

JOURNAL REVIEW

Conscientious objection and refusal to provide reproductive healthcare: a White Paper examining prevalence, health consequences and policy responses

Chavkin W, Leitman L, Polin K; for Global Doctors for Choice. *Int J Gynecol Obstet* 2013;123:S41–S56.

This is a comprehensive analysis of conscientious objection/refusal by doctors, nurses, midwives and pharmacists in five areas of reproductive healthcare: abortion, assisted reproductive technologies (ART), contraception, unavoidable pregnancy loss due to maternal illness and prenatal diagnosis. The rights of objecting providers are balanced against those of patients. A systematic search for data from quantitative, qualitative and ethnographic studies in the last 15 years was done. Objection varied enormously with some objectors being absolute and others making exceptions. The overall impression is that objection is widespread and increasing globally. Because of lack of empirical data on the impact of objection on patient care, logical models of plausible consequences of refusal to treat were drawn up.

- ▶ With respect to abortion, the authors suggest that objection will have less impact in countries with available safe abortion than in those in which access is restricted. Examples of South Africa and Senegal are given with few providers offering services and higher rates of unsafe abortion.
- ▶ In ART, objection leads to refusal of embryo selection, reduction and cryo-preservation. Multiple embryos are implanted with consequent increased maternal and neonatal complications.
- ▶ In countries in which the Catholic Church holds sway (e.g. Poland) there is widespread refusal to provide contraceptive services of any kind. More specifically, in certain countries there is inhumane denial of emergency contraception to rape victims.
- ▶ Examples are given of women dying from septic abortion, uncontrolled inflammatory bowel disease and ectopic pregnancy due to denial of treatment, even in countries where treatment would have been entirely legal.
- ▶ Objection to prenatal diagnosis means some women carry a fetus with a lethal abnormality to term and others are deprived of the time to secure the necessary emotional and practical resources to prepare for a child with special needs.

United Nations treaty monitoring bodies and international professional guidance clearly state that in services

where objection is taking place there must be referral to alternative providers. Also, it is clear that objectors must provide all necessary services in an emergency. Interesting examples of the great variation in approaches to objection are given. Whereas generally it is considered that only individuals can be objectors, Argentinian law permits institutions to object. In Norway, there is an excellent regulatory framework that monitors objection and ensures the availability of providers. In some countries objection must be registered in advance. Some laws and ethical codes require a provider to disclose status as an objector to patients. In a few countries objection to providing abortion services is not permitted by law.

The article has useful flow charts and a table of benefits and limitations of policy interventions. The authors call for providers and professional bodies to lead attempts to respond to conscience-based refusal and to safeguard reproductive health, medical integrity and women's lives.

This is a highly authoritative piece of work with extensive referencing. It is a most valuable resource.

Reviewed by **Sam Rowlands**

Visiting Professor, School of Health and Social Care, Bournemouth University, Bournemouth, UK; srowlands@bournemouth.ac.uk

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Provenance and peer review

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