Study —100% of patients who were denied care oppose "Conscientious Objection"

Belief-based care denial harms patients seeking reproductive care

Introduction

Healthcare providers in Canada are allowed by professional associations to deny services on the basis of their personal beliefs or conscience.

Regulations surrounding the denial of care vary by province. Policies of professional colleges and associations are often vague, leading to confusion. Enforcement mechanisms to address complaints are lacking.

Refusal to provide or refer for contraceptive or abortion care may have a considerable impact on patients. Research exploring Canadians' experiences with belief-based denial of care is scant.

Key terms and definitions

Belief-based denial (aka "conscientious objection"): When a healthcare professional refuses to provide a legal, patient-requested medical service or treatment that falls within their scope of work and qualifications, based on their personal or religious beliefs.

The term originally referred to the principled objection to military service. But it may not apply to medicine in the same way as it does for the military. Due to this debate surrounding the term in medicine, we use the term "belief-based denial".

> If you're a healthcare provider and you're not willing to provide care to people then you shouldn't be a healthcare provider, you should straight up lose your license…
> If they're concerned about their rights and freedoms, they should just do something else…we need to be vigilant against this steady creep that's eroding our rights.
> — **Emma, 28, Manitoba**

Methods

- Conducted in-depth audio-Zoom/telephone interviews between November 2022 to March 2023 in English in Alberta, New Brunswick, and Ontario (Canada)
- Employed a multi-modal recruitment strategy, including posts through community organizations and social media
- Participants had experienced refusal of contraception or abortion care in the ten years before the interview (2012-2023)
- 30 participants aged 21 to 53, most identified as white women
- Analyzed interviews for content and themes using deductive and inductive techniques

Results

- Out of 30 participants:
  - 20 reported being denied contraception (including sterilization, hormonal methods, IUDs, and emergency contraceptive pills)
  - 9 reported being denied abortion care
  - 1 reported being denied both contraception and abortion
- A range of reasons for denial were reported: age, parity, low gestational age, and religious belief
- Most denials indicated that providers' personal biases and judgments about their patients played a role.
- Participants denied care felt angry, scared, disappointed, and frustrated.
- All participants expressed opposition to policies that allow providers to refuse reproductive health services based on their beliefs.

> I wasn't allowed to get the Gardasil vaccine…because of [the doctor's] religious beliefs. Just the assumption that I wouldn't be having sex before marriage so I wouldn't need it…
> I can't get birth control from my doctor. I have to go somewhere else…"
> **— Jo, 27, New Brunswick**

> The nurse calls me over and she's like, 'oh just so you know, because this a Catholic hospital we don't do that here'…
> I said, okay that's new to me because it is, as far as I know, a publicly funded hospital...so I was very frustrated that a hospital that provides healthcare is affiliated with a religion.
> — **Ava, 32, Ontario**

> I felt anger and frustration…that patients had their agency overridden by members of our healthcare system. It just made me more concerned and anxious... I'm not sure why we have the system set up this way.
> **— Anthony, 53, New Brunswick**

About the Study

Title: "Exploring Canadians' experiences with belief-based denial of contraception and abortion care: Results from a qualitative study"

Authors: Anvita Dixit, Joyce Arthur, Sneha Ananth, Meeka Jean-Baptiste, Anni Wu, Kyle Drouillard, Angel M. Foster

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Discussion

- Canadian federal government has repeatedly supported the provision of abortion and a full range of contraception.
- Provider denial creates barriers to accessing necessary health services.
- Reform of regulations allowing denial appears warranted, as well as better enforcement mechanisms.
- Sweden and Finland are two countries that successfully disallow belief-based care denial.

Conclusion

Allowing healthcare providers to deny care based on their personal beliefs creates barriers to accessing necessary health services. Policymakers and clinicians should consider:

- Reforming these regulations with attention to patient-centered outcomes that are informed by patient experiences
- Establishing avenues for patients to report violations of practice standards
- Creating enforcement mechanisms to ensure that Canadians receive the comprehensive reproductive health services they need and deserve.
- Discouraging the practice of belief-based care denial.

References — full list: https://tinyurl.com/5n73243m

Abortion laws – why we don't need any

Harms of a law vs. Benefits of no law

By Joyce Arthur, Executive Director
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Canada has successfully had no abortion law for 36 years.

The Supreme Court of Canada struck down the previous law in 1988 as unconstitutional because it violated women's bodily autonomy. The law was never replaced and the medical profession regulates abortion the same way as for other healthcare.

After Roe v. Wade was overturned in the United States, the Canadian government suggested that abortion rights and access should be protected by law. Reproductive rights groups pointed out that any such law could be amended or repealed, and weaponized by anti-choice forces who could add restrictions or challenge the law. Legislating abortion creates the risk of new barriers even if unintentional. Enshrining the right to abortion into Canada's constitution is also unnecessary because the right is already well protected under the constitutional right of "security of the person." To improve access, other means are available to the government such as enforcing the *Canada Heath Act* to ensure equitable access to abortion care in every province and providing dedicated funding for SRH.

New Zealand, Australia, and South Korea have also decriminalized abortion. New Zealand and all Australian states passed civil laws to regulate abortion practice, but it's still partially criminalized in Western Australia. South Korea's Supreme Court struck down the criminal law in 2019 but abortion access remains mostly blocked, reportedly because the government has failed to amend laws. Also, the abortion pill is not yet approved. But decriminalization should empower healthcare professionals (HCPs) and medical bodies to organize and deliver surgical abortion care on their own.

Social and Economic Impacts

Harms of an abortion law	Benefits of no law
• Stigma is amplified and enduring because abortion is restricted or illegal. Public support for abortion may stagnate or decline.	• Stigma can recede over time because abortion is perceived as part of healthcare and a woman's right. Public support for abortion increases and remains high.
• Restrictive laws are associated with lower status for women. The message sent is that women's childbearing capacity is more important than their status as human beings with rights.	• The status of women rises when their essential healthcare is not criminalized. Public support for gender equality tends to be higher.
• People may be afraid to voice their support for abortion, while people opposed are empowered to speak out.	• People who support abortion speak out freely. Those opposed often speak in euphemisms, adopt a mild public stance, or stay silent – because being anti-choice is seen as socially unacceptable.
• It is challenging to disseminate abortion information, leaving patients more vulnerable to misinformation and unsafe abortion.	• Comprehensive and accurate information on abortion can be published with no impediment, including how to access it. Such information can be accessed from official sources like governments and medical bodies.
• Marginalized populations are the most affected by barriers caused by laws, as they may lack the resources to obtain care or may avoid the medical system out of fear. This leads to disproportionate harms for people of colour, Indigenous people, LGBTQIA+ people, and other minorities.	• When abortion care is fully integrated into the health system, it can help ensure better access for all populations. Medical bodies and advocates can be funded by governments to provide care to vulnerable populations in culturally-appropriate ways.
• Abortion is separated from the larger context of social and structural determinants of health, negatively impacting racial, social, and economic justice. All of society is harmed by abortion criminalization, not just women and marginalized populations.	• Integrating abortion into healthcare systems allows Reproductive Justice to flourish: "The human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities."
• It is often difficult or impossible to establish public funding for abortion when it's legally restricted or criminalized.	• Full public funding for abortion becomes feasible when abortion is integrated into healthcare systems. There's no reason to treat it differently than other funded care.
• No government funding for abortion means that cost becomes a huge barrier for abortion seekers. Low-income people may need to delay or forgo care.	• Everyone who needs an abortion can access one regardless of income level.

Medical Impacts

Harms of an abortion law	Benefits of no law
• Government and law enforcement control how abortion care is delivered and accessed, even though they are unqualified.	• HCPs and medical organizations organize and deliver abortion care according to best medical protocols.
• HCPs must be familiar with the law, what the limits are, and how to navigate them.	• HCPs can focus on following clinical guidelines and professional ethical codes.
• Abortion may be siloed into private clinics, and/or providers tend to specialize in abortion.	• Abortion can be made more widely available in both hospitals and clinics. More providers can be trained and can incorporate abortion into their broader practice.
• Training for abortion providers is unavailable or limited. Diminished training opportunities can lead to a decline in clinical skills and knowledge, which impacts access to care and reinforces stigma.	• Training for abortion providers can be made more readily available by NGOs and at medical schools. Reduced stigma means that abortion training can even be made mandatory, at least for Ob/Gyns.
• HCPs cannot engage in innovation and new protocols because the law may preclude this (eg, patients must attend clinics in-person, some abortion methods are restricted).	• HCPS can implement innovations and new protocols as needed.
• Research into abortion care and practice may be limited or non-existing, making it challenging to improve care standards. HCPs may be using outdated methods that do not meet current standards.	• Researchers are free to carry out studies and even specialize in abortion research at their university (eg, in Canada). HCPs can continually improve care standards by implementing research findings.
• HCPs may not be able to provide the best standard of care because of possible legal consequences and the need to consult lawyers.	• HCPs can focus on providing the best standard of healthcare for their patients without legal worry.
• HCPs may have to turn patients away who don't meet legal requirements for an abortion.	• HCPs are free to provide care for their patients or refer them to other HCPs with the required skills.
• Laws may restrict abortion provision to Obstetrician/Gynecologists, which reduces the pool of providers and narrows access.	• Family doctors can provide abortions, increasing the provider pool. Nurse practitioners and midwives may also be able to provide abortions.
• Criminalization usually means no registration and limited availability of the essential medicines mifepristone and misoprostol.	• There are no legal impediments to approving abortion medication in a country, or to dispensing and distributing it.

Health Impacts

Harms of an abortion law	Benefits of no law
• Countries with restrictive laws have higher maternal mortality rates.	• Maternal mortality from abortion is extremely rare in the absence of a law (eg, in Canada) – and very low in countries with more liberal laws.
• Patients' physical and mental health is put at risk. The law may cause delays and barriers, compel patients to accept unsafe or sub-standard care, or force them to carry to term. These outcomes lead to increased distress and depression.	• Patients can access safe care more easily and quickly, with fewer barriers and reduced stigma, resulting in much less risk of physical or mental health issues.
• Some abortion seekers will be unable to access care due to financial or other barriers, putting them at risk of anxiety and low self-esteem, increased poverty, and staying linked to abusive partners (compared to those who have abortions).	• Everyone who needs an abortion should be able to get one. While some people may still fall through the cracks, it's due to other issues and not the law.
• Patients who experience complications from abortion may be afraid of seeking help in a criminalized environment, putting their health at risk.	• Patients who experience complications from abortion can go to hospital or call their doctor, as they would for any other medical problem.
• Criminal laws with limited or no exceptions force people to carry to term in cases of severe fetal abnormality. This leads to increased physical and mental health risks, and a higher maternal and infant mortality rate.	• Patients are able to access later abortions with fewer barriers and are treated with compassion and dignity.
• Gestational limits mean that HCPs and patients face arbitrary deadlines that interfere with their ability to provide/access care.	• Treatment decisions are based on clinical considerations and patient needs, not legal limits.
• Births of unwanted children are common. They are more likely to be victims of infanticide, abandonment, or abuse.	• Very few unwanted children are born. Access to safe abortion allows people to plan and have wanted children when they're ready, and the children are more likely to thrive.

Legal and Political Impacts

Harms of an abortion law	Benefits of no law
• Criminal laws violate women's constitutional and human rights, including rights to life, health, bodily autonomy, equality, non-discrimination, privacy, conscience, freedom of religion and expression, dignity, and freedom from cruel, inhuman, and degrading treatment (as per CEDAW and other international agreements).	• Women maintain their full constitutional and human rights when they seek and have abortions. • Compliance with international agreements is assured when abortion rights and access are protected.
• Unlike other medical treatments, abortion is singled out for criminalization or legal control.	• Abortion becomes a normal part of reproductive healthcare and can be integrated with other types of care.
• Criminal laws fail in their intent to prevent abortion. Most women will find a way to access abortion, whether safe or unsafe. As a result, abortion rates are broadly similar around the world regardless of law.	• Abortion rates do not increase and are likely to decrease with good access to contraception. Laws are unnecessary because we can trust women as well as the medical expertise of HCPs to manage abortion practice responsibly.
• Abortion seekers and HCPs are criminals if they have/provide abortions outside the law, and risk arrest and prison if reported.	• People who have abortions are law-abiding citizens with rights, and abortion providers are respected professionals who abide by ethical codes.
• Abortion seekers may be afraid to ask for support from friends or families, who in turn may be afraid to help due to potential legal consequences.	• Abortion seekers can feel much more confident in asking for help from their support networks, with no negative consequences for anyone.
• Later gestational limits insultingly imply that a 24-week limit is necessary to stop hordes of irresponsible women from having frivolous 9-month abortions.	• Women's autonomy and decisions are respected and accommodated. This includes difficult but rare decisions to end later pregnancies that have gone wrong.
• When a criminal law allows certain exceptions, it sends the message that women who have abortions for "unjustified" reasons are immoral and criminal.	• Abortion seekers do not have to give a reason. Their decisions are respected as the best choice for themselves.
• Exceptions allowed by a criminal law generally don't work, eg, rape victims may be required to report to police, and emergency exceptions are vaguely worded.	• Those who need abortions for emergency or compassionate reasons can access them without any special requirements.

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Belief-Based Care Denial - Let's Change the Terms of the Debate

So-called "conscientious objection" occurs when a healthcare professional refuses to provide a legal medical service based on their personal or religious beliefs. This happens mostly for abortion and contraceptive care.

A more accurate term is **belief-based care denial**. This makes it clear that treatment is being refused for ideological reasons, not clinical considerations. Further, care denials aren't conscientious because they cause harms to patients and create barriers to care.

How did the term "conscientious objection" get adopted?

In the UK around 1960, Glanville Williams drafted the earliest known example of a "conscience clause", which aimed to protect doctors from liability if they refused to provide legalized abortion. Williams was a legal scholar and president of the Abortion Law Reform Association, but he was also a conscientious objector during World War II. It's likely that Williams simply adopted the term on the assumption that refusing to provide abortions could be equated to refusing to kill in war. But can it?

Military conscientious objection (CO) is nothing like healthcare "conscientious objection" ("CO")

Soldiers are drafted into compulsory service in a subordinate position.	Healthcare professionals compete for training and jobs and enjoy a position of power and authority.
Soldiers must justify their stance before a tribunal and accept punishment or alternate service in exchange for exercising their CO.	Healthcare professionals rarely need to justify their "CO" and usually face no consequences for denying care, often retaining their positions and salaries. Patients bear the burdens of "CO."

Calling the denial of healthcare "conscientious objection" is dishonest – also because it stigmatizes abortion and frames it as immoral.

Safe and legal abortion reduces maternal mortality, improves lives, and furthers gender equality. Objections to providing abortions are based on a denial of that evidence and the known harms of criminalizing abortion.

The provision of abortion is a vital public interest that negates any grounds for belief-based care denial.

Other factors point to the illegitimacy of "CO" in healthcare

Belief-based care denial is linked to religious beliefs, which drive abortion stigma and political action against abortion rights. We must not let religion and patriarchy dictate who gets what medical care.

Society still holds traditional sexist beliefs about women, who are expected to fulfil a motherhood role and may face hostility when requesting abortion. Belief-based care denial is a paternalistic initiative to compel women to give birth.

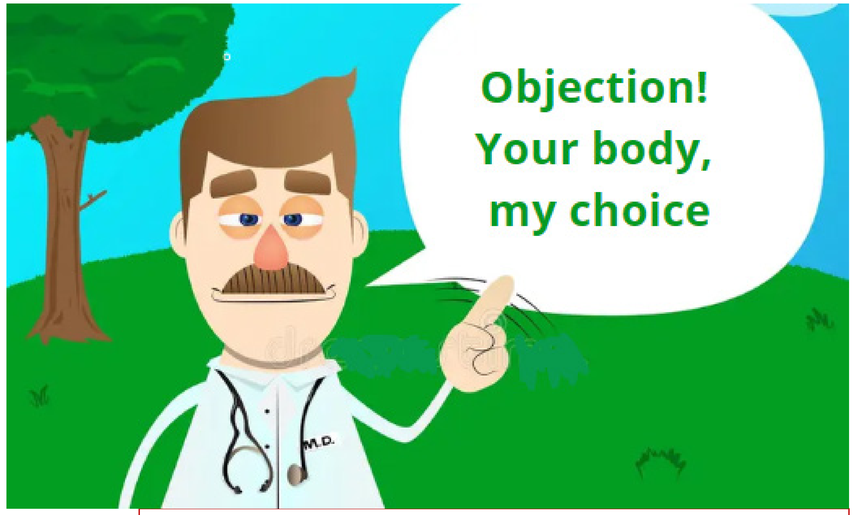
Medicine is a scientific pursuit and doctors are part of a regulated profession. They owe a fiduciary duty to patients and their work fulfills a public trust. Belief-based care denial turns this duty upside down and creates a conflict of interest. Care deniers are abusing their position of trust and authority by imposing their personal views on patients.

Denial of healthcare must not be based on a patient's gender, race, religion, disability, or medical condition. But belief-based care denial is rooted in gender discrimination because reproductive healthcare is largely delivered to women.

Care denials are not an issue of "competing rights" between the doctor and patient because there is no "balance" when an authority figure is allowed to impose their beliefs on a dependent person. A patient's right to life and health has no moral equivalency with a doctor's supposed right to refuse them care.

About eighty stories have been collected from global media and NGO reports where women have suffered serious harm or injustice after being denied legal abortion by "objectors," including death in several cases. These stories are the tip of the iceberg, as few cases ever become public.

Why should society allow belief-based care denial when we have clear evidence of its harms and of the necessity of access to abortion? Supporting it just cedes ground to the anti-choice movement and weakens the causes of reproductive rights and gender equality.



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Over time, it's possible to reduce or eliminate belief-based care denial through disincentives and other measures (it does *not* include forcing doctors to do abortions). We can start by ditching the misleading phrase "conscientious objection," which has become nothing more than an anti-choice propaganda term.

Let's adopt the term belief-based care denial

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