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Conscious Oppression: Conscientious Objection in the Sphere of Sexual and Reproductive Health[1]

Marcelo Alegre

1. Introduction

Although for centuries conscientious objection was primarily claimed by those who for religious or ethical reasons refused to join the ranks of the military (whether out of a general principle or in response to a particular violent conflict), in recent decades a significant broadening of the concept can be seen. In Thailand, for example, doctors recently refused medical attention to injured policemen suspected of having violently repressed a demonstration. In Argentina a few public defenders have rejected for conscientious reasons to represent individuals accused of massive human rights violations. In different countries all over the world there are doctors who refuse to perform euthanasia, schoolteachers who reject to teach the theory of evolution, and students who refuse to attend biology classes where frogs are dissected.

In this piece I will focus my attention on an area where people are making increasingly frequent claims of conscientious objections to excuse themselves from legal obligations: the field of sexual and reproductive rights, particularly the case in Argentina.[2] Various providers (doctors,

[1]I wish to express heartfelt thanks to Gloria Orrego for her very valuable research assistance and to Paola Bergallo for illuminating discussions. I benefited from discussions of previous drafts of the paper at the *Sociedad Argentina de Análisis Filosófico* (in the context of the *Proyecto UBACYT* directed by Florencia Luna), at the *Seminario Jurídico de la Universidad de Palermo,* at the *Seminario de Teoría Constitucional* led by Roberto Gargarella at the *Facultad de Derecho de la Universidad de Buenos Aires*, at a debate organized by the Di Tella University Law School coordinated by Martín Hevia, and of course for the discussions at SELA. I appreciate the comments and suggestions of José Julián Alvarez-González, Roberto Aponte, Lucas Arrimada, Nélida Barros Pacheco de Espiño, Antonio Bascuñán, Gustavo Beade, Robert Burt, Javier Couso, Mario De Antoni, Sebastián Elías, Mariano Fernández Valle, Marcelo Ferrante, Leonardo Filippini, Lucas Grosman, Isabel Cristina Jaramillo, Santiago Legarre, Julieta Lemaitre, Alejandro Lombán, Julieta Manterola, Daniel Markovits, Ignacio Mastroleo, Agustina Ramón Michel, Robert Post, Julio Rivera, Eduardo Rivera López, Carol Rose, Reva Siegel, Ezequiel Spector, and Kenji Yoshino.

[2]Among the works consulted for this piece, some that stand out are: Lidia Casas "La objeción de conciencia en salud sexual y reproductiva. Una ilustración a partir del caso chileno", en *Más Allá del Derecho,* L. Cabal y C. Motta

pharmacists, etc) use the protection of conscientious objection in order to deny providing services such as information on contraception or legal abortions, prescribing or dispensing contraception (including emergency contraception), performing tubal ligation or vasectomies, or carrying out lawful abortions. Occasionally, some health professionals and pharmacists even refuse to provide information on alternatives whose access for patients and clients is guaranteed by legislation. Some go further yet, refusing to refer patients to doctors who do not object to performing the service. Such cases are frequent in Argentina although few make it to the newspaper headlines as did the case of a mentally handicapped rape victim from the province of Entre Ríos who, despite benefiting from a court ruling in her province authorizing the interruption of her pregnancy, was not able to obtain through the provincial health system a legal abortion because of the lack of doctors willing to perform it. The National Health Secretary was obliged to have the woman transported to another province for the abortion to be carried out.[3]

(Comps.), Red Alas, Siglo del Hombre, 2006, Bernard M. Dickens "Conscientious Objection: A Shield or a Sword?" en *First Do No Harm. Law Ethics and Healthcare,* Sheila A.M. McLean (Ed.), pp. 337-51, Katherine A. White, "Crisis of Conscience: Reconciling Religious Health Care, Providers' Beliefs and Patient Rights" en *Stanford Law Review, Vol. 51, No. 6 (Jul., 1999), pp. 1703-49,*Rebecca Dresser, "Professionals, Conformity, and Conscience", en *Hastings Center Report*, Noviembre-Diciembre 2005 pp. 9-10, Julie Cantor y Ken Baum, "The Limits of Conscientious Objection—May Pharmacists Refuse to Fill Prescriptions for Emergency Contraception?" en *The New England Journal of Medicine,* pp. 2008-12, Rebecca Cook, "Accommodating Women´s Differences Under the Women´s Anti-discrimination Convention" *Emory Law Journal*, Vol. 56 No. 1, pp. 1040-91, Rebecca Cook, y Bernard M. Dickens, "The Growing Abuse of Conscientious Objection", en *Virtual Mentor,* Mayo 2006, Vol 8., pp. 337-40, y "Human Rights Dynamics of Abortion Law Reform", en *Human Rights Quarterly* 25 (2003), pp. 1-59, R. Alta Charo, "The Celestial Fire of Conscience—Refusing to Deliver Medical Care", en *The New England Journal of Medicine, 352;24, June 16, 2005, pp. 2471-74*. Regarding considerations which are relevant in the developing world, see Louis-Jacques Van Bogaert, "The Limits of Conscientious Objection in the Developing World" in *Developing World Bioethics,* Vol. 2, N. 2, 2002, pp. 131-143.

[3] "Le practicaron el aborto a la chica discapacitada de Entre Ríos que fue violada" Clarín, 24/9/2007. Cantor and Baum inform us that in Texas a pharmacist refused to dispense emergency contraception to a rape victim who had a doctor's prescription. Julie Cantor and Ken Baum, "The Limits of Conscientious Objection-May Pharmacists Refuse to Fill Prescriptions for Emergency Contraception?" *The New England Journal of Medicine* 351;19, 4/11/2004, n.9. Allison Grady describes the case of a married woman, mother of 4 who tried to buy the Morning-After pill in a pharmacy in Wisconsin. The pharmacist denied her the product and refused to return her the prescription. "Legal Protection for Conscientious Objection by Health Professionals", *Virtual Mentor*, May 2006, Volume 8, N. 5: 327-331.

This work will advance some criteria to establish a more precise framework for conscientious objection than those currently in operation. The objection of health professionals, unlike the traditional cases of objection (such as the refusal of mandatory military service), affects the rights of third parties. For this and other reasons I will detail, the permissive strategies of the model I call "libertarian" (in which the scope of the objection is limitless) and of the model I call "conciliatory" (in which the referral of patients to non-objecting professional comes before the right to conscientious objection) run into serious problems, which is why I will argue in favor of a third model illuminated by the ideal of equality. From this perspective, it is unlikely that conscientious objection can be acceptable for sexual and reproductive health professionals. For it to be so, the limits on its exercise would have to be much stricter than those established by the conciliatory model and, in any case, endorsement of any objections would have to be subordinate to the prior existence of simple, non-discriminatory, universal access to sexual and reproductive health services.

2. Conscientious Objection, Before and After

A) Traditional Conscientious Objection

The right of conscientious objection consists of the right not to be obligated to perform actions that contradict the deepest ethical or religious convictions of an individual.[4] This right has its basis in the constitutional protections of the freedom of religion and conscience and of behavior that does not harm others (Articles 14, 19 of the Argentine Constitution). In our country, the reach of conscientious objection was debated in relative depth with regards to

[4] Singer, Peter. 1973. *Democracy and disobedience*. Oxford: Clarendon Press, Rawls, John. 1971. *A theory of justice*. Cambridge, Mass: Belknap Press of Harvard University Press.

military service when it was still mandatory and, more recently, has progressed in the legislation and regulations concerning sexual and reproductive health.

In 1982 under the dictatorship, the (so-called) Supreme Court considered two cases, *Ascensio*[5] and *Lopardo*,[6] emitting decisions in which a restricted conception of conscientious objection was implicit. The matter in question in *Ascensio* was the constitutionality of the expulsion from primary school of a 10 year-old Jehovah's Witness who had refused to recite the patriotic oaths. The Court struck down the suspension on grounds that the punishment was excessive, that there was no prior misbehavior by the child, that there had been the possibility of applying less strict sanctions, that the child's was a minor and dependent to the parents, and that the expulsion affected the child's right to education under Article 14 of the Constitution. The Court did not come close to recognizing any right to objection. It simply decided that it was appropriate to apply intermediate sanctions before resorting to the expulsion. In the *Lopardo* case the matter discussed was the constitutionality of a punishment assessed to a Jehovah's Witness who had refused to wear the military uniforms (although he had shown up for his mandatory military service). Lopardo alleged that his freedom of religion and conscience were at stake. The Court ruled that the freedom of religion was not absolute and that it had to be reconciled with the duty, also constitutionally required, to perform military service. The antiliberal worldview of the Court under the dictatorship is summed up in its affirmation that "the exercise of the freedom of conscience is bound by the reasonable requirements of just public order, of the common good of

[5] Ascensio, José H. s/Amparo, Fallos 304:1293

[6] Lopardo, Gabriel Fernando (Fallos 304:1524)

society, and of the protection of the existence and legitimate rights of the nation itself. . . ."[7] This worldview does not leave any room for conscientious objection (and perhaps for any other right).

In 1989, a democratic Supreme Court had the opportunity to consider a case of conscientious objection.[8] Gabriel Portillo had refused to appear for his mandatory military service, for which he had been condemned in a criminal court to perform his military service with an additional year as punishment. In the Supreme Court, Portillo challenged the constitutionality of the law requiring military service on the grounds that, among other reasons, it violated the freedom of ideology and of conscience protected by Article 14 of the Constitution, as his Catholic beliefs prevented him from using arms against another human being in violation, as he saw it, of the Fifth Commandment. He was willing, however, to perform any alternative service that would not imply the use of arms. In this case, the Court distanced itself (in Consideration 6) from the simplistic approach of *Lopardo*: "... The matter cannot be resolved by merely referring to the jurisprudence establishing that all rights are relative . . ." In Consideration 8 the Court recognizes the specific value of religious freedom, and goes on to extend the protection of the right of conscience to whoever "establishes a determined hierarchy of ethical values that gives special primacy to not endangering the lives of their fellow men and women" (Consideration 9). It would be a contradiction in terms, the Court continues, "to protect the right to freedom of religion as a manifestation of the right to freedom of conscience without treating the latter as something to be protected itself as well." It adds that in a democracy, the State must be "impartial with regards to the governed, even when they practice religions that the majority repudiate" (Consideration 10). Subsequently an important point is clarified; that in this case "a

[7] Fallos 304:1533.
[8] Portillo, Alfredo s/infracción art. 44 ley 17531 (JA 1989-II-658, Fallos 312:496)

contradiction does not exist between rights *per se*," "but rather between a right and a legal obligation" (Consideration 11) whose non-fulfillment "does not entail serious or imminent harm to interests protected by the State", so that it is possible to find alternatives that reconcile the duties of the objector to the State with their personal convictions. Another crucial affirmation is found in Consideration 12: "What is at stake is not the . . . legal reach of the religious prohibition: 'Thou shall not kill' . . . since this Court lacks the competence to interpret religious dogma." In Consideration 13 the Court establishes that objections must be based on sincere beliefs that seriously conflict with the challenged obligation. In the end, the Court confirmed the sentence on appeal, only changing it so that the military service be completed "without the use of arms."

This was a conciliatory ruling. Liberal values were vindicated but the original punishment imposed on the objector was not challenged, which is not completely consistent with the recognition that the "right of citizens to carry out their mandatory service may be done without the use of arms." It is this right that Portillo simply wanted to exercise. Why should he be punished?

In *Portillo*, the Court established the following jurisprudential criteria regarding the reach of the right to conscientious objection:

1. Freedom of conscience is, to begin with the most obvious, a right, and as such cannot be subordinated (as it was in *Lopardo*) to simple considerations of public utility or convenience.

2. The right to freedom of conscience goes further than the right to freedom of religion, encompassing ethical convictions ("a system of values not necessarily religious," according to *Portillo*).

3. The objection must be sincere.

4. This right requires protection even if the objector belongs to a minority.

5. Distinction must be made between cases where conscientious objection does not run counter to any other rights and cases where it does indeed "entail serious or imminent harm to interests protected by the State."

6. Whenever possible, reconciling compliance of legal obligations with the convictions of the objector must be sought.

In Argentine legislation, conscientious objection is accounted for in Law 24,429 establishing voluntary military service.

B) Contemporary Conscientious Objection

Appeals to conscience to excuse oneself from complying with legal obligations have increased exponentially in every direction. Starting in the second half of the 90s, the debates and regulations concerning conscientious objection have acquired much importance in an area where basic rights are at stake: that of the laws and regulations of sexual and reproductive health. These norms mandate, for example, the creation of programs for public policies on sexual and reproductive health, the liberalization of access to surgical contraception, and the supply of emergency contraception or the access to legal abortions, or access to pregnancy interruption in

cases where pathologies of the fetus incompatible with life (like anencephaly) are diagnosed. Within some of these norms, specific clauses regulate the differing degrees to which health professionals and other actors in the sector have the right to exercise conscientious objection. In general the phenomenon arises when a health professional (doctor, pharmacist, etc) objects to certain practices, such as contraception (including emergency contraception and tubal ligation) or abortion, even in cases where it is legally permitted.

These are not isolated incidents. A survey carried out in Argentina in 2001 by researchers at CEDES[9] revealed that 50% of the professionals surveyed consider that they must not perform vasectomies or tubal ligations or provide information on these services. More than 30% hold the same beliefs with respect to feminine contraception. One head of obstetrics declared: "Emergency contraception is a form of abortion in my opinion, so I won't even speak of it . . . that is why it shouldn't be used and why I won't provide information about it or let anyone else here provide the information."[10] Law 25,673, which created the National Program for Responsible Parenthood and Sexual Health, protects institutional conscientious objection, albeit while establishing the obligation to provide referrals in order to guarantee access to the Program's services. Article 6 of Law 26,130, which establishes the Protocol for Contraceptive Surgery, also recognizes and regulates the right to conscientious objection on an individual level, ascribing to the managers of each establishment the responsibility of making immediate replacements available to patients or clients in these cases.

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[9] S. Ramos, M. Gogna, M. Petracci, M. Romero, D. Szulic, *Los médicos frente a la anticoncepción y el aborto ¿Una transición ideológica?,* CEDES, 2001, p. 94.

[10] Idem, p. 98.

The National Law 26,150 on Sexual Education that creates the National Program of Integrated Sexual Education within the National Education Ministry, however, does not consider conscientious objection. On the provincial level,[11] the reach of the regulations governing conscientious objection vary from one jurisdiction to the next. The federal state and the Argentine provinces adopted different regulatory options at the moment of implementing the constitutional mandate regarding the right to conscientious objection and the rights that it might conflict with (see Appendix 1).

Not all of these options are equally worthy, and some of them are even questionable for the generality they ascribe to the right or for the preference it enjoys over the fundamental rights it may conflict with such as the life, health, or autonomy of patients, generally women.

C) Relevant Factors for Conscientious Objection in the Context of Sexual and Reproductive Health

The following considerations are in my opinion important in evaluating the acceptability and the limits of conscientious objection in the field of sexual and reproductive health. These factors distinguish the new application of conscientious objection from the traditional one and require an innovative approach because of, among other reasons, the rights that are threatened by this practice.

(1) The behavior of objectors is usually motivated by reasons that challenge the morality of certain public policies, for example, when the parts of the Criminal Code that allow abortion in certain situations are denounced as unconstitutional because the objector rejects those exceptions.

[11] See *Derechos sexuales y reproductivos en Argentina,* Edurne Cárdenas y Leah Tandeter, Conders, 2008, available at http://www.conders.org.ar/pdf/DSR_Legislacion_y_Jurisprudencia_en_Argentina.pdf.

(2) The objection is motivated by the desire to derail public policies on sexual and reproductive health. What is sought is not merely an individual exception to a legal obligation. The coordinated nature with which conservative bodies and the authorities within the Catholic Church promote the massive practice of conscientious objection demonstrates that it is a question of collective action that aims for the reform of laws and state decisions and whose consequences affect the State's public policies.

(3) The actions involved affect basic interests of third parties, by impeding or obstructing access to contraceptive methods, or to information on how to avoid unwanted pregnancy, or to legally permitted abortions, actions which pose risks to the lives, health, physical integrity, or autonomy of other people.[12]

(4) The negative impact on rights is made worse by the fact that one group is doubly affected disadvantageously, that of women in a state of poverty, which reinforces a dual source of structural inequality in a context where sexual and reproductive rights are far from being fully guaranteed. For example, denying emergency contraception leads to unwanted births or to abortions, and the refusal to perform legally permitted abortions puts at risk women's lives, health, and physical autonomy and integrity. Furthermore, conscientious objection in the domain of sexual and reproductive health reinforces the imposition of a deeply unequal ethical framework that is based on behavioral stereotypes on women that fixes a subordinate role for them by depriving them of control over their sexual and reproductive lives (and this objective pejorative result occurs even when objectors are not motivated by these stereotypes).

[12] Human right treatises, which are constitutional norms in Argentina, warrantee women's right to "medical care without discrimination" including "family planning".

(5) Sexual and reproductive health service providers are professionals. Professions act as regulated monopolies. In this sense they are different from other monopolies, which we could call irregular and whose existence is undesired. The professionals are granted exclusive access to certain practices deemed especially valuable by society. To be a professional is to be part of a monopoly: anyone who is not a professional is excluded from the practice in question (medicine, law, etc). In exchange for this monopoly, the professionals must satisfy various requirements (including formal education, accreditation, oaths, and so on). Once a privileged position is obtained, a professional does not enjoy the same level of discretion with respect to obligations as a non-professional does.[13] It is not unreasonable to include among the professional obligations the exclusion of the recourse to conscientious objection in the exercise of the profession when this recourse endangers values such as the lives and health of others, or the enjoyment of important constitutional and/or legal rights.

(6) The circumstances of health professionals impose even more stringent restrictions on their autonomy. They have an obligation to care for their patients,[14] and operate in an arena of enormous importance for the type of interests at stake. Cantor and Baum[15] emphasize that, unlike military conscription (which is obligatory by definition), joining the health profession is entirely voluntary, and thus the recourse to conscientious objection must be treated differently.[16] These

[13] R. Alta Charo, “The Celestial Fire of Conscience”, p. 2473.
[14] Los tribunales estadounidenses extienden este deber de cuidado a los farmacéuticos. Hooks Super X, Inc. V. Mc Laughlin, 642 N.E. 2d 514 (Ind. 1994).
[15] Ob. Cit., p. 2009.
[16] This does not deny the high cost of abandoning a profession because the obligations conflict with one’s conscience. Yet the cost imposed on doctors or aspiring doctors by the restrictive model is likely less than the cost that the practice of conscientious objection in this context imposes on other people.

observations appear to support those who assert that being a health professional is incompatible with conscientious objection.[17]

Conscientious objection in this case cannot be likened to a mere failure to act on the part of any normal person intending to abstain from a course of action they reject on moral grounds. The difference between acting and failing to act narrows as regards health professionals. It would be a gross oversimplification to speak of merely "not acting" after having taken an oath to serve the patients' interests, after enlisting in the monopolistic exercise of a given activity, and becoming part of the health network. The failure to act on the part of someone exercising the type of power with which health professionals are invested is morally equivalent to an action, in this case an action of obstruction to the exercise of the right to health.

(7) In Argentina, conscientious objection in the domain of sexual and reproductive health occurs in a context where guarantees of equal access without obstacles to these services do not exist for everyone. The State does not fully meet its obligations to universally provide sexual education. Nor does it meet supply free contraceptive everywhere in its territory to people who lack the resources to purchase it. Lastly, the State fails to enforce the text of the Criminal Code when abortion is legally permitted in cases when the mother's life or health are at risk or when she has been the victim of rape or is mentally handicapped. In these circumstances, enlarging the scope of conscientious objection is not a means to protect rights, but rather to threaten them, and to perpetuate unequal conditions for impoverished women, who comprise the majority of the victims that suffer from a lack of these services. The exception cannot precede the rule.

[17] J. Savulescu, "Conscientious Objection in Medicine", *British Medical Journal* 332 (2006):294-7. A New York Times editorial agrees: "Doctors who cannot talk to patients about legally permitted care because it conflicts with their values should give up the practice of medicine." "Editorial: Doctors Who Fail Their Patients" February 13, 2007. But see Adrienne Asch, "Two Cheers for Conscience Exceptions", Hastings Center Report, November-December 2006, pp. 11-12.

If national and international norms are in place in Argentina for the regulation of the various sexual and reproductive rights,[18] the obstacles to the effective implementation of these norms are such that the unrestricted, free, and universal access to the services established by law remains illusory. For example, the 2008 CELS Report on Human Rights in Argentina[19] makes reference to concealment of contraceptives, impeding access to the surgical contraception regulated by law, limits on information regarding available contraceptives, purposefully and deceitfully failing to place IUDs, and failing to replace expired contraceptives in locations that report shortages, out of negligence or for ideological reasons.[20] At the same time, the sexual and reproductive health policies suffer constant legal harassment by extremist Catholic entities that make use of conservative judges to prevent delivery of emergency contraception under the auspices of the calamitous Supreme Court decision "Portal de Belén."[21]

Perhaps the most serious case is that of legally permitted abortions. Article 86 of the Criminal Code states that abortions will not be punishable in instances where there is danger to the life or health "of the mother," in cases of rape, or of "affront to modesty [*atentado al pudor*] committed against a mentally deficient woman." In these cases, access to free and safe abortion

[18] CEDAW, Sexual Health and Responsible procreation Act, N. 25.673, Law 26.130 regulating contraceptive surgery, Law 26.150 establishing a National Program of Sexual Education, etc., etc.

[19] Cels, 2008 HHRR Report, "El acceso al aborto permitido por la ley: un tema pendiente de la política de derechos humanos en la Argentina", by CEDES researchers Silvina Ramos, Paola Bergallo, Mariana Romero, and Jimena Arias Feijoó.

[20] The current government appears to have included an agreement when fixing the National Program for Sexual and Reproductive Health started in 2003 to reestablish ties with the Church which had been broken after several incidents involving the previous government. The delivery of contraceptives has thus been paralyzed and a veil of silence has been cast over the Protocol for providing legal abortions which was implemented in 2007.

[21] Portal de Belén - Asociación Civil sin Fines de Lucro c/ Ministerio de Salud y Acción Social de la Nación s/ amparo," CSJN, 5 de marzo de 2002 (citing a fictitious Nobel Prize, and the opinions of a genetist from a decision by the Tennessee Supreme Court, hiding that the Court dismissed his opinions because of the lack of expertise in the issues discussed, and for showing a deep confusion between science and religion). Investigation by Virginia Menéndez, included in the appeals procedure before the courts of Córdoba province: "Mujeres por la vida Asoc. sin fines de lucro c. Superior Gobierno de la Provincia de Córdoba – amparo – Recurso de Apelación" expte. N° 1270503/36, in file with author).

is a basic right, given the crucial interests at stake (life or health of the pregnant woman, her autonomy, physical integrity).

There exist, however, many factors which conspire against the effective enforcement of this right. In first place is the unjustifiably restricted interpretation of the law by many doctors and judges who hold that the danger must be very grave, that mental and social health are not included in the concept of health (in opposition to the definition given by the World Health Organization), and that the grounds for rape are only applicable in cases involving mentally handicapped women. Secondly, many doctors do not dare perform abortions that are not punishable because of the latent threat of being subject to criminal complaints. Thirdly, a limited interpretation of doctor-patient confidentiality (again in disagreement with the very text of the Criminal Code and the most basic rules of ethics) is prevalent, a fact that leads many doctors in public hospitals to denounce women who turn to them because of complications suffered in clandestine abortions.

This scenario of structural impediments to access to the most basic services concerning sexual and reproductive health is reflected by the fact that clandestine abortion is the greatest cause of maternal mortality.[22] The analysis of the right to conscientious objection would be radically faulty if it forewent any consideration of the context in which the practice is exercised. When this context is characterized by the systematic denial of rights to groups that suffer structural discrimination as is the case of women and people in poverty, it could well be that the freedom of some is the oppression of others.

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[22] See the 2002 Report by the National Ministry of Health and CEDES on maternal mortality in Argentina, available at http://www.msal.gov.ar/htm/site/pdf/Resumen%20ejecutivo.pdf

(8) Another aspect of the existing conditions that turns out to be relevant is the excessive influence of religion in civic affairs. In many cases, conscientious objectors use their objection to express religious values, such as those who are against sex outside of matrimony, or against sex not oriented to reproduction, or homosexual relations, or the voluntary termination of pregnancy. The line separating the right to adhere to one's religious convictions from an imposition of those religious values on another person is very thin. It is just as thin, coincidentally, as the line separating church and state. One risk, to take an example, is that the health professionals who adhere to the Catholic religion behave as soldiers of faith, illuminated by fatwas such as the Circular Letter of 1995, "Evangelium Vitae" by Karol Wojtyla that (in paragraph 28) describes the current situation as "a dramatic shock between good and evil and between life and death," that describes on p. 72 the laws authorizing abortion and euthanasia as "lacking authentic legal validity," and as they are not "truly rights or morally obligatory" asserts on p. 73 that "abortion and euthanasia are crimes that no human law can legitimate," going on to affirm that "there is no conscientious obligation to obey them and instead a clear and serious obligation to oppose them by conscientious objection."

In societies such as the one in Argentina, in which civic life remains strongly conditioned by the impositions of the Catholic religion, this factor provides an additional reason to be extremely cautious when permitting practices that, in effect, contribute to the cultural hegemony of a religious vision. I hasten to add that the common view, very different from mine, is that given the large majority of Catholics in our society, the saturation of social life by Catholic values is justified. I think, conversely, that in countries where a majority of the population

subscribes to one religion, stronger protection against the influence of that religion in civic life is necessary.[23]

3. Three Approaches to Conscientious Objection

A) The Libertarian and Conciliatory Models

Three different models or strategies can be distinguished with regards conscientious objection in the domain of sexual and reproductive health services. The first strategy is permissive or "libertarian."[24] In this approach, the professional has the right to avoid doing what he objects to and cannot even be required to refer the patient to another professional willing to perform the objected action. Likewise, the professional is free to reproach the patient if they express their intent to use contraceptives or to have an abortion. The professional may give the patient the reasons, be they ethical or religious, for their objection, and can also attempt to dissuade the patient.[25] The patient may of course, as an adult, end the conversation whenever he or she wishes.

This approach presents several problems. First of all, it presupposes equality in the relationship between the professional and the patient, something that in reality is far from the truth. The obvious vulnerability, for example, of women in poverty seeking legal abortion in public hospitals (who comprise the majority of such cases) reveals the illusion of symmetry

[23] Perhaps this paper, as Lucas Arrimada and Gabriel Bouzat suggested, exaggerates the degree of influence of the Catholic Church in Argentina.

[24] This strategy is similar to what Rebecca Dresser calls a "contract model", where the doctor informs at the outset to the patient about the limits of her or his services. R. Dresser, "Professionals, Conformity, and Conscience", Hastings Center Report, Noviembre-Diciembre 2005, p. 9. The libertarian strategy allows even more leeway to the doctor.
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[25] Adrienne Asch afirma que el objetor "ejerce su derecho a una negativa de conciencia solamente a través de una conversación honesta seguida de una derivación en caso de que el paciente persista en sus deseos." Es una cuestión abierta cuáles serían los alcances de esa "conversación". Adrienne Asch, "Two Cheers for Conscience Exceptions", Hastings Center Report, Noviembre-Diciembre 2006, p. 11.

between the patient and doctor. Secondly, it likens the providing health services to providing any other good or service, failing to consider the special importance of health (and sexual and reproductive health in particular). Thirdly, it is unfair, since it forces the patient to seek indefinitely the service they require. Fourthly, the privacy of the patients is compromised, as they are subjected to an unwanted evaluation of their behavior or personal preferences. Keep in mind that decisions regarding sex and reproduction stem from the very core of our conscience. If so, maybe the price of the objector´s purity of conscience is the desecration of the patient´s conscience.

The libertarian model, however, also permits health institutions to refuse to hire objectors. The sanctity of contracts is a universal principle: the objector cannot wield it against their patients or the institution for which they work and then protest if hospitals and pharmacies use the principle to freely contract employees with whatever stipulations they prefer, including the condition that the recruit not be an objector.

The second strategy is the "conciliatory" a.k.a the "referral" strategy.[26] In accordance with this approach, the objecting professional has the right to refuse to perform the service in question, but is required to refer the petitioner of the service to a professional who does not object. This second strategy has problems as well.[27] First of all, from the perspective of the objector, as many people have observed, it does not afford much respect. If someone objects to the practice of abortion because they consider them the murder of innocent and defenseless children, then they will not feel comfortable with a norm that allows them to abstain from

[26] Cantor and Baum (Ob. cit., p. 2011) defend this model.
[27] *See* Dresser (ob. Cit.), p. 9.

practicing abortions without losing their job only if they tell the person seeking an abortion the name and address of some other “assassin” prepared to carry out the despicable chore.[28]

Secondly, the strategy is in the end rather unattractive for the person seeking the service. Some of the reasons are similar to those that throw into question the libertarian model. There is the problem of services that require immediate care (for example in the case of emergency contraception). In these cases, referral may effectively be the same as denying the service. The referral model, after the libertarian model, also depends on the degree of equality in the relationship between the requester of the service and the professional. The doctor-patient relationship is asymmetric because of several reasons. There is an asymmetry of information, obviously with regards to medical science, but also as regards other aspects of medical activity. The doctor is the one who knows medicine, but also the one who knows more about the legal aspects of medicine. It is also to be expected that when the factors at stake are as sensitive as those related to sexual and reproductive health, the patients find themselves in a position of added vulnerability.[29] All of these factors are worsened in countries where doctors are traditionally granted virtually absolute authority over the patients. The objection of health professionals is not an act that occurs in a void or in the context of absolute autonomy of will. It takes place in an asymmetric, nearly hierarchical, relationship, and sometimes involves submission. What otherwise would amount to the simple exercise of individual freedom runs the risk of comprising an act that constrains the freedom and dignity of the patient. The simple expression of the reasons for objection can transform into a sort of personal ethic, an unasked for sermon, or a humiliating intrusion into the sphere of personal decisions of the patient.

[28] R. Dresser, “Professionals, Conformity, and Conscience”, p. 9

[29] El informe del CELS mencionado describe la estigmatización que enfrentan en los hospitales las mujeres que requieren abortos legales, a quienes se les niega anestesia, y hasta resultan violadas.

B) A Third Approach: Conscientious Objection through an Egalitarian Lens

Current debates appear dominated by the controversies generated between the libertarian and conciliatory models. The weakness of each of these models provides incentive for attempting to develop a third strategy, one based on the principle of equality. This principle implies an obligation of the state to show equal respect and consideration towards the people subject to its empire. It also requires that people dispose of equal resources for the development of their life projects. These resources should be understood in a broad sense that includes opportunities, material and symbolical goods, freedoms, and so on. A prominent place is occupied by health, understood integrally, and sexual and reproductive health in particular. Access to health is a basic right, in the sense argued by Henry Shue,[30] inasmuch as it is comprised of a bundle of interests so crucial that they transcend the distinction between positive and negative rights, combining the most salient aspects of both categories.

In this approach, the key is minimizing oppression. A democratic community must make efforts so the dignity of a person does not become vulnerable, putting their moral integrity in danger by forcing them to carry out actions they reject profoundly. If we were not willing to make these efforts the community would be oppressing one person, denying their moral equality by forcing them to choose between their profession and their conscience. But the approach casts one eye on the objector and the other on those affected by the objection. They too have the right to not be put in the humiliating position of having to justify their sexual and reproductive alternatives to another person, or to listen to an unwanted sermon, or to go from one pharmacy or

[30] H. Shue, *Basic Rights,* Princeton, 1980.

hospital to the next until they finally find someone willing to provide them a service to which they have a right for legal and moral reasons.

The egalitarian focus differs from the other models in terms of the level of analysis of the practice in question. The egalitarian perspective adopts a structural point of view[31] that holds different implications than an individualized, atomist analysis of the conscientious objection. From a structural point of view, the combination of the actions of the objectors, which include among other things systematically blocking access to sexual and reproductive healthcare, takes the issue beyond the confines of mere interaction between doctor and patient. The egalitarian approach breaks down the "micro" perspective that obscures an institutionalized practice of denying rights.

If an egalitarian society accepts that, in principle, people can excuse themselves from respecting legal responsibilities for reasons of conscience, in the case of sexual and reproductive health there is room for rigorous limitations, such as the following:

1. *Professional responsibility*. Once a privileged role is occupied, a professional can no longer limit their obligations with the same ease as a non-professional. Conscientious objection must be regulated with special attention in a restrictive manner in the exercise of the profession when objection implies risks for values such as the lives and health of others or for the enjoyment of important constitutional and/or legal rights, especially when joining the ranks of the health professionals is entirely voluntary.[32] If prohibiting the recourse to conscientious

[31] I owe this point to Robert Post.

[32] The idea that voluntary access to a given profession is sufficient reason to disallow exceptions to the corresponding duties of that profession could be countered by pointing out the case in which the duty is established after one has entered the profession. However, what is prior and is not supervening is the obligation to respect the

objections still seems an extreme measure,[33] it must not be forgotten that people are objecting to providing services in circumstances where access to them is either unavailable or highly restricted for the users. The availability of services that are in fact readily accessible is an important variable when it comes to recognizing and implementing the right of objectors who have a monopoly on providing health services.[34]

2. *Objection without obstruction: The need for prioritizing access as a precondition for the exercise of conscientious objection.* Access to health services is a precondition for the admissibility of conscientious objection on the part of health service providers. Otherwise the freedom of the health professionals would be privileged over the right of the patients to life and health. With regards sexual and reproductive health in Argentina, this means that the demands for broad protection of objectors must be preceded by guaranteed access – for everyone and without restrictions – to these services.

The admissibility of objection to the guarantee of effective access to sexual and reproductive health services is subject to the argument that could be questioned if the two phenomena (objection and lack of access to services) were unrelated. For example, let us imagine that women do not have access to safe, legal abortion because of a lack of transportation or roads, and that, in addition, there are doctors who object but still enough non-objectors to meet the demand for services. In this case, the objector would have the right to question whether

legal guidelines in the society in which one chooses to exercise a profession. I thank Javier Couso for laying out the dilemma this way.

[33] No one would wish to undergo an abortion performed by a doctor afraid of losing their medical license. The risk of reaching this undesirable situation can be limited, and should be compared to the harm implicit in the denial of sexual and reproductive rights that the looser notion of conscientious objection can lead to. I thank Kenji Yoshino for his comments on this point.

[34] One alternative to strictly regulate the exceptions to the monopolistic provision of healthcare services (mentioned by Carol Rose) would be breaking the monopoly of doctors by removing the requirement that doctors perform every abortion.

his or her right to objection should be admitted, since objecting has nothing to do with the lack of access to health services. Whatever our response to this hypothetical situation, it is important to emphasize that it is not the case of Argentina. In our connection, the connection between objection and the lack of access to these services is much stronger. The objection produces (together with other factors) the lack of access – the two phenomena are (to a large degree) part of the same problem.[35]

3. Transparency and scrutiny of objectors. Objectors' registry. Public registries must be put in place for conscientious objectors. Public and private institutions would thus be able to organize themselves and their staff to account for the need to prevent ruptures in their capacity to provide the services in order to avoid loss of time and discomfort for the patients.[36] Periodically the registry should be updated. Registration cannot be automatic and should follow the model for conscientious objection used in the military[37]: every objector must present the grounds of their objection ex ante, before a panel comprised of representatives from the medical profession and the State – in particular the agencies that guard against discrimination – that will determine:

a. Whether a sincere ethical or religious belief exists.

b. Whether the health professional is aware of all the relevant scientific knowledge regarding the product or practice in question,[38] making sure their action is not motivated by a desire to ease their workload or by discriminatory beliefs (including prejudices or stereotypical

[35] I thank Agustina Ramon Michel for this observation.
[36] In the Province of Santa Fe, Sexual Health Law 11888 of 2001 in its Article 4 recognizes the right to conscientious objection but mandates the government to en ensure access to the services". The decree regulating the Law creates a registry of objectors, not yet implemented. A similar norm in La Pampa was vetoed by the governor in 2007.
[37] I would like to thank Bo Burt for an illuminating conversation on this point.
[38] This requirement would rule out an objection to prescribing or selling the morning after pill on the grounds of its abortive effects.

attitudes toward women) and that they are not in favor of imposing ethical or religious values on everybody else.

c. Whether serious harm would be done to the moral integrity of the provider if they were forced to perform their professional duty.

4. *Obligatory referral.* The most desirable solution is the one that eliminates the conflict between the right to objection and the necessity of the patients, thus guaranteeing the health service is provided. The cost of the objection must not be transferred to the patient. Health institutions must guarantee that no patient be put in the uncomfortable position of having to confront an objector, and tolerating objection must not entail the least delay or restriction of access to the service. Hence it is the responsibility of the directors of health establishments to guarantee that the practice is carried out by means of an effective and immediate referral, replacing the objecting staff, or a total ban on objection during medical emergencies.

5. *The public health system.* Another factor that justifies the limitation of the right to conscientious objection is found in the case of state employees and functionaries of every rank. Through them the State acts, and for this reason denying health services in public institutions is unacceptable as it would imply a private use of state power, the quintessential abuse of power. The State cannot object to or disobey its own norms, and it would be preferable for the State to set as a condition for occupying a position in the public health system a willingness to carry out all of the services that the position or role requires, unless there is an adjustment available whose impact on the quality of and access to the services would be minimal.

6. *Institutional objection?* An additional limit to the scope of conscientious objection arises in the case of the so called institutional objection. Can an objector be a hospital, a school, or a pharmacy? A problem can be seen at the first glance. Where is the conscience of these objectors? Conscientious objection is indissolubly linked to a mind, to a person of blood and flesh. Hospitals and pharmacies do not possess consciences and therefore cannot object. Challenging institutional objection this way can be questioned. We must attempt to understand the idea of institutional objection in good faith, and it would be unsympathetic to attribute to its defenders the notion that entities composed of people have in turn their own conscience, implying then that they believe in the existence of supraindividual minds that adhere to moral and religious principles. The words “hospital” and “pharmacy” do not invoke supraindividual entities and thus their use does not oblige us to contemplate ontological eccentricities, as would an entity lacking neurons but possessing conscience. These words are used as shortcuts to refer to groups of living, breathing people who interact in a coordinated manner. Hence a defender of institutional objection could try to advance institutional objection as the right of *these* people to object. After all, if an individual has the right to “x” course of action, they should not lose this right for wanting to exercise it in the company of other individuals, all of whom have the right to do “x” as well. Nonetheless, for institutional objection understood in this way to be valid, it must meet the strict requirement that every member of the institution be an objector. I do not see how a constitutional democracy could allow hospitals and pharmacies to meet this requirement, for it would imply setting an exclusive condition for hire at these institutions to being a conscientious objector regarding certain practices. This would constitute a blatant form of workplace discrimination. Law No. 25,673 and its regulatory decree, which (perhaps in violation of the Constitution) recognize institutional objection, establish the obligation of objecting institutions to

guarantee services and to "refer the populace to other assistance centers." This norm at least recognizes that institutional objection cannot be given unlimited range since referral must be provided in all cases.

Is the egalitarian model really a "third" model?[39] I could be reproached for presenting it as a third model when it really is a variant of the referral model. I prefer making a distinction between the two models for the following reason. The egalitarian model admits referral grudgingly, as a concession made out of regard for the need to be realistic, but only after affirming that it would be legitimate (that is, that it would be within the range of admissible actions under a democratic framework) to revoke the medical license of objecting professionals, and that the rules allowing objection must hold as a prior condition the existence of free, unencumbered enjoyment of sexual and reproductive rights. The egalitarian model finishes with its acceptance of referral, whereas the conciliatory model starts with it. The egalitarian model recognizes that it might be necessary to prohibit objection, which is unacceptable in the conciliatory model. Yet it is possible that the difference between the two models is merely one of nuance and emphasis. This is fine, as long as it is understood that the implications of the difference in nuance can be the difference between life and death for the patients involved.

[STOPPED HERE]

4. Objection and disobedience: Classic boundaries and their problems.

Before concluding, I would like to analyze a few similarities and differences between conscientious objection and civil disobedience. To anticipate a point I will come to later, the

[39] I am grateful to Florencia Luna for conversations on this question.

distinction does not, in the end, help very much to resolve the question of objection in the context of health because the actions and failures to act go beyond the framework of civil disobedience in that they represent violations of basic human rights.

The customary characterizations of conscientious objection[40] concern a crucial difference with respect to civil disobedience, that of the type of public commitment that these behaviors display. A person who disobeys is protesting against a norm or political decision they consider unjust and their disobedience is an attempt to trigger the consciences and sense of justice of their fellow citizens in the hope of reforming the norm or decision. Their protest can be directed against a policy or a substantive decision, or against a lack of adequate channels for participation and debate.[41] The person who disobeys is contributing to democratic deliberation by means of their behavior, combining their motives with the decision to risk their freedom or physical safety, even going as far as to force authorities to employ violence. In this manner they draw attention to the lack of grounds for the policies they challenge. People who engage in civil disobedience, despite a superficial appearance of paradox, displays by their conduct a profound sense of loyalty to rights and to the community. Their disobedience is localized in a defined area, and presupposes a confidence in the capacity of their fellows to modify their opinions and listen attentively to the reasons they have. The disobedience is not meant to overthrow the government, but rather to urge it to change its path.

On the other hand, the objector (according to the classical definitions) does not defend an idea in a public way or advocating the reform of a norm or decision. They are simply refusing to take part in a practice that they object to. They do not attempt to convince anyone, they only

[40] That of Rawls, for example in his *Theory of Justice*.
[41] D. Markovits, “Democratic Disobedience”, Yale Law Journal, 2005.

want other to leave them and their beliefs alone and not to make them do the things they profoundly reject. People who disobey seek a change in the institutions or policies, while people who object seek an exception to the norms, not a change in them. In principle, then, the behavior of the objector is less disruptive to public order, and the degree of impact on the interests of others is less as well. As regards the degree of commitment to public deliberation, the deference is notable. Let us take the case of defiance towards patriotic symbols, such as the flag, the national hymn, or official honors. An objector simply explains that their (religious or ethical) convictions prevent them from standing during the hymn or swear loyalty to the flag. Someone who disobeys could be protesting the same obligation, but their refusal to show respect for the patriotic symbols will be accompanied with reasons meant to convince others. This person could, for example, allege that the norm is perfectionist, or that mandating a sentiment (such as loyalty) is contradictory and probably counterproductive. Theoretically, it is even possible that the person who disobeys has deep personal respect for the national symbols but rejects that the obligation be imposed on the public.

Conscientious objection has a more delimited framework than civil disobedience because its aspirations as a vehicle for communicating ideas are much more modest. It would be reasonable to require that the greater the impact of a behavior on the rights of others is, the greater the onus to provide public reasons to justify the behavior. This explains why the range of harm to third parties stemming from conscientious objection that can be legitimately tolerated is narrower than the range of harms that are normally justifiable in the exercise of civil disobedience. Hence we would have at one end of the spectrum of actions that challenge the law those actions that do not affect other people (In Argentina, these would be the ones protected by

Article 19 of the Constitution). This group would include the refusal to show respect for patriotic symbols. Next to these would be the group of actions that hinder state policies or produce inconveniences more or less significant for the rest of society. These are the typical cases of civil disobedience such as sit-ins, blocking roads, etc. The case of refusing to join the armed forces would belong in the first category of actions when it is a matter of actions by isolated individuals for reasons of religious or ethical beliefs. If the refusal to enlist is coordinated and is based on dissent regarding a particular armed conflict, I would interpret the action to be an example of civil disobedience. Beyond disobedience, when the actions affect the rights of others, or involve a higher degree of violence, lie actions we can qualify as rebellious. These last courses of action require a much greater justificatory reasoning. Unlike the case of civil disobedience, the rebel must be prepared to challenge the legitimacy of a political regime in its entirety or prove that their acts prevent much greater harm from occurring. The extreme illegitimacy of the regime or the harm produced by oppression are what justify rebels who, for example, carry out assassination attempts against tyrants even when these endanger the safety of innocent bystanders.

This table regroups what has just been discussed:

Course of Action:	**Conscientious Objection**	**Civil Disobedience**	**Rebellion**
Reasons:	Private (ethical or religious)	Public (denunciation of very unjust norms or policies)	Public (illegitimate regime – oppression)

Motives:	Does not challenge the norm or policy in question – seeks and individual exception for the objector	To appeal to the sense of justice of the community – intent to peacefully change the policy or norm in question	To overthrow the government or system, to weaken it as much as possible, to privately punish the oppressors
Impact on the Interests of Others:	None or minimal	Insignificant – does not violate basic rights	High (may endanger the lives or safety of innocent bystanders)
Examples:	Refusing to show respect for national symbols; refusal to enlist in the army (when the refusal is isolated, individual, and unrelated to dissent with a particular warlike conflict)	Blocking roads, picketing racist restaurants, refusing to enlist in the army (when the refusal is coordinated, includes many people, and is based on dissent regarding a specific war)	Acts of sabotage (setting off explosives in installations), tyrannicide

I recognize that it is difficult to translate the academic tidiness of these distinctions to the complexities of real life. The resistance to the draft is a good example, because it is not absolutely clear when we it counts as objection or as disobedience. But if the boundaries between objection and disobedience are sometimes obscure, I do think the differences between disobedience and rebellion are clearer. The distinction is relevant with regards actions described as conscientious objection in the domain of sexual and reproductive health. Only in the framework of rebellion is it admissible to transgress basic rights of other people. In both cases of objection and of disobedience, the impact on the rights of others either does not occur or touches secondary rights (the right, for example, to go to a certain restaurant that may be affected by a protest that blocks the street). The actions of objecting health service providers threaten the basic rights of other persons (mostly women). This makes them analogous to acts of rebellion (or part

of a moral or religious crusade, as suggested in the encyclical "Evangelium Vitae"), which are difficult to accommodate in a constitutional democracy.

The objecting professional cannot defend his or her conduct by renaming it civil disobedience since disobedience is only legitimate when it does not affect basic rights, and the behavior of objecting health professionals does just that. Therefore, as not even civil disobedience justifies the type of impact on the interests of others as is the case in the situation we are considering, the pretention that tries to legitimate actions whose effect is to block access to contraceptives and safe abortions on the basis of conscientious objection is not acceptable.

5. Conclusion

Conscientious objection inspires natural compassion in freedom loving people. Our intuitive reaction is to protect minorities who navigate against the current, who reject some aspect of the predominant morality, who refrain from following the flock, and who are prepared to sacrifice themselves. The decision of the objector to oppose the power of the state when they believe their deepest principles may be in risk of compromise demonstrates the value of integrity in its greatest splendor. Challenging power is proof of courage, of independent thinking, and of conviction. One example of it is the increasing number of doctors who have become conscientious objectors to the practice of feminine genitalia mutilation in Mali.[42]

That sympathetic reaction, however, dissipates when conscientious objection is used as a means to reinforce structural and systematic barriers to access to sexual and reproductive health services that all people have a right to; when it is used to impose religious or hegemonic belief

[42] S. MacLucas, "Conscientious Objection to Female Genital Mutilation in Mali", *Peacework* 375, Mayo 2007.

systems, or simply to humiliate people who are in a position of vulnerability. In these cases, the objection does not equal rebelling against power, but rather is one of the strategies of the powerful to deny the enjoyment of basic human rights to others. The objector in this case is not swimming against the current; they are part of the current. Protecting the right to objection in these conditions does not necessarily represent a defense of freedom, but instead a rather subtle form of subjugation.

It also bears repeating that conscientious objection in the case of health professionals cannot be understood in terms of a failure to act, given the privileged position and the special obligations that are conferred to professional exercise in the sphere of health.

It makes sense to emphasize once again that conscientious objection exercised by health professionals cannot be understood as a mere refusal to act, given the privileged position they hold and the special responsibilities that are part of the profession licensed to perform health services.

Lastly, I would like to call attention to the fact that the harm inflicted by the objectors is of the same essence as the harm itself they assert they wish to avoid. Conscientious objection does not only affect the basic rights of other people, the majority of whom are women, the majority of whom are poor. Respecting the conscience of the objector can also imply an offense to the consciences of the patients. A woman who has been the victim of rape and solicits a prescription for the day-after pill has made an ethical decision of enormous depth and import. Erecting barriers to this decision is an insult to her conscience. A person who has decided not to have any more children without renouncing their sexuality feels a stranger comes before her conscience when she is denied access to contraceptive surgery. And the women who, in full

command of their moral autonomy, seek legal abortion when their lives or health is endangered and who find themselves blocked from their right, cannot but feel that the system privileges the consciences of some over their own.

Conscientious objection can sometimes constitute conscious oppression.

Appendix: Regulatory models for conscientious objection in the domain of sexual and reproductive health.

In this work three models are mentioned (libertarian, conciliatory, and egalitarian). The egalitarian model has two variants, one restrictive, the other prohibitive. Four regulatory strategies follow from this. This piece contests the first two strategies in favor of the restrictive-prohibitive one.

Model for conscientious objection in health services	**Libertarian**	**Conciliatory**	**Restrictive Egalitarian**	**Prohibitive Egalitarian**
Can the professional deny service?	Yes	Yes, except in cases of emergency (for example, AHE in rural areas or where there are no nearby pharmacies)	Yes, but only: 1) if they do not work in a public establishment, or in an establishment that is part of a health network 2) in a context where there is a high degree of access to the services, 3) If it is explicitly authorized in their labor contract (private domain), 4) following the assembly of a public registry of objectors, inscription of which is conditioned on restrictive criteria (putting each case under scrutiny to ascertain the sincerity and personal importance of the objection)	No, it is part of their professional obligations. If they deny the service they must surrender their license
Can they refuse to provide information?	Yes	Yes	Yes, under the previously mentioned conditions	No
Must they refer patients to willing providers?	No	Yes	Yes	Irrelevante
May they attempt to dissuade and/or morally reproach the patient?	Yes	No	No	No
Does the allowance cover institutions?	Yes	Yes	No	No