



**Conscientious objection and refusal to provide reproductive
healthcare: A white paper examining prevalence, health
consequences, and policy responses**

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ABSTRACT

Background: Global Doctors for Choice—a transnational network of physician advocates for reproductive health and rights—began exploring the phenomenon of conscience-based refusal of reproductive healthcare as a result of increasing reports of harms worldwide. This White Paper examines the prevalence and impact of such refusal and reviews policy efforts to balance individual conscience, autonomy in reproductive decision making, safeguards for health, and professional medical integrity.

Objectives and search strategy: The White Paper draws on medical, public health, legal, ethical, and social science literature published between 1998 and 2013 in English, French, German, Italian, Portuguese, and Spanish. Estimates of prevalence are difficult to obtain, as there is no consensus about criteria for refuser status and no standardized definition of the practice, and the studies have sampling and other methodologic limitations. The White Paper reviews these data and offers logical frameworks to represent the possible health and health system consequences of conscience-based refusal to provide abortion; assisted reproductive technologies; contraception; treatment in cases of maternal health risk and inevitable pregnancy loss; and prenatal diagnosis. It concludes by categorizing legal, regulatory, and other policy responses to the practice.

Conclusions: Empirical evidence is essential for varied political actors as they respond with policies or regulations to the competing concerns at stake. Further research and training in diverse geopolitical settings are required. With dual commitments toward their own conscience and their obligations to patients' health and rights, providers and professional medical/public health societies must lead attempts to respond to

conscience-based refusal and to safeguard reproductive health, medical integrity, and women's lives.

1. Introduction

How can societies find the proper balance between women's rights to receive the reproductive healthcare they need and healthcare providers' rights to exercise their conscience? Global Doctors for Choice (GDC)—a transnational network of physician advocates for reproductive health and rights (www.globaldoctorsforchoice.org)—began exploring the phenomenon of conscience-based refusal of reproductive healthcare in response to increasing reports of harms worldwide. This White Paper addresses the varied interests and needs at stake when clinicians claim conscientious objector status when providing certain elements of reproductive healthcare. (While GDC represents physicians, in this White Paper we use the terms providers or clinicians to also address refusal of care by nurses, midwives, and pharmacists.) As the focus is on health, we examine data on the prevalence of refusal; lay out the potential consequences for the health of patients and the impact on other health providers and health systems; and report on legal, regulatory, and professional responses. Human rights are intertwined with health, and we draw upon human rights frameworks and decisions throughout. We also refer to bedrock bioethical principles that undergird the practice of medicine in general, such as the obligations to provide patients with accurate information, to provide care conforming to the highest possible standards, and to provide care that is urgently needed. Others have underscored the consequences of negotiating conscientious objection in healthcare in terms of secular/religious tension. Our contribution, which complements all of this previous work, is to provide both the medical and public health perspectives and evidence. We focus on the rights of the provider who conscientiously objects—together with that provider's professional obligations, the rights of the women

who need healthcare- and the consequences of refusal for their health, and on the impact on the health system as a whole.

Conscientious objection is the refusal to participate in an activity that an individual considers incompatible with his/her religious, moral, philosophical, or ethical beliefs [1].

This originated as opposition to mandatory military service but has increasingly been raised in a wide variety of contested contexts such as education, capital punishment, driver's license requirements, marriage licenses for same-sex couples, and medicine and healthcare. While health providers have claimed conscientious objection to a variety of medical treatments (e.g. end-of-life palliative care and stem cell treatment), this White Paper addresses conscientious objection to providing certain components of reproductive healthcare. (The terms conscientious objection and conscience-based refusal of care are used interchangeably throughout.) Refusal to provide this care has affected a wide swath of diagnostic procedures and treatments, including abortion and postabortion care; components of assisted reproductive technologies (ART) relating to embryo manipulation or selection; contraceptive services, including emergency contraception (EC); treatment in cases of unavoidable pregnancy loss or maternal illness during pregnancy; and prenatal diagnosis (PND).

Efforts have been made to balance the rights of objecting providers and other health personnel with those of patients. International and regional human rights conventions such as the Convention on the Elimination of All Forms of Discrimination against Women [2], the International Covenant on Civil and Political Rights (ICCPR) [1], the

American Convention on Human Rights [3], and the European Convention for the Protection of Human Rights and Fundamental Freedoms [4] as well as UN treaty-monitoring bodies [5,6] have recognized both the right to have access to quality, affordable, acceptable sexual and reproductive healthcare services and/or the right to freedom of religion, conscience, and thought. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa recognizes the right to be free from discrimination based on religion and acknowledges the right to health, especially reproductive health, as a key human right [7]. These instruments negotiate these apparently competing rights by stipulating that individuals have a right to belief but that the freedom to manifest one's religion or beliefs can be limited in order to protect the rights of others.

The ICCPR, a central pillar of human rights that gives legal force to the 1948 UN Universal Declaration of Human Rights, states in Article 18(1) that [1]:

Everyone shall have the right to freedom of thought, conscience and religion. This right shall include freedom to have or to adopt a religion or belief of his choice, and freedom, either individually or in community with others and in public or private, to manifest his religion or belief in worship, observance, practice and teaching.

Article 18(3), however, states that [1]:

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.

International professional associations such as the World Medical Association (WMA) [8] and FIGO [9]—as well as national medical and nursing societies and groups such as the American Congress of Obstetricians and Gynecologists (ACOG) [10]; Grupo Médico por el Derecho a Decidir de Colombia [11]; and the Royal College of Nursing, Australia [12]—have similarly agreed that the provider's right to conscientiously refuse to provide certain services must be secondary to his or her first duty, which is to the patient. They specify that this right to refuse must be bounded by obligations to ensure that the patient's rights to information and services are not infringed.

Conscience-based refusal of care appears to be widespread in many parts of the world. Although rigorous studies are few, estimates range from 10% of OB/GYNs refusing to provide abortions reported in a UK study [13] to almost 70% of gynecologists who registered as conscientious objectors to abortion with the Italian Ministry of Health [14]. While the impact of the loss of providers may be immediate and most obvious in countries in which maternal death rates from pregnancy, delivery, and illegal abortion are high and represent major public health concerns, consequences at individual and systemic levels have also been reported in resource-rich settings. At the individual level, decreased access to health services brought about by conscientious objection has a disproportionate impact on those living in precarious circumstances, or at otherwise

heightened risk, and aggravates inequities in health status. Indeed, too many women, men, and adolescents lack access to essential reproductive healthcare services because they live in countries with restrictive laws, scant health resources, too few providers and slots to train more, and limited infrastructure for healthcare and means to reach care (e.g. roads and transport). The inadequate number of providers is further depleted by the “brain drain” when trained personnel leave their home countries for more comfortable, technically fulfilling, and lucrative careers in wealthier lands [15]. Access to reproductive healthcare is additionally compromised when gynecologists, anesthesiologists, generalists, nurses, midwives, and pharmacists cite conscientious objection as grounds for refusing to provide specific elements of care.

The level of resources allocated by the health system greatly influences the impact caused by the loss of providers due to conscience-based refusal of care. In resource-constrained settings, where there are too few providers for population need, it is logical to assume the following chain of events: further reductions in available personnel lead to greater pressure on those remaining providers; more women present with complications due to decreased access to timely services; and complications require specialized services such as maternal/neonatal intensive care and more highly trained staff, in addition to incurring higher costs. The increased demand for specialized services and staffing burdens and diverts the human and infrastructural resources available for other priority health conditions. However, it is difficult to disentangle the impact of conscientious objection when it is one of many barriers to reproductive healthcare. It is conceptually and pragmatically complicated to sort the contribution to

constrained access to reproductive care attributable to conscientious objectors from that due to limited resources, restrictive laws, or other barriers.

What are the criteria for establishing objector status and who is eligible to do so? In the military context, conscientious objector applicants must satisfy numerous procedural requirements and must provide evidence that their beliefs are sincere, deeply held, and consistent [16]. These requirements aim to parse genuine objectors from those who conflate conscientious objection with political or personal opinion. For example, the true conscientious objector to military involvement would refuse to fight in any war, whereas the latter describes someone who disagrees with a particular war but who would be willing to participate in a different, “just” war. Study findings and anecdotal reports from many countries suggest that some clinicians claim conscientious objection for reasons other than deeply held religious or ethical convictions. For example, some physicians in Brazil who described themselves as objectors were, nonetheless, willing to obtain or provide abortions for their immediate family members [17]. A Polish study described clinicians, such as those referred to as the White Coat Underground, who claim conscientious objection status in their public sector jobs but provide the same services in their fee-paying private practices [18]. Other investigations indicate that some claim objector status because they seek to avoid being associated with stigmatized services, rather than because they truly conscientiously object [19].

Moreover, some religiously affiliated healthcare *institutions* claim objector status and compel their employees to refuse to provide legally permissible care [20,21]. The right

to conscience is generally understood to belong to an individual, not to an institution, as claims of conscience are considered a way to maintain an individual's moral or religious integrity. Some disagree, however, and argue that a hospital's mission is analogous to a conscience—identity resembling that of an individual, and “warrant[s] substantial deference” [22]. Others dispute this on the grounds that healthcare institutions are licensed by states, often receive public financing, and may be the sole providers of healthcare services in communities. Wicclair and Charo both argue that, since a license bestows certain rights and privileges on an institution [22–24], “[W]hen licensees accept and enjoy these rights and privileges, they incur reciprocal obligations, including obligations to protect patients from harm, promote their health, and respect their autonomy” [22].

There are also disputes as to whether obligations and rights vary if a provider works in the public or private sector. Public sector providers are employees of the state and have obligations to serve the public for the greater good, providing the highest “standard of care,” as codified in the laws and policies of the state [22]. The US Institute of Medicine defines standard of care as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge” and identifies safety, effectiveness, patient centeredness, and timeliness as key components [25]. WHO adds the concepts of equitability, accessibility, and efficiency to the list of essential components of quality of care [26]. There are legal precedents limiting the scope of conscientious objection for professionals who operate as state actors [23]. Some argue that such limitations can be

extended to those who provide health services in the private sector because, as state licensure grants these professions a monopoly on a public service, the professions have a collective obligation to patients to provide non-discriminatory access to all lawful services [23,27]. However, it is more difficult to identify conscience-based refusal of care in the private sector because clinicians typically have discretion over the services they choose to offer, although the same professional obligations of providing patients with accurate information and referral pertain.

An alternative framing is provided by the concept of *conscientious commitment* to acknowledge those providers whose conscience motivates them to deliver reproductive health services and who place priority on patient care over adherence to religious doctrines or religious self-interest [28,29]. Dickens and Cook articulate that conscientious commitment “inspires healthcare providers to overcome barriers to delivery of reproductive services to protect and advance women's health” [28]. They assert that, because provision of care can be conscience based, full respect for conscience requires accommodation of both objection to participation and commitment to performance of services such that the latter group of providers also have the right to not suffer discrimination on the basis of their convictions [28]. This principle is articulated by FIGO [9]; according to the FIGO “Resolution on Conscientious Objection,” “Practitioners have a right to respect for their conscientious convictions in respect both not to undertake and to undertake the delivery of lawful procedures” [30].

We begin this White Paper with a review of the limited data regarding the prevalence of conscience-based refusal of care and objectors' motivations. Descriptive prevalence data are needed in order to assess the distribution and scope of this phenomenon and it is necessary to understand the concerns of those who refuse in order to design respectful and effective responses. We review the data; point out the methodologic, geographic, and other limitations; and specify some questions requiring further investigation. Next, we explore the consequences of conscientious objection for patients and for health systems. Ideally, we would evaluate empirical evidence on the impact of conscience-based refusal on delay in obtaining care for patients and their families, society, healthcare providers, and health systems. As such research has not been conducted, we schematically delineate the logical sequence of events if care is refused.

We then look at responses to conscience-based refusal of care by transnational bodies, governments, health sector and other employers, and professional associations. These responses include establishment of criteria for obtaining objector status, required disclosure to patients, registration of objector status, mandatory referral to willing providers, and provision of emergency care. We draw upon analyses performed by others to categorize the different models used: legislative, constitutional, case law, regulatory, employment requirements, and professional standards of care. Finally, we provide recommendations for further research and for ways in which medical and public health organizations could contribute to the development and implementation of policies to manage conscientious objection.

This White Paper draws upon medical, public health, legal, ethical, and social science literature of the past 15 years in English, French, German, Italian, Portuguese, and Spanish available in 2013. It is intended to be a state-of-the-art compendium useful for health and other policymakers negotiating the balance of an individual provider's rights to "conscience" with the systemic obligation to provide care and it will need updating as further evidence and policy experiences accrue. It is intended to highlight the importance of the medical and public health perspectives, employ a human rights framework for provision of reproductive health services, and emphasize the use of scientific evidence in policy deliberations about competing rights and obligations.

2. Review of the evidence

2.1. Methods

We reviewed data regarding the prevalence of conscientious objection and the motivations of objectors in order to assess the distribution and scope of the phenomenon and to have an empirical basis for designing respectful and effective responses. However, estimates of prevalence are difficult to obtain; there is no consensus about criteria for objector status and, thus, no standardized definition of the practice. Moreover, it is difficult to assess whether findings in some studies reflect intention or actual behavior. The few countries that require registration provide the most solid evidence of prevalence.

A systematic review could not be performed because the data are limited in a variety of ways (which we describe), making most of them ineligible for inclusion in such a

process. We searched systematically for data from quantitative, qualitative, and ethnographic studies and found that many have non-representative or small samples, low response rates, and other methodologic limitations that limit their generalizability. Indeed, the studies reviewed are not comparable methodologically or topically. The majority focus on conscience-based refusal of abortion-related care and only a few examine refusal of emergency or other contraception, PND, or other elements of care. Some examine provider attitudes and practices related to abortion in general, while others investigate these in terms of the specific circumstances for which people seek the service: for example, financial reasons, sex selection, failed contraception, rape/incest, fetal anomaly, and maternal life endangerment. Some rely on closed-ended electronic or mail surveys, while others employ in-depth interviews. Most focus on physicians; fewer study nurses, midwives, or pharmacists.

These investigations are also limited geographically because more were conducted in higher-income than lower-income countries. Because of both greater resources and more liberalized reproductive health laws and policies, many higher-income countries offer a greater range of legal services and, consequently, more opportunities for objection. Assessment of the impact of conscience-based refusal of care in resource-constrained settings presents additional challenges because high costs and lack of skilled providers may dwarf this and other factors that impede access. Acknowledging that conscientious objection to reproductive healthcare has yet to be rigorously studied, we included all studies we were able to locate within the past 15 years, and present the cross-cutting themes as topics for future systematic investigation.

2.2 Prevalence and attitudes

The sturdiest estimates of prevalence come from a limited sample of those few places that require objectors to register as such or to provide written notification. 70% of OB/GYNs and 50% of anesthesiologists have registered with the Italian Ministry of Health as objectors to abortion [31]. While Norway and Slovenia require some form of registration, neither has reported prevalence data [32–34]. Other estimates of prevalence derive from surveys with varied sampling strategies and response rates. In a random sample of OB/GYN trainees in the UK, almost one-third objected to abortion [35]. 14% of physicians of varied specialties surveyed in Hong Kong reported themselves to be objectors [36]. 17% of licensed Nevada pharmacists surveyed objected to dispensing mifepristone and 8% objected to EC [37]. A report from Austria describes many regions without providers and a report from Portugal indicates that approximately 80% of gynecologists there refuse to perform legal abortions [38–40].

Other studies have investigated opinions about abortion and intention to provide services. A convenience sample of Spanish medical and nursing students indicated that most support access to abortion and intend to provide it [41]. A survey of medical, nursing, and physician assistant students at a US university indicated that more than two-thirds support abortion yet only one-third intend to provide, with the nursing and physician assistant students evincing the strongest interest in doing so [42]. The 8 traditional healers interviewed in South Africa were opposed to abortion [43], and an ethnographic study of Senegalese OB/GYNs, midwives, and nurses reported that one-

third thought the highly restrictive law there should permit abortion for rape/incest, although very few were willing to provide services (unpublished).

Some studies indicate that a subset of providers claim to be conscientious objectors when, in fact, their objection is not absolute. Rather, it reflects opinions about patient characteristics or reasons for seeking a particular service. For example, a stratified random sample of US physicians revealed that half refuse contraception and abortion to adolescents without parental consent, although the law stipulates otherwise [44]. A survey of members of the US professional society of pediatric emergency room physicians indicated that the majority supported prescription of EC to adolescents but only a minority had done so [45]. A study of the postabortion care program in Senegal, intended to reduce morbidity and mortality due to complications from unsafe abortion, found that some providers nonetheless delayed care for women they suspected of having had an induced abortion (unpublished).

Willingness to provide abortions varies by clinical context and reason for abortion, as demonstrated by a stratified random sample of OB/GYN members of the American Medical Association (AMA) [46]. A survey of family medicine residents in the USA assessing prevalence of moral objection to 14 legally available medical procedures revealed that 52% supported performing abortion for failed contraception [47]. Despite opposition to voluntary abortion, more than three-quarters of OB/GYNs working in public hospitals in the Buenos Aires area from 1998 to 1999 supported abortion for maternal health threat, severe fetal anomaly, and rape/incest [48]. While 10% of a random

sample of consultant OB/GYNs in the UK described themselves as objectors, most of this group supported abortion for severe fetal anomaly[13].

Other inconsistencies regarding refusal of care derived from the provider's familiarity with a patient, experience of stigmatization, or opportunism. A Brazilian study reported that Brazilian gynecologists were more likely to support abortion for themselves or a family member than for patients [17]. Physicians in Poland and Brazil reported reluctance to perform legally permissible abortions because of a hostile political atmosphere rather than because of conscience-based objection. The authors also noted that conscientious objection in the public sphere allowed doctors to funnel patients to private practices for higher fees [19].

Not surprisingly, higher levels of self-described religiosity were associated with higher levels of disapproval and objection regarding the provision of certain procedures [49]. Additionally, a random sample of UK general practitioners (GPs) [50], a study of Idaho licensed nurses [51], a study of OB/GYNs in a New York hospital [52], and a cross-sectional survey of OB/GYNs and midwives in Sweden [53] found self-reported religiosity to be associated with reluctance to perform abortion. A study of Texas pharmacists found the same association regarding refusal to prescribe EC [54].

Higher acceptance of these contested service components and lower rates of objection were associated with higher levels of training and experience in a survey of medical students and physicians in Cameroon and in a qualitative study of OB/GYN clinicians in

Senegal [55,56]. Similar patterns prevailed in a survey of Norwegian medical students [57] and among pharmacists and OB/GYNs in the USA [45].

Clinicians' refusal to provide elements of ART and PND also varied, at times motivated by concerns about their own lack of competence with these procedures. And, while the majority of Danish OB/GYNs and nurses (87%) in a non-random sample supported abortion and ART, 69% opposed selective reduction [49]. A random sample of OB/GYNs from the UK indicated that 18% would not agree to provide a patient with PND [13].

Several studies report institutional-level implications consequent to refusal of care. Physicians and nurse managers in hospitals in Massachusetts said that nurse objection limited the ability to schedule procedures and caused delays for patients [58]. Half of a stratified random sample of US OB/GYNs practicing primarily at religiously affiliated hospitals reported conflicts with the hospital regarding clinical practice; 5% reported these to center on treatment of ectopic pregnancy [59]. 52% of a non-random sample of regional consultant OB/GYNs in the UK said that insufficient numbers of junior doctors are being trained to provide abortions owing to opting out and conscientious objection [35]. A 2011 South African report states that more than half of facilities designated to provide abortion do not do so, partly because of conscientious objection, resulting in the persistence of widespread unsafe abortion, morbidity, and mortality [60]. A non-random sample of Polish physicians reported that institutional, rather than individual, objection was common [19]. Similar observations have been made about Slovakian hospitals [61].

A few investigations have explored clinician attitudes toward regulation of conscience-based refusal of reproductive healthcare. Two studies from the USA indicate that majorities of family medicine physicians in Wisconsin and a random sample of US physicians believe physicians should disclose objector status to patients [44,47]. A survey of UK consultants revealed that half want the authority to include abortion provision in job descriptions for OB/GYN posts, and more than one-third think objectors should be required to state their reasons [35]. Interviews with a purposive sample of Irish physicians revealed mixed opinions about the obligation of objectors to refer to other willing providers, as well as awareness that women traveled abroad for abortions and related services that were denied at home [62].

While the reviewed literature indicates widespread occurrence of conscientious objection to providing some elements of reproductive healthcare, it does not offer a rigorously obtained evidentiary basis from which to map the global landscape. Assessment of the prevalence of conscientious objection requires ascertainment of the number objecting (numerator) and the total count of the relevant population of providers comprising the denominator (e.g. the number of OB/GYNs claiming conscientious objection to providing EC and the total population of OB/GYNs). Registration of objectors, as required by the Italian Ministry of Health, provides such data. Professional societies could also systematically gather data by surveying members on their practices related to conscience-based refusal of care or by including such self-identification on standard mandatory forms. Academic institutions or other research organizations could

conduct formal studies or add questions on conscience-based refusal of care to ongoing general surveys of clinicians.

Aside from prevalence, there are a host of key questions. Further research on motivations of objectors is required in order to better understand reasons other than conscience-based objection that may lead to refusal of care. As the studies reviewed indicate, these factors may include desire to avoid stigma, to avoid burdensome administrative processes, and to earn more money by providing services in private practice rather than in public facilities; knowledge gaps in professional training; and lack of access to necessary supplies or equipment. Qualitative studies would best probe these complicated motivations.

What is the impact of conscience-based refusal of care? In the next section, we outline systemic and biologically plausible sequences of events when specified care components are refused. Research is needed to see whether these hold true and have health consequences for women and practical consequences for other clinicians and the health system as a whole. Research could illuminate women's experiences when refused care—their understanding, access to safe and unsafe alternatives, emotional response, and course of action. Investigations on the clinician side could further explore the experiences of those who do provide services after others have refused to do so. Each of these questions is likely to have context-specific answers, so research should take place in varied geopolitical settings, and the contextual nature of the findings must be made clear.

Do clinicians consider conscientious objection to be problematic? What kinds of constraints on provider behavior do clinicians consider appropriate or realistic? When enacted, have such policies or regulations been implemented? Have those implemented effectively met their purported objectives? What mechanisms of regulation do women consider reasonable? Do they perceive conscience-based refusal of care as a significant barrier to reproductive health services? Could enhanced training and updated medical and nursing school curricula devoted to reproductive health address the lack of clinical skills that contributes to refusal of care? Could further education clarify which services are permitted by law, and under which circumstances, and thus reassure clinicians sufficiently such that they provide care? Empirical evidence is essential as varied political actors try to respond to these competing concerns with policies or regulations.

3. Consequences of refusal of reproductive healthcare for women and for health systems

We lay out the potential implications of conscience-based refusal of care for patients and for health systems in 5 areas of reproductive healthcare—abortion and postabortion care, ART, contraception, treatment for maternal health risk and unavoidable pregnancy loss, and PND. Because we lack empirical data to explore the impact of conscience-based refusal of care on patients and health systems, we build logical models delineating plausible consequences if a particular component of care is refused. We

provide visual schemata to represent these pathways and we use data and examples of refusal from around the world to ground them.

We attempt to isolate the impact of conscientious objection for each of the 5 reproductive health components, although we recognize the difficulties of identifying the contributions attributable to other barriers to access. These include limited resources, inadequate infrastructure, failure to implement policies, sociocultural practices, and inadequate understanding of the relevant law by providers and patients alike.

We start from the premise that refusal of care leads to fewer clinicians providing specific services, thereby constraining access to these services. We posit that those who continue to provide these contested services may face stigma and/or become overburdened. We specify plausible health outcomes for patients, as well as the consequences of refusal for families, communities, health systems, and providers.

3.1. Conscience-based refusal of abortion-related services

The availability of safe and legal abortion services varies greatly by setting. Nearly all countries in the world allow legal abortion in certain cases (e.g. to save the life of the woman, in cases of rape, and in cases of severe fetal anomaly). Few countries prohibit abortion in all circumstances. While some among these allow the criminal law defense of necessity to permit life-saving abortions, Chile, El Salvador, Malta, and Nicaragua restrict even this recourse. Other countries with restrictive laws are not explicit or clear about those circumstances in which abortion is allowed [63].

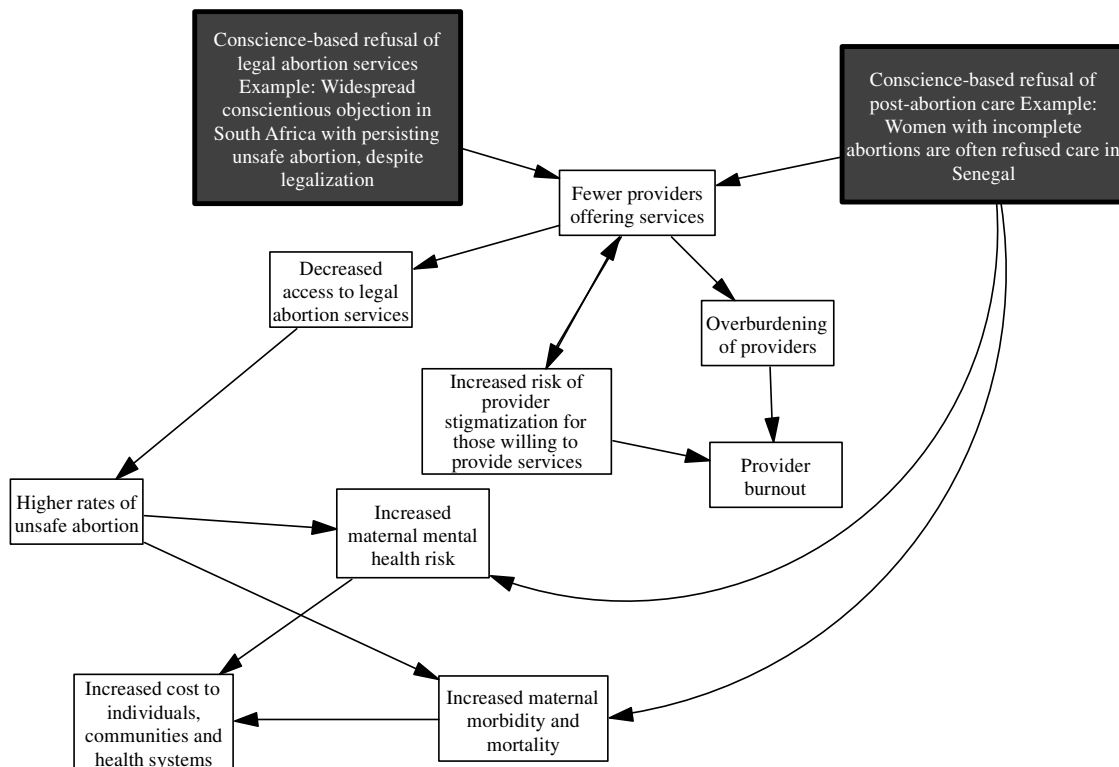
In many countries, particularly in low-resource areas, access to legal services is compromised by lack of resources for health services, lack of health information, inadequate understanding of the law, and societal stigma associated with abortion [64].

There is substantial evidence that countries that provide greater access to safe, legal abortion services have negligible rates of unsafe abortion [65]. Conversely, nearly all of the world's unsafe abortions occur in restrictive legal settings. Where access to legal abortion services is restricted, women seek services under unsafe circumstances. Approximately 21.6 million of the world's annual 46 million induced abortions are unsafe, with nearly all of these (98%) occurring in resource-limited countries [65,66]. In low-income countries, more than half of abortions performed (56%) are unsafe, compared with 6% in high-income areas [66]. Nearly one-quarter (more than 5 million) of these result in serious medical complications that require hospital-based treatment [67,68]; 47 000 women die each year because of unsafe abortion and an additional unknown number of women experience complications from unsafe abortions but do not seek care [68]. While the international health community has sought to mitigate the high rates of maternal morbidity and mortality caused by unsafe abortion through postabortion care programs [56], the implementation and effectiveness of these have been undermined by conscience-based refusal of care [24,56,69].

We posit that conscience-based refusal of care will have less of an impact at the population level in countries with available safe, legal abortion services than in those

where access is restricted. Women living in settings in which legal abortion is widely available and who experience provider refusal will be more likely to find other willing providers offering safe, legal services than women in settings in which abortion is more highly restricted. We ground our model (Figure 1) in the following examples: (1) in South Africa, widespread conscientious objection limits the numbers of willing providers and, thus, access to safe care, and the number of unsafe abortions has not decreased since the legalization of abortion in 1996 [70, 71]; (2) although Senegal’s postabortion care program is meant to mitigate the grave consequences of unsafe abortion, conscientious objection is, nevertheless, often invoked when abortion is suspected of being induced rather than spontaneous (unpublished data) [56].

Fig. 1. Consequences of Refusal of Abortion-related Services.



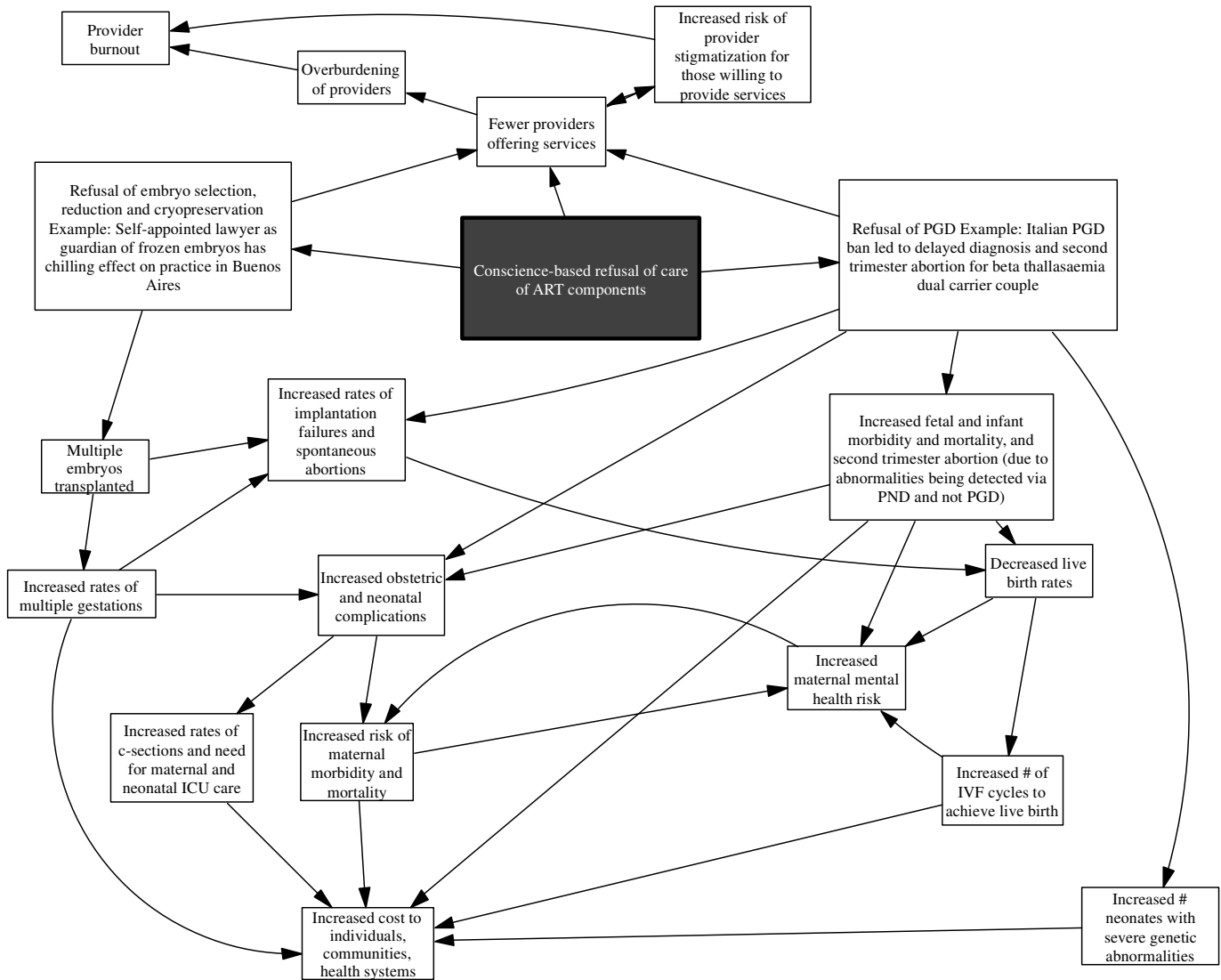
3.2. Conscience-based refusal of components of ART

Infertility is a global public health issue affecting approximately 8%–15% of couples [72,73] or 50–80 million people [74], worldwide. Although the majority of those affected reside in low-resource countries [72,73], the use of ART is much more likely in high-resource countries.

Access to specific ART varies by socioeconomic status and geographic location, between and within countries. In high-resource countries, the cost of treatment varies greatly depending on the healthcare system and the availability of government subsidy [75]. For example, in 2006, the price of a standard in vitro fertilization (IVF) cycle ranged from US \$3956 in Japan to \$12,513 in the USA [76]. After government subsidization in Australia, the cost of IVF averaged 6% of an individual's annual disposable income; it was 50% without subsidization in the USA [77]. In low-income countries, despite high rates of infertility, there are few resources available for ART, and costs are generally prohibitive for the majority of the population. Because these economic and infrastructural factors drive lack of access to ART in low-income countries, we posit that denial of services owing to conscience-based refusal of care is not a major contributing factor to limited access in these settings. Therefore, for the model (Figure 2), we primarily examine the consequences of conscientious objection to components of ART in middle- to high-income countries. At times, regulations and policies regarding ART stem from empirically based concerns, grounded in medical evidence, about health outcomes for women and their offspring or health system priorities. Our focus, however,

is on those instances in which some physicians practice according to moral or religious beliefs, even when these contradict best medical practices. In some Latin American countries, despite the medical evidence that maternal and fetal outcomes are markedly superior when fewer embryos are implanted, the objection to embryo selection/reduction and cryopreservation promoted by the Catholic Church has reportedly led many physicians to avoid these [78]. Anecdotal reports from Argentina describe ART physicians' avoidance of cryopreservation and embryo selection/reduction following the self-appointment of a lawyer and member of Opus Dei as legal guardian for cryopreserved embryos [78,79]. The only example that illustrates the implications of denial of preimplantation genetic diagnosis (PGD) refers to a legal ban, rather than conscience-based refusal of care. Nonetheless, we use it to describe the potential consequences when such care is denied. In 2004, Italy passed a law banning PGD, cryopreservation, and gamete donation [80]. This ban compelled a couple who were both carriers of the gene for β -thalassemia to wait to undergo amniocentesis and then to have a second-trimester abortion rather than allow the abnormality to be detected prior to implantation [80] (Figure 2).

Fig. 2. Consequences of Refusal of Components of Assisted Reproductive Technologies.



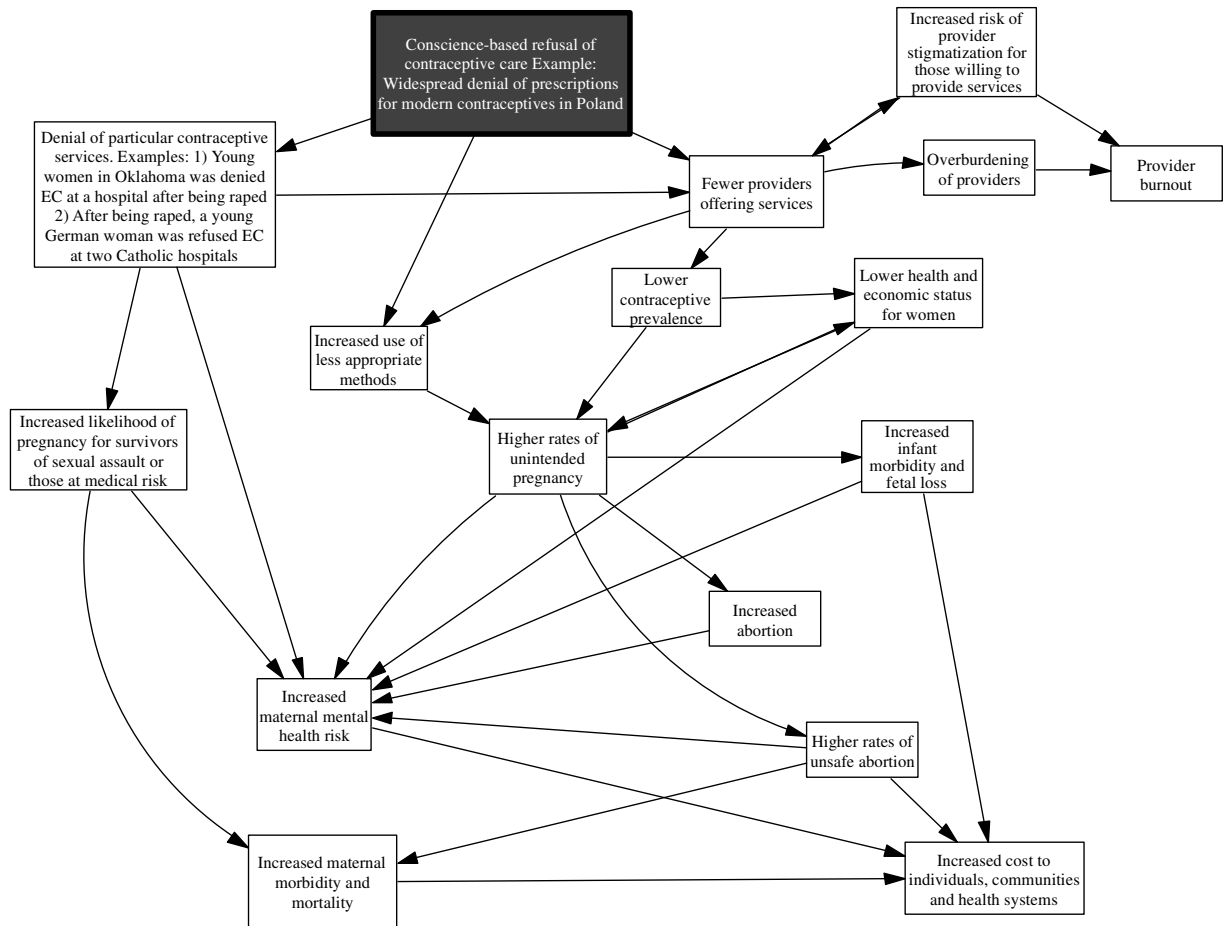
3.3. Conscience-based refusal of contraceptive services

The availability of the range of contraceptive methods varies by setting, as does prevalence of use [81]. In general, contraceptive use is correlated with level of income. In 2011, 61.3% of women aged 15–49 years, married or in a union, in middle–upper-

income countries were using modern methods, compared with 25% in the lowest-resource countries [81,82]. Within countries, access to and use of methods also vary. For example, according to the 2003 Demographic and Health Survey of Kenya (a cross-sectional study of a nationally representative sample), women in the richest quintile were reported to have significantly higher odds for using long-term contraceptive methods (intrauterine device, sterilization, implants) than women in the poorest quintile [82].

The legal status of particular contraceptive methods also varies by setting. In Honduras, Congress passed a bill banning EC, which has not yet been enacted into law [83]. Even when contraception is legal, lack of basic resources allocated by government programs may compromise availability of particular methods. High manufacturing costs or steep prices can also undermine access [84]. In other cases, individual health providers opt not to provide contraception to all or to certain groups of women. Some providers refuse to provide specific methods such as EC or sterilization. In Poland, there is widespread refusal to provide contraceptive services (Personal communication with J Mishtal, April 2012.). In Oklahoma, a rape victim was denied EC by a doctor [85], and in Germany a rape victim was denied EC by 2 Catholic hospitals in 2012 [86]. In Figure 3, we delineate potential implications of conscience-based refusal of contraceptive services.

Fig. 3. Consequences of Refusal of Contraceptive Services.

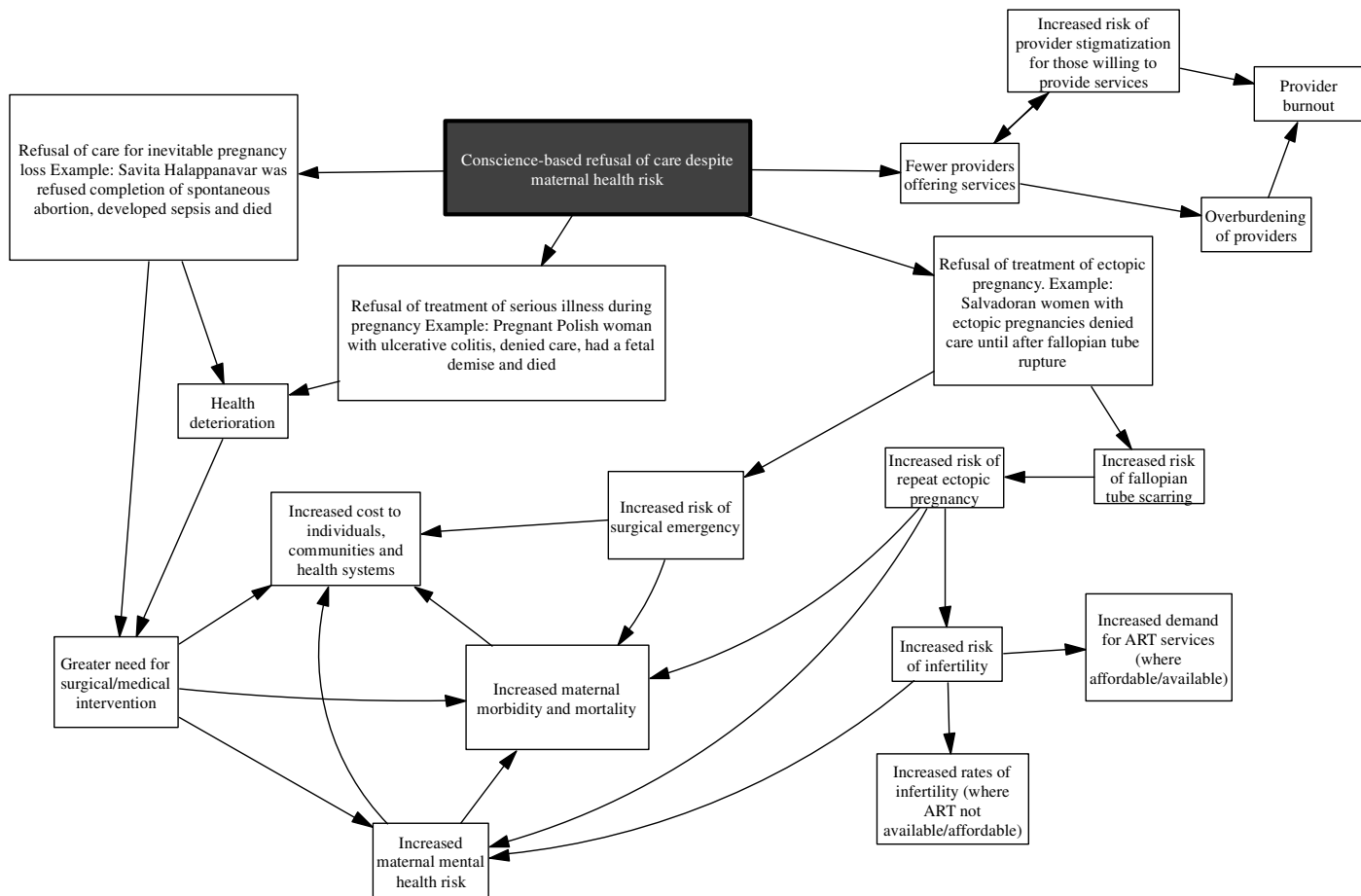


3.4. Conscience-based refusal of care in cases of risk to maternal health and unavoidable pregnancy loss

In some circumstances, pregnancy can exacerbate a serious maternal illness or maternal illness may require treatment hazardous to a fetus. In these cases, women require access to life-saving treatment, which may include abortion. Yet women have been denied appropriate treatment. Women seeking completion of inevitable pregnancy loss due to ectopic pregnancy or spontaneous abortion have also been denied necessary care.

It is beyond the scope of the present White Paper to define the full range of conditions that may be exacerbated by pregnancy and jeopardize the health of the pregnant woman. However, the incidence of ectopic pregnancy ranges from 1% to 16% [87-90], and 10%–20% of all clinically recognized pregnancies end in spontaneous abortion [90]. Often, refusal of care in circumstances of maternal health risk occurs in the context of highly restrictive abortion laws. We refer to 3 cases from around the world (Figure 4) to highlight this phenomenon in our model. In Ireland in 2012, Savita Halappanavar, 31, presented at a Galway hospital with ruptured membranes early in the second trimester. She was refused completion of the inevitable spontaneous abortion, developed sepsis, and subsequently died [91]. Z's daughter, a young Polish woman, was diagnosed with ulcerative colitis while she was pregnant [92]. She was repeatedly denied medical treatment; physicians stated that they would not conduct procedures or tests that might result in fetal harm or termination of the pregnancy [92]. She developed sepsis, experienced fetal demise, and died. The only example that illustrates the implications of denial of treatment for ectopic pregnancy derives from legal bans, rather than from an example of conscience-based refusal of care. In El Salvador, a total prohibition on abortion has led to physician refusal to treat ectopic pregnancy [93]; in Nicaragua, the abortion ban results in delay of treatment for ectopic pregnancies, despite law and medical guidelines mandating the contrary [94] (Figure 4).

Fig. 4. Consequences of Refusal of Care in Cases of Risk to Maternal Health and Unavoidable Pregnancy Loss.

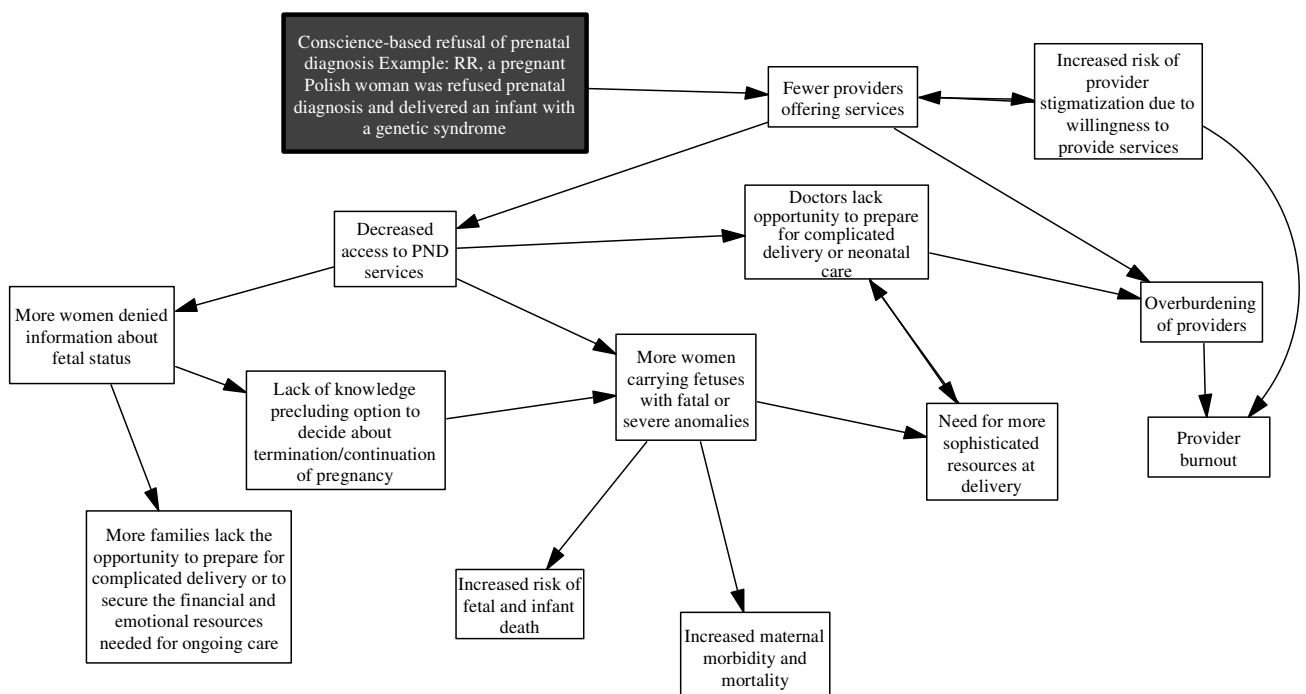


3.5. Conscience-based refusal of PND

The availability of PND varies greatly by setting—with those in middle–upper-income countries having access to testing for a variety of genetic conditions and structural anomalies, and fewer having access to a more limited series of testing in low-income countries. Access to PND provides women with information so that they can make decisions and/or preparations when severe or lethal fetal anomalies are detected. Outcomes for affected neonates vary by country resource level; PND enables physicians to plan for the level of care needed during delivery and in the neonatal

period. With PND, families are also afforded the time to secure the necessary emotional and financial resources to prepare for the birth of a child with special needs [95,96]. In settings in which there are fewer resources available for PND, conscientious objection further restricts women's access to services. Figure 5 presents pathways and implications of provider conscience-based refusal to provide PND services. Because most data on access to PND are from high-resource countries, we must project what would happen in lower-income countries. We use the example of *RR*, a Polish woman who was repeatedly refused diagnostic tests to assess fetal status after ultrasound detection of a nuchal hygroma [97] (Figure 5).

Fig. 5. Consequences of Refusal of Prenatal Diagnosis.



4. Policy responses to manage conscience-based refusal of reproductive healthcare

Here, we review various policy interventions related to conscience-based refusal of care. Initially, we look at the context established by human rights standards or human rights bodies wherein freedom of conscience is enshrined. The Committee on Economic, Social and Cultural Rights (CESCR); the Committee on the Elimination of Discrimination against Women (CEDAW); and the UN Human Rights Committee have commented on the need to balance providers' rights to conscience with women's rights to have access to legal health services [98-104]. CEDAW asserts that "it is discriminatory for a country to refuse to legally provide for the performance of certain reproductive health services for women" and that, if healthcare providers refuse to provide services on the basis of conscientious objection, "measures should be introduced to ensure that women are referred to alternative health providers" [99]. CESCR has called on Poland to take measures to ensure that women enjoy their rights to sexual and reproductive health, including by "enforcing the legislation on abortion and implementing a mechanism of timely and systematic referral in the event of conscientious objection" [104].

The international medical and public health communities, including FIGO in its Ethical Guidelines on Conscientious Objection (2005) [9] and WHO in its updated Safe Abortion Guidelines (2012) [105] have agreed on principles related to the management of conscientious objection to reproductive healthcare provision. While these are non-

binding recommendations, they do assert professional standards of care. These include the following:

- Providers have a right to conscientious objection and not to suffer discrimination on the basis of their beliefs.
- The primary conscientious duty of healthcare providers is to treat, or provide benefit and prevent harm to patients; conscientious objection is secondary to this primary duty.

Moreover, the following safeguards must be in place in order to ensure access to services without discrimination or undue delays:

- Providers have a professional duty to follow scientifically and professionally determined definitions of reproductive health services, and not to misrepresent them on the basis of personal beliefs.
- Patients have the right to be referred to practitioners who do not object for procedures medically indicated for their care.
- Healthcare providers must provide patients with timely access to medical services, including giving information about the medically indicated options of procedures for care, including those that providers object to on grounds of conscience.
- Providers must provide timely care to their patients when referral to other providers is not possible and delay would jeopardize patients' health.
- In emergency situations, providers must provide the medically indicated care, regardless of their own personal objections.

These statements support both sides of the tension: the right of patients to have access to appropriate medical care and the right of providers to object, for reasons of conscience, to providing particular forms of care. They underscore the professional obligation of healthcare providers to ensure timely access to care, through provision of accurate information, referral, and emergency care. At the transnational level, human rights consensus documents have asserted that institutions and individuals are similarly bound by their obligations to operate according to the bedrock principles that underpin the practice of medicine, such as the obligations to provide patients with accurate information, to provide care conforming to the highest possible standards, and to provide care in emergency situations.

At the country level, however, there is no agreement as to whether institutions can claim objector status. For example, Spain [106], Colombia [107], and South Africa [108] have laws stating that refusal to perform abortions is always an individual, not an institutional, decision. Conversely, Argentinian law [109,110] gives private institutions the ability to object and requires private health centers to register as conscientious objectors with local health authorities. In Uruguay, the Ethical Code does not require the institution employing a conscientious objector to provide referral services, although a newly proposed bill would require such referral [111,112]. In the USA, the question of institutional rights and obligations is hotly debated and the situation is complicated and unresolved. Currently, federal law forbids agencies receiving federal funding from discriminating against any healthcare entity that refuses to provide abortion services

[113]. Yet other federal law requires institutions providing services for low-income people to maintain an adequate network of providers and to guarantee that individuals receive services without additional out-of-pocket cost [114].

International and regional human rights bodies, governments, courts, and health professional associations have developed various responses to address conscience-based refusal of care. These responses differ as to whose rights they protect: the rights of a woman to have access to legal services or the rights of a provider to object based on reasons of conscience. They might also have different emphases or targets. Some focus on ensuring an adequate number of providers for a certain service, some concentrate on ensuring that women receive timely referrals to non-objecting practitioners, and some seek to establish criteria for designation as an objector. For example, Norway established a comprehensive regulatory and oversight framework on conscientious objection to abortion, which includes ensuring the availability of providers [33,115]. In Colombia, the Constitutional Court affirmed that conscientious objection must be grounded in true religious conviction, rather than in a personal judgment of “rightness” [116].

Some of these responses are legally binding through national constitutional provisions, legislation, or case law. The European Court of Human Rights (ECHR), whose rulings are legally binding for member nations, clarified the obligation of states to organize the practice of conscience-based refusal of care to ensure that patients have access to legal services, specifically to abortion [97]. Professional associations and employers

have developed other interventions, including job requirements and non-binding recommendations. In Germany, for example, a Bavarian High Administrative Court decision [117], upheld by the Federal Administrative Court [118], ruled that it was permissible for a municipality to include ability and willingness to perform abortions as a job criterion. In Norway, employers can refuse to hire objectors and employment advertisements may require performance of abortion as a condition for employment [112]. In Sweden, Bulgaria, Czech Republic, Finland, and Iceland, healthcare providers are not legally permitted to conscientiously object to providing abortion services [38]. Some require referral to non-objecting providers. For example, in the recent *P and S v. Poland* case, the ECHR emphasized the need for referrals to be put in writing and included in patients' medical records [119]. In Argentina [110] and France [120], legislation requires doctors who conscientiously object to refer patients to non-objecting practitioners. Similar laws exist in Victoria, Australia [121], Colombia [116,122,123], Italy [124], and Norway [115]. Professional and medical associations around the world recommend that objectors refer patients to non-objecting colleagues. ACOG in the USA [125] and El Sindicato Medico in Uruguay [126] recommend that objectors refer patients to other practitioners. The British Medical Association (BMA) specifies that practitioners cannot claim exemption from giving advice or performing preparatory steps (including referral) where the request for an abortion meets legal requirements [127]. The WMA asserts that, if a physician must refuse a certain service on the basis of conscience, s/he may do so after ensuring the continuity of medical care by a qualified colleague [128]. FIGO maintains that patients are entitled to referral to practitioners who do not object [9].

Pharmacists' associations in the USA and UK have made similar recommendations. The American Society of Health-System Pharmacists asserts that pharmacists and other pharmacy employees have the right not to participate in therapies they consider to be morally objectionable but they must make referrals in an objective manner [129]; the AMA guidelines state that patients have the right to receive an immediate referral to another dispensing pharmacy if a pharmacist invokes conscientious objection [130]. In the UK, pharmacists must also have in place the means to make a referral to another relevant professional within an appropriate time frame [131].

Some jurisdictions mandate registration of objectors or require objectors to provide advance written notice to employers or government bodies. In Spain, for example, the law requires that conscientious objection must be expressed in advance and in written form to the health institution and the government [106]. Italian law also requires healthcare personnel to declare their conscientious objection to abortion to the medical director of the hospital or nursing home in which they are employed and to the provincial medical officer no later than 1 month after date of commencement of employment [124]. Victoria, Australia [118]; Colombia [123]; Norway [115]; Madagascar [132]; and Argentina [109] have similar laws. In Norway, the administrative head of a health institution must inform the county municipality of the number of different categories of health personnel who are exempted on grounds of conscience [115]. Argentinian law [109] gives private institutions the ability to object, requiring these institutions to register as conscientious objectors with local health authorities and to guarantee care by

referring women to other centers. Argentinian law also states that an individual objector cannot provide services in a private health center that s/he objects to the provision of in the public health system [110]. Regulation in Canada requires pharmacists to ensure that employers know about their conscientious objector status and to prearrange access to an alternative source for treatment, medication, or procedure [133]. The Code of Ethics for nurses in Australia also requires disclosure to employers [134]. In Northern Ireland, a guidance document by the Department of Health, Social Services and Public Safety asserts that an objecting provider “should have in place arrangements with practice colleagues, another GP practice, or a Health Social Care Trust to whom the woman can be referred” for advice or assessment for termination of pregnancy [135].

Other measures require disclosure to patients about providers’ status as objectors. For example, the law in the state of Victoria, Australia, requires objectors to inform the woman and refer her to a willing provider [121]. In Argentina, the Technical Guide for Comprehensive Legal Abortion Care 2010 [109] requires that all women be informed of the conscientious objections of medical, treating, and/or support staff at first visit.

Portugal’s medical ethical guidelines encourage doctors to communicate their objection to patients [136].

The right to receive information in healthcare, including reproductive health information, is enshrined in international law. For example, the ECHR determined that denial of services essential to making an informed decision regarding abortion can constitute a violation of the right to be free from inhuman and degrading treatment [97]. At the

national level, laws have mandated disclosure of health information to patients. For example, according to the South African abortion law, providers, including objectors, must ensure that pregnant women are aware of their legal rights to abortion [108]. In Spain, women are entitled to receive information about their pregnancies (including prenatal testing results) from all providers, including those registered as objectors [106]. In the UK, objectors are legally required to disclose their conscientious objector status to patients, to tell them they have the right to see another doctor, and to provide them with sufficient information to enable them to exercise that right [137-139].

Professional guidelines have also addressed disclosure of health information. In Argentina, any delaying tactics, provision of false information, or reluctance to carry out treatment by health professionals and authorities of hospitals is subject to administrative, civil, and/or criminal actions [109]. FIGO asserts that the ethical responsibility of OB/GYNs to prevent harm requires them to provide patients with timely access to medical services, including giving them information about the medically indicated options for their care [9].

Some require the provision of services in cases of emergency. For example, legislation in Victoria, Australia [121]; Mexico City [140]; Slovenia [141]; and the UK [138] stipulates that physicians may not refuse to provide services in cases of emergency and when urgent termination is required. US case law determined that a private hospital with a tradition of providing emergency care was still obliged to treat anyone relying on it even after its merger with a Catholic institution. This sets the standard for continuity of

access after mergers of 2 hospitals with conflicting philosophies [142]. Also, ACOG urges clinicians to provide medically indicated care in emergency situations [125]. In Argentina, technical guidelines from the Ministry of Health stipulate that institutions must provide termination of pregnancy through another provider at the institution within 5 days or immediately if the situation is urgent [109]. In the UK, medical standards also prohibit conscience-based refusal of care in cases of emergency for nurses and midwives [143].

Other measures address the required provision of services when referral to an alternative provider is not possible. In Norway, for example, a doctor is not legally allowed to refuse care unless a patient has such reasonable access [115]. FIGO recommends that “practitioners must provide timely care to their patients when referral to other practitioners is not possible and delay would jeopardize patients' health and well being, such as by patients experiencing unwanted pregnancy” [9].

Some interventions obligate the state to ensure services. In Colombia, for example, the health system is responsible for providing an adequate number of providers, and institutions must provide services even if individuals conscientiously object [107]. The law on voluntary sterilization and vasectomies in Argentina obligates health centers to ensure the immediate availability of alternative services when a provider has objected [144]. In Spain, the government will pay for transportation to an alternative willing public health facility [106]. Italian law requires healthcare institutions to ensure that women have access to abortion; regional healthcare entities are obliged to supervise and

ensure such access, which may include transferring healthcare personnel [125]. In Mexico City, the public health code was amended to reinforce the duty of healthcare facilities to make abortion accessible, including their responsibility to limit the scope of conscientious objection [140].

Some measures specify which service providers are eligible to refuse and when they are allowed to do so. In the UK, for example, auxiliary staff are not entitled to conscientiously object [145,146]. According to the BMA guidelines, refusal to participate in paperwork or administration connected with abortion procedures lies outside the terms of the conscientious objection clause [127]. In Spain, only health professionals directly involved in termination of pregnancy have the right to object, and they must provide care to the woman before and after termination of pregnancy [106]. Similarly, doctors in Italy are legally required to assist before and after an abortion procedure even if they opt out of the procedure itself [124]. Also, medical guidelines in Argentina encourage practitioners to aid before and after legal abortion procedures even if they are invoking conscientious objection to participation in the procedure itself [109]. During the Bush administration, the US Department of Health and Human Services extended regulatory “conscience protections” to any individual peripherally participating in a health service [147]. This regulation was contested vigorously and retracted almost fully in February 2011 [148,149].

In Table 1 (below), we lay out some benefits and limitations of policy responses to conscientious objection in order to provide varied actors with a menu of possibilities. As

criteria are developed for invoking refusal, it is essential to address the questions of who is eligible to object, and to the provision of which services. We have added the categories of “data” and “standardization” as parameters in the table in recognition of the scant evidence available and the resulting inability to methodically assess the scope and efficacy of interventions. Selection of the various options delineated below will be influenced by the specific sociopolitical and economic context.

5. Conclusion

Refusal to provide certain components of reproductive healthcare because of moral or religious objection is widespread and seems to be increasing globally. Because lack of access to reproductive healthcare is a recognized route toward adverse health outcomes and inequalities, exacerbation of this through further depletion of clinicians constitutes a grave global health and rights concern. The limited evidence available indicates that objection occurs least when the law, public discourse, provider custom, and clinical experience all normalize the provision of the full range of reproductive healthcare services and promote women’s autonomy. While data on both the prevalence of conscience-based refusal of care and the consequences for women’s health and health system function are inadequate, they indicate that refusal is unevenly distributed; that it may have the most severe impact in those parts of the world least able to sustain further personnel shortages; and that it also affects women in more privileged circumstances.

This White Paper has laid out the available data and outlined research questions for further management of conscience-based refusal of care. It presents logical chains of consequences when refusal compromises access to specific components of reproductive healthcare and categorizes efforts to balance the claims of objectors with the claims of both those seeking healthcare and the systems obligated to provide these services. We highlight the claims of those whose conscience compels them to provide such care, despite hardship. As our emphasis is on medicine and science, we close by considering ways for medical professional and public health societies to develop and implement policies to manage conscientious objection.

One recommendation is to standardize a definition of the practice and to develop eligibility criteria for designation as an objector. Such designation would have accompanying obligations, such as disclosure to employers and patients, and duties to refer, to impart accurate information, and to provide urgently needed care. Importantly, professional organizational voices can uphold conformity with standards of care as the priority professional commitment of clinicians, thus eliminating refusal as an option for the care of ectopic pregnancy, inevitable spontaneous abortion, rape, and maternal illness. In sum, medical and public health professional organizations can establish a clinical standard of care for conscientious objection, to which clinicians could be held accountable by patients, medical societies, and health and legal systems.

There are additional avenues for professional organizations to explore in upholding standards. Clinical specialty boards might condition certification upon demonstration of

proficiency in specific services. Clinical educators could ensure that trainees and members are educated about relevant laws and clinical protocols/procedures. Health systems may consider willingness to provide needed services and proficiency as criteria for employment. These last are noteworthy because they also move us from locating the issue at the individual level to consideration of obligations at the professional and health system levels.

These issues are neither simple nor one-sided. Conscience and integrity are critically important to individuals. Societies have the complicated task of honoring the rights of dissenters while also limiting their impact on other individuals and on communities. Although conscientious objection is only one of many barriers to reproductive healthcare, it is one that medical societies are well positioned to address because providers are at the nexus of health and rights concerns. They have the unique vantage point of caring simultaneously about their own conscience and about their obligations to patients' health and rights and to the highest standards of evidence-based care. This White Paper has disentangled the range of implications for women's health and rights, health systems, and objecting and committed providers. Thus, it equips clinicians and their professional organizations to contribute a distinct medical voice, complementary to those of lawyers, ethicists, and others. We urge medical and public health societies to assert leadership in forging policies to balance these competing interests and to safeguard reproductive health, medical integrity, and women's lives.

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Conflict of interest

The authors have no conflicts of interest.

Table 1 Benefits and limitations of policy interventions

Option	Health system needs	Timely access to care	Balancing rights and obligations	Developing criteria for refusers	Standardization	Data needs
Referral to willing and accessible providers	Enables system planning for service delivery	Expedites patients' access to services	Upholds patients' rights to health-related information; providers' obligations to provide information and make refusal transparent; individual conscience	Establishes obligations of those claiming objector status while acknowledging legitimacy of objection	Policies and procedures for disclosure and referral standardized throughout health system	Provides indirect data on patients' encounters with refusal
Registration of objectors/written notice to employers	Informs on prevalence of objection, enabling system planning for service delivery	Leads to more timely access to care for women who can avoid seeking care from known objectors	Acknowledges provider right to object while informing patients. Requirement of formal documentation acknowledges health system stake in such knowledge	Delineates the specific instances in which objection is permitted, and by whom; formal notification of employers makes explicit the criteria for designation as an objector	Ensures that requirements for designation as objector are standardized throughout the health system	Registries provide data on prevalence by type of provider as well as component of care refused
Required disclosure of objector status to patients	Enables women to avoid unproductive visits to	Women go directly to willing provider	Acknowledges provider right to object while upholding patients' rights to	Defines obligations of objectors	Standardizes information provided to patients	N/A

	objectors and delayed care, promoting smoother functioning of system		autonomy and health-related information			
Required information to patients about available health options	Informed patients are better able to make decisions and to locate the services that they need	Facilitates patient access to appropriate care	Upholds patients' rights to obtain health-related information; underscores providers' obligations to provide accurate information and to inform about legally available options; asserts health system's commitment to science and to patients' rights	Limits scope of objection by specifying components of care individuals obligated to provide	Standardizes information to patients about health system's range of available services	N/A
Mandated provision of services in urgent situations or when no alternative exists	Facilitates planning for provision of emergency care and for associated policies, procedures, and oversight; ensures that	Provides critical care in a timely fashion	Obligations of the provider to operate in the best interests of patients and to provide appropriate care take precedence over the individual	Sets limits on the scope of refusal to protect patients in emergency situations	Ensures that objectors adhere to contractual obligations to provide essential and/or life-saving care	Contributes to the ability to track urgent cases and to plan service provision needs

	medical sequelae of denial or delay of care are minimized		clinician's right to object			
Willingness to provide and proficiency as criteria for employment	Underscores employers' needs to ensure sufficient number of providers to meet demand for specific services	Staff competency and willingness enable ready and timely access to appropriate care	Health systems' needs to employ proficient and willing providers to respond to the health needs of the community trump provider rights to object; providers free to adhere to conscience by choosing other employment	Limits objection because only those willing and trained are eligible for employment	Standardizes such requirements in job postings throughout health system	Tracks the number of proficient and willing candidates seeking employment
Medical certification contingent upon proficiency in specific services	Improves health system-level planning for service delivery by assuring that providers are proficient in needed services	Availability of trained providers facilitates timely access to care	Establishes that objectors have the right to choose other specialties, but not to refuse essential components of a specialty; ensures patient rights to receive appropriate services from providers	Clarifies that specialist objectors must be trained and ready to provide care in emergency situations or when other options not available	Specialty certification guarantees mastery of a set of skills and compliance with explicit obligations	Tracks number of providers certified and, therefore, proficient, thus facilitating planning

designated as
specialists;
defines and
safeguards
professional
standards

Delineates the
rights and
obligations of
providers and
the rights of
patients

Suggests criteria
for designation
as objector and
associated
obligations

Asserts standards
of care

N/A

Medical society
guidelines delineating
expected standards of
care

Recommends
that priority go
to patient
receipt of care
and to
prevention of
shortages of
willing and
qualified
providers;
guidelines may
lack
mechanisms
for
implementation

Recommends
policies and
procedures to
ensure timely
access to care
but may lack
force

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