

ESCRH’s Position Paper on SRHR should not tolerate the denial of care due to personal beliefs

By Joyce Arthur and Christian Fiala, March 2021

Abstract

The *Position Paper on Sexual and Reproductive Health and Rights 2019* by the European Society of Contraception and Reproductive Health (ESCRH) is a strong paper that recognises these rights as fundamental human rights. However, the paper’s messages are undercut by the tacit acceptance of treatment refusals for abortion on grounds of ‘conscience’, despite the acknowledgement of harms caused by these refusals. The paper assumes that denial of abortion care for reasons of ‘conscience’ can be adequately regulated, but where regulations exist to limit the harm of treatment refusals, they often do not work as intended and are rarely enforced. The mistaken belief that ‘conscientious objection’ in reproductive health care is a ‘right’ that should be accommodated has fuelled the practice of these belief-based treatment refusals, resulting in reduced access to abortion in most countries, increased burdens on health care systems, and serious harms to patients including death. We ask the ESCRH to adopt the position that belief-based care denials are unethical and paternalistic and should be discouraged.

The ESCRH’s new *Position Paper on Sexual and Reproductive Health and Rights 2019* – the “Madrid Declaration” – is highly commendable. This strong and comprehensive paper recognises these rights as fundamental human rights, and that evidence-based medicine and respect for human rights must be at the forefront when implementing SRHR policies. Since many people in Europe still experience widespread denials and infringements of their sexual and reproductive rights, this paper is a valuable contribution to the issue.

We would like to point out one drawback to the paper, however. Its admirable key messages are undercut by the tacit acceptance of selective treatment refusals for patients with an unwanted pregnancy on grounds of ‘conscience,’ despite the acknowledgement of harms caused by these refusals in some countries. The paper assumes that the denial of abortion care due to personal beliefs^a can be controlled via adequate regulation and oversight, which are lacking in many countries, and gives some examples of recommended measures to ensure access to abortion, such as requiring referrals, obligating refusers to provide emergency care, limiting care denial to the direct provision of care, making refuser status public, and ensuring adequate numbers of abortion providers.

First, such regulations are essentially legal exemptions from the requirement to do one’s job, and they act as an official endorsement of abortion stigma and gender discrimination because most reproductive health care is delivered to women. No other area of health care allows

a The authors do not support the use of the term ‘conscientious objection’ as it is a misnomer. The practice can be defined 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. Therefore, this paper uses terms such as “denial of care due to personal beliefs” or “belief-based treatment refusals”, which also distinguish this practice from care refusals for other reasons that may be legitimate (e.g., lack of skill, unavailability).

discriminatory refusals, such as on the basis of a patient's race, religion, disability, or medical condition.

Second, where regulations already exist to limit the harm of belief-based treatment refusals, they often do not work as intended. We have shown that many care deniers will also refuse to obey any regulation requiring them to refer, believing it makes them complicit [2]. A few women have died [3] because some refusers will not even intervene in an emergency to save a woman's life, despite being required to do so. The exception 'to save a woman's life' is impossible to enforce in any case because the precise probability or time of a patient's death can never be predicted and many doctors will hold out hope even in serious cases. Only when a woman dies does it become clear she could have been saved by an abortion.

Finally, regulations requiring public hospitals to provide abortions or to keep a register of refusers are usually not monitored and enforced, so it is impossible to know what is really happening. How many governments or health authorities have so far shown the will and the resources to devote to the enforcement of 'conscience' regulations? Indeed, why should governments or health systems be required to expend resources to help providers avoid their duties to patients? And what should be done about the significant number of care deniers who refuse to obey the regulations, or the hospitals that claim a 'conscience' while denying conscience rights to individual pro-choice staff? Further, are governments and medical groups prepared to defend lawsuits by anti-choice doctors and hospitals that expect a *carte blanche* 'right' to refuse any treatment or referral with full immunity against any consequences? [4],[5]

We need to question why we are curtailing the rights and autonomy of patients in a document that has the specific purpose of upholding these same human values. Instead, the ESCRH is enabling a practice that only serves to delay and reduce access and harm patients, and which puts the onus on health systems and governments to mitigate the negligence of those who refuse care.

There is an inherent contradiction in allowing treatment refusals based on personal or religious beliefs, but only within arbitrary limits. How can we give refusers the green light to practice what amounts to faith-based medicine, then ask them to shelve their beliefs at some point in the process, such as when a referral is required? Further, abortion and contraception comprise the vast majority of medical services denied on so-called "moral" grounds, and only to patients capable of pregnancy. But the summary of ESCRH's position paper makes clear that these services are fundamental human rights that save lives and improve health and well-being, which means that SRHR is indisputably ethical, while denial of such care can only be discriminatory and harmful. Such contradictions make 'conscience' rights unenforceable and open the door to abuse.

In researching over 60 stories of women who suffered serious injury or injustice due to belief-based treatment refusals (including several deaths) [3], we found that when health care professionals deny care based on their personal beliefs, it is usually accompanied by various other abusive behaviours, such as refusing to refer, failing to provide necessary information, lying, providing misinformation, judging or criticizing patients, violating their privacy, not listening to them or dismissing their concerns, delaying them, not attending to them in hospital, not providing pain relief, failing to follow standard medical protocols, and waiting until the patient is near death before acting. These abuses happen even when laws, protocols, or ethical codes forbid them.

The ESCRH paper claims that some countries can accommodate objectors while still assuring patients have access to abortion services, but the evidence does not hold up under scrutiny. The

examples of Norway, England, and Portugal come from a single paper by Chavkin et al. [6], which we refuted in a response [7]. In reality, the main finding of this study was that strict regulations around treatment refusals give a false sense of security to those who wish to ‘simultaneously’ protect doctors’ refusal to treat and patients’ right to health (an oxymoron). Regulations to limit treatment refusals are too often proffered as the solution, with the underlying assumption they will work as intended when that is rarely the case.

Firm restrictions on treatment refusals may seem to work, but not because objectors are adhering to the law. For example, Norway and England already had low levels of objectors, resulting in conscience regulations appearing to work well simply because few objectors exist to disobey them (unlike Italy, Austria, and some countries in Latin America, for example). In England, the National Health Service has largely bypassed the ‘conscience’ clause in the UK *Abortion Act* by contracting most abortions to private clinics, which of course do not hire people who would refuse to do their jobs. As for Portugal, the actual extent of treatment refusals and what is happening to patients is unknown, and there is evidence that many hospitals are not obeying the law [7].

Neither the ESCRH position paper nor the Chavkin et al. study cited the positive experiences of Sweden, Iceland, and Finland, where belief-based care denials are not tolerated in reproductive health care. As a result, potential refusers find work in other fields and pregnant people have superior access to abortion care [8]. Why didn’t the ESCRH position paper recommend that other countries follow these proven examples, instead of citing countries whose ‘conscience’ regulations are inadequate or meaningless? In fact, not a single country in the world has successfully put into practice a law or policy that allows belief-based treatment refusals with limitations.

The ESCRH, as well as FIGO and many pro-choice medical professionals and academics, have accepted the notion that ‘conscientious objection’^b in reproductive health care is permissible or even a ‘right’, even though this has only served to fuel the practice of belief-based treatment refusals. The practice is now a seemingly accepted standard in over 70 countries and their abortion laws [9], despite the fact that ‘conscientious objection’ in health care has never been designated as a right by any international human rights body. The WHO and United Nations are aware that it too often denies care to patients and they call for restrictions on its exercise [10].

Belief-based care denials result in reduced access to abortion in most countries (not just a few), increased burdens on health care systems, serious harms to patients including death, and constant attempts to expand treatment refusals by right-wing forces, including beyond reproductive health care, such as for medical assistance in dying and LGBTQIA+ care.

Why did the ESCRH adopt the view that such treatment refusals should be accommodated, even while acknowledging they are highly problematic? Why were no references cited in the position paper showing that the refusal to treat for so-called reasons of ‘conscience’ is inherently wrong and harmful? At least two dozen authors [11] besides ourselves [2],[7],[8],[12] have

^b The term “conscientious objection” must be distinguished from its opposite, conscientious commitment, which the authors support. The authors’ definitions: Conscientious objection: The refusal by a health care professional to provide a legal, patient-requested, medical service that falls within the scope and qualifications for their field, based on their personal or religious beliefs. Conscientious commitment: The provision of necessary or beneficial health care to patients in need despite stigma, unjust laws, or oppressive systems.

demonstrated that these care denials are incompatible with the duties of health care professionals.

We ask the ESCRH to instead adopt the position that care denials based on personal or religious beliefs are unethical and paternalistic and should be discouraged. We also ask the ESCRH to endorse policies and regulations that reduce the number of objectors, and to work towards the goal of eventually prohibiting these discriminatory care denials.[13]

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