

How to Reduce or Eliminate “Conscientious Objection” in Reproductive Health Care

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We oppose the practice of so-called “conscientious objection”¹ in reproductive health care (hereafter called “belief-based treatment refusals”) because it is not conscientious and is [harmful to patients](#).

Working towards an eventual ban on this practice is not only the right thing to do, but also would be more achievable than trying to accommodate and regulate the practice on an ongoing basis – which has [not been proven to work](#) in any country.

Empirically-based criteria for reducing the number of objectors over time can be developed that would be ethical and fair to all parties. There is no need to navigate subjective aspects such as trying to decide if an objector’s reasons are valid. It also does not involve “forcing” doctors to do abortions.

Below are suggested ideas for incrementally reducing or eliminating belief-based treatment refusals in reproductive health care:²

1. Inform medical students entering certain disciplines (in particular Obstetrics/Gynecology and family practice) that their field requires provision of reproductive health care, including abortion and contraception, and that belief-based treatment refusals are discouraged and may not be allowed.
2. Offer guidance and assistance to objecting students to help them transfer to acceptable disciplines or specialties where their objection won’t be a problem.
3. At medical schools, provide compulsory training in contraception provision for all students in family medicine, and compulsory training in abortion provision for all those in Ob/Gyn (and other common services like sterilization etc.).
4. Include the requirement to participate in abortion provision in job descriptions at the point of hiring.

¹ We define “conscientious objection” in health care as the refusal by a healthcare professional to provide a legal, patient-requested medical service or treatment that falls within the scope and qualifications for their field, based on their personal or religious beliefs against the treatment. We distinguish “CO” from its opposite, conscientious commitment (which we support) and define as: “The provision of necessary or beneficial health care to patients in need despite stigma, unjust laws, or oppressive systems.”

² Similar protocols could apply to medical assistance in dying.

5. Require existing objectors to enroll in a Continuing Education course or Values Clarification workshop on the need for reproductive health care services, and why women request abortions. For example:

- Expose them to patients requesting the services.
- Educate them on the negative effects of treatment refusals on patients, and the benefits of abortion care for patients.
- Provide a clear understanding of their fiduciary duty to patients.

(This should decrease the number of objectors because many are arguably just misinformed, uncertain, or using the excuse of “conscience” for the wrong reasons.)

6. For existing objectors who continue to object, assist them and incentivize them to move to other disciplines or areas where their objection won’t be a problem.

7. Increase the burden on those who want to stay and continue objecting, with the goal of encouraging them to eventually transfer, find another career, or retire. These measures would become mostly unnecessary over time as treatment refusals become rarer. For example:

- Require all remaining objectors to register so they can be monitored.
- Require all objectors to file a report every time they refuse services based on their personal or religious beliefs.
- Investigate any inadequate or problematic reports.
- Randomly conduct regular audits on objecting doctors.
- Discipline those who violate the policy, and develop a more robust disciplinary policy (one that does not rely solely on patient complaints).
- Hold objectors financially liable for any harms done to patients.
- Prohibit existing objectors from working alone, especially in small communities where they are the only physician.
- Allow employers to prioritize hiring of non-objecting physicians.
- Pay objecting physicians less (a cut in wages for employed doctors, or a percent reduction in Medicare fees)

8. To improve accountability and transparency, medical organizations should:

- Make the complaint process easier for patients, such as preventing the doctor from learning the complainant’s identity.
- Engage in public advocacy about the right to complain when doctors refuse care or referrals – e.g., create a brochure for doctors’ offices, publish media articles, write a position paper for their website, keep a permanent prominent link to it on their home page, etc.

9. Governments could carry out various initiatives, such as:
 - Regulate public health systems to guarantee abortion provision, such as by requiring all or most hospitals to provide abortions.
 - Provide financial aid to hospitals to recruit abortion providers.
 - Encourage and incentivize new providers, especially outside major cities.
 - Engage in public education to reduce abortion stigma.
 - Implement buffer zones and various security measures to support doctors.
 - Set up a central referring agency that patients can call to be referred to a provider in their area, and maintain a list of doctors who provide this care.
10. The medical profession as a whole should reframe “conscientious objection” as belief-based treatment refusals (or similar term) and never refer to it as a “right.” The practice should be acknowledged as harmful to patients and strongly discouraged.
11. Laws and policies allowing belief-based treatment refusals should be reviewed, and amended or repealed where possible.
12. Where belief-based treatment refusals are allowed, they should be tightly regulated and enforced.
13. Any regulations or amendments limiting the practice of belief-based treatment refusals should have the goal of discouraging objection and reducing the number of objectors over time (in addition to the main goal of ensuring patients receive timely services in a non-judgmental manner).

Over time, such measures should reduce or eliminate the presence of doctors who refuse to deliver health care for which they would normally be responsible.

Sweden, Finland, and Iceland [already disallow belief-based treatment refusals](#) through policy or practice, and also court precedent in the case of Sweden. The assumption that belief-based treatment refusals are legitimate and must be allowed disregards the proven reality that it is indeed possible to disallow such care denials without any negative impacts on health care workers. Objectors simply find other areas to work in and can be assisted to do so.

One might argue that these Nordic countries are unique and unrepresentative because they have high degrees of secularism and gender equality, and less abortion stigma. But that is exactly the point. A strong commitment to secularism and gender equality makes belief-based treatment refusals unnecessary and even unthinkable. (Indeed, these countries have very few objectors.) That’s really what our end goal should be – not trying to accommodate the ongoing oppression of women under the guise of “conscience.” Belief-based treatment refusals represent a patriarchal retaliation against the empowerment of women – enforced mainly by the Catholic Church. The practice should not be defended or tolerated.