beliefs.

As against this approach, however, committed doctors may claim the same rights of conscientious objection to discharge certain tasks that they find personally offensive as their colleagues enjoy. For instance, when
required by legislation to make certain statements to women requesting abortion that they find medically incorrect, or liable to subvert women’s responsible judgment of their own and/or their families’ interests, they may object and refuse. They may invoke grounds of professional conscience, for instance to be truthful in dealings with patients, and to do no harm. Several states’ abortion laws in the U.S. require that specified information be given only when it is medically accurate. This is unobjectionable but may compromise a doctor’s clinical judgment about whether the disclosure is material to the patient, and whether she will afford it proportionate weight. When doctors consider mandated disclosures contrary to the best scientific information and understanding, however, they may conscientiously object to make such disclosures. Refusal to comply with mandatory disclosure (“compelled speech”) laws may be defensible under protection of conscience laws such as in Mississippi, which protect conscientious objection against civil, criminal, and administrative sanctions.

An informative research article provides details of U.S. state laws on abortion disclosure requirements. Many are being challenged in court. For instance, the Texas counseling booklet requires doctors to inform prospective patients seeking abortion that complications “may make it difficult or impossible to become pregnant in the future or carry a pregnancy to term.” However, most abortions are conducted in the first trimester, most commonly by vacuum aspiration, which “poses virtually no long-term risk of infertility, ectopic pregnancy, spontaneous abortion or congenital malformation.”

Many states’ laws require emphasis on psychological or mental health hazards of abortion. Michigan’s law requires disclosure “that as the result of an abortion, some women may experience depression, feelings of guilt, sleep disturbance, loss of interest in work or sex, or anger.” In West Virginia, material to be given to abortion patients states that “many women suffer from Post-Traumatic Stress Disorder Syndrome following abortion. PTSD is a psychological dysfunction resulting from a traumatic experience.” The material includes reference to associated symptoms of depression, drug abuse, eating disorders, chronic relationship problems, and, inter alia, suicidal thoughts or acts.

This material draws from an alleged condition not recorded in the reputable psychiatric literature, post-abortion syndrome, against which anti-abortion advocates propose to protect women. Scientific studies show that, while any medical experience is liable to have a psychological effect, that of abortion is no more significant than that of any other procedure. It is
observed, for instance that: “The relative risk of mental health problems among adult women who have a single, legal, first-trimester abortion of an unwanted pregnancy for non-therapeutic reasons is no greater than the risk among women who deliver an unwanted pregnancy.”

Another study finds no increased resort to psychiatric services for mental disorder after induced abortion, but a slight increase after childbirth. This scientific literature supports doctors who conscientiously object to having to provide their patients with false or misleading “information.” Doctors may indeed be guarded against providing accurate information for fear of the so-called nocebo effect, the reverse of the better-known beneficial placebo effect. The nocebo effect arises when suggestible patients are induced to expect specific negative side-effects of interventions and, by psychosomatic causation, may experience them. Doctors, in their clinical judgment, are entitled to exercise a narrow “therapeutic privilege” not to disclose information they conscientiously believe will cause their patients harm.

Some states claim concern that women having abortions may suffer psychological harm, but the explicit disclosures they require of alarming, unproven, or largely discredited risks, such as of breast cancer and early fetal pain, may aggravate women’s distress. The states’ main purpose may in fact be to deter women from pursuing abortion. Similarly, requirements that ultrasound examinations be conducted before women have abortions make a legal necessity of an invasive procedure, whether by abdominal or vaginal transduction, that is medically unnecessary, though possibly useful. Ultrasound examinations will be recommended by doctors who consider them desirable, without a legislative mandate. The explanations that legislators provide make it evident, however, that the requirement is primarily designed so to bond women to their fetuses in utero that they decide to continue their pregnancies, and punitively to burn an image into their memories if they do not.

Doctors who find their patients resolved on abortion may conscientiously object to enforce ultrasound examination and viewing, consistently with the historical medical ethic to do no harm.

Doctors who choose to comply with laws that mandate disclosures to patients considering abortion are entitled to place that “information” in context. State justifications of compelled speech do not justify prohibitions of speech. Doctors may therefore disclose what the legislature requires, but inform patients that such disclosure is scientifically suspect or false, for instance regarding first-trimester procedures. On physical risk, they may point out, for instance, that medical evidence in the United States shows that risk of death
from routine childbirth is about fourteen times higher than from legal abortion, and that overall morbidity associated with childbirth exceeds that with abortion.\textsuperscript{98} On mental health risk, they may add that post-abortion syndrome has little if any recognition in psychiatry, whereas postpartum depression has an established history in both psychiatry and law. A 2006 study mainly across Western countries showed postpartum depression to affect ten to fifteen percent of mothers.\textsuperscript{99} In law, a woman who kills her child within twelve months of delivering it may be convicted not of murder but only manslaughter (infanticide) if “at the time . . . the balance of her mind was disturbed by reason of her not having fully recovered from the effect of giving birth to the child or . . . lactation consequent upon the birth.”\textsuperscript{100}

Doctors conscientiously committed not to abortions but to their patients being properly informed may therefore counter false mandated speech with scientifically established and professionally accepted facts. The right conscientiously to tell the truth is violated, however, when doctors are prohibited from truthful, relevant discussions with their patients. In the United States, for instance “some religiously affiliated hospitals forbid employees from providing information or counseling about abortion, [from] referring patients to other facilities for abortions, or [from] performing or assisting with abortion procedures at other medical facilities.”\textsuperscript{101}

Not all countries have religiously affiliated hospitals, or such public hospitals, but among countries that do, Roman Catholic hospitals are prominent. Such hospitals are increasingly delivering care, for instance, in the United States and Canada as Catholic and non-Catholic hospitals merge, often for economy, and the new entity functions as Catholic.\textsuperscript{102} This poses questions of how patients, particularly women, access services barred by the Church, and of how health care providers, particularly doctors, discharge conscientious commitments they feel toward patients. In Kentucky, for instance, in December 2011, the Governor refused to approve a merger between a Roman Catholic and a non-Catholic hospital, on the ground that the prospective withdrawal of services, particularly from women, would not be in the public interest.\textsuperscript{103}

In the same way as the right to conscience properly protects conscientious objection to participation in lawful medical care, it should equally protect the conscientious commitment to deliver such care. Doctors engaged in hospitals whose administrations condemn abortion, contraception, and, for instance, contraceptive sterilization, should remain free to provide patients with information, counseling, prescriptions, and referral on these matters, and to
undertake procedures insofar as they can without collaboration of objecting
colleagues and the hospital administration. Further, in the same way that
principles of equality under the law and of nondiscrimination protect doctors
who conscientiously refuse to participate in procedures to which they object,
the same principles should protect doctors who are conscientiously commit-
ted to delivery of particular care, in hospitals whose administrations
disapprove.

Where countries’ constitutions and/or laws prohibit discrimination on
grounds of conscience or religion, secular hospitals cannot decline to engage
service providers on grounds only of their religion. Catholic health care pro-
viders seeking positions cannot be rejected simply because they are Catholic.
Equally, Catholic hospitals cannot reject applicants because they are not, ex-
cept for religiously based positions, such as in hospital chaplaincy. Non-
Catholic doctors engaged in Catholic hospitals are expected to be respectful
of religious directives but should receive reciprocal respect for their conscien-
tious objections and commitments, as do religiously motivated doctors in
nonreligious facilities. They should accordingly be free to inform, counsel,
refer, prescribe for, and treat their patients according to their conscientious
convictions, without subjection to censure, or to discrimination such as is
defined, for instance, in Mississippi’s Health Care Rights of Conscience Act.
That Act is directed, of course, to refusal of care, but a reading according to
equal protection principles could apply its key provisions to conscientious
delivery of care. Legislation protecting only conscientious objection may
deny rights of conscience to those of different conscientious persuasion, in
violation of equal protection of the law guaranteed in human rights law and
many national constitutions.

On this basis, doctors in Catholic hospitals should be free to exercise their
clinical judgment conscientiously to treat pregnant patients suffering prema-
ture rupture of membranes according to medical professional standards and
guidelines, without subjection to religiously based veto. Similarly, they
should be able to treat preeclampsia and eclampsia according to the present-
ing diagnosis and prognosis, and such conditions as ectopic pregnancy, con-
scientiously to serve their patients’ wishes and best interests, without
prohibition because a fetus unavoidably at risk due to treatment indicated for
the pregnant woman records a heartbeat. Doctors should not use drugs for
pregnant women’s treatment, such as for malignant cancer, that risks injury to
or loss of their fetuses, without careful review with the patients of available
alternatives, out of respect for hospitals’ religious directives. If treatment is
indicated, such as for cardiovascular emergencies, to preserve the patients’ lives but with unavoidable loss of their pregnancies, this may be tolerated by Catholic hospitals’ administrations characterizing the treatments not as abortions but as life-saving medical interventions, under the principle of double effect.106

More difficult for doctors willing to participate in abortion procedures in hospitals opposed to such procedures may be to react to abortion requests not indicated by any pathology, but of an elective nature, such as to overcome a contraceptive failure or oversight. Even when there is no medical indication for abortion, it is a legitimate health option when the WHO concept of “health” is applied. The state of health means “physical, mental and social well-being and not merely the absence of disease or infirmity.”107 By this measure, unplanned pregnancy may endanger women’s health, and its termination may promote women’s health.

This provides a legal and ethical framework for the conscientious commitment of health care professionals. Respect for and protection of human rights requires legal protection. In 1991, Pope John Paul II addressed respect for conscience, regarding not abortion but the respect that repressive Communist and other governments should pay to religious conscience. His words were based, of course, on Catholic theology and were intended to be interpreted according to a Catholic understanding of truth, in a somewhat self-serving way to protect rights to Roman Catholic conscience against the hostility of totalitarian, atheistic government, but they also resonate outside that context. The pope observed that “a serious threat to peace is posed by intolerance, which manifests itself in the denial of freedom of conscience to others. The excesses to which intolerance can lead has [sic] been one of history’s most painful lessons.”108 Requiring legal protection of conscience, he nevertheless added that “freedom of conscience does not confer a right to indiscriminate recourse to conscientious objection. When an asserted freedom turns into license or becomes an excuse for limiting the rights of others, the State is obliged to protect, also by legal means, the inalienable rights of its citizens against such abuses.”109 This spirit requires of health care institutions and providers, Catholic and secular alike, tolerance both of conscientious objection, and of conscientious commitment, to delivery of abortion-related services.