Nos. 20-15398, 20-15399, 20-16045 and 20-35044

**IN THE UNITED STATES COURT OF APPEALS**
**FOR THE NINTH CIRCUIT**

CITY AND COUNTY OF SAN FRANCISCO, *Plaintiff-Appellee*,
v.
ALEX M. AZAR II, et al., *Defendants-Appellants*.

COUNTY OF SANTA CLARA, et al., *Plaintiffs-Appellees*,
v.
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., *Defendants-Appellants*.

STATE OF CALIFORNIA, *Plaintiff-Appellee*,
v.
ALEX M. AZAR, et al., *Defendants-Appellants.*

STATE OF WASHINGTON, *Plaintiff-Appellee*,
v.
ALEX M. AZAR II, et al., *Defendants-Appellants.*

On Appeal from the United States District Courts for the
Northern District of California and the Eastern District of Washington

**SUPPLEMENTAL EXCERPTS OF RECORD**
**VOLUME V OF X**

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO,
Plaintiff,
vs.
ALEX M. AZAR II, et al.,
Defendants.

STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,
Plaintiff,
vs.
ALEX M. AZAR, et al.,
Defendants.

COUNTY OF SANTA CLARA et al,
Plaintiffs,
vs.
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,
Defendants.

No. C 19-02405 WHA
No. C 19-02769 WHA
No. C 19-02916 WHA

**DECLARATION OF WENDY CHAVKIN, M.D., MPH IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT**

| | |
|---|---|
| Date: | October 30, 2019 |
| Time: | 8:00 AM |
| Courtroom: | 12 |
| Judge: | Hon. William H. Alsup |
| Action Filed: | 5/2/2019 |

I, Wendy Chavkin, M.D., MPH, declare:

1. The matters stated in this declaration are true based upon my own personal knowledge, except as to those matters stated on information and belief, and as to those matters, I believe them to be true, and if called as a witness, I would competently so testify.

2. I have been retained by the State of California to provide consulting expertise in the area of conscientious objection to providing reproductive health care and consequences of refusal to provide reproductive health care for women and for health systems. As indicated in my C.V. and in this declaration, I have significant experience in these areas. Attached hereto as Exhibit A is a true and correct copy of my current C.V., which accurately describes my educational background and experience.

3. I attended SUNY Medical School and received a Doctor of Medicine degree in 1978. I also have a Masters of Public Health degree from the Columbia University Mailman School of Public Health. I am licensed to practice medicine in the State of New York.

4. I have worked as an OB/GYN. In 2004-2005, I was a Fulbright New Century Scholar for my research on Fertility Decline and the Empowerment of Women. From 1994 to 2002, I was editor-in-chief of The Journal of the American Medical Women's Association. From 1984 to 1988, I was the Director of the New York Department of Health's Bureau of Maternity Services and Family Planning. I am currently a professor emerita of Public Health and Obstetrics-Gynecology in Columbia University's Department of Population and Family Health in the Mailman School of Public Health and in the Department of Obstetrics & Gynecology in Columbia University's College of Physicians and Surgeons.

5. I have received numerous awards from public health organizations for advocacy including the Felicia Stewart Advocacy Award, Jean Pakter Award, and Allan Rosenfield Award.

6. I am a founder and former Chair of the Board of Physicians for Reproductive Health, a doctor-led national advocacy organization that uses evidence-based medicine to promote and improve access to comprehensive reproductive health care, including contraception and abortion, especially to meet the health care needs of economically disadvantaged patients.

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7. I am also the co-founder of Global Doctors for Choice (GDC), a transnational network of physicians who advocate for access to comprehensive reproductive health care, including safe abortion. Many of the doctors who collaborate through GDC have experience working in countries where they have watched women die regularly from unsafe abortions or lack of care.

8. My extensive research work has addressed maternal and infant mortality in the United States, the consequences of welfare reform for the health of women and children, HIV and illegal drug use in pregnancy, policy responses to declining birthrates, and conscientious objection to providing reproductive health care, among other issues. Some of my areas of expertise include Infant Mortality, Disparities/Inequalities in Health, Social/Cultural Issues, Women's Health, Poverty, Healthcare Policy, Welfare Programs, Abortion, Birth Outcomes, Family Planning, Fertility/Infertility Issues, Maternal Health and Mortality, Prenatal/Perinatal Care, Reproductive Health, Reproductive Rights, Addiction/Drug Abuse, Declining Fertility, and Assisted Reproductive Technologies.

9. I have conducted research and written about clinicians who cite religious belief as grounds for refusing to provide components of health care. I have studied this phenomenon in the United States and also in England, Ghana, Ireland, Italy, Norway, and Portugal. I have collaborated with World Health Organization (WHO) and International Federation of Gynecologists-Obstetricians (FIGO) and World Medical Association (WMA) and others in this research and publication (see Exhibit A for a complete list of my publication work in this area).

10. I have also presented several times on conscience based refusal of health care, including at a GDC panel event titled *Respecting Conscience, Protecting Care: The impact of religious-refusal laws on doctors, patients and healthcare systems around the world –lessons for the United States*. This May 12, 2014 event was held at the Elliott School of International Affairs at George Washington University. I have presented as well as at similar panels in Rio de Janeiro, Dublin, Canterbury, Rome, Montevideo, and Seville.

11. Both individual conscience and autonomy in reproductive decision-making are essential rights. As a physician group, GDC advocates for the rights of individual physicians to

maintain their integrity by honoring their conscience. We simultaneously advocate that physicians maintain the integrity of the profession by according first priority to patient needs and to adherence to the highest standards of evidence-based care. We broaden the frame beyond individual physician and patient to also consider the impact of conscientious objection on other clinicians, on health systems, and on communities.

12. Consistent with these beliefs, international professional associations, such as the WMA and FIGO, as well as national medical and nursing societies and groups, such as the American Congress of Obstetricians and Gynecologists (ACOG), have similarly agreed that the provider's right to conscientiously refuse to provide certain services must be secondary to his or her first duty, which is to the patient. They specify that this right to refuse must be bounded by obligations to ensure that that the patient's rights to information and services are not infringed.

13. In the United States, I recently convened highly regarded legal scholars, ethicists, physicians, social scientists, and clergy to discuss how to balance individual beliefs and integrity with societal needs and the obligations of clinicians. We published an article, *Balancing Freedom of Conscience and Equitable Access*, in the fall 2018 American Journal of Public Health in which we discussed the proposed rule, "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority," 83 Fed. Reg. 3880 (Jan. 26, 2018).[1] This work concludes that anticipated harms resulting from refusals as contemplated by the proposed rule include:

- Hindering patients' ability to exercise their right to obtain a legal service or good in the health care setting;
- Exempting providers from their professional and ethical duties will undermine trust and respect for the profession and the medical community. A medical professional's licensure conveys a monopoly or power over the provision of a service which, in exchange for that privilege, carries fiduciary duties to put the

[1] Wendy Chavkin, et al., *Balancing Freedom of Conscience and Equitable Access,* 108 Am. J. Public Health, 1487 (Nov. 2018), https://globaldoctorsforchoice.org/wp-content/uploads/2018-Chavkin-et-al.-AJPH-freedom-of-conscience.pdf. A true and correct copy of this article is attached hereto as Exhibit B.

needs of patients first, keeping in mind that the balance of knowledge favors the physician and patients are vulnerable;

- Refusals could obstruct advancement of a state's public health measures, such as measures to halt the spread of infectious diseases;
- Objections inevitably increase the workload of those willing to provide services. Those willing providers may see their range of practice narrow beyond their liking because providing care that others refuse causes them to spend a disproportionate share of their time doing so; and
- Objections may have a negative impact on the bedrock constitutionally based social values of separation of church and state and tolerance required in a pluralist society.

14. Among my many works, I am the lead author of *Conscientious Objection and Refusal to Provide Reproductive Healthcare: A White Paper Examining Prevalence, Health Consequences' and Policy Responses*, published in the International Journal of Gynecology and Obstetrics.[2] In that White Paper (a true and correct copy of which is attached hereto as Exhibit C), we drew upon existing medical, public health, legal, ethical, and social science literature to cull what is known about conscientious objection and access to reproductive health care.

15. I have reviewed the final rule, "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority," 84 Fed. Reg. 23170 (May 21, 2019) (Rule). The Rule cites to my aforementioned White Paper stating that there is "insufficient evidence to conclude that conscience protections have negative effects on access to care." 84 Fed. Reg. at 23251, n.345. But the Rule misinterprets the conclusions of the White Paper. Specifically, it incorrectly interprets the existence of limited data as an indication that there is a lack of harm from refusals of care. Such is not the case. The White Paper does not indicate that there is no evidence of harm to patients, but rather, that the data concerning the prevalence of conscience-based refusal is a

[2] Wendy Chavkin, et al., *Conscientious Objection and Refusal to Provide Reproductive Healthcare: A White Paper Examining Prevalence, Health Consequences' and Policy Responses*, 123 Int'l J. Gynecol. & Obstet., S41 (2013). AR 000538675-08.

limited data base, and that the White Paper nonetheless schematically delineates the logical consequences of events if care is refused as further explained below.

16. The White Paper builds on logical models to delineate the dangers of decreased access to women's health care due to conscientious objection, including dangers of decreased access to abortion and post abortion care; components of assisted reproductive technologies (ART) relating to embryo manipulation or selection; contraceptive services, including emergency contraception (EC); treatment in cases of unavoidable pregnancy loss or maternal illness during pregnancy; and prenatal diagnosis (PND).

17. At the individual level, decreased access to health services brought about by conscientious objection has a disproportionate impact on those living in precarious circumstances, or at otherwise heightened risk, and aggravates inequities in health status. Access to reproductive healthcare is additionally compromised when gynecologists, anesthesiologists, generalists, nurses, midwives, and pharmacists cite conscientious objection as grounds for refusing to provide specific elements of care.

18. The level of resources allocated by the health system greatly influences the impact caused by the loss of providers due to conscience-based refusal of care. In resource-constrained settings, where there are too few providers for population need, it is logical to assume the following chain of events: further reductions in available personnel lead to greater pressure on those remaining providers; more women present with complications due to decreased access to timely services; and complications require specialized services such as maternal/neonatal intensive care and more highly trained staff, in addition to incurring higher costs. The increased demand for specialized services and staffing burdens and diverts the human and infrastructural resources available for other priority health conditions.

19. The White Paper also delineates the specific consequences of conscience based refusals to particular aspects of women's reproductive health, including:

- **Abortion-related services**: decreased access to legal abortions services and higher rates of unsafe abortions with increased risk of maternal mental health risk,

morbidity and mortality, overburdening willing providers, and increased costs to individuals, communities, and health systems (Exhibit C, Figure 1 at p. S46);

- **Contraceptive services**: increased likelihood of pregnancy for survivors of sexual assault or those at medical risk; lower contraceptive prevalence and increased use of less effective methods with resulting increased maternal mental health risk, morbidity and mortality, abortion (including unsafe abortions), infant morbidity and fetal loss; higher costs to individuals, communities, and health systems; lower economic status for women; and overburdening willing providers (Exhibit C, Figure 3 at p. S48); and
- **maternal medical problems and unavoidable pregnancy loss**: health deterioration with resulting increased surgical/medical intervention (including emergency intervention), maternal mental health risk, morbidity and mortality; higher costs to individuals, communities, and health systems; and overburdening willing providers (Exhibit C, Figure 4 at p. S49).

20. The White Paper also provides specific examples of harm to women from conscience based objections, including the following:

- Limited access to safe care and safe abortions in Senegal and South African due to widespread conscientious objection, including instances of conscientious objections being invoked even for care after miscarriage, Exhibit C, at pp. S45-46;
- Denial of emergency contraception to rape victims in the United States, Poland, and Germany due to conscientious objections, Exhibit C, at p. S46;
- Maternal deaths from conscientious objections to care for pregnancy loss/ectopic pregnancy in Poland and Ireland, Exhibit C at p. S47; and
- Harm to children from conscientious objections to prenatal diagnosis in Poland, Exhibit C, at p. S48.

21. The Rule also cites to one of my more recent articles concerning the impact of conscience-based refusal of care on delivery of reproductive health care, a piece I co-authored titled *Conscientious Objection to Abortion and Reproductive Healthcare: A Review Of Recent*

*Literature And Implications For Adolescents* published in Current Opinion in Obstetrics and Gynecology (a true copy of which is attached hereto as Exhibit C).[3] This work reviewed the recent extensive medical, public health, legal, ethical, and social science research examining the prevalence, character, and impact of conscience-based refusal, and policy efforts to balance individual conscience, autonomy in reproductive decision-making, safeguards for health, and professional medical integrity. It rendered the following conclusions:

- Conscientious objection to reproductive health care has increased globally and constitutes a barrier to these services for many women and particularly to adolescents because some providers object to specific aspects of their reproductive health care because of their status as minors.
- The prevalence of conscientious objection is difficult to measure, as there is no standard definition of the practice.
- The literature demonstrates that some clinicians purport to be objectors when in fact they are uncomfortable with specific patient characteristics or circumstances, rather than because of deeply held religious or ethical convictions. Witness the Norwegian physician whose objection varied according to the reason for abortion and the Brazilian obstetrician–gynecologists whose objection varied according to patient characteristics. This complexity illuminates the difficulty in defining conscientious objection and illustrates the need to disentangle prejudice from a consistently held moral position.
- Nevertheless, the consensus of the international human rights community (the UN Committee on Economic, Social and Cultural Rights, the UN Committee on the Elimination of Discrimination against Women, and the UN Human Rights Committee, the European Court of Human Rights) and the medical and public health community (FIGO, ACOG, WHO, etc.) on conscientious objection affirms that providers have a right to conscientious objection, but that right should be

[3] Kathleen M. Morrell and Wendy Chavkin, *Conscientious objection to abortion and reproductive healthcare: a review of recent literature and implications for adolescents*, 108 Curr. Opin. Obstet. Gynecol., 333 (2015). AR 000538046-51.

secondary to their primary conscientious duty as health care providers to provide benefit and prevent harm to patients.

22. This article concludes that there must be safeguards to ensure patients receive accurate information and timely care through referral, and in emergency situations, a patient must be provided necessary care.

23. I have reviewed the index of the July 22, 2019 administrative record and the August 19, 2019 supplemental administrative record; specifically, the medical articles listed in the indices. I am familiar with several of the medical articles listed and based on my review of the indices, it appears to me that only a limited and select number of articles are included and the list fails to include numerous peer-reviewed articles from reputable medical journals that indicate harm that may result from refusals of care.

24. This Rule relies on the following medical journal articles; however, these articles do not appear to support—and in some cases undermine—the broad conscientious objections proposed by the Rule:

a. Armand H. Matheny Antommaria, *Adjudicating rights or analyzing interests: ethicists' role in the debate over conscience in clinical practice*, 29 Theor. Med. Bioeth. 201 (2008). AR 000537549-60. Antommaria proposes approaches for mediating competing interests regarding emergency contraception, such as over the counter status, advance prescription, and other means of assuring that patients' interests are met while offering objecting providers routes for avoidance, *without* contravening patients' needs and rights. The author concludes that "multiple systems of distribution are possible that may better accommodate both the pharmacists' and the clients' interests." *Id.* at 000537558.

b. Lisa H. Harris, et al., *Obstetrician-Gynecologists' Objections to and Willingness to Help Patients Obtain an Abortion*, 118 Obstet. & Gyn. 905 (2011). AR 000537563-77. This article discusses the results of a survey conducted between October 2008 and January 2009 of a stratified random

sample of 1,800 general ob-gyns, 65 years of age or younger in the American Medical Association Physician Masterfile who were questioned about abortion in seven scenarios: a) a 22-year-old single woman six weeks pregnant after failed hormonal contraception; b) a 38-year-old with five daughters and no sons, after chorionic villus sampling reveals the fetus is a chromosomally normal female (sex selection); c) a 36-year old in the first trimester of pregnancy who needs radiation and chemotherapy for newly diagnosed breast cancer; d) a 28-year-old with type I diabetes, for whom glucose management has become very difficult at 16 weeks' gestation; e) a 34-year-old woman six weeks pregnant after being raped; f) selective reduction in a healthy 37-year-old with a quintuplet pregnancy; and g) a 24-year-old with a cardiopulmonary abnormality associated with a 25% chance of death with gestation. *Id*. at 000537564. The data suggest that even though ob-gyns differentiated responses according to these contextual factors that approximately two-thirds of those who objected to abortion in a given case, nevertheless indicated that they would help patients obtain an abortion. *Id*. at 000537563.

c. Douglas B. White, et al., *Would Accommodating Some Conscientious Objections by Physicians Promote Quality in Medical Care?*, 305 J. Am. Med. Assoc. 1804 (May 4, 2011). AR 000537892-3. In this commentary, the authors conclude that there is some benefit to allowing certain CBRs, or Conscience Based Refusals, including obtaining a "higher quality medical care in aggregate by accommodating some CBRs." AR 000537892. But the commentary also adds that "[p]hysicians should also be asked to make sacrifices by requesting accommodation only for core moral beliefs, not lesser beliefs." *Id*. at AR 000537893. The commentary also recommends "placing of well-defined limits on the accommodation of CBRs [to] optimize the burden-benefit ratio," and advocates for "open, respectful communication

between the physician and patient about CBRs." *Id.* The commentary also recommends that the "societal perspective should be incorporated into efforts to develop a comprehensive framework for when CBRs should and should not be accommodated." *Id.*

d. Josh Hyatt, *Recognizing Moral Disengagement and Its Impact on Patient Safety*, 7 J. of Nursing Regulation 18 (Jan. 2017). AR 000537894-00. Hyatt discusses the harms of moral distress and disengagement in the medical profession and recommends systemic changes. This article does not discuss situations that may implicate conscientious objection as a source of moral distress. *Id.* at 000537895-96.

e. Joan McCarthy, et al., *Moral Distress: A Review of the Argument-Based Nursing Ethics Literature*, 22 Nursing Ethics 131 (2015). AR 00537901-23. McCarthy provides an overview of literature on nursing moral distress, or MD, including its many potential sources: inadequate patient consent, overtreatment, cost cuts, hierarchical structures and imbalance of power, unequal pay and conditions between doctors and nurses, harm to patients, institutional constraints, aggressive care, poor staffing, poor pain management, incompetent care, sensitivity to patient vulnerability, lack of autonomy, conflicts with ethical values, difficult working conditions, corporatization of healthcare, security, time constraints, self-doubt or lack of courage, legal concerns, administrative and institutional policies, workload, discrimination, scarce resources, among other likely sources. *Id.* at 000537906-11. McCarthy concludes that research on moral distress in nursing is timely and necessary. But while the basic consensus on MD may encourage empirical researchers to continue in their attempts to describe, measure and assess its impact, significant concerns about the conceptual "fuzziness" of MD and its operationalization also flag the need to proceed with caution. *Id.* at 000537920-21.

f. Farr A. Curlin M.D., et al., *Religion, Conscience, and Controversial Clinical Practices*, 356 New Eng. J. Med. 593 (Feb. 8, 2007). AR 000537924-31. Curlin surveyed physicians and found that the majority believe that objectors must provide patients with full and accurate information and referrals. AR 000537924.

g. Christy A. Rentmeester, *Moral Damage to Health Care Professional and Trainees: Legalism and other Consequences for Patients and Colleagues*, 33 J. of Med. & Philospy, 27 (2008). AR 000538029-45. Rentmeester discusses potential sources of moral damage, including working under tight time constraints, working long hours, witnessing human suffering and harrowing particulars of illnesses, negotiating communication on difficult and awkward topics with patients and their loved ones, and inflicting pain, among others, as the sources of emotional distress and concludes that its effects on individual caregivers can vary at least as much as individual caregivers vary. AR 000538032. "Moral damage" to clinicians who limit their sense of obligation to patients leads to callousness, damaged professionalism, harm to patients, and to colleagues and trainees. *Id.* at 000538030-31.

h. Emmanuel Scheppers, et al., *Potential Barriers to The Use of Health Services Among Ethnic Minorities: A Review*, 23 Family Practice, 325 (2006). AR 000538052-75. Scheppers enumerates many potential barriers to the use of health services among ethnic minorities, including discourteous care, and stereotypical and/or discriminatory attitudes from healthcare providers. AR at 000538069.

i. Michael P. Combs, et al., *Conscientious Refusals to Refer: Findings From a National Physician Survey*, 37 J. Med. Ethics, 397 (2011). AR 000538670-74. Combs reports data from the survey results of 1,032 physicians regarding conscientious objections and found that more than half (57%) considered it obligatory to refer patients regardless of whether or not the doctor believes the

referral itself is immoral, suggesting there is no uncontroversial way to resolve conflicts in this setting. AR 0 000538670.

j. Stephen J. Genuis, et al., *Ethical Diversity and the Role of Conscience in Clinical Medicine*, 2013 Int'l J. of Family Med. 1 (2019). AR 000538709-27. Genuis recommends exploration of practical approaches to ethical issues in clinical medicine, specifically "a judicious tension of individual freedom and competent regulation within accepted societal boundaries." AR 000538709, 000538722.

k. Fariba Borhari, et al., *The Relationship Between Moral Distress, Professional Stress, and Intent to Stay in the Nursing Profession*, 2013 Int'l. J. Fam. Med. 587541 (2013). AR 000538733-40. Borhari surveyed 220 nurses at two teaching hospitals in Iran about moral distress resulting from providing substandard or insensitive care and correlated it with ambivalence about staying in the profession.

l. Fallon E. Chipidza, et al., *Impact of the Doctor-Patient Relationship*, 17 The Primary Care Companion for CNS Disorders (May 21, 2015). AR 000538792-21. Chipidza states that the doctor-patient relationship is essential in the provision of effective health care. This article does not mention conscientious objection. However, this article emphasizes patient trust and patient locus of control and other relationship factors as being essential to the patient doctor relationship. It can thus be surmised that that patient doctor relationship would be undermined if doctors deny care because of personal beliefs.

m. Ezekiel Emanuel, et al., *Euthanasia and Physician-Assisted Suicide: Attitudes and Experiences of Oncology Patients, Oncologists, and the Public*, 347 Lancet, 1805 (June 29, 1996). AR 000538816-21. Emanuel surveyed oncology clinicians, patients, and the public about euthanasia and physician

assisted suicide and found that the majority were sympathetic to patients requesting such care, but had some reservations.

n. Julie Cantor, *Conscientious Objection Gone Awry, Resorting Selfless Professionalism in Medicine*, 360 New Eng. J. Med. 1484 (April 9, 2009). AR 000548434-35. In this opinion piece, Cantor disputes the necessity of permitting conscientious objections in medicine, concluding patients need complete information about legal choices, referrals, and treatment. AR 00548434-35.

o. Lori Freedman, *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, 98 Amer. J. of Pub. Health, 1774 (Oct. 2008). AR 000548500-04. Freedman reports a series of cases in which physicians working in Catholic hospitals were not permitted to provide care conforming with best practices; specifically, when confronted with a woman with an inevitable miscarriage. The physicians were prohibited from completing the process if a fetal heartbeat was still detected, thus subjecting the woman to risk of serious bleeding, infection and death.[4]

p. Nichole Thorne, et al., *Reproductive Health Care in Catholic Facilities: A Scoping Review*, 133 Obstet. Gynecol., 105 (Jan. 2019). AR 000548505-15. Thorne looks at the literature in medical data bases about reproductive health care provision in U.S. Catholic hospitals and reports that most do not provide basic elements of reproductive health care, including, for example, emergency contraception for rape victims, and that few studies assess the health consequences of this lack of provision or referral. The authors also report that physicians and resident physicians in training were unhappy with this

[4] In Ireland, a similar case led to the death of Savita Halappanavar. Outrage concerning this incident led to the overturning of the ban on abortion and the establishment of a national abortion service. *See e.g.*, Marge Berer, *Termination of Pregnancy as Emergency Obstetric Care: The Interpretation of Catholic Health Policy and The Consequences for Pregnant Women: An Analysis of the Death of Savita Halappanavar in Ireland and Similar Cases*, 21 Reproductive Health Matters, 9 (May 14, 2013), https://www.ncbi.nlm.nih.gov/pubmed/23684182.

prohibition and interference with their ability to provide good care, and some even try to provide the prohibited care. As with the mistaken interpretation of my White Paper, this article does not posit lack of health consequences, but merely reports that the topic has not been fully investigated.

q. Elaine L. Hill, *Reproductive Health Care in Catholic-Owned Hospitals, Working Paper 23768*, National Bureau of Economic Research (Feb. 2016). AR 000548516-98. This working paper examines changes in specific reproductive health related procedures at hospitals that became subject to Catholic directives after mergers, with efforts to control for many potentially confounding parallel trends. The chief finding is a sizeable 31 percent per bed decrease in tubal ligations, and a concurrent decrease in vasectomies (although much smaller numbers and effect as these are primarily performed on an outpatient basis). *Id.* at 000548532. Fewer tubal ligations increase the risk of unintended pregnancies across the United States, imposing a potentially substantial cost for less reliable contraception on women and their partners. *Id.* at 000548553. Also a noteworthy finding is that half of women who delivered at these hospitals prior to the merger switched hospitals for their second delivery. *Id.* at 000548522.

25. There are numerous peer-reviewed articles from reputable medical journals that indicate harm that may result from refusals of care, none of which are included as part of the administrative record. These include, but are not limited to:[5]

- Julia Raifman, et al., *The New US "Conscience and Religious Freedom Division": Imposing Religious Beliefs on Others*, 108 Am. J. Public Health 889 (2018), (conscience refusals will cause substantial harm to LGBT patients, a population that already experiences large disparities),

[5] This list is not exhaustive, and does not include the many additional articles of harm to women from refusals of care in other countries.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5993366/. A true and correct copy of this article is attached hereto as Exhibit D.

- Ronit Y. Stahl, et al., *Contraceptive Coverage and the Balance Between Conscience and Access*, 318 J. Am. Med. Ass'n. 2179 (2017) (overview about how the Rule will lead to patient harm), https://jamanetwork.com/journals/jama/article-abstract/2659390. A true and correct copy of this article is attached hereto as Exhibit E.
- Robin Alta Charo, *The Celestial Fire of Conscience-Refusing to Deliver Medical Care*, 352 New Eng. J. Med. 2471 (2005) (expansion of scope of conscience refusals creates an oppressive atmosphere for minority groups and minority religious views), https://www.nejm.org/doi/full/10.1056/NEJMp058112. A true and correct copy of this article is attached hereto as Exhibit F.
- Bernard M. Dickens, *Legal Protection and Limits of Conscientious Objection: When Conscientious Objection is Unethical*, 28 Med. & L. 337 (2009) (legal limits to conscientious objection exist and the laws in some jurisdictions unethically abuse religious conscience by granting excessive rights to refuse care), https://www.ncbi.nlm.nih.gov/pubmed/19705646. A true and correct copy of this article is attached hereto as Exhibit G.
- Christina Zampas, et al., C*onscientious Objection to Sexual and Reproductive Health Services: International Human Rights Standards and European Law and Practice*, 19 Eur. J. Health L. 231 (2012), (outlines the international and regional human rights obligations and medical standards on conscientious objection), https://www.ncbi.nlm.nih.gov/pubmed/22916532. A true and correct copy of this article is attached hereto as Exhibit H.
- Marco Bo, et al., *Conscientious objection and waiting time for voluntary abortion in Italy*, 20 Eur. J. Contraception Reproductive Health Care 272 (2015) (an Italian study found an inverse correlation between the workloads for non-objectors and timely access to elective abortion),

https://www.ncbi.nlm.nih.gov/pubmed/25592398. A true and correct copy of this article is attached hereto as Exhibit I.

- Anibal Faúndes, et al., *Conscientious Objection or Fear of Social Stigma and Unawareness of Ethical Obligations*, 123 Int'l. J. Gynecology & Obstetrics 557 (any conscientious objection to treating a patient is secondary to the ethical principle that the primary conscientious duty of OB/GYNs is-at all times-to treat, or provide benefit and prevent harm to, the patients for whose care they are responsible), https://www.ncbi.nlm.nih.gov/pubmed/24332235. A true and correct copy of this article is attached hereto as Exhibit J.
- Mark R. Wicclair, *Conscientious Refusals by Hospitals and Emergency Contraception*, 20 Cambridge Q. Healthcare Ethics 130 (2011) (hospitals have obligations to prevent harm to patients, promote patient health, and respect patient autonomy such that their refusals to provide emergency contraception should be limited), https://www.ncbi.nlm.nih.gov/pubmed/21223617. A true and correct copy of this article is attached hereto as Exhibit K.
- Robin Alta Charo, *Health Care Provider Refusals to Treat, Prescribe, Refer or Inform: Professionalism and Conscience*, 1 J. Am. Const. Soc'y Issue Groups 119 (2007) (describing expansion of refusal clauses and arguing for treating health care providers as public accommodations that may not discriminate based on sex, and requiring objecting providers to facilitate referrals), https://media.law.wisc.edu/m/yzdkn/charo_-_health_care_provider_refusals__feb_2007_-_advance_vol_1.pdf. A true and correct copy of this article is attached hereto as Exhibit L.
- Bernard M. Dickens et al., *Conscientious Commitment to Women's Health*, 113 Int'l. J. Gynecology & Obstetrics 163 (2011) (providers' conscientious commitment is to deliver treatments directed to women's health care needs and to give priority to patient care),

https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1832549. A true and correct copy of this article is attached hereto as Exhibit M.

- Lisa H. Harris, *Recognizing Conscience in Abortion Provision*, 367 New Eng. J. Med. 981 (2012) (the exercise of conscience in health care is generally considered synonymous with refusal to participate, but this neglects the fact that the provision of abortion care is also conscience-based, neglecting the rights of those who are compelled by conscience to provide services), https://www.ncbi.nlm.nih.gov/pubmed/22970942. A true and correct copy of this article is attached hereto as Exhibit N.
- Laura A. Davidson, et al., *Religion and Conscientious Objection: A Survey Of Pharmacists' Willingness To Dispense Medications*, 71 Soc. Sci. Med. 161 (2010) (survey of Nevada pharmacists linked religious affiliation with their willingness to dispense emergency contraception), https://www.ncbi.nlm.nih.gov/pubmed/20447746. A true and correct copy of this article is attached hereto as Exhibit O.
- Anna Heino, et al., *Conscientious objection and induced abortion in Europe*, 18 Eur. J. Contraception Reproductive Health Care 231 (2013) (conscientious objection should not be presented as a question that relates only to health professionals and their rights, but as one that mainly concerns women as it has very real consequences for their reproductive health and rights), https://www.ncbi.nlm.nih.gov/pubmed/23848269. A true and correct copy of this article is attached hereto as Exhibit P.
- Debra B. Stulberg, et al., Obstetrician-Gynecologists, Religious Institutions, and Conflicts Regarding Patient-Care Policies, 207 Am. J. Obstet. Gynecol., 73 (Apr. 28. 2012) (many obstetrician-gynecologists practicing in religiously-affiliated institutions have had conflicts over religiously-based policies; the effects of these conflicts on patient care and outcomes are an important area for future research),

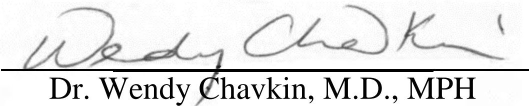
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3383370/. A true and correct copy of this article is attached hereto as Exhibit Q.

- Jane Roe, et al., *Recruitment and Training of British Obstetrician Gynaecologists for Abortion Provision: Conscientious Objection Versus Opting Out*, 7 Reproductive Health Matters, 97 (Nov. 1, 1999) (highlighting issues in Britain of trainee obstetrician-gynaecologists opting out of abortion training and reduction in access to abortion), https://www.tandfonline.com/doi/pdf/10.1016/S0968-8080(99)90010-1. A true and correct copy of this article is attached hereto as Exhibit R.
- Richard M. Anderson, et al, *Pharmacists and Conscientious Objection*, National Reference Center for Bioethics Literature (Dec. 2006) (objections reduce access to emergency contraception), http://bioethics.georgetown.edu/publications/scopenotes/sn46.pdf. A true and correct copy of this article is attached hereto as Exhibit S.

26. Based on my review of the Rule, I believe that these same harms identified as to the proposed rule (see paragraph 13 above) will happen was a result of the Rule.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Date: September 6, 2019



Dr. Wendy Chavkin, M.D., MPH

# EXHIBIT A

**Wendy Chavkin, MD, MPH**
**Heilbrunn Department of Population and Family Health**
**Columbia University's Mailman School of Public Health**
**60 Haven Avenue, New York, NY 10032**
**(212) 304-5220**
**wc9@columbia.edu**

**1) Date of preparation of CV : 9/21/18**

**2) Personal data:**

**Name:** Wendy Chavkin
**Birth date: 2/17/52**
**Birthplace: NYC**
**Citizenship: US**

***3.*** **Academic Appointments/Work Experience**

***ACADEMIC APPOINTMENTS***

| | |
|---|---|
| 6/2010- | Professor Emerita of Public Health and Ob-Gyn, Columbia University Mailman School of Public Health and College of Physicians & Surgeons, New York |
| 6/1997-5/2010 | Professor of Clinical Public Health and Ob-Gyn, Columbia University Mailman School of Public Health and College of Physicians & Surgeons, New York |
| 6/2000-12/2002 | Chair (Interim) Heilbrunn Department of Population and Family Health, Columbia University Mailman School of Public Health |
| 10/1991-5/1997 | Associate Professor of Clinical Public Health and Ob-Gyn, Columbia University School of Public Health & College of Physicians & Surgeons, New York |
| 9/1989- 5/1997 | Senior Research Associate, Chemical Dependency Institute, Beth Israel Medical Center, New York |
| 9/1985-9/1991 | Assistant Professor of Clinical Public Health and Dept. of Ob-Gyn, Columbia Presbyterian Medical Center, New York |

***HOSPITAL APPOINTMENTS***

| | |
|---|---|
| 9/1989-5/1997 | Voluntary Attending Physician, Departments of Ob-Gyn and Medicine, Beth Israel Medical Center |
| 7/1979- 6/1982 | Voluntary Attending Physician, Department of Ob-Gyn and Pediatrics, Albert Einstein College of Medicine, New York |

12/1984-12/1988 Director, Bureau of Maternity Services and Family Planning, New York City Department of Health, New York

4. TRAINING

9/1981-6/1984 Preventive Medicine Residency, New York City Department of Health, New York

7/1978-6/1979 Residency Program in Ob-Gyn, Albert Einstein College of Medicine, New York

9/1979- 8/1980 Public Service Science Fellow, National Science Foundation.

5. EDUCATION

9/1980- 6/1981 Columbia University School of Public Health, Division of Epidemiology; MPH

8/1974- 6/1978 State University of New York at Stony Brook; MD
New York State, July 6, 1979; License # 138819

7/1972- 5/1973 University of Michigan at Ann Arbor; BA
9/1969- 12/1972 University of Chicago, Ill; undergraduate

***7.* Licensure and Board Certification:** *(as applicable)*
***List separately by category as follows:***

- **Licensure : NYS 1979 #138819**

- **Board qualification :**

American Board of Preventive Medicine, February 2, 1987. Certif. # 50333

**8) Honors**

2013 Jean Pakter Award for Commitment to the Underserved, Public Health Association of New York City

2009 Allan Rosenfield Award for Public Health and Social Justice, Public Health Association of New York City

2007 Felicia Stewart Award for Advocacy and Activism, American Public Health Association

2004 Fulbright New Century Scholars Program

2003 Bertha Van Hoosen Award, American Medical Women's Association

2002 President's Award, American Medical Women's Association

1988-89 Research Fellow, Rockefeller Foundation, New York. "The social construction of conflict between mother and fetus, and its impact on the health of poor women."

1987 EEO Award, New York City Department of Health

1984 American Health Magazine Book Award for, Double Exposure: Women's Health Hazards on the Job and at Home

1979 Public Service Science Fellow, National Science Foundation. "Occupational hazards to reproduction.

## *9. PROFESSIONAL ORGANIZATIONS AND SOCIETIES*

○ **Memberships and Positions :** American Medical Women's Association, American Public Health Association, Association of Teachers of Preventive Medicine, Association of Teachers of Maternal-Child Health, Global Doctors for Choice[co-founder 2007, Board member 2007-present], New York Academy of Medicine, New York Academy of Science, Public Health Association of New York City [ Executive Board Member 1982-1990], Physicians for Reproductive Health[ co-founder 1995, Board member 1995-2001, Board Chair 2001-2007]

○ **Consultative (Federal, State, Private, etc.)**

2016- present Member,Task Force Maternal Mortality, New York City Department of Health and Mental Hygiene

2010- present- Strategic Planning Advisor and Leadership Training Academy Faculty, Physicians for Reproductive Health

2003-Present Consultant, New York City Department of Health and Mental Hygiene Bureau of Reproductive Health and Infant Mortality and Maternal Mortality

2000-2003 Provider Advisory Committee, New York City and State Departments of Health, Office of Alcoholism and Substance Abuse Services

1999-Present Committee on Maternal-Child Health, Association of Schools of Public Health

1999-2006 Preventive Medicine Residency Committee, New York Weill Cornell Medical Center

1999-2004 Chair, Reproductive Health Indicators Task Force, Office of Population Affairs

1985-2012 Medical Advisory Board, Planned Parenthood of New York City

1995-2001 Vice Chair, Board of Directors, Physicians for Reproductive Choice and Health

1986-1998 Committee on Maternity and Family Health Services, New York Academy of Medicine

1986-1995 Committee on Perinatal Substance Abuse, New York Academy of Medicine

1993-1994 Chair, Perinatal Substance Abuse Task Force, New York City Health Systems Agency

1992-1996 Maternal/Child Health Advisory Committee, National Association of County Health Officers

1991-1993 Committee on Chemical Dependency Training for Ob-Gyn Residents, American College Obstetrics/Gynecology & March of Dimes

1991-1995 Committee on Women and Chemical Dependency, Southern Governor's Association

1990-1996 Committee on Scientific Activities, Beth Israel Medical Center

1990-1995 Advisory Committees on Detoxification during Pregnancy, Office of Substance Abuse Prevention

1990-1995 Advisory Committees on Mandatory Treatment during Pregnancy, Office of Substance Abuse Prevention

1990-1995 Advisory Committees on Technical Expert Group Evaluation, Office of Substance Abuse Prevention

1991 Initial Review Group, Division of Epidemiology, Services, and Prevention Research, National Institute on Drug Abuse

1990-1992 Maternal/Paternal Fetal Effects Non-Federal Expert Panel, National Institute on Drug Abuse

1990-1995 Task Force on Substance Abuse, Manhattan Borough President

1990-1992 Commission on Chemical Dependency, Child Welfare League of America

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1982-1990 Executive Board Member, Public Health Association of New York City

1988-1990 Medical Consultant, Community Family Planning Council, New York City

1986-1987 Perinatal AIDS Working Group, Hastings Center

1986-1988 Maternal-Fetal Conflict Working Group, Hastings Center

1984-1988 Institutional Review Board, New York City Department of Health

- **Editorial**

1999-2003 Associate Editor, Women's Health, American Journal of Public Health

1994-2002 Editor-in-Chief, Journal of the American Medical Women's Association

1996-1999 Contributing Editor, Topics for Our Times, American Journal of Public Health

1996-2001 Consulting Editor, Choice Notes (Newsletter of Physicians for Reproductive Choice and Health)

***OTHER PROFESSIONAL ACTIVITIES - CLINICAL***

1984-1988 Gynecologist, Columbia Presbyterian Medical Center

1982 Gynecologist, Riverside Social Hygiene Clinic, NYC Department of Health

1982-1985 Gynecologist, Boriken Health Center, New York, NY

1979-1982 Gynecologist, Adolescent GYN Clinic, Comprehensive Family Care Center, Einstein College of Medicine, New York, NY

1980-1982 Gynecologist, Center for Population and Family Health Adolescent GYN Clinic, Columbia University School of Public Health, New York

1980-1981 Preceptor, Residency Program, Department of Pediatrics Adolescent Gynecology, Bronx Municipal Hospital Center, New York, NY

2006-2010 Site director, Charlotte Ellertson Social Science Postdoctoral Fellowship in Abortion and Reproductive Health

2002- 2007 Director, Soros Reproductive Health and Rights Fellowship

***PUBLICATIONS - ORIGINAL, PEER REVIEWED ARTICLES***

Chavkin W, Abu-Odeh D, Clune-Taylor C, Dubow S, Ferber M, Meyer IH. Balancing freedom of conscience and equitable access. American Journal of Public Health, 2018; 108(11), 1487-1488.

Chavkin W, Baffoe P, Awoonor-Williams K. (2018). Implementing safe abortion in Ghana: "We must tell our story and tell it well". International Journal of Gynecology and Obstetrics, 2018; 143, 25-30.

Chavkin W, Stifani BM, Bridgman-Packer D, Greenberg JMS, Favier M. Implementing and expanding safe abortion care: An international comparative case study of six countries. International Journal of Gynecology and Obstetrics, 2018; 143, 3-11.

Harris LF, Halpern J, Prata N, Chavkin W, Gerdts C. Conscientious objection to abortion provision: Why context matters. Global Public Health, An International Journal for Research, Policy and Practice, 2018; 13, 556-566.

Awoonor-Williams JK, Baffoe P, Ayivor PK, Fofie C, Desai S, Chavkin W. Prevalence of conscientious objection to legal abortion among clinicians in northern Ghana. Int J Gynecol Obstet 2017; 140: 31–36.

Chavkin W, Swerdlow L, Fifield J. Much to Debate about Conscientious Objection. Health Hum Rights, 2017 Dec.; 19(2): 303.

Chavkin, W and Diaz-Tello, F. When Courts Fail: Physicians' Legal and Ethical Duty to Uphold Informed Consent. Col Med Rev 2017; 1(2);6-9.

Harris, LF, Halpern, J., Prata, N., Chavkin, W., and Gerdts, C. (2016). Conscientious objection to abortion provision: Why context matters. *Global Public Health*, 1–11. http://doi.org/10.1080/17441692.2016.1229353

Morrell, KM and Chavkin W. Conscientious objection to abortion and reproductive healthcare: A review of recent literature and implications for adolescents Curr Opin Obstet Gynecol 2015, 27:333–338

Chavkin, Wendy, L Leitman, and K Polit. "Conscientious Objection and refusal to provide reproductive health care: a White Paper examining prevalence, health

consequences, and policy responses." Int J Gynecol Obstet 123 (suppl 3) (2013):541-56

Romero,D, Kwan ,A, Chavkin W:Application of Empirical Research Findings in Public Health Advocacy: Focus on Maternal, Child, and Reproductive Health Journal of Social Issues, Vol. 69, No. 4, 2013, pp. 633--644

Chavkin W, Blanchard K. The Ellertson Fellowship: advancing reproductive health through social science and public health research. Womens Health Issues. 2011 May-Jun;21(3 Suppl):S2-4.

Lipkind HS, Duzyj C, Rosenberg TJ, Funai EF, Chavkin W, Chiasson MA. Disparities in cesarean delivery rates and associated adverse neonatal outcomes in New York City hospitals. Obstet Gynecol. 2009 Jun;113(6):1239-47.

Rosenfield A, Charo RA, *Chavkin W*. "Moving Forward on Reproductive Health" New England Journal of Medicine. 2008; 359:1869.

Johnson B. and *Chavkin, W*. "Policy Efforts to Prevent ART-related pre-term birth" Journal of Maternal and Child Health. 2007;11: 219-225.

Chavkin W, Johnson B. Older age, infertility, and multiple pregnancies. JAMA. 2007 Jun 13;297(22):2479-80

Mishtal JZ, Chavkin W. Religion, conscience, and controversial clinical practices. N Engl J Med. 2007 May 3;356(18):1889-92.

Chavkin, W. The Old Meets the New: Religion and Assisted Reproductive Technologies. Development. 2006;49 (4):78-83.

Chavkin W, Paltrow LM. Physician attitudes concerning legal coercion of pregnant alcohol and drug users. Am J Obstet Gynecol. 2003 Jan;188(1):298.

Rosenberg TJ, Garbers S, *Chavkin W*, Chiasson MA. Prepregnancy Weight and Adverse Perinatal Outcomes in an Ethnically Diverse Population. Journal of Obstetrics and Gynecology 2003;102:1022-1027.

Romero D, *Chavkin W*, Wise PH, Smith L, Wood P. Welfare to Work? Impact of Maternal Health on Employment. American Journal of Public Health. 2002; 57(3):1462-1468.

Wise PH, Wampler N, Romero D, *Chavkin W*. Chronic Illness Among Poor Children Enrolled in the Temporary Assistance to Needy Families (TANF) Program. American Journal of Public Health. 2002; 57 (3):1458-1461.

Smith L, Romero D, Wood P, Wampler N, *Chavkin W*, Wise PH. Employment Barriers Among Welfare Recipients and Applicants with Chronically Ill Children. American Journal of Public Health. 2002; 57(3):1453-1475.

Pati S, Romero D, *Chavkin W*. Changes in Utilization of Health Insurance and Food Assistance Programs in Medically Underserved Communities in the Era of Welfare Reform: An Urban Study. American Journal of Public Health. 2002; 57(3):1441-1445.

Wood P, Smith L, Romero D, Bradshaw P, Wise P, *Chavkin W*. Children with Asthma: The Relationship Between Welfare Status, Health Insurance Status and Child Health. American Journal of Public Health. 2002; 57(3):1446-1452.

Maine D, *Chavkin W*. Maternal Mortality: Global Similarities and Differences. Journal of the American Medical Women's Association.

Chavkin W, Wise PH, Romero D. Welfare, Women, and Children: It's Time for Doctors to Speak Out. Journal of the American Medical Women's Association. 2002; 57 (1): 3-4. Editorial.

Chavkin, W. Sex, Lies, and Silence: Reproductive Health in a Hostile Environment. American Journal of Public Health. 2001; 91 (11): 1739-1741.

Romero D, *Chavkin W*, Wise PH. State welfare reform policies and maternal and child health services: A national study. Maternal and Child Health Journal. 2001;5(3):199-206.

Romero D, *Chavkin W*, and Wise, PH. "The Impact of Welfare Reform Policies on Child Protective Services: A National Study," Journal of Social Issues, 2000; 56(4):799-810.

Chavkin W, Draut T, Romero D, and Wise PH. "Sex, Reproduction and Welfare Reform," Georgetown Journal on Poverty Law and Policy, 2000; 7(2):1-11.

Smith L, Wise PH, *Chavkin W*, Romero D, and Zuckerman B. "Implications of welfare reform for child health: emerging challenges for clinical practice policy," Pediatrics, 2000; 106(5): 117-1125.

Chavkin W, Romero D, and Wise PH. "State Welfare Reform Policies and Declines in Health Insurance," American Journal of Public Health, 2000; 90:900-908.

Wise PH, *Chavkin W*, and Romero D. "Assessing the Effects of Welfare Reform Policies on Reproductive and Infant Health," American Journal of Public Health, 1999;89:1514-1521.

Chavkin W, Wise PH and Elman D. "Welfare Reform and Women's Health," American Journal of Public Health, 1998;88(7):1017-1018.

Chavkin W, Wise PH and Elman D. "Policies Towards Pregnancy and Addiction: Sticks Without Carrots." Annals of the New York Academy of Sciences, 1998;846:335-340.

Chavkin W, Elman D and Wise PH. "Mandatory Testing of Pregnant Women and Newborns: HIV, Drug Use and Welfare Policy," Fordham Urban Law Journal, 1998; 24(4): 749-755.

Chavkin W, Breitbart V, Elman D, and Wise P. "National Survey of the States: Policies and Practices Regarding Drug-Using Pregnant Women," American Journal of Public Health, 1998; 88(1):117-119.

Chavkin W and Breitbart V. "Women and Addiction: The United States as a Case Study," Addiction,1997; 92(9):1201-1205.

Chavkin W and Breitbart V. "Reproductive Health Care and Blurred Professional Boundaries, "Journal of Women's Health, 1996; 6:1-8.

Chavkin W, Breitbart V, and Wise P. "Efforts to Reduce Perinatal Mortality, HIV, and Drug Addiction: Survey of the States," Journal of the American Medical Women's Association, 1995; 50(5):164-166.

Chavkin W, Breitbart V, and Wise P. "Finding Common Ground: The Necessity of an Integrated Agenda for Women's and Children's Health," The Journal of Law, Medicine and Ethics, 1994; 22(3):262-269.

Breitbart V, *Chavkin W*, and Wise P. "The Accessibility of Drug Treatment for Pregnant Women: A Survey in Five Cities," American Journal of Public Health, 1994; 84 (10):1658-1661.

Breitbart V, *Chavkin W*, Layton C, and Wise P. "Model Programs Addressing Perinatal Drug Exposure and HIV Infection: Integrating Women's and Children's Needs," Bulletin of New York Academy of Medicine, 1994; 71(2):236-251.

Chavkin W, Paone D, Friedmann P, and Wilets I. "Psychiatric Histories of Drug Using Mothers: Treatment Implications," Journal of Substance Abuse Treatment, 1993; 10:445-448.

Chavkin W, Paone D, Friedmann P, and Wilets I. "Reframing the Debate: Towards Effective Treatment for Inner City Drug Using Mothers," Bulletin of New York Academy of Medicine, Summer 1993; 70(1):50-68.

Chavkin W, Walker N, and Paone D. "Drug Using Families and Child Protection: Results of a Study and Implications for Change," University of Pittsburgh Law Review, 1992; 54:295-324.

Kandall S and *Chavkin W*. "Illicit Drugs in America: History, Impact on Women and Infants, and

Treatment Strategies for Women," Hastings Law Journal, 1992 March; 43(3):615-643.

Paone D, *Chavkin W*, Wilets I, and Friedmann P. "The Impact of Sexual Abuse: Implications for Drug Treatment," Journal of Women's Health, 1992; 1:149-53.

Chavkin W. "Woman and Fetus: The Social Construction of Conflict," Women and Criminal Justice, 1991 Fall; 3(1).

Chavkin W. "Workshop on Public Policy Considerations," Bulletin of the New York Academy of Medicine, 1991; 67:301-303.

Allen MH, *Chavkin W*, and Marinoff J. "Ascertainment of Maternal Deaths in New York City," American Journal of Public Health, 1991; 81:380-382.

Chavkin W. "Mandatory Treatment for Drug Use During Pregnancy," Journal of the American Medical Association, 1991; 266(11):1556-1561.

Chavkin W. "Webster, Health, and History," The Public Historian, 1990; 12(3):53-56.

Chavkin W and Rosenfield A. "Webster and the Health of Women," Journal of the American Medical Association, 1990; 263:947.

Chavkin W and Rosenfield A. "A Chill Wind Blows: Webster, Obstetrics, and the Health of Women," American Journal of Obstetrics and Gynecology, 1990; 163(2):450-452.

Chavkin W. "Drug Addiction and Pregnancy: Policy Crossroads," American Journal of Public Health, 1990; 45(2):55-57.

Chavkin W and St. Clair D. "Beyond Prenatal Care: A Comprehensive Vision of Reproductive Health," Journal of the American Medical Women's Association, 1990 February;45 (2):223-225.

Chavkin W and Kandall S. "Between a 'Rock' and a Hard Place: Perinatal Drug Abuse," Pediatrics, 1990; 85(2):223-225.

Koonin LM, Ellerbrock TV, Atrash HK, Rogers MF, Smith JC, Hogue CJR, Harris MA, *Chavkin W*, Parker AL, and Halpin GJ. "Pregnancy-Associated Deaths Due to AIDS in the United States," Journal of the American Medical Association, 1989; 261:1306- 1309.

Chavkin W, Driver C, and Forman P. "The Crisis in New York City's Perinatal Services," New York State Journal of Medicine, 1989 December; 658-663.

Chavkin W, Busner C, and McClaughlin M. "Reproductive Health: Caribbean Women in New York City, 1980-1984," International Migration Review, 1987; 21:609-625.

Chavkin W. "The Reproductive Experience of Women Living in Hotels for the Homeless," New York State Journal of Medicine, 1987; 87(1).

Chavkin W, Fernandez L, Harris M, Higginson GK, and Pakter J. "Maternal Deaths Associated with Barbiturate Anesthetics--New York City," Morbidity and Mortality Weekly Report, 1986; 35(37).

Chavkin W. "Work and Pregnancy: Review of the Literature and Policy Discussion," Ob/Gyn Survey, 1986; 41(8).

Chavkin W. "The Rise in Ectopic Pregnancy—Exploration of Possible Reasons," International Journal of Gynecology and Obstetrics, 1982; 20(4):341-350.

***PUBLICATIONS – BOOKS***

Inhorn,M and Chavkin,W, Globalized Fatherhood Berghahn Books, New York 2014

ChavkinW and Maher J, The Globalization of Motherhood : Deconstructions and Reconstructions of Biology and Care. Routledge Press: New York. 2010

Chavkin W., Chesler E., eds. Where Human Rights Begin: Essays on Health, Sexuality and Women, Ten Years after Vienna, Cairo and Beijing. Rutgers University Press: 2005.

Chavkin W. Double Exposure: Women's Health Hazards on the Job and at Home. Monthly Review Press, New York, 1984. *Winner of the American Health Magazine Book Award*, 1985.

***PUBLICATIONS - CHAPTERS, MONOGRAPHS AND EDITORIAL***

Swerdlow, L, Chavkin W. Motherhoood in Fragments: The disaggregation of biology and care. In Babies for Sale: Transnational surrogacy, human rights and the politics of reproduction, ed. Miranda Davies (London: Zed Books 2017).

Kahn, LG, Chavkin W. ARTs and the Biological Bottom Line. In Bodies and Borders: Negotiating Motherhood in the 21st Century, eds. Jane Jenson, Sonya Michel and Yasmine Ergas (New York: Columbia University Press 2017).

Chavkin, W: Women, employment, fertility – and other women. In Women Rising eds. Ellen Chesler and Terry McGovern forthcoming 2015

Kahn, LG, Chavkin, W. ARTs and the Biological Bottom Line. In Bodies and Borders: Negotiating Motherhood in the 21st Century, ed. Yasmine Ergas, Jane Jenson, and Sonya Michel (New York: Columbia University Press, 2015).

Kahn, LG, Chavkin, W. The High-Tech Homunculus: New Science, Old Constructs. In: Globalized Fatherhood, ed. Marcia Inhorn and Wendy Chavkin (New York: Berghahm Books, October 2014).

Chavkin, W Guest Editor Conscientious Objection and refusal to provide reproductive health care Int J Gynecol Obstet 2013;123 (suppl 3):Int J Gynecol Obstet 2013;123 (suppl 3):

Chavkin W Guest Editor Abortion, Reproductive Rights and Health: Highlights from the Charlotte Ellertson Social Science Postdoctoral Fellowship 2003-2010. Women's Health Issues May/June 2011 supplement

Chavkin, W. "Working Women, the Biological Clock, and Assisted Reproductive Technologies" Gender, Globalization and Social Reproduction.( Isa Bakker and Rachel Silvey eds). Routledge Press. 2008.

Bischoff, R, Chavkin W. The Relationship between Work-Family Benefits and Maternal, Infant and Reproductive Health NYC Department of Health and Mental Hygiene and Mailman School of Public Health, Columbia University New York 2008

Chavkin, W, Rosenbaum, S. Women and Health Reform: The Key Role of Comprehensive Reproductive Health Care Mailman School of Public Health, Columbia University New York 2007

Chavkin, W. "Biology and Destiny: Women, Work , Birthrates, and Assisted Reproductive Technologies." in Global Empowerment of Women: Responses to Globalization, Politicized Religion and Gender Violence. Ed Carolyn Elliott Routledge Press. 2007.

Chavkin W, Schochet T. . "Breaking the Impasse: Emergency Contraception and the Abortion Debate" Harvard Health Policy Review. 2005.

Chavkin W. Access Denied, Science Denied. American Journal of Public Health. 2004; 57 (8):1298-1299.

Handler A, Zimbeck M, *Chavkin W*, Adams EK. The Effects of Welfare Reform on the Reproductive Health of Women. In Wallace HM, Green G, Jaros KJ, eds. Health and Welfare for Families in the 21st Century. Jones and Bartlett: 2003; 149-163.

Chavkin W. Diagnosis and Prognosis: Women Physicians and Women's Health. In Morgan R, ed. Sisterhood Is Forever. Washington Square Press: 2003; 378-386.

Chavkin, W. Chipping Away at Roe. The Nation, June 30, 2003, p.24.

Handler A, Zimbeck M, *Chavkin W*, Adams EK. The Effects of Welfare Reform on the Reproductive Health of Women. In Wallace HM, Green G, Jaros KJ, eds. Health and Welfare for Families In the 21st Century. Jones and Bartlett: 2003; 149-163.

Chavkin W. Diagnosis and Prognosis: Women Physicians and Women's Health. In Morgan R, ed. Sisterhood Is Forever. Washington Square Press: 2003; 378-386.

Chavkin W, Wise PH, Romero, D. The Data Are In: Health Matters in Welfare Policy. American Journal of Public Health. 2002; 92 (9): 1392-1395.

Chavkin W, Romero D, Wise PH. What Do Sex and Reproduction Have to Do with Welfare? In Piven FF, Acker J, Hallock M, Morgan S, eds. Work, Welfare and Politics: Confronting Poverty in the Wake of Welfare Reform. University of Oregon Press: 2002; 95-112.

Chavkin W. Cocaine and Pregnancy – Time to Look at the Evidence. Journal of the American Medical Association. 2001; 285(12):1626-1628.

Chavkin W. What's a Mother to Do? Welfare, Work, and Family. American Journal of Public Health. 1999; 89: 477-479.

Chavkin W and Bernstein P. "Maternal-Fetal Conflict is Not a Useful Construct" in Prenatal Care: Practice and Potential, Cambridge University Press, 1999.

Chavkin W. "Development of US Family Planning," Lancet, 1997; 350 (9077): 598.

Chavkin W and Elman D. "Mortality From Cardiovascular Causes Among Blacks And Whites In NewYork City," New England Journal of Medicine, 1997; 336(18): 1321.

Chavkin W, Breitbart V, and Elman D. "Integrating HIV Prevention, STD, And Family Planning Services, The Availability of HIV Services At Different Types Of Clinics: A Survey," American Journal of Public Health, 1997; 87(4): 691-2.

Chavkin W. "Affirmative Action and Women's Health," American Journal of Public Health, 1997; 87(5):732-5.

Chavkin W. "Book Review — *Life Support: Three Nurses on the Line*," The Boston Globe, March 16, 1997, N15, N18.

Chavkin W and Wise PH. "Ethics in Context," American Journal of Obstetrics and Gynecology, 1997; 176(3):732.

Chavkin W. "Mandatory Treatment for Pregnant Substance Abusers: Irrelevant and Dangerous," Politics and the Life Sciences, March 1996; 53-54.

Chavkin W. "Abortion, Law, and Public Health," in Man Made Medicine: Women's Health, Public Policy and Reform, K. Moss (Ed.), Duke University Press, 1996.

Chavkin W. "Abortion," Journal of the American Medical Association, 1996; 276(2):164-165.

Chavkin W. "Public Health on the Line—Abortion and Beyond," American Journal of Public Health, 1996; 86(9): 1204-1206.

Chavkin W. "Race/Ethnicity and Women's Health," Journal of the American Medical Women's Association, 1996; 51(4): 131-132.

Chavkin W and Rosenfield A. "Abortion Training: A Necessary Part of the Return to Excellence," American Journal of Obstetrics and Gynecology, 1995; 172(3): 1070.

Chavkin W. "Substance abuse in pregnancy," in Reproductive Health Care for Women and Babies: Politics and Ethics, B. Sachs, et al. (Eds.), Oxford University Press, 1995.

Chavkin W. "Prenatal Care and Women's Health," Journal of the American Medical Women's Association, 1995; 50(5):143.

Chavkin W. "Women and HIV/AIDS," Journal of the American Medical Women's Association, 1995; 50(3/4):72.

Chavkin W. "A Golden Moment for the Reintegration of Abortion," Medical Tribune for the Obstetrician & Gynecologist, 1994; 1(19):3.

Chavkin W. "Medicine and Abortion," Journal of the American Medical Women's Association, 1994; 49(5):130.

Chavkin W. "Women and Clinical Research," Journal of the American Medical Women's Association, 1994; 49(4):99-100.

Chavkin W. "Pneumocystis Carinii Pneumonia in Children with Perinatally Acquired HIV Infection," Journal of the American Medical Association, 1994; 271(2):102-103.

Caschetta MB, Chavkin W, and McGovern T. "FDA Policy on Women and Drug Trials", New England Journal of Medicine, December, 1993; 329(24):1815.

Chavkin W and Allen M. "Violence, Injury, Drugs, and Maternal Mortality," American Journal of Public Health, 1993; 83 (10): 1494.

Chavkin W. "Reproductive Hazards: Not for Women Only", Art Hazard News, 1993; 16:2.

Chavkin W. "Woman and Fetus: The Social Construction of Conflict," Conscience, 1993; 14(1&2): 39.

Paone D and *Chavkin W*. "From the Private Family Domain to the Public Health Forum: Sexual Abuse, Women, and the Risk for HIV Infection," SIECUS REPORT, April- May, 1993; 21:4, 13-16.

Chavkin W. "Enemy of the fetus? The Pregnant Drug User and the Pregnancy Police." Health/PAC Bulletin, 1992 Winter; 5-9.

Chavkin W and Rosenfield A. "Excusing Perinatal Fellows," New England Journal of Medicine, 1992; 327(11):811.

Chavkin W and Allen M. "The Questionable Category of Non-maternal Deaths," Journal of Obstetrics and Gynecology, 1992; 168(5):1640-1641.

Chavkin W and Rosenfield A. "Decline in Maternal Deaths," American Journal of Obstetrics and Gynecology, 1992; 167(3):854-855.

Chavkin W, Cohen J, Ehrhardt A, Fullilove MT, and Worth D. "Women and AIDS," Science, 1991, 251:359-360.

Chavkin W. "Maternal Drug Use", in A Manual for Fetal and Infant Mortality Review, P. Wise, ed. National Fetal and Infant Mortality Review Program and the American College of Obstetrics and Gynecologists, Revised 1991.

Chavkin W. "Women, Work, and Health," Health/PAC Bulletin 1991 Spring; 26-27.

Harris AM, *Chavkin W,* and Oberman M. "Drug Abuse and Pregnancy: Some Questions on Public Policy, Clinical Management and Maternal and Fetal Rights. Birth 1991; 18:124-129.

Chavkin W. "Jennifer Johnson's Sentence: Commentary on the 'Birth Penalty'," The Journal of Clinical Ethics, 1990 Summer; 1(2):140-141.

Chavkin W and Moss K. "Pregnant, Addicted--and Excluded," Christianity and Crisis 1990; 28:170-172.

Chavkin W and Fox H. "The Exclusion of Women from Clinical Trials," Journal of the American Medical Association, 1990; 264:973-4.

Chavkin W and Rosenfield A. "Medicine and Abortion,' Journal of the American Medical Association, 1990; 263(7): 947.

Chavkin W and Kandall S. "Pregnant and Addicted: Jail Is No Answer," The New York Doctor 1990; May; 6.

Chavkin W. "Help, Don't Jail, Addicted Mothers," New York Times, July 18, 1989.

Chavkin W, Katz-Rothman B, and Rapp R. "Alternative Modes of Reproduction: Other Views and Questions," in Reproductive Legislation for the 1990's. Humana Press, 1989.

Chavkin W and Freudenberg N. "Widespread HIV Testing?" New England Journal of Medicine, 1989; 321:1266.

Chavkin W. "Motherhood in Question: The Complicated Issue of Pregnancy and AIDS Prevention," in Proceedings of NIMH Conference on Women and AIDS, S. Blumenthal and G. Weissman, eds. US Department of Health & Human Services 1987.

Chavkin W. “Closed Office Building Syndrome,” in Double Exposure: Women's Health Hazards on the Job and at Home. Monthly Review Press, New York, 1984.

Chavkin W. "Walking a Tightrope: Pregnancy, Parenting, and Work," in Double Exposure: Women's Health on the Job and at Home. Monthly Review Press, New York, 1984.

Chavkin W. "Environmental Hazard to Reproduction," in The Toxic Crisis: What States Should Do. Conference for State and Local Alternatives, Washington, DC, 1983.

Chavkin W. "Keratoconjunctivitis Caused by U.V. Radiation from Damaged Mercury Vapor Lamps," City Health Information 1983 March 9; 2.

Chavkin W. "Neural Tube Defects: A Comparison of Data Sources," City Health Information 1983; 20: 2.

Chavkin W, et al. "Reproductive Hazards in the Workplace--A Curriculum Guide," in Genes and Gender: IV, the Second X and Women's Health, Gordian Press, New York, 1983.

Chavkin W. "Work and the Health of Women: A Review," Women and Health 1981; 6:57- 58.

Chavkin W. "Prenatal Technology," Women's Rights Law Reporter,1981; 7:3.

Chavkin W. "Occupational Hazards to Reproduction: A Review Essay," Feminist Studies, 1979; 5:310.

Chavkin W and Welch L. "Occupational Hazards to Reproduction: An Annotated Bibliography," Department of Social Medicine, Montefiore Hospital, New York City, 1978.

Chavkin W. "Immaculate Deception: A Review," Women and Health, 1978; 3:18.

# EXHIBIT B

# Balancing Freedom of Conscience and Equitable Access

Recently, the Trump Administration created a Conscience and Religious Freedom Division in the US Department of Health and Human Services' (DHHS) Office for Civil Rights. DHHS then proposed a rule to shield those who work in health and social service sites receiving federal funds from consequences for refusing to provide certain medical treatments on the grounds of religious belief or conscience. This rule flags objections related to abortion, sterilization, medical aid in dying, advanced directives for end-of-life care, and, surprisingly, comprehensive approaches to HIV care, occupational health screening, vaccination, hearing screening, and suicide prevention for children. We believe that this new division and rule give a green light to those who invoke claims of conscience as a way to oppose social and political changes. Privileging these claims infringes on the conscience and rights of those holding different beliefs.

We are a group of scholars and activists from medicine, public health, ethics, law, theology, and the social sciences who believe that it is possible—and necessary—to honor individual integrity and moral beliefs without harming those with different beliefs and values. In the last 50 years, conscientious objection has been invoked in the United States by those resisting racially discriminatory laws and the Vietnam War; providing sanctuary to Central American refugees denied political asylum; and working to ensure equitable access to legal abortions, emergency contraception, end-of-life care, same-sex marriage licenses, and wedding cakes. We draw on those experiences and rights-based arguments to propose an alternative to the DHHS rule: a request for exemption from consequences of refusals to fulfill legal or professional duties should be accommodated only if it is not discriminatory and harms can be mitigated. We see this as complementary to Raifman and Galea's recent *AJPH* editorial,[1] because their emphasis is specific and focused, and our approach to conscientious objection applies across topic areas.

## HARMS OF ACCOMMODATING REFUSALS TO DUTIES

The first harm of accommodating refusals to fulfill legal or professional duties is hindering an individual's ability to exercise a right to obtain a legal service or good.[2] Because, almost by definition, the service or good is socially contested, the person might be stigmatized for having sought something contested or for who he or she is. If health care is denied, the patient may suffer from lack of care or delayed care. Members of disenfranchised groups are most likely to experience harms, aggravating the effect on social equity.

Indeed, those who choose to become business owners must comply with tax requirements, as well as worker protection and antidiscrimination laws and policies. Government employees and elected officials must fulfill basic obligations of public service and adhere to laws and regulations that provide equal opportunity regardless of race, color, religion, sex, national origin, age, or disability, and in some jurisdictions, gender identity and sexual orientation (on.doi.gov/2v8ukim).

Second, exempting professionals from duties may undermine trust and respect for the profession. As licensure conveys monopoly and power over provision of that service, with resulting social and economic benefits, the profession becomes a kind of public utility, with obligations to the public trust.[3] In exchange for being granted privileges such as self-governance by the state, certain professionals are expected to fulfill fiduciary duties—that is, to put the needs of patients or clients first, ahead of their own. In medicine, because the balance of knowledge favors the physician, and patients are vulnerable, patients must be able to trust that the physician will put their needs first and to ensure that they can exercise autonomy. Moreover, objection might increase the workload of those willing to provide services as they pick up the slack from those who refuse. Their range of practice may narrow beyond their liking, because providing care that others refuse causes them to spend a disproportionate share of their time doing so. Willing providers may themselves experience stigma, which could jeopardize professional advancement, put them at risk for experiencing public disapprobation, and even result in violence.[4]

The third harm of accommodating refusals is obstruction of bedrock social values. The state is responsible for advancing the social good by promoting public health measures and fundamental values such as pluralism and equity and requires citizens and residents to fulfill duties that contribute to these values.

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Examples include mandatory military service, compulsory education, and mandated compliance with measures to halt the spread of infectious disease. Those objecting must comply with alternative requirements to ensure that they do not undermine these social goods and shared values (e.g., alternative service for those refusing combat or California's exclusion from school for unvaccinated children).[5]

## LIMITING HARMS OF ACCOMMODATING REFUSALS

Individuals have conscience; institutions cannot. Moreover, because some institutions receive many benefits from the state, they should be bound by reciprocal obligations. Institutions that serve a primary function other than religious practice are obligated to follow public rules—including food licensing, licensing for clinicians, sanitary standards, fulfillment of state education standards, and antidiscrimination law—and therefore are accountable to the public for ensuring access to expected goods and services. Institutions certainly should not cherry-pick categories of clients to whom they provide these goods and services. Institutional refusals based on religion constrain the behavior of staff and patients who do not share these religious beliefs, with consequences for health, equity, and dignity.

Another way to limit harms is by restricting the class of possible objectors to direct participants, whose claim must speak to the core of the service (e.g., providing abortion, not making the appointment). Otherwise, those who refuse to provide services extend their objection beyond personal participation and effectively seek to govern the conduct of others who do not share their religious or moral beliefs. By so doing, they subvert pluralism, the animating value underlying protection of individual conscience from the dictates of the majority.

The bar for assessing whether to accommodate objection in health care should be high, because fiduciary duty means that a clinician should never give higher priority to her or his own conscience than to the patient's needs. Some countries permit refusals only to the degree that it does not infringe the state's obligation to offer the service and mandate that the objector provide accurate information, timely referrals, and the contested care in urgent circumstances; American and international medical societies affirm these as clinicians' obligations. Distinct from that in the United States, the national health sectors in Norway and Portugal underscore the health care system's responsibility to ensure that care is available by paying for clinicians' or patients' travel to provide or receive abortions or by limiting the numbers of objector staff at a given site.[6]

## HOW TO DRAW THE LINE

Conscientious objection raises the profound question of when and how to draw the line between support for individual belief and integrity and support for those with other beliefs who are entitled to goods, services, and protections. We are concerned that this central point has been obscured in recent decades, because the term "conscientious objection" has been increasingly invoked in response to hotly contested changes in social norms. Although the US Constitution and many international covenants protect freedom of belief and speech, they stipulate that their exercise may not compromise the rights of others.[7] Nontheocratic states are obligated to treat all citizens' beliefs equally and fairly and to negotiate the boundaries between rights in tension.

DHHS's proposed rule would dramatically tilt the balance toward those who object and simultaneously widen the universe of those affected. We urge that responses to requests for exemption from legal and social duties be based on the bedrock values of pluralism, equity, and nondiscrimination. AJPH

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### CONTRIBUTORS

W. Chavkin conceptualized the project. D. Abu-Odeh conducted most of the background research. W. Chavkin and D. Abu-Odeh co-wrote the first and final drafts of the editorial. C. Clune-Taylor, S. Dubow, M. Ferber, and I. H. Meyer contributed to research in their respective areas of expertise and made significant revisions to multiple drafts of the editorial.

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### REFERENCES

1. Raifman J, Galea S. The new US "Conscience and Religious Freedom Division": imposing religious beliefs on others. *Am J Public Health*. 2018;108(7):889–890.

2. Stahl RY, Lynch HF. Contraceptive coverage and the balance between conscience and access. *JAMA*. 2017;318(22):2179–2180.

3. Charo RA. The celestial fire of conscience - refusing to deliver medical care. *N Engl J Med*. 2005;352(24):2471–2473.

4. Schoen J. *Abortion After Roe*. Chapel Hill: The University of North Carolina Press; 2015.

5. California Senate Bill 277: An Act to Amend Sections 120325, 120335, 120370, and 120375 of, to Add Section 120338 to, and to Repeal Section 120365 of, the Health and Safety Code, Relating to Public Health. June 30, 2015. Available at: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB277. Accessed July, 20, 2018.

6. Chavkin W, Swerdlow L, Fifield J. Regulation of conscientious objection to abortion. *Health Hum Rights*. 2017;19(1):55–68.

7. Melling L, Lim M, Brighouse R, Aviv NM. *Drawing the Line: Tackling Tensions Between Religious Freedom and Equality*. International Network of Civil Liberties Organizations; 2015. Available at: http://www.cels.org.ar/common/documentos/DrawingtheLine.pdf. Accessed May 15, 2018.

# EXHIBIT C

# International Journal of GYNECOLOGY & OBSTETRICS

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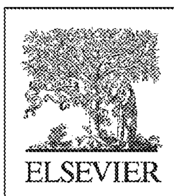


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**Supplement to**

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# Conscientious objection to the provision of reproductive healthcare

Guest Editor:

Wendy Chavkin MD, MPH

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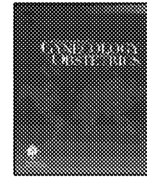

EDITORIAL

# Conscientious objection to the provision of reproductive healthcare

Healthcare providers who cite conscientious objection as grounds for refusing to provide components of legal reproductive care highlight the tension between their right to exercise their conscience and women's rights to receive needed care. There are also societal obligations and ramifications at stake, including the responsibility for negotiating balance between all of these competing interests.

Global Doctors for Choice (GDC) is a transnational network of physicians who advocate for reproductive health and rights (http://www.globaldoctorsforchoice.org).

GDC became concerned about the impact of conscience-based refusal on reproductive healthcare as we began to hear increasing reports of harms from many parts of the globe. Therefore, we began to talk with colleagues and colleague organizations, to compile data, and to review policy efforts to resolve the competing interests at play. This supplement presents the result of these efforts.

GDC starts from the premise that both individual conscience and autonomy in reproductive decision making are essential rights. As a physician group, we advocate for the rights of individual physicians to maintain their integrity by honoring their conscience. We simultaneously advocate that physicians maintain the integrity of the profession by according first priority to patient needs and to adherence to the highest standards of evidence-based care. We broaden the frame beyond individual physician and patient to also consider the impact of conscientious objection on other clinicians, on health systems, and on communities.

When we embarked on this investigation, we found legal and ethical analyses but far fewer data regarding health. Thus, we offer a health-focused White Paper [1] as a complement to this previous work and to spur the design of a research agenda. GDC is particularly eager to bring the findings to the attention of members of FIGO, who care about physician and patient rights, about health, and about the consequences for all of the different players and interests involved. We intend this compilation and analysis of health-related information to provide the evidence base to ground our efforts as we move forward creatively together to uphold the rights and health of all.

This supplement also includes commentaries from 3 critical vantage points. Faúndes et al. [2] provide a perspective from this professional medical society and contrast FIGO's clear-cut articulation that "the primary conscientious duty of obstetrician–gynecologists is at all times to treat, or provide benefit and prevent harm to, the patients for whose care they are responsible" [3] with the patchy and inconsistent physician behaviors they describe. They call for improved dissemination and education regarding bioethical principles and FIGO positions. Johnson et al. [4] discuss the application of WHO's second edition of *Safe Abortion: Technical and Policy Guidance for Health Systems* [5]. They spell out ways in which adherence to the individual and institutional responsibilities described therein allows individuals to exercise conscience, as it requires them to refer and provide urgently needed care and expects systemic provision of sufficient facilities, providers, equipment, and medications to assure uncompromised access to safe, legal abortion services. Zampas [6] discusses international human rights law and state obligation to harmonize the practice of conscientious objection with women's rights to sexual and reproductive health services. She reports that UN human rights treaty-monitoring bodies have raised concern about the insufficient regulation of the practice of conscientious objection to abortion and consistently recommend that states ensure that the practice is well defined and well regulated in order to avoid limiting women's access to reproductive healthcare. She emphasizes that *women's* conscience must also be fully respected.

This supplement reflects the work of many. We are grateful to Drs Dragoman, Faúndes, Johnson, and Temerman, and to Graciana Alves Duarte, Maria José Duarte Osis, Eszter Kismödi, and Christina Zampas for the cogent commentaries they have authored. We are also very appreciative of their ongoing collaboration.

Further, GDC thanks the following for their contributions to the White Paper: the writing team (Wendy Chavkin, Liddy Leitman, and Kate Polin); the research team (Mohammad Alyafi, Linda Arnade, Teri Bilhartz, Kathleen Morrell, Kate Polin, and Dana Schonberg); and the supplement peer reviewers (Giselle Carino, Alta Charo, Kelly Culwell, Bernard Dickens, Debora Diniz, Monica V. Dragoman, Laurence Finer, Jennifer Friedman, Ana Cristina González Vélez, Lisa H. Harris, Brooke Ronald Johnson, Eszter Kismödi, Anne Lyerly, Alberto Madeiro, Terry McGovern, Howard Minkoff, Joanna Mishtal, Jennifer Moodley, Sara Morello, Charles Ngwena, Andrea Rufino, Siri Suh, Johanna Westeson, Christina Zampas, and Silvia de Zordo).

There are too many barriers to access to reproductive healthcare. Conscience-based refusal of care may be one that we can successfully address.

## Conflict of interest

The author has no conflicts of interest.

## References

[1] Chavkin W, Leitman L, Polin K; for Global Doctors for Choice. Conscientious objection and refusal to provide reproductive healthcare: A White Paper examining prevalence, health consequences, and policy responses. Int J Gynecol Obstet 2013;123(Suppl 3):S41–56 (this issue).

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[2] Faúndes A, Alves Duarte G, Duarte Osis MJ. Conscientious objection or fear of social stigma and unawareness of ethical obligations. Int J Gynecol Obstet 2013;123(Suppl 3):S57–9 (this issue).
[3] FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health. Ethical Issues in Obstetrics and Gynecology. http://www.figo.org/files/figo-corp/English%20Ethical%20Issues%20in%20Obstetrics%20and%20Gynecology.pdf. Published October 2012.
[4] Johnson BR Jr, Kismödi E, Dragoman M, Temmerman M. Conscientious objection to provision of legal abortion care. Int J Gynecol Obstet 2013;123(Suppl 3):S60–2 (this issue).
[5] WHO. Safe Abortion: Technical and Policy Guidance for Health Systems. Second Edition. Geneva: WHO; 2012.
[6] Zampas C. Legal and ethical standards for protecting women's human rights and the practice of conscientious objection in reproductive healthcare settings. Int J Gynecol Obstet 2013;123(Suppl 3):S63–5 (this issue).

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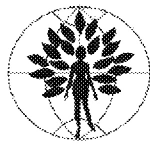


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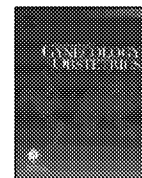

CONSCIENTIOUS OBJECTION

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

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ABSTRACT

*Background:* Global Doctors for Choice—a transnational network of physician advocates for reproductive health and rights—began exploring the phenomenon of conscience-based refusal of reproductive healthcare as a result of increasing reports of harms worldwide. The present White Paper examines the prevalence and impact of such refusal and reviews policy efforts to balance individual conscience, autonomy in reproductive decision making, safeguards for health, and professional medical integrity.
*Objectives and search strategy:* The White Paper draws on medical, public health, legal, ethical, and social science literature published between 1998 and 2013 in English, French, German, Italian, Portuguese, and Spanish. Estimates of prevalence are difficult to obtain, as there is no consensus about criteria for refuser status and no standardized definition of the practice, and the studies have sampling and other methodologic limitations. The White Paper reviews these data and offers logical frameworks to represent the possible health and health system consequences of conscience-based refusal to provide abortion; assisted reproductive technologies; contraception; treatment in cases of maternal health risk and inevitable pregnancy loss; and prenatal diagnosis. It concludes by categorizing legal, regulatory, and other policy responses to the practice.
*Conclusions:* Empirical evidence is essential for varied political actors as they respond with policies or regulations to the competing concerns at stake. Further research and training in diverse geopolitical settings are required. With dual commitments toward their own conscience and their obligations to patients' health and rights, providers and professional medical/public health societies must lead attempts to respond to conscience-based refusal and to safeguard reproductive health, medical integrity, and women's lives.
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## 1. Introduction

How can societies find the proper balance between women's rights to receive the reproductive healthcare they need and healthcare providers' rights to exercise their conscience? Global Doctors for Choice (GDC)—a transnational network of physician advocates for reproductive health and rights (www.globaldoctorsforchoice.org)—began exploring the phenomenon of conscience-based refusal of reproductive healthcare in response to increasing reports of harms worldwide. The present White Paper addresses the varied interests and needs at stake when clinicians claim conscientious objector status when providing certain elements of reproductive healthcare. (While GDC represents physicians, in the present White Paper we use the terms providers or clinicians to also address refusal of care by nurses, midwives, and pharmacists.) As the focus is on health, we examine data on the prevalence of refusal; lay out the potential consequences for the health of patients and the impact on other health providers and health systems; and report on legal, regulatory, and professional responses. Human rights are intertwined with health, and we draw upon human rights frameworks and decisions throughout. We also refer to bedrock bioethical principles that undergird the practice of medicine in general, such as the obligations to provide patients with accurate information, to provide care conforming to the highest possible standards, and to provide care that is urgently needed. Others have underscored the consequences of negotiating conscientious objection in healthcare in terms of secular/religious tension. Our contribution, which complements all of this previous work, is to provide the medical and public health perspectives and the evidence. We focus on the rights of the provider who conscientiously objects, together with that provider's professional obligations; the rights of the women who need healthcare and the consequences of refusal for their health; and the impact on the health system as a whole.

Conscientious objection is the refusal to participate in an activity that an individual considers incompatible with his/her religious, moral, philosophical, or ethical beliefs [1]. This originated as opposition to mandatory military service but has increasingly been

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raised in a wide variety of contested contexts such as education, capital punishment, driver's license requirements, marriage licenses for same-sex couples, and medicine and healthcare. While health providers have claimed conscientious objection to a variety of medical treatments (e.g. end-of-life palliative care and stem cell treatment), the present White Paper addresses conscientious objection to providing certain components of reproductive healthcare. (The terms conscientious objection and conscience-based refusal of care are used interchangeably throughout.) Refusal to provide this care has affected a wide swath of diagnostic procedures and treatments, including abortion and postabortion care; components of assisted reproductive technologies (ART) relating to embryo manipulation or selection; contraceptive services, including emergency contraception (EC); treatment in cases of unavoidable pregnancy loss or maternal illness during pregnancy; and prenatal diagnosis (PND).

Efforts have been made to balance the rights of objecting providers and other health personnel with those of patients. International and regional human rights conventions such as the Convention on the Elimination of All Forms of Discrimination against Women [2], the International Covenant on Civil and Political Rights (ICCPR) [1], the American Convention on Human Rights [3], and the European Convention for the Protection of Human Rights and Fundamental Freedoms [4], as well as UN treaty-monitoring bodies [5,6], have recognized both the right to have access to quality, affordable, and acceptable sexual and reproductive healthcare services and/or the right to freedom of religion, conscience, and thought. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa recognizes the right to be free from discrimination based on religion and acknowledges the right to health, especially reproductive health, as a key human right [7]. These instruments negotiate these apparently competing rights by stipulating that individuals have a right to belief but that the freedom to manifest one's religion or beliefs can be limited in order to protect the rights of others.

The ICCPR, a central pillar of human rights that gives legal force to the 1948 UN Universal Declaration of Human Rights, states in Article 18(1) that [1]:

> Everyone shall have the right to freedom of thought, conscience and religion. This right shall include freedom to have or to adopt a religion or belief of his choice, and freedom, either individually or in community with others and in public or private, to manifest his religion or belief in worship, observance, practice and teaching.

Article 18(3), however, states that [1]:

> Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health or morals or the fundamental rights and freedoms of others.

International professional associations such as the World Medical Association (WMA) [8] and FIGO [9]—as well as national medical and nursing societies and groups such as the American Congress of Obstetricians and Gynecologists (ACOG) [10]; Grupo Médico por el Derecho a Decidir/GDC Colombia [11]; and the Royal College of Nursing, Australia [12]—have similarly agreed that the provider's right to conscientiously refuse to provide certain services must be secondary to his or her first duty, which is to the patient. They specify that this right to refuse must be bounded by obligations to ensure that the patient's rights to information and services are not infringed.

Conscience-based refusal of care appears to be widespread in many parts of the world. Although rigorous studies are few, estimates range from 10% of OB/GYNs refusing to provide abortions reported in a UK study [13] to almost 70% of gynecologists who registered as conscientious objectors to abortion with the Italian Ministry of Health [14]. While the impact of the loss of providers may be immediate and most obvious in countries in which maternal death rates from pregnancy, delivery, and illegal abortion are high and represent major public health concerns, consequences at individual and systemic levels have also been reported in resource-rich settings. At the individual level, decreased access to health services brought about by conscientious objection has a disproportionate impact on those living in precarious circumstances, or at otherwise heightened risk, and aggravates inequities in health status. Indeed, too many women, men, and adolescents lack access to essential reproductive healthcare services because they live in countries with restrictive laws, scant health resources, too few providers and slots to train more, and limited infrastructure for healthcare and means to reach care (e.g. roads and transport). The inadequate number of providers is further depleted by the "brain drain" when trained personnel leave their home countries for more comfortable, technically fulfilling, and lucrative careers in wealthier lands [15]. Access to reproductive healthcare is additionally compromised when gynecologists, anesthesiologists, generalists, nurses, midwives, and pharmacists cite conscientious objection as grounds for refusing to provide specific elements of care.

The level of resources allocated by the health system greatly influences the impact caused by the loss of providers due to conscience-based refusal of care. In resource-constrained settings, where there are too few providers for population need, it is logical to assume the following chain of events: further reductions in available personnel lead to greater pressure on those remaining providers; more women present with complications due to decreased access to timely services; and complications require specialized services such as maternal/neonatal intensive care and more highly trained staff, in addition to incurring higher costs. The increased demand for specialized services and staffing burdens and diverts the human and infrastructural resources available for other priority health conditions. However, it is difficult to disentangle the impact of conscientious objection when it is one of many barriers to reproductive healthcare. It is conceptually and pragmatically complicated to sort the contribution to constrained access to reproductive care attributable to conscientious objectors from that due to limited resources, restrictive laws, or other barriers.

What are the criteria for establishing objector status and who is eligible to do so? In the military context, conscientious objector applicants must satisfy numerous procedural requirements and must provide evidence that their beliefs are sincere, deeply held, and consistent [16]. These requirements aim to parse genuine objectors from those who conflate conscientious objection with political or personal opinion. For example, the true conscientious objector to military involvement would refuse to fight in any war, whereas the latter describes someone who disagrees with a particular war but who would be willing to participate in a different, "just" war. Study findings and anecdotal reports from many countries suggest that some clinicians claim conscientious objection for reasons other than deeply held religious or ethical convictions. For example, some physicians in Brazil who described themselves as objectors were, nonetheless, willing to obtain or provide abortions for their immediate family members [17]. A Polish study described clinicians, such as those referred to as the White Coat Underground, who claim conscientious objection status in their public sector jobs but provide the same services in their fee-paying private practices [18]. Other investigations indicate that some claim objector status because they seek to avoid being associated with stigmatized services, rather than because they truly conscientiously object [19].

Moreover, some religiously affiliated healthcare *institutions* claim objector status and compel their employees to refuse to provide

legally permissible care [20,21]. The right to conscience is generally understood to belong to an individual, not to an institution, as claims of conscience are considered a way to maintain an individual's moral or religious integrity. Some disagree, however, and argue that a hospital's mission is analogous to a conscience–identity resembling that of an individual, and "warrant[s] substantial deference" [22]. Others dispute this on the grounds that healthcare institutions are licensed by states, often receive public financing, and may be the sole providers of healthcare services in communities. Wicclair and Charo both argue that, since a license bestows certain rights and privileges on an institution [22–24], "[W]hen licensees accept and enjoy these rights and privileges, they incur reciprocal obligations, including obligations to protect patients from harm, promote their health, and respect their autonomy" [22].

There are also disputes as to whether obligations and rights vary if a provider works in the public or private sector. Public sector providers are employees of the state and have obligations to serve the public for the greater good, providing the highest "standard of care," as codified in the laws and policies of the state [22]. The Institute of Medicine in the USA defines standard of care as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" and identifies safety, effectiveness, patient centeredness, and timeliness as key components [25]. WHO adds the concepts of equitability, accessibility, and efficiency to the list of essential components of quality of care [26]. There are legal precedents limiting the scope of conscientious objection for professionals who operate as state actors [23]. Some argue that such limitations can be extended to those who provide health services in the private sector because, as state licensure grants these professions a monopoly on a public service, the professions have a collective obligation to patients to provide non-discriminatory access to all lawful services [23,27]. However, it is more difficult to identify conscience-based refusal of care in the private sector because clinicians typically have discretion over the services they choose to offer, although the same professional obligations of providing patients with accurate information and referral pertain.

An alternative framing is provided by the concept of *conscientious commitment* to acknowledge those providers whose conscience motivates them to deliver reproductive health services and who place priority on patient care over adherence to religious doctrines or religious self-interest [28,29]. Dickens and Cook articulate that conscientious commitment "inspires healthcare providers to overcome barriers to delivery of reproductive services to protect and advance women's health" [28]. They assert that, because provision of care can be conscience based, full respect for conscience requires accommodation of both objection to participation and commitment to performance of services such that the latter group of providers also have the right to not suffer discrimination on the basis of their convictions [28]. This principle is articulated by FIGO [9]; according to the FIGO "Resolution on Conscientious Objection," "Practitioners have a right to respect for their conscientious convictions in respect both not to undertake and to undertake the delivery of lawful procedures" [30].

We begin the present White Paper with a review of the limited data regarding the prevalence of conscience-based refusal of care and objectors' motivations. Descriptive prevalence data are needed in order to assess the distribution and scope of this phenomenon and it is necessary to understand the concerns of those who refuse in order to design respectful and effective responses. We review the data; point out the methodologic, geographic, and other limitations; and specify some questions requiring further investigation. Next, we explore the consequences of conscientious objection for patients and for health systems. Ideally, we would evaluate empirical evidence on the impact of conscience-based refusal on delay in obtaining care for patients and their families, society, healthcare providers, and health systems. As such research has not been conducted, we schematically delineate the logical sequence of events if care is refused.

We then look at responses to conscience-based refusal of care by transnational bodies, governments, health sector and other employers, and professional associations. These responses include establishment of criteria for obtaining objector status, required disclosure to patients, registration of objector status, mandatory referral to willing providers, and provision of emergency care. We draw upon analyses performed by others to categorize the different models used: legislative, constitutional, case law, regulatory, employment requirements, and professional standards of care. Finally, we provide recommendations for further research and for ways in which medical and public health organizations could contribute to the development and implementation of policies to manage conscientious objection.

The present White Paper draws upon medical, public health, legal, ethical, and social science literature of the past 15 years in English, French, German, Italian, Portuguese, and Spanish available in 2013. It is intended to be a state-of-the-art compendium useful for health and other policymakers negotiating the balance of an individual provider's rights to "conscience" with the systemic obligation to provide care and it will need updating as further evidence and policy experiences accrue. It is intended to highlight the importance of the medical and public health perspectives, employ a human rights framework for provision of reproductive health services, and emphasize the use of scientific evidence in policy deliberations about competing rights and obligations.

## 2. Review of the evidence

### 2.1. Methods

We reviewed data regarding the prevalence of conscientious objection and the motivations of objectors in order to assess the distribution and scope of the phenomenon and to have an empirical basis for designing respectful and effective responses. However, estimates of prevalence are difficult to obtain: there is no consensus about criteria for objector status and, thus, no standardized definition of the practice. Moreover, it is difficult to assess whether findings in some studies reflect intention or actual behavior. The few countries that require registration provide the most solid evidence of prevalence.

A systematic review could not be performed because the data are limited in a variety of ways (which we describe), making most of them ineligible for inclusion in such a process. We searched systematically for data from quantitative, qualitative, and ethnographic studies and found that many have non-representative or small samples, low response rates, and other methodologic limitations that limit their generalizability. Indeed, the studies reviewed are not comparable methodologically or topically. The majority focus on conscience-based refusal of abortion-related care and only a few examine refusal of emergency or other contraception, PND, or other elements of care. Some examine provider attitudes and practices related to abortion in general, while others investigate these in terms of the specific circumstances for which people seek the service: for example, financial reasons, sex selection, failed contraception, rape/incest, fetal anomaly, and maternal life endangerment. Some rely on closed-ended electronic or mail surveys, while others employ in-depth interviews. Most focus on physicians; fewer study nurses, midwives, or pharmacists.

These investigations are also limited geographically because more were conducted in higher-income than lower-income countries. Because of both greater resources and more liberalized reproductive health laws and policies, many higher-income coun-

tries offer a greater range of legal services and, consequently, more opportunities for objection. Assessment of the impact of conscience-based refusal of care in resource-constrained settings presents additional challenges because high costs and lack of skilled providers may dwarf this and other factors that impede access. Acknowledging that conscientious objection to reproductive healthcare has yet to be rigorously studied, we included all studies we were able to locate within the past 15 years, and present the cross-cutting themes as topics for future systematic investigation.

*2.2. Prevalence and attitudes*

The sturdiest estimates of prevalence come from a limited sample of those few places that require objectors to register as such or to provide written notification. 70% of OB/GYNs and 50% of anesthesiologists have registered with the Italian Ministry of Health as objectors to abortion [31]. While Norway and Slovenia require some form of registration, neither has reported prevalence data [32–34]. Other estimates of prevalence derive from surveys with varied sampling strategies and response rates. In a random sample of OB/GYN trainees in the UK, almost one-third objected to abortion [35]. 14% of physicians of varied specialties surveyed in Hong Kong reported themselves to be objectors [36]. 17% of licensed Nevada pharmacists surveyed objected to dispensing mifepristone and 8% objected to EC [37]. A report from Austria describes many regions without providers and a report from Portugal indicates that approximately 80% of gynecologists there refuse to perform legal abortions [38–40].

Other studies have investigated opinions about abortion and intention to provide services. A convenience sample of Spanish medical and nursing students indicated that most support access to abortion and intend to provide it [41]. A survey of medical, nursing, and physician assistant students at a US university indicated that more than two-thirds support abortion yet only one-third intend to provide, with the nursing and physician assistant students evincing the strongest interest in doing so [42]. The 8 traditional healers interviewed in South Africa were opposed to abortion [43], and an ethnographic study of Senegalese OB/GYNs, midwives, and nurses reported that one-third thought the highly restrictive law there should permit abortion for rape/incest, although very few were willing to provide services (unpublished data).

Some studies indicate that a subset of providers claim to be conscientious objectors when, in fact, their objection is not absolute. Rather, it reflects opinions about patient characteristics or reasons for seeking a particular service. For example, a stratified random sample of US physicians revealed that half refuse contraception and abortion to adolescents without parental consent, although the law stipulates otherwise [44]. A survey of members of the US professional society of pediatric emergency room physicians indicated that the majority supported prescription of EC to adolescents but only a minority had done so [45]. A study of the postabortion care program in Senegal, intended to reduce morbidity and mortality due to complications from unsafe abortion, found that some providers nonetheless delayed care for women they suspected of having had an induced abortion (unpublished data).

Willingness to provide abortions varies by clinical context and reason for abortion, as demonstrated by a stratified random sample of OB/GYN members of the American Medical Association (AMA) [46]. A survey of family medicine residents in the USA assessing prevalence of moral objection to 14 legally available medical procedures revealed that 52% supported performing abortion for failed contraception [47]. Despite opposition to voluntary abortion, more than three-quarters of OB/GYNs working in public hospitals in the Buenos Aires area from 1998 to 1999 supported abortion for maternal health threat, severe fetal anomaly, and rape/incest [48]. While 10% of a random sample of consultant OB/GYNs in the UK described themselves as objectors, most of this group supported abortion for severe fetal anomaly [13].

Other inconsistencies regarding refusal of care derived from the provider's familiarity with a patient, experience of stigmatization, or opportunism. A Brazilian study reported that Brazilian gynecologists were more likely to support abortion for themselves or a family member than for patients [17]. Physicians in Poland and Brazil reported reluctance to perform legally permissible abortions because of a hostile political atmosphere rather than because of conscience-based objection. The authors also noted that conscientious objection in the public sphere allowed doctors to funnel patients to private practices for higher fees [19].

Not surprisingly, higher levels of self-described religiosity were associated with higher levels of disapproval and objection regarding the provision of certain procedures [49]. Additionally, a random sample of UK general practitioners (GPs) [50], a study of Idaho licensed nurses [51], a study of OB/GYNs in a New York hospital [52], and a cross-sectional survey of OB/GYNs and midwives in Sweden [53] found self-reported religiosity to be associated with reluctance to perform abortion. A study of Texas pharmacists found the same association regarding refusal to prescribe EC [54].

Higher acceptance of these contested service components and lower rates of objection were associated with higher levels of training and experience in a survey of medical students and physicians in Cameroon and in a qualitative study of OB/GYN clinicians in Senegal [55,56]. Similar patterns prevailed in a survey of Norwegian medical students [57] and among pharmacists and OB/GYNs in the USA [45].

Clinicians' refusal to provide elements of ART and PND also varied, at times motivated by concerns about their own lack of competence with these procedures. And, while the majority of Danish OB/GYNs and nurses (87%) in a non-random sample supported abortion and ART, 69% opposed selective reduction [49]. A random sample of OB/GYNs from the UK indicated that 18% would not agree to provide a patient with PND [13].

Several studies report institutional-level implications consequent to refusal of care. Physicians and nurse managers in hospitals in Massachusetts said that nurse objection limited the ability to schedule procedures and caused delays for patients [58]. Half of a stratified random sample of US OB/GYNs practicing primarily at religiously affiliated hospitals reported conflicts with the hospital regarding clinical practice; 5% reported these to center on treatment of ectopic pregnancy [59]. 52% of a non-random sample of regional consultant OB/GYNs in the UK said that insufficient numbers of junior doctors are being trained to provide abortions owing to opting out and conscientious objection [35]. A 2011 South African report states that more than half of facilities designated to provide abortion do not do so, partly because of conscientious objection, resulting in the persistence of widespread unsafe abortion, morbidity, and mortality [60]. A non-random sample of Polish physicians reported that institutional, rather than individual, objection was common [19]. Similar observations have been made about Slovakian hospitals [61].

A few investigations have explored clinician attitudes toward regulation of conscience-based refusal of reproductive healthcare. Two studies from the USA indicate that majorities of family medicine physicians in Wisconsin and a random sample of US physicians believe physicians should disclose objector status to patients [44,47]. A survey of UK consultants revealed that half want the authority to include abortion provision in job descriptions for OB/GYN posts, and more than one-third think objectors should be required to state their reasons [35]. Interviews with a purposive sample of Irish physicians revealed mixed opinions about the obligation of objectors to refer to other willing providers, as well as awareness that women traveled abroad for abortions and related services that were denied at home [62].

While the reviewed literature indicates widespread occurrence of conscientious objection to providing some elements of reproductive healthcare, it does not offer a rigorously obtained evidentiary basis from which to map the global landscape. Assessment of the prevalence of conscientious objection requires ascertainment of the number objecting (numerator) and the total count of the relevant population of providers comprising the denominator (e.g. the number of OB/GYNs claiming conscientious objection to providing EC and the total population of OB/GYNs). Registration of objectors, as required by the Italian Ministry of Health, provides such data. Professional societies could also systematically gather data by surveying members on their practices related to conscience-based refusal of care or by including such self-identification on standard mandatory forms. Academic institutions or other research organizations could conduct formal studies or add questions on conscience-based refusal of care to ongoing general surveys of clinicians.

Aside from prevalence, there are a host of key questions. Further research on motivations of objectors is required in order to better understand reasons other than conscience-based objection that may lead to refusal of care. As the studies reviewed indicate, these factors may include desire to avoid stigma, to avoid burdensome administrative processes, and to earn more money by providing services in private practice rather than in public facilities; knowledge gaps in professional training; and lack of access to necessary supplies or equipment. Qualitative studies would best probe these complicated motivations.

What is the impact of conscience-based refusal of care? In the next section, we outline systemic and biologically plausible sequences of events when specified care components are refused. Research is needed to see whether these hold true and have health consequences for women and practical consequences for other clinicians and the health system as a whole. Research could illuminate women's experiences when refused care—their understanding, access to safe and unsafe alternatives, emotional response, and course of action. Investigations on the clinician side could further explore the experiences of those who do provide services after others have refused to do so. Each of these questions is likely to have context-specific answers, so research should take place in varied geopolitical settings, and the contextual nature of the findings must be made clear.

Do clinicians consider conscientious objection to be problematic? What kinds of constraints on provider behavior do clinicians consider appropriate or realistic? When enacted, have such policies or regulations been implemented? Have those implemented effectively met their purported objectives? What mechanisms of regulation do women consider reasonable? Do they perceive conscience-based refusal of care as a significant barrier to reproductive health services? Could enhanced training and updated medical and nursing school curricula devoted to reproductive health address the lack of clinical skills that contributes to refusal of care? Could further education clarify which services are permitted by law, and under which circumstances, and thus reassure clinicians sufficiently such that they provide care? Empirical evidence is essential as varied political actors try to respond to these competing concerns with policies or regulations.

## 3. Consequences of refusal of reproductive healthcare for women and for health systems

We lay out the potential implications of conscience-based refusal of care for patients and for health systems in 5 areas of reproductive healthcare—abortion and postabortion care, ART, contraception, treatment for maternal health risk and unavoidable pregnancy loss, and PND. Because we lack empirical data to explore the impact of conscience-based refusal of care on patients and health systems, we build logical models delineating plausible consequences if a particular component of care is refused. We provide visual schemata to represent these pathways and we use data and examples of refusal from around the world to ground them.

We attempt to isolate the impact of conscientious objection for each of the 5 reproductive health components, although we recognize the difficulties of identifying the contributions attributable to other barriers to access. These include limited resources, inadequate infrastructure, failure to implement policies, sociocultural practices, and inadequate understanding of the relevant law by providers and patients alike.

We start from the premise that refusal of care leads to fewer clinicians providing specific services, thereby constraining access to these services. We posit that those who continue to provide these contested services may face stigma and/or become overburdened. We specify plausible health outcomes for patients, as well as the consequences of refusal for families, communities, health systems, and providers.

### 3.1. Conscience-based refusal of abortion-related services

The availability of safe and legal abortion services varies greatly by setting. Nearly all countries in the world allow legal abortion in certain cases (e.g. to save the life of the woman, in cases of rape, and in cases of severe fetal anomaly). Few countries prohibit abortion in all circumstances. While some among these allow the criminal law defense of necessity to permit life-saving abortions, Chile, El Salvador, Malta, and Nicaragua restrict even this recourse. Other countries with restrictive laws are not explicit or clear about those circumstances in which abortion is allowed [63].

In many countries, particularly in low-resource areas, access to legal services is compromised by lack of resources for health services, lack of health information, inadequate understanding of the law, and societal stigma associated with abortion [64].

There is substantial evidence that countries that provide greater access to safe, legal abortion services have negligible rates of unsafe abortion [65]. Conversely, nearly all of the world's unsafe abortions occur in restrictive legal settings. Where access to legal abortion services is restricted, women seek services under unsafe circumstances. Approximately 21.6 million of the world's annual 46 million induced abortions are unsafe, with nearly all of these (98%) occurring in resource-limited countries [65,66]. In low-income countries, more than half of abortions performed (56%) are unsafe, compared with 6% in high-income areas [66]. Nearly one-quarter (more than 5 million) of these result in serious medical complications that require hospital-based treatment [67, 68]; 47,000 women die each year because of unsafe abortion and an additional unknown number of women experience complications from unsafe abortions but do not seek care [68]. While the international health community has sought to mitigate the high rates of maternal morbidity and mortality caused by unsafe abortion through postabortion care programs [56], the implementation and effectiveness of these have been undermined by conscience-based refusal of care [24,56,69].

We posit that conscience-based refusal of care will have less of an impact at the population level in countries with available safe, legal abortion services than in those where access is restricted. Women living in settings in which legal abortion is widely available and who experience provider refusal will be more likely to find other willing providers offering safe, legal services than women in settings in which abortion is more highly restricted. We ground our model (Fig. 1) in the following examples: (1) in South Africa, widespread conscientious objection limits the numbers of willing providers and, thus, access to safe care, and the number of unsafe abortions has not decreased since the legalization of abortion in

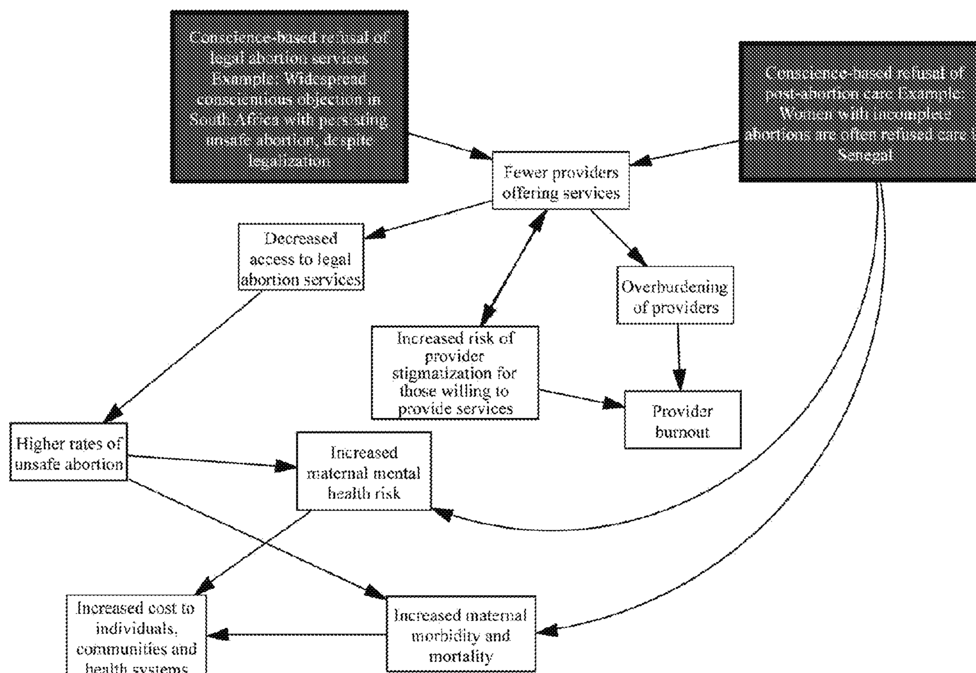


**Fig. 1.** Consequences of refusal of abortion-related services.

1996 [70,71]; (2) although Senegal's postabortion care program is meant to mitigate the grave consequences of unsafe abortion, conscientious objection is, nevertheless, often invoked when abortion is suspected of being induced rather than spontaneous [56] (unpublished data).

*3.2. Conscience-based refusal of components of ART*

Infertility is a global public health issue affecting approximately 8%–15% of couples [72,73], or 50–80 million people [74], worldwide. Although the majority of those affected reside in low-resource countries [72,73], the use of ART is much more likely in high-resource countries.

Access to specific ART varies by socioeconomic status and geographic location, between and within countries. In high-resource countries, the cost of treatment varies greatly depending on the healthcare system and the availability of government subsidy [75]. For example, in 2006, the price of a standard in vitro fertilization (IVF) cycle ranged from US$3956 in Japan to $12,513 in the USA [76]. After government subsidization in Australia, the cost of IVF averaged 6% of an individual's annual disposable income; it was 50% without subsidization in the USA [77]. In low-income countries, despite high rates of infertility, there are few resources available for ART, and costs are generally prohibitive for the majority of the population. Because these economic and infrastructural factors drive lack of access to ART in low-income countries, we posit that denial of services owing to conscience-based refusal of care is not a major contributing factor to limited access in these settings. Therefore, for the model (Fig. 2), we primarily examine the consequences of conscientious objection to components of ART in middle- to high-income countries. At times, regulations and policies regarding ART stem from empirically based concerns, grounded in medical evidence, about health outcomes for women and their offspring or health system priorities. Our focus, however, is on those instances in which some physicians practice according to moral or religious beliefs, even when these contradict best medical practices. In some Latin American countries, despite the medical evidence that maternal and fetal outcomes are markedly superior when fewer embryos are implanted, the objection to embryo selection/reduction and cryopreservation promoted by the Catholic Church has reportedly led many physicians to avoid these [78]. Anecdotal reports from Argentina describe ART physicians' avoidance of cryopreservation and embryo selection/reduction following the self-appointment of a lawyer and member of Opus Dei as legal guardian for cryopreserved embryos [78,79]. The only example that illustrates the implications of denial of preimplantation genetic diagnosis (PGD) refers to a legal ban, rather than conscience-based refusal of care. Nonetheless, we use it to describe the potential consequences when such care is denied. In 2004, Italy passed a law banning PGD, cryopreservation, and gamete donation [80]. This ban compelled a couple who were both carriers of the gene for β-thalassemia to wait to undergo amniocentesis and then to have a second-trimester abortion rather than allow the abnormality to be detected prior to implantation [80] (Fig. 2).

*3.3. Conscience-based refusal of contraceptive services*

The availability of the range of contraceptive methods varies by setting, as does prevalence of use [81]. In general, contraceptive use is correlated with level of income. In 2011, 61.3% of women aged 15–49 years, married or in a union, in middle-upper-income countries were using modern methods, compared with 25% in the lowest-resource countries [81,82]. Within countries, access to and use of methods also vary. For example, according to the 2003 Demographic and Health Survey of Kenya (a cross-sectional study of a nationally representative sample), women in the richest quintile were reported to have significantly higher odds for using long-term contraceptive methods (intrauterine device, sterilization, implants) than women in the poorest quintile [82].

The legal status of particular contraceptive methods also varies by setting. In Honduras, Congress passed a bill banning EC, which has not yet been enacted into law [83]. Even when contraception is legal, lack of basic resources allocated by government programs may compromise availability of particular methods. High manufacturing

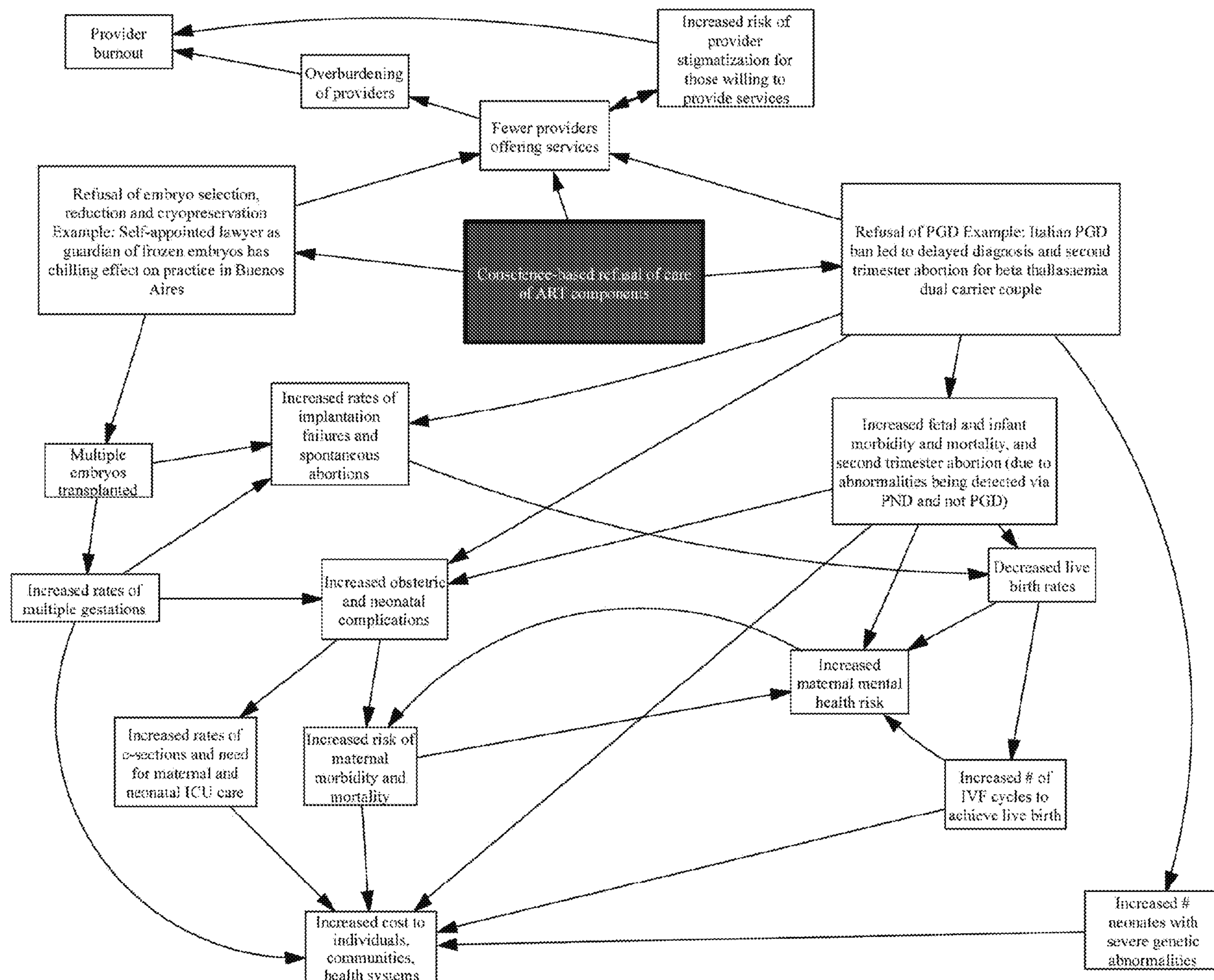


**Fig. 2.** Consequences of refusal of components of assisted reproductive technologies.

costs or steep prices can also undermine access [84]. In other cases, individual health providers opt not to provide contraception to all or to certain groups of women. Some providers refuse to provide specific methods such as EC or sterilization. In Poland, there is widespread refusal to provide contraceptive services (J. Mishtal, personal communication, April 2012). In Oklahoma, a rape victim was denied EC by a doctor [85], and in Germany a rape victim was denied EC by 2 Catholic hospitals in 2012 [86]. In Fig. 3, we delineate potential implications of conscience-based refusal of contraceptive services.

*3.4. Conscience-based refusal of care in cases of risk to maternal health and unavoidable pregnancy loss*

In some circumstances, pregnancy can exacerbate a serious maternal illness or maternal illness may require treatment hazardous to a fetus. In these cases, women require access to life-saving treatment, which may include abortion. Yet women have been denied appropriate treatment. Women seeking completion of inevitable pregnancy loss due to ectopic pregnancy or spontaneous abortion have also been denied necessary care.

It is beyond the scope of the present White Paper to define the full range of conditions that may be exacerbated by pregnancy and jeopardize the health of the pregnant woman. However, the incidence of ectopic pregnancy ranges from 1% to 16% [87–90], and 10%–20% of all clinically recognized pregnancies end in spontaneous abortion [90]. Often, refusal of care in circumstances of maternal health risk occurs in the context of highly restrictive abortion laws. We refer to 3 cases from around the world (Fig. 4) to highlight this phenomenon in our model. In Ireland in 2012, Savita Halappanavar, 31, presented at a Galway hospital with ruptured membranes early in the second trimester. She was refused completion of the inevitable spontaneous abortion, developed sepsis, and subsequently died [91]. Z's daughter, a young Polish woman, was diagnosed with ulcerative colitis while she was pregnant [92]. She was repeatedly denied medical treatment; physicians stated that they would not conduct procedures or tests that might result in fetal harm or termination of the pregnancy [92]. She developed sepsis, experienced fetal demise, and died. The only example that illustrates the implications of denial of treatment for ectopic pregnancy derives from legal bans, rather than from an example of conscience-based refusal of care. In El Salvador, a total prohibition on abortion has led to physician refusal to treat ectopic pregnancy [93]; in Nicaragua, the abortion ban results in delay of treatment for ectopic pregnancies, despite law and medical guidelines mandating the contrary [94] (Fig. 4).

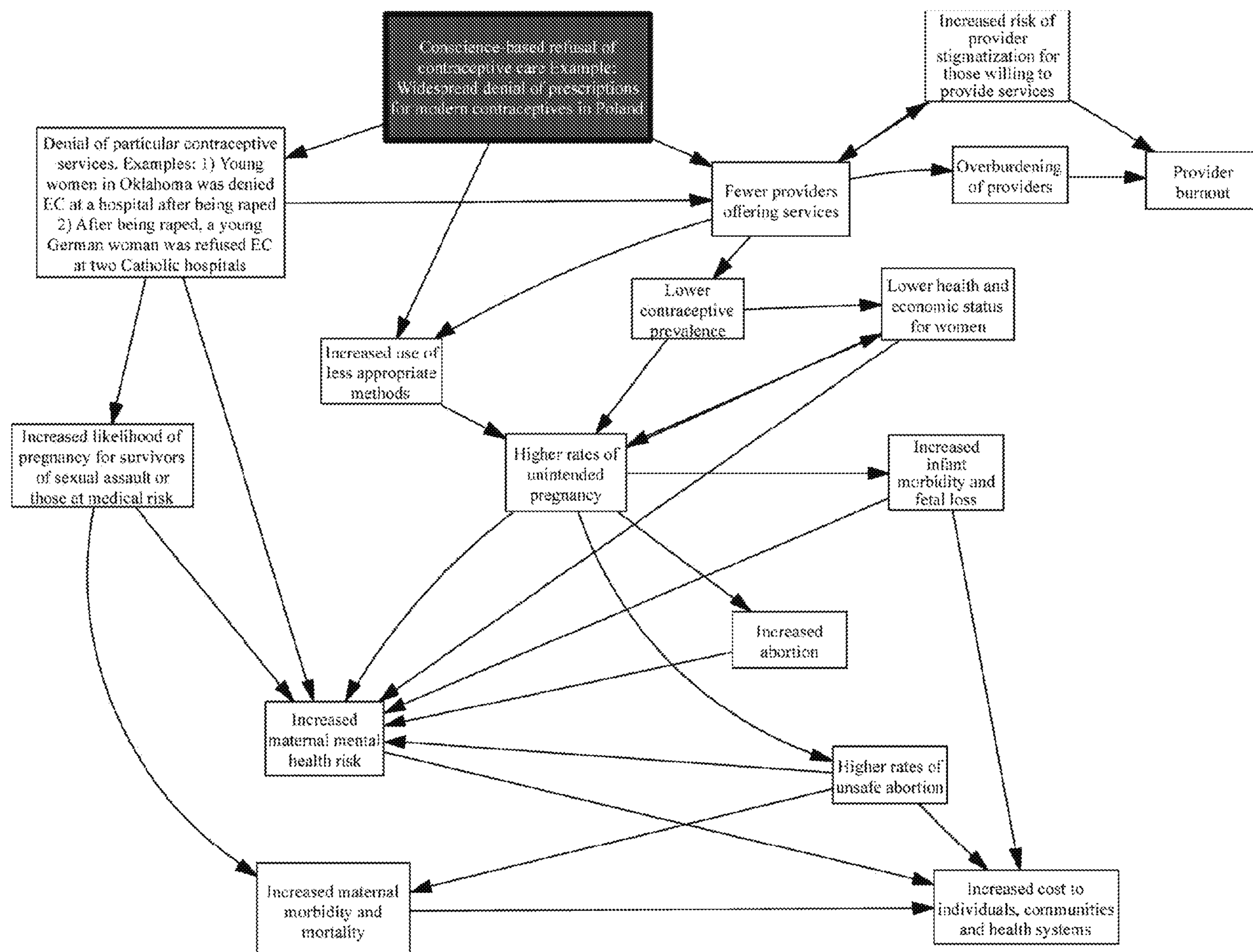


**Fig. 3.** Consequences of refusal of contraceptive services.

*3.5. Conscience-based refusal of PND*

The availability of PND varies greatly by setting—with those in middle–upper-income countries having access to testing for a variety of genetic conditions and structural anomalies, and fewer having access to a more limited series of testing in low-income countries. Access to PND provides women with information so that they can make decisions and/or preparations when severe or lethal fetal anomalies are detected. Outcomes for affected neonates vary by country resource level; PND enables physicians to plan for the level of care needed during delivery and in the neonatal period. With PND, families are also afforded the time to secure the necessary emotional and financial resources to prepare for the birth of a child with special needs [95,96]. In settings in which there are fewer resources available for PND, conscientious objection further restricts women's access to services. Figure 5 presents pathways and implications of provider conscience-based refusal to provide PND services. Because most data on access to PND are from high-resource countries, we must project what would happen in lower-income countries. We use the example of *R.R.*, a Polish woman who was repeatedly refused diagnostic tests to assess fetal status after ultrasound detection of a nuchal hygroma [97] (Fig. 5).

## 4. Policy responses to manage conscience-based refusal of reproductive healthcare

Here, we review various policy interventions related to conscience-based refusal of care. Initially, we look at the context established by human rights standards or human rights bodies wherein freedom of conscience is enshrined. The UN Committee on Economic, Social and Cultural Rights (CESCR); the UN Committee on the Elimination of Discrimination against Women (CEDAW); and the UN Human Rights Committee have commented on the need to balance providers' rights to conscience with women's rights to have access to legal health services [98–104]. CEDAW asserts that "it is discriminatory for a country to refuse to legally provide for the performance of certain reproductive health services for women" and that, if healthcare providers refuse to provide services on the basis of conscientious objection, "measures should be introduced to ensure that women are referred to alternative health providers" [99]. CESCR has called on Poland to take measures to ensure that women enjoy their rights to sexual and reproductive health, including by "enforcing the legislation on abortion and implementing a mechanism of timely and systematic referral in the event of conscientious objection" [104].

The international medical and public health communities, including FIGO in its Ethical Guidelines on Conscientious Objection (2005) [9] and WHO in its updated Safe Abortion Guidelines (2012) [105], have agreed on principles related to the management of

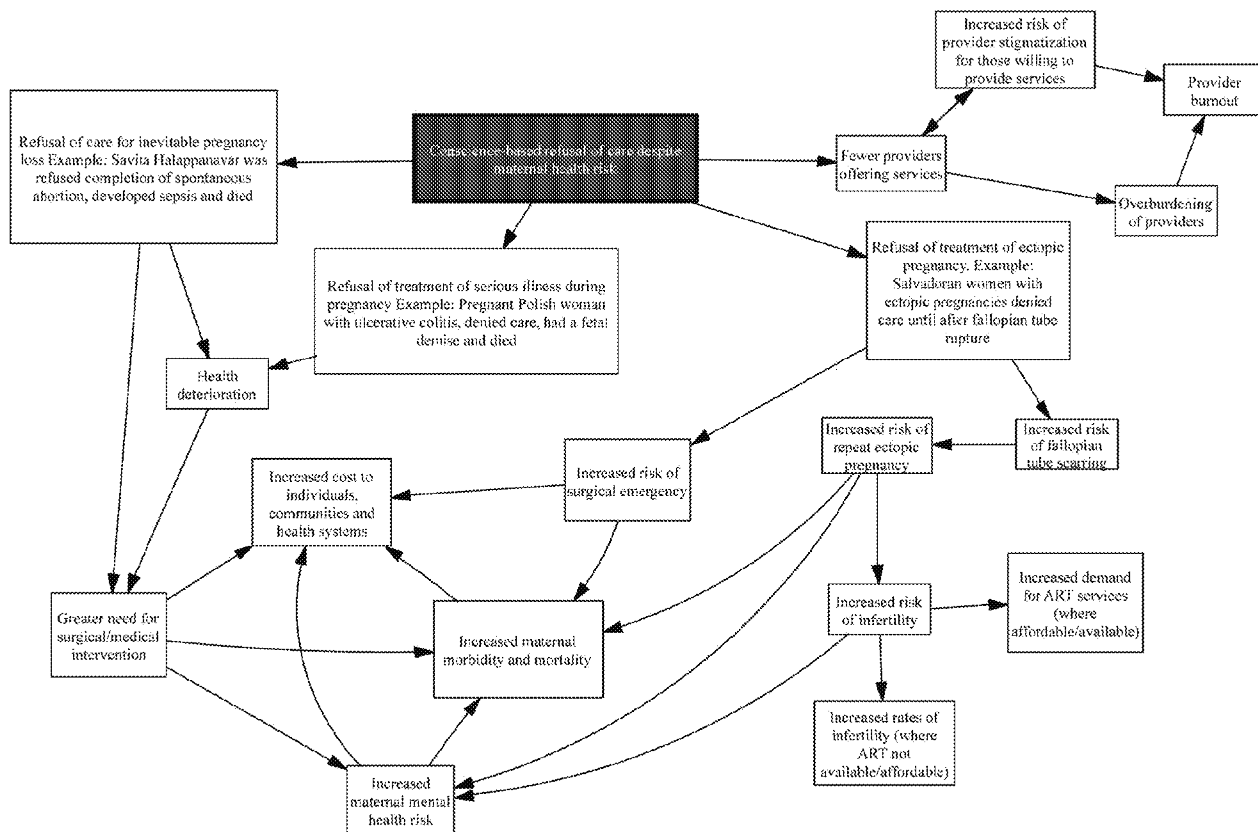


**Fig. 4.** Consequences of refusal of care in cases of risk to maternal health and unavoidable pregnancy loss.

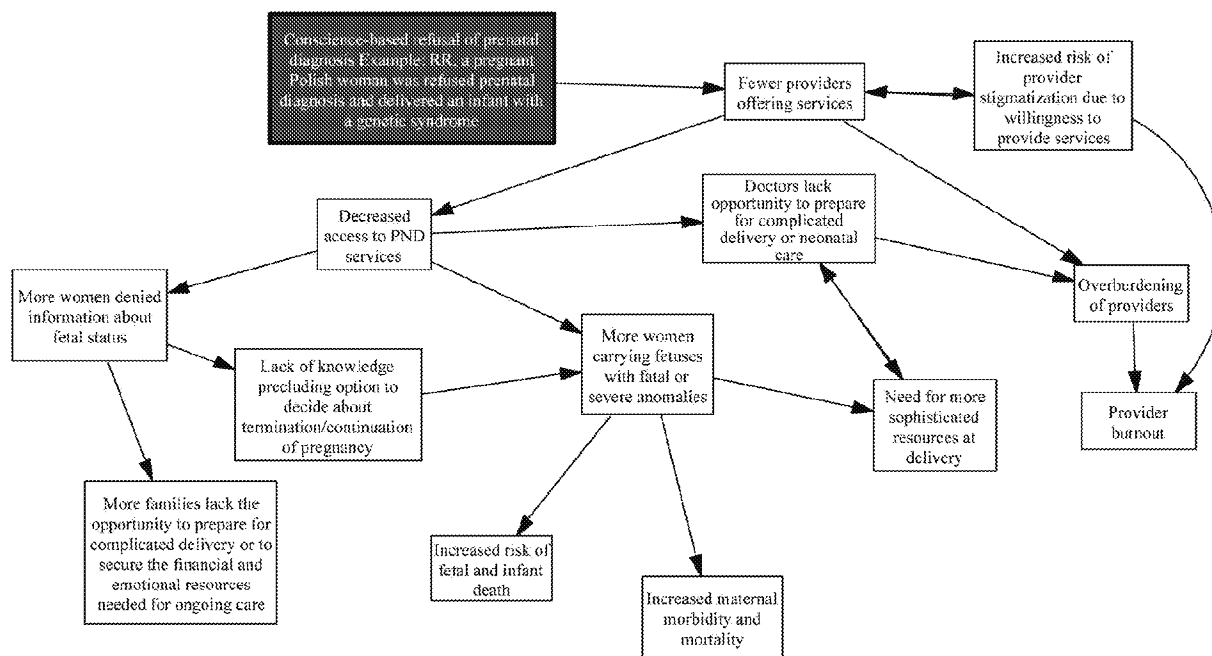


**Fig. 5.** Consequences of refusal of prenatal diagnosis.

conscientious objection to reproductive healthcare provision. While these are non-binding recommendations, they do assert professional standards of care. These include the following:

- Providers have a right to conscientious objection and not to suffer discrimination on the basis of their beliefs.
- The primary conscientious duty of healthcare providers is to

treat, or provide benefit and prevent harm to patients; conscientious objection is secondary to this primary duty.

Moreover, the following safeguards must be in place in order to ensure access to services without discrimination or undue delays:

- Providers have a professional duty to follow scientifically and professionally determined definitions of reproductive health services, and not to misrepresent them on the basis of personal beliefs.
- Patients have the right to be referred to practitioners who do not object for procedures medically indicated for their care.
- Healthcare providers must provide patients with timely access to medical services, including giving information about the medically indicated options of procedures for care, including those that providers object to on grounds of conscience.
- Providers must provide timely care to their patients when referral to other providers is not possible and delay would jeopardize patients' health.
- In emergency situations, providers must provide the medically indicated care, regardless of their own personal objections.

These statements support both sides of the tension: the right of patients to have access to appropriate medical care and the right of providers to object, for reasons of conscience, to providing particular forms of care. They underscore the professional obligation of healthcare providers to ensure timely access to care, through provision of accurate information, referral, and emergency care. At the transnational level, human rights consensus documents have asserted that institutions and individuals are similarly bound by their obligations to operate according to the bedrock principles that underpin the practice of medicine, such as the obligations to provide patients with accurate information, to provide care conforming to the highest possible standards, and to provide care in emergency situations.

At the country level, however, there is no agreement as to whether institutions can claim objector status. For example, Spain [106], Colombia [107], and South Africa [108] have laws stating that refusal to perform abortions is always an individual, not an institutional, decision. Conversely, Argentinian law [109,110] gives private institutions the ability to object and requires private health centers to register as conscientious objectors with local health authorities. In Uruguay, the Ethical Code does not require the institution employing a conscientious objector to provide referral services, although a newly proposed bill would require such referral [111,112]. In the USA, the question of institutional rights and obligations is hotly debated and the situation is complicated and unresolved. Currently, federal law forbids agencies receiving federal funding from discriminating against any healthcare entity that refuses to provide abortion services [113]. Yet other federal law requires institutions providing services for low-income people to maintain an adequate network of providers and to guarantee that individuals receive services without additional out-of-pocket cost [114].

International and regional human rights bodies, governments, courts, and health professional associations have developed various responses to address conscience-based refusal of care. These responses differ as to whose rights they protect: the rights of a woman to have access to legal services or the rights of a provider to object based on reasons of conscience. They might also have different emphases or targets. Some focus on ensuring an adequate number of providers for a certain service, some concentrate on ensuring that women receive timely referrals to non-objecting practitioners, and some seek to establish criteria for designation as an objector. For example, Norway established a comprehensive regulatory and oversight framework on conscientious objection to abortion, which includes ensuring the availability of providers [33,115]. In Colombia, the Constitutional Court affirmed that conscientious objection must be grounded in true religious conviction, rather than in a personal judgment of "rightness" [116].

Some of these responses are legally binding through national constitutional provisions, legislation, or case law. The European Court of Human Rights (ECHR), whose rulings are legally binding for member nations, clarified the obligation of states to organize the practice of conscience-based refusal of care to ensure that patients have access to legal services, specifically to abortion [97]. Professional associations and employers have developed other interventions, including job requirements and non-binding recommendations. In Germany, for example, a Bavarian High Administrative Court decision [117], upheld by the Federal Administrative Court [118], ruled that it was permissible for a municipality to include ability and willingness to perform abortions as a job criterion. In Norway, employers can refuse to hire objectors and employment advertisements may require performance of abortion as a condition for employment [112]. In Sweden, Bulgaria, Czech Republic, Finland, and Iceland, healthcare providers are not legally permitted to conscientiously object to providing abortion services [38]. Some require referral to non-objecting providers. For example, in the recent *P. and S. v. Poland* case, the ECHR emphasized the need for referrals to be put in writing and included in patients' medical records [119]. In Argentina [110] and France [120], legislation requires doctors who conscientiously object to refer patients to non-objecting practitioners. Similar laws exist in Victoria, Australia [121], Colombia [116,122,123], Italy [124], and Norway [115]. Professional and medical associations around the world recommend that objectors refer patients to non-objecting colleagues. ACOG in the USA [125] and El Sindicato Médico in Uruguay [126] recommend that objectors refer patients to other practitioners. The British Medical Association (BMA) specifies that practitioners cannot claim exemption from giving advice or performing preparatory steps (including referral) where the request for an abortion meets legal requirements [127]. The WMA asserts that, if a physician must refuse a certain service on the basis of conscience, s/he may do so after ensuring the continuity of medical care by a qualified colleague [128]. FIGO maintains that patients are entitled to referral to practitioners who do not object [9].

Pharmacists' associations in the USA and UK have made similar recommendations. The American Society of Health-System Pharmacists asserts that pharmacists and other pharmacy employees have the right not to participate in therapies they consider to be morally objectionable but they must make referrals in an objective manner [129]; the AMA guidelines state that patients have the right to receive an immediate referral to another dispensing pharmacy if a pharmacist invokes conscientious objection [130]. In the UK, pharmacists must also have in place the means to make a referral to another relevant professional within an appropriate time frame [131].

Some jurisdictions mandate registration of objectors or require objectors to provide advance written notice to employers or government bodies. In Spain, for example, the law requires that conscientious objection must be expressed in advance and in written form to the health institution and the government [106]. Italian law also requires healthcare personnel to declare their conscientious objection to abortion to the medical director of the hospital or nursing home in which they are employed and to the provincial medical officer no later than 1 month after date of commencement of employment [124]. Victoria, Australia [118]; Colombia [123]; Norway [115]; Madagascar [132]; and Argentina [109] have similar laws. In Norway, the administrative head of a health institution must inform the county municipality of the number of different categories of health personnel who are exempted on grounds of conscience [115]. Argentinian law [109] gives private institutions the ability to object, requiring these

institutions to register as conscientious objectors with local health authorities and to guarantee care by referring women to other centers. Argentinian law also states that an individual objector cannot provide services in a private health center that s/he objects to the provision of in the public health system [110]. Regulation in Canada requires pharmacists to ensure that employers know about their conscientious objector status and to prearrange access to an alternative source for treatment, medication, or procedure [133]. The Code of Ethics for nurses in Australia also requires disclosure to employers [134]. In Northern Ireland, a guidance document by the Department of Health, Social Services and Public Safety asserts that an objecting provider "should have in place arrangements with practice colleagues, another GP practice, or a Health Social Care Trust to whom the woman can be referred" for advice or assessment for termination of pregnancy [135].

Other measures require disclosure to patients about providers' status as objectors. For example, the law in the state of Victoria, Australia, requires objectors to inform the woman and refer her to a willing provider [121]. In Argentina, the Technical Guide for Comprehensive Legal Abortion Care 2010 [109] requires that all women be informed of the conscientious objections of medical, treating, and/or support staff at first visit. Portugal's medical ethical guidelines encourage doctors to communicate their objection to patients [136].

The right to receive information in healthcare, including reproductive health information, is enshrined in international law. For example, the ECHR determined that denial of services essential to making an informed decision regarding abortion can constitute a violation of the right to be free from inhuman and degrading treatment [97]. At the national level, laws have mandated disclosure of health information to patients. For example, according to the South African abortion law, providers, including objectors, must ensure that pregnant women are aware of their legal rights to abortion [108]. In Spain, women are entitled to receive information about their pregnancies (including prenatal testing results) from all providers, including those registered as objectors [106]. In the UK, objectors are legally required to disclose their conscientious objector status to patients, to tell them they have the right to see another doctor, and to provide them with sufficient information to enable them to exercise that right [137–139].

Professional guidelines have also addressed disclosure of health information. In Argentina, any delaying tactics, provision of false information, or reluctance to carry out treatment by health professionals and authorities of hospitals is subject to administrative, civil, and/or criminal actions [109]. FIGO asserts that the ethical responsibility of OB/GYNs to prevent harm requires them to provide patients with timely access to medical services, including giving them information about the medically indicated options for their care [9].

Some require the provision of services in cases of emergency. For example, legislation in Victoria, Australia [121]; Mexico City [140]; Slovenia [141]; and the UK [138] stipulates that physicians may not refuse to provide services in cases of emergency and when urgent termination is required. US case law determined that a private hospital with a tradition of providing emergency care was still obliged to treat anyone relying on it even after its merger with a Catholic institution. This sets the standard for continuity of access after mergers of 2 hospitals with conflicting philosophies [142]. Also, ACOG urges clinicians to provide medically indicated care in emergency situations [125]. In Argentina, technical guidelines from the Ministry of Health stipulate that institutions must provide termination of pregnancy through another provider at the institution within 5 days or immediately if the situation is urgent [109]. In the UK, medical standards also prohibit conscience-based refusal of care in cases of emergency for nurses and midwives [143].

Other measures address the required provision of services when referral to an alternative provider is not possible. In Norway, for example, a doctor is not legally allowed to refuse care unless a patient has such reasonable access [115]. FIGO recommends that "practitioners must provide timely care to their patients when referral to other practitioners is not possible and delay would jeopardize patients' health and well being, such as by patients experiencing unwanted pregnancy" [9].

Some interventions obligate the state to ensure services. In Colombia, for example, the health system is responsible for providing an adequate number of providers, and institutions must provide services even if individuals conscientiously object [107]. The law on voluntary sterilization and vasectomies in Argentina obligates health centers to ensure the immediate availability of alternative services when a provider has objected [144]. In Spain, the government will pay for transportation to an alternative willing public health facility [106]. Italian law requires healthcare institutions to ensure that women have access to abortion; regional healthcare entities are obliged to supervise and ensure such access, which may include transferring healthcare personnel [125]. In Mexico City, the public health code was amended to reinforce the duty of healthcare facilities to make abortion accessible, including their responsibility to limit the scope of conscientious objection [140].

Some measures specify which service providers are eligible to refuse and when they are allowed to do so. In the UK, for example, auxiliary staff are not entitled to conscientiously object [145,146]. According to the BMA guidelines, refusal to participate in paperwork or administration connected with abortion procedures lies outside the terms of the conscientious objection clause [127]. In Spain, only health professionals directly involved in termination of pregnancy have the right to object, and they must provide care to the woman before and after termination of pregnancy [106]. Similarly, doctors in Italy are legally required to assist before and after an abortion procedure even if they opt out of the procedure itself [124]. Also, medical guidelines in Argentina encourage practitioners to aid before and after legal abortion procedures even if they are invoking conscientious objection to participation in the procedure itself [109]. During the Bush administration, the US Department of Health and Human Services extended regulatory "conscience protections" to any individual peripherally participating in a health service [147]. This regulation was contested vigorously and retracted almost fully in February 2011 [148,149].

In Table 1, we lay out some benefits and limitations of policy responses to conscientious objection in order to provide varied actors with a menu of possibilities. As criteria are developed for invoking refusal, it is essential to address the questions of who is eligible to object, and to the provision of which services. We have added the categories of "data" and "standardization" as parameters in the table in recognition of the scant evidence available and the resulting inability to methodically assess the scope and efficacy of interventions. Selection of the various options delineated below will be influenced by the specific sociopolitical and economic context.

## 5. Conclusion

Refusal to provide certain components of reproductive healthcare because of moral or religious objection is widespread and seems to be increasing globally. Because lack of access to reproductive healthcare is a recognized route toward adverse health outcomes and inequalities, exacerbation of this through further depletion of clinicians constitutes a grave global health and rights concern. The limited evidence available indicates that objection occurs least when the law, public discourse, provider custom, and clinical experience all normalize the provision of the full range of reproductive healthcare services and promote women's autonomy. While data on both the prevalence of conscience-based refusal of

**Table 1**
Benefits and limitations of policy interventions

| Option | Health system needs | Timely access to care | Balancing rights and obligations | Developing criteria for refusers | Standardization | Data needs |
|---|---|---|---|---|---|---|
| Referral to willing and accessible providers | Enables system planning for service delivery | Expedites patients' access to services | Upholds patients' rights to health-related information; providers' obligations to provide information and make refusal transparent; individual conscience | Establishes obligations of those claiming objector status while acknowledging legitimacy of objection | Policies and procedures for disclosure and referral standardized throughout health system | Provides indirect data on patients' encounters with refusal |
| Registration of objectors/written notice to employers | Informs on prevalence of objection, enabling system planning for service delivery | Leads to more timely access to care for women who can avoid seeking care from known objectors | Acknowledges provider right to object while informing patients. Requirement of formal documentation acknowledges health system stake in such knowledge | Delineates the specific instances in which objection is permitted, and by whom; formal notification of employers makes explicit the criteria for designation as an objector | Ensures that requirements for designation as objector are standardized throughout the health system | Registries provide data on prevalence by type of provider as well as component of care refused |
| Required disclosure of objector status to patients | Enables women to avoid unproductive visits to objectors and delayed care, promoting smoother functioning of system | Women go directly to willing provider | Acknowledges provider right to object while upholding patients' rights to autonomy and health-related information | Defines obligations of objectors | Standardizes information provided to patients | N/A |
| Required information to patients about available health options | Informed patients are better able to make decisions and to locate the services that they need | Facilitates patient access to appropriate care | Upholds patients' rights to obtain health-related information; underscores providers' obligations to provide accurate information and to inform about legally available options; asserts health system's commitment to science and to patients' rights | Limits scope of objection by specifying components of care individuals obligated to provide | Standardizes information to patients about health system's range of available services | N/A |
| Mandated provision of services in urgent situations or when no alternative exists | Facilitates planning for provision of emergency care and for associated policies, procedures, and oversight; ensures that medical sequelae of denial or delay of care are minimized | Provides critical care in a timely fashion | Obligations of the provider to operate in the best interests of patients and to provide appropriate care take precedence over the individual clinician's right to object | Sets limits on the scope of refusal to protect patients in emergency situations | Ensures that objectors adhere to contractual obligations to provide essential and/or life-saving care | Contributes to the ability to track urgent cases and to plan service provision needs |
| Willingness to provide and proficiency as criteria for employment | Underscores employers' needs to ensure sufficient number of providers to meet demand for specific services | Staff competency and willingness enable ready and timely access to appropriate care | Health systems' needs to employ proficient and willing providers to respond to the health needs of the community trump provider rights to object; providers free to adhere to conscience by choosing other employment | Limits objection because only those willing and trained are eligible for employment | Standardizes such requirements in job postings throughout health system | Tracks the number of proficient and willing candidates seeking employment |
| Medical certification contingent upon proficiency in specific services | Improves health system-level planning for service delivery by assuring that providers are proficient in needed services | Availability of trained providers facilitates timely access to care | Establishes that objectors have the right to choose other specialties, but not to refuse essential components of a specialty; ensures patient rights to receive appropriate services from providers designated as specialists; defines and safeguards professional standards | Clarifies that specialist objectors must be trained and ready to provide care in emergency situations or when other options not available | Specialty certification guarantees mastery of a set of skills and compliance with explicit obligations | Tracks number of providers certified and, therefore, proficient, thus facilitating planning |
| Medical society guidelines delineating expected standards of care | Recommends that priority go to patient receipt of care and to prevention of shortages of willing and qualified providers; guidelines may lack mechanisms for implementation | Recommends policies and procedures to ensure timely access to care but may lack force | Delineates the rights and obligations of providers and the rights of patients | Suggests criteria for designation as objector and associated obligations | Asserts standards of care | N/A |

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care and the consequences for women's health and health system function are inadequate, they indicate that refusal is unevenly distributed; that it may have the most severe impact in those parts of the world least able to sustain further personnel shortages; and that it also affects women in more privileged circumstances.

The present White Paper has laid out the available data and outlined research questions for further management of conscience-based refusal of care. It presents logical chains of consequences when refusal compromises access to specific components of reproductive healthcare and categorizes efforts to balance the claims of objectors with the claims of both those seeking healthcare and the systems obligated to provide these services. We highlight the claims of those whose conscience compels them to provide such care, despite hardship. As our emphasis is on medicine and science, we close by considering ways for medical professional and public health societies to develop and implement policies to manage conscientious objection.

One recommendation is to standardize a definition of the practice and to develop eligibility criteria for designation as an objector. Such designation would have accompanying obligations, such as disclosure to employers and patients, and duties to refer, to impart accurate information, and to provide urgently needed care. Importantly, professional organizational voices can uphold conformity with standards of care as the priority professional commitment of clinicians, thus eliminating refusal as an option for the care of ectopic pregnancy, inevitable spontaneous abortion, rape, and maternal illness. In sum, medical and public health professional organizations can establish a clinical standard of care for conscientious objection, to which clinicians could be held accountable by patients, medical societies, and health and legal systems.

There are additional avenues for professional organizations to explore in upholding standards. Clinical specialty boards might condition certification upon demonstration of proficiency in specific services. Clinical educators could ensure that trainees and members are educated about relevant laws and clinical protocols/procedures. Health systems may consider willingness to provide needed services and proficiency as criteria for employment. These last are noteworthy because they also move us from locating the issue at the individual level to consideration of obligations at the professional and health system levels.

These issues are neither simple nor one-sided. Conscience and integrity are critically important to individuals. Societies have the complicated task of honoring the rights of dissenters while also limiting their impact on other individuals and on communities. Although conscientious objection is only one of many barriers to reproductive healthcare, it is one that medical societies are well positioned to address because providers are at the nexus of health and rights concerns. They have the unique vantage point of caring simultaneously about their own conscience and about their obligations to patients' health and rights and to the highest standards of evidence-based care. The present White Paper has disentangled the range of implications for women's health and rights, health systems, and objecting and committed providers. Thus, it equips clinicians and their professional organizations to contribute a distinct medical voice, complementary to those of lawyers, ethicists, and others. We urge medical and public health societies to assert leadership in forging policies to balance these competing interests and to safeguard reproductive health, medical integrity, and women's lives.

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## Conflict of interest

The authors have no conflicts of interest.

## References

[1] International Covenant on Civil and Political Rights, *adopted* Dec. 16, 1966, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* March 23, 1976).

[2] Convention on the Elimination of All Forms of Discrimination against Women, *adopted* December 18, 1979, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46 (*entered into force* September 3, 1981).

[3] Organization of American States. American Convention on Human Rights, *"Pact of San Jose", Costa Rica*. November 22, 1969. http://www.unhcr.org/refworld/docid/3ae6b36510.html. Accessed February 10, 2013.

[4] Council of Europe. European Convention for the Protection of Human Rights and Fundamental Freedoms, as amended by Protocols Nos. 11 and 14. November 4, 1950, ETS 5. http://www.unhcr.org/refworld/docid/3ae6b3b04.html. Accessed February 10, 2013.

[5] UN Committee on Economic, Social and Cultural Rights (CESCR). General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant). August 11, 2000, E/C.12/2000/4. http://www.refworld.org/docid/4538838d0.html. Accessed May 7, 2013.

[6] L.C. v. Peru, Communication No. 1153/2003, Human Rights Committee, para. 6.3, U.N. Doc. CCPR/C/85/D/1153/2003 (2005).

[7] Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, *adopted* July 11, 2003, 2nd African Union Assembly, Maputo, Mozambique (*entered into force* 2005).

[8] World Medical Association. Declaration of Helsinki—Ethical Principles for Medical Research Involving Human Subjects. Adopted 1964. http://www.wma.net/en/30publications/10policies/b3/. Accessed June 15, 2013.

[9] FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health. Ethical guidelines on conscientious objection. FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health. Int J Gynecol Obstet 2006;92(3):333–4.

[10] American College of Obstetricians and Gynecologists (ACOG). ACOG Committee Opinion. Committee on Ethics. The Limits of Conscientious Refusal in Reproductive Health Care. Number 385, November 2007 (*reaffirmed* 2010). http://www.acog.org/Resources%20And%20Publications/Committee%20Opinions/Committee%20on%20Ethics/The%20Limits%20of%20Conscientious%20Refusal%20in%20Reproductive%20Medicine.aspx. Accessed March 22, 2013.

[11] González Vélez AC. Refusal of Care due to Conscientious Objection. Grupo Médico por el Derecho a Decidir. Global Doctors for Choice/Colombia 2012. http://globaldoctorsforchoice.org/wp-content/uploads/Negaci%C3%B3n-de-servicios-por-razones-de-conciencia.pdf. Accessed October 23, 2013.

[12] Royal College of Nursing, Australia. Position Statement. Conscientious Objection. http://www.rcna.org.au/wcm/RCNA/Policy/Position_statements/rcna/policy/position_statements_guidelines_and_communiques.aspx. Accessed March 22, 2013.

[13] Green JM. Obstetricians' views on prenatal diagnosis and termination of pregnancy: 1980 compared with 1993. British J Obstet Gynaecol 1995;102(3):228–32.

[14] Zampas C, Andion-Ibaniez X. Conscientious objection to sexual and reproductive health services: international human rights standards and European law and practice. Eur J Health Law 2012;19:231–56.

[15] Dodani S, LaPorte R. Brain drain from developing countries: how can brain drain be converted into wisdom gain? J R Soc Med 2005;98(11):487–91.

[16] United States Department of Defense Regulations. DoD Directive 1300.6: Conscientious Objectors. http://www.dtic.mil/whs/directives/corres/pdf/130006p.pdf. Published May 31, 2007. Accessed October 23, 2013.

[17] Faundes A, Duarte GA, Neto JA, de Sousa MH. The closer you are, the better you understand: the reaction of Brazilian obstetrician-gynaecologists to unwanted pregnancy. RHM 2004;12(24 Suppl):47–56.

[18] Mishtal J. Contradictions of Democratization: The Politics of Reproductive Rights and Policies in Postsocialist Poland. Dissertation submitted to the Faculty of the Graduate School of the University of Colorado in partial fulfillment of the requirement for the degree of Doctor of Philosopy. Department of Anthropology. 2006. http://federa.org.pl/dokumenty_pdf/prawareprodukcyjne/Mishtal%20dissertation.pdf. Accessed June 17, 2013.

[19] De Zordo S, Mishtal J. Physicians and abortion: Provision, political participation and conflicts on the ground—The cases of Brazil and Poland. Women's Health Issues 2011;21(Suppl 3):S32-6.

[20] MergerWatch. Religious Restrictions: Refusals to Provide Care. http://www.mergerwatch.org/refusals/. Accessed August 17, 2012.

[21] Shelton DL. Chicago Tribune News. Appeals court sides with pharmacists in emergency contraceptives care. http://articles.chicagotribune.com/2012-09-22/news/ct-met-emergency-contraceptives-20120922_1_emergency-contraceptives-conscience-act-pharmacists. Published September 22, 2012. Accessed March 22, 2013.

[22] Wicclair MR. Refusals by hospitals and emergency contraception. Cambridge Quarterly of Healthcare Ethics 2011;20(1):130–8.
[23] Charo RA. American Constitution Society for Law and Policy. Health Care Provider Refusals to Treat, Prescribe, Refer or Inform: Professionalism and Conscience. The Journal of the ACS Issue Groups 2007: 119–35. https://media.law.wisc.edu/m/yzdkn/charo_-_health_care_provider_refusals_-_feb_2007_-_advance_vol_1.pdf.
[24] Wicclair MR. Conscientious Objection in Health Care. Cambridge: Cambridge University Press; 2011.
[25] Institute of Medicine. Shaping the Future of Health. Crossing the Quality Chasm: A New Health System for the 21st Century. http://www.iom.edu/~/media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf. Published 2001. Accessed May 8, 2013.
[26] WHO. Quality of Care: A Process for Making Strategic Choices in Health Systems. Geneva: WHO; 2006. http://www.who.int/management/quality/assurance/QualityCare_B.Def.pdf.
[27] Endres v. Indiana State Police, 349 F.3d 922 (7th Cir. 2003) (cert. denied, 541 U.S. 989 (2004)), *cited in* Charo RA. American Constitution Society for Law and Policy, Health Care Provider Refusals to Treat, Prescribe, Refer or Inform: Professionalism and Conscience. The Journal of the ACS Issue Groups 2007: 119–35. https://media.law.wisc.edu/m/yzdkn/charo_-_health_care_provider_refusals_-_feb_2007_-_advance_vol_1.pdf.
[28] Dickens BM, Cook RJ. Conscientious commitment to women's health. Int J Gynecol Obstet 2011;113:163–6.
[29] Harris L. Recognizing Conscience in Abortion Provision. N Engl J Med 2012;367(11):981–3.
[30] FIGO. Resolution on Conscientious Objection. http://www.figo.org/projects/conscientious. Published 2005. Accessed June 1, 2013.
[31] Republic of Italy. Ministry of Health. Report of the Ministry of Health on the Performance of the Law Containing Rules for the Social Care of Maternity and Voluntary Interruption of Pregnancy: 2006-2007 (2008).
[32] The Act (13 June 1995 no. 50), concerning Termination of Pregnancy, with Amendments in the Act dated 16 June 1978 no. 5, at 14 (Norway).
[33] Health Services Act, Art. 56, Official Gazette of the Republic of Slovenia (Slovenia).
[34] The Abortion Act, Act No. 595/1974, as amended through Act No. 998/2007 (Sweden).
[35] Roe J, Francome C, Bush M. Recruitment and training of British obstetrician-gynaecologists for abortion provision: conscientious objection versus opting out. RHM 1999;7(14):97–105.
[36] Lo SS, Kok WM, Fan SY. Emergency contraception: knowledge, attitude and prescription practice among doctors in different specialties in Hong Kong. J Obstet Gynaecol Research 2009;35(4):767–74.
[37] Davidson LA, Pettis CT, Cook DM, Klugman CM. Religion and conscientious objection: a survey of pharmacists' willingness to dispense medications. Soc Sci Med 2010;71(1):161–5.
[38] Heino A, Gissler M, Apter D, Fiala C. Conscientious objection and induced abortion in Europe. Euro J Contracept Reprod Health Care 2013;18:231–3.
[39] Austrian Ministry of Health. Austrian Women's Health Report 2010/2011. Vienna: Ministry of Health; 2011.
[40] Oliveira da Silva M. Reflections on the legalisation of abortion in Portugal. Eur J Contracept Reprod Health Care 2009;14:245–8.
[41] Rodríguez-Calvo MS, Martínez-Silva IM, Concheiro L, Muñoz-Barús JI. University students' attitudes towards Voluntary Interruption of Pregnancy. Legal Medicine 2012;14(4):209–13.
[42] Guttmacher Institute. Attitudes and intentions of future health care providers toward abortion provision. Perspectives Sexual Reprod Health 2004;36(2):58–63.
[43] Rakhudu MA, Mmelesi AMM, Myburgh CPH, Poggenpoel M. Exploration of the views of traditional healers regarding the termination of pregnancy (TOP) law. Curationis 2006;29(3):56–60.
[44] Curlin FA, Lawrence RE, Chin MH, Lantos JD. Religion, conscience, and controversial clinical practices. N Engl J Med 2007;356(6):593–600.
[45] Goyal M, Zhao H, Mollen C. Exploring emergency contraception knowledge, prescription practices, and barriers to prescription for adolescents in the emergency department. Pediatrics 2009;123(3):765–70.
[46] Harris LH, Cooper A, Rasinski KA, Curlin FA, Lyerly AD. Obstetrician–gynecologists' objections to and willingness to help patients obtain an abortion. Obstet Gynecol 2011;118(4):905–12.
[47] Frank JE. Conscientious refusal in family medicine residency training. Family Medicine 2011;43(5):330–3.
[48] Gogna M, Romero M, Ramos S, Petracci M, Szulik D. Abortion in a restrictive legal context: the views of obstetrician-gynaecologists in Buenos Aires, Argentina. RHM 2002;10(19):128–37.
[49] de la Fuente Fonnest I, Sondergaard F, Fonnest G, Vedsted-Jacobsen A. Attitudes among health care professionals on the ethics of assisted reproductive technologies and legal abortion. Acta Obstet Gynecol Scand 2000;79(1):49–53.
[50] Marie Stopes International. General practitioners: attitudes to abortion 2007. http://www.mariestopes.org.uk/documents/GP%20attitudes%20to%20abortion%202007.pdf. Published 2007. Accessed June 17, 2013.
[51] Davis S, Schrader V, Belcheir MJ. Influencers of ethical beliefs and the impact on moral distress and conscientious objection. Nurs Ethics 2012;19(6):738–49.
[52] Aiyer AN, Steinman A, Ho GY. Influence of physician attitudes on willingness to perform abortion. Obstet Gynecol 1999;93(4):576–80.
[53] Hammarstedt M, Jacobsson L, Wulff M, Lalos A. Views of midwives and gynecologists on legal abortion—a population-based study. Acta Obstet Gynecol Scand 2005;84(1):58–64.
[54] Griggs SK, Brown CM. Texas community pharmacists' willingness to participate in pharmacist-initiated emergency contraception. JAPhA 2007;47(1):48–57.
[55] Wonkam A, Hurst SA. Acceptance of abortion by doctors and medical students in Cameroon. Lancet 2007;369(9578):1999.
[56] Suh S. Abortion Politics without Borders: The Implementation and Practice of Post-Abortion Care in Senegal. SSRN 2013. http://ssrn.com/abstract=2250193. Published April 13, 2013.
[57] Hagen GH, Hage CO, Magelssen M, Nortvedt P. Attitudes of medical students towards abortion. Tidsskr Nor Laegeforen 2011;131(18):1768–71.
[58] Kade K, Kumar D, Polis C, Schaffer K. Effect of nurses' attitudes on hospital-based abortion procedures in Massachusetts. Contraception 2004;69(1):59–62.
[59] Stulberg DB, Dude AM, Dahlquist I, Curlin FA. Obstetrician-gynecologists, religious institutions, and conflicts regarding patient-care policies. Am J Obstet Gynecol 2012;207(1):73 e1–5.
[60] Guttmacher Institute. Making Abortion Services Accessible in The Wake of Legal Reforms: A Framework And Six Case Studies. http://www.guttmacher.org/pubs/abortion-services-laws.pdf. Published 2012. Accessed June 15, 2013.
[61] International Planned Parenthood Federation. Abortion, Legislation in Europe. http://www.ippfen.org/NR/rdonlyres/ED17CA78-43A8-4A49-ABE7-64A836C0413E/0/Abortionlegislation_May2012corr.pdf. Updated May 2012. Accessed May 8, 2013.
[62] Mishtal J. Quiet Contestations of Irish Abortion Law: Reproductive Health Politics in Flux. In: Penny Light T, Stetmer S, eds. The History and Politics of Abortion. Toronto: University of Toronto Press; 2014 (in press).
[63] Center for Reproductive Rights. The World's Abortion Laws Map 2013 and Update. http://reproductiverights.org/sites/crr.civicactions.net/files/documents/AbortionMap_Factsheet_2013.pdf and http://worldabortionlaws.com/. Published 2013. Accessed June 15, 2013.
[64] Cohen SA. Facts and Consequences: Legality, Incidence and Safety of Abortion Worldwide. Guttmacher Policy Review 2009;12(4).
[65] Grimes DA, Benson J, Singh S, Romero M, Ganatra B, Okonofua FE, et al. Unsafe abortion: the preventable pandemic. Lancet 2006;368(9550):1908–19.
[66] Guttmacher Institute. In Brief: Fact Sheet. Facts on Induced Abortion Worldwide. http://www.guttmacher.org/pubs/fb_IAW.html. Published 2012. Accessed June 17, 2013.
[67] Singh S. Hospital admissions resulting from unsafe abortion: estimates from 13 developing countries. Lancet 2006;369(9550):1887–92.
[68] Guttmacher Institute. Media Kit. Worldwide Abortion: Legality, Incidence and Safety. http://www.guttmacher.org/media/presskits/abortion-WW/statsandfacts.html. Accessed June 15, 2013.
[69] Ipas. Report on successes in achieving UN Global Strategy for Women's and Children's Health–September 2012. http://www.who.int/woman_child_accountability/ierg/reports/2012_10S_Ipas_submission_forIERGreport_1May2012.pdf. Published 2012. Accessed June 15, 2013.
[70] Sangonet. Unsafe Abortion in South Africa: A Preventable Pandemic. http://www.ngopulse.org/blogs/unsafe-abortion-south-africa-preventable-pandemic. Published July 2012. Accessed May 8, 2013.
[71] Republic of South Africa. Saving Mothers: Short. http://www.doh.gov.za/docs/reports/2012/savingmothersshort.pdf. Published 2012.
[72] Poongothai J. Genetics of human male infertility. Singapore Med J 2009;50(4):337.
[73] WHO. Mother or nothing: The agony of fertility. Bull World Health Organ 2010;88(12):877–953.
[74] WHO. Genomic Resource Centre. Gender and Genetics. Assisted Reproductive Technologies (ARTs). http://www.who.int/genomics/gender/en/index6.html.who.int/genomics/gender/en/index6.html. Accessed October 23, 2013.
[75] Inhorn M. Global infertility and the globalization of new reproductive technologies: illustrations from Egypt. Soc Sci Med 2003;56(9):1837–51.
[76] Chambers GM, Sullivan EA, Ishihara O, Chapman MG, Adamson GD. The economic impact of assisted reproductive technology: a review of selected developed countries. Fertil Steril 2009;91(6):2281–94.
[77] Chambers GM. The costs and consequences of assisted reproductive technology: an economic perspective. Hum Reprod Update 2010;6(6):603–13.
[78] Chavkin W. The Old Meets the New: Religion and assisted reproductive technologies. Development 2006;49(4):78–83.
[79] Giubellino G. I Would Not Freeze My Children. Clarín. http://edant.clarin.com/diario/2005/07/26/sociedad/s-03101.htm. Published July 26, 2005.
[80] Turone, F. Italian court upholds couple's demands for preimplantation genetic diagnosis. BMJ 2007;335(7622):687.

[81] United Nations. Department of Economic and Social Affairs. Population Division. World Contraceptive Use 2011, Wall Chart, Front Side. http://www.un.org/esa/population/publications/contraceptive2011/contraceptive2011.htm. Accessed May 8, 2013.
[82] Creanga AA, Gillespie D, Karklins S, Tsui AO. Low use of contraception among poor women in Africa: an equity issue. Bull World Health Organ 2011;89(4):258–66.
[83] Center for Reproductive Rights. Over 700,000 Petitioners Demand Honduran Congress Reject Law Criminalizing Emergency Contraception. http://reproductiverights.org/en/press-room/over-700000-petitioners-demand-honduran-congress-reject-law-criminalizing-emergency-contr. Published May 16, 2012.
[84] WHO. Emergency Contraception Pills. . . Too Expensive? http://www.who.int/reproductivehealth/topics/family_planning/ec/en/index.html. Accessed October 23, 2013.
[85] Pieklo J. Care2. Oklahoma Rape Victim Turned Away from Hospital. http://www.care2.com/causes/oklahoma-rape-victim-turned-away-from-hospital.html. Published 2012. Accessed June 15, 2013.
[86] Spiegel Online. Cologne Archbishop Meisner approves "morning after" pill for rape victims. http://www.spiegel.de/panorama/gesellschaft/koelner-erzbischof-meisner-billigt-pille-danach-fuer-vergewaltigungsopfer-a-880814.html. Published January 31, 2013. Accessed June 15, 2013.
[87] Murray H, Baakdah H, Bardell T, Tulandi T. Diagnosis and treatment of ectopic pregnancy. CMAJ 2005;173(8):905.
[88] Togas T. Incidence, risk factors, and pathology of ectopic pregnancy. http://www.uptodate.com/contents/incidence-risk-factors-and-pathology-of-ectopic-pregnancy. Accessed February 23, 2012.
[89] Sivalingam VN, Duncan WC, Kirk E, Shephard LA, Home AW. Diagnosis and management of ectopic pregnancy. J Fam Plann Reprod Health Care 2011;37(4):231–40.
[90] American Pregnancy Association. Promoting Pregnancy Wellness. Miscarriage. http://americanpregnancy.org/pregnancycomplications/miscarriage.html. Accessed February 23, 2012.
[91] Berer M. Termination of pregnancy as emergency obstetric care: the interpretation of Catholic health policy and the consequences for pregnant women: An analysis of the death of Savita Halappanavar in Ireland and similar cases. RHM 2013;21(41):9–17.
[92] Case of Z v. Poland. Application no. 46132/08. Judgment (Merits and Just Satisfaction). http://hudoc.echr.coe.int/sites/eng-press/pages/search.aspx?i=001-114521#{"itemid":["001-114521"]}. Published 2012. Accessed June 15, 2013.
[93] Harvard University. David Rockefeller Center for Latin American Studies. Remobilization, Demobilization, and Incarceration: Women and Abortion in Post-war El Salvador. http://www.drclas.harvard.edu/node/853. Accessed October 23, 2013.
[94] Mollmann M. Over Their Dead Bodies—Denial of Access to Emergency Obstetric Care and Therapeutic Abortion in Nicaragua. Human Rights Watch 2007;19(2)(B). http://womenshealthnews.blogspot.com/2006/04/women-of-el-salvador.html. Published 2009. Accessed June 8, 2013.
[95] Skotko B. Mothers of children with Down syndrome reflect on their postnatal support. Pediatrics 2005;115(1):64–77.
[96] Hoehn KS, Wernovsky G, Rychik J, Tian ZY, Donaghue D, Gaynor JW, et al. Parental decision-making in congenital heart disease. Cardiol Young 2004;14(2004):309–14.
[97] R.R. v. Poland, No. 27617/04 ECHR. (2011).
[98] UN Human Rights Committee. General Comment 22, Article 18: The Right to Freedom of Thought, Conscience and Religion. A/48/40 vol. I (1993), para. 11.2.
[99] UN Committee on the Elimination of Discrimination against Women. General Recommendation 24: Article 12 of the Convention (women and health) (20th Sess., 1999), para.11. http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom24. Accessed February 23, 2012.
[100] UN Committee on the Elimination of Discrimination against Women. Concluding Observations. Croatia, UN Doc. A/53/38 (1998), paras. 109, 117.
[101] UN Committee on the Elimination of Discrimination against Women. Concluding Observations. Italy. UN Doc. A/52/38 Rev.1, Part II (1997), paras. 353, 360.
[102] UN Committee on the Elimination of Discrimination against Women. Concluding Observations. South Africa. UN Doc. A/53/38/Rev.1 (1998), para. 113.
[103] UN. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover—Mission to Poland, 20 May 2010, UN Doc. A/HRC/14/20/Add.3.
[104] CESCR Committee. Concluding Observations. Poland. UN Doc. E/C.12/POL/CO/5 (2009), para. 28.
[105] WHO. Safe abortion: technical and policy guidance for health systems. Second edition. http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf. Published 2012. Accessed June 8, 2013.
[106] Ley Orgánica 2/2010, de 3 de marzo, de Salud Sexual y Reproductiva y de la Interrupción Voluntaria del Embarazo. [Law of Sexual and Reproductive Health and Abortion] (2010). Arts.17(4) and 14(a) (Spain).
[107] Law C-355 of 2006 (Colombia).
[108] Choice of Termination of Pregnancy Act 1996 (South Africa).
[109] Regulation to National Law No. 25.673, Art.10 (Argentina). Ministerio de Salud de la Nación [National Health Ministry]. Guía Técnicapara la Atención Integral de los Abortos No Punibles [Technical Guide for Comprehensive Care for Legal Abortions] (2010) (Argentina).
[110] National Law No. 26.130, Art.6 (Argentina).
[111] Codigo de Ética Medica [Ethical Medical Code], Chapter 5. (Uruguay). http://www.smu.org.uy/elsmu/institucion/documentos/doc/cem.html#cap5. Accessed February 23, 2013.
[112] Vique AB, Cabrera OA, Lugo FG, Hevia M. Women and Health in Uruguay. The Uruguayan Executive Veto for the Decriminalization of Abortion: Deconstructing the fundamentals. Notebooks: Contributions to the debate on health, citizenship and right. 2010; Epoca 1 (1). http://www.archivos.hacelosvaler.org/Cuaderno%201%20Final.pdf. Published 2010. Accessed February 23, 2012.
[113] Public Health Service Act (1973) (United States).
[114] Sonfeld A. Guttmacher Institute. Delineating the Obligations That Come with Conscientious Refusal: A Question of Balance. Guttmacher Policy Review 2009;12(30). http://www.guttmacher.org/pubs/gpr/12/3/gpr120306.html.
[115] Regulations for the Implementation of the Act dated 13 June 1995 no. 50 concerning Termination of 31 Pregnancy, with Amendments in the Act dated 16 June 1978, no. 66, §20 (Norway).
[116] Constitutional Court Decision, T-209 of 2008 (Colombia). http://www.alcaldiabogota.gov.co/sisjur/normas/Norma1.jsp?i=30206. Published February 28, 2008.
[117] Judgment of the Bavarian Higher Administrative Court of 03/07/1990, BayVGH DVBl. 1990, 880-82 41 (Federal Republic of Germany).
[118] Judgment of the Federal Administrative Court of 12/13/1991, BVerwGE 89, 260-70 (Federal Republic of Germany).
[119] P. and S. v. Poland, Application no. 57375/08, Decision, October 30, 2012. http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-114098#{%22itemid%22:[%22001-114098%22]}. Accessed February 23, 2012.
[120] Code de la Sante Publique, arts. L2212-8, R4127-18 32 (France).
[121] Abortion Law Reform Act, Sec. 8 (Australia, Victoria).
[122] Constitutional Court Decision, T-388 of 2009 (Colombia).
[123] Colombia. Ministry of Social Protection. Governmental Decree 4444 of 2006, article 6. http://www.womenslinkworldwide.org/pdf_programs/es_prog_rr_col_legaldocs_decreto4444.pdf. Accessed July 19, 2012.
[124] Law No. 194 of 22 May 1978 on the social protection of motherhood and the voluntary termination of pregnancy, Gazz. Uff., Part I, 22 May 1978, No. 140, 3642-46 (Italy). http://www.columbia.edu/itc/history/degrazia/courseworks/legge_194.pdf. Accessed February 23, 2012.
[125] American Congress of Obstetricians and Gynecologists. ACOG Committee Opinion. The Limits of Conscientious Refusal in Reproductive Medicine 2007; Opinion Number 385. http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Ethics/The_Limits_of_Conscientious_Refusal_in_Reproductive_Medicine. Accessed August 27, 2013.
[126] El Sindicato Médico del Uruguay [Medical Association of Uruguay]. Chap 5, Art. 37 (Uruguay). http://www.smu.org.uy/publicaciones/libros/laetica/cem.htm#cap5. Accessed August 20, 2013.
[127] British Medical Association. Ethics Department. The Law and Ethics of Abortion: BMA Views. November 2007.
[128] World Medical Association. World Medical Association Declaration on Therapeutic Abortion. http://www.wma.net/e/policy/a1.htm. Published 2006.
[129] American Society of Health-System Pharmacists, Council on Legal and Public Affairs. ASHP Statement: Pharmacist's Right of Conscience and Patient's Right of Access to Therapy (0610). 2010.
[130] Anderson RM, Bishop LJ, Darragh M, Gray H, Nolen A, Poland SC, et al. National Reference Center for Bioethics Literature. The Joseph and Rose Kennedy Institute of Ethics. Pharmacists and Conscientious Objection. http://bioethics.georgetown.edu/publications/scopenotes/sn46.pdf. Accessed August 27, 2013.
[131] General Pharmaceutical Council. Standards of conduct, ethics and performance. July 2012.
[132] Decree No. 98-945 of 4 December 1998, setting forth the Code of Medical Ethics (Madagascar).
[133] National Association of Pharmacy Regulatory Authorities. Model Statement Regarding Pharmacists' Refusal to Provide Products or Services for Moral or Religious Reasons. http://www.nbpharmacists.ca/LinkClick.aspx?fileticket=wcx0ugUqRRE%3D&tabid=261&mid=695. Published 1999.
[134] Code of Ethics for Nurses in Australia, developed under the auspices of Australian Nursing and Midwifery Council, Royal College of Nursing, Australia, Australian Nursing Federation. 2008.
[135] Guidance on the Termination of Pregnancy: The Law and Clinical Practice in Northern Ireland, 16 July 2008, the Department of Health, Social Services and Public Safety.
[136] Codigo Deontologico da Ordem dos Medicos [Code of Ethics of the Association of Doctors] (2008), Art. 37 (Portugal); 39 Lei No. [Law No.] 16/2007 de 17 de abril, Exclusão da ilicitudenos casos de interrupção voluntária da gravidez [Exclusion of cases of voluntary interruption of pregnancy] 40 (Portugal).

(1069 of 2377)
Case: 20-15398, 10/12/2020, ID: 11855269, DktEntry: 46-5, Page 72 of 273
Case 3:19-cv-02769-WHA Document 68 Filed 09/12/19 Page 65 of 230



[137] Health Service Guidance HSG (94)39 (US).
[138] Abortion Act 1967 (England) (Section 4(1) of the 1967 Act permits that "no person shall be under any duty, whether by contractor by any statutory or other legal requirement, to participate in any treatment ... to which he has a conscientious objection." This does not apply to emergency procedures.).
[139] Enright and another v. Kwun and Another, [2003] E.W.H.C. 1000 (Q.B.).
[140] Decree reforming Articles 145 and 148 of the new Penal Code of Mexico City and adding Articles 16 bis 6 and 16 bis 7 to the Health Law of Mexico City, reported in Official Gazette of Mexico City, 14, no. 7, 24 January 2004, pp. 6-7 (Mexico).
[141] Health Services Act, Art. 56, Official Gazette of the Rep. of Slovenia 36, No. 9, enacted 1992 (Slovenia).
[142] Wilmington General Hospital v. Manlove, 174 A2d 135 (Del SC 1961) (US).
[143] Nursing and Midwifery Council, The Code of Conduct, Professional standards for nurses and midwives (UK).
[144] National Law on Medical Practice, Dentistry, and Auxiliary Practices, Law 17.132 (Argentina).
[145] Janaway v. Salford Health Authority, 1988 (UK).
[146] Brahams D. Conscientious Objection and Referral Letter for Abortion. Lancet 1988;331(8590):893.
[147] 73 Fed. Reg. 78071 (December 19, 2008). 45 CFR Part 88 (2008).
[148] Galston WA, Rogers M. Brookings Institute. Governance Studies at Brookings. Health Care Providers' Consciences and Patients' Needs: The Quest for Balance. http://www.brookings.edu/~/media/research/files/papers/2012/2/23%20health%20care%20galston%20rogers/0223_health_care_galston_rogers.pdf. Published February 23, 2012.
[149] Office of the Secretary of Health and Human Services. Final Rule, Regulation for the Enforcement of Federal Health Care Provider Conscience Protection Laws. http://www.gpo.gov/fdsys/pkg/FR-2011-02-23/pdf/2011-3993.pdf. Published February 23, 2011.

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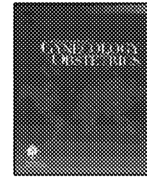

CONSCIENTIOUS OBJECTION

# Conscientious objection or fear of social stigma and unawareness of ethical obligations

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ABSTRACT

Conscientious objection is a legitimate right of physicians to reject the practice of actions that violate their ethical or moral principles. The application of that principle is being used in many countries as a justification to deny safe abortion care to women who have the legal right to have access to safe termination of pregnancy. The problem is that, often, this concept is abused by physicians who camouflage under the guise of conscientious objection their fear of experiencing discrimination and social stigma if they perform legal abortions. These colleagues seem to ignore the ethical principle that the primary conscientious duty of OB/GYNs is—at all times—to treat, or provide benefit and prevent harm to, the patients for whose care they are responsible. Any conscientious objection to treating a patient is secondary to this primary duty. One of the jobs of the FIGO Working Group for the Prevention of Unsafe Abortion is to change this paradigm and make our colleagues proud of providing legal abortion services that protect women's life and health, and concerned about disrespecting the human rights of women and professional ethical principles.
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## 1. The concept of conscientious objection

Conscientious objection is a legitimate right of physicians to reject the practice of actions that violate their ethical or moral principles. It allows them, for example, to reject participation in the process of interrogation of suspects, which may include procedures reaching the limits of torture. In the context of providing legal abortion care, the FIGO Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health states that [1]:

> Some doctors feel that abortion is not permissible whatever the circumstances. Respect for their autonomy means that no doctor (or other member of the medical team) should be expected to advise or perform an abortion against his or her personal conviction. Their careers should not be prejudiced as a result. Such a doctor, however, has an obligation to refer the woman to a colleague who is not in principle opposed to termination.

The application of that principle is being used in several countries in Latin America and other parts of the world as a justification to deny safe abortion care to women who have the legal right to have access to safe termination of pregnancy.

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## 2. Inappropriate utilization of conscientious objection to deny legal abortion services

Latin America is a region with very restrictive abortion laws and it includes most of the few countries in the world where abortion is not permitted in any circumstances: Chile, Honduras, El Salvador, and more recently Dominican Republic and Nicaragua (all of which are relatively small countries) [2]. In most other countries in Latin America, abortion is considered a crime but is not punished in certain circumstances: for example, when performed to preserve women's life and/or health; in cases of rape or incest; and in the presence of very severe fetal defects incompatible with extrauterine life.

Abortion is permitted in broad circumstances in Cuba, Mexico City, Colombia, and more recently Uruguay up to 12 weeks of pregnancy [2–5]. The problem is that most women who meet the requirements for obtaining a permissible abortion do not receive the care they need in public hospitals—instead, resorting to clandestine abortions, which can be unsafe. In recent years, there have been efforts from private organizations and governments to make abortion accessible to women who meet the legal conditions, following International Conference on Population and Development recommendations [6]. The main obstacle to the provision of services is unwillingness of physicians claiming conscientious objection to providing abortion care.

The problem is that, often, the concept of conscientious objection is abused by physicians in at least 2 different ways:

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(1) By not respecting their obligation to give priority to the needs of the women for whose care they are responsible. In the words of the FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health: "The primary conscientious duty of obstetrician-gynecologists is at all times to treat, or provide benefit and prevent harm to, the patients for whose care they are responsible. Any conscientious objection to treating a patient is secondary to this primary duty" [1].

(2) By camouflaging under the guise of conscientious objection their fear of experiencing discrimination if they perform legal abortions.

A previous study surveyed 3337 members of the Brazilian Federation of Gynecology and Obstetrics Societies who responded to an anonymous questionnaire inquiring under which circumstances abortion should be permitted by law. Almost 85% agreed that women who become pregnant after rape should have the legal right to obtain a safe termination of pregnancy. Only 50%, however, were willing to perform such an abortion or prescribe abortifacient drugs [7].

A subsequent qualitative study of 30 OB/GYNs from the state of Sao Paulo showed that the reasons for refusing to perform legal abortion derived mostly from personal convictions and religious principles [8]. Religious justification is usually accepted without argument. Some study participants, however, expressed their doubt that the religious rationale was always genuine because they suspected that the main reason for unwillingness to perform abortion was the fear of social stigma [9].

Physicians know that refusal to perform pregnancy termination while alleging conscientious objection will have no consequences such as complaints or disciplinary action against them. By contrast, they fear negative legal or social consequences if they do perform terminations and prefer to avoid these. The concept that "the primary conscientious duty of obstetrician-gynecologists is at all times to treat, or provide benefit and prevent harm to, the patients for whose care they are responsible" is rarely taken into account [1]. It is much easier to use conscientious objection to hide the real reason, which is that it is simply more comfortable to deny the service that the woman needs than to fulfill their professional and ethical obligation of providing safe abortion services according to the country's law.

It is disappointing to observe that many of our colleagues, at least in the Latin American region, appear to fear being stigmatized for carrying out a legal procedure that would avert the serious complications that could occur if the procedure were performed unsafely and clandestinely but are not afraid of being stigmatized for avoiding their ethical duty "to treat, or provide benefit and prevent harm to, the patients for whose care they are responsible" [1].

## 3. How to promote proper balance between conscientious objection and ethical obligations to patients

It appears that those of us who occupy positions of leadership in the professional organizations of gynecologists and obstetricians have not done our job sufficiently in terms of promoting and normalizing these ethical principles among our colleagues. It appears that they are unaware that our "... primary conscientious duty ... is at all times to ... provide benefit and prevent harm to the patients" under our care [1].

We have often been in meetings with honest and sensitive colleagues who, in general, promote and defend women's sexual and reproductive rights, but who nevertheless find excuses—under the guise of conscientious objection—for not providing abortion services within the limits of the local law.

One explanation for this situation is the incorrect idea that facilitating access to safe and legal abortion services promotes abortions. Many obstetricians, accustomed to work protecting the life and health of the fetuses of women who want to have children, feel uncomfortable with the notion of increasing the number of abortions. This indicates that we have failed to disseminate the evidence of the statistically significant inverse relationship between the proportion of women living in countries with liberal abortion laws and the induced abortion rate among the same women. These data show unequivocally that giving broader access to safe legal abortion does not lead to increased rates of abortion [9].

In other words, rather than solely criticizing the behavior of the many colleagues who hide their fear of stigma under the guise of conscientious objection, we should work to disseminate some basic ethical principles clearly stated by the FIGO Committee on the Ethical Aspects of Human Reproduction and Women's Health. We should also disseminate the evidence that making legal abortion more broadly available does not increase the abortion rate but does reduce maternal mortality and morbidity.

The FIGO Working Group for the Prevention of Unsafe Abortion promotes the prevention of unintended pregnancy as a primary strategy and then asserts that, if unintended pregnancy has occurred and the abortion is inevitable, safe abortion services should be available within the limits of the law [10]. Although some progress has occurred in Latin America—namely, in Brazil, Colombia, Argentina, and Uruguay—there is still strong resistance from many of our colleagues, and the number of women with legal rights to abortion who lack access to services is much greater than the number of women who receive appropriate care. The situation is not much different in Africa and many countries in Asia, indicating that we have to seek stronger commitments from national OB/GYN societies, who are all bound to follow the FIGO ethical guidelines described above.

The FIGO Working Group for the Prevention of Unsafe Abortion will need the support of the FIGO Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health to change this paradigm and make our colleagues proud of providing legal abortion services that protect women's life and health, and concerned about disrespecting the human rights of women and professional ethical principles. That is our task for the immediate future.

## Conflict of interest

The authors have no conflicts of interest.

## References

[1] FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health. Ethical Issues in Obstetrics and Gynecology. http://www.figo.org/files/figo-corp/English%20Ethical%20Issues%20in%20Obstetrics%20and%20Gynecology.pdf. Published October 2012.
[2] Center for Reproductive Rights. The World's Abortion Laws Map 2011. http://reproductiverights.org/sites/crr.civicactions.net/files/documents/AbortionMap_2011.pdf. Published 2011. Accessed August 15, 2013.
[3] Decree reforming Articles 145 and 148 of the new Penal Code of Mexico City and adding Articles 16 bis 6 and 16 bis 7 to the Health Law of Mexico City, reported in Official Gazette of Mexico City, 14, no. 7, 24 January 2004, pp. 6–7 (Mexico).
[4] Center for Reproductive Rights. The World's Abortion Laws Map 2013 Update. Fact Sheet. http://reproductiverights.org/sites/crr.civicactions.net/files/documents/AbortionMap_Factsheet_2013.pdf. Accessed August 15, 2013.
[5] Law C-355 of 2006 (Colombia).
[6] UN. Report of the International Conference on Population and Development, Cairo: United Nations, 5–13 September 1994. http://www.unfpa.org/webdav/site/global/shared/documents/publications/2004/icpd_eng.pdf. Accessed August 15, 2013.
[7] Faúndes A, Simoneti RM, Duarte GA, Andalaft-Neto J. Factors associated to knowledge and opinion of gynecologists and obstetricians about the Brazilian legislation on abortion. Rev Bras Epidemiol 2007;10(1):6–18.
[8] Faúndes A, Hardy E, Duarte G, Osis MJD, Makuch MY. The role of religion over the perspective and actions of gynecologists with reference to legal

International Journal of Gynecology and Obstetrics 123 (2013) S60–S62

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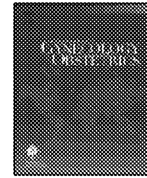

CONSCIENTIOUS OBJECTION

# Conscientious objection to provision of legal abortion care

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ABSTRACT

Despite advances in scientific evidence, technologies, and human rights rationale for providing safe abortion, a broad range of cultural, regulatory, and health system barriers that deter access to abortion continues to exist in many countries. When conscientious objection to provision of abortion becomes one of these barriers, it can create risks to women's health and the enjoyment of their human rights. To eliminate this barrier, states should implement regulations for healthcare providers on how to invoke conscientious objection without jeopardizing women's access to safe, legal abortion services, especially with regard to timely referral for care and in emergency cases when referral is not possible. In addition, states should take all necessary measures to ensure that all women and adolescents have the means to prevent unintended pregnancies and to obtain safe abortion.
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## 1. Introduction

Over the past 2 decades, the scientific evidence, technologies, and human rights rationale for providing safe abortion care have advanced considerably. Despite these advances, however, a broad range of cultural, regulatory, and health system barriers that deter access to abortion continues to exist in many countries, and the numbers and proportion of unsafe abortions continue to increase, especially in low- and middle-income countries [1]. When conscientious objection to provision of abortion becomes one of these barriers, it can create risks to women's health and their human rights.

In view of the continuing need for evidence- and human rights-based recommendations for providing safe abortion care, WHO published the second edition of *Safe Abortion: Technical and Policy Guidance for Health Systems* in June 2012 [2]. In addition to providing recommendations for clinical care and service delivery, the document highlights a number of regulatory and policy barriers, including conscientious objection, and provides guidance to eliminate them. If implemented at country level, the WHO guidance provides a comprehensive framework that can have a substantive public health impact on reducing preventable abortion-related deaths and disability.

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## 2. What is conscientious objection to provision of abortion?

Conscientious objection means that healthcare professionals or institutions exempt themselves from providing or participating in abortion care on religious and/or moral or philosophical grounds. While other regulatory and health system barriers also hinder women's right to obtain abortion services, conscientious objection is unique because of the tension existing between protecting, respecting, and fulfilling women's rights and health service providers' right to exercise their moral conscience. Although the right to freedom of thought, conscience, and religion is protected by international human rights law, the law stipulates that freedom to manifest one's religion or beliefs may be subject to limitations to protect the fundamental human rights of others [3]. Therefore, laws and regulations should not entitle health service providers or institutions to impede women's access to legal health services [4].

Health services should be organized in such a way as to ensure that an effective exercise of the freedom of conscience of healthcare professionals does not prevent women and adolescents from obtaining access to services to which they are entitled under the applicable legislation [2]. Based on available health evidence and human rights standards, the WHO safe abortion guidance stipulates that healthcare professionals who claim conscientious objection must refer women to a willing and trained service provider in the same or another easily accessible healthcare facility, in accordance with national law. Where referral is not possible, the healthcare professional who objects must provide safe abortion to save the woman's life and to prevent damage to her health. Furthermore, women who present with complications from an abortion, including illegal or unsafe abortion, must be treated urgently and respectfully, in the same way as any other emergency patient, without punitive, prejudiced, or biased behaviors [2]. Adherence to the individual

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and institutional responsibilities outlined in the WHO guidance allows for the exercise of moral conscience without compromising women's and adolescents' access to safe, legal abortion services if sufficient facilities, service providers, necessary equipment, and drugs are made available.

### 3. Conscientious objection as a barrier to abortion care

In theory, conscientious objection need not be a barrier to women seeking abortion. However, not all claims to conscientious objection reflect a genuine concern about compromising an individual provider's moral integrity; rather, they may represent reluctance to provide certain sexual and reproductive health services such as abortion, discriminatory attitudes, or other motivations stemming from self-interest [5]. In practice, individual or institutional refusal to provide timely referral and emergency care interferes with women's access to services and may increase health risks. In addition to limiting women's access to lawful services in general, abuse of conscientious objection can result in inequities in access, creating disproportionate risks for poor women, young women, ethnic minorities, and other particularly vulnerable groups of women who have fewer alternatives for obtaining services. Women's access to health services is jeopardized not only by providers' refusal of care but also by governments' failure to ensure adequate numbers and distribution of providers and facilities to offer abortion services.

In contexts in which conscientious objection risks harming women's health and their human rights, it is likely to coexist with a broad range of other regulatory and health system barriers, which may be intended to discourage and limit women's access to legal abortion. For example, lack of public information about safe abortion, poorly defined or narrowly interpreted legal grounds for abortion, requirements for third-party authorizations to receive abortion, mandatory waiting periods, requirements for medically unnecessary tests or procedures, restrictions on public funding and private insurance coverage, and requirements for the provision of misleading or inaccurate information may all be intended to discourage women from having an abortion [2,6]. In addition, unregulated conscientious objection opens the door for disingenuous claims of moral conscience for refusing care and compromises accountability for ensuring timely access to care. When combined, these and other barriers may exacerbate inequities to access and delays in seeking services, or serve as a deterrent to seeking legal services altogether, potentially increasing the likelihood of unsafe abortion.

Any barrier, including abuse of conscientious objection, potentially causes delays in gaining access to a needed health service. Legal abortion using WHO-recommended methods and practice is one of the safest of all medical procedures that women undergo. However, although the risk of mortality from safe abortion is low, the risk increases for each additional week of gestation. A study on legal abortion in the USA from 1988 to 1997 found that the overall risk of death from abortion was 0.7 per 100,000 legal abortions [7], with gestational age at time of abortion the greatest risk factor for abortion-related death. The mortality rate for abortions at a gestational age of 8 or fewer weeks was 0.1, but for abortions at 21 or more weeks the rate was 8.9, which was comparable to mortality associated with childbirth in the USA, between 1998 and 2005 [8].

Because conscientious objection is just one of a potentially large number of interconnected barriers to safe abortion services, it is difficult to evaluate the direct impact on access of disingenuous claims of conscientious objection, of conscientious objection without referral, and of refusal to treat emergencies. Indeed, the extent to which conscientious objection to abortion directly results in pregnancy-related mortality and morbidity is unknown and merits further investigation.

### 4. Policy, health system, and service delivery interventions to protect women's health and their human rights

UN treaty-monitoring bodies, and regional and national courts have increasingly called upon states to provide comprehensive sexual and reproductive health information and services to women and adolescents, to eliminate regulatory and administrative barriers that impede women's access to safe abortion services, and to provide treatment for abortion complications [9–33]. This requires states to train and equip health service providers, along with other measures to ensure that such abortion is safe and accessible [34]. Human rights bodies have also called upon states to ensure that the exercise of conscientious objection does not prevent individuals from obtaining services to which they are legally entitled [17,18,26,35,36]. When laws, policies, and programs do not take into consideration the multiple challenges inherent in implementing conscientious objection to abortion care, women's health and their human rights can be compromised. Specifically, there should be regulations for health service providers on how to invoke conscientious objection without jeopardizing women's access to safe, legal abortion services, especially with regard to referral and in emergency cases when referral is not possible.

In addition to providing guidance for regulating providers' conscientious objection to legal abortion, the WHO safe abortion document highlights a number of health system interventions that can facilitate equitable access to and availability of safe abortion [2]. As a first step, the provision and use of effective contraception can reduce the likelihood of unintended pregnancy and, thus, women's need for recourse to abortion. As a remedy to shortages of willing providers of legal abortion care, states should consider improving access through training mid-level providers and offering abortion services at the primary-care level and through outpatient services. Abortion care can be safely provided by any properly trained healthcare provider, including nurses, midwives, clinical officers, physician assistants, family welfare visitors, and others who are trained to provide basic clinical procedures related to reproductive health. Abortion care provided at the primary-care level and through outpatient services in higher-level settings can be done safely and minimizes costs while maximizing the convenience and timeliness of care for the woman. Allowing home use of misoprostol following provision of mifepristone at the healthcare facility can further improve the privacy, convenience, and acceptability of services, without compromising safety. Financing mechanisms can facilitate equitable access to good-quality services and, to the extent possible, abortion services should be mandated for coverage under insurance plans.

Governments have many options for facilitating good access to safe, legal abortion. Ultimately, to mitigate the potential impacts of conscientious objection, well-trained and equipped healthcare providers and affordable services should be readily available and within reach of the entire population. This is essential for ensuring access to safe abortion and should be both a public health and a human rights priority.

### Conflict of interest

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### References

[1] WHO. Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2008. Sixth Edition. Geneva: WHO; 2011.

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[2] WHO. Safe Abortion: Technical and Policy Guidance for Health Systems. Second Edition. Geneva: WHO; 2012.
[3] International Covenant on Civil and Political Rights, Article 18. United Nations; entry into force 23 March 1976.
[4] Verein Kontakt-Information-Therapie (KIT) and Hagen v. Austria, No. 11921/86 ECHR (1988).
[5] Dressers R. Professionals, conformity and conscience. Hastings Cent Rep 2005;35:9–10.
[6] Guttmacher Institute. An Overview of Abortion Laws. State Policies in Brief. New York: Guttmacher Institute; 2013.
[7] Bartlett LA, Berg CJ, Shulman HB, Zane SB, Green CA, Whitehead S, et al. Risk factors for legal induced abortion-related mortality in the United States. Obstet Gynecol 2004;103(4):729–37.
[8] Raymond EG, Grimes DA. The comparative safety of legal induced abortion and childbirth in the United States. Obstet Gynecol 2012;119(2, Part 1):215–9.
[9] UN Human Rights Committee. General comment 28: equality of rights between men and women (Article 3). United Nations; 20 March 2000.
[10] UN Human Rights Committee. Concluding observations: Ecuador. United Nations; 18 August 1998.
[11] UN Human Rights Committee. Concluding observations: Guatemala. United Nations; 27 August 2001.
[12] UN Human Rights Committee. Concluding observations: Poland. United Nations; 2 December 2004.
[13] UN Human Rights Committee. Concluding observations: Madagascar. United Nations; 11 May 2007.
[14] UN Human Rights Committee. Concluding observations: Chile. United Nations; 18 May 2007.
[15] UN Human Rights Committee. Concluding observations: Colombia. United Nations; 26 May 2004.
[16] UN Human Rights Committee. Karen Noella Llantoy Huaman v. Peru, UN Doc. CCPR/C/85/D/1153/2003. United Nations; 2005.
[17] UN Committee on the Elimination of Discrimination against Women. Concluding observations: Columbia. United Nations; 5 February 1999.
[18] UN Committee on the Elimination of Discrimination against Women. Concluding observations: Nicaragua. United Nations; 2 February 2007.
[19] UN Committee on the Elimination of Discrimination against Women. Concluding observations: Brazil. United Nations; 10 August 2007.
[20] UN Committee on the Elimination of Discrimination against Women. Concluding observations: Nepal. United Nations; 24 September 2001.
[21] UN Committee on Economic, Social and Cultural Rights. Concluding observations: Costa Rica. United Nations; 22 April 2008.
[22] UN Committee on the Rights of the Child. Concluding observations: Chile. United Nations; 23 April 2007.
[23] African Commission on Human and Peoples' Rights. Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, Article 14.2. Maputo: African Commission on Human and Peoples' Rights; adopted 11 July 2003.
[24] UN Committee on Economic, Social and Cultural Rights. Concluding observations: Malta. United Nations; 4 December 2004.
[25] UN Committee on Economic, Social and Cultural Rights. Concluding observations: Monaco. United Nations; 13 June 2006.
[26] UN Committee on the Elimination of Discrimination against Women. General recommendation no. 24: Women and health (Article 12). United Nations; 1999.
[27] UN Committee on the Elimination of Discrimination against Women. Concluding comments: Dominican Republic. United Nations; 18 August 2004.
[28] UN Committee on Economic, Social and Cultural Rights. Concluding observations: Nepal. United Nations; 29 August 2001.
[29] UN Committee on Economic, Social and Cultural Rights. Concluding observations: Chile. United Nations; 1 December 2004.
[30] UN Committee on the Elimination of Discrimination against Women. Concluding observations: Sri Lanka. United Nations; 1 February 2002.
[31] UN Committee on the Elimination of Discrimination against Women. Concluding observations: Honduras. United Nations; 10 August 2007.
[32] UN Committee on the Elimination of Discrimination against Women. L.C. v. Peru, CEDAW/C/50/D/22/2009. United Nations; 4 November 2011.
[33] UN Committee on the Rights of the Child. Concluding observations: Chile. United Nations; 23 April 2007.
[34] Key actions for the further implementation of the Programme of Action of the International Conference on Population and Development, adopted by the twenty-first special session of the General Assembly, New York, 30 June–2 July 1999. New York, United Nations; 1999.
[35] UN Human Rights Committee. Concluding observations: Zambia. United Nations; 9 August 2007.
[36] R.R. v. Poland, No. 27617/04 ECHR (2011).

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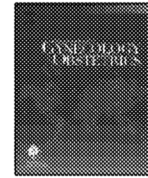

CONSCIENTIOUS OBJECTION

# Legal and ethical standards for protecting women's human rights and the practice of conscientious objection in reproductive healthcare settings

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ABSTRACT

The practice of conscientious objection by healthcare workers is growing across the globe. It is most common in reproductive healthcare settings because of the religious or moral values placed on beliefs as to when life begins. It is often invoked in the context of abortion and contraceptive services, including the provision of information related to such services. Few states adequately regulate the practice, leading to denial of access to lawful reproductive healthcare services and violations of fundamental human rights. International ethical, health, and human rights standards have recently attempted to address these challenges by harmonizing the practice of conscientious objection with women's right to sexual and reproductive health services. FIGO ethical standards have had an important role in influencing human rights development in this area. They consider regulation of the unfettered use of conscientious objection essential to the realization of sexual and reproductive rights. Under international human rights law, states have a positive obligation to act in this regard. While ethical and human rights standards regarding this issue are growing, they do not yet exhaustively cover all the situations in which women's health and human rights are in jeopardy because of the practice. The present article sets forth existing ethical and human rights standards on the issue and illustrates the need for further development and clarity on balancing these rights and interests.
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## 1. Introduction

Ethical, health, and human rights standards have attempted to harmonize the practice of conscientious objection with women's right to sexual and reproductive health services. They consider regulation of the unfettered use of conscientious objection essential to the realization of sexual and reproductive rights. Under international human rights law, states have a positive obligation to act in this regard. These standards and recommendations should be universally adopted and applied. While ethical and human rights standards on this issue are growing, they do not yet exhaustively cover all the situations in which women's health and human rights are in jeopardy because of the practice. The present article sets forth existing ethical and human rights standards on the issue and illustrates the need for further development and clarity on balancing these rights and interests.

The practice of conscientious objection by healthcare workers is growing across the globe. It is most common in reproductive healthcare settings because of the religious or moral values placed on beliefs as to when life begins. It is often invoked in the context of abortion and contraceptive services, including the provision of information related to such services. Frequently, such invocation is not transparent and women are neither directly told of providers' beliefs nor referred to another provider. Instead, they are subjected to attempts to sway them away from undergoing abortion. While OB/GYNs may most often be the healthcare workers claiming conscientious objection, pharmacists, nurses, anesthesiologists, and cleaning staff have been reported to refuse to fill their job duties in connection to acts they consider objectionable. In addition, public healthcare institutions are informally refusing to provide certain reproductive health services, often owing to beliefs of individual hospital administrators [1].

The practice arises in countries with relatively liberal abortion laws, such as the USA, Slovakia, and South Africa, as well as in countries with more restrictive laws, such as most Latin American and certain African countries [2,3]. The implications for women's health and lives can be grave in both contexts and urgent questions arise as to how to effectively reconcile respect for the practice of conscientious objection with the right of women to have access to lawful reproductive healthcare services.

Ethical standards in this area can provide some answers. In fact, ethical standards have not only helped shape the development of national law but also recently influenced the development of international human rights law in this area. While these are welcome developments, many gaps remain both in ethics and in law.

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## 2. International human rights law

The right to access to reproductive healthcare is grounded in numerous human rights, including the rights to life, to health, to non-discrimination, to privacy, and to be free from inhuman and degrading treatment, as explicitly articulated by UN and regional human rights bodies. Such rights place obligations on states to ensure transparent access to legally entitled reproductive health services and to remove barriers limiting women's access to such services [4,5]. Such barriers include conscientious objection. UN bodies monitoring state compliance with international human rights treaties have raised concern about the insufficient regulation by states of the practice of conscientious objection to abortion. They have consistently recommended that states ensure that the practice is well defined and well regulated in order to avoid limiting women's access to reproductive healthcare. They encourage, for example, implementing a mechanism for timely and systematic referrals, and ensuring that the practice of conscientious objection is an individual, personal decision and not that of an institution as a whole [1,6–8].

The UN Special Rapporteur on the Right to the Highest Attainable Standard of Health issued a groundbreaking report in 2011 on the negative impact that the criminalization of abortion has had on women's health and lives, and specifically articulated state obligations to remove barriers—including some laws and practices on conscientious objection—that interfere with individual decision making on abortion. The report notes that such laws and their use create barriers to access by permitting healthcare providers and ancillary personnel to refuse to provide abortion services, information about procedures, and referrals to alternative facilities and providers. These and other laws make safe abortions unavailable, especially to poor, displaced, and young women. The report notes that such restrictive regimes serve to reinforce the stigma of abortion being an objectionable practice. The Rapporteur recommended that, in order to fulfill their obligations under the right to health, states should "[E]nsure that conscientious objection exemptions are well-defined in scope and well-regulated in use and that referrals and alternative services are available in cases where the objection is raised by a service provider" [9].

Conscientious objection is grounded in the right to freedom of religion, conscience, and thought—recognized in many international and regional human rights treaties, as well as in national constitutions. Under international and regional human rights law, the freedom to manifest one's religion or beliefs can be limited for the protection of the rights of others, including reproductive rights [8,10–12].

The Human Rights Committee, which monitors state compliance with the International Covenant on Civil and Political Rights (one of the major UN human rights treaties), has recognized that religious attitudes can limit women's rights and called on states to "... ensure that traditional, historical, religious or cultural attitudes are not used to justify violations of women's right to equality before the law and to equal enjoyment of all Covenant rights" [13].

Two recent decisions of the European Court of Human Rights shed light on the meaning of such limitations in the context of conscientious objection to abortion-related reproductive health services. In these separate cases against Poland, an adolescent and a woman have complained that access to lawful abortion and prenatal diagnostic services was hindered, in part, by the unregulated practice of conscientious objection. While Poland has one of the most restrictive abortion laws in Europe, the law does allow for abortion in cases of threat to a pregnant woman's health or life, and in cases of rape and cases of fetal abnormality. It also entitles women to receive genetic prenatal examinations in this context. In *R.R. v. Poland* (2011), the applicant was repeatedly denied prenatal genetic testing after her doctor discovered fetal abnormalities during a sonogram [14]. The exam results would have informed *R.R.*'s decision on whether to terminate her pregnancy, yet doctors, hospitals, and administrators repeatedly denied her information and diagnostic tests until the pregnancy was too advanced for abortion to be a legal option [14]. In a case decided a year later, *P. and S. v. Poland* (2012), a 14-year-old who became pregnant as a result of rape faced numerous barriers and delays in obtaining a lawful abortion, including coercive and biased counseling by a priest; divulgence of confidential information about her pregnancy to the press and others; removal from the custody of her mother, who supported her decision to undergo an abortion; and the unregulated practice of conscientious objection [15]. The procedure eventually took place but in a clandestine-like manner and without proper postabortion care [15].

In both cases, the Court found violations of Articles 3 (right to be free from inhuman and degrading treatment) and 8 (right to private life) of the European Convention on Human Rights for obstructing access to lawful reproductive healthcare information and services [16]. With regard to conscientious objection, it held that the Convention does not protect every act motivated or inspired by religion: "... States are obliged to organise the health services system in such a way as to ensure that an effective exercise of the freedom of conscience of health professionals in the professional context does not prevent patients from obtaining access to services to which they are entitled under the applicable legislation" [14,15].

It also noted problems with lack of implementation and respect for the existing law governing this practice, and specified that reconciliation of conscientious objection with the patient's interests makes it mandatory for such refusals to be made in writing and included in the patient's medical record, mandating that the objecting doctor refer the patient to another physician competent and willing to carry out the same service [15].

These cases are groundbreaking for numerous reasons, but for the purposes of the present article I will focus on 2 reasons. First, it is the first time any international or regional human rights body in *an individual complaint* has articulated states' *positive* obligations to regulate the practice of conscientious objection in relation to abortion and to prenatal diagnostic services. These cases required an international human rights tribunal to take a look at abuse of the practice in a specific situation and the experiences of the women subject to the practice. The Court's finding in the case related to prenatal diagnostic care is groundbreaking because it is the first time a human rights body has addressed objection to providing information to a patient about her health. While the Court's judgments provide minimal guidance, it is developing its standards in this area.

The second reason is that, for the first time, the Court directly relied on FIGO's ethical standards/guidelines and resolution on the issue of conscientious objection to support its decision [14,17].

## 3. Ethical and health standards

The FIGO Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health submitted an amicus brief in the case of *R.R. v. Poland*, presenting its resolution and ethical guidelines on conscientious objection to the Court [18]. In articulating state obligations to regulate the practice, the Court directly relied on the information provided by FIGO to support its judgment, citing the material provided in FIGO's amicus brief as a source of relevant law and practice [14]. FIGO's ethical guidelines and resolution on the subject have, thus, directly influenced the emerging human rights standards regarding conscientious objection to reproductive health services. This is a rare example of how ethical standards can shape the development of international human rights law and reflects the critical importance that ethical standards can have in protecting and promoting human rights.

In fact, FIGO has the most comprehensive ethical guidelines on conscientious objection of any international medical professional organization. The ethical guidelines note that any conscientious objection to treating a patient is secondary to the primary duty—which is to treat, provide benefit, and do no harm, and includes provision of accurate information and referral/obligatory provision of care when referral is not possible or need is urgent [17]. A resolution mirroring these guidelines was adopted a year later by the FIGO General Assembly [19]. The resolution also recognized the duty of practitioners as professionals to abide by scientifically and professionally determined definitions of reproductive health services and not to mischaracterize them on the basis of personal beliefs [18].

WHO has also recognized that, as a barrier to lawful abortion services, conscientious objection can impede women from reaching the services for which they are eligible, potentially contributing to unsafe abortion. In its recent edition of guidelines on safe abortion, WHO notes that health services should be organized in such a way as to ensure that an effective exercise of the freedom of conscience of health professionals does not prevent patients from obtaining access to services to which they are entitled under the applicable legislation. It recommends the establishment of national standards and guidelines facilitating access to and provision of safe abortion care, including the management of conscientious objection [18,20,21].

While these health and ethical standards provide some guidance for regulating the practice of conscientious objection and have an important role in influencing the development of the nascent human rights standards on the topic, many issues that arise in this context are not fully addressed by international legal, health, or ethical standards.

## 4. Conclusion

International ethical and health bodies, and international and regional human rights mechanisms are well positioned to fill in the gaps in guidance. Such standards can help in the development of national laws and regulations on the subject and can be used to hold states accountable when associated violations of human rights occur. The standards should cover the numerous systemic and individual barriers leading to denial of services. Such guidance should clearly establish that only individuals, not institutions, can have a conscience and that only those involved in the direct provision of services should be allowed to invoke conscientious objection. Medical students, for example, cannot object to learning to perform a service that they may need to provide in case of emergency. They should also establish under which circumstances individuals can and cannot object. For example, the practice should be prohibited when a patient's life or physical/mental health is in danger. In addition, the types of services for which objection is impermissible should be specified, such as providing referrals, information, and diagnostic services. Standards should also clearly articulate state obligations to guarantee that the practice of conscientious objection does not hinder the availability and accessibility of providers, including by employing sufficient staff who are available and willing to deliver services competently; by ensuring oversight and monitoring of the practice; and by holding to account those in violation [1,6,12,22].

Moreover, as in all circumstances, healthcare systems should be transparent, and services should respect women's dignity and autonomy in decision making. In other words, *women's* conscience should be fully respected [23].

## Conflict of interest

The author has no conflicts of interest.

## References

[1] Zampas C, Andion-Ibanez X. Conscientious objection to sexual and reproductive health services: international human rights standards and European law and practice. Eur J Health Law 2012;19(3):231–56.
[2] Lema VM. Conscientious objection and reproductive health service delivery in sub-Saharan Africa. Afr J Reprod Health 2012;16(1):15–21.
[3] Casas L. Invoking Conscientious Objection in Reproductive Health Care: Evolving Issues in Latin America [thesis]. Toronto: University of Toronto; 2005.
[4] Cook, RJ. Transparency in the delivery of lawful abortion services. CMAJ 2009;180(3):272–3.
[5] UN Committee on the Elimination of Discrimination against Women. General Recommendation 24: Article 12 of the Convention (women and health) (20th Sess., 1999), para. 11. http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom24. Published 1999. Accessed October 31, 2013.
[6] Dickens B. Legal Protection and Limits of Conscientious Objection: When Conscientious Objection is Unethical. Medicine and Law 2009;28:337–47.
[7] UN Committee on the Elimination of Discrimination against Women, Concluding Observations, Hungary, UN Doc. CEDAW/C/HUN/CO/7-8 (2013).
[8] Bueno de Mesquita J, Finer L. University of Essex Human Rights Centre. Conscientious Objection: Protecting Sexual and Reproductive Health Rights. http://www.essex.ac.uk/hrc/research/projects/rth/docs/Conscientious_objection_final.pdf. Published 2008. Accessed October 31, 2013.
[9] UN. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Interim report, Anand Grover, 3 August 2011, UN Doc. A/66/254. 2011.
[10] International Covenant on Civil and Political Rights, *adopted* Dec. 16, 1966, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, at 52, article 18, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* March 23, 1976).
[11] UN Human Rights Committee. General Comment 22, Article 18: The Right to Freedom of Thought, Conscience and Religion. A/48/40 vol. 1 (1993) 208, para. 11.2.
[12] Skuster P. When a Health Professional Refuses: Legal and regulatory limits on conscientious objection to provision of abortion care. Ipas 2012.
[13] UN Human Rights Committee. General Comment 28, Article 3: The equality of rights between men and women. UN Doc/ CCPR/C/21/Rev.1/Add.10 (2000).
[14] R.R. v. Poland, No. 27617/04 ECHR (2011).
[15] P. and S. v. Poland, Application no. 57375/08, Decision, October 30, 2012, para. 106.
[16] Westeson J. Reproductive health information and abortion services: Standards developed by the European Court of Human Rights. Int J Gynecol Obstet 2013;122(2):173–6.
[17] FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health. Ethical Guidelines on Conscientious Objection. Int J Gynecol Obstet 2006;92(3):333-4.
[18] Faúndes A, Alves Duarte G, Duarte Osis MJ. Conscientious objection or fear of social stigma and unawareness of ethical obligations. Int J Gynecol Obstet 2013;123(Suppl 3):S57–9 (this issue).
[19] FIGO. Resolution on Conscientious Objection. http://www.figo.org/projects/conscientious. Published 2005. Accessed June 1, 2013.
[20] WHO. Safe abortion: technical and policy guidance for health systems. Second edition. http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf. Published 2012. Accessed June 8, 2013.
[21] Johnson BR Jr, Kismödi E, Dragoman MV, Temmerman M. Conscientious objection to provision of legal abortion care. Int J Gynecol Obstet 2013;123(Suppl 3):S60–2 (this issue).
[22] Chavkin W, Leitman L, Polin K; for Global Doctors for Choice. Conscientious objection and refusal to provide reproductive healthcare: A white paper examining prevalence, health consequences, and policy responses. Int J Gynecol Obstet 2013;123(Suppl 3):41–56 (this issue).
[23] Dickens BM, Cook RJ. Conscientious commitment to women's health. Int J Gynecol Obstet 2011;113(2):163–6.

# EXHIBIT D

# The New US "Conscience and Religious Freedom Division": Imposing Religious Beliefs on Others

The core mission of the United States Department of Health and Human Services (DHHS) is "to enhance and protect the health and well-being of all Americans." The Trump administration recently announced the creation of the Conscience and Religious Freedom Division (CRFD) of the DHHS Office for Civil Rights to accept complaints by health care providers who feel that they have had to participate in medical procedures counter to their religious values. The CRFD directly contradicts the DHHS mission as well as standards of medical ethics.

## JEOPARDIZING CARE

The proposed CRFD rules[1] outline a wide-ranging plan that allows members of the health care workforce to avoid providing any health-related services, programs, research activities, or insurance coverage that conflict with their religious beliefs. The rules apply to all health care professionals, ranging from doctors and nurses to front desk staff and insurance administrators. Hospitals or clinics that do not allow their care providers to refuse patients for religious reasons face repercussions that could include a loss of federal funding.

Under the proposed CRFD rules, health care providers are encouraged to prioritize their religious beliefs above the welfare of their patients. The 95% of Americans who report having sex before marriage[2] may risk their health care provider denying them care or contraceptive counseling if they disclose their sexual behavior. In the midst of an opioid epidemic, the 25 million Americans who report using illicit drugs[3] risk being turned away from care if they disclose their drug use. With some providers, the 52% of Americans who drink alcohol[3] may risk being turned away as well.

## DISCOURAGING DISCLOSURES

The proposed CRFD rules would make each provider an unknown, unwritten law unto her- or himself. Patients could reasonably be concerned about disclosing stigmatized characteristics or behaviors to any provider, given that the information might be entered into electronic medical records that other providers would see. The rules would permit doctors to refuse to continue their visit with a man whose medical record references an extramarital affair or with an adolescent whose record indicates that she is a lesbian.

## LGBT PATIENTS

The rules could pose a particular danger of broad discrimination affecting lesbian, gay, bisexual, and transgender (LGBT) patients, especially given that Office for Civil Rights chief Roger Severino has argued that health care providers should be able to refuse to provide transition-related care to transgender patients.[4]

Turning away or stigmatizing LGBT patients will cause substantial harm to a population that already experiences large disparities. In 2015, 33% of transgender patients reported mistreatment in medical care and 23% reported delaying care owing to fear of mistreatment,[5] figures that would increase if the CRFD sanctions discrimination. Stigma, including that which the CRFD could allow on the part of health care providers, is also linked to high suicidality among LGBT individuals, particularly youths.[6]

Perhaps most chillingly, the CRFD rules contain no protections to ensure life-saving care for patients if they present in an emergency. This means that doctors can, according to the rules as currently written, refuse life-saving care if they deem a patient's characteristics or behaviors to somehow run counter to their "conscience." This is in direct contravention of not only centuries of medical practice but also the American Medical Association's Code of Medical Ethics. The first section of the code,[7] the modern-day equivalent of the Hippocratic Oath, is devoted to patient–provider relationships. According to the code, patient–physician trust "gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare."[7]

## IMPOSING BELIEFS ON OTHERS

In the spirit of prioritizing patient welfare above all, it is a proud tradition in American medicine to provide care to everyone, regardless of who they are or what they have done. The Tsarnaev brothers received medical care at a Boston hospital after detonating bombs at the Boston Marathon. Surviving school shooters are treated for their wounds. And doctors today regularly treat people who carry out any number of heinous acts. That is as it should be; health

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care as a right is a cornerstone of our shared humanity.

The proposed CRFD rules turn providers' prioritization of patient welfare on its head, creating a scenario in which providers are encouraged not only to prioritize their own religious beliefs over the welfare of their patients but to impose their beliefs on others, potentially to the harm of patient welfare.

## PROTECTING PATIENTS FROM HARM

Ironically, the DHHS Office for Civil Rights was created explicitly to counter the harmful effects of discrimination on patient health. The CRFD will serve as a pernicious Trojan horse, allowing harm to be wrought on patients within the very office that was created to protect patients from harm.

The cornerstone of health care is a trusting relationship between patients and providers. Patients routinely disclose to providers intimate thoughts and behaviors that they may not even disclose to their spouses or parents. Discussions of sexual behavior, substance use, mental health issues, and other stigmatized subjects are critical for health promotion.

For decades, the DHHS has promoted the health and well-being of all Americans. The CRFD should not harm health by disrupting the trusting relationships Americans have with health care providers or by endorsing discrimination. Newly confirmed DHHS secretary Alex Azar should not proceed with the CRFD, and health care providers and public health practitioners should discourage the DHHS from proceeding with the division. If the CRFD is implemented, legal challenges should be brought against health care providers who discriminate on the basis of gender identity, sexual orientation, race, ethnicity, or religion. Finally, regardless of CRFD policies, the principles of medical ethics do not sanction turning away or treating patients differently according to their characteristics or behaviors; health care providers should continue to observe standards of medical ethics and serve all patients to the best of their ability. AJPH

*Julia Raifman, ScD*
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### CONTRIBUTORS

Both authors originated the editorial. J. Raifman drafted the editorial, and S. Galea revised it.

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### REFERENCES

1. US Department of Health and Human Services. Protecting statutory conscience rights in health care: delegations of authority. Available at: https://www.federalregister.gov/documents/2018/01/26/2018-01226/protecting-statutory-conscience-rights-in-health-care-delegations-of-authority. Accessed April 26, 2018.

2. Finer LB. Trends in premarital sex in the United States, 1954–2003. *Public Health Rep*. 2007;122(1):73–78.

3. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Key substance use and mental health indicators in the United States: results from the 2016 National Survey on Drug Use and Health. Available at: https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.htm. Accessed April 26, 2018.

4. Anderson R, Severino R. Proposed Obamacare gender identity mandate threatens freedom of conscience and the independence of physicians. Available at: https://www.heritage.org/health-care-reform/report/proposed-obamacare-gender-identity-mandate-threatens-freedom-conscience. Accessed April 26, 2018.

5. James S, Herman JL, Rankin S, Keisling M, Mottet L, Anafi M. The report of the 2015 US Transgender Survey. Available at: https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf. Accessed April 26, 2018.

6. Hatzenbuehler ML, Phelan JC, Link BG. Stigma as a fundamental cause of population health inequalities. *Am J Public Health*. 2013;103(5):813–821.

7. American Medical Association. Code of Medical Ethics. Available at: https://www.ama-assn.org/sites/default/files/media-browser/code-of-medical-ethics-chapter-1.pdf. Accessed April 26, 2018.

# Health Challenges and Opportunities for an Aging China

If there is an issue of concern to all nations of the world in the past, present, and future, it is population aging. The most populous nation in the world, China also has the largest elderly population. There were 143.9 million elderly adults (aged 65 years or older) living in China at the end of 2015, accounting for 10.5% of the total population.[1] China's older population is larger than the sum of the elderly populations of European nations.

China is also one of the nations where population aging is taking place most rapidly. In 2000, the percentage of the population aged 65 years or older in China reached 7%, and, according to estimates, it will take only 26 years to double this percentage to 14%.[2] By contrast, the same rise required 115 years in France and 85 years in Sweden.[2] The old-age dependency ratio in China has reached 14.3%, indicating substantial social and family burdens. The significant numbers of older adults, as well as their health, living conditions, social security status, and support networks, are matters of great concern to the government and to families.

At the same time as this demographic transition, China has been undergoing rapid social, economic, and institutional changes. Since the Chinese economic reform of the late 1970s and 1980s, advances in medicine and technology have helped lead to an increase in the life expectancy of the Chinese population (from 67.8 years in 1981 to 76.3 years in 2015).[1] Moreover, the age-standardized death rate among older adults decreased from 45.8 per 1000 population in 2005 to 31.2 per 1000 in 2015.[1]

However, the main causes of death among older adults have not changed significantly. As shown in Figure 1, noncommunicable diseases—such as diseases of the circulation system, diseases of the respiratory system, and neoplasms—and injuries, poisonings, and consequences of external causes are still

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# EXHIBIT E

VIEWPOINT

# Contraceptive Coverage and the Balance Between Conscience and Access

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**When the Obama administration** included contraception in the essential benefits package to be covered by employer-sponsored health insurance plans under the Affordable Care Act, it sought to preserve access for women while addressing the concerns of employers with religious objections. Although the accommodations and exemptions were not enough for some employers, balance was the ultimate goal. This also was reflected in *Zubik v Burwell*, the Supreme Court's most recent decision on the matter; on May 16, 2016, the justices remanded the litigants to the lower court so they could be afforded the opportunity to reach a compromise between religious exercise and seamless contraceptive coverage. No further compromise was forthcoming.

Now the Trump administration has rejected balance as a worthwhile goal.[1] Its new contraceptive coverage rules, released on October 6, 2017, prioritize conscientious objection over access.[2,3] The rules take effect immediately, and new legal challenges, this time on behalf of patients rather than objecting employers, have already begun.[4] The new rules preserve the default requirement that employers must include free access to contraceptives as part of their insurance plans. However, the rules now exempt employers with religious or moral objections to contraceptives, without requiring any alternative approaches to ensure that beneficiaries can obtain contraceptives at no cost.[2,3]

This regulatory shift highlights the limits of legal rights to health care in the United States and fundamentally contrasts with ethical obligations to prioritize the interests of patients. The Obama administration justified the contraceptive coverage mandate on the basis of a "compelling government interest" in gender equality, and the ability of women to participate equally in the workforce and society by controlling the timing and number of their pregnancies.[5] In contrast, the Trump administration disclaimed any such interest in facilitating access to free contraceptives sufficient to overcome the claims of objecting employers.[2,3] In rejecting the government interests as they had been articulated by the Obama administration, the Trump administration pointed to the fact that the contraceptive mandate stemmed from administrative rulemaking rather than congressional decree, exemptions had already been offered to some religious entities resulting in incomplete access, and assertions about potentially negative consequences of contraceptives. Rather than women's interests, the new rules focus exclusively on the government's interests in protecting religious freedom.[1-3]

This privileging of religious freedom over other interests finds support in the current legal system. The Religious Freedom Restoration Act, passed in 1993, prohibits the government from "substantially burdening" the exercise of religion, by making it more difficult or impossible to exercise religious beliefs due to the imposition of significant penalties or other barriers, unless it uses the least restrictive approach to advancing a compelling government interest. There is no similarly stringent standard applied when the government makes it more difficult for patients to access health care, and the government is under no obligation to facilitate access to care at all. As the new rules make plain, the Trump administration views the contraceptive coverage mandate as a benefit that never needed to be offered, implying that it could have been wiped away completely. According to that framing, the government can bestow as much or as little of an optional benefit as it sees fit to accommodate rights it deems more important.

This approach underscores that patients' interests are subject to the prerogative of whichever administration is writing the regulations, leaving patients wholly dependent on political discretion. Conversely, "substantially burdening" religion (a threshold typically interpreted generously in favor of religious freedom) is permitted only when there is a compelling government interest. But even if a compelling government interest exists, the government may choose not to act on that interest; as in this case, the government may deny that it has a compelling interest at all.[1,2]

This legal advantage to religious interests is problematic for some patients and subjects them to the consequences of religious objections unilaterally unless the government specifically and carefully intervenes. For example, patients are the ones left to pay out of pocket for contraceptives (or to find alternative insurance coverage separate from their employer-based plan), while objecting employers are protected completely. Even if the government should be protective of religious freedom, when there is conflict, why should one party have to bear all the costs rather than requiring negotiations and compromise? Rather than facilitating such compromise, however, the Trump administration's rules abandon the concept. By granting exemptions rather than crafting accommodations, the rules offer greater protection of conscientious objection than the law requires or than has typically been offered.

The new rules cater to some objectors' expansive desire to avoid any consequence of their objections or any complicity in the chain of events that may lead to contraceptive coverage. This is not what the courts that considered challenges to the Obama administration's rules demanded because the law does permit the government to impede on religious exercise, sometimes even substantially, under the right circumstances.



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Moreover, conscientious objectors historically have been required to partake in some level of sacrifice or alternative contribution to ensure that their objections do not substantially affect other members of society. Although the Trump administration points to existing conscience protection in the regulation of health care at the state and federal levels for additional support of its approach,[2,3] it fails to acknowledge that some state legislatures and courts have required noninterference with patient care before accommodating religious objections. Far from noninterference, the effects of the Trump administration's rules on patients may be extreme given renewed governmental efforts to undermine the health insurance exchanges and defund family planning organizations that might otherwise offer alternative mechanisms of accessing contraceptives should an employer object to covering them.

There is also another serious imbalance demonstrated by the new rules: the Trump administration accepts the stated claims of conscientious objectors while spurning evidence-based arguments in favor of contraceptive access. Most obviously, the administration defers to objectors' claims (rejected by many courts) that their religious exercise will be "substantially burdened" if they are forced to comply with the contraceptive coverage mandate or the available accommodation process. But more important, the administration has not questioned objectors' assumptions about whether contraceptives included in the mandate actually work as abortifacients, despite scientific evidence to the contrary. Objectors ought to be the arbiter of their own beliefs but should not be permitted to get the facts wrong.[6]

The administration also makes a number of problematic assumptions of its own, for example, that even without coverage in their employer-based health insurance plans, women will be able to easily obtain contraceptives through government programs or paying out of pocket. These assumptions ignore threshold limits for subsidies and the administration's own assessment that contraceptives may cost nearly as much as $600 per year,[2,3] a substantial price for many women. The administration cites discredited theories correlating contraceptives and cancer, and perhaps most concerning, it rejects evidence suggesting that free contraceptives reduce unintended pregnancies, dismissing it as association rather than causation.[2,3] Ultimately, the new rules reject the Obama administration's emphasis on evidence-based policy to support its contraceptive coverage mandate and even use previous attempts to accommodate religious objectors to suggest that a mandate is not needed at all.[2,3]

There is no doubt that the loss of cost-free access to contraception—which had been deemed an essential preventive service by the Institute of Medicine—will impose hardships on some women, forcing them to bear the costs of their employers' conscientious objections.[1] The existing legal structure privileges religion and supports this imbalance, but as the Obama administration's rules demonstrate, patient interests need not always come last. Rather than relying on vacillating estimations of government interests, which can easily change from administration to administration, stronger protections of patient interests are needed, similar to those offered for religious freedom. Although a legal right to health care is politically infeasible at the present moment, health is certainly as central to people's lives as religion may be, and legal protections ought to reflect that. Requiring a compelling government interest and evidence-based policy making before access to care may be impeded could be an important step toward giving patient interests their due.

ARTICLE INFORMATION

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REFERENCES

1. Jost T, Keith K. Trump administration regulatory rebalancing favors religious and moral freedom over contraceptive access. Health Affairs Blog. http://healthaffairs.org/blog/2017/10/07/trump-administration-regulatory-rebalancing-favors-religious-and-moral-freedom-over-contraceptive-access/. Published October 7, 2017. Accessed October 7, 2017.

2. Internal Revenue Service; Employee Benefits Security Administration; Department of Health and Human Services. Religious exemptions and accommodations for coverage of certain preventive services under the Affordable Care Act. Federal Register, Interim Final Rule, October 6, 2017. https://federalregister.gov/d/2017-21851. Accessed October 6, 2017.

3. Internal Revenue Service; Employee Benefits Security Administration; Department of Health and Human Services. Moral exemptions and accommodations for coverage of certain preventive services under the Affordable Care Act. Federal Register, Interim Final Rule, October 6, 2017. https://federalregister.gov/d/2017-21852. Accessed October 6, 2017.

4. McCullough M. State backlash grows against Trump's birth control rollback. Tribune News Service. http://www.governing.com/topics/health-human-services/tns-pennsylvania-birth-control-trump-lawsuit.html. Published October 13, 2017. Accessed October 13, 2017.

5. *Zubik v Burwell*. Supplemental brief for the respondents. http://www.scotusblog.com/wp-content/uploads/2016/04/US-response-to-Zubik-order-4-12-16.pdf. Published April 12, 2016. Accessed October 7, 2017.

6. Lipper GM. Zubik v Burwell, part 3: birth control is not abortion. Bill of Health blog. http://blogs.harvard.edu/billofhealth/2016/03/19/zubik-v-burwell-part-3-birth-control-is-not-abortion/. Published March 19, 2016. Accessed October 7, 2017.



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# EXHIBIT F

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The Celestial Fire of Conscience -- Refusing to Deliver Medical Care

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Apparently heeding George Washington's call to ``labor to keep alive in your breast that little spark of celestial fire called conscience,'' physicians, nurses, and pharmacists are increasingly claiming a right to the autonomy not only to refuse to provide services they find objectionable, but even to refuse to refer patients to another provider and, more recently, to inform them of the existence of legal options for care.

Largely as artifacts of the abortion wars, at least 45 states have ``conscience clauses'' on their books -- laws that balance a physician's conscientious objection to performing an abortion with the profession's obligation to afford all patients nondiscriminatory access to services. In most cases, the provision of a referral satisfies one's professional obligations. But in recent years, with the abortion debate increasingly at the center of wider discussions about euthanasia, assisted suicide, reproductive technology, and embryonic stem-cell research, nurses and pharmacists have begun demanding not only the same right of refusal, but also -- because even a referral, in their view, makes one complicit in the objectionable act -- a much broader freedom to avoid facilitating a patient's choices (see Figure).!*State Requirements Governing the Refusal by Pharmacists to Fill Certain Prescriptions.Illinois has a regulation that requires pharmacies to fill valid contraception prescriptions in a timely manner, but a resolution has been introduced to permit refusals. Massachusetts has a pharmacy-board policy that requires pharmacists to fill valid prescriptions in a timely manner. North Carolina has a pharmacy-board policy that requires pharmacists to ensure that valid prescriptions are filled in a timely manner. Wyoming has a bill that would permit providers to refuse to abide by advance directives that might, in some scenarios, apply to pharmacists who refuse to fill certain prescriptions. Adapted from a map compiled by the National Women's Law Center *.**FIGURE OMITTED**

A bill recently introduced in the Wisconsin legislature, for example, would permit health care professionals to abstain from ``participating'' in any number of activities, with ``participating'' defined broadly enough to include counseling patients about their choices. The privilege of abstaining from counseling or referring would extend to such situations as emergency contraception for rape victims, in vitro fertilization for infertile couples, patients' requests that painful and futile treatments be withheld or withdrawn, and therapies developed with the use of fetal tissue or embryonic stem cells. This last provision could mean, for example, that pediatricians -- without professional penalty or threat of malpractice claims -- could refuse to tell parents about the availability of varicella vaccine for their children, because it was developed with the use of tissue from aborted fetuses.

This expanded notion of complicity comports well with other public policy precedents, such as bans on federal funding for embryo research or abortion services, in which taxpayers claim a right to avoid supporting objectionable practices. In the debate on conscience clauses, some professionals are now arguing that the right to practice their religion requires that they not be made complicit in any practice to which they object on religious grounds.

Although it may be that, as Mahatma Gandhi said, ``in matters of conscience, the law of majority has no place,'' acts of conscience are usually accompanied by a willingness to pay some price. Martin Luther King, Jr., argued, ``An individual who breaks a law that conscience tells him is unjust, and who willingly accepts the penalty of imprisonment in order to arouse the conscience of the community over its injustice, is in reality expressing the highest respect for law.''

What differentiates the latest round of battles about conscience clauses from those fought by Gandhi and King is the claim of entitlement to what newspaper columnist Ellen Goodman has called ``conscience without consequence.''

And of course, the professionals involved seek to protect only themselves from the consequences of their actions -- not their patients. In Wisconsin, a pharmacist refused to fill an emergency-contraception prescription for a rape victim; as a result, she became pregnant and subsequently had to seek an abortion. In another Wisconsin case, a pharmacist who views hormonal contraception as a form of abortion refused not only to fill a prescription for birth-control pills but also to return the prescription or transfer it to another pharmacy. The patient, unable to take her pills on time, spent the next month dependent on less effective contraception. Under Wisconsin's proposed law, such behavior by a pharmacist would be entirely legal and acceptable. And this trend is not limited to pharmacists and physicians; in Illinois, an emergency medical technician refused to take a woman to an abortion clinic, claiming that her own Christian beliefs prevented her from transporting the patient for an elective abortion.

At the heart of this growing trend are several intersecting forces. One is the emerging norm of patient autonomy, which has contributed to the erosion of the professional stature of medicine. Insofar as they are reduced to mere purveyors of medical technology, doctors no longer have extraordinary privileges, and so their notions of extraordinary duty -- house calls, midnight duties, and charity care -- deteriorate as well. In addition, an emphasis on mutual responsibilities has been gradually supplanted by an emphasis on individual rights. With autonomy and rights as the preeminent social values comes a devaluing of relationships and a diminution of the difference between our personal lives and our professional duties.

Finally, there is the awesome scale and scope of the abortion wars. In the absence of legislative options for outright prohibition, abortion opponents search for proxy wars, using debates on research involving human embryos, the donation of organs from anencephalic neonates, and the right of persons in a persistent vegetative state to die as opportunities to rehearse arguments on the value of biologic but nonsentient human existence. Conscience clauses represent but another battle in these so-called culture wars.

Most profoundly, however, the surge in legislative activity surrounding conscience clauses represents the latest struggle with regard to religion in America. Should the public square be a place for the unfettered expression of religious beliefs, even when such expression creates an oppressive atmosphere for minority groups? Or should it be a place for religious expression only if and when that does not in any way impinge on minority beliefs and practices? This debate has been played out with respect to blue laws, school prayer, Christmas creche scenes, and workplace dress codes.

Until recently, it was accepted that the public square in this country would be dominated by Christianity. This long-standing religious presence has made atheists, agnostics, and members of minority religions view themselves as oppressed, but recent efforts to purge the public square of religion have left conservative Christians also feeling subjugated and suppressed. In this culture war, both sides claim the mantle of victimhood -- which is why health care professionals can claim the right of conscience as necessary to the nondiscriminatory practice of their religion, even as frustrated patients view conscience clauses as legalizing discrimination against them when they practice their own religion.

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For health care professionals, the question becomes: What does it mean to be a professional in the United States? Does professionalism include the rather old-fashioned notion of putting others before oneself? Should professionals avoid exploiting their positions to pursue an agenda separate from that of their profession? And perhaps most crucial, to what extent do professionals have a collective duty to ensure that their profession provides nondiscriminatory access to all professional services?

Some health care providers would counter that they distinguish between medical care and nonmedical care that uses medical services. In this way, they justify their willingness to bind the wounds of the criminal before sending him back to the street or to set the bones of a battering husband that were broken when he struck his wife. Birth control, abortion, and in vitro fertilization, they say, are lifestyle choices, not treatments for diseases.

And it is here that licensing systems complicate the equation: such a claim would be easier to make if the states did not give these professionals the exclusive right to offer such services. By granting a monopoly, they turn the profession into a kind of public utility, obligated to provide service to all who seek it. Claiming an unfettered right to personal autonomy while holding monopolistic control over a public good constitutes an abuse of the public trust -- all the worse if it is not in fact a personal act of conscience but, rather, an attempt at cultural conquest.

Accepting a collective obligation does not mean that all members of the profession are forced to violate their own consciences. It does, however, necessitate ensuring that a genuine system for counseling and referring patients is in place, so that every patient can act according to his or her own conscience just as readily as the professional can. This goal is not simple to achieve, but it does represent the best effort to accommodate everyone and is the approach taken by virtually all the major medical, nursing, and pharmacy societies. It is also the approach taken by the governor of Illinois, who is imposing an obligation on pharmacies, rather than on individual pharmacists, to ensure access to services for all patients.

Conscience is a tricky business. Some interpret its personal beacon as the guide to universal truth. But the assumption that one's own conscience is the conscience of the world is fraught with dangers. As C.S. Lewis wrote, ``Of all tyrannies, a tyranny sincerely exercised for the good of its victims may be the most oppressive. It would be better to live under robber barons than under omnipotent moral busybodies. The robber baron's cruelty may sometimes sleep, his cupidity may at some point be satiated; but those who torment us for our own good will torment us without end for they do so with the approval of their own conscience."

**---- Index References ----**

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# EXHIBIT G

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*Medical Ethics*

# LEGAL PROTECTION AND LIMITS OF CONSCIENTIOUS OBJECTION: WHEN CONSCIENTIOUS OBJECTION IS UNETHICAL

**Bernard M. Dickens** *

**Abstract:** The right to conscientious objection is founded on human rights to act according to individuals' religious and other conscience. Domestic and international human rights laws recognize such entitlements. Healthcare providers cannot be discriminated against, for instance in employment, on the basis of their beliefs. They are required, however, to be equally respectful of rights to conscience of patients and potential patients. They cannot invoke their human rights to violate the human rights of others.

There are legal limits to conscientious objection. Laws in some jurisdictions unethically abuse religious conscience by granting excessive rights to refuse care.. In general, healthcare providers owe duties of care to patients that may conflict with their refusal of care on grounds of conscience. The reconciliation of patients' rights to care and providers' rights of conscientious objection is in the duty of objectors in good faith to refer their patients to reasonably accessible providers who are known not to object.

Conscientious objection is unethical when healthcare practitioners treat patients only as means to their own spiritual ends. Practitioners who would place their own spiritual or other interests above their patients' healthcare interests have a conflict of interest, which is unethical if not appropriately declared.

**Keywords:** Conscientious Objection; Contraception; Abortion; Conflict of Interest; Pharmacists

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## THE PROTECTION OF CONSCIENCE

A key principle of human rights law, founded in leading international human rights covenants and the constitutional law of many countries, is the right of individuals to act according to their own conscience. Conscience is often based on individuals' religious convictions, but religion has no monopoly on conscience. The Universal Declaration of Human Rights, 1948, Article 18(1) provides that "Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to manifest his religion or belief in teaching, practice, worship and observance." The UN International Covenant on Civil and Political Rights similarly embodies those words, but Article 18(3) recognizes that freedom to manifest one's religion or beliefs "may be subject only to such limitations as...are necessary or protect public safety, order, health or morals, or the fundamental rights and freedoms of others."

The right to act according to one's own conscience, subject to the above limitations, is available to believers in all religious faiths, and in none, and equally to those whose conscience responds to their philosophical, social, political and other convictions. The right to manifest one's conscience "subject...to...health...of others" is significant, since forces particularly of conservative religion are urging their adherents to object to providing some health services related to fertility, both fertility control and fertility promotion by medically assisted means, and end-of-life care.[1] Services to which objection may be taken include provision of contraception, emergency contraception, sterilization, abortion, *in vitro* fertilization and at the end of life, terminal sedation and withdrawal of artificial life support.

How far protection of conscience can go is illustrated in legislation enacted in several US states. In Mississippi, for instance, objection is comprehensively accommodated not only for direct participants in delivery of healthcare services, but also for those who deliver "any...care or treatment rendered by health care providers or health care institutions." The state's Health Care Rights of Conscience Act, in force since July 2004, covers providers of:

> any phase of patient medical care, treatment or procedure, including, but

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1. B.M. Dickens, "Conscientious Objection: A Shield or a Sword?" In S.A.M. McLean (editor) "First Do No Harm: *Law, Ethics and Healthcare.*" Aldershot, U.K.: Ashgate 2006, pp. 337-51.

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> not limited to, the following: patient referral, counseling, therapy, testing, diagnosis or prognosis, research, instruction, prescribing, dispensing or administering any device, drug, or medication, surgery or any other care or treatment rendered by health care providers or health care institutions (section 2(a)).

The Act allows all health service providers to refuse to undertake such services, including any:

> physician, physician's assistant, nurse, nurse's aide, medical assistant, hospital employee, clinic employee, nursing home employee, pharmacist, pharmacy employee, researcher, medical or nursing school faculty student or employee, counselor, social worker or any professional, paraprofessional, or any other person who furnishes, or assists in the furnishing of a health care procedure (section 2(b)).

Health care institutions and health care payers such as private insurers are defined in comparably comprehensive terms and are accorded the same rights to invoke their "conscience," presumably related to their mission statements and affiliations. In order not to appear to privilege religious faith, the Act defines "conscience" to mean "the religious, moral or ethical principles held by a health care provider, the health care institution or health care payer" (section 2(h)).

Against this definitional background, section 3 of the Act provides:

> (1) ***Rights of Conscience***. A health care provider has the right not to participate, and no health care provider shall be required to participate, in a health care service that violates his or her conscience...
>
> (2) ***Immunity from Liability***. No health care provider shall be civilly, criminally, or administratively liable for declining to participate in a health care service that violates his or her conscience...
>
> (3) ***Discrimination.*** It shall be unlawful for any person, health care provider, health care institution, public or private institution, public official, or any board which certifies competency in medical specialties to discriminate against any health care provider in any manner based on his or her declining to participate in a health care service that violates his or her conscience. For the purposes of this Act, discrimination includes, but is not limited to: termination,

> transfer, refusal of staff privileges, refusal of board certification, adverse administrative action, demotion, loss of career specialty, reassignment to a different shift, reduction of wages or benefits, refusal to award any grant, contract or other program, refusal to provide residency training opportunities or any other penalty, disciplinary or retaliatory action.

Health care institutions and health care payers are afforded comparable rights, immunities and protection against discrimination.

Protection against discrimination is in principle a legitimate goal of legislation, since discrimination is an act of superiority directed against those seen to be in an inferior position. Anti-discrimination laws are intended to relieve less powerful people from oppression by the more powerful. In this legislation, however, the protection is designed to privilege adherents primarily of religious faith, and to exploit the dependency and inferior status of patients, primarily women, who want access to reproductive health services. Enactment of laws to empower individuals to subordinate others to their preferences by denial of medically indicated care, especially which they enjoy a legal monopoly to provide is an abuse of the anti-discrimination principle.

Under the protection of legislation such as Mississippi has introduced, which over 20 American states have enacted or are considering enacting, hospital employees may, for instance, refuse to clean instruments used in abortion or sterilization procedures, nurses may refuse to provide care including pre- and post-operative care, or to serve meals to patients whose treatment they disapprove and physicians may refuse to provide their patients with information not only of medical options for their care but also of their diagnosis and prognosis if they believe that patients may make decisions on the basis of such information of which the physicians disapprove. In short, such legislation that protects religious, moral or ethical preferences deprives patients of many of their reproductive and other rights, and often empowers health service providers and institutions in effect to impose their will at patients' cost, including cost of their health..

With the development of non-surgical, drug-induced (that is, "medical") abortion, pharmacists refuse to stock or to dispense the drugs in question. In many cases, however, invoking their religious beliefs, they are also refusing to fill prescriptions for emergency contraceptives, applied within 72 hours of contraceptively unprotected intercourse and required to be offered to women

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victims of rape, and regular contraceptive products.[2] The objection to emergency contraception is based on opposition to abortion, and a fundamentalist opinion of the point at which unborn human life warrants protection. In 1869, the Roman Catholic Church abandoned its historical view that "quickening" provides evidence of life in utero, and determined that life begins at conception, after which a pregnancy cannot be deliberately terminated. Further, pharmacists are declining to refer women to other pharmacists or pharmacies known to be willing to fill patients' prescriptions, and instances have been recorded in which they have refused to return patients' prescription forms for emergency contraception, in order to prevent patients from taking them to other pharmacists.[3]

Many of these enactments in American states reflect the preferences of evangelical or fundamentalist Protestant Christian religious denominations, but their purpose coincides with Roman Catholic purposes not only to protect adherents' conscientious convictions, but also actively to reduce access to healthcare services to which that church is opposed.

## THE LIMITS OF CONSCIENCE

The expansion of legislated protection of conscientious objection seen in Mississippi, and other US states with comparable provisions, exceeds the limits set by internationally prescribed human rights, as seen, for instance, in Article 18(3) of the UN International Covenant on Civil and Political Rights. This Covenant precludes an individual's right to manifest religious or other beliefs in a way that compromises the health of another, such as by denial or obstruction of medically indicated care. The US has ratified this Covenant, but international treaties usually require adoption by US domestic law to be applicable, and neither the federal US Congress nor the State of Mississippi, nor other states with comparable legislation, have enacted the Covenant. The constitutions of many countries provide that, on ratification, international treaties are incorporated into national law, but the US is not such a country. Similarly, the highest courts of many countries in which ratified treaties are not automatically incorporated

2. M. Davy, P. Belluck. "Pharmacies Balk on After-Sex Pill and Widen Fight." New York Times, 19 April 2005, p. 1, 16.

3. T. Zwillick, "US Pharmacies Vow to Withhold Emergency Contraception." The *Lancet* 2005; 365: 1677-8.

into domestic law interpret such law by presuming that it intends to be applied compatibly with international legal commitments, unless the law explicitly provides to the contrary. However, the US Supreme Court has not generally been persuaded to interpret US domestic law according to this principle.

An example of an appropriate limit of conscientious objection is found in the British legislation, the Abortion Act, 1967. At the initiative of Catholic Parliamentarians, a provision was added to the draft Bill to accommodate conscientious objection. Section 4(1) of the Act provides that:

> Subject to subsection (2) of this section, no person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorized by this Act to which he has a conscientious objection:
>
> Provided that in any legal proceedings the burden of proof of conscientious objection shall rest on the person claiming to rely on it.

This latter provision prevents doctors from invoking conscience to object to participate in abortion procedures in public hospitals when they participate in such procedures in private facilities.

The limitation in section 4(2) to the right of conscientious objection provided in section 4(1), is that:

> Nothing in subsection (1)... shall affect any duty to participate in treatment which is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman.

The absence of any comparable language in the Mississippi Act leaves the Act, and the legislators who enacted it, open to condemnation for violation of human rights principles and standards of ethical conduct.

The UK courts also interpret the right not "to participate" in abortion narrowly. The highest court has ruled that typing a referral letter for abortion is not "to participate" in the procedure, so that a typist or secretary could not invoke conscience to refuse to prepare such a letter.[4] Similarly, for a doctor who objects to perform abortion to refer the patient to a non-objecting doctor is not "to participate" in any procedure that doctor performs, and the objecting doctor

4. Janaway v. Salford Health Authority, [1989] A.C. 537 (House of Lords). See also *Spellacy v. Tri-County* Hospital, 395 A.2d 998 (Pennsylvania Superior Ct. 1978).

therefore cannot invoke conscience to refuse to refer.[5]

The duty to refer in good faith is widely recognized as a condition of accommodating conscientious objection. Those who require respect for their own conscience cannot show disrespect for the different conscience of others, including of patients requesting medically indicated care in which the objectors decline to participate, and of professional colleagues who do not object to provide such care. Governments have duties both to accommodate health service providers' conscientious objections to the greatest extent they can, including provision of appropriate legal protection against discrimination, and also to ensure patients' timely access to the forms of lawful care that some providers may object to undertake.

Limits on rights of conscientious objection were recognized by the late Pope, John Paul II in 1991, when he declared that:

> Freedom of conscience does not confer a right to indiscriminate recourse to conscientious objection. When an asserted freedom turns into licence or becomes an excuse for limiting the rights of others, the State is obliged to protect, also by legal means, the inalienable rights of its citizens against such abuses.[6]

The European Court of Human Rights has applied the European Convention for the Protection of Human Rights and Fundamental Freedoms to limit oppressive abuse of claims to conscience. Article 9(1) of the Convention, reflecting Article 18(1) of the UN Covenant on Civil and Political Rights, protects freedom of conscience and religion, and Article 9(2) subjects such freedom to "such limitations as are prescribed by law and are necessary...for the protection of public order, health or morals, or for the protection of the rights and freedoms of others." When French owners of a pharmacy that was the only reasonably accessible pharmacy in their area, refused to provide prescribed contraceptive products and were convicted of breach of the Consumer Code, they appealed to the Court, claiming violation of their rights to manifest their religion under Article 9(1) of the Convention. The Court dismissed their application, however, ruling that:

5. *Barr v. Matthews* (1999), 52 B.M.L.R. 217 (Queen's Bench Division).

6. John Paul II Address "If You Want Peace, Respect the Conscience of Every Person," Vatican City 1991 Message for the 24th World Day of Peace 1991, para. 24.

> as long as the sale of contraceptives is legal and occurs on medical prescription nowhere other than in a pharmacy, the applicants cannot give precedence to their religious beliefs and impose them on others as justification for their refusal to sell such products, since they can manifest those beliefs in many ways outside the professional sphere.[7]

Professionalism in all of the healthcare disciplines shapes the scope of accommodation of conscience. The compromise between practitioners' rights of conscience and patients' rights to professional care is in the duty of referral. That is, the doctor, nurse, pharmacist or other professional whose conscience would be compromised by participation in delivery of health service should refer the patient in good faith to an appropriate alternative provider of that service. The duty to refer is particularly necessary when licensed professionals enjoy a legal monopoly on the provision of services. A doctor, who in some jurisdictions is legally bound by a fiduciary duty to the patient, should refer the patient to another non-objecting doctor to whom the patient has reasonably convenient access, the nurse should seek replacement by an available colleague, the pharmacist can ask the patient to have a colleague fill the prescription, and a pharmacy owner can refer the patient to another accessible pharmacy.[8]

Employers of objecting pharmacists, for instance, have a reciprocal duty of reasonable accommodation of their employees' convictions, such as by employment of other, non-objecting pharmacists. Non-objection to provision of such services can then be a bona fide condition or job description of another pharmacist's employment without offending usual anti-discrimination laws. The same principle would justify a hospital seeking to recruit a doctor or nurse to serve in its reproductive health or abortion clinic in rejecting as unqualified any applicants who would invoke conscientious objection to decline participation in the clinic's main functions.

The limit on conscience, however, is that if no alternative provider is able to meet the patient's healthcare needs in a timely way, remembering, for instance, that emergency contraception is most effective within 72 hours of unprotected intercourse, the initially requested provider must discharge the service. This principle, embodied in section 4(2) of the Abortion Act, 1967 in Britain and the

7. *Pichon and Sajous v. France* (2001) App. No. 49853/99 (Eur. Ct. of Human Rights).

8. B.P. Knestout "An Essential Prescription: Why Pharmacist-Inclusive Conscience Clauses are Necessary." *J. Contemporary Health Law and Policy* 2006; 22: 349-382.

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ruling of the European Court of Human Rights, requires professionals to maintain the standards of their profession, which historically might include an element of self-sacrifice, and not give priority to their personal religious or other beliefs.

## CONFLICT OF INTEREST AND UNETHICAL CONSCIENCE

The ethical commitment of doctors and related health service providers, embodied in many codes of professional conduct, is to give priority to patients' well-being. The duty to place patients' health interests above their own is not observed, however, when providers give priority to their own interests. That is, when patients' interests in receiving medically-indicated and timely care are opposed by providers' interests in observing their own religious faith or other beliefs, the providers have a conflict of interest. This in itself is not necessarily unethical, because in some circumstances conflicts of interest are unavoidable. It is better, of course, that conflicts be avoided, but when they cannot be, they should be appropriately disclosed, so that those seeking providers' care can attend providers, such as doctors and pharmacists, who have no conflict, or patients can accept care within the limits of the providers' disclosed conscience.

This requires that health service providers who propose, on grounds of conscientious objection, not to provide particular forms of care that others within their customary scope of practice do provide, will so inform those who seek their services. That is, obstetrician/gynecologists, for example, who will not undertake contraceptive care, sterilization, or abortion, should inform prospective patients and hospitals in which they seek practice privileges, and general practitioners who will not prescribe contraceptives will inform prospective patients. Similarly, pharmacists who object to filling prescriptions for contraceptive or emergency contractive products will inform prospective employers, and pharmacies whose owners decline to stock those products will provide clear notice to prospective customers, and advise them where such services are reasonably available to them.

The ethical duty of prior disclosure, based on the principle of respect for persons and patients' autonomy, may be reinforced by the law. A provider or hospital that invokes conscientious objection and thereby delays or obstructs a woman's resort to emergency contraception may become legally responsible for her failure to prevent pregnancy following unprotected sexual intercourse. Legal liability may be for her gestation or delivery, or for compelling her resort to abortion, and exemplary or aggravated damages may be awarded if her avoidable pregnancy was due to rape but an emergency doctor or hospital

department refused or failed to provide medically indicated emergency contraception.

Some practitioners who refuse to participate in treatments on grounds of conscience may also refuse to refer, on the ground that referral for a "wrongful" procedure makes them equally guilty for complicity in that wrong. This type of fundamentalism is often rooted in religious belief. Religious dedication has underpinned much altruistic healthcare in the world. Many hospitals are named after Christian saints, and in the Islamic, Jewish and other religious traditions, the commitment to provide health aid is considered particularly worthy. However, if healthcare providers' principal goal is promoting their own spiritual worth through the offer of care to those in need, they may be using sick, dependent people instrumentally, as objects or a means to serve their own spiritual ends.

Health service delivery has a justifiably proud history of self-sacrifice. In their dedication to care for the sick, health service providers have long knowingly exposed themselves to peril. This is not a feature just of history. In recent times, the doctor who first diagnosed and named the severe acute respiratory syndrome (SARS) died of it, and many who died or whose health was severely impaired from it were health service providers infected by the patients for whom they cared. If providers intend only to give treatment to patients, but not to care for or about patients, and sacrifice their patients' needs to their own spiritual comfort in invoking conscientious objection to deny or obstruct indicated healthcare, their instrumental use of patients is unethical.

They violate the Kantian categorical imperative, which is to:

> [a]ct so that you treat humanity, whether in your own person or in that of another, always as an end and never as a means only.[9]

Modern religious doctrine is to oppose the instrumental use of human beings, but the teaching of Immanuel Kant has not been uniformly respected or advocated. Indeed, when the Vatican's Office of the Inquisition maintained its list of Prohibited Books ( the Index Librorum Prohibitorum), it banned Roman Catholics from reading Kant's writing, as containing immoral or theologically erroneous material. In 1965, the successor to this Vatican Office became the

9. Kant. I. 1785. *Groundwork of the Metaphysics of Morals*. In *Groundwork of the Metaphysics of Morals and What is Enlightenment?*(Translator: Lewis Beck White) New York: The Liberal Arts Press, 1959, p.47.

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Congregation for the Doctrine of the Faith, whose Prefect, Cardinal Ratzinger, left that position to become the present pope, Benedict XVI, in 2006.

The Roman Catholic hierarchy is commonly supportive of strident expressions of conscientious objection to many medical treatments that fall within the concepts of reproductive health and rights. The concept of reproductive health was internationally approved and adopted at the UN International Conference on Population and Development (Cairo 1994) and the UN International Conference on Women (Beijing 1995). The definition provides that:

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

The Vatican, through the unique privilege that the international juridical status of the Holy See affords it as one religious denomination among many (in 2008 representing an estimated 17.4% of world population), participated in the 1994 and 1995 UN Conferences, where it bitterly opposed the concept of reproductive health. It continues to oppose individuals' having "freedom to decide if, when and how often" to have children through use of medically assisted means, and to support efforts to frustrate such use, including promoting health service providers' objection to contributing to the achievement of reproductive health goals, on grounds of their conscience. This stance appears, however, to contradict the plea of Pope John Paul II in 1991, "that each individual's conscience be respected by everyone else; people must not attempt to impose their own 'truth' on others." Conscientious objectors risk failing to heed his warning, that " [i]ntolerance can also result from the recurring temptation to fundamentalism, which easily leads to serious abuses".[10]

10. See Note 6 above, paras 4 and 15.

# EXHIBIT H

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# Conscientious Objection to Sexual and Reproductive Health Services: International Human Rights Standards and European Law and Practice

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**Abstract**

The practice of conscientious objection often arises in the area of individuals refusing to fulfil compulsory military service requirements and is based on the right to freedom of thought, conscience and religion as protected by national, international and regional human rights law. The practice of conscientious objection also arises in the field of health care, when individual health care providers or institutions refuse to provide certain health services based on religious, moral or philosophical objections. The use of conscientious objection by health care providers to reproductive health care services, including abortion, contraceptive prescriptions, and prenatal tests, among other services is a growing phenomena throughout Europe. However, despite recent progress from the European Court of Human Rights on this issue (*RR v. Poland*, 2011), countries and international and regional bodies generally have failed to comprehensively and effectively regulate this practice, denying many women reproductive health care services they are legally entitled to receive. The Italian Ministry of Health reported that in 2008 nearly 70% of gynaecologists in Italy refuse to perform abortions on moral grounds. It found that between 2003 and 2007 the number of gynaecologists invoking conscientious objection in their refusal to perform an abortion rose from 58.7 percent to 69.2 percent. Italy is not alone in Europe, for example, the practice is prevalent in Poland, Slovakia, and is growing in the United Kingdom. This article outlines the international and regional human rights obligations and medical standards on this issue, and highlights some of the main gaps in these standards. It illustrates how European countries regulate or fail to regulate conscientious objection and how these regulations are working in practice, including examples of jurisprudence from national level courts and cases before the European Court of Human Rights. Finally, the article will provide recommendations to national governments as well as to international and regional bodies on how to regulate conscientious objection so as to both respect the practice of conscientious objection while protecting individual's right to reproductive health care.

**Keywords**

reproductive health; conscientious objection; human rights; right to health care; European Court of Human Rights; sexual and reproductive rights

[*)] This article builds on research, advocacy and litigation undertaken in the International Legal Program of the Center for Reproductive Rights since 2004.

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## 1. Introduction

Conscientious objection is the refusal to participate in an activity that an individual considers incompatible with his/her religious, moral, philosophical or ethical beliefs. The practice of conscientious objection has historically arisen in the context of opposition to mandatory military service,[1] but is increasingly being raised in the context of objection to engaging in certain medical procedures, particularly in the area of sexual and reproductive health.[2] While standards regulating the practice of conscientious objection to military service are generally well-developed, legal standards governing the practice in health care settings are often inadequate to address the multiple scenarios in which the practice arises. The law and practice in European countries is peppered with differences, indicating a great need to develop comprehensive standards in this area.

A large number of States worldwide have conscientious objection clauses in laws and/or medical ethical standards that are applicable to sexual and reproductive health care services. These clauses are usually included in deontology (ethics) codes,[3] or in general health care laws and/or in laws that regulate a specific reproductive health care service such as abortion or sterilization.[4] The scope of conscientious objection clauses and the legal rights and obligations of patient and provider that they create vary from country to country.

According to established international human rights and medical standards, states should regulate conscientious objection to both accommodate health care providers' beliefs and also ensure women's access to adequate and timely sexual and reproductive health care services. Regulations should thus, for example, ensure an adequate number of providers willing and able to perform lawful health services, clearly establish the types of health services and circumstances in which conscientious objection can be invoked, and establish legal and ethical duties of

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1) The concept of a conscientious objector emerged at the beginning of the 20th Century when some people refused to fight in World War I, and it gained international recognition in 1989 when the United Nations Commission on Human Rights adopted the resolution "Conscientious objection to military service". UN Commission on Human Rights, *Conscientious objection to military service*, U.N. Doc. E/CN.4/1989/L.19/Add.15 (9 Mar. 1989). For more, *see generally*, Rachel Brett, Quaker United Nations Office, International Standards on Conscientious Objection to Military Service (2008), *available at* http://www.quno.org/geneva/pdf/humanrights/CO/COintlStds200811-English.pdf.

2) *See* Judith Bueno de Mesquita and Louise Finer, University of Essex Human Rights Centre, Conscientious Objection: Protecting Sexual and Reproductive Health Rights (2008) available at http://www.essex.ac.uk/human_rights_centre/research/rth/docs/Conscientious_objection_final.pdf; *see also* Rebecca Cook, Bernard Dickens and Mahmoud Fatallah, *Reproductive Health and Human Rights: Integrating Medicine, Ethics And Law* (2003).

3) Deontology or medical ethics codes, while not legally binding, are a highly persuasive authority since the development of deontology codes is mandated by public health laws. Often times they are used by national courts as persuasive authority.

4) *See* Center for Reproductive Rights' Third Party Intervention to the European Court of Human Rights in the case of *Tysiąc* v. *Poland*, App. No. 5410/03, Eur. Ct. H.R. para. 21 (filed 21 Sept. 2005), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/Tysiac%20Amicus%20AS%20SENT%20TO%20ECHR%209%2020%2005.pdf.

health care providers who invoke conscientious objection, such as timely referral of patients to providers willing and able to provide services.[5] Such regulations should also establish oversight mechanisms, penalties for healthcare providers who do not comply with their duties and effective appeal mechanisms for women who are denied services.[6] Moreover, in cases where women's right to health services are violated, legislation should establish appropriate remedies.[7]

This article examines the law and practice of conscientious objection to sexual and reproductive health services in Europe. It first outlines the international (UN) and European human rights standards as well as the medical and ethical standards regarding the regulation of conscientious objection in reproductive health care settings. It then examines national European laws and jurisprudence on the practice, offering a more detailed articulation of the issues and concerns, and providing guidance on the regulation of the practice. The article shows that often in European countries conscientious objection clauses are being applied too broadly and sometimes even abused. The lack of adequate legal and policy framework to regulate the practice and prevent abuse results in serious violations of women's right to access quality sexual and reproductive health services with potentially detrimental impact on their health and lives.

## 2. International (UN) Standards on Conscientious Objection to Sexual and Reproductive Health Care Services

The Programme of Action of the International Conference on Population and Development (ICPD), agreed to by governments around the globe, recognised that reproductive rights are human rights:

> Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other relevant UN consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes

[5] *See* Eur. Parl. Assemb., Social, Health & Family Affairs Comm., *Explanatory memorandum — Women's access to lawful medical care: the problem of unregulated use of conscientious objection*, Doc. 12347 (2010) [hereinafter Eur. Parl. Assemb., *Explanatory Memorandum — Unregulated use of conscientious objection*].

[6] *See* Judgment, *Tysiąc* v. *Poland*, App. No. 5410/03, Eur. Ct. H.R. paras. 116-17 (2007).

[7] The right to an effective remedy is a fundamental right recognised in most international and regional human rights treaties. *See, e.g.*, International Covenant on Civil and Political Rights, adopted 16 Dec. 1966, Art. 2, para. 3, G.A. Res. 2200A (XXI), UN GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (entered into force 23 Mar. 1976) [hereinafter ICCPR]; *see also* Convention for the Protection of Human Rights and Fundamental Freedoms, adopted 4 Nov. 1950, Art. 13, 213 U.N.T.S. 222, Europ. T.S. No. 5 (entered into force 3 Sept. 1953) [hereinafter European Convention on Human Rights].

their right to make decisions regarding reproduction free of discrimination, coercion and violence, as expressed in human rights documents.[8]

The content and scope of these internationally recognised human rights have been developed and interpreted by UN and regional human rights bodies for decades. For instance, the U.N. treaty monitoring bodies (UNTMBs) which monitor states compliance with the major international human rights treaties and provide interpretation of those treaties, have articulated protection for reproductive rights including in the areas of abortion, family planning, female genital mutilation, gender-based violence, sexuality education and maternal mortality, among others.[9] Their recognition is grounded in the fundamental rights to life, to be free from inhumane and degrading treatment, health, non-discrimination and equality, self-determination and access to information. At the regional level, the European Convention on Human Rights also protects women's reproductive rights.[10]

Conscientious objection is grounded in the right to freedom of religion, conscience and thought, recognised in many international and regional human rights treaties as well as national constitutions.[11] Under international and regional human rights law, the freedom to manifest one's religion or beliefs can be limited for the protection of the rights of others, including women's sexual and reproductive rights.[12] Human rights bodies have established standards for state regulation of conscientious objection clauses, including the legal obligation of health care providers to ensure that patients are not denied access to health care services.[13]

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8) *Programme of Action of the International Conference on Population and Development*, Cairo, Egypt, 5-13 Sept. 1994, at 7.3, U.N. Doc. A/CONF.171/13/Rev.1 (1995).

9) *See generally Center for Reproductive Rights, Bringing Rights to Bear* (2008), *available at* http://reproductiverights.org/en/resources/publications/briefing-papers.

10) *See, e.g.*, Judgment, *Tysiąc v. Poland, supra* note 6. The Court has noted that "legislation regulating the interruption of pregnancy touches upon the sphere of private life, since whenever a woman is pregnant her private life becomes closely connected with the developing foetus." Eur. Comm. HR, *Brüggemann and Scheuten v. The Federal Republic of Germany*, App. No. 6959/75, 10 Eur. H.R. Rep. (1977) (Commission Report).

11) *See, e.g.*, Human Rights Committee, *General Comment No. 22: The Right to freedom of thought, conscience and religion*, (48th Sess., 1993), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies (Vol. I), at 204, para. 11, U.N. Doc. HRI/GEN/1/Rev.9 (2008) (recognizing that the right to conscientious objection can be derived from the right to freedom of thought, conscience and religion as guaranteed in the International Covenant on Civil and Political Rights); *see also* European Convention on Human Rights, *supra* note 7, Art. 9; EU Network of Independent Experts on Fundamental Rights, The right to conscientious objection and the conclusion by EU Member States of concordats with the Holy See, Eur. Comm'n., Opinion No. 4-2005, at 9-12 (14 Dec. 2005), available at http://158.109.131.198/catedra/images/experts/CONSCIENTIOUS%20OBJECTION%20%2810%29.pdf [hereinafter EU Network of Independent Experts].

12) *See, e.g.*, ICCPR, *supra* note 7, Art. 18, para. 3; *see also* European Convention on Human Rights, *supra* note 7, Art. 9, para. 2.

13) *See, e.g.*, Human Rights Committee, *Concluding Observations: Poland*, para. 12, U.N. Doc. CCPR/C/POL/CO/6 (2010) [hereinafter HRC, *Poland* (2010)]; Committee on Economic, Social and Cultural Rights, *Concluding Observations: Poland*, para. 28, U.N. Doc. E/C.12/POL/CO/5 (2009) [hereinafter

UNTMBs which interpret and monitor state compliance with UN human rights treaties, have specifically recognised that conscientious objection is a potential barrier to access reproductive health services[14] and have stated that governments have a positive obligation to ensure that the application of conscientious objection clauses does not violate women's right to access to quality, affordable and acceptable sexual and reproductive health care services.[15]

The CEDAW Committee, which interprets and monitors state compliance with the Convention on the Elimination of All Forms of Discrimination against Women, has recognised that: "It is discriminatory for a State party to refuse to legally provide for the performance of certain reproductive health services for women. For instance, if health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers."[16] In the context of abortion, it specifically noted that provisions allowing conscientious objection without ensuring alternate means of accessing abortion violate women's reproductive rights and that measures should be introduced to guarantee the referral to alternative health care providers.[17] This Committee has expressed concern to countries over the lack of access to abortion services due to the practice of conscientious objection by hospital personnel[18] and has also recommended that states parties ensure access to abortion in public health services.[19]

The Human Rights Committee, which interprets and monitors state compliance with the International Covenant on Civil and Political Rights (ICCPR),

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ESCR Committee, *Poland* (2009)] (calling on the state to take all effective measures to ensure that women enjoy their right to sexual and reproductive health, including by "enforcing the legislation on abortion and implementing a mechanism of timely and systematic referral in the event of conscientious objection"); *see also* EU Network of Independent Experts, *supra* note 11, at 20.

[14] *See, e.g.*, Committee on the Elimination of Discrimination against Women, *Concluding Observations: Croatia*, para. 109, U.N. Doc. A/53/38 (1998) [hereinafter CEDAW Committee, *Croatia* (1998)]; *Concluding Observations: Italy*, para. 353, U.N. Doc. A/52/38 Rev.1 (1997) [hereinafter CEDAW Committee, *Italy* (1997)]; *Concluding Observations: Poland*, para. 25, U.N. Doc. CEDAW/C/POL/CO/6 (2007) [hereinafter CEDAW Committee, *Poland* (2007)]; Human Rights Committee, *Concluding Observations: Poland*, para. 8, U.N. Doc. CCPR/CO/82/POL (2004) [hereinafter HRC, *Poland* (2004)]; ESCR Committee, *Poland* (2009), *supra* note 13, para. 28.

[15] *See, e.g.*, Committee on the Elimination of Discrimination against Women, *Concluding Observations: Slovakia*, paras. 42-43, U.N. Doc. A/63/38 (2008) [hereinafter CEDAW Committee, *Slovakia* (2008)]; HRC, *Poland* (2004), *supra* note 13, para. 8.

[16] Committee on the Elimination of Discrimination against Women, *General Recommendation No. 24: Article 12 (women and health)*, (20th Sess., 1999), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies (Vol. II), at 358, para. 11, U.N. Doc. A HRI/GEN/1/Rev.9 (2008).

[17] *See, e.g.*, CEDAW Committee, *Slovakia* (2008), *supra* note 15, para. 43.

[18] *See, e.g.*, CEDAW Committee, *Croatia* (1998), *supra* note 14, para. 109; *Italy* (1997), *supra* note 14, para. 353; *Poland* (2007), *supra* note 14, para. 25.

[19] *See, e.g.*, Committee on the Elimination of Discrimination against Women, *Concluding Observations: Colombia*, para. 23, U.N. Doc. CEDAW/C/COL/CO/6 (2007); *Croatia* (1998), *supra* note 14, para. 117; *Italy* (1997), *supra* note 14, para. 360.

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established that states parties have an obligation, under the right to life, to ensure women's access to abortion, by removing barriers to the procedure, and has raised concerns over the practice of conscientious objection and the obstacles it poses to women's access to lawful abortion.[20]

In its General Comment 14, the Committee on Economic, Social and Cultural Rights (ESCR Committee) established that the right to the highest attainable standard of health entails "not only to timely and appropriate health care but also to the underlying determinants of health, such as... access to health-related education and information, including on sexual and reproductive health."[21] The Committee stressed that States should "refrain from... censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information."[22] This Committee has expressed concern at the refusal of physicians and clinics to perform legal abortions on the basis of conscientious objection and has recommended States to "take all effective measures to ensure that women enjoy their right to sexual and reproductive health, including by enforcing the legislation on abortion and implementing a mechanism of timely and systematic referral in the event of conscientious objection."[23]

Concern over the lack of availability of reproductive health care services due to laws and practices concerning conscientious objection in Europe has been specifically raised by UN TMBs when reviewing European countries compliance with their treaty obligations, such as Croatia,[24] Italy,[25] Poland[26] and Slovakia.[27] These bodies have called on state parties to adequately regulate the practice and ensure that effective referral mechanisms are in place.

In 2010, the Human Rights Committee in monitoring Poland's compliance with the ICCPR, raised concerns 'that, in practice, many women are denied access to reproductive health services, including contraception counselling, prenatal testing and lawful interruption of pregnancy'... and recommended that Poland to be in compliance with its obligations to respect, protect and fulfil its obligations under the right to life '... introduce regulations to prohibit the improper use and performance of the "conscience clause" by the medical profession.'[28] Similarly, the ESCR Committee expressed concern over the high

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[20] *See* HRC, *Poland* (2010), *supra* note 13, para. 12; *Poland* (2004), *supra* note 13, para. 8 (in both sets of concluding observations, the Committee references ICCPR article 6, on the right to life, in the context of expressing concern that women in Poland are denied access to legal abortions in part due to inappropriate application of Poland's conscientious objection clause).

[21] *See* Committee on Economic, Social and Cultural Rights, *General Comment 14: The Right to the Highest Attainable Standard of Health (Art. 12)*, para. 11, U.N. Doc. E/C.12/2000/4 (2000).

[22] *Ibid.*, para. 34.

[23] ESCR Committee, *Poland* (2009), *supra* note 13, para. 28.

[24] CEDAW Committee, *Croatia* (1998), *supra* note 14, para. 109.

[25] CEDAW Committee, *Italy* (1997), *supra* note 14, para. 353.

[26] HRC, *Poland* (2010), *supra* note 13, para. 12; *Poland* (2004), *supra* note 13, para. 8; ESCR Committee, *Poland* (2009), *supra* note 13, para. 28.

[27] CEDAW Committee, *Slovakia* (2008), *supra* note 15, para. 43.

[28] HRC, *Poland* (2010), *supra* note 13, para. 12.

number of clandestine abortions in Poland and the fact that women often resort to these procedures "because of refusal of physicians and clinics to perform the legal operations on the basis of conscientious objection."[29] It recommended Poland to "take all effective measures to ensure that women enjoy their right to sexual and reproductive health, including by enforcing the legislation on abortion and implementing a mechanism of timely and systematic referral in cases of conscientious objection."[30]

In 2008, the CEDAW Committee in its Concluding Observations to Slovakia noted that it "... is deeply concerned about the insufficient regulation of the exercise of conscientious objection by health professionals with regard to sexual and reproductive health"[31] and recommended that Slovakia "... adequately regulate the invocation of conscientious objection by health professionals so as to ensure that women's access to health and reproductive health is not limited."[32] The Committee recalled its "general recommendation No. 24, which states that it is discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women" and recommended "... that, if health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers."[33]

The UN Special Rapporteur on the Right to the Highest Attainable Standard of Health, issued a groundbreaking report in 2011 on the devastating impact the criminalization of abortion has on women's health and lives and specifically articulated state obligations to remove barriers, including laws and practices on conscientious objection which interfere with individual decision-making on abortion.[34] The report notes that such laws and their use create barriers to access by permitting health care providers and ancillary personnel, such as receptionists and pharmacists, to refuse to provide abortion services, information about procedures, and referrals to alternative facilities and providers. He noted that these and other laws make safe

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[29] ESCR Committee, *Poland* (2009), *supra* note 13, para. 28.

[30] *Ibid.*; see also Anand Grover, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health: Mission to Poland, para. 53*, U.N. Doc. A/HRC/14/20/Add.3 (2010), *para. 50* [hereinafter Special Rapporteur on the right to health — Poland 2010] ("Health systems should have procedures, such as administrative procedures to provide immediate alternatives to healthcare users when conscientious objection would otherwise lead to a denial of services, and effective remedies, in place to ensure that in practice, legitimate conscientious objection does not obstruct the enjoyment by women and men of their sexual and reproductive health rights. States should also monitor the exercise of conscientious objection with a view to ensuring that all services are available and accessible in practice. In short, health service providers who conscientiously object to a procedure have the responsibility to treat an individual whose life or health is immediately affected, and otherwise to refer the patient to another provider who will perform the required procedure.").

[31] CEDAW Committee, *Slovakia* (2008), *supra* note 15, para. 42.

[32] *Ibid.* para. 43.

[33] *Ibid.*

[34] Anand Grover, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Interim report*, A/66/254 (2011) [hereinafter Special Rapporteur on the right to health — Criminalisation of abortion 2011].

abortions unavailable, especially to poor, displaced and young women and noted that such restrictive regimes serve to reinforce the stigma that abortion is an objectionable practice. He recommended that states, in order to fulfil their obligations under the right to health should "[E]nsure that conscientious objection exemptions are well-defined in scope and well-regulated in use and that referrals and alternative services are available in cases where the objection is raised by a service provider."[35]

## 3. European Regional Human Rights Standards

The Council of Europe and other European regional bodies have issued numerous reports, recommendations and resolutions on the practice of conscientious objection in the military.[36] They have stressed the need for member states to enact legislation to regulate the right to conscientious objection[37] and that there should be a procedure for the examination of applications for conscientious objector status.[38] However, few such standards exist on the regulation of the practice of conscientious objection in health care settings. Below is a review of the few existing standards from Council of Europe and European Union bodies.

### 3.1. *The European Union*

#### *The European Union Network of Experts Opinion on the Right to Conscientious Objection*[39]

The European Union Network of Experts on Fundamental Rights has addressed the concern over the law and practice of conscientious objection in relation to access to various health services, including abortion. In 2005, it issued an opinion

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[35] *Ibid.*

[36] *See, e.g., Resolution 337 on the right of conscientious objection*, EUR. PARL. ASSEMB. (1967); *see also Recommendation 816 on the right of conscientious objection to military service*, EUR. PARL. ASSEMB. (1977) [hereinafter *Eur. Parl. Assemb., Recommendation 816*]; *Recommendation 1518 on exercise of the right of conscientious objection to military service in Council of Europe member states*, Eur. Parl. Assemb. (2001); *Resolution on conscientious objection and alternative civilian service*, Eur. Parl. Doc. A3-15/89 (1989); COUNCIL OF EUR., *Recommendation No. R(87)8 of the Committee of Ministers to member states regarding conscientious objection to compulsory military service* (1987) [hereinafter *Council of Eur., Recommendation No. R(87)8*]; *Directorate General of Hum. Rts., Council of Eur., Conscientious objection to compulsory military service* (2002), available at http://www.coe.int/t/e/human_rights/cddh/2._activities/Conscientious Objection_en.pdf.

[37] *See, e.g., Recommendation 478 (1967) on the right of conscientious objection*, EUR. PARL. ASSEMB. (1967); *see also Eur. Parl. Assemb., Recommendation 816, supra* note 36.

[38] *See, e.g., Council of Eur., Recommendation No. R(87)8, supra* note 36, sec. B, paras. 2-8.

[39] The E.U. Network of Independent Experts on Fundamental Rights was set up by the European Commission upon the request of the European Parliament. It monitors the situation of fundamental rights in the Member States and in the Union, on the basis of the Charter of Fundamental Rights. It issued reports on the situation of fundamental rights in the Member States and in the Union, as well as opinions on specific issues related to the protection of fundamental rights in the Union. In 2007, the Network's mandate was merged with the newly formed European Union Fundamental Rights Agency.

on the conformity of a draft treaty on conscientious objection between the Holy See and Slovakia with the European Union Charter on Fundamental Rights, which guarantees both the right to respect for private life (Article 7) and freedom of thought, conscience and religion (Article 10). The draft treaty essentially allowed for the unlimited exercise of conscientious objection in a wide range of areas, including health care, education and legal services. If accepted, it would have been one of the broadest and most encompassing treaties between the Holy See and a state on conscientious objection. The Network recognised that while conscientious objection can be considered a part of the freedom of thought, conscience and religion, when it conflicts with other rights and freedoms, it is necessary to restrict its exercise by means of creating adequate balance between conflicting rights and freedoms.[40] The opinion notes that "this right [to conscientious objection] should be regulated in order to ensure that, in circumstances where abortion is legal, no woman shall be deprived from having effective access to the medical service of abortion."[41] In addition, they noted that denying a woman the effective possibility to terminate the pregnancy in circumstances where abortion is lawful may "amount to the infliction of an inhuman and degrading treatment..."[42]

### 3.1.1. *The European Parliament*

In 2002, the European Parliament passed a resolution recognizing the disparities in Europe in the area of sexual and reproductive health and rights, including access to contraception, unwanted pregnancies and abortion, as well as adolescent sexual and reproductive health, including sexuality education.[43] The resolution identified barriers to exercising sexual and reproductive rights, including the practice of conscientious objection, and made recommendations to Member States and Accession Countries of the European Union on how to address the situation. It recommended, for example that states develop a national policy on sexual and reproductive health, in cooperation with civil society organizations, which ensures the provision of comprehensive information concerning effective and responsible methods of family planning as well as equal access to a range of high quality contraceptive methods.[44] It further recommended states to ensure the provision of unbiased, scientific and clearly understandable information and counselling on sexual and reproductive health, including the prevention of unwanted pregnancies and the risks involved in unsafe abortions carried out under unsuitable conditions.[45] Finally, it reinforced the importance of safeguarding

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40) EU Network of Independent Experts, *supra* note 11, at 16.
41) *Ibid.* at 20.
42) *Ibid.* at 19. This opinion played a role in the treaty not being adopted by the government.
43) *Resolution on sexual and reproductive health and rights, Eur. Parl. Assemb.* 2001/2128(INI) (2002).
44) *Ibid.*, para. 2.
45) *Ibid.*, para. 10.

women's reproductive health and rights by making abortion legal, safe and accessible to all[46] and that in case of legitimate conscientious objection of the provider, referral to other service providers that can perform the service should be required.[47]

### 3.2. *The Council of Europe*

#### 3.2.1. *European Convention on Human Rights*

The European Court of Human Rights has addressed the issue of conscientious objection in health related settings in only two cases. First, in an Article 9 admissibility decision concerning pharmacists refusal to fill prescriptions for contraceptives[48] and most recently in *RR v. Poland* (2011), a case concerning denial of a prenatal genetic examination due, in part, to the practice of conscientious objection.[49] The latter being the first time ever an international or regional human rights tribunal has articulated that states have a *positive* obligation to regulate the practice of conscientious objection in a reproductive health care setting.

In *R.R v. Poland*, the Court noted that R.R.'s access to genetic testing "was marred by procrastination, confusion and lack of proper counselling and information given to [her]" . . . and that ultimately she obtained admission to a hospital where the genetic tests were conducted "by means of subterfuge." The Court found that this 'shabby treatment' and the 'acute anguish' it caused her violated her right to be free from inhumane and degrading treatment (article 3).[50] This is the first time the Court ever found a violation of Article 3 in a reproductive rights case. The Court also made clear that access to diagnostic services was decisive for the "possibility of exercising her right to take an informed decision as to whether to seek an abortion or not."[51] The Court noted the crucial importance of timely access to information on one's health condition by stating that, "in the context of pregnancy, the effective access to relevant information on the mother's and foetus' health, where legislation allows for abortion in certain situations, is directly relevant for the exercise of personal autonomy."[52] It noted that effective implementation of abortion laws is important for ensuring a right to lawful abortion and found Poland's failure to do so also a violation of Poland's positive obligations to respect private life (Article 8).[53]

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46) *Ibid.*, para. 12.
47) *Ibid.*, para. 11.
48) *Pichon and Sajous v. France*, 2001-X Eur. Ct. H.R.
49) Judgement, *R.R. v. Poland*, App. No. 27617/04, Eur. Ct. H.R. (26 May 2011).
50) *Ibid.*, paras. 15 and 159-162.
51) *Ibid.*, para. 208.
52) *Ibid.*, para. 197.
53) *Ibid.*, paras. 213-214. The Court also found a violation of Article 3, the right to be free from inhumane and degrading treatment.

The Court added that freedom of conscience does not protect "each and every act or form of behaviour motivated or inspired by a religion or a belief,"[54] and made clear that states have an obligation "to organise the health services system in such a way as to ensure that an effective exercise of the freedom of conscience of health professionals in the professional context does not prevent patients from obtaining access to services to which they are entitled under the applicable legislation."[55]

In 2001, The European Court of Human Rights while considering the admissibility of a complaint regarding a French court's decision that ethical or religious principles are not legitimate grounds to refuse to sell a contraceptive by pharmacists, recognised the limitations of conscientious objection when a person is completely reliant on a certain profession to obtain legally authorised health care services.[56] The Court noted that "as long as the sale of contraceptives is legal and occurs on medical prescription nowhere other than in a pharmacy, the applicants cannot give precedence to their religious beliefs and impose them on others as justification for their refusal to sell such products, since they can manifest those beliefs in many ways outside the professional sphere."[57] The Court explained that Article 9 of the European Convention on Human Rights, which guarantees the right to freedom of thought, conscience and religion, protects acts closely linked to personal convictions and religious beliefs, such as acts of worship, teaching, practice, and observance. However, it noted that Article 9 does not always guarantee the right to behave in public in a manner governed by that belief. The Court said that Article 9(1) does not protect "each and every act or form of behaviour motivated or inspired by a religion or a belief."[58]

In another admissibility decision unrelated to access to health care, but useful nonetheless given the growing practice of public health care *institutions* not providing certain lawful health care services on grounds of conscience, the European Commission of Human Rights noted that the right to freedom of conscience is by its very nature an individual right and therefore it cannot be exercised by an institution.[59] In finding so, the Commission made a distinction between exercise of religious freedom and exercise of conscience, the former being applicable to institutions, such as churches, the latter solely an individual right.[60]

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[54] *Ibid.*, para. 206.
[55] *Ibid.*
[56] *Pichon and Sajous v. France, supra* note 48.
[57] *Ibid.*, at 4.
[58] *Ibid.* For a detailed analysis of the *Pichon and Sajous* decision, see Adriana Lamačková, 'Conscientious Objection in Reproductive Health Care: Analysis of *Pichon and Sajous v. France*', *European Journal of Health Law 15* (2008) 7-43.
[59] *Kontakt-information-Therapie and Hagen v. Austria*, 57 Eur. Ct. H.R. 81 (1988) ("Moreover, the rights primarily invoked, i.e. the right to freedom of conscience under Article 9 (Art. 9) of the Convention and the right not to be subjected to degrading treatment or punishment (Article 3) (Art. 3), are by their very nature not susceptible of being exercised by a legal person such as a private association").
[60] *Ibid.*

3.2.2. *Commissioner for Human Rights*

In 2007, the Council of Europe Commissioner for Human Rights recognised the concerns raised by Polish civil society that "Doctors often refuse to issue a certificate required for termination of pregnancy (relying on the 'conscience clause'). Even when they do issue a certificate, the doctor who performs the termination can question the certificate's validity and refuse the service."[61] In his report to the Polish government he stressed "that access to legal abortion... in Poland is frequently hindered" and urged the "government to ensure that women falling within the categories foreseen by the law are allowed, in practice, to terminate their pregnancy without additional hindrance or reproach."[62]

3.2.3. *Parliamentary Assembly of the Council of Europe (PACE)*[63]

PACE has recently passed two resolutions that address the practice of conscientious objection in Council of Europe Member States. The first resolution passed in 2008 concerns women's right to abortion. Entitled *Access to Safe and Legal Abortion in Europe*,[64] this resolution calls upon member states to decriminalise abortion, guarantee women's effective exercise of their right to safe and legal abortion, remove restrictions that hinder *de jure* and *de facto* access to abortion, and adopt evidence-based sexual and reproductive health strategies and policies, such as access to contraception at a reasonable cost and of suitable nature, and compulsory age appropriate and gender-sensitive sex and relationship education for young people. The adoption of this resolution is particularly significant as it recognises that in many member states there are conditions which hinder effective access to legal abortion, including, "the lack of doctors willing to carry out abortions... [which has] the potential to make access to safe affordable, acceptable and appropriate abortion services more difficult, or even impossible in practice."[65] PACE affirmed the right of all women to respect for their physical integrity and to freedom to control their own bodies and in this context recognised that the "... ultimate decision on whether or not to have an abortion should be a matter for the woman concerned, who should have the means of exercising this right in an effective way."[66] In addition, PACE recognises the need to prevent unwanted

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61) Council of Europe, Commissioner for Human Rights, *Memorandum to the Polish Government: Assessment of the Progress Made in Implementing the 2002 Recommendations of the Council of Europe Commissioner for Human Rights*, para. 95, CommDH(2007)13 (2007).

62) *Ibid.*, para. 98.

63) The parliamentary body of the Council of Europe is made up of parliamentarians who come from the national parliaments of the organization's 47 member states. They meet four times a year to discuss topical issues relating to democacy, human rights and the rule of law and ask European governments to undertake initiatives and report back on their progress.

64) *Resolution 1607 (2008) Access to safe and legal abortion in Europe*, Eur. Parl. Assemb. (2008).

65) *Ibid.*, para. 3.

66) *Ibid.*, para. 6.

pregnancies[67] and to address barriers that affect women's access to contraceptives,[68] which would include pharmacists refusing to fill prescriptions for contraceptives on grounds of conscience. While not legally binding, this resolution is the most progressive pronouncement on the right to abortion by any international or regional human rights system and was PACE's first recognition of the growing unregulated practice of conscientious objection to reproductive health care services in Europe.

Recognising the need to elaborate on the standards regarding conscientious refusal to provide services and the growing problem in Europe, two years later, a resolution was introduced and overwhelmingly passed by PACE's Committee on Family and Social Affairs. This resolution titled 'Women's Access to Lawful Medical Care: the problem of unregulated use of conscientious objection', set forth comprehensive recommendations to member states on regulating the practice of conscientious objection in health care settings, including reproductive healthcare.[69] The resolution called on member states to recognise that the exercise of conscientious objection belongs to an individual and not to institutions and applies only to those directly involved in the performance of the procedure.[70] It also called on member states to oblige health care providers to: inform patients about all treatment options; inform and refer patients on their refusal; and perform services regardless of conscience in cases of emergency or when referral is not possible.[71] Finally, the resolution called on member states to provide oversight and monitoring mechanisms and effective complaints mechanisms.[72]

However, when the resolution was up for vote in plenary amendments were introduced by anti-abortion parliamentarians that resulted in the original resolution being undercut and undermined the original proposal and diminished the seriousness of the problem.[73] For example, the resolution includes a clause contradicting the decision of the European Court in *Tysiąc v. Poland* that recognised

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[67] *Ibid.*, paras. 1, 7.7.
[68] *Ibid.*, paras. 7.5-7.6.
[69] Draft Resolution, *Women's access to lawful medical care: the problem of unregulated conscientious objection, Eur. Parl. Assemb. Doc.* 12347 (2010).
[70] *Ibid.*, para. 4.1.1.
[71] *Ibid.*, para. 4.1.2.
[72] *Ibid.*, para. 4.2.
[73] *Resolution 1763 (2010) The right to conscientious objection in lawful medical care*, EUR. PARL. ASSEMB. (2010), *available at* http://assembly.coe.int/ASP/APFeaturesManager/defaultArtSiteView.asp?ID=950 [hereinafter *Eur. Parl. Assemb., Resolution 1763*]. The amendments were passed by a slight majority (56 to 51 with 4 abstentions. For example, the resolution now recognises that providers and health care institutions can refuse to provide women care in emergency situations, which violates basic medical ethics, World Health Organization standards, human rights standards and laws in many member states. Moreover, the amendments contradict universally recognised fundamental human rights and rule of law principles by removing from liability any person or institution for their conduct, even if the exercise of conscientious objection was unlawful and led to serious harm. This contradicts basic concepts of lawfulness and the rule of law in a democratic society that require that persons who have been harmed have a right to have access to review procedures before an independent body. *See, e.g., Rotaru v. Romania*,

that a state has a positive obligation to *prevent* harm that could arise from a dispute between a patient and her doctor when a doctor refuses to perform an abortion. It noted that "[O]nce the legislature decides to allow abortion, it must not structure its legal framework in a way which would limit real possibilities to obtain it" and found Poland in violation of Article 8 of the ECHR which protects the right to private life, for failing to have in place a mechanism to resolve disputes between a patient and her doctor.[74]

Nevertheless, the operative paragraph of the non-binding resolution asks member states to develop comprehensive and clear regulations to ensure patients' appropriate treatment, particularly in cases of emergency.[75] This operative paragraph is in line with UN standards, its own earlier resolution, and supported by growing evidence in this field as reflected in the resolution's own explanatory memorandum.[76]

## 4. Non-binding International Medical and Ethical Standards

International medical and ethical regulations have also recognised that conscientious objection should be regulated and that health care providers have a primary duty to treat their patients and prevent any harm. Standards issued by international medical bodies stress the importance of timely referrals especially with respect to reproductive healthcare services, ensuring availability of providers willing to perform abortions and prohibiting the exercise of conscientious objection in emergency situations.

The World Health Organization (WHO) has recognised the problem of lack of access to abortion services even where women are legally entitled to have the procedure, and the resulting increased risk of unsafe abortion.[77] In its safe abortion guidelines for national health systems, the WHO recommends that govern-

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2000-V Eur. Ct. H.R. paras. 55-63; *see also AGOSI v. United Kingdom*, 180 Eur. Ct. H.R. (ser. A) para. 55 (1986); *Jokela v. Finland*, 2002-IV Eur. Ct. H.R. para. 45.

74) Judgment, *Tysiąc v. Poland, supra* note 6, para. 116.

75) *Eur. Parl. Assemb., Resolution 1763, supra* note 73, para. 4.

76) Eur. Parl. Assemb., *Explanatory memorandum — Unregulated use of conscientious objection, supra* note 5, para. 15 ("... many [European] countries facing problems in the area of conscientious objection in healthcare settings lack a comprehensive and effective legal and policy framework, as well as oversight mechanisms to govern the practice of conscientious objection by healthcare providers").

77) *World Health Organization, Safe Abortion: Technical and Policy Guidance for Health Systems* 82 (2003). The problem of access helps explain the fact that unsafe abortion is a leading cause of maternal mortality and morbidity worldwide, despite the fact that abortion is legal for at least some reasons in most countries. Lack of access to safe abortion services is due to a range of health systems problems and broader policy and social factors, including lack of trained providers or their concentration in urban areas; negative provider attitudes; use of inappropriate or outdated methods of inducing abortion; lack of knowledge of the law and women's rights under the law by providers and the public, or lack of application of the law by providers; stigmatization and fears about privacy and confidentiality; and the perceived quality of care provided. *Ibid.*, at 14-15.

ments establish policies that ensure access to quality abortion services where abortion is legal.[78] The guidelines urge ministries of health to clarify legal requirements for abortion and remove common barriers that constrain access to services allowed by law.[79] In the context of the exercise of conscientious objection, WHO notes that providers have 'an ethical obligation to follow professional ethical codes, which usually require health professionals to refer women to skilled colleagues who are not, in principle, opposed to termination of pregnancy allowed by law.'[80] According to general WHO guidelines, a well-functioning referral system is critical to the provision of safe abortion services and all health personnel should be able to direct women to appropriate services if they are unavailable on site.[81] The guidelines further establish that '[t]raining and equipping health professionals at the primary level to provide early abortion services and to make appropriate referrals may thus be one of the most important investments to consider.'[82] In addition, the WHO has stated that regardless of the personal perspectives of health care personnel, the managers should ensure the availability of trained health care providers to provide care for abortion complications.[83]

The International Federation of Gynecology and Obstetrics (FIGO) has affirmed that: "The primary conscientious duty of obstetrician-gynaecologists [...] is at all times to treat, or provide benefit and prevent harm to, the patients for whose care they are responsible. Any conscientious objection to treating a patient is secondary to this primary duty."[84] In its Code of Ethics, FIGO stated that while health care providers have the right to preserve their moral or religious values, this should not result in the imposition of such values on others.[85] The World Medical Association has also echoed this position stating that while health

[78] *Ibid.*, at 82. The guidelines recognise that health professionals themselves have ethical and legal obligations to respect women's rights, and appeal to such individuals to "understand and apply their national law related to abortion, and contribute to the development of regulations, policies and protocols to ensure access to quality services to the extent permitted by law and respecting women's rights to humane and confidential treatment." *Ibid.*, at 15.

[79] *Ibid.*, at 90.

[80] *Ibid.*, at 66.

[81] *Ibid.*, at 64.

[82] *Ibid.*, at 59.

[83] *World Health Organization, Complications of Abortion: Technical and Managerial Guidelines for Prevention and Treatment* 95 (1995), *available at* http://whqlibdoc.who.int/publications/1995/9241544694.pdf.

[84] *Ethical Guidelines on Conscientious Objection*, in *International Federation of Gynecology and Obstetrics (FIGO), Comm. for the Study of the Ethical Aspects of Human Reproduction and Women's Health, Ethical Issues in Obstetrics and Gynecology* 25, 26 (2009). (The International Federation of Gynecology and Obstetrics (FIGO) is the only worldwide organisation that groups obstetricians and gynecologists. It has member associations in 124 countries/territories. Its Secretariat is based in London, the UK. FIGO's mission is to promote the wellbeing of women and to raise the standards of practice in obstetrics and gynecology.)

[85] International Federation of Gynecology and Obstetrics (FIGO), *Code of Ethics: Professional and Ethical Responsibilities Concerning Sexual and Reproductive Rights*, at A(5), adopted Nov. 2003, available at http://www.figo.org/Codeofethics (last visited 19 Dec. 2011).

care providers should act on their conscience, they must always act in the best interest of the patient to guarantee her/his "autonomy and justice".[86] Hence, FIGO's resolution on conscientious objection establishes that in emergency situations health care providers should "provide care regardless of practitioners' personal objections."[87]

## 5. The Law and Practice in Europe

There is a growing body of domestic standards that lay out state obligations and duties of health care providers that should guide the legal and policy frameworks on conscientious objection to sexual and reproductive health services and related ethical and legal standards and practice in European countries. These standards are rooted in international and regional human rights standards (see above) and have been articulated and defined in European domestic legislation and jurisprudence. They are guided by the principle that states and public institutions have a positive obligation to ensure that women are able to access sexual and reproductive health care services provided for by law.[88] These standards, set forth below, are followed by examples of European law, including jurisprudence, governing the issue.

### 5.1. *General State Obligations: Establish Adequate and Effective Legal and Policy Frameworks to Ensure that Conscientious Objection Clauses Do not Prevent Women from Accessing the Services They Are Legally Entitled to Receive*

#### 5.1.1. *Ensure Adequate Availability of Healthcare Providers for Sexual and Reproductive Health Services*

The availability of providers for sexual and reproductive health services, especially abortion, is specifically impacted by the practice of conscientious objection. While many countries in Europe exempt health care providers from performing procedures to which they conscientiously object, including abortion, only a few have regulated the practice by requiring notification of their objecting status to authorities and organizing the health care system and job recruitment to ensure that there are doctors willing, trained and able to provide services. As illustrated

[86] World Medical Association, *Declaration on the Rights of the Patient, adopted* Oct. 1981, *available at* http://www.wma.net/en/30publications/10policies/l4/index.html (last visited 26 Feb. 2011).

[87] International Federation of Gynecology and Obstetrics (FIGO), *Resolution on "Conscientious Objection"*, adopted Nov. 2006, available at http://www.figo.org/projects/conscientious (last visited 26 Feb. 2011) [hereinafter FIGO, *Resolution on Conscientious Objection*].

[88] *See* Rebecca J. Cook and Bernard M. Dickens, *World Health Organization, Considerations for Formulating Reproductive Health Laws* 34 (Doc. WHO/RHR/00.1, 2nd ed. 2000), *available at* http://whqlibdoc.who.int/hq/2000/WHO_RHR_00.1.pdf; *see also* Rebecca J. Cook, Monica Arango Olaya and Bernard M. Dickens, 'Healthcare responsibilities and conscientious objection,' 104 *Int'l J. Gyn. & Obst.* 249-252 (2009); Bueno de Mesquita and Finer, *supra* note 2.

in the case of Italy, below, the rising number of objectors is a worrisome trend that will test health systems approach to balancing interests of the provider with the rights of women.

Norway is one of the few countries in Europe with a comprehensive regulatory and oversight framework on conscientious objection to abortion that includes ensuring the availability of providers willing and able to perform abortions. Norway's abortion law guarantees that a woman can obtain an abortion at anytime by requiring that medical services are organised to take into account health personnel who conscientiously object to abortion.[89] Regulations on conscientious objection require healthcare providers to give written notice to their employer hospital if they refuse to assist with an abortion and those hospitals, in turn, to report to government authorities.[90] If requested, persons applying for hospital employment must give notice of their conscientious objection to performing or assisting in abortion procedures.[91] Furthermore, in employment advertisements, hospitals may require as a condition for employment that hired health-care personnel be willing to perform or assist in abortion procedures.[92] As the regulations state, these provisions are in place to ensure the availability of an adequate number of providers so that women are able to exercise their right to abortion.[93]

In Germany, a 1990 decision by the Bavarian High Administrative Court,[94] which was upheld by the Federal Administrative Court of Germany,[95] ruled that a municipality's job advertisement for a chief physician in a women's hospital, which included a requirement that the physician be willing to perform abortions, was not in violation of a law providing that no one is obligated to perform abortions. The court referred the need to provide abortions in public hospitals and took into consideration that private hospitals may not be willing to provide abortions due to religious or moral reasons. It emphasized that public hospitals must enable women to realize their entitlement to abortion under the law and, thus, the criteria for the job was deemed permissible.[96]

[89] The Act dated 13 June 1995 no. 50 concerning Termination of Pregnancy, with Amendments in the Act dated 16 June 1978 no. 5, at 14 (Nor.).

[90] Regulations for the Implementation of the Act dated 13 June 1995 no. 50 concerning Termination of Pregnancy, with Amendments in the Act dated 16 June 1978, no. 66, § 20 (Nor.) [hereinafter Norway Regulations for Implementation of Abortion Act]. Slovenia's Health Services Act contains similar provisions, which require healthcare workers to report their conscientious objection to their employer institution, and the institution to ensure that patients' rights to health care are accessible "without disruption." Health Services Act [*Zakon o zdravstveni dejavnosti*], Art. 56, Official Gazette of the Rep. of Slovenia [*Uradni list Republike Slovenije*], No. 9, enacted 1992.

[91] Norway Regulations for Implementation of Abortion Act, *supra* note 90, at 20.

[92] *Ibid.*

[93] *Ibid.*

[94] *Judgment of the Bavarian Higher Administrative Court of 03/07/1990*, BayVGH DVB1. 1990, 880-82 (F.R.G.).

[95] *Judgment of the Federal Administrative Court of 12/13/1991*, BVerwGE 89, 260-70 (F.R.G.).

[96] *Judgment of the Bavarian Higher Administrative Court, supra* note 105, at 880-82.

Guidelines on the appointment of doctors to hospital posts issued by the United Kingdom National Health Service recommend that termination of pregnancy duties should be a feature of the job when adequate services for termination of pregnancy "would not otherwise be available," the job description should be explicit about termination of pregnancy duties, and applicants should be "prepared to carry out the full range of duties which they might be required to perform if appointed," including duties related to termination of pregnancy.[97] The British Medical Association (BMA) has recommended that conscientious objectors' position be disclosed to supervisors, managers or partners at as early a stage in employment as possible to ensure the availability of an adequate number of providers to perform abortions.[98]

Italy's abortion law requires healthcare institutions to ensure that women have access to abortion.[99] Specifically, regional health care bodies are required to supervise and ensure such access, which may include transfer of health care personnel.[100] In accordance with this requirement, the law mandates health care personnel to submit a written declaration of their conscientious objection to abortion to the medical director of their employer healthcare institution and to the regional medical officer.[101] However, a recent report by Italy's Ministry of Health indicates potential problems in implementation of the law due to growing numbers of conscientious objectors. The report shows that nearly 70 percent of gynaecologists in Italy refuse to perform abortions on moral grounds.[102] It noted that between 2003 and 2007 the number of gynaecologists invoking conscientious objection in their refusal to perform an abortion rose from 58.7 percent to 69.2 percent,[103] and that the percentage of anaesthesiologists who refused to help in an abortion rose from 45.7 percent to 50.4 percent.[104] In the southern parts of the country, the numbers are higher.[105]

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97) National Health Service Guidelines, Appointment of doctors to hospital posts: termination of pregnancy, NHS Executive HSG (94)39 (1994) (U.K.).
98) British Medical Association, 'Contraception, abortion, and birth', in *Medical Ethics Today: The BMA's Handbook of Ethics and Law* 248-50 (2d ed., 2004) [hereinafter *BMA's Handbook of Ethics and Law*].
99) Law No. 194 of 22 May 1978 on the social protection of motherhood and the voluntary termination of pregnancy, Gazz. Uff., Part I, 22 May 1978, No. 140, 3642-46 (Italy) [hereinafter *Italy Voluntary Termination of Pregnancy Act*].
100) *Ibid.*, § 9.
101) *Ibid.*
102) *Republic of Italy, Ministry of Health, Report of the Ministry of Health on the Performance of the Law Containing Rules for the Social Care of Maternity and Voluntary Interruption of Pregnancy:* 2006-2007 4 (2008).
103) *Ibid.*
104) *Ibid.*
105) *Ibid.*

5.1.2. *Regulate the Unlawful Practice of Institutional Conscientious Objection*
The refusal of public health care *institutions* to provide certain services on grounds of conscientious objection is a growing problem in some countries in Europe. As discussed above, it's an individual that can hold a conscience, not an institution. Health care facilities, as state entities, have a duty to ensure that legal health services are available and accessible to the public. However, laws in Europe generally do not explicitly prohibit this practice and there is little, if any, oversight and monitoring. Women in these countries are often turned away and denied the health care services they need because of a decision by management not to perform abortions. In addition, travel to another health facility that does perform abortions may be burdensome, especially to low income. In addition, women may be unable to access services outside the geographical range of their insurance plans.

For example, in Slovakia and Poland, conscientious objection is sometimes abused by top management of hospitals, who have an unwritten policy banning performance of some lawful interventions (usually abortions) throughout the hospital, regardless of the opinion of the healthcare staff.[106] In Slovakia's capital, Bratislava, it has been reported that one of the public hospitals does not perform abortions and in the regional capital of Trnava, no hospitals perform abortions[107] and the state has not taken any steps to address this growing problem. In a case against Poland pending before the European Court of Human Rights, a woman with a wanted pregnancy was denied health services in numerous hospitals in part on grounds of conscience. Unable to get the diagnostic and medical treatment she needed, she developed sepsis, which led to a miscarriage and then to her death.[108]

A 2001 decision of the French Constitutional Court recognised the principle that conscientious objection is a right afforded to individuals, not institutions, and upheld the repeal of paragraphs in the Code of Public Health, removing the possibility that department heads of public health establishments could refuse to allow the provision of abortion services in their departments.[109] The case was brought by senators who claimed, in part, that the repeal of these provisions violated the principle of freedom of conscience protected by the Constitution.[110] While the Constitutional Council recognised the fundamental nature of the freedom of conscience, it also clarified that such freedom was that of *individual*, not

[106] Eur. Parl. Assemb., *Explanatory Memorandum — Unregulated use of conscientious objection*, *supra* note 5, para. 47.
[107] Information provided by the Slovak Family Planning Association, 2010.
[108] *Z. v. Poland*, App. No. 46123/08, Eur. Ct. H.R. (filed 16 Sept. 2008) (on file with the Center for Reproductive Rights and the Federation for Women and Family Planning in Poland).
[109] *CC decision no. 2001-446DC*, June 27, 2001, Rec. 74, paras. 11-17 (Fr.), available at http://www.conseilconstitutionnel. fr/conseil-constitutionnel/root/bank_mm/anglais/a2001446dc.pdf.
[110] *Ibid.*, para. 12.

institutional or departmental, conscience "...which cannot be exerted at the expense of that of other doctors and medical staff working in his service."[111] The Council also provided that "... these provisions [of the Health Code] contribute in addition to respect for the constitutional principle of the equality of users before the law and before the public service."[112]

5.1.3. *Ensure that Conscientious Objection Is only Exercised in Direct Performance of Treatment Services*

Many legal frameworks are unclear about who can conscientiously object and for what services. Some conscientious objection clauses in Europe, however, state either explicitly that they apply only to healthcare personnel involved in the *actual performance* of procedures or have been interpreted as such. For example, Norway's regulation implementing the abortion law expressly provides that the right to refuse to assist in an abortion belongs only to personnel who perform or assist the actual procedure, not to staff providing services, care or treatment to the woman before or after the procedure.[113] Italy's abortion law does not exempt health-care personnel from providing pre and post-abortion care.[114]

The scope of the conscientious objection clause in the United Kingdom's abortion law was articulated by House of Lords decision in 1988, which made clear that the clause applies only to participation in treatment.[115] The case involved a doctor's secretary who objected to signing an abortion referral letter on grounds of conscience. The House of Lords held that such an act did not constitute part of the treatment for abortion and, thus, was not covered by the conscience clause of the abortion law.[116] The decision supports the proposition that doctors cannot claim exemption from giving advice or performing the preparatory steps to arrange an abortion if the request for abortion meets legal requirements.

In a recent 2011 decision, a judge in Málaga, Spain, declared that a family doctor from a public medical centre could not object to give referrals to pregnant women seeking terminations.[117] In this decision, which comes soon after the liberalization of the abortion law in Spain, the judge established that as a public employee, his "duty to provide adequate health care prevailed over that of conscience". The decision reaffirms that the conscientious clause in the abortion law, allowing providers to refuse to provide services, applies only to the performance

[111] *Ibid.*, para. 15.
[112] *Ibid.*
[113] Norway Regulations for Implementation of Abortion Act, *supra* note 90, § 20.
[114] Italy Voluntary Termination of Pregnancy Act, *supra* note 99, § 9.
[115] *Janaway v. Salford Health Authority*, 3 All E.R. 1079 (H.L. 1988).
[116] *Ibid.*
[117] *Auto del Juzgado Contencioso-Administrativo No. 3 de Málaga*, Pieza separada medidas provisionales nº 12.1/2011, Pmto. Especial protección derechos fundamentales nº 39/2011. 29 March, 2011.

of a termination of pregnancy and not to the provision of information and referrals to non-objecting providers.[118]

### 5.2. *State Regulation of Duties of Healthcare Providers*

#### 5.2.1. *Duty to Provide Accurate and Non-biased Information about Patients' Health Status and Available Procedures*

Health care providers have the duty to offer accurate and non-biased information about all legally available medical procedures, treatment options and products to the patient, even if they object to providing the services themselves. Failure to do so denies women the ability and the right to make free and informed health care decisions. For example, the European Court of Human Rights recently found Poland in violation of the European Convention, in part, because it did not fulfil its duty to regulated conscientious objection. The case, as referred to above, regarded a woman who was repeatedly denied diagnostic genetic prenatal examinations because doctors argued that the results could lead to a termination of pregnancy, in contravention of their conscience. While the Court's judgment did not provide detailed reasoning, it implied that healthcare providers should not be allowed to invoke conscientious objection with regards to healthcare information, including *diagnostic* care that may or may not lead to an objectionable act.[119]

A 2003 United Kingdom High Court of Justice Queens Bench Division judgment sheds further light on the unlawfulness of such acts. It found a doctor negligent for failing to properly counsel — in part because of his religious beliefs — his patient about her increased risk of giving birth to a baby with Down's syndrome and the availability of prenatal screenings for such abnormalities.[120] The woman was denied a chance to make an informed decision regarding her pregnancy, and gave birth to a child with Down's syndrome. The doctor, a devout Catholic, noted that he did not routinely and explicitly discuss screening for abnormalities with every pregnant woman. He testified that he thought pregnancy was a happy event and would want to "soothe, not alarm patients," but that he expected he would have told someone of the plaintiff's age that she was "at a slightly raised risk" for foetal abnormalities.[121] The court noted that "[o]n his own account Dr. Kwun's approach to the subject [of informing patients about screening for abnormalities] was coloured by his belief in Roman Catholic doctrine."[122] The court ultimately found that if the doctor had used the phrase "slightly raised risk," as the doctor testified, "it would have been seriously misleading," considering that experts

118) *Ibid.*
119) Judgement, *R.R. v. Poland, supra* note 49; *see also* Center for Reproductive Rights, *R.R. v. Poland*, http://reproductiverights.org/en/feature/poland-a-victory-of-firsts.
120) *Enright and Another v. Kwun and Another*, [2003] E.W.H.C. 1000 (Q.B.).
121) *Ibid.*, paras. 29, 55.
122) *Ibid.*, para. 30.

testified that the risk for foetal abnormalities increases significantly at the plaintiff's age.[123] As a result of the doctor's failure to provide such information, the patient could not make an informed choice about whether or not to carry her pregnancy to term, given the risk that her child would have Down's syndrome.

### 5.2.2. *Duty to Refer Patients and to Maintain Quality of Care*

The duty that is reflected in most laws and ethical codes across Europe and in international human rights standards is the duty to refer patients to non-objecting providers. Almost all countries in Europe require this.[124] Some countries also explicitly add that the referral should be done in a timely manner and should apply from the moment the patient first requests medical intervention from a healthcare provider. In addition, the duty implies quality referral; ensuring women can receive quality treatment. In its Declaration on Therapeutic Abortion, the World Medical Association established that "If the physician's convictions do not allow him or her to advise or perform an abortion, he or she may withdraw while ensuring the continuity of medical care by a qualified colleague."[125]

In the Netherlands and France, for example, laws place a legal obligation on healthcare professionals and physicians to immediately communicate to a pregnant woman their refusal to perform an abortion.[126] Similarly, Portugal's Medical Association Code of Ethics mandates that a physician immediately communicate his or her objection to patients,[127] while the law requires that physicians communicate their objections to patients in a "timely fashion."[128] In France, doctors who

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[123] *Ibid.*, para. 56. *See also Barr v. Matthews*, 52 BMLR 217 (Q.B. 1999). In 1999, the UK Queen's Bench Division held that plaintiff's medical negligence claim against defendant for failure to provide medical advice on termination of pregnancy because of defendant being "philosophically opposed to abortion, [and] unwilling to facilitate one," thus *resulting in the birth of a child suffering from cerebral palsy*, was not successful. The court did emphasise that "once a termination of pregnancy is recognised as an option, the doctor invoking the conscientious objection clause should refer the patient to a colleague at once."

[124] *See, e.g., BMA's Handbook of Ethics and Law, supra* note 98, at 16-17 (U.K.); National Health Service Guidelines, Guidance on fundholder purchase of terminations of pregnancy, HSG (95)37, para. 6 (1995) (U.K.) [hereinafter *NHS Guidelines* HSG (95)37]; Code de la Sante Publique, arts. L2212-8, R4127-18 (Fr.); Zakon o liječništvu (Zl) [Law of Doctoring], Art. 20 (2003) (Croat.) [hereinafter Croatia Law of Doctoring]; Kodeks medicinske etike i deontologije [Code of Medical Ethics and Deontology] Art. 2, para. 15 (Croat.) [hereinafter Croatia Code of Medical Ethics]; Act No. 154 of 1997: Health Care (1997. évi CLIV. törvény az egészségügyről) §§ 125-37 (Croat.) [hereinafter Croatia Act No. 154]; Ministry of Health Decree No. 30/2007: The Code of Ethics of Health Care Service Providers [30/2007. (VI. 22.) EüM rendelet az egészségügyi dolgozók rendtartásáról] § II (Hung.) [hereinafter Hungary Ministry of Health Decree No. 30/2007]; Codigo Deontologico da Ordem dos Medicos (2008), Art. 37 (Port.); Lei No. 16/2007 de 17 de abril, Exclusão da ilicitude nos casos de interrupção voluntária da gravidez (Port.).

[125] World Medical Association, *Declaration on Therapeutic Abortion*, adopted Aug. 1970, available at http://www.wma.net/en/30publications/10policies/a1/index.html (last visited Dec. 19. 2011).

[126] *See* Code de la Sante Publique (Fr.), *supra* note 124, arts. L2212-8, R4127-18; *see also* Law of 1 May 1981 (Stb. 257) prescribing rules concerning the termination of pregnancy, § 20 (2) (Neth.).

[127] Codigo Deontologico da Ordem dos Medicos (Port.), *supra* note 124, Art. 37(2).

[128] Lei No. 16/2007 (Port.), *supra* note 124, § 4.

conscientiously object also have a legal duty to the woman seeking abortion to "give her the name of experts to perform the procedure."[129] In Poland, Croatia and Hungary, laws require physicians to inform patients of their objection to a procedure and to provide a referral to such patients, but they do not have an oversight mechanism to ensure that this occurs, leaving many women without a referral.[130]

In the United Kingdom, guidelines issued by the British Medical Association (the "BMA") and the Royal College of Obstetricians and Gynaecologists (RCOG),[131] two of Britain's leading medical associations, have informed the implementation and judicial interpretation[132] of the conscientious objection provisions of the 1967 Abortion Act, and obligate physicians who conscientiously object to providing abortion services to take preparatory steps to arrange for an abortion and provide referrals to another doctor without delay.[133] The BMA guidelines explicitly provide that "[i]t is not sufficient simply to tell the patient to seek a view elsewhere since other doctors may not agree to see her without appropriate referral."[134] RCOG has issued recommended referral times for abortion services.[135] In addition, the UK National Health Service guidelines, which are issued to provide guidance to practitioners, note that all doctors who conscientiously object to "recommending termination should quickly refer a woman who seeks their advice about a termination to a different [general practitioner]...If doctors fail to do so, they could be alleged to be in breach of their terms of service."[136]

In the absence of regulations requiring timely notification of a healthcare provider's objection, accompanied by a timely referral, women may be unable to locate another provider to perform such procedure in a timely manner, foregoing their right to an abortion. For example, in Denmark, a woman who scheduled an appointment at a clinic to undergo an abortion was not informed by the doctor of such doctor's conscientious objection to the performance of abortions, nor was

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[129] Code de la Sante Publique (Fr.), *supra* note 124, Art. L2212-8.
[130] *See* Act of 5 December 1996 on the Medical Profession [Dz. U. z 2002 r. Nr 21 poz. 204 z po*n. zm.], Art. 39 (Pol.); *see also* Croatia Law of Doctoring, *supra* note 124, Art. 20; Croatia Code of Medical Ethics, *supra* note 124, Art. 2, para. 15; Croatia Act No. 154, *supra* note 124, §§ 125-37; Hungary Ministry of Health Decree No. 30/2007, *supra* note 124, § II.9.
[131] *Royal College of Obstetricians & Gynaecologists, The Care of Women Requesting Induced Abortion* 2004 [hereinafter *RCOG Guidelines*].
[132] *See, e.g., Family Planning Ass'n of Northern Ireland v. Minister for Health, Soc. Serv. and Pub. Safety*, 2004 NICA 39 (Transcript) (Q.B.).
[133] *BMA's Handbook of Ethics and Law, supra* note 98, at 249; RCOG Guidelines, *supra* note 143, at 16-17.
[134] *BMA's Handbook of Ethics and Law, ibid.*, at 249.
[135] *RCOG Guidelines, supra* note 131, at 23-24.
[136] *NHS Guidelines HSG* (95)37, *supra* note 124, para. 6.

she provided a timely referral.[137] A member of the Danish Board of Health and legal commentator, in reviewing this case noted the impact this could have on the exercise of her right to an abortion, 'the failure to immediately inform the patient of a conscientious objection to abortion and to provide a referral could delay the time period within which a woman can legally exercise her right to a voluntary termination of pregnancy. Such delay could cause the woman to exhaust the 12-week period during which she may legally procure an abortion, and thereby cause her to unwillingly forego her right to this procedure.'[138]

A corollary to such duty is that in situations in which the healthcare provider is unable to guarantee that women will receive quality treatment, such healthcare provider must provide treatment to the patient, regardless of whether it conflicts with her or his conscience.[139] For example, in Norway, a physician may not refuse to treat a patient unless the patient has reasonable access to another doctor who can provide treatment.[140] Additionally, in San Marino, a physician that conscientiously objects to the performance of a procedure must refer the patient to another medical professional who can provide adequate treatment, and the physician must ensure that the patient continues to receive care during the transition period.[141]

### 5.2.3. *Duty to Provide Care in Emergency Situations*

International and regional medical and human rights standards establish that conscientious objection cannot be invoked in emergency situations when life-saving treatment is needed.[142] While most countries impose a general duty on

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[137] *Doctor refuses to refer pregnant women to abortion* (Læge nægter at henvise gravide til abort), Tv2Lorry, July 10, 2007, http://ekstrabladet.dk/nyheder/samfund/article94950.ece (last visited 19 Dec. 2011).

[138] *Ibid.*,; see also Janne Rothmar Hermann, 'Ethical issues regarding abortion: How far does the right go?' (*Etisk forbehold ved abort: Hvor langt rækker retten?*), 169 *Ugeskrift for Læger (Journal of the Danish Medical Association)* (2007) 4488.

[139] *See* FIGO, *Resolution on Conscientious Objection, supra* note 87 ("FIGO affirms that to behave ethically, practitioners shall... Provide timely care to their patients when referral to other practitioners is not possible and delay would jeopardise patients' health and well-being").

[140] Code of Ethics for Doctors [*Den Norske Legeforening*], § 6 (Nor.).

[141] Code and Rules of Ethics for the Medical Profession, Art. 16 (San Marino).

[142] *See, e.g.*, FIGO Ethical Guidelines, *supra* note 84, para. 8; Committee on the Elimination of Discrimination against Women, *Concluding Observations: Morocco*, para. 78, U.N. Doc. A/52/38/Rev.1 (1997); *Concluding Observations: Pakistan*, para. 41, U.N. Doc. CEDAW/C/PAK/CO/3 (2007); *Concluding Observations: Peru*, para. 340, U.N. Doc. A/53/38/Rev.1 (1998); *see also* Human Rights Committee, *Concluding Observations: Mali*, para. 14, U.N. Doc. CCPR/CO/77/MLI (2003). Various UN Treaty Monitoring Bodies have reaffirmed the need to guarantee women's access to emergency care services in order to ensure their health and prevent maternal mortality and morbidity. *See e.g.*, Committee on Economic, Social and Cultural Rights, *General Comment 14: The Right to the Highest Attainable Standard of Health (Art. 12)* (22nd Sess., 2000), *in* Compilation of General Comments and General Recommendations by Human Rights Treaty Bodies, at 90, ¶ 14, U.N. Doc. HRI/GEN/1/Rev.7 (2004). The UN Committee on the Elimination of Discrimination Against Women recently issued a decision against Brazil for the State's failure to provide quality medical emergency care to a pregnant woman. Decision *Alyne vs Brazil*, CEDAW/C/49/D/17/2008, Communication No. 17/2008 (10 August 2011).

health care providers to provide care in emergency situations,[143] only eleven European countries expressly prohibit the invocation of conscientious objection in the case of emergency or risk of death as well as danger to patient's health.[144] Some countries do not explicitly provide any exceptions to the right to conscientious objection.[145] This is an area of law and policy that must be clarified in order to guarantee access to emergency healthcare services. For example, under the United Kingdom Abortion Act, doctors have a right to opt out of participating in abortion but are obliged to provide necessary treatment in emergencies. If a woman's life or long-term health care is at stake, doctors who hold a conscientious objection to terminating a pregnancy are obliged to provide necessary care.

## 6. Conclusion

Despite the progress achieved in the last fifteen years on expanding the recognition and enjoyment of women's rights to sexual and reproductive healthcare services, the unregulated practice of conscientious objection is increasingly restricting women's access to a wide range of legal health services, including abortion and contraception. In many European countries, the practice of conscientious objection is largely unregulated. The absence of a comprehensive and effective legal and policy frameworks governing the practice is putting women's health and lives at risk and violating their human rights.

While existing international and regional human rights, medical and ethical standards as well as national laws and jurisprudence, provide some guidance on how to adequately regulate the practice, further guidance is needed. International and regional human rights bodies are well-positioned to provide such guidance. These bodies should monitor state compliance with their obligations to ensure timely and adequate sexual and reproductive health services and hold governments accountable when violations of such rights occur. In addition, medical and ethical bodies should also uphold women's reproductive rights and promote the regulation of conscientious objection.

In order to guarantee access to health care services provided by law and to uphold their international human rights commitments, European states should develop comprehensive laws and policies that define and regulate the practice of

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143) *See* Eur. Parl. Assemb., *Explanatory Memorandum — Unregulated use of conscientious objection, supra* note 5, at 10.

144) Bosnia & Herzegovina; Croatia; Czech Republic; Hungary (risk of death applies only to abortion); Italy; Lithuania; Poland; Portugal; San Marino; Slovakia; and the United Kingdom (abortion only).

145) In Denmark, there are no explicit exceptions to the right to conscientious objection; however, the Danish Constitution only protects religious belief to the extent that it does not provide "reasons [to] evade compliance with any common civic duty." Danmarks Riges Grundlov, § 70 (1953) (Den.), *available at* http://www.grundloven.dk/. In the Netherlands, legislation, regulations and codes do not provide any clear exceptions to the right to conscientious objection.

conscientious objection. The regulations should clearly establish who can object, under which circumstances and to which services. They should also establish the duties of health care providers and set up oversight mechanisms to ensure that these duties are fulfilled and that redress is provided when those duties are violated.

Basic principles, derived from medical and international and regional human rights standards, governing the regulation of conscientious objection should ensure the following:

- Availability and accessibility of reproductive health care providers, including by employing adequate staff available and willing to competently deliver services.
- Availability of timely services within a convenient distance for the patient.
- A duty on providers to ensure timely notice to patients that they are conscientious objectors.
- A duty on providers to refer the patient, to another provider willing and able to perform the health care procedure/treatment. Such a provider must be conveniently accessible and the referral should be done in a timely manner.
- Conscientious objection cannot be invoked in emergency situations when the life or health of the patient is at risk. Health care providers should be trained in performing all legal reproductive health care services, irrespective if objectionable. This will ensure access to health care services in emergency and other situations where conscientious objection is not applicable.
- Conscientious objection applies only to direct health care treatment/procedures, not diagnostic care that may or may not lead to an objectionable act by the patient.
- Conscientious objection should not apply to staff in performing general care functions, such as preparing operating rooms, making appointments, issuing referral notices, etc.
- Conscientious objection cannot be invoked in information services; patients must be informed of their health status and all risks, benefits and alternatives to treatment/procedures.
- Conscientious objection can only be invoked by individuals; it cannot be invoked by institutions.
- Oversight and monitoring of the practice of conscientious objection so as to ensure women are able to access the timely medical services they need and are legally entitled to receive.
- Legal remedies be available when harm results from the practice of conscientious objection.

# EXHIBIT I

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# Conscientious objection and waiting time for voluntary abortion in Italy

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ABSTRACT

**Objectives** This study sought to determine whether a correlation exists in Italy between conscience-based refusal by physicians to perform an abortion and waiting times for elective abortion.

**Methods** Data on the number of objectors and of elective abortions performed within different time intervals were retrieved from annual Italian ministerial reports. Spearman's correlation coefficients were calculated between an indicator of the increase in workload for non-objectors when conscientious objection is exercised by physicians refusing to provide an abortion and the proportion of women whose request for an abortion was met within 14 days, or later, in 13 regions in Italy.

**Results** An inverse correlation emerged between the workload for non-objectors and the proportion of abortions performed within 14 days of the request in seven regions (statistically significant in Emilia-Romagna and Tuscany). There was a direct correlation between increased workload and the proportion of abortions performed later than 21 days in nine regions. The same trends were highlighted at national level.

**Conclusions** Our results suggest that when data spanning at least more than a decade are available, a trend toward an inverse correlation can be noted between the workloads for non-objectors and timely access to elective abortion. This holds organisational and ethical implications.

KEYWORDS Conscience-based refusal of care; Abortion; Waiting lists; Health personnel; Italy

## INTRODUCTION

The European Parliament recently returned to the Committee on Women's Rights and Gender Equality a motion, *Edite Estrela*, proposed in May 2013 which asked all European Union (EU) member states to regulate and monitor the use of conscientious objection so as to ensure that reproductive health care is guaranteed as an individual's right[1]. The motion underlined that nearly 70% of gynaecologists in six member states, including Italy, claim conscientious objection to abortion and that unregulated exemption from providing abortion constitutes one of the main obstacles women face when seeking access to reproductive health services in Europe.

The right of health-care providers to exercise conscientious objection to abortion is sanctioned in Norway and Switzerland and in 21 EU member states. Legislation regulating conscientious objection varies from country to country, as does the prevalence of conscience-based refusal. The proportion of objectors among physicians in Italy, Poland, Slovakia, Portugal

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and Austria is already high and it is increasing in the UK[2].

Several aspects of national abortion legislation can have a significant impact on access to abortion services. According to updated guidance on safe abortion issued by the World Health Organization (WHO), the absence of mandatory referral to amenable providers, together with other limitations including targeted restriction of abortion providers and narrow interpretation of national legislation on abortion, represent a legal barrier to a woman's right to have an abortion. Furthermore, such restrictions may delay access to reproductive health services, create disparities in access to adequate health care, and possibly even discourage women from visiting a public health-care facility in their country. The WHO therefore recommends that objecting physicians should refer women requesting an abortion to another health care professional who is willing to provide the procedure or to another easily accessible health care facility and that member states ensure that the exercise of conscientious objection does not prevent individuals from accessing services to which they are legally entitled[3,4].

In Italy, elective abortion is regulated under the provisions of law 194/1978. Medical and surgical treatment for the termination of pregnancy must be carried out in a public hospital. A woman can request an abortion for health-related, social, economic or family reasons during the first trimester of pregnancy, after which termination can be performed only if the woman's health is at risk or a fetal abnormality has been diagnosed. To have an abortion, a woman must submit a written request to an authorised physician (her general practitioner, a gynaecologist working in a public health facility or a physician working in a public family planning clinic). After having verified that the legal requirements for an elective abortion are met, the physician will issue a medical certificate. At this point, the law imposes a 7-day waiting period, after which the woman can go to any public hospital for an abortion.

Under the provisions of section 9 of the abortion law, health care professionals can claim conscientious objection to abortion. A written statement of conscientious objection must be submitted in writing to the administrative office of the public health facility where the professional works. The professional's objector status can be revoked when he or she so requests or officially by the hospital administration if a professional with objector status performs an abortion. Objectors are exempted from performing any actions that may directly cause an abortion, except when there is a medical emergency and non-objecting physicians are unavailable to perform the procedure. Under Italian law, individuals or entities refusing to carry out an abortion are not required to provide a referral for abortion services; however, to ensure a woman's rights to access to abortion, the regional governments are mandated to provide for staff mobility and differentiated recruitment of non-objecting health care staff.

This particular legislative aspect was pointed out by the Committee for the Elimination of All Forms of Discrimination against Women as a grievance requiring Italy to redress resort to conscientious objection by health professionals in the absence of an adequate regulatory framework[5].

More recently, the International Planned Parenthood Federation European Network (IPPF EN) lodged a collective complaint against the Italian state, requesting that the European Committee of Social Rights (ECSR) declare that section 9 of law 194/1978 does not ensure adequate access to safe abortion care. In fact, section 9 does not indicate the precise means through which hospitals and regional authorities are to guarantee the adequate presence of non-objecting medical personnel in all public hospitals, so as to always ensure the right of access to procedures for the termination of pregnancy.

In the opinion of the IPPF EN, this lack in the normative framework has led to an inadequate number of non-objecting physicians in public health facilities, with the result that some women must travel outside their region of residence or to another country to have an abortion. In March 2014, the ECSR received the complaint by the IPPF EN and decided that section 9 of law 194/1978 violates the rights to health protection and to non-discrimination enshrined in the European Social Charter (Article 11 and Part V, Article E, respectively)[6].

Italy is one of the few European countries to have current data on conscientious objection to abortion. Every year the regions notify the Ministry of Health of the total number of health professionals employed within a regional public health facility with an obstetrics/gynaecology department and the number of objecting physicians practising there. The data supplied to the ministry show that over the last 15 years the national proportion of health care professionals declaring conscientious objection has gradually risen from

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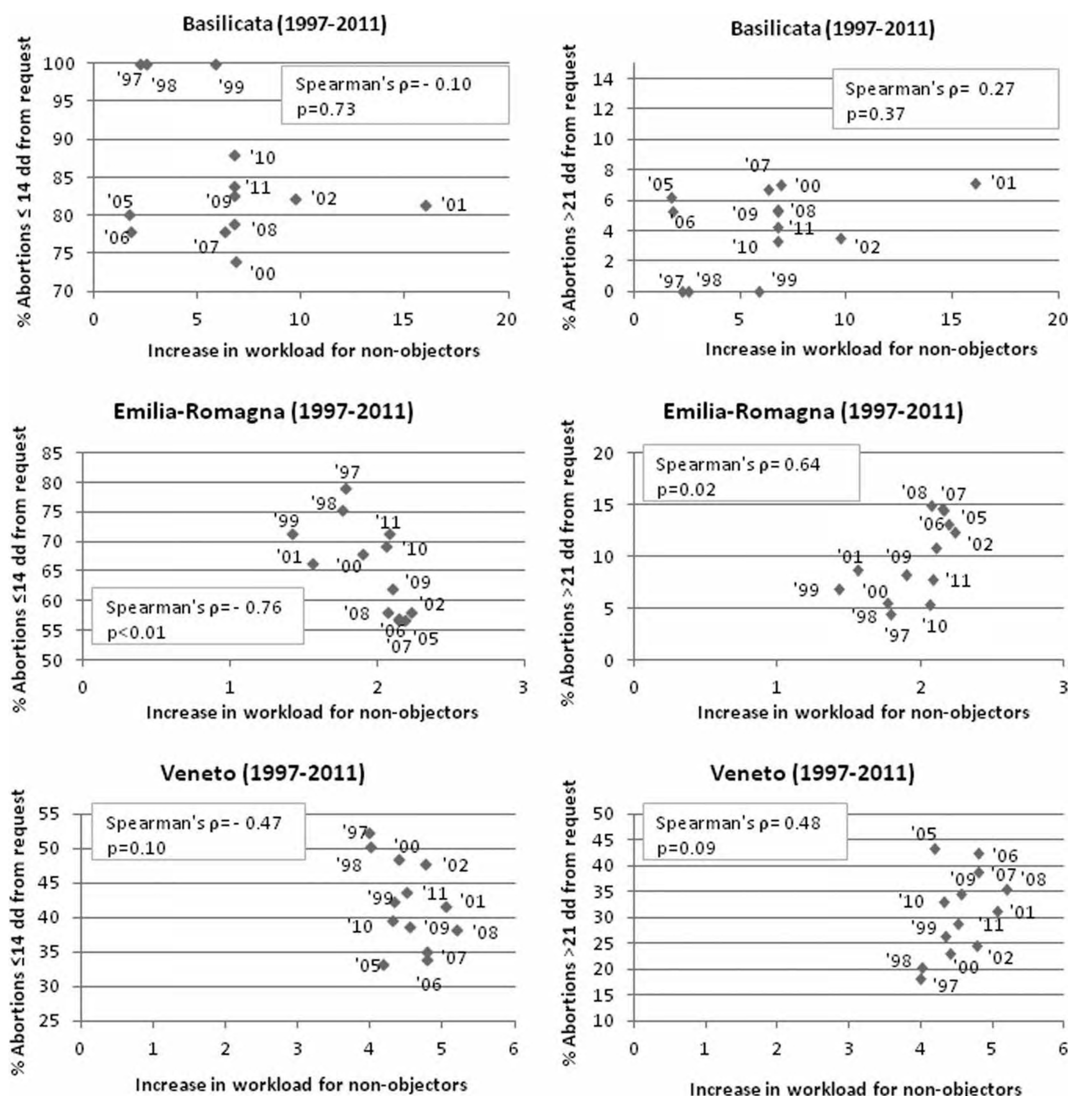


**Figure 1** Scatter diagrams of the proportion of abortions performed within 14 days and later than 21 days after the request (ordinate) and the increased workload for non-objectors (abscissa) in the three regions that provided complete data from 1997 to 2011 (Basilicata, Emilia-Romagna and Veneto). In all these regions there was an inverse correlation between the increased workload for non-objectors and abortions performed within 14 days and a direct correlation with the proportion of women who waited more than 21 days to have an elective abortion. The test was statistically significant for Emilia-Romagna.

59.1% in 1983, to 62.8% in 2007, to 69.3% in 2011, with more than 80% of gynaecologists against participating in elective abortion in some regions of the country, and a national average that has stabilised at 70% in recent years[7].

This phenomenon, coupled with the increase in first-person media accounts of women who encountered obstacles in obtaining an abortion, continues to fuel public debate over the legitimacy of conscientious objection in health care services in Italy, which has been strongly polarised by fierce pro-choice and pro-life campaigns by national advocacy groups.

In 2012, the Italian National Committee on Bioethics (NBC) took a stance on the issue[8]. The second appendix to its formal opinion statement on conscientious objection states that official data indicate that conscientious objection has not restricted the access to abortion services in Italy. In particular, part of the available data on induced abortion collected in 2006 was directly compared with the corresponding data collected in 2009.



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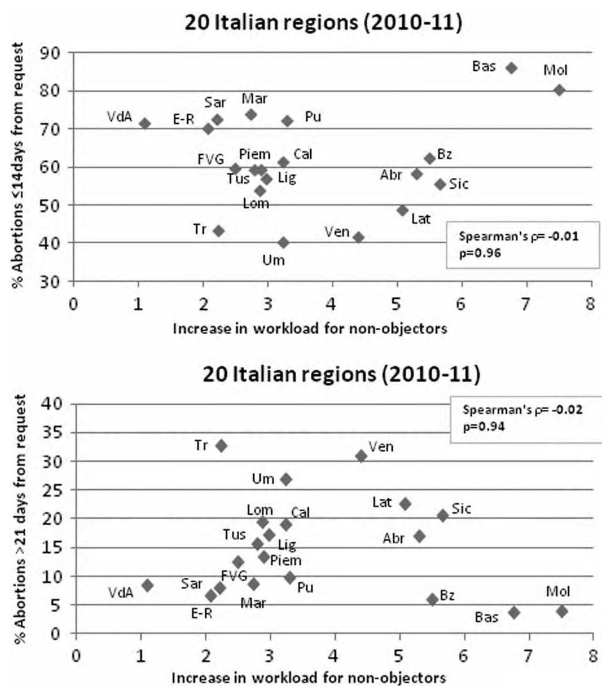


Figure 2 Scatter diagrams of the proportion of abortions performed within 14 days and later than 21 days after the request (ordinate) and the increased workload for non-objectors (abscissa) in the regions that provided complete data in 2010 and 2011 (20 out of 21). No clear trend is observable in either case, as demonstrated by Spearman's rank correlation coefficients near zero. What can be seen is a marked variability of the phenomenon across the regions, as highlighted by the difference in the proportion of abortions performed during these two waiting time intervals, the workload for non-objectors being equal, and for two regions in particular (Basilicata and Molise for the ≤14-day interval), both of which appear to be outliers with respect to the other regions.

Specifically, the proportion of gynaecologists who opted for conscientious objection to abortion (objectors) was compared with the proportion of women who waited fewer than 14 days or up to 22 to 28 days to obtain an induced abortion in some regions. The appendix further documented that in several regions, such as Latium and Piedmont, the proportion of objectors increased and waiting times decreased, whereas in others, such as Lombardy and Umbria, the proportion of objectors decreased and waiting times increased. From this the NBC concluded that no correlation exists between the number of objectors and the length of waiting times for women seeking abortion. According to the NBC, the difference in waiting times between 2006 and 2009 depended merely on the organisational model a region operates for abortion services, e.g., policies providing for health care worker mobility or differentiated recruitment.

More recently, in September 2013 the Italian minister of health presented the latest annual report on the application of abortion legislation. Though it confirms the high proportion of conscientious objectors, the report documents that while the proportion of objectors increased by 17.3% from 1983 to 2011, the rate of elective abortions in Italy decreased during the same period (number of abortions per 1000 live births) from 26.6% in 1997, to 22.4% in 2007, to 20.6% in 2011. The report concluded that the number of non-objecting gynaecologists has always been adequate and that any disruptions in access to abortion cannot be attributed to the increase in the number of objectors but rather to an inadequate distribution of health care personnel in heath-care facilities in some regions of the country[7].

But as things stand today, no referral system exists and the proportion of abortion objectors is more than 80% in some regions of the country. And as this situation inevitably impinges on the delivery of health care, the waiting time between the initial request for elective abortion and its actual performance and the differences in waiting times across regions cannot be due merely to provider availability or how abortion services are organised.

The aim of this study was to verify whether a correlation exists between conscientious objection and the length of waiting times between requesting and having an abortion in Italy.

## METHODS

All available annual ministerial reports concerning the application of Italian abortion legislation were downloaded from the Italian Ministry of Health website[9]. Among the annual regional data collected, we considered: (1) the absolute number of elective abortions performed at different time intervals; (2) the absolute and relative (%) number of objectors on duty (number of gynaecologists employed at a public facility with an obstetrics or gynaecology department and registered as conscientious objectors). Specifically, ministerial reports distinguish four time intervals (≤ 14 days, 15–21 days, 22–28 days, > 28 days) in relation to the time between the date of the initial

referral and the date the procedure is performed. The intervals are inclusive of the 7-day mandatory waiting period. Because the number of annual abortions varies considerably from region to region, the number of abortions performed within each time interval was divided by the total annual number of abortions reported for a given region (excluding the proportion of abortions for which the time interval between initial referral and time of abortion was not known). This was done to obtain a comparable estimate of the proportion of women who accessed abortion services quickly and those who had to wait longer to have an abortion. As a general rule, we considered the proportion of abortions performed within 14 days of initial request as an indicator of timely access to abortion services. However, because the total number of annual abortions performed later than 28 days after the date of the initial request were so few (less than 5% at the national level), these data were aggregated with those for the 22- to 28-day interval in order to obtain more stable estimates for the proportion of abortions performed later than 21 days after the request. We then used this value as an indicator of prolonged waiting time.

In this way, we constructed an indicator for measuring the extra workload for non-objecting physicians created when there was a proportion of objecting physicians in the obstetrics/gynaecology unit. To do this, we first calculated the workload for non-objectors by dividing the total annual number of abortions in each region by the number of non-objectors. We then calculated, for each region, the theoretical workload for each gynaecologist, if there were no objecting physicians, by dividing the total annual number of abortions by the total number of gynaecologists. The ratio between these two indicators represented the measure of the extra workload for the non-objectors due to the presence of objectors. This indicator was calculated for each region and for all years in which the data sources contained the data needed for its construction.

Finally, we identified the regions that reported current data for at least 9 years from 1997 to 2011 on both the number of abortions performed in the four time intervals of interest (plus the data on waiting times longer than 21 days) and the proportion of objectors, from which we calculated the indicator for the increased workload for non-objectors. Spearman's rank correlation coefficients were calculated for these regions to verify whether a correlation existed between the two indicators.

We then evaluated whether there was an observable correlation at the national level between these two measures. The national figures were obtained from data collected between 2007 and 2011, since nearly all regions (except for three regions with data missing for more than 1 year) had reasonably complete data sets for the 5-year period. The data from each region were then combined in the national data set using the number of abortions as weights. Spearman's rank correlation coefficients were calculated for the time intervals ≤14 days, 15–21 days, 22–28 days, and later than 28 days from the initial request. The correlation for abortions performed later than 21 days after the initial request at the national level was also evaluated by aggregating the data from the two time intervals: 22 to 28 and later than 28 days.

Finally, we made a cross-sectional comparison of 20 regions by calculating for each region the mean values of the last available data (2010 and 2011). One region was excluded from this analysis because data on the number of objecting physicians were missing for both reference years. With these data we then calculated the Spearman's correlation coefficients between the increased workload for non-objectors and the average proportion of abortions performed within 14 days of the initial request and those performed later than 21 days.

Statistical significance was set at $p < 0.05$.

All data were analysed with Stata 13 (StataCorp LP, College Station, TX, USA).

## RESULTS

Annual ministerial reports on abortion services for the periods 1999 to 2005 and 2007 to 2013 reported official data on elective abortions performed between 1997 and 2003 and between 2005 and 2011. No ministerial reports were available for the elective abortions performed during other years when the law was in force (1978–1996 and 2004). Moreover, data on abortions carried out in 2003 were not analysed because the proportion of procedures was not available for any of the four time intervals between the request for abortion and its actual performance.

Annual regional data on the number of abortions performed within any of the four time intervals and

the number of objectors on duty were not regularly reported by all regions. Current data on the distribution of abortions performed within the four time intervals were available only for eight regions before 2000. For some of the years analysed, some regions reported the number of objectors on duty in one of the previous years rather than the current year (e.g., Calabria from 2001 to 2005 or Puglia in 2000, 2005 and 2008).

Table 1 shows the Spearman's rank correlation coefficients between the increased workload for non-objectors and the proportion of abortions performed within the four time intervals (< 14 days, 15–21 days, 22–28 days, > 28 days) and later than 21 days in those regions that reported complete data for at least 9 years from 1997 to 2011 and at the national level from 2007 to 2011. In seven regions, the increased workload for non-objectors appeared to correlate inversely with the proportion of abortions performed within 14 days of the request (statistically significant for Emilia-Romagna and Tuscany) and directly with the proportion of abortions performed within the other time intervals (15–21 days, 22–28 days, > 28 days, and later than 21 days after the request), and, again, statistically significant for Emilia-Romagna and Tuscany. By contrast, the proportion of abortions performed within 14 days of the request appeared to rise with the increase in the workload for non-objectors in Bolzano, Latium, Lombardy, Piedmont, Sardinia and Trento (statistically significant only for Piedmont), whereas the proportion of abortions performed later than 14 days after the request seemed to decrease, although the correlation was generally not significant and the trend was not always observable for all time intervals. Specifically, a direct correlation was found between an increase in workload for non-objectors and the proportion of abortions performed later than 28 days (and when combined with the > 21-day interval) after the initial request for Sardinia and Trento.

Figure 1 shows these trends for the three regions that provided complete data from 1997 to 2011. Analysis of national data (Italy, 2007–2011) showed an inverse correlation between an increased workload for non-objectors and the proportion of abortions performed within 14 days, and a direct association between increased workload and abortions performed within 15 to 21 days and later than 28 days after the request. The same trend was seen when the > 21-day interval was considered as the last cut-off.

Figure 2 shows the scatter diagrams of the proportion of abortions performed within 14 days and later than 21 days after the request (ordinate) and the increased workload for non-objectors (abscissa) in the regions that provided complete data in 2010 and 2011 (20 out of 21).

## DISCUSSION

The present study shows that in many Italian regions the increased workload for non-objectors due to the high proportion of objectors is inversely correlated with the proportion of women whose request for abortion was met within 14 days. It also shows that in these regions there is a direct trend between the workload of non-objectors and the proportion of women who had to wait longer than 14 days (15–21, 22–28 or > 28 days) to obtain an abortion, which is consistent with a similar national trend in recent years. This study has two main strengths. It is the first study to compare all available official data on conscientious objection to elective abortion with the data on waiting times for abortion services and to investigate whether a correlation between them exists. To do this, we analysed a considerable body of current data on abortion services collected from an official information system for a lengthy period of time (about 15 years).

The study has several limitations. It analyses aggregated data collected from current regional information sources; therefore, it cannot demonstrate whether and to what extent the rise in the proportion of gynaecologists who refuse to practise abortion led directly to a prolongation of waiting times for abortion services. Also, it does not take into account the influence of other variables – such as the proportion of migrant women, education levels, the number and the distribution of abortion services – which may have affected the correlations between the measures considered in this analysis. Although the data on these variables are largely contained in the ministerial reports, it is difficult to control for confounders at the population level in studies based on routine data carried out at an aggregate level.

Unfortunately, the data reported in the ministerial reports are patchy: in previous reports (1997–1999) the data on abortions performed within the four time intervals after the date of the initial request (≤ 14 days, 15–21 days, 22–28 days, > 28 days) were available for


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**Table 1** Correlation between the increase in workload for non-objecting physicians and the proportion of abortions performed within the four time intervals (≤14 days, 15–21 days, 22–28 days and >28 days after the initial request) in those regions that provided complete data for at least 9 years in the period 1997–2011. The national data refer to the period 2007–2011.

| *Waiting time for voluntary abortion* | *Within 14 days* | | | *15–21 days* | | | *22–28 days* | | | *>28 days* | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Mean | sp_rho | *p* | Mean | sp_rho | *p* | Mean | sp_rho | *p* | Mean | sp_rho | *p* | Mean | sp_rho | *p* |
| Region | | | | | | | | | | | | | | | |
| Basilicata [13] (mean abortions 670) | 576 | −0.10 | 0.73 | 68 | 0.14 | 0.66 | 16 | 0.11 | 0.73 | 10 | 0.42 | 0.16 | 26 | 0.27 | 0.37 |
| Bolzano [10] (mean abortions 534) | 285 | 0.39 | 0.26 | 166 | 0.05 | 0.89 | 62 | −0.56 | 0.09 | 21 | **−0.70** | **0.03** | 83 | **−0.67** | **0.03** |
| Emilia-Romagna [13] (mean abortions 11,020) | 7176 | **−0.76** | **<0.01** | 2733 | **0.79** | **<0.01** | 860 | **0.70** | **<0.01** | 251 | **0.68** | **0.01** | 1083 | **0.64** | **0.02** |
| Friuli Venezia Giulia [12] (mean abortions 2097) | 1216 | −0.25 | 0.44 | 504 | −0.22 | 0.49 | 281 | 0.33 | 0.29 | 96 | 0.34 | 0.28 | 377 | 0.30 | 0.35 |
| Latium [9] (mean abortions 13,899) | 7267 | 0.36 | 0.34 | 3996 | −0.41 | 0.27 | 1956 | −0.05 | 0.88 | 680 | −0.49 | 0.18 | 2636 | −0.09 | 0.81 |
| Lombardy [9] (mean abortions 20,303) | 11,593 | 0.40 | 0.29 | 5163 | −0.29 | 0.44 | 2359 | −0.47 | 0.20 | 1187 | −0.01 | 0.98 | 3547 | −0.31 | 0.42 |
| Piedmont [10] (mean abortions 10,396) | 5642 | **0.66** | **0.04** | 2950 | −0.29 | 0.41 | 1303 | −0.54 | 0.11 | 500 | −0.63 | 0.05 | 1803 | −0.60 | 0.07 |
| Sardinia [10] (mean abortions 2314) | 1802 | 0.07 | 0.85 | 369 | −0.03 | 0.93 | 102 | 0.02 | 0.95 | 41 | 0.31 | 0.38 | 142 | 0.01 | 0.97 |
| Trento [12] (mean abortions 1149) | 632 | 0.20 | 0.53 | 278 | −0.48 | 0.11 | 172 | −0.10 | 0.76 | 67 | 0.22 | 0.48 | 239 | 0.04 | 0.90 |
| Tuscany [12] (mean abortions 8187) | 5743 | **−0.87** | **<0.01** | 1651 | **0.77** | **<0.01** | 586 | **0.82** | **<0.01** | 207 | **0.76** | **<0.01** | 793 | **0.85** | **<0.01** |
| Umbria [9] (mean abortions 2049) | 1056 | −0.15 | 0.70 | 624 | 0.64 | 0.06 | 268 | 0.18 | 0.65 | 101 | 0.18 | 0.63 | 369 | 0.08 | 0.83 |
| Valle d'Aosta [10] (mean abortions 246) | 147 | −0.43 | 0.21 | 70 | 0.53 | 0.11 | 22 | 0.51 | 0.14 | 6 | −0.27 | 0.46 | 28 | 0.34 | 0.34 |

(*Continued*)

Table 1 (*Continued*)

| *Waiting time for voluntary abortion* | *Within 14 days* | | | *15–21 days* | | | *22–28 days* | | | *> 28 days* | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Mean | sp_rho | *p* | Mean | sp_rho | *p* | Mean | sp_rho | *p* | Mean | sp_rho | *p* | Mean | sp_rho | *p* |
| Veneto [13] (mean abortions 6613) | 2754 | −0.47 | 0.10 | 1794 | −0.54 | 0.06 | 1315 | 0.36 | 0.23 | 751 | 0.46 | 0.11 | 2066 | 0.48 | 0.09 |
| Italy*°(2007–2011) (mean abortions 101,522) | 58,990 | −0.60 | 0.28 | 25,304 | 0.30 | 0.62 | 11,958 | −0.20 | 0.75 | 5269 | 0.40 | 0.50 | 17,156 | 0.60 | 0.28 |

The number of years with complete data in the period 1997–2011 for each region is given in square brackets.
The mean was calculated from the data available for each region from 1997 to 2011 and refers to the mean number of total abortions performed during each time interval. The total number of abortions refers to those abortions for which the time interval was given.
^Because the proportion of abortions performed more than 28 days after the initial request was small, the table presents the aggregate data for a waiting time longer than 21 days, comprising the two intervals of 22–28 days and > 28 days.
*Excluding three regions (Abruzzi, Campania, Molise) because data were missing for more than one year in the period 2007–2011.
°National data were calculated for the period 2007–2011 by combining the complete regional data (data missing for only one year in the period 2007–2011), weighted for the number of abortions, to account for the weight of each region in the national total.
Statistically significant results are given in bold.

only some regions. Also, both current data on the number of objectors on duty and the number of abortions performed within different time intervals after the request date were not reported by all regions during the period examined. This limited the possibility to verify whether a correlation exists between our indicators within the different time intervals at the national level. For this reason, we were able to calculate correlation coefficients on aggregated annual national data only for the last 5 years (2007–2011) rather than for a longer period (1997–2011), as would have been desirable. Again, for this same reason we had to restrict the cross-sectional comparison of the regions to the last 2 years (2010–2011), for which complete data were available for 20 out of 21 regions.

Importantly, data were missing for some regions where the proportion of objectors was high and where such proportions increased noticeably between 1997 and 2011 (e.g., Abruzzi, Molise and Sicily).

Independently of the statistical significance of our results, the trends that emerged from our analyses are noteworthy. The limitations of this study notwithstanding, it is reasonable to assume that the marked increase in the proportion of gynaecologists who refuse to practise abortion, and the consequent increase in the workload for non-objectors, might have influenced waiting times for elective abortion in Italy, especially in certain regions of the country.

Our results seem to contradict those documented in the appendix of the NBC's formal opinion statement on conscientious objection[8]. The discrepancy can be explained by the way we analysed the available data with respect to the methods the NBC applied. The NBC compared the changes in the number of elective abortions performed within 14 days and within 22 to 28 days of the request reported for two non-consecutive years (2006 and 2009) and the differences between the 2 years in the proportion of objecting gynaecologists on the basis of data reported by five regions (Emilia-Romagna, Latium, Lombardy, Piedmont and Umbria). The NBC document gave no explanation of the selection criteria for the two sampling years or for the five regions. In addition, it failed to mention that the regional data in the ministerial reports had not been updated for several years. For example, the regional data on the percentage of objectors for Latium reported in 2006 was actually the percentage reported for 2001. Furthermore, the correlation coefficients were not calculated for these

variables. The absence of a relationship between the proportion of objectors and the number of elective abortions performed within the two time periods was simply inferred from the lack of an apparently similar or coherent trend for the data from the five regions selected for the analysis. We believe that by using this method the NBC might have overestimated random trend differences and that a relationship between the proportion of objectors and abortion waiting times cannot be precluded.

The fact that in our study a correlation between the increase in workload for non-objectors and the proportion of abortions performed within the waiting time intervals can be observed by analysing the longitudinal data for individual regions but not with a cross-sectional comparison of the regional data may be in part related to the years in which the data were collected and on which the analysis is based. The data contained in the ministerial reports show that a major increase in the number of objectors occurred around 2000, after which the proportion stabilised at over 80% in some regions and at about 70% nationally. Hence, it is possible that the long-term trend (at least 9 years between 1997 and 2011) seen for many regions is less evident at the national level (data from the period 2007–2011) and that no trend can be observed in a cross-sectional comparison of the regions (data from the period 2010–2011) when analysis is restricted to more recent years when both phenomena had reached a sort of steady state.

Our study shows trends and regional differences that sometimes diverge from the national scenario. The reasons for these differences are many: (1) various organisational models for delivering abortion services and differences in the distribution of objecting and non-objecting physicians between regions and within the same region; (2) the regional data refer to time periods that do not always overlap with one another; (3) the reference populations in the individual regions differ for some confounders, and the present study was not designed to account for this; (4) the data on abortions performed within 14 days of the initial request might have been overestimated with respect to the other waiting time intervals (11–21 days, 22–28 days, and > 28 days) for some regions. As documented in the most recent ministerial report available, the proportion of elective abortions carried out within 14 days of the initial request may be influenced by the increase in the number of emergency abortions performed in order to avoid exceeding the 90-day limit imposed by law. As the 90-day limit approaches, the woman's risk of losing her right to abortion increases, unless the referral for elective abortion is motivated by ascertained fetal abnormality or serious consequence for the woman's health[7]. In some regions and provinces this phenomenon may be related to women who travel outside their region or province of residence because they are unable to obtain a timely abortion[6].

Another point to consider is the number of abortions recorded in Italy. Whilst official data indicate a decline in the abortion rate over the past 15 years, the Italian National Institute of Statistics estimates that the illegal abortion rate is rising. The recent perceptible rise in illegal abortion has been substantiated in national surveys[10] and other observations shared by the ECSR[6]. The question arises whether the rates of legal abortion and the estimated illegal abortion rates still reflect the present national situation. An evaluation of these factors lies outside the scope of this study, yet given the relevance of this problem for women's health, and that of immigrant woman in particular, and for the right to safe and legal abortion, further research into this area is undoubtedly necessary. Our study sheds light on issues of importance for reproductive health, since an increase in waiting time for abortion raises the risk of performing an abortion at a later stage of pregnancy, further increasing the risk of complications associated with the procedure.

Among the several factors influencing waiting times to obtain termination of pregnancy, the availability of abortion practitioners is a relevant one. Previous studies demonstrated that when the proportion of healthcare professionals who refuse to practise abortion is high, women encounter undue difficulties and delays in obtaining elective termination of pregnancy. In 1994, Cannold reported that between 1988 and 1990 it was nearly impossible to obtain a second trimester abortion because only one private practitioner provided the service in South Australia and that there was a mass refusal by nurses to participate in abortion[11]. More recently, Dobie *et al.* reported that in the period 1993 to 1994 women residing in rural areas of Washington State who requested pregnancy termination were almost universally unable to find an abortion practitioner in their county and obtained the procedure at later gestational ages than in the period 1983–1984[12]. A survey carried out at the time found that

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only 1.2% of certified physicians agreed to perform an abortion. Interestingly, 66.5% of the physicians stated that they would refuse on moral grounds to carry out an abortion and 69% said they would not because they felt the community they served opposed it[13].

About a decade later, in 2005, Jones *et al*. reported on the continuing decline in the United States in the number of providers willing to perform an abortion and on the increasing difficulty women encountered trying to find abortion services, with some 3 to 10% travelling over 100 miles to have an abortion. No clear pattern between the number of abortion providers and abortion rates could be found, however[14]. More recently, the findings of the 2013 British Columbia Abortion Providers Survey revealed that in many rural areas of Canada only one physician would be willing to perform an abortion and that an overwhelming majority of nurses and anaesthetists would refuse participation in order to maintain a 'low public profile' among non-objectors and avoid harassment[15].

In conclusion, access to elective abortion is strongly influenced by the organisational models individual regions operate in the delivery of abortion services; however, our study findings seem to suggest that timely access to abortion may be a problem at national level and that it may also be influenced by policy decisions regulating conscientious objection. In regions where the proportion of objecting physicians is already high or increasing, it will become more difficult to ensure adequate provision of abortion services. This problem is compounded by the lack of clear legislation on abortion referral systems and a proper legal framework for recruiting non-objecting physicians, which some consider discriminatory. Furthermore, differently from other countries, Italy still does not have targeted strategies in place that would facilitate access to abortion, including ambulatory medical abortion and properly trained non-medical personnel to deliver abortion care[16].

More generally, this study illustrates how difficult it is to evaluate and control the effects of conscientious objection on the availability of health services even in a country where data on abortion services are regularly collected and systematically analysed. Therefore, given the relevance of the problem the present study addresses and the difficulty in providing a clear interpretation of its findings, further research is needed to elucidate the various ways in which conscientious objection can affect access to abortion services in Italy.

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## REFERENCES

1. Committee on Women's Rights and Gender Equality. Draft report on sexual and reproductive health rights: 2013/2040 (INI). European Parliament, 31 May 2013. Accessed 5 October 2014 from: www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//NONSGML+COMPARL+PE-513.082+01+DOC+PDF+V0//EN&language=EN
2. Heino A, Gissler M, Apter D, Fiala C. Conscientious objection and induced abortion in Europe. *Eur J Contracept Reprod Health Care* 2013;18(4):231–3.
3. World Health Organization. Safe abortion: Technical and policy guidance for health systems, 2nd ed. Geneva: WHO 2012. Accessed 21 October 2014 from: http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf
4. Johnson BR Jr, Kismödi E, Dragoman MV, Temmerman M. Conscientious objection to provision of legal abortion care. *Int J Gynaecol Obstet* 2013;123:S60–2.
5. Committee on the Elimination of Discrimination Against Women. Third periodic report of states parties, Italy, CEDAW/C/ITA/3, New York: United Nations 9 June 1998. Accessed 29 October 2014 from: http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N97/273/10/IMG/N9727310.pdf?OpenElement
6. European Committee for Social Rights. Decision on the merits: Complaint no. 87/2012: International Planned Parenthood Federation European Network (IPPF EN) v. Italy. Brussels, 10 March 2014.

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7. Relazione del Ministro della salute sulla attuazione della legge contenente norme per la tutela sociale della maternità e per l'interruzione volontaria di gravidanza (Legge 194/78). Rome: Ministero della Salute 13 September 2013. Accessed 5 October 2014 from: www.salute.gov.it/imgs/C_17_pubblicazioni_2023_allegato.pdf
8. Obiezione di coscienza e bioetica. Rome: Comitato Nazionale per la Bioetica 12 July 2012. Accessed 24 October 2014 from: www.palazzochigi.it/bioetica/pdf/5Obiezione%20di%20coscienza%20°%20bioetica.pdf
9. Italian Ministry of Health. Accessed 24 October 2014 from: www.salute.gov.it/portale/documentazione/p6_2_2.jsp?lingua = italiano&area = Salute + donna&btnCerca = cerca
10. Minerva F. Conscientious objection in Italy. *J Med Ethics* 2013;pii:1–4.
11. Cannold L. Consequences for patients of health care professionals' conscientious actions: The ban on abortions in South Australia. *J Med Ethics* 1994;20:80–6.
12. Dobie SA, Hart LG, Glusker A, *et al.* Abortion services in rural Washington State, 1983–1984 to 1993–1994: Availability and outcomes. *Fam Plann Perspect* 1999;31:241–5.
13. Dobie SA, Rosenblatt RA, Glusker A, *et al.* Reproductive health services in rural Washington State: Scope of practice and provision of medical abortions, 1996–1997. *Am J Public Health* 2000;90:624–6.
14. Jones RK, Zolna MR, Henshaw SK, Finer LB. Abortion in the United States: Incidence and access to services, 2005. *Perspect Sex Reprod Health* 2008;40:6–16.
15. Norman WV, Soon JA, Maughn N, Dressler J. Barriers to rural induced abortion services in Canada: Findings of the British Columbia Abortion Providers Survey (BCAPS). PLoS One 2013;8:e67023.
16. Renner RM1, Brahmi D, Kapp N. Who can provide effective and safe termination of pregnancy care? A systematic review. *BJOG* 2013;120:23–31.



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# EXHIBIT J

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CONSCIENTIOUS OBJECTION

# Conscientious objection or fear of social stigma and unawareness of ethical obligations

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ABSTRACT

Conscientious objection is a legitimate right of physicians to reject the practice of actions that violate their ethical or moral principles. The application of that principle is being used in many countries as a justification to deny safe abortion care to women who have the legal right to have access to safe termination of pregnancy. The problem is that, often, this concept is abused by physicians who camouflage under the guise of conscientious objection their fear of experiencing discrimination and social stigma if they perform legal abortions. These colleagues seem to ignore the ethical principle that the primary conscientious duty of OB/GYNs is—at all times—to treat, or provide benefit and prevent harm to, the patients for whose care they are responsible. Any conscientious objection to treating a patient is secondary to this primary duty. One of the jobs of the FIGO Working Group for the Prevention of Unsafe Abortion is to change this paradigm and make our colleagues proud of providing legal abortion services that protect women's life and health, and concerned about disrespecting the human rights of women and professional ethical principles.
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## 1. The concept of conscientious objection

Conscientious objection is a legitimate right of physicians to reject the practice of actions that violate their ethical or moral principles. It allows them, for example, to reject participation in the process of interrogation of suspects, which may include procedures reaching the limits of torture. In the context of providing legal abortion care, the FIGO Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health states that [1]:

> Some doctors feel that abortion is not permissible whatever the circumstances. Respect for their autonomy means that no doctor (or other member of the medical team) should be expected to advise or perform an abortion against his or her personal conviction. Their careers should not be prejudiced as a result. Such a doctor, however, has an obligation to refer the woman to a colleague who is not in principle opposed to termination.

The application of that principle is being used in several countries in Latin America and other parts of the world as a justification to deny safe abortion care to women who have the legal right to have access to safe termination of pregnancy.

## 2. Inappropriate utilization of conscientious objection to deny legal abortion services

Latin America is a region with very restrictive abortion laws and it includes most of the few countries in the world where abortion is not permitted in any circumstances: Chile, Honduras, El Salvador, and more recently Dominican Republic and Nicaragua (all of which are relatively small countries) [2]. In most other countries in Latin America, abortion is considered a crime but is not punished in certain circumstances: for example, when performed to preserve women's life and/or health; in cases of rape or incest; and in the presence of very severe fetal defects incompatible with extrauterine life.

Abortion is permitted in broad circumstances in Cuba, Mexico City, Colombia, and more recently Uruguay up to 12 weeks of pregnancy [2–5]. The problem is that most women who meet the requirements for obtaining a permissible abortion do not receive the care they need in public hospitals—instead, resorting to clandestine abortions, which can be unsafe. In recent years, there have been efforts from private organizations and governments to make abortion accessible to women who meet the legal conditions, following International Conference on Population and Development recommendations [6]. The main obstacle to the provision of services is unwillingness of physicians claiming conscientious objection to providing abortion care.

The problem is that, often, the concept of conscientious objection is abused by physicians in at least 2 different ways:

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(1) By not respecting their obligation to give priority to the needs of the women for whose care they are responsible. In the words of the FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health: "The primary conscientious duty of obstetrician–gynecologists is at all times to treat, or provide benefit and prevent harm to, the patients for whose care they are responsible. Any conscientious objection to treating a patient is secondary to this primary duty" [1].

(2) By camouflaging under the guise of conscientious objection their fear of experiencing discrimination if they perform legal abortions.

A previous study surveyed 3337 members of the Brazilian Federation of Gynecology and Obstetrics Societies who responded to an anonymous questionnaire inquiring under which circumstances abortion should be permitted by law. Almost 85% agreed that women who become pregnant after rape should have the legal right to obtain a safe termination of pregnancy. Only 50%, however, were willing to perform such an abortion or prescribe abortifacient drugs [7].

A subsequent qualitative study of 30 OB/GYNs from the state of Sao Paulo showed that the reasons for refusing to perform legal abortion derived mostly from personal convictions and religious principles [8]. Religious justification is usually accepted without argument. Some study participants, however, expressed their doubt that the religious rationale was always genuine because they suspected that the main reason for unwillingness to perform abortion was the fear of social stigma [9].

Physicians know that refusal to perform pregnancy termination while alleging conscientious objection will have no consequences such as complaints or disciplinary action against them. By contrast, they fear negative legal or social consequences if they do perform terminations and prefer to avoid these. The concept that "the primary conscientious duty of obstetrician–gynecologists is at all times to treat, or provide benefit and prevent harm to, the patients for whose care they are responsible" is rarely taken into account [1]. It is much easier to use conscientious objection to hide the real reason, which is that it is simply more comfortable to deny the service that the woman needs than to fulfill their professional and ethical obligation of providing safe abortion services according to the country's law.

It is disappointing to observe that many of our colleagues, at least in the Latin American region, appear to fear being stigmatized for carrying out a legal procedure that would avert the serious complications that could occur if the procedure were performed unsafely and clandestinely but are not afraid of being stigmatized for avoiding their ethical duty "to treat, or provide benefit and prevent harm to, the patients for whose care they are responsible" [1].

## 3. How to promote proper balance between conscientious objection and ethical obligations to patients

It appears that those of us who occupy positions of leadership in the professional organizations of gynecologists and obstetricians have not done our job sufficiently in terms of promoting and normalizing these ethical principles among our colleagues. It appears that they are unaware that our "… primary conscientious duty … is at all times to … provide benefit and prevent harm to the patients" under our care [1].

We have often been in meetings with honest and sensitive colleagues who, in general, promote and defend women's sexual and reproductive rights, but who nevertheless find excuses—under the guise of conscientious objection—for not providing abortion services within the limits of the local law.

One explanation for this situation is the incorrect idea that facilitating access to safe and legal abortion services promotes abortions. Many obstetricians, accustomed to work protecting the life and health of the fetuses of women who want to have children, feel uncomfortable with the notion of increasing the number of abortions. This indicates that we have failed to disseminate the evidence of the statistically significant inverse relationship between the proportion of women living in countries with liberal abortion laws and the induced abortion rate among the same women. These data show unequivocally that giving broader access to safe legal abortion does not lead to increased rates of abortion [9].

In other words, rather than solely criticizing the behavior of the many colleagues who hide their fear of stigma under the guise of conscientious objection, we should work to disseminate some basic ethical principles clearly stated by the FIGO Committee on the Ethical Aspects of Human Reproduction and Women's Health. We should also disseminate the evidence that making legal abortion more broadly available does not increase the abortion rate but does reduce maternal mortality and morbidity.

The FIGO Working Group for the Prevention of Unsafe Abortion promotes the prevention of unintended pregnancy as a primary strategy and then asserts that, if unintended pregnancy has occurred and the abortion is inevitable, safe abortion services should be available within the limits of the law [10]. Although some progress has occurred in Latin America—namely, in Brazil, Colombia, Argentina, and Uruguay—there is still strong resistance from many of our colleagues, and the number of women with legal rights to abortion who lack access to services is much greater than the number of women who receive appropriate care. The situation is not much different in Africa and many countries in Asia, indicating that we have to seek stronger commitments from national OB/GYN societies, who are all bound to follow the FIGO ethical guidelines described above.

The FIGO Working Group for the Prevention of Unsafe Abortion will need the support of the FIGO Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health to change this paradigm and make our colleagues proud of providing legal abortion services that protect women's life and health, and concerned about disrespecting the human rights of women and professional ethical principles. That is our task for the immediate future.

**Conflict of interest**

The authors have no conflicts of interest.

## References

[1] FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health. Ethical Issues in Obstetrics and Gynecology. http://www.figo.org/files/figo-corp/English%20Ethical%20Issues%20in%20Obstetrics%20and%20Gynecology.pdf. Published October 2012.
[2] Center for Reproductive Rights. The World's Abortion Laws Map 2011. http://reproductiverights.org/sites/crr.civicactions.net/files/documents/AbortionMap_2011.pdf. Published 2011. Accessed August 15, 2013.
[3] Decree reforming Articles 145 and 148 of the new Penal Code of Mexico City and adding Articles 16 bis 6 and 16 bis 7 to the Health Law of Mexico City, reported in Official Gazette of Mexico City, 14, no. 7, 24 January 2004, pp. 6–7 (Mexico).
[4] Center for Reproductive Rights. The World's Abortion Laws Map 2013 Update. Fact Sheet. http://reproductiverights.org/sites/crr.civicactions.net/files/documents/AbortionMap_Factsheet_2013.pdf. Accessed August 15, 2013.
[5] Law C-355 of 2006 (Colombia).
[6] UN. Report of the International Conference on Population and Development, Cairo: United Nations, 5–13 September 1994. http://www.unfpa.org/webdav/site/global/shared/documents/publications/2004/icpd_eng.pdf. Accessed August 15, 2013.
[7] Faúndes A, Simoneti RM, Duarte GA, Andalaft-Neto J. Factors associated to knowledge and opinion of gynecologists and obstetricians about the Brazilian legislation on abortion. Rev Bras Epidemiol 2007;10(1):6–18.
[8] Faúndes A, Hardy E, Duarte G, Osis MJD, Makuch MY. The role of religion over the perspective and actions of gynecologists with reference to legal

# EXHIBIT K

Special Section: Open Forum

# *Conscientious Refusals by Hospitals and Emergency Contraception*

MARK R. WICCLAIR

Hospitals sometimes refuse to provide goods and services or honor patients' decisions to forgo life-sustaining treatment for reasons that appear to resemble appeals to conscience.[1] For example, based on the *Ethical and Religious Directives for Catholic Health Care Services* (ERD), Catholic hospitals have refused to forgo medically provided nutrition and hydration (MPNH), and Catholic hospitals have refused to provide emergency contraception (EC) and perform abortions or sterilization procedures.[2] I consider whether it is justified to refuse to offer EC to victims of sexual assault who present at the emergency department (ED).[3] A preliminary question, however, is whether a hospital's refusal to provide services can be conceptualized as *conscience based*.

### Can Refusals by Hospitals Be Conscience Based?

If taken literally, it would be implausible to claim that hospitals can have and exercise a conscience. Hospitals do not appear to have the characteristics that would warrant ascribing to them those capacities. According to George Annas, "Hospitals are corporations that have no natural personhood, and hence are incapable of having either 'moral' or 'ethical' objections to actions."[4] To be sure, hospitals are not living, conscious organisms. They lack awareness and do not have the capacity to think, form intentions, or feel good or bad. Moreover, in contrast to healthcare professionals, hospitals cannot *experience* the effects of a loss of moral integrity, and they cannot *experience* guilt or *suffer* from injury to their identity. Nevertheless, claims can be advanced on behalf of hospitals that bear a family resemblance to appeals to conscience by individuals and warrant substantial deference.

In some cases, a hospital's mission can be considered an analogue to the conscience of a physician, nurse, or pharmacist. As Kevin Wildes puts it:

> [A]n institution can have a moral identity and conscience. A necessary condition for talking about institutional conscience is the moral identity of an institution. One way to explore this moral identity is to look at the mission of an institution.[5]

Although most, if not all, hospitals have mission *statements*, only some can purport to have genuine *missions* (i.e., a commitment to goals, values, and principles) that comprise a distinct *identity* and provide the basis for what might be considered analogues to appeals to conscience.[6] Hospitals with a commitment to religious principles often have genuine missions, and a paradigm example is provided by Catholic hospitals whose mission involves a commitment to the

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ERD.[7] For such hospitals, adherence to the ERD is essential to their identity and integrity.[8] Accordingly, a failure to adhere to the ERD would comprise a failure to maintain the hospital's identity and integrity that is analogous to the loss of moral integrity when healthcare professionals fail to adhere to their core moral values.[9]

Even if it is plausible to contend that a hospital can have an identity and that certain actions can result in a loss of its identity and (moral) integrity, it remains to ask why it should matter whether a hospital is able to preserve its identity and moral integrity. Unlike individuals, hospitals cannot have or lose self-respect or a sense of dignity, and they cannot experience a loss of identity or moral integrity as a harm or injury. Hence, it might seem that in contrast to individuals, there is no sound basis for valuing the preservation of institutional identity and integrity. Accordingly, although it might be conceded that there are grounds to accommodate individual physicians, nurses, and pharmacists who accept the ERD, it might be maintained that there is no ethical basis for a similar accommodation for hospitals. For example, it might be conceded that protecting the identity and moral integrity of individual ED physicians and nurses with conscience-based objections to EC provides a good reason for reasonable accommodation. However, it might be argued that preserving the identity and (moral) integrity of a Catholic hospital that is committed to the ERD fails to provide a good reason to support exempting its ED from an obligation to offer EC to rape victims.

In response, there are several reasons for enabling hospitals to maintain their identity and integrity and exempting them from general institutional obligations that would compromise their identity and integrity. First, it can be important to physicians, nurses, pharmacists, and other personnel to be able to practice and work in a *community* that shares a commitment to a core set of goals, values, and principles. Practicing or working in an institution that permits actions that violate a healthcare professional's core values might compromise her moral integrity. At the very least, it can contribute to considerable moral distress. Second, it can be important to patients to receive care in a facility that is committed to their fundamental values. Even if a patient's moral integrity is not at stake, it can be a considerable source of distress to be cared for in a facility that engages in practices that are inconsistent with one's fundamental ethical or religious values. Third, even when they are not hospital or nursing home patients, members of a faith community may have an interest in the existence of hospitals that exemplify its fundamental principles. Fourth, it might be claimed that the existence of hospitals dedicated to upholding perceived moral ideals is intrinsically valuable. To be sure, there are exceptions. For example, there is nothing intrinsically valuable about hospitals such as Nazi hospitals that are committed to "racial purity" and other clearly unacceptable goals. However, excluding such outliers, it nevertheless might be claimed that, generally, a society with hospitals whose identity is based in part on perceived moral ideals is a better society than one without such hospitals. Fifth, it might be claimed that such hospitals are instrumentally valuable insofar as they sustain and nourish diversity. Finally, it might be claimed that insofar as such hospitals have a *social* mission, which is perhaps especially true of religiously affiliated facilities, they promote social justice and contribute to social welfare. For example, in a section of the ERD entitled "The Social Responsibility of Catholic Health Care Services," the Third Directive states:

> In accord with its mission, Catholic health care should distinguish itself by service to and advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination: the poor; the uninsured and the underinsured; children and the unborn; single parents; the elderly; those with incurable diseases and chemical dependencies; racial minorities; immigrants and refugees.[10]

In view of this social mission, it might be claimed that enabling Catholic hospitals to maintain a coherent identity and integrity benefits the community. If Catholic hospitals are not able to maintain their distinctive identity, they might decide to close their doors rather than compromise their integrity, which would leave more vulnerable members of the community worse off. Moreover, in some communities, the closing of one healthcare facility can substantially reduce convenient access to health services for all residents.

Arguably, these reasons provide grounds for exempting Catholic hospitals from an obligation to provide a good or service such as EC, abortion, or sterilization if doing so would compromise the institution's identity and integrity. However, there are limits to such accommodations. Hospitals have obligations and responsibilities to patients, including obligations to promote their health, protect them from harm, and respect their autonomy. First, hospitals and nursing homes are licensed by states with a legitimate expectation that they will protect patients from harm, promote their health, and respect their autonomy, and corresponding obligations can be said to derive from a commitment by licensees when they accept a license to operate a facility.[11] Second, those obligations can be said to derive from considerations of reciprocal justice. A hospital license confers certain exclusive rights and privileges on the licensee, and when licensees accept and enjoy these rights and privileges, they incur reciprocal obligations, including obligations to protect patients from harm, promote their health, and respect their autonomy. Third, those obligations might be derived from general ethical principles, such as respect for autonomy, beneficence, nonmaleficence, and justice, together with certain assumptions about the connection between safe and effective healthcare and health, the potential for harm if patients do not receive timely and competent healthcare, the vulnerability of people who are ill and require healthcare, and so forth. Accordingly, obligations to patients set limits to identity- and integrity-preserving refusals by hospitals.

## Emergency Contraception

Women 17 years and older may purchase EC at U.S. pharmacies without a prescription. Nevertheless, hospital EDs are likely to remain a frequent access point to EC for victims of sexual assault. Yet many studies[12] report that most Catholic hospitals in the U.S. do not provide EC even to rape victims.[13] Some Catholic hospitals that offer EC to rape victims reportedly do so only with conditions, such as requiring a negative pregnancy test or police notification. Some of the studies reported that most Catholic hospitals that do not provide EC also do not refer to practitioners who do, and even when referrals are provided, they often turn out to be unhelpful to patients. These studies used telephone calls to determine whether an ED will provide EC to a patient who requests it, and they were not designed to determine whether the option of EC is disclosed to

assault victims who present at an ED. However, a small pilot study of 28 Catholic and 30 non-Catholic hospitals did ask whether hospital policy prohibits a discussion of EC with rape victims.[14] The study reported that none of the non-Catholic hospitals had such a policy. By contrast, 12 Catholic hospitals had such a policy (1 did not respond to the question). The study, however, found a significant difference between policy and practice in several of the Catholic hospitals that, according to respondents, had a policy prohibiting discussing EC with rape victims. In 4 of the hospitals, ED staff reportedly discussed EC in violation of hospital policy; in 2 hospitals, patients received information about EC from a provider outside the ED; and rape counselors provided information about EC in the ED in 2 hospitals.[15]

Because women 17 years and older no longer require a prescription for EC, when considering the obligations of Catholic hospitals in relation to rape victims who present at an ED, it is necessary to distinguish between rape victims who do and do not need a prescription for EC. Reasonable people might disagree about whether Catholic hospitals have an obligation to provide EC to rape victims who are 17 years or older. However, at the very least, it is the responsibility of all hospitals, including Catholic hospitals, to ensure that rape victims, no matter their age, who present at the ED have an opportunity to receive information about EC without delay and have timely and convenient access to it if they decide to take it.

Optimally, to minimize delay and additional emotional distress, information about EC should be offered and, if requested, provided on site. If information is provided on site, it need not be by hospital staff. For example, a hospital might have a standing arrangement with a rape crisis or counseling center to make personnel available to explain EC to patients in the hospital. Off-site alternative arrangements can suffice, but only if they ensure that rape victims have an opportunity to make informed decisions about and receive EC in a convenient and timely manner. For example, hospitals might offer to arrange for patients to be transported at no charge to a rape crisis or counseling center. However, hospitals that pursue this option have an obligation to disclose the following information to rape victims: (1) there is a medication to prevent pregnancy, (2) the medication should be taken as soon as possible but no later than 72 hours after the sexual assault,[16] and (3) it is contrary to the hospital's mission to provide additional information or the medication, but the hospital will provide free transportation to an organization that can give a full explanation about the medication and facilitate timely and convenient access to it. In view of the trauma of rape and the urgency of the situation, however, it is at least arguable that if a rape victim objects to having to go elsewhere for information about EC, hospitals should provide it.

If hospitals provide information about EC but do not provide the medication, if requested, they should at least provide information about conveniently located pharmacies that dispense it. If there are no nearby pharmacies that stock EC and are open 24/7, hospitals arguably have an obligation to stock a supply so that the medication can be given to rape victims if needed to prevent excessive inconvenience or delay.

For rape victims who are under 17 years old, hospitals that do not routinely provide prescriptions for EC have an obligation to ensure that such patients have a timely and convenient opportunity to get a prescription for it. This obligation

might be discharged by offering to provide free transportation to a rape crisis or counseling center. However, if there are no alternative means to ensure that rape victims under 17 years old have an opportunity to receive prescriptions for EC without excessive delay or inconvenience, hospitals have an obligation to provide them.

Fulfilling these obligations might require some Catholic hospitals to compromise their identity and integrity. Nevertheless, there are several reasons for ascribing these obligations to all hospitals, including those whose identity and integrity might be compromised.

First, some rape victims may depend on the ED for timely information about EC. Studies have reported that many women are either unaware of EC or lack sufficient understanding to use it effectively. A study of California women between the ages of 18 and 44 reported that 36.5% of the respondents stated that there was nothing women could do in the three days after intercourse to prevent pregnancy, and an additional 11.6% stated that they did not know.[17] A second study reported that only 67% of women respondents answered that there is something that women can do after sexual intercourse to prevent pregnancy.[18] Moreover, among the women who knew that EC could prevent post coital pregnancy, only 74% knew that it should be taken within 72 hours after intercourse, and almost half of them mistakenly believed that it must be taken immediately or within 24 hours. A third study reported that 85.3% of respondents were unable to answer correctly two questions that were designed to test comprehension of the concept of EC.[19] Because there is a 72-hour window of maximum effectiveness of EC,[20] if women do not leave the ED with an adequate understanding of emergency contraception, even if they acquire that knowledge later, it may be too late to enable them to substantially reduce the risk of pregnancy. Moreover, because patients generally can reasonably expect that physicians will tell them about all clinically relevant options, it might not even occur to rape victims to look for other options on their own (e.g., from their obstetrician-gynecologist or on the Internet). Accordingly, if an ED does not make available an opportunity for a rape victim to receive information about EC, she may not be able to make an informed choice about whether or not to take a medication that significantly reduces the risk of becoming pregnant. Because sexual assault victims who present at an ED are likely to be traumatized, distraught, and especially vulnerable, even if a rape victim is aware of EC, an offer to review and explain her options may enhance her ability to make an informed decision.

Second, deciding whether or not to become pregnant is undoubtedly among the most intimate, personal, and important life choices that a woman can make. EC obviously cannot undo or reverse the violation of a rape victim's bodily integrity and personhood. However, it can at least restore her ability to control whether or not she will become pregnant and, in this respect, restore her control over her own body and procreative future. Moreover, if a rape victim does not have an opportunity to choose EC and prevent a pregnancy, she may be confronted later with a difficult choice between giving birth to a child that is genetically related to her rapist and having an abortion. Whereas providing information about and access to EC can be a substantial benefit to rape victims, a failure to offer an opportunity to receive information about and access to it can result in additional substantial harm. Hence, timely knowledge about EC and

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access to it can be of utmost importance to the health and well-being of rape victims.

Third, any delay in offering means to prevent pregnancy can be unbearable to rape victims. It is unreasonable to expect anxious rape victims who insist on knowing *now* to patiently wait until they can be transported to another location to find out how they can lower the risk of becoming pregnant. Moreover, it would be insensitive at best and cruel at worst to, in effect, tell a rape victim who is fearful of becoming pregnant and insists on taking immediate preventive measures: "Since no conveniently located pharmacies that dispense EC are open now, you will have to wait until tomorrow to do anything about it."

Fourth, offering EC to rape victims who present at an ED is standard of care.[21] It is explicitly endorsed in policies of the American College of Emergency Physicians (ACEP) and the AMA. An ACEP policy statement entitled, "Management of the Patient with the Complaint of Sexual Assault," states: "A victim of sexual assault should be offered prophylaxis for pregnancy and for sexually transmitted diseases, subject to informed consent and consistent with current treatment guidelines."[22] The policy statement provides an accommodation for conscience-based objections, but it clearly limits accommodations to those that will not interfere with the obligation to ensure that rape victims receive a timely offer of EC:

> Physicians and allied health practitioners who find this practice morally objectionable or who practice at hospitals that prohibit prophylaxis or contraception should offer to refer victims of sexual assault to another provider who can provide these services in a timely fashion.

The AMA affirms that "information about emergency contraception is part of the comprehensive information to be provided as part of the emergency treatment of sexual assault victims."[23]

Finally, withholding information about EC is contrary to the reasonable expectations of rape victims who present at an ED. It is a reasonable expectation that hospital EDs will offer standard of care treatment.[24] Thus, insofar as offering EC is standard of care for rape victims, not ensuring that this option is presented to them in a timely fashion is contrary to a reasonable expectation. Surely, patients can reasonably expect that a hospital will neither condone nor permit staff to intentionally withhold information about clinically appropriate options.

For all these reasons, it is arguable that (1) a hospital's general obligations to promote patients' health, protect them from harm, and respect their autonomy are appropriately specified to include an obligation to implement measures to ensure that rape victims who present at the ED have an opportunity to receive information about EC without delay and have timely access to it if they decide to take it and (2) this obligation applies to all hospitals, including those whose identity and integrity might be compromised by fulfilling it.

## Conclusion

Hospitals do not have characteristics that would appear to warrant ascribing to them the capacity to have and exercise a conscience. Nevertheless, they can attempt to justify refusals to offer goods and services by appealing to their identity and integrity, and such claims can bear a family resemblance to appeals

to conscience by individuals and can warrant substantial deference. Hospitals, however, have obligations to prevent harm to patients, promote patient health, and respect patient autonomy. These obligations set limits to identity- and integrity-maintaining refusals to offer EC. Specifically, even if it might compromise their identity and integrity, hospitals have an obligation to ensure that rape victims, no matter their age, who present at the ED have an opportunity to receive information about EC without delay and have timely and convenient access to it if they decide to take it.

## Notes

1. This paper draws on some material that will be published in *Conscientious Objection in Health Care: An Ethical Analysis*. Cambridge, UK: Cambridge University Press; 2011.
2. United States Conference of Catholic Bishops. *Ethical and Religious Directives for Catholic Health Care Services*, 5th ed. November 2009; available at http://www.usccb.org/meetings/2009Fall/docs/ERDs_5th_ed_091118_FINAL.pdf (last accessed 9 Jul 2010). The previous (fourth) edition of the ERD went into effect in June 2001.
3. In *Conscientious Objection in Health Care: An Ethical Analysis*, I also consider refusals by hospitals to honor decisions to forgo MPNH and to provide medical interventions in emergency situations that will terminate or risk terminating a pregnancy.
4. Annas GJ. Transferring the ethical hot potato. *Hastings Center Report* 1987;17(1):20–1 at 21.
5. Wildes KW. Institutional identity, integrity, and conscience. *Kennedy Institute of Ethics Journal* 1997;7(4):413–9 at 416.
6. Mission statements, according to William Stempsey, "are the primary means by which institutions express their identity and serve as standards to measure the integrity with which an institution lives out its identity." Stempsey WE. Institutional Identity and Roman Catholic Hospitals. *Christian Bioethics* 2001;7(1):3–14 at 14. Although it would be implausible to attribute this function to all mission statements, it might be credible to limit the claim to the mission statements of hospitals, such as those that adhere to the ERD, that involve a commitment to goals, values, and principles that comprise the institution's identity.
7. For an account of mission statements associated with a hospital's "Catholic identity," see O'Rourke K. Catholic hospitals and Catholic identity. *Christian Bioethics* 2001;7(1):15–28. Although other religions can provide the basis for conceptions of institutional identity and integrity, this analysis is limited to Catholic hospitals. Because of their strong commitment to maintaining their Catholic identity, they have been a major source of institutional appeals to conscience. Moreover, a significant percent of community hospitals in the United States are Catholic (12.4%); Catholic hospitals account for more than 20% of admissions in 22 states; and there are Catholic hospitals in all but 6 states. Catholic Health Association. Newsroom; available at http://www.chausa.org/Pages/Newsroom/Fast_Facts/ (last accessed 9 Jul 2010).
8. Ana Smith Iltis provides an analysis of institutional integrity according to which it "can be understood as the coherence between what an institution claims to value (its stated moral character), what an institution does (its manifest moral character), and an institution's fundamental moral commitments (its deep moral character)." Smith Iltis A. Institutional integrity in Roman Catholic health care institutions. *Christian Bioethics* 2001;7(1):95–103, at p. 98. According to Smith Iltis, "when there is a lack of coherence between an institution's manifest moral character and its identity, then the institution has failed to maintain its integrity" (p. 101).
9. For the purpose of this discussion, I am only considering aspects of a Catholic hospital's identity that affect the kinds of interventions that it does and does not offer. Accordingly, I am not considering theological commitments or "transcendent goals." Some commentators claim that the commitment to spiritual goals is fundamental. William Stempsey expresses a view along these lines:

> Any hospital might refuse to allow abortion and physician-assisted suicide, but Catholic hospitals refuse these things because they are fundamentally inconsistent with Christian values. Directive 1 of the ERD (1995) states: 'A Catholic institutional health care service is a community that provides health care to those

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> in need of it. This service must be animated by the Gospel of Jesus Christ and guided by the moral tradition of the Church.' This is unambiguous. Catholic health care is not the same as secular health care. To hold that Catholic hospitals have lost their identity because their surgical procedures do not look different from those in secular hospitals is a conclusion based upon a false dichotomy. The question is. Is the care animated by Gospel values?

See note 6, Stempsey 2001:11. H. Tristram Engelhardt, Jr., laments the increasing secularization of Catholic hospitals, which is characterized by a failure to give priority to their spiritual mission. See Engelhardt Jr HT. The deChristianization of Christian health care institutions, or, How the pursuit of social justice and excellence can obscure the pursuit of holiness. *Christian Bioethics* 2001;7(1):151–61.

10. See note 2, United States Council of Catholic Bishops 2009. A review of 25 Catholic hospital mission statements reportedly revealed a consistent commitment to social justice. See Shannon TA. Living the vision: Health care, social justice and institutional identity. *Christian Bioethics* 2001;7(1):49–65.
11. In August 2009, the Joint Commission, which provides accreditation for hospitals in the United States, adopted a revised mission statement. According to that statement, its mission is "[t]o continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value"; available at: http://www.jointcommission.org/NR/rdonlyres/2F04C126-906D-4155-B16F-1F1A6570C387/0/jconlineAug1209.pdf (last accessed 9 Jul 2010). This mission statement identifies general patient-centered goals for hospitals and nursing homes that seek Joint Commission accreditation. Accordingly, Joint Commission accreditation requirements provide a *prudential* reason for hospitals and nursing homes to protect patients from harm, promote their health, and respect their autonomy.
12. Nunn A, Miller K, Alpert H, Ellertson C. Contraceptive emergency: Catholic hospitals overwhelmingly refuse to provide EC. *Conscience* 2003;24:38–41; Harrison T. Availability of emergency contraception: A survey of hospital emergency department staff. *Annals of Emergency Medicine* 2005;46(2):105–10; Polis C, Schaffer K, Harrison T. Accessibility of emergency contraception in California's Catholic hospitals. *Women's Health Issues* 2005;15:174–78.
13. One exception is a study of Massachusetts Catholic hospitals, which reported that respondents in only three of nine hospitals stated that EC was not available for sexual assault victims. Temin E, Coles T, Feldman JA, Mehta SD. Availability of emergency contraception in Massachusetts emergency departments. *Academic Emergency Medicine* 2005;12(10):987–93. The California study reported that in 66% of the 44 Catholic hospitals, EC is not provided under any circumstances. See note 12, Polis et al. 2005. However, data for the study predates a California law requiring provision of EC to rape victims. Accordingly, the situation may have changed in California and other states that have subsequently adopted similar legislation. On the other hand, some Catholic EDs reportedly violated existing state EC requirements, so there appears to be a gap between legal requirements and actual practice. See note 12, Nunn et al. 2003. It is noteworthy that all of the studies reported that a significant percent of non-Catholic hospitals do not provide EC for rape victims.
14. Smugar SS, Spina BJ, Merz JF. Informed consent for emergency contraception: Variability in hospital care of rape victims. *American Journal of Public Health* 2000;90(9):1372–6.
15. The study also found significant differences in the practices of Catholic hospitals in relation to providing prescriptions for and dispensing EC. Such variation is not surprising if, as some commentators have claimed, the ERD (specifically Directive 36) does not provide unambiguous guidance in relation to EC for victims of sexual assault. Directive 36 states:

> Compassionate and understanding care should be given to a person who is the victim of sexual assault. Health care providers should cooperate with law enforcement officials and offer the person psychological and spiritual support as well as accurate medical information. A female who has been raped should be able to defend herself against a potential conception from the sexual assault. If, after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization. It is not permissible, however, to initiate or to

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> recommend treatments that have as their purpose or direct effect the removal, destruction, or interference with the implantation of a fertilized ovum.

Directive 36 includes the following footnote:

> It is recommended that a sexually assaulted woman be advised of the ethical restrictions that prevent Catholic hospitals from using abortifacient procedures; cf. Pennsylvania Catholic Conference, "Guidelines for Catholic Hospitals Treating Victims of Sexual Assault," *Origins* 22 (1993):810.

16. ACOG Practice Bulletin Emergency Oral Contraception. *International Journal of Gynecology & Obstetrics* 2002;78:191–8. According to a recent study, "ulipristal acetate prevents pregnancies when used as emergency contraception up to 120 hours after intercourse, making it the first hormonal method of emergency contraception with solid evidence of efficacy for late intake." Fine P, Mathé H, Ginde S, Cullins V, Morfesis J, Gainer E. Ulipristal acetate taken 48-120 hours after intercourse for emergency contraception. *Obstetrics & Gynecology* 2010;115(2):257-63 at 263. It has been approved for sale in the European Union under the product name "ellaOne." As of June 2010, under the product name "ella," it was approved by a U.S. FDA advisory panel, but not yet by the FDA. Harris G. Panel recommends approval of after-sex pill. *The New York Times* 2010 Jun 18:14,20. If the FDA approves ella, it will be available by prescription only.
17. Foster DG, Harper CC, Bley JJ, Mikanda JJ, Induni M, Saviano EC, et al. Knowledge of emergency contraception among women aged 18 to 44 in California. *American Journal of Obstetrics and Gynecology* 2004;191:150–6.
18. Abbott J. Emergency contraception: What should our patients expect? *Annals of Emergency Medicine* 2005;46(2):111–3.
19. Merchant RC, Casadei K, Gee EM, Bock BC, Becker BM, Clark MA. Patients' emergency contraception comprehension, usage, and view of the emergency department role for emergency contraception. *The Journal of Emergency Medicine* 2007;33(4):367–75. One question asked: "If a woman has had vaginal sexual intercourse with a man (without using birth control), can she take birth control pills AFTERWARDS to prevent pregnancy?" The second question asked respondents whether they agree or disagree with the following statement: "A woman can take birth control pills shortly AFTER having vaginal intercourse with a man to prevent pregnancy." Because the questions referred to "birth control pills" rather than "emergency contraception," "the morning-after pill," or simply "medication," they may have failed to accurately test respondents' understanding of the "concept of EC." The study also asked respondents whether they agree or disagree with the following statement: "Taking birth control pills AFTER having sexual intercourse with a man causes an abortion." Only 9.8% expressed their agreement. However, before concluding that over 90% of the respondents had an accurate understanding of the mechanism of EC, one has to consider the possibility that their responses might have been significantly different if the statement had referred to "emergency contraception" or "the morning-after pill" rather than "birth control pills."
20. See note 16.
21. Bishai D. Measuring the quality of medical care for women who experience sexual assault with data from the National Hospital Ambulatory Medical Care Survey. *Annals of Emergency Medicine* 2002;39(6):631–8. See also note 14, Smugar et al. 2000.
22. Available online at http://www.acep.org/practres.aspx?id=29562 (last accessed 9 Jul 2010).
23. Access to Emergency Contraception, House of Delegates. Health Policy 75.985. House of Delegates Health Policy statements can be accessed online by means of "PolicyFinder", which can be downloaded at the AMA website http://www.ama-assn.org/ama/no-index/about-ama/11760.shtml (last accessed 9 Jul 2010).
24. See note 12, Nunn et al. 2003.

# EXHIBIT L

# Health Care Provider Refusals to Treat, Prescribe, Refer or Inform: Professionalism and Conscience

R. Alta Charo*

## I. INTRODUCTION

A woman who has been raped is refused emergency contraception by a pharmacist. Another who wants a child is refused fertility services by a physician because she is gay. Another is refused a prescription for a drug needed for the aftermath of a miscarriage, because the pharmacist thinks it may be used for an abortion. A physician refuses to forward medical records for a patient who had an abortion after the fetus was diagnosed with severe deformities. Another physician refuses to perform a routine physical as part of an adoption procedure, because the woman is single.[1]

Largely as artifacts of the abortion wars, almost every state has some form of a "conscience clause" on its books—laws that seek to balance a health care provider's conscientious objection to performing an abortion with the profession's obligation to afford all patients nondiscriminatory access to services. Traditionally, these laws referred to physician obligations to provide abortion services and, in most cases, the provision of a referral satisfied one's professional obligations. But in recent years, with the abortion debate increasingly at the center of wider discussions about contraception, end of life care, assisted suicide, genetic screening, reproductive technologies, and embryonic stem-cell research, nurses and pharmacists have begun demanding the same right of refusal. Even more expansively, some professionals are claiming that even a referral or the provision of information makes one complicit in the objectionable act, and therefore are asserting a much broader freedom to avoid facilitating a patient's health care needs.

The debate surrounding health care provider ("HCP") right of conscience has emerged with fresh force in the last few years, embedded in a larger national debate about the role of religion in public and professional lives. This debate, which ranges from displays of religious symbols on public property to public acts of religious conviction during public events, is implicated in the discussion of private acts of personal religious conviction in the course of providing professional services to the general public.

This paper describes early refusal clauses and more recent efforts to expand them to allow more HCPs to refuse to provide more kinds of services, as well as some legislative and regulatory actions pushing back in the other direction by limiting pharmacist refusals to fill prescriptions. The ethical arguments for provider refusals to

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[1] Rob Stein, *Seeking Care, and Refused*, WASH. POST, July 16, 2006, at A06.

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perform services are briefly summarized, along with rejoinders to them. The paper then discusses in more detail the duty of professionals to provide services, based on the prevailing medical ethic of universal care, the principle of non-discrimination, and other considerations. Finally, several policy options are suggested, such as treating health care providers as public accommodations that may not discriminate based on sex, and requiring refusing providers to facilitate the referral of patients to other providers to ensure that every member of the public has access to needed products and services.

## II. REFUSAL LAWS FOR ABORTION

Shortly after the U.S. Supreme Court's decision in *Roe v. Wade* in 1973, Congress passed legislation to protect institutions' ability to refuse to offer abortion services.2 The federal abortion conscience clause, called the Church Amendment, amended the Public Health and Welfare Act and protects federally funded individuals and entities that refuse to provide sterilization or abortion services when those individuals and entities declare the services to be "contrary to [their] religious beliefs or moral convictions."3 The protection takes two forms—institutions may not be denied eligibility for federal grants, and they are prohibited from taking action against personnel because of their participation, nonparticipation or beliefs about abortion and sterilization. The Church Amendment concerned provision of services only, and did not address refusals to make referrals or to provide information about legal options for care, as part of the informed consent process. Forty-five states followed suit and passed laws to allow certain healthcare providers to refuse to provide abortion services. According to the Guttmacher Institute:

> Almost every state in the country also has decades-old policies allowing individual health care providers to refuse to participate in abortion; many of these laws also apply to sterilization, and in 10 states, to contraception more broadly… . Only a handful of these laws specifically provide an exception to refusal rights in emergency circumstances; most do not require health care providers to notify their employers if they intend to opt-out of certain services, and only three require any notice to patients; and about a dozen go so far as to allow providers to refuse to provide information, despite the broadly recognized obligations around obtaining patients' informed consent.[4]

In recent years, Congress has again demonstrated interest in facilitating HCP refusals to provide health care that, in the HCP's individual judgment, is contrary to religious or personal conviction. For example, Congress passed the Weldon Amendment, prohibiting state and local authorities from "discriminating" against any health care entity that will not "pay for, provide coverage for or refer for abortions." It also allows a hospital to refuse care to a woman who is in need of an emergency abortion, even if

[2] Rachel Benson Gold & Adam Sonfield, *Refusing to Participate in Health Care: A Continuing Debate*, GUTTMACHER REP. ON PUB. POL'Y, 8 (Feb. 2000).

[3] 42 U.S.C. § 300a-7 (2000).

[4] Adam Sonfield, *Rights vs. Responsibilities: Professional Standards and Provider Refusals*, GUTTMACHER REP. ON PUB. POL'Y, 7 (Aug. 2005).

the state law requires abortion coverage in such an emergency situation.[5] Another effort, in the 109th Congress, was jointly sponsored by Senators Kerry and Santorum. Entitled the Workplace Religious Freedom Act of 2005, the bill went beyond the issue of abortion-related refusals, and would have required employers to accommodate employees who refuse to provide a wide range of health care services due to religious objection, albeit with a requirement that alternate arrangements be made available for the patient to receive the requested services.

## III. EXPANDING ALONG FOUR AXES: RANGE OF PROVIDERS, RANGE OF PROCEDURES, RANGE OF REFUSALS, RANGE OF PROTECTIONS

While conscience clauses originated with an emphasis on physicians, recent legislative efforts have broadened to include pharmacists, nurses or even all persons connected with health care delivery. Such efforts would encompass the growing trend toward pharmacist refusals to fill prescriptions for emergency contraception. (Although emergency contraception has recently been made available over-the-counter for adult women, teens still require prescriptions, and thus may continue to encounter pharmacist refusals.) The most expansive bills would also extend refusal privileges to ancillary personnel, theoretically encompassing medical assistants or even orderlies and clerical workers.

In addition, while earlier conscience clauses focused on abortion and sterilization, the newer proposals include other reproductive services, such as traditional contraception, emergency contraception, and IVF or other fertility services. They also include non-reproductive services, such as end of life care (i.e. withholding and withdrawing heroic measures) or any therapy derived from fetal tissue or embryonic stem cell research (including, for example, some childhood vaccinations).

Further, the range of refusals now includes not only a refusal to perform a procedure, but also the refusal to provide a referral, to offer information or counseling on the legality of options that might be elsewhere available, or to do anything that the HCP regards as “participating” in the service in any way.

Finally, protections in some of the newer proposals recite an expansive list of actions that can no longer be taken against professionals who refuse to provide health care services. These protections include immunity from medical or other professional malpractice liability; protection from state licensing board disciplinary action; and protection from employment practices that might put those who assert a right of conscience at a disadvantage in hiring, retention and promotion.

A law passed in Mississippi in 2004 is a good example of the expansive new breed of refusal clause. It allows almost anyone connected with the health care industry—from doctors, nurses and pharmacists to the clerical staff of hospitals, nursing homes and drug stores—to refuse to participate or assist in any type of health care service, including referral and counseling, without liability or consequence.[6]

Similarly, a bill passed by the Wisconsin legislature (albeit vetoed by the Governor) would have permitted health care professionals to abstain from “participating” in any number of activities, with “participating” defined broadly enough to include not only performance of a service, but also counseling patients about their choices or

[5] Consolidated Appropriations Act, 2005, Pub. L. No. 108-447, §§ 508(a), 508(d)(1)-(2), 118 Stat. 2809, 3163 (2004).

[6] S.B. 2619, Reg. Sess. (Miss. 2004); Miss. Code Ann. § 41-41-215 (Enacted 1998; Last Amended 1999).

providing referrals to other providers.[7] The full range of refusal privileges would extend to such situations as emergency contraception for rape victims, in vitro fertilization for infertile couples, managing patients' requests that painful and futile treatments be withheld or withdrawn, and offering therapies developed with the use of fetal tissue or embryonic stem cells. This last provision could mean, for example, that pediatricians—without professional penalty or threat of malpractice claims—could refuse to tell parents about the availability of varicella (chicken pox) and rubella (German measles) vaccine for their children, because it was developed with the use of tissue from aborted fetuses. Indeed, the issue of vaccine origins in fetal tissue research also raised issues of schools and parents conscientiously objecting to provision of medical services.[8]

With respect to pharmacist refusals in particular, Arkansas, Georgia, Mississippi, and South Dakota have passed laws or adopted regulations explicitly allowing a pharmacist the right to refuse to fill prescriptions based on his or her religious, moral, or personal beliefs or protecting a pharmacist from adverse employment action for doing so. None of these legislative or administrative actions requires the pharmacists to serve the patients' interests by other means, such as referrals or prescription transfers to other pharmacies.[9]

But at the same time that proposals to expand the scope of permitted refusals are proliferating, some actions have been taken to limit refusals, especially by pharmacists. Policies by statute, regulation or administrative interpretation in a number of states attempt to ensure that patients have access to legally prescribed medications, often by requiring a pharmacy to meet this need even if an individual pharmacist it employs refuses. Several proposals forbid pharmacists from refusing to refer or transfer prescriptions, verbally abusing patients, and threatening to breach patients' confidentiality. Moreover, the AMA adopted a resolution supporting legislative efforts that require pharmacists and pharmacies to fill valid prescriptions or "provide immediate referral to an appropriate alternative dispensing pharmacy without interference."[10]

The North Carolina and Massachusetts pharmacy boards, for example, have issued statements indicating that pharmacists who impede patients' access to prescription medications will be met with disciplinary action under existing state laws and regulations.[11] According to the National Women's Law Center, pharmacy boards in Delaware, New York, Oregon and Texas have also issued policies so that when a

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[7] Assemb. B. 207, 2005-2006 Leg. (Wis. 2005) (available at http://www.legis.state.wi.us/2005/data/AB-207.pdf).

[8] *See Vatican Condemns Vaccines Using Fetal Tissues*, Jul. 22, 2005, available at http://www.cwnews.com/news/viewstory.cfm?recnum=38498 (last visited Feb. 20, 2007); *Medical Cannibals: The Moral Implications of Fetal Tissue Vaccines*, American Life League, available at http://www.all.org/article.php?id=10169 (last visited Feb. 20, 2007); Louis J. Salome, *Shot Down: Prep School Rejects Rubella Vaccine Catholic Headmaster Cites Link to Abortion*, Atlanta Journal-Const., Nov. 20, 1994, at A16.

[9] Jill Morrison & Gretchen Borchelt, *Don't Take "No" for an Answer, A Guide to Pharmacy Refusal Laws, Policies and Practices*, 5 (2007) (available at http://nwlc.org/pdf/donttakeno2007.pdf) (citing Ark. Ann. § 20-16-304 (1973); Ga. Comp. R. & Regs. r. 480-5-.03 (2001); Miss. Ann. § 41-107-1 (2004); S.D. Codified Laws § 36-11-70 (1998)).

[10] Sonfield, *supra* note 4.

[11] Morrison & Borchelt, *supra* note 9 (citing Letter from President James T. DeVita, The Commonwealth of Massachusetts Board of Registration in Pharmacy, to Dianne Luby, President/CEO, Planned Parenthood League of Massachusetts, Inc. (May 6, 2004); North Carolina Board of Pharmacy, Pharmacist FAQs: Frequently Asked Questions for Pharmacists on Conscience Clause, available at http://www.ncbop.org/faqs/Pharmacist/faq_ConscienceClause.htm(last visited Nov. 20, 2006)).

pharmacist refuses to fill a prescription or provide medication, the pharmacy nonetheless ensures delivery of services to the patient.[12]

And state professional licensing boards have on occasion proceeded to discipline their members for failure to provide services. For example, in one of the country's most egregious cases, a Wisconsin pharmacist not only refused to fill a prescription for birth control, but also refused to transfer it to another pharmacy or to return it to the patient, thus leaving her unable to seek services elsewhere. The pharmacist was eventually disciplined by the state licensing board, although the case turned in large part upon his untruthful claims to his employer that he was prepared to provide a full range of services, rather than upon a finding that such actions are impermissible as a matter of professional obligation and the terms of the license to be a pharmacist.[13]

In June 2006, California's Board of Pharmacy went further, and disciplined a pharmacist who both refused to fill a prescription for emergency contraception and refused to enter it into the necessary database for it to be transferred. Based on California state law, the Board of Pharmacy was able to fine the pharmacist $750, in this case for the refusal to fill the prescription, and not merely (as in Wisconsin) for failing to transfer it.[14]

In the realm of state administrative action, the Nevada pharmacy board now limits pharmacist refusals to those based on professional, not religious, reasons. A similar rule is pending in Washington State.[15] And in April 2005 the Governor of Illinois issued an emergency rule that required pharmacists in that state to fill prescriptions for contraception "without delay."[16] Several pharmacists sued the Governor and other state officials, alleging that an administrative rule requiring them to dispense emergency contraception violated their First Amendment rights to freely exercise their religious beliefs, and also Title VII of the Civil Rights Act of 1964, because it required employers

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[12] *Id.* (citing Considering Moral and Ethical Objections, Delaware State Board of Pharmacy News (Delaware State Board of Pharmacy, Dover, Del.), Mar. 2006, at 4; Letter from Lawrence H. Mokhiber, Executive Secretary, New York State Board of Pharmacy, to Supervising Pharmacists, Re: Policy Guideline Concerning Matters of Conscience (Nov. 18, 2005), available at http://www.op.nysed.gov/pharmconscienceguideline.htm; Oregon Board of Pharmacy, Position Statement: Considering Moral and Ethical Objections (June 7, 2006), available at http://www.oregon.gov/Pharmacy/M_and_E_Objections_6-06.pdf.; Texas State Board of Pharmacy, Plan B, available at http://www.tsbp.state.tx.us/planb.htm (last visited Dec. 13, 2006)).

[13] *Wisconsin Judge Upholds Pharmacy Board's Punishment of Pharmacist Who Refused to Refill Oral Contraceptive Prescription*, MEDICAL NEWS TODAY, available at http://www.medicalnewstoday.com/medicalnews.php?newsid=37525.

[14] Morrison & Borchelt, *supra* note 9, at 6 (citing In re Becker-Ellison, Citation No. CI 2005 31291 (Cal. Bd. of Pharmacy, Dep't of Consumer Affairs, June 30, 2006) (citation and fine) (on file with the National Women's Law Center)).

[15] *Id.* at 4-5 (citing Adopted Regulation of the Nevada State Board of Pharmacy, LCB File No. R036-06 (effective May 4, 2006); Cy Ryan, *Pharmacy Asked to Withhold Judgment*, LAS VEGAS SUN, May 6, 2006, available at http://www.lasvegassun.com/sunbin/stories/sun/2006/may/06/566613322.html; Draft Text WAC 246-869-010 Pharmacies' Responsibilities, available at http://www3.doh.wa.gov/policyreview/ (last visited Dec. 12, 2006)).

In 1997, the pharmacy manager of a California drug store was reprimanded by his employer for refusing to fill a woman's prescription for emergency contraception. The woman, who had medical reasons for preventing pregnancy, did get her prescription filled elsewhere, but she also pressed complaints with the pharmacy management and the licensing officials. The state pharmacy board declined to take action, however, as no state law or regulation at the time required pharmacists to fill the prescriptions presented to them. Brian P. Knestout, *An Essential Prescription*, 22 J. CONTEMP. HEALTH L. & POL'Y 349 (Spring 2006).

[16] Emergency Amendment to 68 Ill. Admin. Code § 1330.91. (enacted as 68 Ill. Admin. Code § 1330.91(j) on August 25, 2005).

to discriminate against them based on their religious beliefs. Although the state officials filed a motion to dismiss, the federal court ruled that the case may proceed to full consideration. Key to the court's decision was the assertion that the Governor's actions were intended to discriminate on the basis of religious affiliation.[17]

While not addressing the broader class of health care providers, nor the broader range of services now being refused, in recent years a number of states have passed legislation or issued regulations to ensure that women seeking medications are not disadvantaged by pharmacists who refuse to fill their prescriptions. As of early 2007, five states explicitly require pharmacists or pharmacies to ensure that valid prescriptions are filled: California, Illinois, Massachusetts, Maine, and Nevada. California's law prohibits pharmacist refusals except when the patient can nonetheless receive her services in a timely manner, the employer has been notified in writing, and the employer can make an accommodation without hardship.[18] Maine pharmacy law and regulations restrict pharmacist refusals to professional and medical reasons. Religious or personal convictions do not justify refusals.[19]

Despite these changes in state law, refusals continue to be a problem in states without applicable legislation or regulation, even if pharmacy policies require that patients be given service. In Ohio, for example, a woman and her boyfriend requested Plan B, a form of emergency contraception, but the pharmacist "shook his head and laughed," according the woman. The pharmacist, she reports, told her that he stocked Plan B but would not sell it to her because he believed it to be a form of abortion.[20] Wal-Mart, in whose pharmacy this occurred, has a corporate policy to stock Plan B, and allows any Wal-Mart worker who does not feel comfortable dispensing a product to refuse service, but also directs such employees to refer customers to another pharmacist, pharmacy worker or sales associate.[21]

At the federal level, a number of bills have been introduced to limit HCP refusals, at least in the context of pharmacies. For example, Senator Barbara Boxer introduced the Pharmacy Consumer Protection Act of 2005, which would require pharmacies to fill all valid prescriptions in a timely manner. If the medication is not in stock, the pharmacy would be required to order the medication, transfer the prescription or return the prescription to the patient, depending on the patient's preference. Senator Frank Lautenberg introduced the Access to Legal Pharmaceuticals Act of 2005, which would require pharmacies to dispense all valid prescriptions even if their individual pharmacists refuse to participate. The bill also seeks to ensure that pharmacies avoid hiring pharmacists who refuse to return a patient's prescription, refuse to transfer a prescription, subject a patient to humiliation or harassment, or fail to keep a patient's records confidential.[22]

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[17] *Menges v. Blagojevich*, 451 F. Supp. 2d 992, 999-1002 (C.D. Ill. 2006).

[18] Morrison & Borchelt, *supra* note 9, at 4 (citing CAL. BUS. & PROF. CODE §§ 4314, 4315, 733 (2005)).

[19] *Id*. (citing Me. R. 02-392 ch. 19, § 11 (citing Me. Rev. Stat. Ann. tit. 32 § 13795(2))).

[20] Associated Press, *Wal-Mart Pharmacist Denies Couple Morning-after Pill*, Jan. 16, 2007.

[21] Misti Crane, *Some Still Refuse to Dispense Plan B*, COLUMBUS DISPATCH, Jan. 15, 2007, at 01A.

[22] Morrison & Borchelt, *supra* note 9, at 4 (citing Access to Legal Pharmaceuticals Act, S. 809, 109th Cong. (2005) (introduced Apr. 14, 2005, by Sen. Frank Lautenberg); Pharmacy Consumer Protection Act of 2005, S. 778, 109th Cong. (2005) (introduced Apr. 13, 2005, by Sen. Barbara Boxer); An Act to Amend the Public Health Service Act with Respect to the Responsibilities of a Pharmacy When a Pharmacist Employed by the Pharmacy Refuses to Fill a Valid Prescription for a Drug on the Basis of Religious Beliefs or Moral Convictions, and for Other Purposes, H.R. 1539, 109th Cong. (2005) (introduced Apr. 8, 2005, by Rep. Carolyn McCarthy)).

Overall, according to the The Guttmacher Institute, as of 2006:

- 46 states allow individual HCPs to refuse to provide abortion services;
- 43 states allow institutions to refuse to provide abortion services (15 limiting the privilege of refusal to private institutions and one to religiously-affiliated institutions);
- 13 states allow some HCPs to refuse services related to contraception (four of them specifically mentioning pharmacists, and another four with refusal clauses broad enough to encompass pharmacies);
- 9 states allow institutions to refuse to provide services related to contraception (six of them limited to private institutions); and
- 17 states allow some individual HCPs and institutions to refuse to provide sterilization services.[23]

## IV. ETHICAL ARGUMENTS FOR AND AGAINST THE PERMISSIBILITY OF PROVIDER REFUSALS TO PROVIDE SERVICES

In a 2005 article entitled "Dispensing With Liberty," philosophers Elizabeth Fenton and Loran Lomasky delineate the major lines of traditional argumentation concerning provider refusals on the grounds of religious belief or personal conscience.[24] Their conclusion, which paralleled that presented in a 2005 New England Journal of Medicine piece by this author,[25] is that traditional arguments are undermined by their primary focus on a contest between the moral claims of individual patients and providers. Both articles conclude that attention to the power imbalance between the parties, and the special obligations placed upon professionals as a group due to their privileged, quasi-monopoly status as health care providers, form the basis for what is arguably a collective obligation of the profession to provide non-discriminatory access to all lawful services.

Fenton and Lomasky begin by noting that "obligations to perform typically have to meet a higher burden of justification than do obligations to desist."[26] In other words, an analysis of traditional arguments about the conflict between individual providers and individual patients must begin with the acknowledgment that an obligation to perform an act requires more justification than a mere obligation to avoid thwarting someone else's actions. And it is true that the law rarely requires individuals to rescue or otherwise take action on behalf of another, absent special justification, such as having put the other person in danger or having previously taken on custodial or other responsibilities that engender a special duty of care.

Following this line of analysis, one can argue that failure to perform a service, whether performing an abortion, filling a contraceptive prescription, or informing a parent of the timeliness of a childhood varicella vaccine, simply constitutes a refusal to act, and that forcing a professional to act in such circumstances requires a high level of justification. As Fenton and Lomasky argue, "By refusing to enter into a

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[23] Guttmacher Institute, *State Policies in Brief: Refusing to Provide Health Services*, Feb. 1, 2007, available at http://www.guttmacher.org/statecenter/spibs/spib_RPHS.pdf (last visited Feb. 27, 2007); National Conference of State Legislatures, *Pharmacist Conscience Clauses: Laws and Legislation*, Oct. 2006, available at http://www.ncsl.org/programs/health/ConscienceClauses.htm (last visited Feb. 27, 2007).

[24] Elizabeth Fenton & Loren Lomasky, *Dispensing with Liberty: Conscientious Refusal and the "Morning After Pill*," 30 J. Med. & Phil 579 (2005).

[25] R. Alta Charo, *The Celestial Fire of Conscience*, 352 New England J. Med. 2471 (2005).

[26] Fenton & Lomasky, *supra* note 24, at 581.

transaction that the other party desires, one thereby *fails to provide a benefit* but not to *inflict a liability*. If that were not so, then anyone who turns down an offer from a prospective buyer, seller, employer, or suitor is guilty of inflicting a harm on the disappointed party. This would be to expand the notion of harm beyond usability."[27]

Responses to this argument are several-fold. First, it clearly separates out the calls for right to conscience that encompass forcibly imposing unwanted medical interventions, such as ventilators or feeding tubes, on competent patients who have refused further treatment. Given the recent bills attempting to extend refusal clauses to a refusal to abide by patient wishes in this regard, it is important to note that in this case, at least, it is a provider's actions, not inactions, that are at issue. And of course, such actions would also constitute a common-law battery. Further, state legislation protecting HCPs who inflict such unwanted care on competent patients would run afoul of constitutional protections for patient autonomy.

Second, and perhaps most interestingly, it is suggestive of an as-yet undiscussed aspect of the refusal clause debate. Specifically, the so-called "right of conscience" may be far easier to defend in the case of the non-professional than in the case of the professional. A clothing store salesperson who refuses to assist a single woman shopping for maternity clothes may indeed be leaving her no better or worse off than before she entered the store, and be under no ethical duty to do more than this. But where an affirmative duty to provide a service does exist, then failure to act is not merely nonfeasance, but rather is an active form of misfeasance. Thus, refusal by a licensed taxi driver to pick up an African-American man is more than nonfeasance; due to legal obligations to provide non-discriminatory service, this failure to act is a form of active misfeasance.

Thus, whether the refusal to provide a service should be regarded as mere nonfeasance or as a more serious problem of misfeasance turns, somewhat tautologically, on whether there is a duty to provide service. But on this, there is indeed some guidance, as the statements of the relevant professional societies suggest that just such a duty does indeed exist:

> "The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable assistance and sufficient opportunity to make alternative arrangements for care." —*World Medical Association, Declaration on the Rights of the Patient*

> "The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice." —*American Medical Association*

> "Where a particular treatment, intervention, activity, or practice is morally objectionable to the nurse....the nurse is justified in refusing to participate on moral grounds....The nurse is obliged to provide for the patient's safety, to avoid patient abandonment, and to withdraw only when assured that alternative sources of nursing care are available to the patient."—*American Nurses Association, Code of Ethics*

[27] *Id* at 583 (emphasis in original).

> "A [physician assistant] has an ethical duty to offer each patient the full range of information on relevant options for their health care. If personal moral, religious, or ethical beliefs prevent a PA from offering the full range of treatments available or care the patient desires, the PA has an ethical duty to refer an established patient to another qualified provider. PAs are obligated to care for patients in emergency situations and to responsibly transfer established patients if they cannot care for them." —*American Academy of Physician Assistants, Guidelines for Ethical Conduct for the Physician Assistant Profession*

> "[P]harmacists [should] be allowed to excuse themselves from dispensing situations which they find morally objectionable, but that removal from participation must be accompanied by responsibility to the patient and performance of certain professional duties which accompany the refusal....ensuring that the patient will be referred to another pharmacist or be channeled into another available health system...."—*American Pharmacists Association, 1997-98 policy committee report on pharmacist refusal clause*

> "Pediatricians should not impose their values on the decision-making process and should be prepared to support the adolescent in her decision or refer her to a physician who can.... Should a pediatrician choose not to counsel the adolescent patient about sexual matters such as pregnancy and abortion, the patient should be referred to other experienced professionals."—*American Academy of Pediatrics, position statement on counseling the adolescent about pregnancy options*

> "Nurses have the right, under responsible procedures, to refuse to assist in the performance of abortion and/or sterilization procedures.... Nurses have the professional responsibility to provide high quality, impartial nursing care to all patients in emergency situations ... to provide nonjudgmental nursing care to all patients, either directly or through appropriate and timely referral ... [And] to inform their employers, at the time of employment, of any attitudes and beliefs that may interfere with essential job functions."—*Association of Women's Health, Obstetric and Neonatal Nurses, position statement on nurses' rights and responsibilities related to abortion and sterilization*

By failing to abide by the standards set by their own professions, those practicing refusal without informing patients of their options and providing referrals or other alternatives are not merely denying a discretionary benefit to the consumer but rather are affirmatively violating a duty to their patients.

A rejoinder might be that these professional standards are wrongheaded, because they deny to HCPs the opportunity to avoid being transformed into mere purveyors of goods and services. The essence of professionalism, the argument goes, involves discretion and judgment, which is why the physician ought to have more authority over

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patient choices than a candy seller has over consumer purchases. To do otherwise is to render medical services no different than gumballs. As Fenton and Lomasky present this argument:

> "Just as physicians or lawyers or accountants enjoy a liberty to decline to transact with those who seek their services, so too do pharmacists…. [O]ther professionals also turn down potential clients with whom they feel uncomfortable working either for moral or other reasons. It is not inconsistent with professional practice to limit one's clientele. Indeed, just the reverse; one attribute of professionalism is an entitlement to employ one's own judgment concerning which associations to enter."[28]

Two responses to this argument are in order. First, in the context of health care, refusals have most traditionally been based on medical inappropriateness. That is, an internist can refuse to do surgeries due to lack of qualification or a pediatrician can refuse to provide a drug to a teenager because its risks are poorly understood in younger patients. Refusals based on moral disapprobation, however, are not typical of medical ethics. Thus, the physician is trained to heal the criminal, regardless of personal feelings about the criminal's moral culpability, and leaves to the criminal justice system the task of working to ensure that the now-healed criminal will not use his good health to engage in further criminal acts. This is as true of the thief shot by the homeowner as it is of the battering spouse who presents for repair of his broken knuckles. Even knowing that the act of healing may result in further abusive and criminal acts does not yield a medical ethic that calls for refusing care lest one become complicit in those acts. Instead, the prevailing medical ethic is one of universal care.

Second, the choice of refusals follows a pattern that suggests a discriminatory effect, whether direct or indirect. The argument from complicity, that is, the argument that one ought not be forced to become complicit in an immoral act, is not frequently raised in the context of setting the broken hand bones of the wife-beating husband who might then batter again. Instead, it is raised most frequently in the context of refusing to be complicit with acts that form families with single or gay mothers or with acts that prevent conception or gestation of a child. These are settings in which the parties most frequently affected are women. And while the recent expansion of refusal clause legislation to include a competent patient's request to withhold or withdraw unwanted heroic measures, and the occasional report of refusals to fill erectile dysfunction prescriptions for single or gay men may ultimately undercut this point, for the moment the focus of most refusals has been on actions associated with sexual or reproductive decisions of women.

Actions that have a disparate impact on one class of persons—here, on women—are not necessarily unethically or illegally discriminatory (although they may be in some circumstances). But the disparate impact does raise legitimate questions about the underlying motivations of the actors, and the sufficiency of their justifications. This is especially true when those actions impinge upon protected classes of persons, that is, those whom we have historically disadvantaged in law and practice and for whom court now offer more protection from discriminatory state action. It is also true when those actions impinge upon protected classes of rights, of which reproductive

[28] Fenton & Lomasky, *supra* note 24, at 582.

choice is one. Some protections are offered by the courts only in the context of state action, but it is illuminating even in a non-legal and purely ethical context to note the intersection of protected class and protected rights at the center of the category of people and services most typically denied on the basis of a right of conscience. One might ask whether the current debate over refusal clauses would sound any different if it were more baldly framed as the asserted right of health care providers to refuse service to "bad women."

A last major source of argument in favor of the right to exercise conscientious objection is the assertion that in most cases the services requested are not really medical services. Even if there is a duty to provide emergency medical care (and arguably all medical care), services such as abortion, contraception, IVF and sterilization can be viewed as lifestyle services rather than medical services. They do not cure a disease, the argument goes, but rather use drugs and medical techniques to accomplish a lifestyle goal.

Again, the argument has multiple responses. First, medical professionals consider these services, at least in most circumstances, to be an important part of good health care. For example, given that pregnancy is a condition with significant medical consequences and a risk of both morbidity and mortality, contraception constitutes preventive health care. To trivialize these services as "lifestyle" issues is to ignore women's health care needs.

Second, to the extent these may in some circumstances be viewed as choices dictated more by lifestyle than by medical necessity, they are nonetheless choices that are constrained by the state-created limits on consumer access to the products and services needed to accomplish these goals. The situation is not one in which a free market of products, suppliers and buyers seek one another out without constraint. Even beyond the practical constraints of insurance coverage (which often directs patients to a limited range of physicians and pharmacies lest coverage be denied), the very products and services themselves cannot be sold except by those who are members of a special collective, that is, licensed health care providers. To practice medicine or sell prescription drugs without a license is a criminal act throughout the country. If these professionals, who have a state-created and state-maintained collective monopoly on these products and services, will not provide service, the patients have nowhere to turn. Thus, what might otherwise be an issue of lifestyle choices is transformed by state action into an issue of medical choice, in which patient and provider stand not as equals with competing moral compasses but rather as petitioner and grantor in a regulated relationship.

## V. AN ALTERNATIVE VIEW OF THE REFUSAL CLAUSE DEBATE: COLLECTIVE DUTIES OF THE PROFESSIONAL COMMUNITY

There is ample precedent for limiting the range of conscientious objection for professionals who operate as state actors. The question arises, then, whether such limitations might appropriately be extended to those who, although private actors, are nonetheless in possession of unique privileges by virtue of state licensing schemes that grant them, as a professional group, a monopoly on a public service.

In *Endres v. Indiana State Police*, for example, the 7th Circuit considered a case arising from a religious objection on the part of a state trooper who claimed that his assignment to work as a Gaming Commission agent—an assignment that would require him to assist in the management of the casino industry—would violate his religious beliefs concerning the immorality of gambling. When his request for

reassignment was refused, he filed an employment discrimination action under Title VII of the Civil Rights Act of 1964, claiming that the state could refuse his request only if it could show that accommodation of his religious practice posed an undue burden on the state police, his employer.[29]

Judge Easterbrook, writing for court, held that the relevant provision of Title VII did not oblige states "to afford the sort of accommodation that Endres requested…" as, otherwise, "law enforcement personnel [would have] a right to choose which laws they will enforce, and whom they will protect from crime."[30] He further wrote:

> Many officers have religious scruples about particular activities: to give just a few examples, Baptists oppose liquor as well as gambling, Roman Catholics oppose abortion, Jews and Muslims oppose the consumption of pork, and a few faiths ... include hallucinogenic drugs in their worship and thus oppose legal prohibitions of those drugs. If Endres is right, all of these faiths, and more, must be accommodated by assigning believers to duties compatible with their principles. Does [the Civil Rights Act] require the State Police to assign Unitarians to guard the abortion clinic, Catholics to prevent thefts from liquor stores, and Baptists to investigate claims that supermarkets misweigh bacon and shellfish? Must prostitutes be left exposed to slavery or murder at the hands of pimps because protecting them from crime would encourage them to ply their trade and thus offend almost every religious faith?[31]

This might seem, then, to be limited to a concern about the hardship that accommodations would place upon state agencies. Such a concern would be entirely in keeping with existing federal precedent, such as the 2000 decision in *Shelton v. Univ. of Medicine & Dentistry of N.J.*, where the court found that the civil rights of an employee were not violated when a reasonable accommodation, in the form of a lateral transfer, was effectuated in response to her refusal to participate in providing emergency abortion services in life-threatening situations.[32] But the *Endre*s opinion went further, stating that accommodation would be unreasonable even in the absence of hardship. Agencies "designed to protect the public from danger may insist that all of their personnel protect all members of the public - that they leave their religious (and other) views behind so that they may serve all without favor on religious grounds."

Of course, the *Endres* case concerned agents of the state, and of what one commentator has called a "paramilitary organization" in need of special restrictions on professional autonomy.[33] But, one commentator notes:

> Endres's claim … reflects currently prevailing views as to the importance of self-realization, the role of religion in self-realization, and the degree to which religious values are commonly thought to be privileged as against other values. Obviously, we are far removed

[29] *Endres v. Indiana State Police*, 349 F.3d 922 (7th Cir. 2003) (cert. denied, 541 U.S. 989 (2004)).

[30] *Id*. at 925.

[31] *Id*. at 925.

[32] *Shelton v. Univ. of Medicine & Dentistry of N.J.*, 223 F.3d 220 (3d Cir. 2000).

[33] *See* Barry Sullivan, *Naked Fitzies and Iron Cages: Individual Values, Professional Virtues, and the Struggle for Public Space*, 78 Tul. L. Rev. 1687, 1709 (2004).

> from the time when Justice Holmes could dispose of an analogous claim with the aphorism that someone "may have a constitutional right to talk politics, but [not] to be a policeman," as he did in *McAuliffe v. Mayor of New Bedford*. On the other hand, I would submit that only thirty or forty years ago, most policemen assigned to protect a casino or a barroom would have accepted that as part of their jobs; they would have done it, regardless of their personal, religious views. This is not to say that they took their religious beliefs less seriously, but that they did not think that it was the state's job to design their public responsibilities in a way that accommodated or complemented their personal religious views.[34]

It is this emerging norm of "self realization" in the professions that is in tension with the fact that some professions operate in a restricted market. The restricted nature of the medical products and services markets functions to create a new relationship between provider and patient. As Fenton and Lomasky put it, in their discussion specifically of pharmacist refusals:

> "[T]he salient point is that pharmacist and prospective client do not stand to each other as any two random agents endeavoring to secure their various ends as they make their way through the world. With regard specifically to the liberty to transact in the distribution/procurement of regulated drugs, they do not stand as moral equals. The institutional structure within which pharmacy is practiced has advantaged one party, and that advantage is secured to some extent at the expense of the other. It cannot, therefore, be presumed that the general principle of rejecting coerced cooperation with other persons' endeavors continues to hold. Specifically, … some limitation of pharmacists' right to choose their clients is justifiable compensation to that clientele for having their own domain of choice limited."[35]

By analogy, other state-created limitations on product and service sales are accompanied by a restriction on the liberty of the providers. The public utility that sells electricity is not permitted to refuse service to the KKK or to the Planned Parenthood clinic, regardless of the moral and religious views of the management or shareholders. The medallion cabs (that is, the taxis with the exclusive right to pick up hailing passengers from the street) are not permitted to refuse service to women immodestly dressed or men whose clothes denote a particular religious affiliation. (Indeed, in reaction to a growing number of Muslim taxi drivers at the Minneapolis airport refusing to pick up passengers carrying duty-free bags with alcoholic beverages, a new directive was issued forcing them to serve these passengers or pay a fine.[36]) The prison official who denies emergency contraception to an inmate who was raped is denounced.[37] And while the federal public accommodations law, which prohibits discrimination "of

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[34] *Id*. at 1709-10.

[35] Fenton & Lomasky, *supra* note 24, at 585.

[36] David Van Biema, *Minnesota's Teetotal Taxis*, TIME MAGAZINE, Jan. 29, 2007, at 30.

[37] Editorial, *Jailing Victim is Outrageous*, ST. PETERSBURG TIMES, Jan. 31, 2007, at 10A.

the goods, services, facilities, privileges, advantages and accommodations of any place of public accommodation ... without discrimination or segregation on the ground of race, color, religion, or national origin," does not list "sex" as an impermissible basis for exclusion, it might be argued that it is time to enshrine in law the notion that health care provider institutions should be treated as public accommodations that, at a minimum, do not discriminate directly or indirectly on the basis of sex.

A natural result of such an analysis might well be that, at the very least, a profession in possession of a state-created right to be the sole purveyor of products and services must ensure that every member of the public have non-discriminatory access to its products and services. That is, the profession as a collective unit takes upon itself a collective obligation to the patients it serves. How that obligation is fulfilled may vary from state to state, or profession to profession, provided that the collective obligation is met. In the early era of the AIDS crisis, for example, some HCPs resisted treating HIV-positive patients for fear of becoming infected themselves. Yet as professional groups, HCPs recognized the obligation to provide care. In some settings, the obligation was fulfilled by having only volunteer HCPs treat the infected patients, while other HCPs opted out. In other settings, the obligation to treat was shared by every member of the profession and no opt-out provisions were made. In all cases, though, there was a shared agreement that there was indeed an obligation to provide care, because no other market for care existed outside the profession.

In the context of today's debates, one means of meeting a collective obligation is to require every individual HCP to provide all products and services, thus denying the legitimacy of even the narrowest conscientious refusal laws of the 1970s, which focused almost exclusively on the actual performance of abortions and sterilizations. This could be accomplished at the state level either by establishing such a duty as a condition of licensing, or by enshrining such a duty in state law such that violation rendered the HCP vulnerable to medical malpractice litigation. Another approach would be to modify employment discrimination laws to make it more difficult for employees in health care professions to sustain religious discrimination claims when they are penalized for failing to perform their duties to their patients. Outside of state measures, professional societies can continue to articulate their own ethical standards, and in this way lay the groundwork both for individual HCPs to see their way clear to serving patients even in ways that violate their own preferences and beliefs, as well as to assist courts in determining the customary and standard practice in medical malpractice cases based on refusal of service or medical abandonment.

A less extreme means for achieving a reasonable result for patients is to accept a collective responsibility to make all legal products and services reasonably available. This is the tactic taken by those laws that focus on establishments rather than individual professionals. Thus, such laws may require that all licensed pharmacies have at least one pharmacist on hand during business hours who can fill all prescriptions, without requiring that each and every pharmacist at the establishment actually fill the prescriptions. While potentially burdensome for small pharmacy practices, it is manageable for larger establishments and most chains. (And indeed, many public accommodation laws make some exception for small family-owned businesses where compliance would be unusually burdensome.)

This approach still requires the refusing provider to inform patients of their legal options and to make a referral (or pass along a prescription) where necessary to facilitate the patient's request. For many who assert a right of refusal, such a solution still fails to meet their objection to being made complicit in the patient's choices. This

expanded notion of complicity is consistent with other areas of public discourse, such as bans on federal funding for embryo research or abortion services, in which taxpayers claim a right to avoid supporting objectionable practices. In the debate on refusal clauses, some professionals are now arguing that the right to practice their religion requires that they not be made complicit in any practice to which they object on religious or moral grounds, even if their concerns about complicity do not extend to the situations of criminals (discussed above) nor comport with modern notions of non-discrimination against women.

A less discussed and potentially more thorough alternative is to alter licensing laws in a fashion that would permit pharmacies to join different kinds of guilds, one of which offers all legal services but others of which offer only those services that are consonant with their own particular religious or moral vision. Such a parallel system exists in the world of hospital care, in which Catholic hospitals refuse to provide contraception, sterilization, abortion or in vitro fertilization services. This compromise is highly imperfect—where such hospitals are the only available health care centers in a community, or where hospital and HMO mergers have resulted in extension of such doctrinal restrictions to the secular facilities in the area, the practical result is indistinguishable from a legal prohibition on obtaining these services. Further, as the market for medical care is distinctly different than markets for consumer goods, such market system solutions may leave patients without viable alternatives. For example, even where full-service providers exist in a patient's area, the patient's insurance may restrict coverage in a manner that limits reimbursements to those services offered at the covered institution, thus preventing patients from acting as autonomous agents in a purer market. Nonetheless, such a balkanized version of the health care system could at least provide notice to prospective patients (assuming the notice is prominent and effective), and avoid the creation of reliance interests—a reliance on the pharmacy or health care center to provide requested services—in such a way that at least affords a theoretical possibility that patients could protect themselves by knowing ahead of time that they will need to search farther afield.

More ominously, some establishments are seeking to avoid these battles entirely by simply choosing not to stock the products that are the most contentious. In the most well-known example of this tactic, Wal-Mart made the decision to avoid stocking emergency contraception, thus eliminating the problem of managing individual pharmacist refusals, either by hiring additional pharmacists to provide the service or by forcing all employees to respect patient requests. As described in a 2005 piece from The Guttmacher Report:

> The potential reach of this policy, and its impact on women's ability to access emergency contraception in a timely manner, should not be underestimated. For women living in rural areas, Wal-Mart may be the only pharmacy within miles. Moreover, with almost 4,000 locations nationwide, the retailer is a behemoth by industry standards and still growing: A 2003 projection estimated that it would control 25% of the drug store industry by 2007.[38]

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[38] Cynthia Dailard, *Beyond the Issue of Pharmacist Refusals: Pharmacies That Won't Sell Emergency Contraception*, GUTTMACHER REP. ON PUB. POL'Y, Aug 2005, at 10.

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While Wal-Mart subsequently reversed this policy, it was an object lesson for other businesses that may be considering a wholesale withdrawal from the field of selling contraceptives or providing reproductive care. The reversal of the Wal-Mart policy followed a very vocal public campaign, but smaller businesses—which may nonetheless be significant factors in their local markets—may choose the same strategy, with little risk of generating a national outcry sufficient to trigger a reversal of their policy.

## VI. CONCLUSION

The problem of access due to a combination of refusals or the decision not to stock certain products is poorly documented, but reports are slowly emerging. The Washington Post ran a series of articles in July 2006 with personal stories of refusals for services ranging from contraception to artificial insemination. In August 2006, the Associated Press ran a story that read in part:

> In complaints filed Monday with the Washington State Board of Pharmacy, the women said they were unable to get a total of 17 prescriptions for Plan B filled in June and July at four stores in the state capital and neighboring Lacey.
>
> One, Stephanie Conrad, said she filed her complaint because of an experience weeks earlier after a condom broke.
>
> "I couldn't find a Plan B pill for 45 hours after. I ended up getting pregnant. Then I had a miscarriage," Conrad said. "It was very painful emotionally and physically. I just wish it could have been avoided."
>
> The complaints show "that there are major access problems in this community," said Janet Blanding, a medical transcriptionist. "These were legal prescriptions given to women of childbearing age."
>
> Samantha Lee Margerum, one of the women, said she was sent from one store to another to another until, nearly an hour after beginning her quest, she was able to get a prescription filled at the fourth store, a Walgreens in west Olympia.[39]

At the heart of this debate and the growing trend toward countenancing service refusals are several intersecting forces. One is the emerging norm of patient autonomy, which has contributed to the erosion of the professional stature of medicine. Insofar as they are reduced to mere purveyors of medical technology, doctors no longer have extraordinary privileges, and so their notions of extraordinary duty—house calls, midnight duties, and charity care—deteriorate as well. In addition, an emphasis on mutual responsibilities has been gradually supplanted by an emphasis on individual rights. With autonomy and rights as the preeminent social values comes a devaluing of relationships and a diminution of the difference between our personal lives and our professional duties.

Second, there is the ever expanding range of topics linked to the core debate concerning female sexuality and the right to obtain an abortion. Cast as an issue of "right

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[39] Associated Press, *9 Women Complain Plan B Not at Pharmacies*, Aug. 1, 2006.

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to life" rather than equality for women, opposition to abortion has now been linked to topics such as emergency contraception, research involving human embryos, the donation of organs from anencephalic neonates, and the right of persons in a persistent vegetative state to die. While abortion draws the most public attention, the battleground is in fact much larger.

Most profoundly, however, the surge in legislative activity surrounding refusal clauses represents the latest struggle with regard to religion in America. Should the health care marketplace—a part of the public square—be a place for the unfettered expression of religious beliefs, even when such expression causes injury to others, such as patients? Or should it be a place for religious expression only if and when that does not in any way impinge on others? The debate here is part of the debate that has been played out with respect to blue laws, school prayer, Christmas creche scenes, and workplace dress codes. It is, at core, a debate about whether tolerance of individual patients' choices and enhancing a duty of public obligation when engaging in public, professional activities, constitutes an advance in civil society or an unacceptable secularization of what, for many, is or ought to be a religious country.

Conscience is a tricky business. Some interpret its personal beacon as the guide to universal truth and undoubtedly many of the health care providers who refuse to treat or refer or inform their patients do so in the sincere belief that it is in the patients' own interests, regardless of how those patients might view the matter themselves. But the assumption that one's own conscience is the conscience of the world is fraught with dangers. As C.S. Lewis wrote, "Of all tyrannies, a tyranny sincerely exercised for the good of its victims may be the most oppressive. It would be better to live under robber barons than under omnipotent moral busybodies. The robber baron's cruelty may sometimes sleep, his cupidity may at some point be satiated; but those who torment us for our own good will torment us without end for they do so with the approval of their own conscience."[40]

[40] C. S. Lewis, God in the Dock: Essays on Theology and Ethics, 292 (Walter Hooper ed., Wm. B. Eerdmans Publishing Co., 1994) (1970).

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ETHICAL AND LEGAL ISSUES IN REPRODUCTIVE HEALTH

# Conscientious commitment to women's health

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ABSTRACT

Conscientious commitment, the reverse of conscientious objection, inspires healthcare providers to overcome barriers to delivery of reproductive services to protect and advance women's health. History shows social reformers experiencing religious condemnation and imprisonment for promoting means of birth control, until access became popularly accepted. Voluntary sterilization generally followed this pattern to acceptance, but overcoming resistance to voluntary abortion calls for courage and remains challenging. The challenge is aggravated by religious doctrines that view treatment of ectopic pregnancy, spontaneous abortion, and emergency contraception not by reference to women's healthcare needs, but through the lens of abortion. However, modern legal systems increasingly reject this myopic approach. Providers' conscientious commitment is to deliver treatments directed to women's healthcare needs, giving priority to patient care over adherence to conservative religious doctrines or religious self-interest. The development of in vitro fertilization to address childlessness further illustrates the inspiration of conscientious commitment over conservative objections.
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## 1. Introduction

The right to live according to one's conscience is a key human right. The United Nations (UN) International Covenant on Civil and Political Rights, giving legal effect to the UN's 1948 Universal Declaration of Human Rights, provides in Article 18(1) that "[e]veryone shall have the right to freedom of thought, conscience and religion. This right shall include [an individual's] freedom…in public or private, to manifest his religion or belief in worship, observance, practice and teaching." To preserve everyone's freedom of conscience against religious or other oppression, Article 18(3) provides that "[f]reedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health or morals or the fundamental rights and freedoms of others."

Recognition that the law may limit manifestations of conscience when "necessary to protect public…morals" was the basis on which laws in many countries historically prohibited many practices seen today as contributing to reproductive health, which includes the health of women liable to suffer unwanted burdens of repeated pregnancy and childbearing. Healthcare practitioners once almost uniformly faced legal constraints and punishments, instituted or supported by religious authorities, for advising and providing contraception, contraceptive sterilization, and abortion [1]. In the course of the twentieth century, these laws were challenged and eventually considerably liberalized, particularly in westernized, democratic countries. However, some laws, particularly regarding abortion, are retained by independent countries in which they were introduced under European colonization, such as in Sub-Saharan Africa and Latin America.

The progressive relaxation of restrictive laws affecting women's reproductive health has generated a reaction, particularly among healthcare practitioners who hold conservative religious beliefs, of invoking rights of conscience to object to participation in such practices as prescribing or dispensing contraceptive products and undertaking contraceptive sterilization procedures and elective abortions. Their modern claims to conscientious objection, which may be required and/or channeled by religious institutions, reflect an earlier history of conscientious commitment to challenge the restrictive laws in regard to these practices and procedures that previously prevailed.

## 2. Historical conscientious commitment

Conscientious commitment to advocacy for means of birth control has a distinguished history [2]. The English philosopher and social reformer Jeremy Bentham advocated means of birth control as long ago as 1797, and in 1824 his follower and colleague the philosopher John Stuart Mill was arrested and briefly imprisoned for distributing birth control literature to the poor in London. Similarly, in 1886, the English secular politician Charles Bradlaugh was prosecuted, with the socialist activist Annie Besant, for republishing a pamphlet advocating birth control—the conviction subsequently being annulled on appeal.

Religious and conservative opposition to the promotion of birth control fuelled the prosecution of proponents of family planning well into the twentieth century. In 1914, Margaret Sanger, an American nurse

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working in the impoverished and overcrowded ghettos of New York, published a magazine that provided advice on contraception, and in 1916 founded the first American birth-control clinic in Brooklyn, New York City, for which she was prosecuted and imprisoned. The previous year, to forestall prosecution, she had travelled to England, where she met and motivated the botanist Marie Stopes. Appalled at the marital unhappiness caused by ignorance about sex and contraception, Marie Stopes began to disseminate information about these subjects. In 1918, she published her book *Married Love*, which caused great controversy and was banned in the USA.

The momentum toward public and political acceptance of family planning generated by these courageous pioneers, who defied the authority of organized religion, conservative convention, and at first the medical establishment, rewarded their conscientious commitment to serve women's health and reproductive self-determination. Nevertheless, until 1969, the Canadian Criminal Code reflected the history of earlier times in penalizing the spread of knowledge of contraceptive means as a "crime against morality." The courts had previously approved so many exceptions that the prohibition was effectively nullified, but family-planning initiatives remain under attack wherever they are proposed, particularly from the Roman Catholic Church hierarchy.

Voluntary sterilization was historically similarly contentious, although opposition declined with acceptance of contraceptive means. Involuntary, punitive sterilization, by castration of vanquished foes and later of sexual offenders, has a long history [3], and non-consensual eugenic sterilization has been approved by legislatures and courts since the 1920s, with continuing effect. The leading US Supreme Court decision of 1927 in Buck v. Bell [4], approving sterilization without her consent of an 18-year-old woman—the daughter of a mentally impaired mother and herself the mother of an allegedly impaired child—has never been reversed. However, the case remains highly controversial and it is commonly believed that it would not now be followed. In modern times, the legality of voluntary sterilization of mentally competent adult individuals is not generally doubted. An echo of earlier conservatism was heard in England in 1954, however, when a judge in a divorce case considering matrimonial cruelty described voluntary male sterilization as "degrading to the man himself and injurious to his wife and any woman whom he may marry" [5]. The other 2 judges in the case rejected this view, which was widely regarded as anachronistic at the time it was expressed.

Considerably greater conscientious commitment was required to liberalize restrictive abortion laws than to undertake voluntary sterilization. The incidence of deaths and injuries due to unskilled abortion among English families caused great concern in the mid-1930s, perhaps associated with economic depression and child-rearing costs. In 1938, the Ministry of Health and the Home Office, responsible for criminal law and its enforcement, set up the Interdepartmental (Birkett) Committee on Abortion to plan "the reduction of maternal mortality and morbidity arising from this cause."

A consultant obstetrician at a London hospital, Aleck Bourne, had terminated the early pregnancy of a 14-year-old gang-rape victim, to save her from becoming "a mental wreck," and informed the Birkett Committee of the realities of therapeutic abortion. For admitting to deliberately terminating a pregnancy, he was prosecuted for the crime of criminal abortion. The judge instructed the jury on the legal difference between the secretive actions of an unqualified person and a physician acting in a public hospital in good faith to preserve a patient's physical and/or mental health. This statement of the law in the Bourne case [6], distinguishing between criminal and lawful abortion, resulted in acquittal and remains an influential landmark in the laws of many countries inheriting English criminal law, establishing the legality of therapeutic abortion to preserve women's physical or mental health.

Conscientious commitment to the health of pregnant women is illustrated in the largely parallel careers of 2 physicians: the American William Harrison in Arkansas; and the Canadian Henry Morgentaler in Quebec and later Ontario. Both were motivated by the plight of usually poor, vulnerable women who sought their help in the late 1960s. Dr. Harrison explained that he was affected by seeing in his hospital emergency room "girls and women with raging fevers, extraordinary uterine and pelvic infections, enormous blood loss and a multitude of serious injuries of the pelvic and intra-abdominal organs as a result of illegal and self-induced abortions" [7]. He set up the Fayetteville Women's Clinic in Arkansas in 1972, a year before the US Supreme Court recognized abortion as a constitutional right. Nevertheless, for many years, he faced fury, fire-bombing, and death threats from anti-abortion activists for providing safe, legal abortion care.

Henry Morgentaler, whose abortion clinic in Toronto was picketed and also fire-bombed, began his abortion practice in Montreal when, after speaking out against Canada's restrictive criminal abortion law, he felt conscientiously bound to assist the often desperate, disadvantaged women who then flocked to him for treatment. He opened his abortion clinic in 1969 but acted outside the restrictively demanding requirements for lawful performance of abortion. He was prosecuted in 1973 but his acquittal by jury was exceptionally reversed by the Quebec Court of Appeal, and in 1975 he was imprisoned for 10 months of an 18-month sentence. On relocating his clinic to Toronto, he was further prosecuted in 1984. When his case was decided by the Supreme Court of Canada in 1988, the Court accepted his argument that the criminal abortion law was unconstitutional. The Chief Justice of Canada condemned the provisions that made lawful abortion often inaccessible and observed that "[f]orcing a woman, by threat of criminal sanction, to carry a foetus to term unless she meets certain criteria unrelated to her own priorities and aspirations, is a profound interference with a woman's body and thus a violation of security of the person," which failed to conform to principles of fundamental justice [8]. Modern governments in Canada express no interest in recriminalizing abortion. In 2008, Dr Morgentaler was awarded the Order of Canada, the country's highest honor.

## 3. Modern conscientious commitment

The call for healthcare practitioners' conscientious commitment to undertake procedures to protect women's health often arises in response to other practitioners' failures or refusals to provide care. Refusals of care may be based on explicit claims of conscientious objection or on reasoning that affords priority to the perceived interests of embryos and/or fetuses over the rights and interests of the pregnant women who bear them. For instance, early in 2010, the Inter-American Commission on Human Rights required Nicaragua to act on a complaint arising from denial of indicated care to a 27-year-old, 10-week-pregnant woman, given the disguised name of Amelia. She suffered from life-endangering cancer, but physicians and the state-run hospital denied indicated cancer treatment such as chemotherapy and radiotherapy, for fear of causing spontaneous abortion and being accused of violating Nicaragua's extremely repressive abortion law [9]. Practitioners conscientiously committed to promoting the health of pregnant women would recognize that the women, rather than the fetuses, are their patients [10]. Accordingly, as patients, the women rather than their caregivers determine whether or not they receive available treatment indicated for their care, unrelated to pregnancy itself, that may affect the fetuses they bear or may bear in the future.

A similar concern has been observed regarding the treatment of women who experience spontaneous abortion. In hospitals owned or operated by Roman Catholic authorities, religious doctrines may be applied to prevent uterine evacuation in the event of threatened spontaneous abortion while a fetal heartbeat is detected. In a 2008 review of practice in the USA, cases were observed in which:

> Catholic-owned hospital ethics committees denied approval of uterine evacuation while fetal heart tones were still present, forcing physicians to delay care or transport miscarrying patients to non-

> Catholic-owned facilities. Some physicians intentionally violated protocol because they felt patient safety was compromised. [11]

Protocols, ethics committee decisions on clinical cases, and rulings in such cases by religious office-holders that deny patients the available care their physicians consider to be in their best interests or that result in injury by delay of care or because of transportation of patients to other facilities raise serious concerns in law and in healthcare providers' professional ethics. Treating threatened spontaneous abortion via uterine evacuation is legally distinguishable from deliberately inducing abortion. Legal concerns about denying or delaying treatment involve liability for negligence, particularly due to failure to satisfy professional standards of timely care, possibly for breach of physician–patient contracts and breach of physicians' fiduciary duties to their patients, and criminal liability for negligence, reaching even as far as manslaughter. Liability, including criminal liability, may attach not only to individual physicians but also to third parties who intervene to obstruct indicated care, in addition to hospital institutions. Concerns in professional ethics include whether conscientious physicians can allow compromise of their judgment, and of their provision of best care to their patients, by third-party doctrinal intervention. Conscientious commitment to patients' safest care and healthcare providers' own safety from legal liability and professional censure may coincide.

Comparable concerns arise in the treatment of ectopic or "tubal" pregnancy. This is the leading cause of pregnancy-related death during the first trimester in the USA, and accounts for an estimated 9% of all pregnancy-related deaths. It also accounts for considerable morbidity in survivors, whose future ability to have children may be lost or severely compromised [12]. Treatment of this condition in the USA is aided by advances in anesthesia, antibiotics, and blood transfusion. In countries and regions where these means are not easily accessible or of a high standard, surgical interventions may be unavailable or unsuccessful. Fetal survival occurs rarely, if ever, and gestation to the point of rupture of the fallopian tube is hazardous to women's survival and to survivors' future health. After 1 ectopic pregnancy, evidence shows that a woman has a 7- to 13-fold increase in the likelihood of having another ectopic pregnancy [12].

Care guidelines for women with ectopic pregnancies are established by several specialist medical associations such as the American College (or Congress) of Obstetricians and Gynecologists [13] and the UK Royal College of Obstetricians and Gynaecologists [14]. In addition, the Cochrane Collaboration's review of evidence provides a synopsis of randomized controlled trials of treatment for tubal pregnancy and assessments of short-term and long-term outcome measures [15]. The range of treatment and management options for non-ruptured ectopic pregnancy includes salpingectomy, salpingostomy, medical treatment, and expectant management. Selection is based on the patient's clinical circumstances and future fertility intentions [16] (pp. 56–7).

Surgical and non-surgical management options are determined as a medical matter, directed to the woman's condition and taking account of her informed choice. By contrast, religious hierarchies, particularly those not including and explicitly excluding women, may direct their attention to the embryo or fetus, and whether its removal constitutes abortion. The Ethical and Religious Directives for Catholic Health Care Services, issued by the US Conference of Catholic Bishops, are ambivalent. Directive 48 provides that:

> In case of extrauterine pregnancy, no intervention is morally licit which constitutes a direct abortion. [16] (p. 58)

This is consistent with long-standing Catholic teaching but it follows a directive that appears more accommodating of physicians' conscientious commitment to women's health. Directive 47 provides that:

> Operations, treatment, and medications that have as their direct purpose the cure of a proportionately serious pathological condition of a pregnant woman are permitted when they cannot be safely postponed until the unborn child is viable, even if they will result in the death of the unborn child. [16] (p. 58)

From a medical perspective, the ectopic embryo or fetus may never be considered viable, but much turns on how the purpose of a treatment is characterized (e.g. whether by an attending physician, a hospital committee or chaplain, or a more senior church official such as a bishop) and by whom decision makers are influenced.

For instance, a leading Catholic healthcare theologian, Thomas O'Donnell, claims that no intervention is permissible unless, or until, the fallopian tube is so pathologically affected that ending the tubal pregnancy is justified. Further, he finds that removal of a non-viable fetus from the fallopian tube is not theologically different from its removal from the uterus, which is condemned as abortion [17]. However, the Catholic bioethicist Kevin O'Rourke claims that all treatment options are permissible. Removing the affected fallopian tube (salpingectomy) is justified because the direct intention is to save the mother's life—the fetal death being an unintended but unpreventable effect. Salpingostomy, in which the tube is not removed, is similarly defensible because the intention is to remove the woman's damaged tubal tissue and the damaging trophoblastic tissue (e.g. by use of methotrexate), not to kill or destroy the embryo [18].

Theologic analysis and debate are governed by their own principles, but what constitutes abortion is also a matter of law. This is shown in the context of emergency contraception [19], which allows conscientiously committed physicians scope to enjoy legal protection when they provide care (e.g. to women who have been raped) contrary to religious directives [20]. A judgment of the California Court of Appeal concerned a rape victim treated at a Catholic hospital, where she was not informed about emergency contraception. She sued, not for compensation, but for 2 judicial declarations. The first was that the hospital's failure "to provide information about and access to estrogen pregnancy prophylaxis to rape victims…constitutes a failure to provide optimal emergency treatment of rape victims in accordance with the [local] standard of good medical practice." The second was that the hospital must "provide rape victims with information and access to estrogen pregnancy prophylaxis, including the morning-after pill," or discontinue treatment and transport patients to the nearest facility that, within 72 hours of the sexual assault, would provide complete emergency medical treatment, including emergency contraception [21].

The hospital's defense was that these forms of emergency treatment would constitute abortion had fertilization occurred and that, as a non-profit religious institution, the hospital had legal protection against having to undertake such a procedure. However, the Court found that, as a matter of law, emergency contraception as described in the requested declarations does not constitute abortion because its purpose and effect are not to terminate but rather to avoid pregnancy by preventing fertilization or implantation. The Court followed earlier judgments that abortion, as it is commonly and legally understood, does not include intrauterine devices, the morning-after pill, or birth-control pills. The Court agreed with the contention that the rape victim's right to control her treatment must prevail over the moral and religious convictions under which a hospital is conducted and that, whether or not the hospital would transfer her care to another facility, failure to provide her with information of the emergency contraception option constitutes medical malpractice. Accordingly, even in a religiously run hospital, a conscientious physician is entitled, and perhaps obliged, to inform the patient about emergency contraception and, at her request, to administer such treatment if it is not feasible to transfer the patient to another facility in time for the treatment to be effective.

In view of the assertiveness of Roman Catholic leaders that treatments the law does not consider to be abortion remain condemned as such in their teachings, it is perhaps not surprising that they react strongly regarding treatments that laws clearly do characterize as

abortion. This creates the danger, however, of reacting too aggressively, even in ways that senior church officials themselves find excessive. This occurred in Recife, Brazil, in early 2009, when physicians conscientiously terminated the life-endangering twin pregnancy of a 9-year-old rape victim. The young girl's stepfather reportedly admitted sexually abusing her repeatedly since she was 6 years old, and was taken into police custody. The police had no interest in the abortion because this is lawful in Brazil when rape is proven [22].

However, Archbishop Sobrinho of Recife made public pronouncement of the resultant excommunication of the doctors involved in procuring the abortion and of the girl's mother, who requested it. The girl herself, being a minor, was not liable to excommunication and the church announced no ecclesiastic penalty regarding the stepfather. The Archbishop's requirement that this 9-year-old girl, whose pelvis was too small to accommodate even a single fetus, should continue a pregnancy imposed by rape and risk her life to become the mother of twins sadly reflects the insensitivity to the needs and feelings of children shown more widely in the inadequate, self-protective initial response of the church leadership to sexual depredations against children committed by their own priests.

Support for the physicians who were conscientiously committed to the young girl's survival, health, and wellbeing came from a bioethicist within the Vatican, Archbishop Fisichella, who was subsequently removed from his position as President of the Pontifical Academy for Life. Writing in the Vatican's newspaper *L'Osservatore Romano* on March 15, 2009, to express his dismay at the reaction of the Archbishop of Recife, he stressed that abortion is always bad but that the local prelate's apparent lack of compassion for the young girl's plight “hurts the credibility of our teaching, which appears in the eyes of many as insensitive, incomprehensible and lacking mercy” [22]. This marks the contrast with the compassion, sensitivity, and care shown by the physicians who lawfully terminated the pregnancy. Archbishop Fisichella's view proved controversial within the church, but political and popular sentiment in Brazil was that the physicians had acted conscientiously and humanely.

Conscientious commitment to assist infertile patients has been internationally acclaimed via the award of the 2010 Nobel Prize in Physiology or Medicine to Robert Edwards. His pioneering work with the late Patrick Steptoe resulted, in 1978, in the birth of the world's first infant from in vitro fertilization (IVF). He persevered to surmount the disappointments of denial of UK governmental research-funding support and of the lack of enthusiasm of peers in his commitment to overcome the childlessness of infertile patients. He also faced condemnation on some ethical and religious doctrinal grounds that continues to this day. Edwards himself was deeply involved in advancing the ethical analysis of IVF research and practice, however, and—as long ago as 1971—co-authored an important paper that initiated debate on many of the complex ethics and legal concerns to which IVF has given rise [23]. He proposed strict ethical guidelines for embryo research, acted with keen regard for the ethical propriety of IVF research and clinical practice, and ensured that an ethics committee for IVF was established at the clinic he founded with Steptoe at Bourne Hall, Cambridge, UK, which was the world's first IVF clinic [24].

## 4. Conclusion

The need has grown for physicians' and other healthcare providers' conscientious commitment to delivery of women's reproductive health services, to counter the rise of providers' religiously based claims to deny services on grounds of their conscientious objection. Conservative legislatures in many countries have enacted laws to protect such objection, publicly invoking the virtues of conscience to pursue the sometimes less visible aim of reduction of women's reproductive choices. In the USA, for instance, the 2010 report of the National Health Law Program, entitled Health Care Refusals: Undermining Quality Care for Women [16], covers the spectrum of reproductive health services to show how women's care is denied or obstructed.

Respect for conscience requires accommodation of both objection to participation in services and commitment to their delivery. Conscientious commitment may call for courage when treatment is provided that contradicts non-medical directives such as those by religious institutions and officers. Healthcare providers' professional ethics require mutual tolerance and accommodation, however, and resistance to forces of intolerance. The FIGO Ethical Guidelines on Conscientious Objection provide, in Guideline 4, that “[p]ractitioners have a right to respect for their conscientious convictions in respect both of undertaking and not undertaking the delivery of lawful procedures, and not suffer discrimination on the basis of their convictions” [25]. Institutions that would apply punitive sanctions against those whose exercising of their rights to conscience the institutions disapprove weaken the justification for protection of the exercise of conscience they require or approve.

## References

[1] Williams G. The sanctity of life and the criminal law. London: Faber and Faber; 1958.
[2] Dickens B. Conscientious commitment. Lancet 2008;371(9620):1240–1.
[3] Mason JK. Medico-legal aspects of reproduction and parenthood. Aldershot, UK: Ashgate; 1998. p. 67–84.
[4] 274 United States Reporter 200 (US Sup Ct).
[5] Bravery v Bravery, [1954] 3 All England Reports 59 (Court of Appeal), Lord Denning at 67–8.
[6] R v Bourne, [1938] 3 All England Reports 615 (Central Criminal Court).
[7] Boseley S. Obituary: William Harrison. Lancet 2010;376(9751):1460.
[8] R. v. Morgentaler (1988), 44 Dominion Law Reports (4th) 385, Dickson CJC at 402, 417.
[9] Carroll R. Nicaragua prevents treatment of pregnant cancer patient. The Guardian (UK); 23 February 2010.
[10] Dickens BM, Cook RJ. Ethical and legal approaches to ‘the fetal patient’. Int J Gynecol Obstet 2003;83(1):85–91.
[11] Freedman LR, Landy U, Steinauer J. When there's a heartbeat: miscarriage management in Catholic-owned hospitals. Am J Public Health 2008;98(10): at 1774–8.
[12] Sepilian VP, Wood E. Ectopic pregnancy. eMedicine Obstetrics and Gynecology. http://emedicine.medscape.com/article/258768-overview. Updated: Dec 23, 2010.
[13] American College of Obstetricians and Gynecologists. ACOG Practice Bulletin No. 94: Medical management of ectopic pregnancy. Obstet Gynecol 2008;111(6): 1479–85.
[14] Royal College of Obstetricians and Gynaecologists. The management of tubal pregnancy. Guideline No. 21. London: Royal College of Obstetricians and Gynaecologists; May 2004.
[15] Hajenius PJ, Mol F, Mol BW, Bossuyt PM, Ankum WM, van der Veen F. Interventions for tubal ectopic pregnancy. Cochrane Database Syst Rev 2007;1 CD000324.
[16] Fogel SB, Weitz TA. Health care refusals: undermining quality care for women. Los Angeles: National Health Law Program (NHeLP), 2010.
[17] O'Donnell TJ. Medicine and Christian Morality. Third Edition. New York: Alba House; 2002, at 180.
[18] O'Rourke KD. Applying the Directives. The Ethical and Religious Directives concerning three medical situations require some elucidation. Health Prog 1998;79(4):64–9.
[19] Cook RJ, Dickens BM, Ngwena C, Plata MI. The legal status of emergency contraception. Int J Gynecol Obstet 2001;75(2):185–91.
[20] Cook RJ, Dickens BM, Erdman JN. Emergency contraception, abortion and evidence-based law. Int J Gynecol Obstet 2006;93(2):191–7.
[21] Brownfield v. Daniel Freeman Marina Hospital, 256 California Reporter 240. (Ct Appeal, Second District, Div 4, California 1989).
[22] “Mercy” needed in Brazil abortion case: Fisichella. Int Herald Tribune, March 16, 2009.
[23] Edwards RG, Sharpe DJ. Social values and research in human embryology. Nature 1971;231(5298):87–91.
[24] Kirby T. Robert Edwards: Nobel Prize for father of in-vitro fertilisation. Lancet 2010;376(9749):1293.
[25] FIGO Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health. Ethical Issues in Obstetrics and Gynecology. London: FIGO; 2009.

# EXHIBIT N

The NEW ENGLAND JOURNAL of MEDICINE

Perspective
SEPTEMBER 13, 2012

# Recognizing Conscience in Abortion Provision

Lisa H. Harris, M.D., Ph.D.

The exercise of conscience in health care is generally considered synonymous with refusal to participate in contested medical services, especially abortion. This depiction neglects the fact that the provision of abortion care is also conscience-based. The persistent failure to recognize abortion *provision* as "conscientious" has resulted in laws that do not protect caregivers who are compelled by conscience to provide abortion services, contributes to the ongoing stigmatization of abortion providers, and leaves theoretical and practical blind spots in bioethics with respect to positive claims of conscience — that is, conscience-based claims for offering care, rather than for refusing to provide it.

Pairing of "conscience" and antiabortion sentiment is an understandable consequence of the evolution of conscientious objection in health care. The first conscience legislation, the Church Amendment, arose in 1973 in the wake of *Roe v. Wade*. It declares that a health care worker cannot be required to perform or assist in the performance of abortion (or sterilization) procedures that conflict with "his [sic] religious beliefs or moral convictions,"[1] and it prohibits discrimination against workers who refuse to provide care on the basis of their moral convictions. It also prohibits discrimination against those who do perform "a lawful sterilization procedure or abortion," though it does not recognize that moral convictions might drive such care. Thus, opposition to abortion, and to fertility control generally, catalyzed the development of law, theory, and practice of conscientious objection in medicine. Conscientious refusals and opposition to abortion grew up together, so to speak.

Over the past 40 years, the idea that conscience-based care means *not* providing or referring for abortion or other contested services has become naturalized. In 2008, the Bush administration extended the protections offered by the Church Amendment to workers who chose not to participate, even indirectly, in care that violated their moral beliefs. The Obama administration rescinded that rule. Antiabortion groups embraced Bush's rule and criticized Obama's rescinding of it; prochoice groups responded in the opposite manner. The result is an ongoing false dichotomization of abortion and conscience, making it appear that all abortion opponents support legal protections of conscience and all supporters of abortion rights oppose such protections, with little nuance in either position.

Whether or not abortion pro-



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vision is "conscientious" depends on what conscience is. Most ideas of conscience involve a special subset of an agent's ethical or religious beliefs — one's "core" moral beliefs.[2] The conclusion that abortion provision is indeed "conscientious" by this standard is best supported by sociologist Carole Joffe, who showed in *Doctors of Conscience* that skilled "mainstream" doctors offered safe, compassionate abortion care before *Roe*.[3] They did so with little to gain and much to lose, facing fines, imprisonment, and loss of medical license. They did so because the beliefs that mattered most to them compelled them to. They saw women die from self-induced abortions and abortions performed by unskilled providers. They understood safe abortion to be lifesaving. They believed their abortion provision honored "the dignity of humanity" and was the right — even righteous — thing to do. They performed abortions "for reasons of conscience."[3]

Though abortion providers now work within the law, they still have much to lose, facing stigma, marginalization within medicine, harassment, and threat of physical harm. However, doctors (and, in some states, advanced practice clinicians) continue to offer abortion care because deeply held, core ethical beliefs compel them to do so. They see women's reproductive autonomy as the linchpin of full personhood and self-determination, or they believe that women themselves best understand the life contexts in which childbearing decisions are made, or they value the health of a woman more than the potential life of a fetus, among other reasons.[3] Abortion providers continue to describe their work in moral terms, as "right and good and important,"[4] and articulate their sense that the failure to offer abortion care generates a crisis of conscience.[5]

Persistent neglect of the compatibility between conscience and abortion provision not only misrepresents their relationship, but has consequences for law, clinical practice, and bioethics. First, U.S. federal and state laws continue to protect only conscience-based refusals to perform or refer for abortion, offering minimal legal protection for conscience-based abortion provision. For example, the recent Georgia and Arizona bans on abortion after 22 and 20 weeks' gestation, respectively, include no allowances for providers conscience-bound to offer care after that limit. And the global "gag rule" forbidding workers at organizations funded by the U.S. Agency for International Development to discuss abortion has no conscience exemptions.

Second, the equation of conscience with nonprovision of abortion contributes to the stigmatization of abortion providers. If physicians who offer abortion care don't have a legitimate claim to act in "good conscience," like their counterparts who oppose abortion, the implication is that they act in "bad conscience" or lack conscience altogether. This understanding reinforces images of abortion providers as morally bankrupt. Such stereotypes may deter doctors from offering abortion services, thereby contributing to provider shortages. More important, stereotyping may have dangerous consequences: sociologists confirm that harassment and violence are extreme extensions of stigmatization.

Finally, bioethicists have focused on defining conditions under which conscientious refusals are acceptable but, with rare exceptions, have neglected to make the moral case for protecting the conscientious provision of care. Indeed, there is a real asymmetry between negative duties (to not do something) and positive duties (to do something) and, accordingly, between negative and positive claims of conscience. Violations of negative claims are considered morally worse than violations of positive ones.[2] However, as bioethicist Mark Wicclair argues, the moral-asymmetry thesis does not provide adequate ethical justification for current conscience law, which protects only conscience-based refusals.[2] Moral integrity can be injured as much by not performing an action required by one's core beliefs as by performing an action that contradicts those beliefs.[2]

The moral contours of positive claims of conscience require further elaboration, since they have implications for many other arenas of health care and research in which workers may be conscience-bound to do something — for example, physician-assisted suicide or stem-cell investigation. *Doing* something reflects a conscientious commitment, as legal scholars Bernard Dickens and Rebecca Cook would say, and it is a moral gesture, to borrow the words of bioethicist Laurie Zoloth. Bioethical scholarship, however, is dominated by considerations of conscientious refusal, not conscientious provision.

Abortion opponents may argue that abortion providers are motivated not by conscience but solely by political beliefs. Although I disagree, this critique indeed highlights the importance of distin-



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guishing claims of conscience from other types of claims. Certainly, if abortion providers' conscience-based claims require scrutiny, so do conscience-based refusals, to ensure that refusals are indeed motivated by conscience and not by political beliefs, stigma, habit, erroneous understanding of medical evidence, or other factors.

Despite nearly four decades of debate about conscientious refusals, we have no clear path for operationalizing them — no standard curriculum to teach health care professionals how to humanely conscientiously object, and no clinical standard of care for conscientious refusals — although there are presumably good and bad, skillful and haphazard, safe and unsafe ways of carrying them out. Since we need both a standard curriculum and a standard of care, it is perhaps premature to introduce a whole new set of conscience claims. The terms used in the current debate, however, are inadequate and inaccurate.

Recognizing only negative claims of conscience with respect to abortion — or any care — is a kind of hemineglect. Health care workers with conflicting views about contested medical procedures might all be "conscientious," even though their core beliefs vary. Failure to recognize that conscience compels abortion provision, just as it compels refusals to offer abortion care, renders "conscience" an empty concept and leaves us all with no moral ground (high or low) on which to stand.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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1. Health Programs Extension Act of 1973 (the Church Amendment), Pub. L. No. 93-45, § 401, 87 Stat. 91, 95.
2. Wicclair MR. Conscientious objection in health care. Cambridge, United Kingdom: Cambridge University Press, 2011.
3. Joffe CE. Doctors of conscience: the struggle to provide abortion before and after Roe v. Wade. Boston: Beacon Press, 1995.
4. Poppema SP. Why I am an abortion doctor. Amherst, NY: Prometheus Books, 1996.
5. Parker W. A perspective on later abortion . . . from someone who does them. Conscience 2012;33:17-9.

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# The Supreme Court and the Future of Medicaid

Timothy Stoltzfus Jost, J.D., and Sara Rosenbaum, J.D.

Perhaps the biggest of the many surprises found in the Supreme Court's June 28 decision on the Affordable Care Act (ACA) was the Court's conclusion that the law's Medicaid expansion scheduled for 2014 was unconstitutional.[1] Attention before June 28 was focused on whether the Court would uphold the individual mandate to obtain health insurance coverage, but in the wake of the Court's decision, focus has shifted to the question of whether states will refuse to participate in expanding the Medicaid program, given the Court's holding that the Secretary of Health and Human Services cannot enforce the expansion as a mandate.

Sommers et al. now provide in the *Journal* (pages 1025–1034) a glimpse of the impact of Medicaid expansion in New York, Maine, and Arizona. Medicaid expansion in these states was associated not only with improved health care coverage but also with reduced mortality. The question of whether the states will expand Medicaid, therefore, is not just a question of politics; it is a question of life, health, and death.

The expansion is one of several important Medicaid changes in the ACA. But as Justice Ruth Bader Ginsburg noted in her opinion, changes in Medicaid are not new. Medicaid itself was established in 1965 as an amendment to the preexisting Medical Assistance for the Aged program. Since then, Congress has amended Medicaid at least 50 times, mandating coverage of new categories of beneficiaries (e.g., low-income pregnant women in 1988) and dramatically expanding coverage for others (e.g., low-income children in 1989). Indeed, the Social Security Act has always reserved to Congress "the right to alter, amend, or repeal any provision" of the Medicaid statute.[2] The ACA's expansion of Medicaid to cover all nonelderly low-income persons with household incomes below 138% of the federal poverty level was the latest in a long line of evolutionary program reforms.

The 26 state challengers claimed that the ACA Medicaid amendments crossed a constitutional line. It is clear that Congress cannot force states to par-



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Short report

# Religion and conscientious objection: A survey of pharmacists' willingness to dispense medications

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A B S T R A C T

Some US states allow pharmacists to refuse to dispense medications to which they have moral objections, and federal rules for all health care providers are in development. This study examines whether demographics such as age, religion, gender influence 668 Nevada pharmacists' willingness to dispense or transfer five potentially controversial medications to patients 18 years and older: emergency contraception, medical abortifacients, erectile dysfunction medications, oral contraceptives, and infertility medications. Almost 6% of pharmacists indicated that they would refuse to dispense and refuse to transfer at least one of these medications. Religious affiliation significantly predicted pharmacists' willingness to dispense emergency contraception and medical abortifacients, while age significantly predicted pharmacists' willingness to distribute infertility medications. Evangelical Protestants, Catholics and other-religious pharmacists were significantly more likely to refuse to dispense at least one medication in comparison to non-religious pharmacists in multinomial logistic regression analyses. Awareness of the influence of religion in the provision of pharmacy services should inform health care policies that appropriately balance the rights of patients, physicians, and pharmacists alike. The results from Nevada pharmacists may suggest similar tendencies among other health care workers, who may be given latitude to consider morality and value systems when making clinical decisions about care.

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In the United States on December 19, 2008, the Bush Administration published a rule to strengthen protection of conscientious objectors in the health care profession from workplace discrimination when acting on their moral or religious convictions. A regulation (45 CFR part 88) became effective on January 20, 2009 that requires health care entities receiving federal funds to certify in writing that they will not require any individual to perform or assist in the performance of any part of a health service program or research activity that they deem contrary to their religious beliefs or moral convictions (Department of Health and Human Services, 2008). Among others, this rule could have been used to protect pharmacists who refuse to dispense medications they find morally or religiously objectionable from discrimination. However, in March 2009, the Obama administration proposed that this rule be rescinded (74 FR 10207). Currently, the rescission is still in the comment review phase, which leaves the Bush Administration rule in effect, but stalled in implementation.

Even without federal oversight, many US states already have laws addressing the issue of pharmacists' right to conscientious objection. These laws generally fall into three categories: (1) mandatory fill laws (e.g. Nevada, Maine, and Massachusetts), (2) mandatory access laws (e.g. California, Illinois, New Jersey, and Washington), and (3) pharmacist moral conscience protection laws (e.g. Arkansas, Georgia, Mississippi, and South Dakota), (National Conference of State Legislatures, 2009; National Women's Law Center, 2008). These apparently conflicting viewpoints and pending rules emphasize the continued importance of discussions regarding conscience clauses for pharmacists.

Although several surveys have examined physicians' perspectives on the issue (Curlin, Lawrence, Chin, & Lantos, 2007; Dickinson, Clark, Winslow, & Marple, 2005; MacDonald, 1998), less is known about how moral conscience clauses might influence other health care providers, including pharmacists. This paper reports results from a survey of 668 pharmacists practicing in

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a mandatory fill state about their willingness to dispense medications that sometimes conflict with religious doctrine.

## Background

The advent of legal, reproductive-related medications in recent history has become a divisive moral issue to certain religious groups. Because many faiths have explicit regulations related to contraception, conception, and abortion, medications like emergency and oral contraception, medical abortifacients, infertility medications, and erectile dysfunction medications have ignited widespread debate among religious leaders. Although the US Food and Drug Administration has firmly established the safety and effectiveness of these medications, leaders of Christian and non-Christian based faiths have expressed a broad range of stances on whether the use of reproductive-related medications constitutes a violation of religious beliefs.

Unlike Protestant Churches, the Roman Catholic Church has specific teachings regarding sexuality and reproduction that are considered authoritative for all Catholics. Pope Benedict XVI, for example, affirmed the Catholic Church's previous stance against the use of emergency contraception when he exhorted pharmacists to act only in ways that ensure that "all human beings are protected from conception to natural death, and so that medicines truly play a therapeutic role" (Associated Press, 2007). Although the Catholic Church indicates that individuals do not have the "right to a child", infertility and erectile dysfunction medications are considered morally acceptable if used to promote marital intercourse with the intention of procreation (Pontifical Academy for Life, 2004). Many Evangelical Protestant faiths, represented by such groups as Focus on the Family (Earll, 2002) and individuals such as Albert Mohler (Mohler, 2006) have similarly condemned the use of contraception, linking it to an abortifacient and a dishonoring of the procreative act (Shorto, 2006). Mormon leaders, in contrast, recently rephrased their position towards reproduction-related medications, asserting that their use is a private family decision rather than an issue constituting a violation of religious beliefs (Farnsworth, 2004).

Previous research has suggested that the influence of physicians' religious beliefs on their clinical practice can be considerable. In a study of 1144 medical doctors, 55% reported that religious beliefs influenced their practice, 63% were moderately-to-highly religious, and most objected to physician-assisted suicide (Curlin, Nwodim, Vance, Chin, & Lantos, 2008). The same study found that physicians who are more religious are less likely to believe they are obligated to disclose information about or help patients obtain procedures to which they object (Curlin et al., 2007).

There appears to be a similarly strong influence of religion on pharmacists' attitudes towards dispensing certain controversial medications. In a sample of 300 community pharmacists in Texas, 27.4% opposed dispensing emergency contraception, 86.1% of whom listed their religious beliefs as grounds for their objection (Griggs & Brown, 2007). A large survey of US pharmacists' attitudes towards dispensing standard hormonal contraception as a nonprescription service found that 57% were interested in initiating the service for patients (Landau et al., 2009). Among those opposed to expanding access to contraception, 58% said personal/religious beliefs were important influences.

Although the health professions have long recognized physicians' and nurses' right to conscientious refusal (Beal & Cappiello, 2008), extension of this right to the pharmacy profession has remained controversial, even among pharmacists (Brock, 2008; Cantor, 2009; Weisberg & Fraser, 2009). One small study showed that 41% of 54 surveyed pharmacists believed that they should have the right to refuse to dispense medications that are in opposition to their moral beliefs (Szatkowski, 2005). Another survey administered to pharmacists in Oregon and New Jersey found that between 59% and 68% of pharmacists believed they should be allowed to refuse to fill prescriptions that violate their religious or moral beliefs (Peter D. Hart Research Associates, 2000).

Some pharmacists state that they should be allowed to refuse to fill a prescription, as well as refuse to transfer a prescription or refer the patient to another pharmacist. The official American Pharmacists Association (APhA) "does not support lecturing a patient or taking any action to obstruct patient access to clinically appropriate, legally prescribed therapy" (American Pharmacists Association, 2009, p. 3).

Pharmacists' refusal to dispense certain medications poses a particular concern for patients living in more rural areas (Lynch, 2008), like those found throughout Nevada. Approximately 91.6% of pharmacists are located in Nevada's two metropolitan counties. Thus, some isolated towns are serviced by only one or two pharmacists, which may limit patients' ability to find an alternate pharmacy that is within a reasonable walking or driving distance. Given that levonorgestrel is most effective in preventing pregnancy when taken within 72 h of unprotected sex, the ability to access another pharmacy in the event of a refusal could pose a substantial barrier to Nevada's rural patients.

In light of these concerns, the purpose of this paper is to identify, among a sample of pharmacists practicing in a state with a mandatory fill law and a high proportion of rural areas, how many are willing to dispense selected medications, and the characteristics associated with refusing to dispense.

## Procedure

### *Design and participants*

In 2008, a confidential, 4-page questionnaire was mailed to all 1975 practicing pharmacists in Nevada. Addresses were acquired through the Nevada State Board of Pharmacy address database—a catalog that includes all pharmacists who hold a license in the state of Nevada. Pharmacists received up to two separate mailings of the questionnaire and two reminder mailings with the option to take the survey online through SurveyMonkey.com. Pharmacists could participate in a raffle drawing for several $50 gift certificates if they agreed to participate. A total of 34% of the pharmacists contacted agreed to participate and completed the survey, resulting in a sample size of 668. The University of Nevada, Reno IRB approved this study.

Males comprised 53.8% of respondents. Pharmacists had worked in their profession from 1 to 58 years ($M = 21$, $SD = 13.86$) and practiced pharmacy from 0 to 96 h per week ($M = 37$, $SD = 12.6$). They reported ages ranging from 31 to 91 ($M = 54$, $SD = 12.8$). Ninety-four percent of pharmacists reported that the next closest pharmacy to theirs was less than five miles away; 4.3% reported that it was 5–20 miles away; 0.8% reported it was 21–50 miles away; and 1.4% reported that it was over 50 miles away.

### *Measures*

The primary criterion variables in this study were pharmacists' willingness to distribute five medications identified as controversial by the literature (Andrist et al., 2004, Bigbee, et al., 2007; Seelig, Gelberg, Tavrow, Lee, & Rubenstein, 2006; Sutkin, Grant, Irons, & Borders, 2006) and a panel of Nevada pharmacists: emergency contraception, medical abortifacients, erectile dysfunction medications, oral contraceptives, and infertility medications to patients 18 or older. Pharmacists were asked to "circle the option that best describes your level of comfort in dispensing the following drugs on moral grounds (not medical or legal)."

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**Table 1**
Percentage and number of pharmacists' willingness to dispense five medications.

| Medication | Dispense without moral objection | Dispense but morally object | Refuse to dispense on moral grounds but transfer | Refuse to dispense on moral grounds and refuse to transfer |
|---|---|---|---|---|
| Erectile dysfunction drugs | 93.4% (581) | 4.8% (30) | 1.1% (7) | 0.6% (4) |
| Emergency contraception | 85.0% (544) | 7.5% (48) | 5.2% (33) | 2.3% (15) |
| Oral contraceptives | 98.3% (632) | 1.2% (8) | 0.2% (1) | 0.3% (2) |
| Infertility drugs | 90.7% (606) | 2.5% (17) | 0.9% (6) | 0.5% (3) |
| Medical abortifacients | 72.4% (444) | 10.4% (64) | 11.3% (69) | 5.9% (36) |

Table 1 reports the frequency of responses in each of four possible categories: (1) Dispense without moral objection; (2) Dispense but morally object; (3) Refuse to dispense on moral grounds but transfer to another pharmacist; and (4) Refuse to dispense on moral grounds and refuse to transfer. Analyses examine the association of pharmacists' responses with the following demographic variables: religious affiliation, age, sex, and distance to the next nearest pharmacy.

Although more than 20 distinct religions were listed in pharmacists' open-ended responses, we collapsed responses into five categories based on the findings of prior research identifying the most meaningful religious categories and taking into account sample size: Catholic (24.5%), Evangelical Protestant (19.7%), Non-Religious (18.7%), Mainline Protestant (12.1%), and Other Religion (14.5%).

Evangelical Protestant includes Baptists, Evangelical Christians, non-denominational Christians, Pentecostals, and born-again Christians. Mainline Protestants include Lutherans, Presbyterians, and Methodists. Non-Religious included atheists and the non-practicing. The remaining category of Other Religion was more diverse and included Jews (4.5%), Mormons (3.6%), Eastern religions (3.4%), and those who were spiritual, but non-religious (3.0%). Although problematic to include such diverse groups within one category, the number of individuals in each subgroup was too small to create reliable statistical models; thus we grouped them together rather than exclude them. Finally, responses from the 10.3% of pharmacists who refused to provide their religious affiliation were omitted from logistic regression analyses. Non-Religious pharmacists were used as the comparison group in logistic regression analyses.

Age ranges were also categorized from open-ended responses into the following groups: 31–40, 41–50, 51–60, 61–70, and 71 and older. Distance to next nearest pharmacy was collapsed from four categories to two (less than five miles away or more than five miles away) because of the small number of responses from pharmacists in more remote areas of the state. Additionally, many individuals may not be able to walk to another pharmacy that is further than five miles away, thereby still presenting a significant barrier to patients' ability to obtain a medication in the event that their primary pharmacist refuses to fill it. Pharmacists aged 31–40, females, and pharmacists practicing less than 5 miles away from the next nearest pharmacy served as reference groups in logistic regression models.

## Results

### *Descriptives*

Pharmacists were less willing to dispense medical abortifacients and emergency contraception in comparison to other drugs, with 7.5% unwilling to dispense emergency contraception and 17.2% unwilling to dispense medical abortifacients (Table 1). Approximately 5.8% (39 total) of pharmacists indicated that they would refuse to dispense at least one of the five drugs listed and another 2.5% (16 total) of pharmacists indicated that they would refuse to fill two or more medications. Approximately 13.2% of pharmacists (85 total) indicated that they would refuse to dispense at least one medication but would be willing to transfer the prescription elsewhere, and another 4.5% (29 total) indicated that they would refuse to fill two or more medications but would transfer them to another pharmacist.

Table 2 presents a series of chi-square analyses assessing whether demographics significantly predict willingness versus unwillingness to dispense the five medications. For this table, the four categories of the dependent variable were collapsed into two to better gauge percentage of pharmacists willing and unwilling to

**Table 2**
Percent and chi-square comparisons of pharmacists' willingness to dispense five medications by demographics.

| | Emergency contraception | | Medical abortifacients | | Erectile dysfunction medications | | Oral contraceptives | | Infertility medications | |
|---|---|---|---|---|---|---|---|---|---|---|
| | $\chi^2$ | % Willing | $\chi^2$ | % Willing | $\chi^2$ | % Willing | $\chi^2$ | % Willing | $\chi^2$ | % Willing |
| *Religion* | 19.13*** | | 29.02*** | | 4.39 | | 4.21 | | 5.50 | |
| Non-religious | | 97.50% | | 94.70% | | 99.10% | | 100.00% | | 99.20% |
| Evangelical protestant | | 85.40% | | 74.80% | | 97.60% | | 98.50% | | 99.20% |
| Catholic | | 90.10% | | 74.70% | | 96.80% | | 99.40% | | 98.80% |
| Mainline protestant | | 97.40% | | 93.20% | | 98.70% | | 100.00% | | 100.00% |
| Other | | 95.70% | | 82.10% | | 100.00% | | 100.00% | | 95.80% |
| *Age range* | 4.22 | | 8.06 | | 5.14 | | 3.72 | | 22.85*** | |
| 30–40 | | 95.80% | | 76.80% | | 98.30% | | 100.00% | | 100.00% |
| 41–50 | | 92.00% | | 85.60% | | 100.00% | | 100.00% | | 100.00% |
| 51–60 | | 89.90% | | 79.70% | | 96.80% | | 98.70% | | 98.10% |
| 61–70 | | 92.20% | | 85.60% | | 98.60% | | 99.40% | | 99.30% |
| 71+ | | 95.20% | | 90.50% | | 96.80% | | 100.00% | | 92.20% |
| *Distance* | 1.49 | | 0.37 | | 3.00 | | 0.20 | | 0.80 | |
| 0–4 miles | | 92.10% | | 82.60% | | 98.40% | | 99.50% | | 99.00% |
| 5+ miles | | 97.40% | | 86.50% | | 94.40% | | 100.00% | | 97.40% |
| *Sex* | 0.24 | | 2.53 | | 1.4 | | 3.49 | | 0.35 | |
| Male | | 92.90% | | 85.00% | | 98.80% | | 100.00% | | 98.80% |
| Female | | 91.90% | | 80.10% | | 97.50% | | 99.00% | | 98.30% |

***$p < .001$.

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**Table 3**
Multinomial logistic regression model predicting willingness to dispense at least one controversial medication.

| | Dispense, but morally object | Refuse to dispense on moral grounds |
|---|---|---|
| | OR (CI) | OR (CI) |
| *Religion* | | |
| Non-religious[a] | 1.00*** | 1.00*** |
| Evangelical protestant | 1.76 (0.78–3.95) | 6.87*** (2.71–17.41) |
| Catholic | 1.63 (0.75–3.55) | 7.38*** (2.99–18.24) |
| Mainline protestant | 0.75 (0.26–2.13) | 1.53 (0.47–5.01) |
| Other | 2.69* (1.16–6.22) | 5.31*** (1.96–14.44) |
| *Sex*[b] | 2.08* (1.16–3.72) | 1.55 (0.94–2.54) |

*$p < .05$; **$p < .01$; ***$p < .001$.
[a] Non-Religious is referent.
[b] Male is referent. Non-significant age and distance to next nearest pharmacy demographics not displayed.

dispense each of five medications by their demographic characteristics. Pharmacists who were willing to dispense and had no moral objection to doing so as well as pharmacists who were willing to dispense in spite of a moral objection to doing so were categorized as "willing." Pharmacists who would refuse to fill but *would* transfer and pharmacists who would neither fill *nor* transfer were categorized as "unwilling."

Chi-square analyses indicate that religion was significantly associated with pharmacists' willingness to dispense emergency contraception and medical abortifacients ($p < .001$) and age was significantly associated with willingness to distribute infertility medications ($p < .001$). No other demographics emerged as significant predictors of willingness to dispense medications.

### *Multinomial logistic regression model predicting willingness to distribute medications*

Finally, the likelihood that a pharmacist would refuse to dispense at least one of the five medications listed was assessed using multinomial logistic regression, a technique appropriate for use with multiple discrete, non-ordinal response categories. Because of the small numbers in each group, all pharmacists who indicated that they would refuse to dispense a medication were collapsed into a single group to increase statistical precision, even though some would transfer prescriptions elsewhere and some would not. Table 3 summarizes the results from the multinomial logistic regression models predicting the odds that pharmacists would have a moral objection to distributing at least one medication or would refuse to dispense at least one medication. Odds ratios and confidence intervals for membership in these two categories are presented in reference to the baseline category (willing to dispense with no moral objection).

Other-religious pharmacists and females were significantly more likely than non-religious pharmacists and male pharmacists to report that they would distribute but have a moral objection to at least one of the five medications listed ($p < .05$). Evangelical Protestant, Catholic, and other-religious pharmacists were significantly more likely than non-religious pharmacists to report that they would refuse to fill a medication ($p < .001$). Age and distance to next nearest pharmacy did not significantly predict willingness to dispense medications.

## Discussion and conclusion

Among pharmacists in Nevada, significant minorities report moral objections to one or more classes of controversial pharmaceuticals and occasionally report an unwillingness to dispense them at all. Religion emerged as a significant predictor of unwillingness to dispense medical abortifacients and emergency contraception and age significantly predicted unwillingness to dispense infertility medications. Evangelical Protestant, Catholic, and "Other Religious" pharmacists were significantly more likely to refuse to dispense medications while non-religious pharmacists were significantly more willing to dispense all medications. These findings are consistent with studies revealing the influence of religion among other health professionals and hospitals, especially regarding contraception, abortion, and end-of-life decisions (Curlin et al., 2008; Freedman, Landy, & Steinauer, 2008).

This study suggests that religious beliefs, and the absence of them, shape pharmacists' judgments about the boundaries of ethical practice, at least insofar as that practice involves dispensing controversial medications. Between 2% to 6% of pharmacists indicated that they would refuse to dispense at least one medication and refuse to transfer that prescription to another pharmacist. This finding suggests that a small minority of pharmacists is occasionally willing to violate a state's mandatory fill law and the ethical guidelines issued by the American Pharmacists Association to conscientiously refuse to fill a prescription. The remainder of the pharmacists in our sample, however, indicated either that they had no moral objection to the drugs on our list or that they would fill medications even when they found them morally objectionable. In the comments section of our survey, a number of pharmacists reported that, although they may personally object to a medication, their professional code implies a duty to serve patients regardless of their moral convictions: "I think it is inappropriate to apply personal moral beliefs outside the professional code of conducts in the practice."

Although according to these findings the vast majority of pharmacists in Nevada are likely willing to dispense controversial medications, the current policy debate about extending moral conscience protection for pharmacists necessarily asks two questions: (1) *should* pharmacists be required to act against their conscience and (2) would the provision or absence of a moral conscience clause affect patients' access to medication? Future research should address these questions. Although several studies have examined the impact and prevalence of moral conflict in the nursing (e.g. Corley, Elswick, Gorman, & Clor, 2001) and physician professions (e.g. Curlin et al., 2007), much less work has examined the ethical dilemmas facing pharmacists. Even in a state with a mandatory fill law, the results of our study suggest that a small minority of pharmacists report that they would refuse to dispense medications to which they have moral objections. Whether they do, in fact, refuse such medications is unknown. Future research should elucidate the relationship between pharmacists' moral beliefs and their actual clinical practice.

Although some controversial medications, like emergency contraception (levonorgestrel), are now available over-the-counter, pharmacists can affect availability through their stocking practices when the law remains ambiguous (Shacter, Gee, & Long, 2007). Therefore, pharmacists' attitudes towards controversial medications could continue to influence medication access in the future through direct refusal to stock or fill objectionable medications. Although this study suggests that refusals to fill prescriptions in rural areas are likely rare, a recent California telephone survey found that refusals to fill emergency contraception were more common in rural areas (Sampson et al., 2009). Research should continue to assess the frequency of refusals in areas with few pharmacy alternatives.

Several limitations of this study warrant discussion. First, the low response rate may have contributed to a self-selection bias such that pharmacists who strongly opposed controversial medications were more likely to respond, perhaps inflating the proportion of refusals found among state pharmacists. Indeed, although demographics of our sample mirror the population characteristics of Nevada, there

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was a slightly higher proportion of Evangelical Protestants in our sample than in the general Nevada population (Polis Center, 2001).

Second, there are trends in the data suggesting that certain religious sub-groups were significantly more willing to refuse to fill prescriptions than others (e.g. 50% of Mormon pharmacists indicated they would refuse to fill at least one prescription versus 10% of Jewish pharmacists). Unfortunately, small numbers in those categories limited our ability to assess differences within broader religious groupings. Future research using larger samples of these less common religions and including variables assessing religiosity, church attendance, and attitudes towards abortion and contraception would contribute to more detailed knowledge about the relationship between religious affiliation and pharmacists' willingness to distribute medications. Finally, Nevada's unique demographics and state fill regulation limit the generalizability of these findings to other areas of the country.

Despite these limitations, the study findings imply a number of future directions for policy formation and regulation enforcement. An open policy process that considers the possible influence of religion would help ensure patients' access to care is protected, but considered alongside pharmacists' individual rights and professional obligations. Pharmacists who refuse to stock or dispense medications should make their intentions transparent to prescribing physicians and consumers to allow patients to choose a pharmacy capable of meeting their medical needs. Alternately, patients could be referred to a hotline or other resource during cases of conscientious refusals, and regulators could review refusals as they do other professional conduct (Hepler, 2005). Awareness of the influence of religion in the provision of pharmacy services should inform any efforts to improve communications and enhanced expectations of quality care that is acceptable to patients, physicians, and pharmacists alike. The results from pharmacists may suggest similar tendencies among other health care workers who may be given latitude to consider morality and value systems when making clinical decisions about care.

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## References

Andrist, L. C., Arias, R. D., Nucatola, D., Kaunitz, A. M., Musselman, B. L., Reiter, S., et al. (2004). Women's and providers' attitudes toward menstrual suppression with extended use of oral contraceptives. *Contraception, 70*(5), 359–363.

American Pharmacists Association. (2009). Federal conscience clause. *Government Affairs Issue Brief, March*, 1–4, Retrieved from. http://www.pharmacist.com/AM/Template.cfm?Section=Home2&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=15688.

Associated Press. (2007, October 29). Pope warns pharmacists over 'immoral drugs'. *MSNBC*. Retrieved January 12, 2010, from. http://www.msnbc.msn.com/id/21535017/.

Beal, M. W., & Cappiello, J. (2008). Professional right of conscience. *Journal of Midwifery & Womens Health, 53*(5), 406–412.

Bigbee, J. L., Abood, R., Landau, S. C., Maderas, N. M., Foster, D. G., & Ravnan, S. (2007). Pharmacy access to emergency contraception in rural and frontier communities. *Journal of Rural Health, 23*(4), 294–298.

Brock, D. W. (2008). Conscientious refusal by physicians and pharmacists: who is obligated to do what, and why? *Theoretical Medicine and Bioethics, 29*(3), 187–200.

Cantor, J. D. (2009). Conscientious objection gone awry–restoring selfless professionalism in medicine. *New England Journal of Medicine, 360*(15), 1484–1485.

Corley, M. C., Elswick, R. K., Gorman, M., & Clor, T. (2001). Development and evaluation of a moral distress scale. *Journal of Advanced Nursing, 33*(2), 250–256.

Curlin, F. A., Lawrence, R. E., Chin, M. H., & Lantos, J. D. (2007). Religion, conscience, and controversial clinical practices. *New England Journal of Medicine, 365*(6), 593–600.

Curlin, F. A., Nwodim, C., Vance, J. L., Chin, M. H., & Lantos, J. D. (2008). To die, to sleep: US physicians' religious and other objections to physician-assisted suicide, terminal sedation, and withdrawal of life support. *American Journal of Hospice Palliative Care, 25*(2), 112–120.

Department of Health and Human Services. (2008). Ensuring that department of health and human services funds do not support coercive or discriminatory policies or practices in violation of federal law; final rule. *Federal Register, 73* (245), 78071–78101, Retrieved from. http://edocket.access.gpo.gov/2008/E8-30134.htm.

Dickinson, G. E., Clark, D., Winslow, M., & Marple, R. (2005). US physicians' attitudes concerning euthanasia and physician-assisted death: a systematic literature review. *Mortality, 10*, 43–52.

Earll, C. G. (2002). Morning after pill (emergency contraception). Retrieved January 12, 2010, from. http://www.citizenlink.org/FOSI/bioethics/abortion/A000002277.cfm.

Farnsworth, K. (2004, January 21). LDS Church not opposed to birth control. *Universe*. Retrieved February 4, 2010, from. http://newnewsnet.byu.edu/story.cfm/47736.

Freedman, L. R., Landy, U., & Steinauer, J. (2008). When there's a heartbeat: miscarriage management in catholic-owned hospitals. *American Journal of Public Health, 98*(10), 1774–1778.

Griggs, S. K., & Brown, C. M. (2007). Texas community pharmacists' willingness to participate in pharmacist-initiated emergency contraception. *Journal of the American Pharmacists Association (2003), 47*(1), 48–57.

Hepler, C. D. (2005). Balancing pharmacists' conscientious objections with their duty to serve. *Journal of the American Pharmacists Association (2003), 45*(4), 434–436.

Landau, S., Besinque, K., Chung, F., Dries-Daffner, I., Maderas, N. M., McGhee, B. T., et al. (2009). Pharmacist interest in and attitudes toward direct pharmacy access to hormonal contraception in the United States. *Journal of the American Pharmacists Association (2003), 49*(1), 43–50.

Lynch, H. F. (2008). *Conflicts of conscience in health care: An institutional compromise*. Cambridge MA: MIT Press.

MacDonald, W. L. (1998). Situational factors and attitudes toward voluntary euthanasia. *Social Science & Medicine, 46*, 73–81.

Mohler, A. (2006, May 8). Can Christians use birth control?. Retrieved January 12, 2010, from. http://www.albertmohler.com/?cat=Commentary&cdate=2006-05-08.

National Conference of State Legislatures. (2009, May). Pharmacist conscience clauses: laws and legislation. Retrieved February 8, 2010, from. http://www.ncsl.org/programs/health/conscienceclauses.htm#p.

National Women's Law Center. (2008, January). Pharmacy refusals: state laws, regulations, and policies. Retrieved October 13, 2008, from. http://www.nwlc.org/pdf/PharmacyRefusalPoliciesJanuary2008.pdf.

Peter D. Hart Research Associates. (2000). A survey among the general public and licensed pharmacists in New Jersey and Oregon conducted on behalf of RHTP. Retrieved October 13, 2008, from. http://ec.princeton.edu/news/survey.html.

Polis Center. (2001). North American religion atlas. Retrieved December 10, 2009, from. http://www.religionatlas.org/default.asp?page=rel_region&ext=htm.

Pontifical Academy for Life. (2004). Final communique on the dignity of human procreation and reproductive technologies: anthropological and ethical aspects. *Donum Vitae, II*(6).

Sampson, O., Navarro, S. K., Khan, A., Hearst, N., Raine, T. R., Gold, M., et al. (2009). Barriers to adolescents' getting emergency contraception through pharmacy access in California: differences by language and region. *Perspectives on Sexuality and Reproductive Health, 41*(2), 110–118.

Seelig, M. D., Gelberg, L., Tavrow, P., Lee, M., & Rubenstein, L. V. (2006). Determinants of physician unwillingness to offer medical abortion using mifepristone. *Womens Health Issues, 16*(1), 14–21.

Shacter, H. E., Gee, R. E., & Long, J. A. (2007). Variation in availability of emergency contraception in pharmacies. *Contraception, 75*(3), 214–217.

Shorto, R. (2006, May 7). Contra-contraception. *New York Times*. Retrieved February 4, 2010, from. http://www.nytimes.com/2006/05/07/magazine/07contraception.html.

Sutkin, G., Grant, B., Irons, B. K., & Borders, T. F. (2006). Opinions of West Texas pharmacists about emergency contraception. *Pharmacy Practice, 4*(4), 151–155.

Szatkowski, M. (2005). The findings of a survey regarding the right of a pharmacist to refuse dispensing medicine to a patient based on personal beliefs. Retrieved April 12, 2009, from. http://rxethics.org/szatkowski2005.pdf.

Weisberg, E., & Fraser, I. S. (2009). Rights to emergency contraception. *International Journal of Gynaecology and Obstetrics, 106*(2), 160–163.

# EXHIBIT P

*The European Journal of Contraception and Reproductive Health Care, 2013; 18: 231–233*

# Conscientious objection and induced abortion in Europe

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ABSTRACT The issue of conscientious objection (CO) arises in healthcare when doctors and nurses refuse to have any involvement in the provision of treatment of certain patients due to their religious or moral beliefs. Most commonly CO is invoked when it comes to induced abortion. Of the EU member states where induced abortion is legal, invoking CO is granted by law in 21 countries. The same applies to the non-EU countries Norway and Switzerland. CO is not legally granted in the EU member states Sweden, Finland, Bulgaria and the Czech Republic. The Icelandic legislation provides no right to CO either. European examples prove that the recommendation that CO should not prevent women from accessing services fails in a number of cases. CO puts women in an unequal position depending on their place of residence, socio-economic status and income. CO should not be presented as a question that relates only to health professionals and their rights. CO mainly concerns women as it has very real consequences for their reproductive health and rights. European countries should assess the laws governing CO and its effects on women's rights. CO should not be used as a subtle method for limiting the legal right to healthcare.

KEYWORDS Conscientious objection; Induced abortion

## INTRODUCTION

Induced abortion and the rights of the woman, of the fetus, and of the health professional in this respect, are the subjects of an ongoing debate throughout western countries. Even in countries where the right to abortion is guaranteed by law, the efforts undertaken by certain groups to obtain limited access to abortion have kept the controversy going.

The issue of conscientious objection (CO) arises in healthcare when doctors and nurses refuse to have any involvement in the provision of guidance or treatment of certain patients due to their religious, moral or philosophical beliefs[1]. Most commonly, in healthcare, CO is invoked when it comes to induced abortion or euthanasia. Proponents of CO claim the right to refuse to provide certain services as a right to freedom of religion, conscience and thought. To withhold procedures that clash with one's moral beliefs is presented as a basic human right. In addition to this, induced abortions can be seen as conflicting with the doctor's oath to do no harm and to respect life. The discussion about CO is often driven by religious organisations. Other organisations such as trade unions, associations of health professionals, and patient groups have mostly not partaken in this discussion.

The active role played by some religious, anti-choice and other conservative groups was also evident in 2010 during the Parliamentary Assembly of the Council of Europe debate and the vote on the Resolution and Recommendation on Women's access to lawful

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medical care with regard to unregulated use of CO. The recommendation aimed to develop clear guidelines and regulations for healthcare personnel to provide necessary information about all treatment options and to ensure treatment in emergencies. The recommendation was rejected due to a tactical intervention by the anti-choice groups[2].

## CONSCIENTIOUS OBJECTION IN EUROPE

In 25 European Union (EU) member states, induced abortion is legal[3]. In 21 of these countries, invoking conscientious objection to performing abortion is granted by law. The same applies to the non-EU countries Norway and Switzerland. Legislations vary: in some countries CO is a constitutional right whereas in others it is mentioned in the specific laws regulating induced abortion or medical practice. In most countries it is possible for doctors to invoke CO in one workplace (e.g., the state hospital) and to perform abortions in another institution (e.g., a private clinic where they are better paid for the procedure).

Health professionals in the EU member states Sweden, Finland, Bulgaria and the Czech Republic are legally not entitled to conscientiously object to the provision of abortion services. The Icelandic legislation grants no right to CO either. The question of conscientious objection has nevertheless often been raised in these countries too. For instance, at the time of writing this piece the Finnish government is contemplating allowing CO.

## THE EFFECTS OF CONSCIENTIOUS OBJECTION

It has been reported that in Italy, in 2008, nearly 70% of gynaecologists refused to perform abortions on moral grounds; the rate of CO augmented relatively rapidly over the first decade of this century. The practice seems to be quite prevalent also in Poland and the Slovak Republic, and has gained in importance even in the United Kingdom[1]. By country reports, the situation is also alarming in Portugal where an estimated 80% of gynaecologists refuse to carry out induced abortions[4] and in Austria, where entire regions lack abortion providers[5].

These European examples prove that the WHO guidance[6] on the right to conscientious objection and this organisation's recommendation that recognition of the aforementioned right should not prevent women from accessing services are not workable in a number of cases. CO puts women in an unequal position depending on their place of residence, socio-economic status, income, and their ability to travel long distances to access a service to which they are legally entitled. It may require money, time and resources to establish where the nearest abortion provider is. When a woman is the main caretaker of the family, travelling may be impossible; further, missing work may jeopardise employment, and leaving children or older persons unattended for a significant period of time may cause considerable difficulties or may not be possible at all.

CO should not be presented as a question that relates only to health professionals and their rights. On the contrary, CO mainly concerns women as it has very real consequences for their reproductive health and reproductive rights. CO has resulted in limited access to abortion in several European countries, and can prevent women from accessing altogether the services sought: it comes down to a refusal to treat.

Not allowing CO enhances equality and access to a legal service. European countries should critically assess the laws governing CO and its effects on women's legal rights. CO should not be used as a subtle method for limiting the legal right to healthcare. While it is important to reduce the abortion rate this should be achieved by preventing unwanted pregnancies, not by restricting access to induced abortion.

## THE RIGHTS OF HEALTH PROFESSIONALS

Under human rights laws, the right to abide by the teachings of one's religious faith or one's moral beliefs can be limited with the view of protecting the rights of others, including women's reproductive rights[1].

CO can put health professionals in an unequal position in relation to each other. Many health professionals stress that access to abortion is an important right and that, therefore, terminations within legal boundaries ought to be feasible. Invoking CO by some results in more work for professionals who do not call upon a conscience clause.

Caring for women with unwanted pregnancies – including performing abortions – should be part of

the specialty training, and of the skills that gynaecologists and other professionals must acquire. Refusing treatment by invoking CO can put the health and life of a woman in danger if the doctor specialising in gynaecology is not capable of carrying out abortions in emergency situations.

CO and women's right to services are often reconciled by stating that the health professional as an individual has the right to refuse to perform induced abortions but that the organisation has the responsibility to guarantee access to abortion. European examples show that, in the real world, this is not always the case and it is hard to ignore that inequalities result from elevating CO above women's right to legal healthcare.

All in all, CO strengthens the stigma associated with abortion, and if granted, the use of CO should be overseen by competent national or regional authorities that guarantee equal access to abortion for all women regardless of their place of residence or financial situation. Disclosing one's position on CO should also be a part of the recruitment process when applying for positions where it might be invoked.

***Declaration of interest:*** D. Apter and C. Fiala have actively taken part in the provision of abortion services. M. Gissler and A. Heino have been involved in the monitoring of reproductive health, including induced abortions, but report no other conflicts of interest. The authors alone are responsible for the content and the writing of the paper. Their opinions do not necessarily reflect the official opinion of the institutions they represent.

## REFERENCES

1. Zampas C, Andión-Ibanez X. Conscientious objection to sexual and reproductive health services: International human right standards and European law and practice. *Eur Health Law* 2012;19:231–56.
2. EPF. *Analysis on the Vote on the Resolution 1763 (2010) and Recommendation on "Women's access to lawful medical care: the problem of unregulated use of conscientious objection"*. European Parliamentary Forum on Population and Development. Accessed 24 June 2013 from: http://politicsreligion.eu/epf-analysis-on-the-vote-on-resolution-17632010/
3. Gissler M, Fronteira I, Jahn A, *et al.*; REPROSTAT group. Terminations of pregnancy in the European Union. *BJOG* 2012;119:324–32.
4. Oliveira da Silva M. Reflections on the legalisation of abortion in Portugal. *Eur J Contracept Reprod Health Care* 2009;14:245–8.
5. Austrian Ministry of Health. *Österreichischer Frauengesundheitsbericht 2010/2011* [*Austrian Women's Health Report 2010/2011*]. Vienna: Ministry of Health 2011.
6. WHO. *Safe abortion: Technical and policy guidance for health systems,* 2nd edn. Geneva: World Health Organization 2012. Accessed 3 June 2013 from: http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf

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# EXHIBIT Q

EDUCATION

# Obstetrician-gynecologists, religious institutions, and conflicts regarding patient-care policies

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**OBJECTIVE:** The purpose of this study was to assess how common it is for obstetrician-gynecologists who work in religiously affiliated hospitals or practices to experience conflict with those institutions over religiously based policies for patient care and to identify the proportion of obstetrician-gynecologists who report that their hospitals restrict their options for the treatment of ectopic pregnancy.

**STUDY DESIGN:** We mailed a survey to a nationally representative sample of 1800 practicing obstetrician-gynecologists.

**RESULTS:** The response rate was 66%. Among obstetrician-gynecologists who practice in religiously affiliated institutions, 37% have had a conflict with their institution over religiously based policies. These conflicts are most common in Catholic institutions (52%; adjusted odds ratio, 8.7; 95% confidence interval, 1.7–46.2). Few reported that their options for treating ectopic pregnancy are limited by their hospitals (2.5% at non-Catholic institutions vs 5.5% at Catholic institutions; $P = .07$).

**CONCLUSION:** Many obstetrician-gynecologists who practice in religiously affiliated institutions have had conflicts over religiously based policies. The effects of these conflicts on patient care and outcomes are an important area for future research.

**Key words:** ectopic pregnancy, ethics, religion

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Religious denominations sponsor a significant share of health care institutions in the United States.[1] Catholic hospitals account for 16% of admissions to community hospitals,[2] and 4 of the 10 largest health systems are Catholic.[3] Such institutions often have policies regarding patient care that are derived from religious teachings; at times those policies lead to conflicts with physicians regarding how best to care for patients. Popular media have reported recently on cases in which Catholic moral teaching has conflicted with physicians' judgments about patient care,[4] and a national survey of internists and family physicians found that 1 in 5 of those who had worked in religiously affiliated institutions had experienced conflict with the institution over religiously based policies for patient care.[5] Obstetrician-gynecologists' experiences of conflict over religious hospital policies have not been examined formally in the literature.

Obstetrician-gynecologists are the physicians perhaps most likely to be impacted by religiously based policies for patient care. Hospitals that are sponsored by a range of religious denominations restrict abortion[6]; Catholic institutions, in particular, prohibit many common and professionally accepted practices that are related to sexuality and reproduction. For example, the Ethical and Religious Directives for Catholic Health Care Services (hereafter, the Directives), which are authoritative for all Catholic health care institutions in the United States, prohibit abortion, sterilization, contraception, and most uses of assisted reproductive technologies.[7]

One area of ambiguity has been how Catholic teaching applies to the treatment of ectopic pregnancy. The Directives state, "In case of extrauterine pregnancy, no intervention is morally licit which constitutes a direct abortion."[7] In the past, many Catholic ethicists had interpreted Catholic teaching as banning any direct treatment of ectopic pregnancy unless the fallopian tube had already ruptured.[8] Today Catholic ethicists generally agree that salpingectomy may be used to treat an ectopic pregnancy (without the need to wait for tubal rupture) because, in removing the diseased fallopian tube, the fetus is destroyed indirectly as a secondary effect.[8-10] However, Catholic ethicists still disagree about the moral permissibility of salpingostomy and methotrexate, which are 2 safe and effective methods that are supported by the American College of Obstetrics and Gynecology.[11] There are Catholic ethicists who endorse their use,[10] but others argue that, when the fetus has heart tones (and therefore

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TABLE 1
**Characteristics of obstetrician-gynecologists, by whether they practice in a religiously affiliated institution (n = 1128)**

| Characteristic | Practice in religiously affiliated institution?, n (%)[a] Yes (n = 241) | No (n = 887) | P value[b] |
|---|---|---|---|
| Age, y[c] | 47.3 ± 9.0 | 47.7 ± 9.2 | .58 |
| Sex | | | .58 |
| Male | 120 (21.0) | 485 (79.0) | |
| Female | 121 (22.5) | 402 (77.5) | |
| Race/ethnicity | | | .43 |
| White, non-Hispanic | 177 (23.4) | 583 (76.6) | |
| Black, non-Hispanic | 11 (17.3) | 54 (82.7) | |
| Hispanic or Latino | 12 (18.2) | 51 (81.8) | |
| Asian | 33 (17.9) | 163 (82.1) | |
| Other | 3 (14.4) | 19 (85.6) | |
| Geographic region | | | .002 |
| Northeast | 37 (12.5) | 246 (87.5) | |
| South | 85 (24.1) | 278 (75.9) | |
| Midwest | 67 (27.1) | 179 (72.9) | |
| West | 52 (22.0) | 182 (78.0) | |
| Immigration history | | | .25 |
| Born in the United States | 179 (22.5) | 622 (77.5) | |
| Immigrated to the United States at any age | 60 (18.8) | 255 (81.2) | |
| Religious affiliation | | | .32 |
| No religion | 21 (17.3) | 96 (82.7) | |
| Hindu | 15 (15.4) | 73 (84.6) | |
| Jewish | 38 (25.5) | 118 (74.5) | |
| Muslim | 9 (14.5) | 44 (85.5) | |
| Catholic | 58 (22.5) | 200 (77.5) | |
| Evangelical Protestant | 22 (24.5) | 68 (75.5) | |
| Nonevangelical Protestant | 61 (21.0) | 233 (79.0) | |
| Other religion | 15 (34.0) | 31 (66.0) | |
| Importance of religion | | | .02 |
| The most important | 35 (23.5) | 120 (76.5) | |
| Very important | 86 (23.4) | 287 (76.6) | |
| Fairly important | 77 (25.9) | 240 (74.1) | |
| Not very important | 40 (14.4) | 227 (85.6) | |

[a] Counts do not equal 241 or 887 for all variables because of the partial nonresponse; percentages are adjusted for survey design to estimate the portion of all obstetrician-gynecologists who practice in the United States with a given characteristic who practice in a religion- or nonreligion-affiliated institution (for example, 21.0% of all male obstetrician-gynecologists are estimated to practice in religion-affiliated institutions); [b] $\chi^2$ test; [c] Data are given as mean ± SD.

*Stulberg. Religious institutions and conflict. Am J Obstet Gynecol 2012.*

under Catholic teaching is treated as a living person), performing a salpingostomy (to remove the embryo while leaving the fallopian tube in place) or giving methotrexate constitutes a direct abortion.[9] In interviews, some physicians working at Catholic hospitals report that their hospitals prohibit them from offering methotrexate for women with ectopic pregnancies.[12] To our knowledge, no previous research has assessed quantitatively the experiences of obstetrician-gynecologists with hospital policies that would restrict options for the treatment of ectopic pregnancy.

This study surveyed a nationally representative sample of practicing obstetrician-gynecologists to characterize those who practice in religiously affiliated institutions and to determine the prevalence and correlates of physician-institution conflicts over religiously based policies for patient care. The study also measured the proportion of obstetrician-gynecologists who say that the policies of their institution limit their options for the treatment of ectopic pregnancy and how that proportion varied by the religious affiliation of the institution.

## MATERIALS AND METHODS

### Data

The methods of this study have been reported elsewhere.[13] From October 2008 to January 2009, we mailed a self-administered confidential survey to a stratified random sample of 1800 practicing obstetrician-gynecologists aged ≤65 years. We obtained our sample from the American Medical Association Physician Masterfile, which is a database that is intended to include all practicing physicians in the United States. To increase minority representation (especially minority religious perspectives), we used validated surname lists to create 4 strata.[14-16] We sampled 180 physicians with typical South Asian surnames, 225 physicians with typical Arabic surnames, 180 physicians with typical Jewish surnames, and 1215 other physicians (from all those whose surnames were not on one of these ethnic lists). Physicians received up to 3 separate mailings of the questionnaire; the first included $20, and the third offered an additional $30 for participating. Physicians also received an advance letter and a postcard reminder after the first questionnaire mailing. The University of Chicago Institutional Review Board approved this survey. The requirement for written consent was waived,



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which is typical for confidential, self-administered surveys.

### Variables

For the present study, we asked respondents, "Is your primary place of practice religiously affiliated?" (yes/no). Those who indicated "yes" were asked, "What is the religious affiliation of that hospital/practice?" (Jewish, Roman Catholic, Christian non-Catholic, other), and "Have you ever had a conflict with that hospital/practice over religiously-based policies for patient care?" (yes/no).

We also presented the following clinical vignette: "A 24-year-old patient has left lower quadrant pain. Vaginal ultrasound scanning reveals a 7-week ectopic pregnancy implanted in the fallopian tube, with fetal heart tones present." We then asked respondents, "Assuming it was technically feasible and you have the appropriate surgical skills, would you be willing to perform a salpingostomy in this case?" (yes/no) and "...would you be willing to perform a salpingectomy in this case?" (yes/no). In addition, we asked, "Do the policies of your hospital or employer limit the options you have for treating ectopic pregnancy in cases like this one?" (yes/no).

Predictors were physician age, sex, race/ethnicity, region, immigration status (born in the United States or immigrated), religious affiliation, and importance of religion. Participants indicated their religious affiliation as Hindu, Muslim, Catholic (Roman Catholic or Eastern Orthodox), Jewish, evangelical Protestant, nonevangelical Protestant, other, or none. They were also asked, "How important would you say your religion is in your own life?" Response options were not very important in my life, fairly important in my life, very important in my life, and the most important thing in my life.

### Statistical analysis

We used $\chi^2$ tests for bivariate analyses and logistic regression for multivariate analyses. We carried out all analyses using the survey design adjusted commands in STATA software (release 11.0; StataSoft Corp, College Station, TX). All analyses were adjusted with the use of probability weights to account for oversampling of physicians by ethnic surname and to account for differential response rates among physicians from each of the 4 different strata. In this way, we were able to generate estimates for the population of obstetrician-gynecologists who currently are practicing in the United States. Missing data were excluded from analyses, and we considered findings significant at a probability value of < .05.

TABLE 2
**Conflicts over religious policies for patient care**

| | Have had conflict over religiously based policies (n = 90) | | |
|---|---|---|---|
| Physician characteristics | n (%)[a] | *P* value[b] | Multivariable odds ratio (95% CI) |
| Sex | | | |
| Male | 40 (31) | .07 | 1.0 (Reference) |
| Female | 50 (43) | | 1.4 (0.7–2.9) |
| Geographic Region | | | |
| Northeast | 11 (30) | .53 | 1.0 (Reference) |
| South | 31 (38) | | 1.6 (0.5–5.3) |
| Midwest | 30 (55) | | 1.1 (0.3–3.9) |
| West | 18 (31) | | 0.4 (0.1–1.8) |
| Immigration history | | | |
| Born in the United States | 75 (41) | .003 | 1.0 (Reference) |
| Immigrated to the United States at any age | 15 (18) | | 0.4 (0.1–1.5) |
| Religious affiliation (physician) | | | |
| No religion | 8 (44) | .002 | 1.0 (Reference) |
| Hindu | 7 (35) | | 1.4 (0.2–12.9) |
| Jewish | 16 (41) | | 1.6 (0.3–8.1) |
| Muslim | 2 (22) | | 0.6 (0.1–3.7) |
| Catholic | 21 (35) | | 0.7 (0.2–2.9) |
| Evangelical Protestant | 1 (5) | | 0.1 (0.0–1.3) |
| Nonevangelical Protestant | 25 (41) | | 0.9 (0.2–3.6) |
| Other religion | 10 (76) | | 4.4 (0.2–22.9) |
| Importance of religion | | | |
| Most important | 8 (20) | .010 | 1.0 (Reference) |
| Very important | 30 (30) | | 1.0 (0.3–3.4) |
| Fairly important | 34 (49) | | 1.8 (0.5–6.1) |
| Not very important | 18 (48) | | 1.9 (0.4–8.9) |
| Hospital religious affiliation | | | |
| Other religious facility | 3 (16) | < .001 | 1.0 (Reference) |
| Jewish facility | 1 (9) | | 0.6 (0.0–8.4) |
| Christian, non-Catholic facility | 9 (17) | | 1.9 (0.3–11.7) |
| Catholic facility | 77 (52) | | 8.7 (1.7–46.2)[c] |

[a] Counts do not equal 90 for all variables because of the partial nonresponse; percentages are adjusted for survey design to estimate the portion of all obstetrician-gynecologists who practice in the United States and who work in religious institutions with a given characteristic who have had conflict (for example, 31% of all male obstetrician-gynecologists who work in religious institutions are estimated to have had a conflict); [b] $\chi^2$ test; [c] $P < .05$.

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**TABLE 3**
**Ectopic pregnancy treatment**

| Variable | n (%)[a] | P value |
|---|---|---|
| Physician willingness to perform selected procedures to treat ectopic pregnancy | | |
| Salpingectomy (n = 1111) | 1006 (91.6) | |
| Salpingostomy (n = 1114) | 1057 (95.1) | |
| Hospital/employer limits options for treating ectopic pregnancy: all obstetrician-gynecologists (n = 1111) | 31 (2.9) | |
| By hospital/practice affiliation | | |
| Nonreligious (n = 871) | 21 (2.4) | .14[b] |
| Religious (n = 240)[c] | 10 (4.4) | |
| Roman Catholic (n = 143) | 7 (5.5) | .07[d] |
| Christian, non-Catholic (n = 56) | 3 (4.6) | |
| Jewish (n = 18) | 0 | |
| Other (n = 21) | 0 | |

[a] Survey design-adjusted percentages of obstetricians-gynecologists who responded "yes" to each question; [b] Comparison of respondents who work at religion-affiliated vs nonreligion-affiliated institutions; [c] Responses do not equal 240 because 2 respondents did not report the religious affiliation of their hospital/practice; [d] Comparison of respondents who work at Catholic vs all other (non-Catholic) institutions.

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## RESULTS

Of 1800 physicians who were sampled, 40 were ineligible for this study because they either had retired or had an invalid address. The overall response rate of the survey was 66% (1154/1760). Among respondents, 19 physicians had missing data on whether they worked in a religiously affiliated institution, and an additional 7 physicians had missing data on whether they had experienced conflict with their institution, which left an analytical sample of 1128 physicians.

Approximately 22% of US obstetrician-gynecologists (n = 241) primarily practice in religiously affiliated institutions. Most of these (59%; n = 143) practice in Catholic institutions; 23% (n = 56) practice in Christian non-Catholic institutions; 8% (n = 19) practice in Jewish institutions; 9% (n = 21) practice in institutions with other religious affiliations, and 1% (n = 2) did not report where they practiced. Those who work in the Northeast are less likely to work in religiously affiliated institutions than those in the South, Midwest, or West (Table 1). Those for whom religion is not personally important are also less likely to work in religiously affiliated institutions than are their colleagues who rate religion as fairly, very, or most important. However, obstetrician-gynecologists who work in religious hospitals are themselves religiously diverse and do not differ from other obstetrician-gynecologists with respect to religious affiliations. Physicians who identify as Roman Catholic are no more likely (when the data are controlled for other characteristics) to work in a Catholic hospital (odds ratio, 1.7, compared with those who report no religious affiliation; 95% confidence interval, 0.7–4.1; data not reported).

Among physicians who work in religiously affiliated institutions, 37% (n = 90) have had a conflict with their institution regarding religiously based policies for patient care. Those who work in Catholic institutions were most likely to report such conflicts (52%). Although age, immigration history, religious affiliation, and religious motivation were all associated in bivariate analyses with having had a conflict (Table 2), only working in a Catholic institution remained significant after adjustment for other variables (odds ratio, 8.7; 95% confidence interval, 1.7–46.2).

With respect to the treatment of an ectopic pregnancy with fetal heart tones present, the great majority of obstetrician-gynecologists would be willing to perform a salpingectomy and/or a salpingostomy (Table 3). Furthermore, few physicians (n = 31; 2.9%) reported that policies of their institution limit the options that they have for the treatment of ectopic pregnancy in similar cases: 2.5% of those who work in non-Catholic institutions vs 5.5% in Catholic institutions ($P = .07$).

## COMMENT

Among obstetrician-gynecologists who practice in religiously affiliated institutions, >1 in 3 has had a conflict with their institution over religiously based patient care policies. This is true for more than one-half of those who work in Catholic facilities. As expected, these conflicts appear to be more common among obstetrician-gynecologists than was reported among general internists and family physicians in a previous study.[5]

These conflicts may have implications for both physicians and patients. Yoon et al[17] found that obstetrician-gynecologists who have religiously based ethical conflicts with patients and colleagues exhibit higher rates of emotional exhaustion and lower levels of empathy. Physicians may wish to ask detailed questions about hospital policies before signing a contract for employment, medical privileges, or office space to minimize these conflicts. Similarly, patients who seek care may wish to ask about hospital policies that affect the treatments that their physicians will be allowed to offer. However, particularly in rural areas and certain regions of the country, there is not always a wide variety of institutions for practitioners and patients alike to choose from.[18] Furthermore, new conflicts can arise when previously nonreligious facilities merge with religious ones and longstanding physicians and patients find themselves working under new policies.[19]

Based on obstetrician-gynecologists' experiences, hospital policies frequently do not restrict options for the treatment of ectopic pregnancy. Although physicians at Catholic hospitals were slightly more likely ($P = .07$) to report institutional restrictions than those at non-

Catholic hospitals, restrictions were uncommon in all institutions. These findings suggest that, although Catholic ethicists debate whether the use of salpingostomy and methotrexate constitute direct abortion, few institutions prohibit these practices. Confusion on this issue can lead to unnecessary delays (eg, if physicians transfer patients to other institutions) and potentially to patient harms (eg, from ruptured pregnancy).[12] Therefore, leaders of religiously affiliated institutions should work to clarify and educate physicians about their policies regarding which (if any) treatments of ectopic pregnancy are prohibited. Further research is warranted to understand those less common cases in which physicians' choices in the treatment of ectopic pregnancy are restricted by their hospitals.

This study has several limitations. First, we surveyed only obstetrician-gynecologists, not other physicians who may provide care to patients with ectopic pregnancies, including emergency and family physicians. In addition, survey nonrespondents might differ from respondents in terms of religion, potential for conflict, or other characteristics in ways that would bias the study's findings. Information on religious affiliation, religiosity, and conflict was self-reported and thus is subject to measurement error. We did not ask whether the respondents were aware of specific religiously based policies in their hospitals, so it is possible that physicians disagree with policies they are unaware of and thus under-report conflict. We also did not ask whether obstetrician-gynecologists who work in secular hospitals had ethical or other patient-care conflicts with their hospitals. In addition, limited survey space kept us from asking about the qualitative aspects of physicians' conflicts with religious hospitals, if and how religious restrictions affected patient care, or the strategies that they have used to resolve them. In ongoing research, we are inviting survey respondents to participate in qualitative interviews to elicit more detail about the nature of their conflicts and relationships with their hospitals. Finally, our study cannot directly assess how institutional policies constrain physicians' decisions or otherwise affect patients.

Notwithstanding these limitations, this study suggests that conflict over religiously based patient care policies is common among obstetrician-gynecologists who work in religiously affiliated institutions, particularly Catholic institutions. Further research should explore the actual effects on patients of the Catholic Directives and other religiously based patient care policies. ■

## REFERENCES

**1.** Uttley L, Pawelko R. No strings attached: public funding of religiously-sponsored hospitals in the United States, Albany, NY: MergerWatch; 2002. Available at: http://www.mergerwatch.org/storage/pdf-files/bp_no_strings_hilights.pdf. Accessed Jan. 23, 2012.

**2.** Catholic Health Association of the United States. Fast facts, 2011. Available at: http://www.chausa.org/Pages/Newsroom/Fast_Facts/. Accessed Jan. 23, 2012.

**3.** Modern Healthcare's 2011 Hospital System Survey. Available at: http://www.modernhealthcare.com/section/lists?djoPage=product_details&djoPid=23117&djoTry=1326343481. Accessed Jan. 12, 2012.

**4.** Stein R. Reproductive care restrictions at Catholic hospitals spark conflict, scrutiny. Washington Post Jan 20, 2011:A01.

**5.** Stulberg DB, Lawrence RE, Shattuck J, Curlin FA. Religious hospitals and primary care physicians: Conflict over policies for patient care. J Gen Intern Med 2010;25:725-30.

**6.** Freedman LR, Landy U, Steinauer J. When there's a heartbeat: miscarriage management in Catholic-owned hospitals. Am J Public Health 2008;98:1774-8.

**7.** United States Conference of Catholic Bishops. Ethical and religious directives for Catholic Health Care Services, 5th ed; 2009. Available at: http://www.ncbcenter.org/document.doc?id=147. Accessed Jan. 23, 2012.

**8.** Kelly DF. Contemporary Catholic health care ethics. Washington, DC: Georgetown University Press; 2004.

**9.** Pivarunas AR. Ethical and medical considerations in the treatment of ectopic pregnancy. Linacre Q 2003;70:195-209.

**10.** Kaczor C. The ethics of ectopic pregnancy: a critical reconsideration of salpingostomy and methotrexate. Linacre Q 2009;76:265-82.

**11.** American College of Obstetricians and, Gynecologists. ACOG practice bulletin no. 94: medical management of ectopic pregnancy. Obstet Gynecol 2008;111:1479-85.

**12.** Foster AM, Dennis A, Smith F. Do religious restrictions influence ectopic pregnancy management? A national qualitative study. Womens Health Issues 2011;21:104-9.

**13.** Lawrence RE, Rasinski KA, Yoon JD, Curlin FA. Obstetrician-gynecologists' beliefs about assisted reproductive technologies. Obstet Gynecol 2010;116:127-35.

**14.** Lauderdale DS, Kestenbaum B. Asian American ethnic identification by surname. Popu Res Policy Rev 2000;19:283-300.

**15.** Lauderdale DS. Birth outcomes for Arabic-named women in California before and after September 11. Demography 2006;43:185-201.

**16.** Sheskin IM. A methodology for examining the changing size and spatial distribution of a Jewish population: a Miami case study. Shofar 1998;17:97-116.

**17.** Yoon JD, Rasinski KA, Curlin FA. Conflict and emotional exhaustion in obstetrician-gynaecologists: a national survey. J Med Ethics 2010;36:731-5.

**18.** Uttley LJ. How merging religious and secular hospitals can threaten health care services. Soc Policy 2000;30:4-13.

**19.** Gallagher J. Religious freedom, reproductive health care, and hospital mergers. J Am Med Womens Assoc 1997;52:65-8.

# EXHIBIT R

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# Recruitment and Training of British Obstetrician-Gynaecologists for Abortion Provision: Conscientious Objection versus Opting Out

*Jane Roe, Colin Francome, Maureen Bush*

*Abortion has been legal in Britain for more than 30 years but local access to hospital-based abortion services within the National Health Service can range from less than 50 per cent to almost 100 per cent, depending on where women live. Recently, a number of older gynaecologists in the UK expressed concerns that many trainee obstetrician-gynaecologists are not motivated to carry out abortions, as their own generation had been, by back-street, botched abortions and the stigma of illegitimate children. A survey of 226 consultants and 131 trainees in obstetrics-gynaecology in 1998 asked about recruitment to hospital posts that include abortion provision, numbers of trainees who had received abortion training and the role of conscientious objection and attitudes towards providing abortions. The number of doctors with the necessary skills and experience for providing abortions does not appear to be improving and in some places may be dwindling as a substantial minority of trainees opt out of abortion training. Action will be needed by medical schools, by training authorities and by the Government to ensure continuing and improved provision of abortion services. One answer may be dedicated abortion services and making abortion training part of all gynaecologists' training — as well as extending training in doing first trimester abortions, especially early medical abortion, to other health care providers.*

ANECDOTAL evidence and discussions in 1997 with a number of older consultant gynaecologists in Britain who are experienced abortion providers in Brighton, London, Oxford and Sheffield, suggested that a substantial number of younger generation obstetrician-gynaecologists lacked a strong commitment to abortion as an important service for women and were reluctant to be involved in the termination of pregnancy. It was felt that this was at least partly because they had no direct personal experience of the life-threatening results of back-street or self-induced abortions, unlike those now approaching retirement age, and little awareness of the damaging effect of unwanted pregnancies on women and their families. Concerns were also expressed that recent changes in the mid-1990s in the national training programme for obstetrics-gynaecology and restrictions on job advertisements in the speciality of obstetrics and gynaecology[1] – that abortion duties must not be included in job advertisements and applicants cannot be asked about their personal beliefs at interview – are resulting in an insufficient number of doctors acquiring the necessary skills to provide an adequate abortion service in the future.

Most health services in Britain are free at the point of use. However, official statistics show that only 51 per cent of all abortions in England and Wales are carried out in National Health Service (NHS) premises and a further 22 per cent are currently NHS-funded but carried out in private clinics.[2] The remaining 23 per cent are

carried out by non-profit-making and profit-making private clinics, for fees which in 1998, when this study was done, were UK£350 for abortions up to 14 weeks of pregnancy and UK£600 for second trimester abortions.[3]

Whilst many health authorities report difficulties in funding or staffing a service to meet the full demand for abortions in their areas, others meet almost 100 per cent of the local demand. In Scotland, 98 per cent of abortions are done in NHS hospitals and very few Scottish women have to pay.[4] Hence, it is not the letter of the law or policy that are the problem, but how these are being interpreted and applied locally. The willingness of doctors to do abortions is a key factor in relation to access, when women seek an abortion. To maintain or improve the current levels of provision on the NHS, a sufficient number of doctors need to be willing to provide this service and be fully trained to do so.

Concerns that there are a dwindling number of younger doctors who are both fully trained and willing to provide abortions when they qualify prompted the London-based Abortion Law Reform Association (ALRA) to carry out a two-part national survey to determine the extent of this problem. One part was a survey of all consultant obstetrician-gynaecologists responsible for training junior doctors in Britain. The other was a survey of a random sample of approximately a third of trainee junior doctors.

## Methods

A questionnaire was posted to 23 regional advisers and 287 district tutors in obstetrics and gynaecology in England, Scotland and Wales in March 1998. Of the total of 310, ten either could not be contacted or stated that they were not qualified to respond to the survey, leaving a sample size of 300, of which 226 replied, a 75 per cent response rate.

The consultants were asked the following questions, and were encouraged to add their own comments:

- Currently are you able to recruit sufficient Senior/Specialist Registrars (SRs) and Senior House Officers (SHOs) to fulfil termination of pregnancy (TOP) schedules?[5]
- Will the current numbers of SRs and SHOs being trained in TOP provide sufficient resources for future TOP services?
- What percentage of trainees attended TOP training in the last year?
- What percentage of current trainees do not participate in TOP because they conscientiously object?

We also asked them a series of questions on their own attitudes to training in doing abortions and the provision of abortion by the NHS.

For the second part of the survey, which was also carried out in March 1998, the Royal College of Obstetricians and Gynaecologists provided us with a list of the national total of 175 senior registrars, 224 specialist registrars and 99 senior house officers. From this number (498), we randomly selected 220 to whom we posted another questionnaire. Nineteen were returned unanswered, either marked 'gone away' or because the recipient said the survey was not relevant, leaving a sample of 201 registrars and house officers. Of these, 131 valid replies were received, a 65 per cent response rate.

Trainees were asked the following questions, and were also encouraged to add comments:

- Have you ever attended a clinical TOP training session?
- Have you trained in first trimester and second trimester abortions?
- Do you conscientiously object to TOP in the first trimester and in the second trimester of pregnancy?
- Will you perform TOP in the first or second trimester of pregnancy?
- Are you willing to be involved in the following aspects of TOP procedures: assess patients, clerk patients, obtain consent from patients, evacuate the uterus, carry out an abortion for fetal abnormality (mostly done in the second trimester).

We did not examine the records of all trainees to determine with accuracy how many had been trained in providing abortions, and we had no comparable data from previous years for comparison purposes. Hence, this survey did not provide definitive answers as to whether the number of trainees was decreasing or not. It did, however, reflect the unevenness in provision across the country and why this was continuing to occur. Almost a third of consultants and nearly half of junior doctors replying to the question-

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naire added comments which provided a great deal of insight into their attitudes to abortion. Although their comments may or may not be representative of consultants and trainees in the field as a whole, they do indicate the range of views and give some sense as to which views are more commonly held.

## Results

### Current and future recruitment levels

Just over half the consultants (52 per cent) considered that they were currently able to recruit sufficient numbers of junior doctors to carry out abortions in their hospitals, while almost a quarter (23 per cent) said they were not able to recruit enough junior doctors. Another quarter (24 per cent) said that because abortions were either carried out by other agencies or only by the hospital's consultants (but not junior doctors), the question was not relevant. Among these, however, there may have been some cases where lack of consultant involvement and/or insufficient junior doctor recruitment led to abortions being done by other agencies in the first place.

Somewhat fewer consultants (48 per cent) felt that the numbers of junior doctors currently being trained in abortion would provide sufficient resources for future TOP services, but 29 per cent felt they would not. Thus, somewhat more of the consultants had fears for the future than felt there were current problems with recruitment.

The restrictions on mentioning abortion in advertisements or interviews when recruiting for posts in obstetrics and gynaecology units were mentioned by several consultants.

*'You are not allowed to ask if applicants are willing to carry out TOP and while there is this shield under "equal opportunities" the problem will get worse.'*

*'We have recently appointed a consultant to replace a retiring one. Prior to appointment he said he would be happy to do TOPs. Following appointment he promptly announced that he does not and would not do TOP. As the retiring consultant offered this service, it means the TOP burden now falls on the existing consultants. Although in my view this was dishonest of the new appointee, the law and practice allow this. The residents of the area are gradually losing consultants' service for TOP. One of the existing consultants also does not do TOP (on religious grounds) so now only two out of four will. I shudder to think in about five years' time when one of the two who currently offer TOP service retires and is replaced (inadvertently or not) by one who does not.'*

More than half of consultants (56 per cent) thought that it should be possible to specify that abortions are part of the job description in advertisements for posts in obstetrics and gynaecology.

### Abortion training for junior obstetrician-gynaecologists

In 1996, the Calman system of training specialists in obstetrics and gynaecology was introduced to try to establish national standards. Training is now more structured but still varies widely around the country. Specialist registrars normally attend specific training sessions on all aspects of the speciality as part of their employment and keep a log book specifying levels of expertise on a broad range of subjects. In the module on contraception and assisted reproduction, trainees are expected to be able to use medical methods of abortion, to perform suction evacuation and to have some knowledge of dilatation and evacuation of the uterus. Other expertise will be acquired on-the-job through watching consultants and taking part in treatment under supervision.

Only 13 per cent of consultants stated that all their junior doctors had received training in pregnancy termination in the year prior to the survey, while nearly a third (32 per cent) said that none of their trainees had done so. Overall, this implies that two in five (40 per cent) of the trainees under these consultants had attended TOP training while about 38 per cent had opted out of being trained. According to several of these consultants, as many as a quarter to a half of their trainee doctors had opted out of TOP training. However, several consultants indicated that they did not have this information.

Of the 131 junior doctors who replied to the second survey, only 28 per cent said they had attended a specialised clinical training session on TOP. However, when asked a more general



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question about training in doing abortions, a much larger number said that they had been trained – 69 per cent said they had been trained in first trimester abortions and 57 per cent in second trimester abortions. Several commented that they had received on-the-job training, usually with consultants, rather than attending a specific training session on TOP. However, the extent of their experience is unclear. The discrepancy between what the consultants and the juniors say (that 40 per cent vs 69 per cent had had training) may have been due to how our questions were phrased. It may be that the 40 per cent had had clinical training sessions while a further 29 per cent had had on-the-job training as well, at least in doing assessment and obtaining consent, if not in doing actual abortions.

Several consultants said that they themselves and in some cases their senior colleagues preferred to do all the abortions in their hospitals themselves and did not involve junior doctors. Others said that nevertheless training was made available to those junior doctors who asked for it.

Most consultants (86 per cent) thought that trainees who opted out of abortion training conscientiously objected to abortion on religious or moral grounds. Even so, many consultants thought that there were other reasons why junior doctors opted out of abortion training, which gave considerable cause for concern. A significant proportion (38 per cent) felt that when trainees said they have a conscientious objection to abortion, they should be obliged to state their reasons. A similar number (35 per cent) thought that trainees did not do TOP training because it was easy to opt out or because (33 per cent) performing abortions was seen to be of low status professionally.

One consultant said that during the three years prior to the survey, out of 35 trainees in his unit, only one wished to be trained in TOP counselling and techniques. Others said:

*'TOPs account for a large proportion of our gynae work yet the provision for this service in terms of manpower training nationally is pitiable.'*

*'When the present generation of physicians goes there will be a major problem.'*

*'I feel the number of trainees opting out is increasing and to say "I don't do them" is an easy option now.'*

*'The specialist registrar finds this an easy way to avoid distasteful work. For political correctness the hospital is avoiding the issue.'*

*'Nobody likes doing them and so to opt out, firstly, gets them out of a distasteful job and also gives them free time.'*

On the other hand, several consultants pointed out that as all abortions in their catchment area were carried out by private agencies, there was no opportunity for training junior doctors in their hospitals. Sixteen consultants of the 74 who gave additional comments said that their hospitals did not do first trimester abortions in the general obstetrics-gynaecology ward, but instead either ran a separate dedicated service or contracted these abortions out to private agencies.

*'Private provider does all TOPs; no training now provided in TOP under 12 weeks' gestation.'*

And two consultants said, confirming the range of difference between hospitals and local areas:

*'I do not see the point of this study; most learn TOP as part of their training.'*

*'If a trainee wishes to learn, there is opportunity within the NHS.'*

Several consultants commented that trainees should be exposed to the issues surrounding termination to fully understand and be able to make up their own minds on the subject. In contrast, others felt that abortion should be an integral part of gynaecological training, not least because abortions are often essential both for medical reasons in the woman and due to fetal abnormality. Indeed, the taught syllabus presents abortion as a women's health need, according to 74 per cent of the consultants.

A large majority (72 per cent) also thought that abortion should be included as part of the specialisation in obstetrics and gynaecology, and 70 per cent thought it should be an essential part of training for junior doctors. However, these numbers, although high, also indicate that a



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significant minority of consultants disagree on these basic points.

One consultant felt that abortion issues were 'poorly dealt with at undergraduate level, providing a poor basis for a sensible post-graduate approach'. To improve the situation, nearly half the consultants (49 per cent) thought that liaison with a dedicated, private clinic would facilitate training, though one rightfully raised the question of who would pay for the costs of this training. One suggested that a more relevant option would be to have separate certification of competence in TOP work.

### Conscientious objection and willingness to participate in abortion provision

The 1967 Abortion Act, which applies in England, Scotland and Wales, requires two doctors to certify that a woman has legal grounds for an abortion before the procedure can be performed. It also allows doctors with a religious or ethical objection not to be involved in abortion procedures, except where the woman's life is at risk. The clause states:

*'No person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorised by this Act to which he has a conscientious objection, provided that in any legal proceedings the burden of proof of conscientious objection shall rest on the person claiming to rely on it.'*

Insofar as the aim of this clause is to protect health workers who object to abortion on religious or moral grounds from discrimination in obtaining jobs in obstetrics and gynaecology, it has worked well. Thus, of the considerable number of junior doctors and consultants who stated that they held a conscientious objection to abortions except in cases of fetal abnormality or life-threatening illness in the woman, only one said he had suffered discrimination for this reason, and one other mentioned pressure and hostility though not outright discrimination.

*'In my 25 years in obstetrics and gynaecology, TOP has not been a problem issue in that the vast majority accept the necessity to do TOP and the minority 0-25 per cent who are not prepared to do TOP are respected and not victimised.'*

JOANNE O'BRIEN/FORMAT

Where this part of the law has not worked well is in ensuring that women who encounter objecting doctors and other health workers still have timely access to abortions services and are not blocked from obtaining otherwise lawful abortions. Some health authorities provide inadequate abortion services with an unacceptably long waiting time, so many women are forced to seek and pay for services from the private sector, even though they have a right to NHS treatment for all their other health needs.[6]

As many as 31 per cent of the trainee doctors in our survey said they conscientiously objected to abortion in the first trimester of pregnancy and 37 per cent in the second trimester. Slightly fewer said they were actually unwilling to perform abortions in the first trimester (28 per cent) while 38 per cent said they would be unwilling to do second trimester abortions. As many as 88 per cent said they would participate in a termination for fetal abnormality.

A higher number of trainees also said they were willing to be involved in other aspects of care for abortion patients: 81 per cent would assess patients; 83 per cent would clerk patients; 80 per cent would obtain consent from patients; and 74 per cent would evacuate the uterus.

When asked their views on doing abortions as part of their work as obstetrician-gynaecologists and as part of the NHS, 71 per cent said they did perceive termination of pregnancy to be part of their job, but as many as 45 per cent said they preferred to concentrate on other aspects of their job. On a more positive note, 84 per cent said they believed abortions should be performed on the NHS.

Some trainees showed a poor understanding of the law when they drew a distinction between abortions for clearly defined obstetric or medical reasons and those where the woman's personal circumstances led her to request an abortion, both of which are permitted under British law. Several others expressed objections to abortion being used for 'contraceptive purposes' though it was not clear exactly what they meant by this. Several made negative comments about what they described as abortions for 'social reasons'.

*'Social TOPs are different from proper reasons i.e. abnormality, and should not be available on the NHS.'*

*'TOP should never be a contraceptive service but has a place in proven rape or fetal anomaly.'*

*'I believe it is the woman's prerogative to choose and would fully support the decision unless it is being used as a mode of contraception.'*

On the other hand, several trainee doctors clearly felt strongly about the need for access to abortion within the NHS. Comments like the following were echoed by many:

*'I feel that providing a reliable, efficient and good termination service to patients is an extremely important part of our services.'*

Others felt an abortion service was essential despite personal reservations. In their additional comments, 11 of 26 trainees said they considered abortion unpleasant but necessary and a similar number mentioned the importance of women's choice or protecting women's health by providing a safe service:

*'I can't believe anyone undertakes performing TOP without a degree of sadness. Whatever I personally feel about them I see them as an essential and indivisible part of our job.'*

**The need for improvement: separate TOP units and specialisation**

The largest number of comments by far were from consultants on the need for improvements in abortion services. Many suggested breaking the link with gynaecology and obstetrics and setting up special units:

*'TOP should be performed by paramedics recruited specifically for the job – backed up by a small number of interested gynaecologists who do difficult cases and sort out problems.'*

*'The NHS should provide a separate TOP service, thus avoiding overloading clinics and operating lists and providing a faster, more satisfactory service for clients.'*

Two consultants who said they were personally not willing to do abortions for other than strictly medical reasons supported NHS-funded provision of abortion and training by private agencies. One said:

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*'I feel funding and clinics should be established outside the NHS framework to serve the population who require this service – training of personnel can be undertaken at these institutions.'*

The other referred both to allowing doctors to opt out so that there was equality of opportunity for them to become gynaecologists and to the fact that abortion complications are lower in the private sector and that 'quality of care...may not be present in the NHS'.

## Discussion

This study shows that in 1998 almost one third of post-graduate trainees working in NHS hospitals had not had any training in abortion procedures and that a similar number stated a conscientious objection to abortion. Only 28 per cent said they had attended a clinical TOP training session though many more said they had received on-the-job training, with an unspecified amount of experience.

Three out of ten consultant obstetricians and gynaecologists responsible for training in British hospitals said they have experienced difficulties in recruiting sufficient junior doctors to carry out abortions. Four out of ten felt this problem would get worse because not enough junior doctors were currently acquiring skills in TOP to meet future needs, combined with wide interpretation of the conscientious objection clause in the current law.

Most consultants thought junior doctors opted out of training because they held a genuine religious or moral objection, but many also suspected that they did so because they find abortion distasteful, of low status or, because participation is voluntary, it is easy not to do it. However, many trainees did consider abortion provision necessary and a part of their jobs, and even where they had objection to it, they supported the service being provided by others.

A trend towards carrying out only second trimester abortion procedures, which are mainly carried out for medical reasons and in cases of fetal abnormality, was discernible in the comments of a number of consultants. This is probably a consequence of the NHS reforms in 1990 which encouraged NHS authorities to contract out health care to private dedicated agencies when their own consultants were unwilling or unable to meet demand. As almost a quarter of all abortions are now contracted out in this way, and in some areas the majority of abortions are done by these agencies, NHS hospitals would have few or no clinical sessions in which to give trainees the required hands-on training.

Despite the fact that some young doctors say that taking part in abortion is against their consciences, they did not offer specific reasons in their comments on this survey. Some trainees' comments about women's reasons for seeking abortion were judgmental and even punitive, and suggested a lack of understanding of what is permitted under the law, which explicitly allows a woman's social circumstances and the effect on her existing children to be taken into account when deciding whether a pregnancy can be terminated.

Given that contraceptive prevalence in the UK is over 70 per cent[7] it is unlikely that many women are opting to use abortion instead of contraception, though some trainees' comments appeared to imply women were doing this. Abortion is a means of fertility control, but many doctors' expressed attitudes in this survey indicate that it is still seen to have low status professionally more than 30 years after the law changed. Because the abortion procedure has become such a simple one, at least in the first trimester, it will be difficult to change this.

We cannot draw any firm conclusions from our results whether the number of gynaecologists with the necessary willingness, skills and experience to carry out abortions is declining, remaining steady or improving, though we have found clear evidence from some consultants that the numbers were too low and even dwindling. Indeed, as long as pregnancy termination is viewed as a voluntary task which trainees can opt into – rather than an essential health need offered as part of an overall women's health service – it is not surprising that many doctors (both junior and senior) are not moved to take up training and offer this service.

If the responses of the trainees in our survey were representative nationally, it would certainly appear that a substantial minority of trainees in obstetrics and gynaecology have received little or no abortion training or an unspecified amount. Our survey did not systematically seek information about training in dedicated services within general obstetric-gynaecology departments nor



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in private agencies. What it did uncover is the fact that the transition in abortion service provision away from general obstetric-gynaecology wards to separate, dedicated services, and particularly out of the NHS into private clinics, has implications for training which need to be taken much more into account in national policy.

British NHS services for termination of pregnancy have grown in a piecemeal fashion during the past 30 years and would benefit from a major overhaul to ensure an efficient, high quality, prompt and sympathetic service is available to women throughout the country. This holds true for training and recruitment policies as well. We believe steps should be taken by the relevant authorities in Britain to prevent a shortfall in skilled gynaecologists able and willing to perform abortions, and to extend training to other health professionals, to improve access to and availability of abortion through the NHS in future.

To accomplish this, we would recommend that junior doctors seeking a gynaecology post who hold a conscientious objection to abortion should be obliged to declare this to their potential employers at the earliest opportunity and to state their reasons. Further, advertisements for positions in NHS gynaecology departments should be required to mention abortion if it is included in the duties which the applicant will normally be expected to undertake and this should also be a permitted item in job interviews. Where health authorities decide to hire conscientious objectors to abortion, they should be obliged to make alternative arrangements for women seeking abortions so that access to services is not denied or made more difficult than best practice permits.

Training in abortion procedures should be considered essential for specialists in obstetrics and gynaecology so that abortions for medical or obstetric reasons can be safely carried out when necessary. Training for all doctors should include the terms of the law and its interpretation, the ethical arguments on abortion, the links between contraceptive use and the need for abortion, the benefits to women's health of safe abortion, the adverse effects of unwanted pregnancy on women's general well-being and on their existing children, and the consequences of illegal abortion. In areas where abortion services are contracted out to private agencies, provision should be made for junior doctors to liaise with the agency and to gain experience of doing abortions as part of that contract.

A number of both consultants and trainees strongly suggested that the best course of action would be to separate abortion services from general gynaecology and obstetrics services, with a well-trained, dedicated and willing staff. This could be arranged either as special sessions and operating lists within hospital gynaecology units or in a separate unit, not necessarily staffed by consultants or by career-grade doctors. With cover for emergencies, late and difficult cases from an experienced consultant gynaecologist, an effective service could be offered in conjunction with family planning and community health services within an integrated reproductive/sexual health clinic.

Consideration should be given to training other medical personnel such as GPs, family planning doctors, nurse practitioners or clinical assistants to carry out first trimester surgical abortions (up to 14 weeks) and also early medical abortions (up to 9 weeks with mifepristone + prostaglandin) within specialist services. In many settings, including in the NHS, dedicated services are better not only for the women concerned but also for the medical staff, as well as being more cost effective. The Labour government has expressed a commitment to more equitable service provision within the NHS generally, including to abortion services,[8] and these recommendations would go a long way towards fulfilling that commitment.

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## References and Notes

1. *Health Service Guidelines.* HSG(94)39, 1994.
2. Office for National Statistics. *1997 Abortion Statistics*. Series AB No. 24.
3. Marie Stopes International.
4. *Health Briefing* No. 98/05, Information and Statistics Division of the Common Services Agency for the NHS in Scotland.
5. An SR is specialising in obstetrics and gynaecology; an SHO is a general practice trainee.
6. Abortion Law Reform Association, 1997. *Report on NHS Abortion Services 1997.* ALRA, London.
7. Dodd T, Freeth S, 1999. *Contraception and Sexual Health 1997*. Office for National Statistics, UK.
8. Baroness Hayman, *Hansard*, House of Lords, 30 July 1999. (Parliamentary Written Answer)

## Résumé

L'avortement est légal en Grande-Bretagne depuis plus de 30 ans, mais l'accès local aux services hospitaliers d'interruption de grossesse dans le cadre du National Health Service oscille de moins de 50% à près de 100%, en fonction du lieu de résidence des femmes. Récemment un certain nombre de gynécologues parmi les plus âgés se sont inquiétés de voir que beaucoup d'internes en gynécologie-obstétrique manquent de motivation pour pratiquer des avortements, à la différence de leur génération, marquée par les avortements clandestins et les stigmates attachés à une naissance illégitime. En 1998, une enquête portant sur 226 consultants et 131 internes en gynécologie-obstétrique a étudié les recrutements pour des postes hospitaliers comportant la pratique d'avortements, le nombre d'internes ayant reçu une formation à l'avortement et le rôle de l'objection de conscience et des attitudes à l'égard de la pratique de l'avortement. Le nombre de médecins possédant les compétences nécessaires et l'expérience suffisante pour mener des avortements ne semble pas augmenter et dans certains endroits, il pourrait même diminuer alors qu'une minorité importante d'internes ne suivent pas de formation à l'avortement. Les écoles de médecine, les responsables de la formation et le Gouvernement devront prendre des mesures afin de garantir la continuité et l'amélioration des services d'interruption de grossesse. La solution consiste peut être à créer des services d'avortement spécialisés et inclure des cours sur l'interruption de grossesse dans le cursus de tous les gynécologues – ainsi qu'à dispenser une formation à la pratique d'avortements pendant le premier trimestre de grossesse, particulièrement des avortements médicaux précoces, à d'autres prestataires de soins de santé.

## Resumen

El aborto ha estado legal en Gran Bretaña desde hace más de 30 años, pero el acceso a servicios de aborto en los hospitales que pertenecen al Servicio Nacional de Salud varia de entre menos del 50 por ciento hasta casi un 100 por ciento, según la localidad. Recientemente, algunos ginecólogos británicos de mayor edad se manifestaron preocupados porque muchos studiantes de esta especialidad no son motivados a practicar abortos, ya que no conocen los abortos clandestinos y mortales, ni el estigma de los hijos ilegítimos, que impulsaron a los médicos de la generación anterior. En 1998, una encuesta a 226 especialistas en obstetricia y ginecología, y 131 médicos estudiantes de esta especialidad, indagó acerca del reclutamiento para llenar puestos en hospitales que incluían la provisión de servicios de aborto, el número de estudiantes de obstetricia y ginecología que habían recibido entrenamiento para practicar abortos, y el papel que jugara sus actitudes respecto al aborto. No parece mejorar el número de médicos que tienen la experiencia y formación necesarias para proveer servicios de aborto. Se precisa acción de parte de las escuelas de medicina y del gobierno para asegurar la continuación y mejoramiento de la provisión de servicios de aborto. Como solución, se podría exigir que todos los ginecólogos reciban entrenamiento en el procedimiento, además de extender esta formación a otros proveedores de atención en salud, para que ellos también sean capacitados para practicar abortos del primer trimestre.

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*Scope Note 46*

# Pharmacists and Conscientious Objection*

In March 2005, a Wisconsin pharmacist's act of conscience garnered headlines across the United States. After a married woman with four children submitted a prescription for the morning-after pill, the pharmacist, Neil Noesen, not only refused to fill it, but also refused to transfer the prescription to another pharmacist or to return the prescription to the customer. As more such incidents occurred, many states ". . . decided to consider and enact laws setting the bounds of pharmacists' and other health care workers' professional obligations" (III, Grady 2006, p. 327). Discussions of objector legislation, also referred to as "conscience clauses," "refusal clauses," and "abandonment laws" (III, Appel 2005, p. 279), are not limited to professional ethics, but also draw from philosophical, theological, and legal perspectives. The purpose of this Scope Note is to present a wide variety of viewpoints on the health provider's right to conscience.

More than 40 years ago the development of "The Pill" as the first reliable method of birth control not only ushered in a feminist revolution, but also provided a new focus for concerns of conscience for those who were part of the anti-abortion movement based on religious belief in the sanctity of life. Similarly, in the past ten years, worldwide, and seven years (1999) since the emergency contraception "morning after" pill first became available as a prescription item, there has been an upsurge in the number of medical personnel who refuse to prescribe or dispense it on grounds of personal conscience, whether for religious reasons or not. Their actions bring into play issues of power and control for health care personnel and for patients—in this case women, which also raises women's rights issues. Ironically, studies in France, Sweden, and the United Kingdom have shown that emergency contraception does not reduce the abortion rate—it is too infrequently used (II, Glasier 2006).

It is important to underline the difference between the "morning-after" pill or "Plan B," which is made up of two progestin pills containing levonorgestrel (a synthetic derivative of the female hormone progesterone), and RU-486 (Mifiprex

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or mifipristone with misoprostol). Plan B, if taken within 72 hours post-coitus prevents implantation, and therefore pregnancy, by suppressing the output of luteinizing hormone, the hormone that triggers the ovulation process. Scientists have been unable to determine whether this action could destroy already fertilized eggs, but even if it does, it uses the same mechanism as occurs with the birth-control pill, that was developed some 45 years ago. By contrast, RU-486 acts up to 49 days after implantation by blocking the action of progesterone in order to terminate the pregnancy and as such is an abortifacient (II, US FDA 1).

On 24 August 2006, the U.S. Food and Drug Administration announced approval of the Plan B pill for over-the-counter (OTC ) sales (II, US FDA 2). Although this action makes the drug more widely available, it remains to be seen whether pharmacists who are conscientious objectors and who refuse to dispense it also will refuse to provide it OTC.

A survey article by Rebecca Dresser (II, 2005, p. 9) succinctly sums up the problem for conscientious objectors: "Because emergency contraception can act to block implantation of a fertilized egg, people who believe in protection of human life after conception find it morally objectionable."

When conscientious objections are raised over abortion or birth control services performed, prescribed, or dispensed, they affect not only the health professionals—physicians, pharmacists, nurses, and health technicians—who may object, as well as their colleagues and/or managers, but also the consumers: the female patients who are then forced to reconsider or to seek an alternative supplier, as well as their spouses or partners. Alta Charo (II, 2005, p. 2473) makes the point that the patient needs to have access to a system of counseling and referral "so that every patient can act according to his or her own conscience just as readily as the professional."

The literature and online resources cited below include (1) policy statements and codes by professional organizations; (2) review essays on conscientious objection in health care and articles on the current debate regarding the field of pharmacy; and (3) legal perspectives and cases.

## I. OFFICIAL POSITION STATEMENTS AND CODES

American Pharmacists Association (APhA). Code of Ethics for Pharmacists. Washington, DC: APhA. 27 October 1994. 2 p. [Online.] Available at *http://www.aphanet.org/AM/Template.cfm?Section=Search&template=/CM/HTMLDisplay.cfm&ContentID=2809*. Accessed 20 October 2006.

Eight principles and interpretation include "[a] pharmacist respects the autonomy and dignity of each patient" and "[a] pharmacist promotes the good of every patient in a caring, compassionate, and confidential manner." This Code also was endorsed and reviewed by the American Society of Health-System Pharmacists [ASHP] in June 1996 and 2002, respectively (see *http://www.ashp.org/bestpractices/ethics/Ethics_End_Code.pdf*, accessed 20 October 2006).

American Medical Association (AMA). AMA Policy Finder. Chicago, IL: American Medical Association, ongoing. [Online.] Available at *http://www.ama-assn.org/go/policyfinder*. Accessed 19 October 2006.

The AMA has no single statement on conscientious objection but addresses its various facets and issues through a combination of policy documents, which can be accessed through its Policy Finder. Documents include the AMA Code of Medical Ethics, its Principles and Opinions, Opinion E-9.12 "Patient-Physician Relationship: Respect for Law and Human Rights" (updated 1994), Opinion E-10.05 "Potential Patients," and Policy H-296.896 "Conscience Clause: Final Report" (1998–for medical students.) Proceedings of the AMA House of Delegates also provide additional information. As a detailed example, Policy D-120.975 (2005), "Preserving Patient's Ability to Have Legally Valid Prescriptions Filled," indicates the AMA's resolve to work with state medical societies and relevant associations to ensure that patients receive an immediate referral to another dispensing pharmacy if a pharmacist makes a conscientious refusal to fill. It also states that, in the absence of other remedies, the AMA plans to seek state legislation to permit physicians to dispense medication to their own patients if no pharmacist within a 30 mile radius will do so.

American Pharmacists Association (APhA). Pharmacists & Physicians: Not Just a Matter of Conscience. Statement by John A. Gans, Executive Vice President and CEO APhA, 23 June 2005. [Online.] Available at *http://www.aphanet.org/AM/Template.cfm?Section=Search§ion=June6&template=/CM/ContentDisplay.cfm&ContentFileID=686* Accessed 14 November 2006.

Responding to the AMA's June 2005 policy statement regarding patients' rights to have legally valid prescriptions filled, Gans reiterates the APhA's policy that "supports the ability of the pharmacist to step away from participating in an activity to which they have personal objections—but not to step in the way." He says that seamless systems exist due to the efforts of individual pharmacists and pharmacies, and their ongoing collaboration with physicians, such that most patients receive their prescriptions without being aware of a pharmacist's choice to step away.

American Pharmacists Association (APhA). APhA Statement on FDA's Recent Approval of Plan B for OTC Status. 24 August 2005. 1 p. [Online.] Available at *http://www.aphanet.org/AM/Template.cfm?Section=Search&template=/CM/HTMLDisplay.cfm&ContentID=6569* Accessed 14 November 2006.

APhA "applauds" the FDA's decision because it expands access to medications in a way that is safe and provides individuals with access to pharmacists able to answer questions about emergency contraception. This statement also outlines the novel approach in nine states in which women under 18 can seek information and emergency contraception directly from pharmacists.

American Society of Health-System Pharmacists (ASHP). Pharmacist's Right of Conscience and Patient's

Right of Access to Therapy, Policy No. 0610. [Online.] Available at *http://www.ashp.org/bestpractices/ethics/Ethics_Positions.pdf*. Accessed 20 October 2006.

Recognizing the right of pharmacists and other pharmacy employees not to participate "in therapies they consider to be morally, religiously, or ethically troubling," this policy also supports systems that protect the patient's right to obtain legally prescribed treatments and reasonably accommodate rights of conscience. Pharmacists must be respectful of patients and make referrals without trying to impose their views on patients.

Canadian Healthcare Association (CHA), Canadian Medical Association (CMA), Canadian Nurses Association (CNA), and Catholic Health Association of Canada (CHAC). Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care, 1998 December 4–5; 4 p. [Online.] Available at *http://www.cna-aiic.ca/CNA/documents/pdf/publications/prevent_resolv_ethical_conflict_e.pdf*. Accessed 26 September 2006.

All health care organizations ought to have a conflict resolution policy in place that incorporates the 12 elements identified in the joint statement in ways appropriate for the health care setting and the situation. Elements involve gathering those in conflict together with facilitation and outside resources if necessary. Health care providers who cannot support the decision made should be allowed "to withdraw without reprisal from participation in carrying out the decision, after ensuring that the person receiving care is not at risk of harm or abandonment."

Canadian Pharmacists Association (CHA). CHA Guidelines for the Provision of Plan B (levonorgestrel 0.75 mg) as a Schedule II Product, 2003. Available at *http://www.pharmacists.ca/content/about_cpha/whats_happening/cpha_in_action/pdf/ECP_CPhAGuidelinesforProvisionECPasSchII.pdf*. Accessed 8 November 2006.

As of 19 April 2005, Plan B is available to women directly from a pharmacist without a physician's prescription as a Schedule II or behind the counter product. The 2003 guidelines still serve "as a template that pharmacists can use or adapt, in conjunction with other training and support materials to conduct individual consultations with women requesting emergency contraception" (p. 1).

Christian Medical & Dental Society. Healthcare Right of Conscience: Protecting the Freedom to Heal. [Online.] Available at *http://www.cmawashington.org/index.cgi?CONTEXT=art&art=2183&BISKIT=8598249* Accessed 6 November 2006.

This statement links the Hippocratic Oath with Judeo-Christian principles, and holds that adherence to these values is the basis of medical professionalism.

Royal Pharmaceutical Society of Great Britain. Codes of Ethics. Available at *http://www.rpsgb.org.uk/protectingthepublic/ethics/*. Accessed 18 October 2006.

"Consultation on the Structure of the Revised Code of Ethics for Pharmacists and Pharmacy Technicians,"

dated June 2006, looks at the RPS Code of Ethics and Standards, now under review by the Society. The document advises pharmacists to "ensure your professional judgment is not impaired by personal or professional interests, incentives, targets or similar measures; declare any personal or professional interests to those who may be affected;" and "ensure that, if you have a conscientious objection to particular services, this is clearly known by your patients and employer, and have in place the means to make a referral to another relevant professional within an appropriate time frame." [See also II. Bramstedt 2006; Balmer 2006.]

## II. GENERAL LITERATURE

Benn, Piers. The Role of Conscience in Medical Ethics. In *Philosophical Reflections on Medical Ethics*, ed. Nafsika Athanassoulis, pp. 160–79. Basingstoke [England]/New York: Palgrave/Macmillan, 2005.

After reviewing philosophical arguments on conscience from Thomas Aquinas to Richard M. Hare, the author focuses on conscientious refusal in the health care context. Contrasting a doctor who objects to performing abortions with a doctor who refuses to provide pain relief, Benn posits that ". . . [t]he question of whether to allow conscientious objection may well turn on whether the ethical position of the doctor or nurse connects intelligibly with the core values of medicine" (p. 177). The chapter concludes with a discussion of the ". . . fact of reasonable pluralism—that when well-informed and well-intentioned people disagree about [an issue of conscience], laws and institutions should not take extreme stances" (pp. 177–78).

Bramstedt, Katrina A. When Pharmacists Refuse to Dispense Prescriptions. *Lancet* 367 (9518): 1219–20, 15–21 April 2006.

In this comment piece, the author states that "the question of what constitutes a moral objection is a valid one" and points out that legalizing the refusal to prescribe emergency contraception may be a precedent for allowing objections to other drugs prescribed for other reasons, such as, for example, human growth hormone for short stature. She discusses the situation in Illinois, where a state law that aims to deal with current refusals to dispense emergency contraception shifts the duty to dispense from the individual pharmacist to the pharmacy as a business.

Balmer, Lynsey. Royal Society of Pharmacists and Conscientious Objectors. [Letter, Reply] *Lancet* 367 (9527):1980, 17 June 2006. [See I. Royal Pharmaceutical Society of Great Britain 2006.]

Brodsho, Kelsey C. Patient Expectations and Access to Prescription Medication Are Threatened by Pharmacist Conscience Clauses. *Minnesota Journal of Law, Science & Technology* 7 (1): 327–36, December 2005.

Brodsho asserts that the professional duties of the physician are distinct from those of the pharmacist, because the central patient-provider relation-

ship is between physician and patient. The physician creates and develops a treatment plan with the patient; the pharmacist is one of possibly many health providers who effectuates an established plan. "[T]he needs of the patient must trump the pharmacist's moral objection" (p. 331).

Cahill, Judith A.; Maddux, Michael S.; Gans, John A.; and Manasse, Henri R. Pharmacist Critique Woefully Outdated and Uninformed. Available online from the Academy of Managed Care Pharmacy. Statement from AMCP; American College of Clinical Pharmacy; American Pharmacists Association; American Society of Health-System Pharmacists at *http://www.amcp.org/data/nav_content/Letter%20to%20the%20Editor%20%2D%20OBGYN%20final%2Epdf*. Accessed 28 September 2006.

Cahill and her colleagues attack the critique by Wall and Brown (see below), calling it "mixing apples with oranges," and argue that pharmacists are professionals skilled in taking medication histories and giving medication advice, not merely dispensing.

Canadian Pharmaceutical Association letter to the Canadian Medical Association, 8 December 2006. Available at *http://www.pharmacists.ca/content/about_cpha/Whats_Happening/CPhA_in_Action/pdf/CMAJECP_CPhADec8-05.pdf*. Accessed 2 November 2006.

The Canadian Pharmaceutical Association protested in this letter what they saw as the CMAJ's "need to create controversy at the expense of another health profession." They state that "[O]n December 6, CMAJ dedicated two full pages to present its position that pharmacists' services are not professional or kept confidential, and that pharmacists should not be paid for the services they provide (CMAJ 2005, 173 (12): 1435–36)." They added that the CMAJ's "editorial position last April regards the consultation a pharmacist provides regarding emergency contraception (EC) as subjecting women to '. . . fair game for unwanted questioning and unsought advice—at their own expense' and refers to '. . . a lingering paternalism in matters affecting women's reproductive health . . . still hiding behind the counter' (CMAJ 2005, 172 (7): 845). These two articles certainly come across as part of a continued campaign by CMAJ against pharmacists." A chronology entitled "CHA Takes Action: Emergency Contraception" can be found at *http://www.pharmacists.ca/content/about_cpha/whats_happening/cpha_in_action/emerge_contra.cfm*. Accessed 2 November 2006. (See also Eggertson and Sibbald 2005 below.)

Cantor, Julie, and Baum, Ken. The Limits of Conscientious Objection: May Pharmacists Refuse to Fill Prescriptions for Emergency Contraception? *New England Journal of Medicine* 351 (19): 2008–12, 4 November 2004.

Although noting that ". . . [f]ormer Supreme Court Chief Justice Charles Evans Hughes called the quintessentially American custom of respect for conscience a "happy tradition" (p. 2012), the authors depict the serious consequences of conscientious refusal for both health care providers and patients before presenting arguments on both sides of the issue.

CBS News. The Early Show: HealthWatch: "Are Pharmacists Right to

Choose? Debate over Letting Them Refuse to Provide Birth Control Pills," 29 March 2005. [Online.] Available at *http://www.cbsnews.com/stories/2005/03/29/earlyshow/health/main683753.shtml*. 7 November 2006.

Karen Pearl, President of Planned Parenthood, and Karen Brauer, President of Pharmacists for Life International, discuss their opposing views on the right of pharmacists to refuse to fill prescriptions for birth control. Viewers can link to a related video on "Druggists' Right to Choose" in which Steven H. Aden of the Christian Legal Society also appears.

Charo, R. Alta. The Celestial Fire of Conscience: Refusing to Deliver Medical Care. *New England Journal of Medicine* 352 (24): 2471–73, 16 June 2005.

Echoing Ellen Goodman's description of refusal clauses as "conscience without consequence," the author sees the conscience clause argument as a subset of the current debate about what it means to be a health care professional. Charo notes that "[w]ith autonomy and rights as the preeminent social values comes a devaluing of relationships and a diminution of the difference between [health care providers'] personal lives and our professional duties" (p. 2472). The author proposes that ". . . a genuine system for counseling and referring patients [be put] in place, so that every patient can act according to his or her own conscience just as readily as the professional can" (p. 2473).

Chervenak, Frank A., and McCullough, Laurence B. A Group Practice Disagrees about Offering Contraception. *American Family Physician* 65 (6):1230, 1233, 15 March 2002. [Online.] Available at *http://www.aafp.org/afp/20020315/curbside.html*. Accessed 6 November 2006.

The authors discuss a case in which the pro-life beliefs of some physicians in a group practice are adopted as the standard of care for the practice as a whole. Chervenak and McCullough detail the implications of this decision for informed consent and physician-patient relations and describe other options for addressing issues of conscience in clinical care.

Davis, John K. Conscientious Refusal and a Doctor's Right to Quit. *Journal of Medicine and Philosophy* 29 (1): 75–91, 2004.

Davis argues that a doctor may refuse to treat a patient who requests a procedure the doctor finds morally objectionable only if quitting the physician-patient relationship leaves the patient "not worse off than she would have been if she had not gone to that doctor in the first place" (p. 75). He addresses the duty to refer, moral counseling from a physician, whether the doctor should provide these services if no other physician is available, moral consensus among physicians, and the responsibility of a doctor to stay out of fields where the standard of care includes objectionable procedures.

Dowling, Katherine, and Sonfield, Adam. Should Pro-Life Health Providers Be Allowed to Deny Prescriptions on the Basis of Conscience? In *Taking Sides: Clashing Views in Health and Society*, 7th ed., ed. Eileen L. Daniel, pp. 242–54, Dubuque, IA: McGraw Hill, 2006. 393 p.

Dowling, a physician, describes the reactions she receives from other

health professionals when expressing her pro-life positions and acting on her right to conscientious refusal. Sonfield, a journalist, focuses on the harm to patients that can result when health professionals invoke the right to conscience.

Dresser, Rebecca. Professionals, Conformity, and Conscience. *Hastings Center Report* 35 (6): 9–10, November–December 2005.

Dresser enumerates five models for handling conflicts over conscientious objection by health professionals: the contract; the duty to refer to another health professional; the obligation to perform certain treatments as part of the profession's basic standards; the "draft board"; and the compromise. The drawbacks of each are enumerated. She writes "many laws protect health professionals from employment penalties if they refuse to assist with abortion or sterilization procedures" (p. 9). She goes on to add that other laws allow professionals to refuse to perform such actions as forgoing life-sustaining treatment, giving "futile" treatment, supplying life-ending medication (Oregon), doing prenatal diagnosis (in the interests of disability rights) or sex selection, administering infertility treatment, procuring cadaver organs, or using animals in education or research.

Eggertson, Laura, and Sibbald, Barbara. Privacy Issues Raised over Plan B: Women Asked for Names, Addresses, Sexual History [news]. *CMAJ/JAMC: Canadian Medical AssociationJournal* 173 (12): 1435–36, 6 December 2005.

Although not a case of conscientious objection to dispensing of Plan B (levonorgestrel), a situation that may have hindered its availability in Canada arose in April 2005, after it changed from being a prescription drug to a behind-the-counter medication. The Canadian Pharmacists Association (CHA) posted guidelines for pharmacists online (*www.pharmacists.ca*) on distributing the drug, including instructions on the need to counsel women and a form to guide this counseling. A counseling fee—e.g., $25 a pill—could be charged, although it is not clear that Canada's public health system would pay for it.

Following a CHA complaint to the CMA about the above CMAJ news story while it was under preparation, the editors were instructed by a CMA executive to suppress the details of the stories the journalists had gathered from 13 women from across Canada, who had gone to their local pharmacist to request emergency contraception and experienced frustrating effects resulting from the guidelines. A subsequent editorial on editorial autonomy of the CMAJ presumably led to the "without cause" dismissal of the CMAJ editor, Dr. John Hoey, and the Senior Deputy Editor, Anne Marie Todkill, as well as the resignations of other CMAJ journalists. The controversy can be followed by Letters to the Editor that cite the original story in the online edition available at *http://www.cmaj.ca/cgi/content/full/173/12/1435*, and by a chronology by Barbara Sibbald available at *http://www.caj.ca/mediamag/awards2006/pages/Magazine.htm*. (Both accessed 2 November 2006) (See also above: Canadian Pharmaceutical Association letter to the Canadian Medical Association, 8 December 2006.)

Fenton, Elizabeth, and Lomasky, Loren. Dispensing with Liberty: Conscientious Refusal and the "Morning-After Pill." *Journal of Medicine and Philosophy* 30 (6): 579–92, December 2005.

The authors argue that, although "the liberty of conscientious refusal grounds a strong moral claim" and five arguments for requiring pharmacists to fill prescriptions can be defeated, nevertheless, "moral equality does not obtain," because "the pharmacist is in a privileged position vis-à-vis potential clients." However, they use the economics "Theory of Second Best" to suggest that the best compromise between conscientiously-objecting pharmacists and their clients—women seeking emergency contraception—could be "a geographically restricted policy of requiring prescription fulfillment."

Furton, Edward J. Vaccines and the Right to Conscience. *National Catholic Bioethics Quarterly* 4 (1): 53–62, Spring 2004.

Furton discusses the ramifications of broader interpretations of exercising one's right to object to medical procedures, even if participation is mandated by state legislation. Seeking an exemption to state mandated vaccinations for their children, parents argue an appeal to conscience. The argument is grounded in their rejection of the use of tissue from aborted fetuses which are reputed to be the source of tissue used by researchers and pharmaceutical companies for the creation and production of vaccines. "Can this appeal for an exemption be valid when there is no specific Catholic teaching on this topic?" (p. 54). Furton argues that the facts of the development and production of vaccines are unfortunate, but the burden to act in good conscience is on the researchers and drug producers, rather than the parents. Citing the continuum of moral theology from Aquinas to Pope John Paul II, Furton maintains that justice for the most vulnerable prevails over the conscience of the parents. Protecting the children, born and unborn, from these dangerous diseases is more compelling than disassociating oneself from abortion, no matter how remote the connection. In this instance, seeking an exemption to the rule is not justified by the conscience of the individual parent.

Glasier, Anna. Emergency contraception. [Editorial.] *BMJ: British Medical Journal* 333 (7568): 560–61, 16 September 2006.

Glasier editorializes on the effectiveness of emergency contraception in reducing abortion rates in Sweden, France, and the U.K., where it has been used for 10 years. Only small proportions of women undergoing abortion have claimed to have used emergency contraception in the past—the greatest being 12 percent, in the U.K. However, in Sweden and the U.K., the abortion rate actually has increased in the last 10 years.

Greenberger, Marcia D., and Vogelstein, Rachel. Pharmacist Refusals: A Threat to Women's Health. *Science* 308 (5728): 1557–58, 10 June 2005. [Online.] Available at *http://www.sciencemag.org/cgi/reprint/308/5728/1557.pdf*. Accessed 20 October 2006.

In a "Policy Forum" piece, the authors, who are with the National Women's Law Center, review legal and professional standards for pharmacists

in the United States and recommend that "women . . . be provided timely access to prescription medication" (p. 1558).

Imbody, Jonathan. Doctors in the Lion's Den. *Today's Christian Doctor: The Journal of the Christian Medical & Dental Society* 32 (3):19–23, Fall 2001.

The author asserts that the December 2000 decision of the Equal Employment Opportunity Commission (EEOC) holding that health insurance coverage for contraception is a civil right violates health care providers' ability to refuse to prescribe contraception as their human right. The article includes the Christian Medical & Dental Society position statement "Protecting the Freedom to Heal," which observes that ". . . many within the medical and scientific communities appear to be moving further away from . . . absolute values and truth. The resulting clash of values has made professionals who hold [such values] vulnerable to discrimination, ostracism and punishment" (p. 22).

Manasse, Henri R., Jr. Conscientious Objection and the Pharmacist. *Science* 308 (5728): 1558–59, 10 June 2005. [Online.] Available at *http://www.sciencemag.org/cgi/reprint/308/5728/1558.pdf*. Accessed 20 October 2006.

Manasse, the executive vice president of the American Society of Health-System Pharmacists, views the extreme actions of some pharmacists and the equally extreme reactions of some policymakers as "not the appropriate answer to the dilemma we face" ( p.1559). He suggests a variety of solutions to address the problem.

May, Thomas. Conscience, Rights of. In *Encyclopedia of Bioethics*, 3d ed., ed. Stephen G. Post, vol. 1, pp. 517–19. New York: Macmillan Reference USA/Thomson/Gale, 2004.

Calling matters of conscience ". . . a balancing of autonomy rights and social harm," May delineates the conditions that must exist for the legitimate exercise of a right to conscience.

National Public Radio (NPR), Programs Archive. Washington, DC, multiple dates. [Online.] Available at *http://www.npr.org*. Accessed 23 October 2006.

NPR has broadcast a number of audio programs related to the emergency contraceptive called Plan B, or "the morning after pill," and issues of conscience for pharmacists and nurses. These programs, which can be accessed free online, range from brief news reports to extended online discussions of the topic, such as "News and Notes" with Ed Gordon, 31 March 2005 (16:41), and "Talk of the Nation: Pharmacists and Contraceptive Prescriptions," 7 April 2005 (29:40). Search for pharmacists, conscience, Plan B, Alabama nurses, etc. Additional information and links are sometimes provided.

Pellegrino, Edmund D. The Physician's Conscience, Conscience Clauses, and Religious Belief: A Catholic Perspective. *Fordham Urban Law Journal* 30 (1): 221–44, November 2002.

Within a symposium volume on religious values and legal dilemmas in bioethics, Pellegrino sets physician conflict of conscience within the larger context of changes in America's democratic and pluralistic society and society's understanding and structur-

ing of its medical system and care providers. Drawing on Aquinas, Pellegrino describes how, for a Catholic, conscience is divinely inserted so that "to ignore, repress, or act against conscience for any reason is a violation of philosophical as well as theological ethics, an error in moral agency and a sin against God" (pp. 227–28).

Pellegrino states that society is obliged to protect both physician and patient conscientious objection, without empowering one over the other. He rejects as unsatisfactory the common proposals to resolve or limit conflicts of conscience, namely, he argues that physicians cannot separate or rank their professional and personal commitments because such a value dichotomy is incompatible with personal integrity; physicians cannot refrain but refer to another physician because doing so would be to cooperate in a morally wrong act; and the practice, study, or provision of health care by a Catholic (or other religious) physician or hospital cannot be circumscribed without a loss to society. Therefore, "the only ethically viable course for the religious physician is to maintain fidelity to moral integrity and dictates of conscience while practicing in a secular world" (p. 242). Physicians must inform their patients of what they can and cannot in good conscience do before any crisis occurs. Although conscience cannot be compromised even in an emergency or when provider choice is limited, a physician must care for a patient until a referral or transfer can be arranged by the patient, a family member, or social services and must always "treat her patients with respect, avoid moralizing condemnations, explain reasons for her moral objections . . . and recognize that not all matters of conscience are of equal gravity" (p. 243).

Savulescu, Julian. Conscientious Objection in Medicine. *BMJ: British Medical Journal* 332 (7536): 294–97, 4 February 2006.

Savulescu offers that not allowing conscientious objection constrains the liberty of the health care professional. Nevertheless, he marshals more arguments against it: the inefficiency, inequity, and inconsistency of services offered; the questions it raises about the commitment of a doctor to his or her specialty of medical care; and the specter of discrimination, religious vs. secular. He suggests that "doctors who claim it [conscientious objection] should be prepared to refer the patient to someone else who can perform the services in a timely manner" and adds that "if people are not prepared to offer legally permitted, efficient, and beneficial care to a patient because it conflicts with their values, they should not be doctors." (Savulescu's article stimulated much discussion, posted at the Rapid Responses section of BMJ's website, available at: *http://bmj.bmjjournals.com/cgi/eletters/332/7536/294#127992*. Accessed 6 November 2006.)

Swartz, Martha S. "Conscience Clauses" or "Unconscionable Clauses": Personal Beliefs Versus Professional Responsibilities. *Yale Journal of Health Policy, Law, and Ethics* 6 (2): 269–350, Summer 2006.

Swartz argues that because medical professionals essentially are granted monopolies due to state licensing regulations, they should be precluded from injecting personal beliefs into professional practice. Thus she distinguishes

professional integrity based on medical ethics from personal morality for two reasons: one, protection of patient access to health care, and two, implementation of the fiduciary obligation health care professionals owe to patients. She concludes that by doing this, patients will have increased trust in health care and the health care system.

[US FDA 1.] U.S. Food and Drug Administration. Center for Drug Evaluation and Research. Drug Information: Mifeprex (mifepristone) Questions and Answers. August 2005. Available at *http://www.fda.gov/cder/drug/infopage/mifepristone/mifepristone-qa.htm* and 10 April 2006 update at *http://www.fda.gov/cder/drug/infopage/mifepristone/default.htm*. Both accessed 16 October 2006.

[US FDA 2.] U.S. Food and Drug Administration. Center for Drug Evaluation and Research. Drug Information. FDA Approves Over-the-Counter Access for Plan B for Women 18 and Older, Prescription Remains Required for Those 17 and Under. 24 August 2006. Available at *http://www.fda.gov/bbs/topics/NEWS/2006/NEW01436.html*. Accessed 7 November 2006.

Wall, L. Lewis, and Brown, Douglas. Refusals by Pharmacists to Dispense Emergency Contraception: A Critique. [Current Commentary.] *Obstetrics & Gynecology* 107 (5): 1148–51, May 2006.

In a controversial article that drew strong replies from pharmacists, the authors contend that pharmacists should not be permitted "[to exercise their] personal opinions and values [in dispensing] medications to patients" since "[emergency] contraception does not interfere with an implanted pregnancy and therefore does not cause abortion" and "because pharmacists do not control the therapeutic decision to prescribe medication." In addition, "pharmacists at the counter . . . [are not trained to] make clinically sound ethical decisions" since they lack "access to the patient's complete medical background . . . [and] do not understand the context in which the patient's clinical problem is occurring." (See Cahill et al. (above) for a reply.)

Wicclair, Mark R. Pharmacies, Pharmacists, and Conscientious Objection. *Kennedy Institute of Ethics Journal* 16 (3): 225–50, September 2006.

Noting that ". . . the recognized principle that physicians are not obligated to participate in practices that violate their ethical beliefs is limited by obligations to the ill, such as a duty to provide medically indicated emergency care . . ." (p. 240), Wicclair holds that pharmacists who refuse to fulfill and/or transfer prescriptions for emergency contraception have crossed the line ". . . from [conscientious] objection to obstruction . . . " (p. 242).

Winckler, Susan C., and Gans, John A. Conscientious Objection and Collaborative Practice: Conflicting or Complementary Initiatives? *Journal of the American Pharmacists Association* 46 (1): 12–13, January–February 2006.

Winckler and Gans discuss the relationship of conscience clauses and collaborative practice agreements in relation to prescribing and dispensing emergency contraceptives by pharmacists, arguing that they complement

rather than conflict with each other. Conscience clauses allow pharmacists to opt out of activities to which they morally object while the collaborative practices ensure patient access to legally prescribed emergency contraceptives.

Wood, Susan F. The Role of Science in Health Policy Decisionmaking: The Case of Emergency Contraception. The Oliver C. Schroeder, Jr., Scholar-in-Residence Lecture, Case Western Reserve University School of Law; 27 September 2006. Webcast available at *http://law.case.edu/lectures*. Accessed 20 October 2006.

Wood, former Assistant Commissioner for Women's Health and Director of the Food and Drug Administration Office of Women's Health, addresses the following questions: Was clinical and scientific evidence ignored in deliberations concerning approval of Plan B emergency contraception as an over-the-counter drug? What impact do the decisions of the Food and Drug Administration have on women and families? And what impact do they have on its own credibility?

Zellmer, William A., and American Society of Health-System Pharmacists. *The Conscience of a Pharmacist: Essays on Vision and Leadership for a Profession*. Bethesda, MD: American Society of Health-System Pharmacists, 2002.

Editorials published in the *American Journal of Health-System Pharmacy* from 1978 to 2000 focusing on professionalism in pharmaceutical practice comprise this collection of reprints.

## III. LEGAL PERSPECTIVES AND CASES

Appel, Jacob M. Judicial Diagnosis: "Conscience" vs. Care: How Refusal Clauses are Reshaping the Rights Revolution. *Medicine and Health, Rhode Island* 88 (8): 279–81, August 2005. [Online.] Available at *http://www.rimed.org/documents/RIMedAugust2005.pdf*. Accessed 6 November 2006.

Appel describes how refusal legislation which ". . . once seemed benign to many pro-choice lawmakers—and to some a crucial part of the personal freedom championed by civil libertarians" is ". . . now shielding insurance companies and major hospital networks" (pp. 279–80). Cautioning that "[t]he door opened by refusal legislation may prove wider than many advocates imagined" (p. 280), the author suggests that standard care, such as the implementation of advance directives and the care of HIV-infected patients, could be denied by providers invoking their right to conscience.

Bleich, J. David. The Physician as Conscientious Objector. *Fordham Urban Law Journal* 30 (1): 245–65, November 2002.

Bleich first argues that conscientious objection merits serious consideration despite the loss of respect for the role of religion in society and in individual lives and a general ignorance of the historical and practical reasons behind the principle of religious freedom. He then describes the existing legal commentary on physician conscientious

objection using a series of cases. Bleich concludes that further legislative action could help clarify both protection for physicians and their obligations toward patients.

Collins, Mary K. Conscience Clauses and Oral Contraceptives: Conscientious Objection or Calculated Obstruction? *Annals of Health Law* 15: 37–60, Winter 2006.

Collins traces the scientific and religious bases for the state conscience clause legislation. She discusses the rights of the health care provider and the health care consumer before examining areas where those rights can be compromised and reconciled.

Davey, Monica, and Belluck, Pam. Pharmacies Balk on After-Sex Pill and Widen Fight; Right of Refusal Cited; Many States Take up the Issue, Citing Religious and Moral Concerns. *New York Times* (19 April 2005): A1, A16.

In this front page story, reporters Davey and Belluck focus on the wide range of state and federal responses to the controversial morning-after pill and the refusal of some pharmacists to fill such prescriptions. The story continues with a discussion of the legislative landscape in various states and includes a map identifying states with legislation either enacted or pending that would either limit or promote accessibility of the morning-after pill. (See also Kreischer below.)

Dickens, Bernard M. Ethical Misconduct by Abuse of Conscientious Objection Laws. *Medicine and Law: The World Association for Medical Law*, 25 (3): 513–22, September 2006.

Dickens begins by distinguishing conscientious objection (refusal to undertake a legal act) from civil disobedience (refusal to act in compliance with mandatory public law). The overlap occurs when health care providers refuse to refer patients to alternatives for lawful health care services, thus defying private laws that protect a patient's right to care. He compares balanced laws on conscientious objection in Britain to abusive laws on it in the U.S. Dickens sees the right to conscience abused when it extends beyond protection of an individual's religious rights to compel others to comply involuntarily with religious doctrines that they do not believe in.

Duvall, Melissa. Pharmacy Conscience Clause Statutes: Constitutional Religious "Accommodations" or Unconstitutional "Substantial Burdens" on Women? *American University Law Review* 55 (5): 1485–1522, June 2006.

Duvall begins with a background section on the evolution of conscience clause legislation and the judicial response, which began in the mid-1970s following the United States Supreme Court abortion decision in *Roe v. Wade*. Pharmacists are the latest group seeking conscience clause protection. She surmises how the Supreme Court could decide in applying government accommodation to religious beliefs under the First Amendment on conscience clause statutes.

Eide, Karissa. Can a Pharmacist Refuse to Fill Birth Control Prescriptions on Moral or Religious Grounds? *California Western Law Review* 42 (1): 121–48, Fall 2005.

Eide surveys in detail current and proposed conscience clause legislation

among the states. She also examines the position of the American Pharmacists Association, which adopted in 1998 its official policy recognizing "the individual pharmacist's right to exercise conscientious refusal" and supporting "the establishment of systems to ensure patient access to legally prescribed therapy without compromising the pharmacist's right of conscientious refusal" (p.144).

Grady, Allison. Legal Protection for Conscientious Objection by Health Professionals. *Virtual Mentor: Ethics Journal of the American Medical Association* 8 (5): 327–31, May 2006. [Online.] Available at *http://www.ama-assn.org/ama1/pub/upload/mm/384/healthlaw_16187.pdf*. Accessed 6 November 2006.

Using Michigan's proposed refusal clause legislation as an example, Grady reviews the range of opinions on health care provider conscientious objection from individual practitioners and professional associations.

Kreischer, Madeline, comp. Pharmacist Conscience Clauses: Laws and Legislation, updated October 2006. National Conference of State Legislatures. [Online.] Available at *http://www.ncsl.org/programs/health/conscienceclauses.htm*. Accessed 6 November 2006.

This website has two entries on legislation, the one referenced above for 2006 and another below it updated for 2006 and for all of 2005, entitled Pharmacist Refusal Clause. Currently only four states—Arkansas, Georgia, Mississippi, and South Dakota—have laws allowing pharmacists to refuse to dispense emergency contraceptive drugs; Illinois is the lone state requiring them to dispense such; and four others—Colorado, Florida, Maine, and Tennessee—have broader conscience clause laws. California has a hybrid, where a pharmacist can only refuse to dispense a prescription if the employer approves the refusal and if the woman can get her prescription in a timely manner. The website links to the laws as well as to pending bills in other states and their status.

Lowell, Staci D. Striking a Balance: Finding a Place for Religious Conscience Clauses in Contraceptive Equity Legislation. *Cleveland State Law Review* 52: 441–65, 2004–2005.

Lowell looks at the intersection of the Constitution, specifically the First and Fourteenth Amendments, with the Pregnancy Discrimination Act within Title VII of the 1964 Civil Rights Act concerning access to contraception. She asserts that the most equitable solution would be "to tailor statutory conscience clause language to cover only organizations that primarily employ and serve those who are their own adherents," or, in other words, a narrow religious exemption.

Lumpkin, Cristina Arana. Does a Pharmacist Have the Right to Refuse to Fill a Prescription for Birth Control? *University of Miami Law Review* 60: 105–30, 2005–2006.

Lumpkin writes about pharmacists and conscience clauses within the broader topic of contraception, specifically birth control requiring prescription. Her article frames the debate as one of rights: the right to use contraceptives generally versus the right to refuse to dispense oral contraceptives. She also touches on the disciplinary powers of the state

licensing board and the options of the pharmacist's employer.

Miller, Courtney. Reflections on Protecting Conscience for Health Care Providers: A Call for More Inclusive Statutory Protection in Light of Constitutional Considerations. *Southern California Review of Law and Social Justice* 15 (2): 327–62, Spring 2006.

Miller briefly summarizes the history of conscience clause legislation and then analyzes the forces behind the conscience clause movement. She looks at justification of "the right of conscience" under the Fourteenth Amendment's due process involving autonomy and privacy and under the First Amendment's right to the establishment and free exercise of religion.

Nikas, Nikolas T. Law and Public Policy to Protect Health-Care Rights of Conscience. *National Catholic Bioethics Quarterly* 4 (1): 41–52, Spring 2004.

Catholic medical ethics conflicts with some modern medical practices, particularly those related to the beginning and ending of human life. The Catholic health care provider practices in the midst of this conflict and must have the right to refuse to provide care s/he finds morally objectionable. This discussion outlines the necessity for legislation on a state and federal level to protect the rights of health care providers especially in light of a growing institutional protection for which the right to choose becomes the right to coerce.

Protection of Conscience Project (PCP), British Columbia, Canada. [Online.] Available at *http://www.consciencelaws.org*. Accessed 26 September 2006.

PCP, a "non-denominational, non-profit initiative," advocates for protection of conscience legislation for health care professionals and serves as an information resource for professionals and the public via its website. The site includes an extensive literature archive of news stories, commentaries, and journal articles on issues of conscience; position papers and policies from medical organizations; and links to a text collection of international, national, and state proposed legislation to protect conscience. PCP collects information across the range of issues that have the potential for conflicts of conscience including abortion, birth control, assisted suicide, human and embryonic experimentation, and interspecies breeding.

United States. Congress. House. Committee on Small Business. Freedom of Conscience for Small Pharmacies, 25 July 2005. [Online.] Available at *http://wwwc.house.gov/smbiz/hearings/databaseDrivenHearingsSystem/hearingPage.asp?hearingIdDateFormat=050725*. Accessed 18 September 2006.

Inspired by Illinois Governor Rod Blagojevich's 1 April 2005 emergency rule requiring all Illinois pharmacies selling contraceptives to fill all prescriptions for FDA-approved contraceptives "without delay," this hearing focused on the effect of "duty-to-fill" laws on small pharmacies. Online testimony is available from: Luke Van der Bleek, a pharmacist, who filed suit against the Governor; Linda Garrelts MacLean, on behalf of the American Pharmacist Association (APhA), a former pharmacy owner instrumental in developing Washington State's emergency contraceptive plan; J.

Michael Patton, executive director of the Illinois Pharmacists Association; Sheila Nix, senior policy advisor to Governor Blagojevich; and Megan Kelly, a patient, who was referred away from her primary pharmacy to obtain contraceptive medications.

United States District Court, Western District of Washington. *Erickson v. Bartell Drug Co*. Date of Decision, 12 June 2001. *Federal Supplement, 2d Series* 141: 1266–77, 2001.

*Erickson v. Bartell* is the first case in the federal courts on the issue of sexual discrimination due to an employer's prescription drug plan excluding prescribed contraceptives, which are available only to women. This unequal treatment is unlawful under the 1964 Civil Rights Act. By not offering coverage for contraceptives like birth control pills and devices, the employer created "a gaping hole in the coverage offered to female employees, leaving a fundamental and immediate healthcare need uncovered" (p. 1277).

United States District Court, Western District of Wisconsin. *Noesen v. Medical Staffing Network*. Memorandum and Order, 1 June 2006. Case No. 06-C-071-S. Available at *http://www.wiwd.uscourts.gov/bcgi-bin/opinions/district_opinions/C/06-06-C-071-S-06-01-06.PDF*. Accessed 7 November 2006.

This case comes after the disciplinary hearing below [Wisconsin Pharmacy Examining Board]. Noesen claimed that Wal-Mart violated his civil rights because he was terminated for his refusal to distribute contraceptives. The court found that Wal-Mart had reasonably accommodated Noesen by having another pharmacist available to fill birth control prescriptions and to answer customer questions. Instead of notifying the other pharmacist about a customer for birth control, Noesen either ignored such a customer by walking away or leaving them on hold. The court dismissed the claim against the State of Wisconsin and granted summary judgment in favor of Medical Staffing Network and Wal-Mart.

White, Matthew. Conscience Clauses for Pharmacists: The Struggle to Balance Conscience Rights with the Rights of Patients and Institutions. *Wisconsin Law Review* 2005 (6): 1611–48, 2005.

White begins with a brief history of conscience clauses and then surveys the current legislation. He looks at conscience from two viewpoints, that of the individual and that of the institution, along with the patient's privacy rights and the employer's right to conduct business as the employer sees fit. After analyzing conscience clauses, both narrow and broad, White proposes stronger and broader patient protection as necessary to preserve the conscience rights of the pharmacist. Some of his suggestions include pharmacist-provided notice to both the patient and the employer, along with mandatory referral.

Wisconsin Pharmacy Examining Board. *In the Matter of the Disciplinary Proceedings Against Noesen*. Final Decision and Order, 13 April 2005. Case No. LS0310091PHM. Available at *http://drl.wi.gov/dept/decisions/docs/0405070.htm*. Accessed 7 November 2006.

The Pharmacy Board's decision begins with an extensive factual background. Essentially, Neil Noesen, a pharmacist who objects to birth control and abortion in accordance with

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his Catholic faith, refused to refill the birth control prescription of customer AR. Furthermore, he refused to transfer her prescription so that another pharmacy could refill it. The board found Noesen's refusal to transfer and his refusal to inform AR of her options for obtaining a refill to constitute a danger to her health, safety, and welfare. Noesen was reprimanded, and his license limited, meaning he is required to provide written notice of his conscientious objections to a pharmacy five days prior to his employment.



SER 1188

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*CITY AND COUNTY OF SAN* FRANCISCO

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

| | |
|---|---|
| CITY AND COUNTY OF SAN FRANCISCO,<br>Plaintiff,<br>vs.<br>ALEX M. AZAR II, et al.,<br>Defendants. | No. C 19-02405 WHA<br>*Related to*<br>No. C 19-02769 WHA<br>No. C 19-02916 WHA |
| STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,<br>Plaintiff,<br>vs.<br>ALEX M. AZAR, et al.,<br>Defendants. | **DECLARATION OF DR. ALICE CHEN IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT**<br><br>Date: October 30, 2019<br>Time: 8:00 AM<br>Courtroom: 12<br>Judge: Hon. William H. Alsup<br>Action Filed: 5/2/2019 |
| COUNTY OF SANTA CLARA et al,<br>Plaintiffs,<br>vs.<br>U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,<br>Defendants. | |

I, Dr. Alice Chen, declare as follows:

1. I have personal knowledge of the facts set forth in this declaration and, if called as a witness, could and would testify competently to the matters set forth below.

2. I am the Chief Medical Officer and Deputy Director for the San Francisco Health Network ("SFHN"), a branch of the San Francisco Public Health Department. I have served in this role since 2015.

3. Prior to assuming this role, starting in 2005, I served as Medical Director of the General Medicine Clinic, Medical Director of the Adult Medical Center, Director of the eReferral Program, Director of the Center for Innovation in Access and Quality, and Chief Integration Officer for San Francisco General Hospital.

4. I attended Yale University, Stanford University Medical School, and the Harvard School of Public Health.

5. SFHN runs a full scope health care delivery system that includes primary and preventive care, specialty care, mental health and substance use disorder services, jail health services, maternal child adolescent health services, urgent care, emergency department services, psychiatric emergency room services, level one trauma center services and long term care.

6. SPDPH recognizes and respects that an individual's religious beliefs, cultural values, and ethics may make that person reluctant to participate in an aspect of patient care. However, it would be an untenable situation if staff could categorically refuse to participate in patient care based on an objection to the service the patient seeks or needs.

7. In order to support the legitimate conscience rights of individual health care professionals while meeting fundamental obligations of the medical profession and the right of patients to receive timely, quality patient care, we developed a policy concerning "requests not to participate in an aspect of patient care."

8. Administrative Policy 5.15 states:

> In the event that a staff member feels reluctant to participate in an aspect of patient care because the patient's condition, treatment plan, or physician's orders are in conflict with the staff member's religious beliefs, cultural values or ethics, the staff member's written request for accommodation will be considered if the request does not negatively affect the quality of patient's care.

> In situations where the immediate nature of the patient's needs do not allow for the substitution of personnel, the patient's right to receive the necessary quality patient care will take precedence over the staff member's individual beliefs and rights until other competent personnel can be provided.

9. The Policy explains that "[a]n accommodation may include personnel substitutions through a change in patient assignment or transfer of the staff member to a different patient care area in accordance with organizational standards." It is also clear in the Policy that the individual's "manager and/or supervisor must determine if the staff member's request for accommodation negatively affects the quality of the patient's care," and "[i]f the patient's needs do not allow for the substitution of personnel, the manager and/or supervisor must inform the staff member to stay at their post until other competent personnel can be provided."

10. A true and correct copy of Administrative Policy 5.15 is attached hereto as Exhibit A.

11. This policy has enabled us to appropriately balance the important interests at stake.

12. If we are required to alter this policy to provide for a categorical right to refuse to participate in an aspect of patient care—even in urgent situations when other personnel is not immediately available to step in—patient care will be significantly compromised.

13. If we are required to alter this policy to prohibit the involuntary transfer of individuals who have a religious or moral objection to performing critical aspects of their job, it will impede the ability of our hospitals and clinics to function efficiently.

14. In my professional experience as a doctor, the phrase "assist in the performance" is a term of art. "Assist in the performance" is generally used only in the context of a surgical or non-surgical procedure, or an exam, and refers to a doctor, nurse, medical assistant or other medical professional who physically helps the treating doctor, either by physically handling necessary instruments or by physically handling the patient. Generally, in a surgical context, only those who had "scrubbed in" to the sterile environment could be viewed as "assisting in the performance" of a surgical procedure.

15. An example of someone who could be said to "assist in the performance of a procedure" would be a medical assistant who physically ensures that a patient stays in the correct

position for a doctor to perform a lumbar puncture. An example of someone who would not be said to "assist in the performance" of a procedure would be a medical interpreter who is present for the duration of a pelvic exam, but does not play any role in physically administering the exam.

16. In my experience as a doctor, in generally accepted medical parlance, the phrase "assist in the performance" would not include, for example, and individual without medical training, such as a receptionist or scheduler. Nor would it include someone who merely sterilizes instruments or prepares a room for a procedure.

I declare under penalty of perjury that the foregoing is true and correct and that this declaration was executed on September 9, at Berkeley, California.

Alice Chen, M.D., M.P.H.

# EXHIBIT A

[GO TO END]

**Administrative Policy Number:** 5.15

# TITLE: REQUESTS NOT TO PARTICIPATE IN AN ASPECT OF PATIENT CARE

## PURPOSE

The purpose of this policy is to establish guidelines for processing staff member's requests not to participate in patient care in a manner which ensures continuity of quality patient care.

## STATEMENT OF POLICY

It is the policy of San Francisco General Hospital and Trauma Center to respect the diversity of its staff and patients and the right of patients to receive quality patient care. In the event that a staff member feels reluctant to participate in an aspect of patient care because the patient's condition, treatment plan, or physician's orders are in conflict with the staff member's religious beliefs, cultural values or ethics, the staff member's written request for accommodation will be considered if the request does not negatively affect the quality of patient's care.

In situations where the immediate nature of the patient's needs do not allow for the substitution of personnel, the patient's right to receive the necessary quality patient care will take precedence over the staff member's individual beliefs and rights until other competent personnel can be provided.

All managers and supervisors are responsible for informing employees of this policy and changes in departmental scope of practice. Managers and supervisors are also responsible for implementing this policy as appropriate.

## PROCEDURE

I. Staff Notification

At the time of employment, the manager and/or supervisor must review the departmental scope of service with new staff **member** as outlined in the Record of Orientation. The employee signs the Record of Orientation which is forwarded to Human Resources Services by the manager or supervisor for inclusion in the employee's personnel file.

II. Requests not to Participate in an Aspect of Care

A. It is recognized that staff may have certain ethical and religious beliefs or cultural values and, in good conscience, may feel compelled to request not to participate in an aspect of patient care and requests an accommodation.

- An accommodation may include personnel substitutions through a change in patient assignment or transfer of the staff member to a different patient care area in accordance with organizational standards.

B. The manager and/or supervisor must determine if the staff member's request for accommodation negatively affects the quality of the patient's care. If the patient's needs do not allow for the substitution of personnel, the manager and/or supervisor must inform the staff member to stay at their post until other competent personnel can be provided.

## APPENDIX

None

## CROSS REFERENCES

SFGHMC Administrative Policies and Procedures:
3.07 Competency Assessment and Improvement Plan
16.04 Patient Rights and Responsibilities

Staff Nurses and Per Diem Nurses Memorandum of Understanding between Service Employees International Union and the City and County Of San Francisco - July 1, 2014 and June 30, 2016, Section 40 Article II.K. Conscientious Objector

Supervising Nurses Memorandum of Understanding between Teamster Local 856 and the City and County of San Francisco - July 1, 2012 to June 30, 2016, Section 30 – H. Conscientious Objection to Areas of Moral and Religious Concerns

**APPROVAL**

| | |
|---|---|
| Nursing Executive and Patient Care Services Committee | 6/2/15 |
| Medical Executive Committee | 6/18/15 |
| Quality Council | 6/16/15 |
| Exec Committees B-25 Readiness | 12/17/15 |

**Date Adopted:** 09/95
**Reviewed:** 04/99, 2/05, 06/07, 02/08, 03/11, 4/15
**Revised:** 12/2001

[GO TO TOP]

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO,
Plaintiff,

vs.

ALEX M. AZAR II, et al.,
Defendants.

STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,
Plaintiff,

vs.

ALEX M. AZAR, et al.,
Defendants.

COUNTY OF SANTA CLARA, et al.,
Plaintiffs,

vs.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,
Defendants.

No. C 19-02405 WHA
*Related to*
No. C 19-02769 WHA
No. C 19-02916 WHA

**DECLARATION OF SARA H. CODY, M.D., HEALTH OFFICER AND DIRECTOR OF COUNTY OF SANTA CLARA PUBLIC HEALTH DEPARTMENT, IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT**

Date: October 30, 2019
Time: 8:00 AM
Courtroom: 12
Judge: Hon. William H. Alsup
Action Filed: 5/2/2019

I, SARA H. CODY, M.D., declare:

1. I am a resident of the State of California. I submit this declaration in support of the County of Santa Clara's ("County"), and its co-plaintiffs', Motion for Summary Judgment. I am over the age of 18 and have personal knowledge of all the facts stated herein. If called as a witness, I could and would testify competently to all the matters set forth below.

2. I am the Director of the County's Public Health Department, as well as the Health Officer for the County and each of the 15 cities located within Santa Clara County. I have held the Health Officer position from 2013 to the present and have held the Public Health Department Director position from 2015 to the present. In these roles, I provide leadership on public health issues for all of Santa Clara County and oversee approximately 450 Public Health Department employees, who provide a wide array of services to safeguard and promote the health of the community.

3. Prior to becoming the Health Officer for the County and each of its cities, I was employed for 15 years as a Deputy Health Officer/Communicable Disease Controller at the County's Public Health Department, where I oversaw surveillance and investigation of individual cases of communicable diseases, investigated disease outbreaks, participated in planning for public health emergencies, and responded to Severe Acute Respiratory Syndrome (SARS), influenza A virus subtype H1N1 (also known as "swine flu" or H1N1), and other public health emergencies.

4. The mission of the Public Health Department is to promote and protect the health of Santa Clara County's entire population. None of Santa Clara County's 15 cities have a health department. All 15 cities, and all Santa Clara County residents, rely on the Public Health Department to perform essential public health functions. The Public Health Department's work is guided by core public health principles of equity, the value of every life, and harm prevention. The Public Health Department's direct services primarily benefit low-income persons, children, people of color, and people living with chronic diseases, such as HIV/AIDS.

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5. The work of the Public Health Department is focused on three main areas: (1) infectious disease and emergency response, (2) maternal, child, and family health, and (3) healthy communities.

6. The Public Health Department provides care focused on some of the County's most vulnerable populations including, but not limited to, the LGBTQ community, low-income residents, people who abuse controlled substances, and young women who are pregnant. Approximately 25% of the County's nearly two million residents are considered to be among these vulnerable populations. It is critical that Public Health Department staff be willing and able to serve these populations. For that reason, in recruitment for employment in the Public Health Department, the County inquires into job applicants' experiences with the LGBTQ community and with other vulnerable populations. This recruitment practice ensures that our Department is staffed with employees who are prepared to serve, and are experienced with serving, the needs of all County residents who may interact with the Public Health Department.

7. Several specific programs would be undermined if the Public Health Department were prevented from ensuring that employees staffing those programs were willing to provide the health care services required. For example, the Public Health Department operates a needle exchange program that is critical to preventing the spread blood-borne pathogens such as HIV, hepatitis B and hepatitis C, and also helps to address substance abuse in Santa Clara County. County employees participating in this program necessarily interact with people who abuse controlled substances and typically engage in services such as providing clean needles, safer-sex kits, and referrals for substance abuse treatment. If the Department could not ensure that employees staffed on the needle exchange program are willing to provide these services, the program would not be able to operate efficiently or effectively. Similarly, if the Department could not reassign an employee who objected to providing such services, we would not be able to staff appropriately, undermining this critical program.

8. The Public Health Department provides a range of STI-related services, including sexual-health counseling, STI-prevention services, STI screening, STI treatment, and HIV pre-exposure and post-exposure prophylaxis. Through both the Crane Center, which focuses on STI

1 screening for HIV and Hepatitis C, and the STI clinic, which provides examinations and
2 treatment for a wide range of STIs, such as syphilis, gonorrhea and chlamydia, the Public Health
3 Department regularly serves the LGBTQ community, women who are pregnant including those
4 who may be considering abortion, and people who are seeking contraceptive care. If a broad
5 swath of Public Health employees—even those not directly providing patient care—could refuse
6 to facilitate or refer patients for certain care based on religious or moral objections, these
7 programs would be dramatically impacted. Such refusals would interfere with the relationship of
8 trust between our providers and our patients and result in situations where patients seeking care
9 are turned away or provided with incomplete information regarding the health care services
10 available.

11 9. A policy that broadly permits employees to refuse to facilitate patient care could
12 have a serious negative impact on public health. Indeed, STIs are already a serious public health
13 concern in Santa Clara County, which has recently experienced a rise in chlamydia, gonorrhea,
14 and syphilis. Between 2010 and 2017, cases of chlamydia steadily increased from 271.3 cases
15 per 100,000 people in 2010 to 392.7 cases in 2017, and gonorrhea rates increased nearly fourfold
16 from 33.1 cases per 100,000 people in 2010 to 126.4 cases in 2017, with a 26% rapid increase
17 from 2016 to 2017. Rates of early syphilis (i.e., primary, secondary, and early latent syphilis)
18 diagnoses nearly tripled from 6.2 cases per 100,000 people in 2010 to 21.1 cases in 2017, with a
19 sharp 57% increase between 2015 and 2016. HIV/AIDS is another serious public health concern
20 in the County. In 2015, there were 2,734 people living with HIV/AIDS in the County, and in
21 2017, that number had risen to 3,361 people living with HIV/AIDS in the County. Any
22 requirements that obstruct patient access to treatment are likely to exacerbate these serious public
23 health problems and thus increase the burden on the County to address and prevent the spread of
24 these infections.

25 10. Public Health's STD/HIV Prevention and Control program distributes free
26 condoms at its clinical sites and through outreach events to the community. If Public Health were
27 unable to require advance notice of religious objections or reassign objecting employees, an
28 employee who has a religious objection to contraceptives or premarital sex could refuse to

participate in and seriously undermine this program. Decreased access to, and education about, contraception is likely to increase unintended pregnancies, triggering immediate and long-term costs to the County and communities nationwide. As the safety-net healthcare provider, the County funds many of the medical services associated with preventing and treating both STIs and unintended pregnancies, which disproportionately affect young, low-income, minority women, without access to higher education, who are likely to rely on County-funded services. The County is also burdened by the long-term costs of unplanned pregnancies, which can limit individuals' ability to succeed in education and the workplace and to contribute as taxpayers and citizens.

11. The Public Health Department depends heavily upon federal funding from the U.S. Department of Health and Human Services. The elimination of this federal funding would be devastating for the residents of Santa Clara County. It would result in a drastic reduction of services and staff positions in Public Health Department programs providing direct services to clients, as well as other programs integral to protecting and promoting public health. Vulnerable communities would be most severely impacted by a loss of federal funding to the Public Health Department.

12. In the County's 2018-19 fiscal year, from July 1, 2018 through June 30, 2019, the Public Health Department's total gross expenditures amounted to approximately $118.7 million. Total revenues from federal funds in the 2018-19 fiscal year amounted to approximately $33.7 million, or more than a quarter of the Department's gross expenditures. Most of these federal funds pass through the State of California to the County.

13. Federal funding is critical to many of the Public Health Department's programs that address infectious diseases. The Public Health Department is responsible for safeguarding the public health by preventing and controlling the spread of infectious diseases and planning for and responding to public health emergencies. Programs in this branch of the Public Health Department receive reports on 85 different diseases and conditions; track overall trends in infectious diseases; investigate individual cases of concern; provide long-term case management for certain categories of patients (e.g., active tuberculosis cases); provide immunizations and

1 preventive therapy; identify, investigate and control outbreaks; and plan for and respond to public
2 health emergencies. They also ensure that all children attending school or childcare facilities in
3 Santa Clara County comply with State immunization requirements; conduct HIV and other STI
4 testing and education for vulnerable communities; and distribute opioid overdose prevention kits
5 for at-risk individuals. To support its communicable disease control function, the Public Health
6 Department has a public health laboratory, which serves as a local and regional resource which
7 local health providers, clinics, hospitals, and even law enforcement rely on to test and identify
8 infectious diseases, toxins, biohazards, and other substances that could pose a serious risk to
9 public health. This branch of the Public Health Department also includes two pharmacies.
10 14. For example, in Fiscal Year 2018-19, Public Health Department programs
11 supported by federal funding included the following:
12 a. Under the federal government's Ryan White HIV/AIDS Program, the
13 County received $4.4 million in funds to provide core medical services and support services to
14 low-income individuals living with HIV/AIDS in the County. The majority of this $4.4 million
15 consists of federal funds, with state funds comprising the remainder. The funded services include
16 drugs provided to uninsured and underinsured HIV/AIDS patients enrolled in the AIDS Drug
17 Assistance Program. The recipients are patients who are at or below 500% of the Federal Poverty
18 Level and do not qualify for no-cost Medi-Cal. In calendar year 2018, there were 1,782 Ryan
19 White-funded clients in Santa Clara County—slightly more than half (52%) of all the persons
20 living with HIV/AIDS in Santa Clara County.
21 b. The Public Health Department received approximately $1.7 million in
22 federal financial assistance, including an Immunization Local Assistance Grant, to support its
23 immunization programs and its Tuberculosis (TB) Prevention and Control Program, which
24 provides TB immunizations and testing and investigates all reports of persons with suspected or
25 confirmed TB disease. There were 169 cases of TB reported in Santa Clara County in 2018.
26 c. Through the National Hospital Preparedness Program and Public Health
27 Emergency Preparedness Cooperative Agreement Programs, the Public Health Department has
28 received $2.2 million in federal funding to prepare for emergencies, such as natural disasters,

mass casualties, biological and chemical threats, radiation emergencies and terrorist attacks.

15. Further, in the area of maternal, child, and family health, the Public Health Department provides services for Santa Clara County's most vulnerable children and families. The following are some of the Public Health Department's federally funded programs in this area:

a. The California Children's Services (CCS) program provides diagnostic and treatment services, medical case management, and medically necessary physical and occupational therapy services to children under 21 years of age with CCS-eligible medical conditions, such as cystic fibrosis, hemophilia, cerebral palsy, muscular dystrophy, spina bifida, heart disease, cancer, and traumatic injuries. The CCS program serves well over 5,000 children each year, and in Fiscal Year 2018-2019, it received $5.8 million in federal funds, not including payments from Medi-Cal.

b. The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) program safeguards the health of low-income pregnant, postpartum, and breastfeeding women, infants, and children up to age 5 who are at nutritional risk by providing nutritious foods to supplement diets, information on healthy eating, breastfeeding promotion and support, and referrals to health care. The program has a caseload of nearly 16,000 individuals each month, and it received $4.2 million in federal funds in Fiscal Year 2018-2019.

c. The Child Health and Disability Prevention (CHDP) Program, which received $1.7 million in federal funds in Fiscal Year 2018-2019, ensures that low-income children and youth receive routine health assessments and treatment services. Within the CHDP Health Care Program for Children in Foster Care (HCPCFC) Program, public health nurses provide care coordination for foster care youth to ensure that their medical, dental, mental health, and developmental needs are met.

d. The Public Health Nursing Home Visitation program, which received $1.7 million in federal funds (Targeted case management) in Fiscal Year 2018-2019, provides case management services to Medi-Cal beneficiaries in specific target populations to gain access to needed medical, social, educational, and other services.

e. The Childhood Lead Poisoning Prevention Program, which received approximately $50,577 in federal funds in Fiscal Year 2018-2019, provides nursing and

1 environmental case management and follow-up for lead-poisoned children, promotes screening
2 for lead poisoning, and provides community education regarding lead poisoning prevention.
3 16. To create and maintain healthy communities, the Department conducts localized
4 health assessments and planning throughout Santa Clara County, and works with community
5 partners and County leadership to promote system-wide and environmental changes to reduce the
6 incidence of chronic diseases and injuries in Santa Clara County. In Fiscal Year 2018-2019, the
7 chronic disease and injury prevention unit received $1.7 million in federal funds to provide
8 nutrition education and obesity prevention activities and interventions for low-income
9 Californians for primary prevention of nutrition-related chronic disease.
10 17. In addition to the programs described above, the Public Health Department
11 received $3.9 million in Medi-Cal payments and $2.7 million in Medicare payments in Fiscal
12 Year 2018-2019 for health care provided to patients with Medi-Cal or Medicare coverage. The
13 payments from Medicare, which is the federal health insurance program for elderly and disabled
14 individuals, consist entirely of federal funds. Medi-Cal is financed by the State and federal
15 governments, and the Medi- Cal payments therefore contain a mixture of State and federal funds.
16 Although the apportionment of the funding is not readily known to the County, the Medi-Cal
17 payments are dependent on receipt of federal funding from Medicaid, the federal health insurance
18 program for low-income individuals.
19 18. The Public Health Department relies on continual receipt of comparable federal
20 funding from the U.S. Department of Health and Human Services annually, with anticipated
21 increases in line with future increases in the population of the County.
22 19. Many, if not most, of the individuals served through the Public Health
23 Department's various programs simply would not get the care and resources that they need
24 without federally funded services. For example, without federal funding for WIC, thousands
25 more women would not have the appropriate nutrition to ensure healthy pregnancies, healthy
26 birth outcomes, and healthy children, and thousands more children would suffer from poor
27 nutrition. This would impact not only their immediate health but also their developmental
28 readiness for kindergarten and chances for future health and success in life. As another example,

1 loss of funding for CCS would result in reduced therapy and other necessary services for
2 thousands of medically fragile and disabled children with expensive and complicated medical
3 conditions. And as yet another example, loss of funding for clients with HIV/AIDS would mean
4 that hundreds of low-income, chronically ill individuals in our community would not receive the
5 health care, drugs, and other essential services they need to survive and enjoy a reasonable quality
6 of life. Patients with HIV infection who are not adequately treated are also at greater risk of
7 spreading HIV to others. The fees the STI clinic collects do not cover the costs of providing STI-
8 related services, and if the Department's budget loses federal funding, we would not be able to
9 continue with the same level of services going forward.

10 20. The impact of any loss in federal funding would not be limited to services
11 traditionally funded by federal dollars. A withdrawal of federal funding for the County would
12 require a countywide realignment of funding and priorities, and money that is currently allocated
13 to the Public Health Department from the County's General Fund could be reduced to make up
14 for a loss of federal funds in other departments. A loss of federal funding, combined with a
15 reduction in the General Fund allocation for the Public Health Department, would require the
16 Public Health Department to make difficult decisions about how to reallocate its remaining funds,
17 which communities to prioritize, and which diseases and health conditions to focus on at the
18 expense of others. Rather than being in a position to create and implement proactive strategies to
19 promote health and prevent disease, the Public Health Department would almost certainly be
20 forced into focusing on reactive services designed to address public health crises (e.g.,
21 communicable disease control), services that the Public Health Department and Health Officer are
22 mandated by law to provide (e.g., birth and death registration), and a modicum of services for the
23 neediest populations.

24 21. A withdrawal of federal funding would compromise the Public Health
25 Department's ability to prevent public health emergencies and outbreaks, to prevent chronic
26 diseases, to provide equal opportunity to vulnerable children for a healthy start and optimal
27 health, and to foster healthy families and healthy communities.

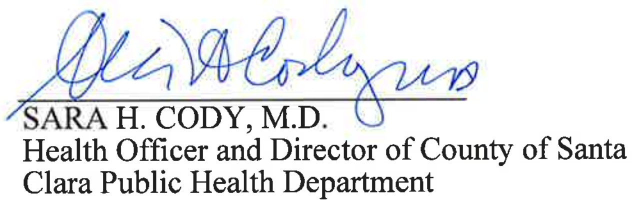
28 22. A sustained loss of federal funding to the County would ultimately result in a far

1 sicker and less healthy community overall and for generations to come. The collateral costs
2 would be many: greater health care costs for individuals, their families, their employers, and for
3 the County itself, which is mandated by law to provide health care to the medically indigent. In
4 addition, I am familiar with a wide body of studies and literature showing that an increase in
5 incidents of sickness and illness can result in financial instability for families, a less productive
6 workforce, and poorer educational and economic outcomes for children.

7 I declare under penalty of perjury under the laws of the United States of America that the
8 foregoing is true and correct.

9 Executed on September 9, 2019 in San José, California.

10



11 SARA H. CODY, M.D.
12 Health Officer and Director of County of Santa Clara Public Health Department

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

| | |
|---|---|
| CITY AND COUNTY OF SAN FRANCISCO,<br>Plaintiff,<br>vs.<br>ALEX M. AZAR II, et al.,<br>Defendants. | No. C 19-02405 WHA<br>*Related to*<br>No. C 19-02769 WHA<br>No. C 19-02916 WHA |
| STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,<br>Plaintiff,<br>vs.<br>ALEX M. AZAR, et al.,<br>Defendants. | **DECLARATION OF DR. GRANT COLFAX IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT**<br><br>Date: October 30, 2019<br>Time: 8:00 AM<br>Courtroom: 12<br>Judge: Hon. William H. Alsup<br>Action Filed: 5/2/2019 |
| COUNTY OF SANTA CLARA et al,<br>Plaintiffs,<br>vs.<br>U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,<br>Defendants. | |

1 I, Dr. Grant Colfax, declare as follows:

2 1. I have personal knowledge of the facts set forth in this declaration and, if called as
3 a witness, could and would testify competently to the matters set forth below.

4 2. I am Director of the San Francisco Department of Public Health ("SFDPH"). I
5 have served in this position since February 2019.

6 3. Prior to becoming Director of SFDPH, I served as director of Marin County's
7 Department of Health and Human Services for nearly four years. Prior to that, I worked as
8 Director of HIV Prevention and Research at SFDPH, and as the Director of the Office of National
9 AIDS Policy at the White House. I attended Harvard College and Harvard Medical School, and
10 completed my residency at University of California, San Francisco.

11 4. The mission of SFDPH is to protect and promote health and well-being for all in
12 San Francisco. SFDPH is dedicated to reducing health inequities and providing inclusive care to
13 *all* patients.

14 5. For example, SFDPH established Gender Health SF to provide access to
15 transgender surgeries and related education and preparation services to eligible transgender adult
16 residents. Currently, SFDPH also provides a range of health services to transgender residents such
17 as primary care, prevention, behavioral health, hormone therapy, specialty, and inpatient care.

18 6. SFDPH strives to achieve its mission through the work of two main branches—the
19 Population Health Division and the San Francisco Health Network.

20 7. **San Francisco Health Network:** Through the San Francisco Health Network
21 ("SFHN"), SFDPH administers a complete heath care system including primary care for all ages,
22 dental care, emergency and trauma treatment, medical and surgical specialties, diagnostic testing,
23 skilled nursing and rehabilitation, and behavioral health to residents of San Francisco, and within
24 the county jail system.

25 8. SFHN includes two hospitals: Zuckerberg San Francisco General Hospital
26 ("ZSFG") and Laguna Honda Hospital.

27 9. ZSFG is a licensed general acute care hospital and trauma center owned and
28 operated by the City and County of San Francisco. ZSFG delivers over one thousand babies a

year, has been at the forefront of HIV/AIDS care from the beginning of the AIDS crisis, and provides inpatient medical and psychiatric treatment. ZSFG also routinely provides both first- and second-trimester abortion care at the Women's Options Center.

10. The hospital provides care for approximately one in eight San Franciscans a year, regardless of their ability to pay. As the City's safety net hospital, ZSFG provides the highest-quality services, including to many patients covered through Medi-Cal (California's Medicaid program). As the only level one trauma center serving a region of more than 1.5 million people, it provides life-saving emergency care to individuals and victims of mass tragedies like airplane crashes and natural disasters. With the busiest emergency room in San Francisco, ZSFG receives one-third of all ambulances in the City, and treats nearly four thousand patients with traumatic injuries, annually. ZSFG's emergency department regularly treats people experiencing ectopic pregnancies and other emergent complications from pregnancy whose treatment may necessarily result in the termination of the pregnancy. ZSFG's emergency department also regularly treats rape victims, and its rape protocol requires offering the patient emergency contraception, consistent with the medical standard of care. Many of ZSFG's programs focus on providing life-saving care in emergency situations.

11. Laguna Honda Hospital provides a full range of skilled nursing services to adult residents of San Francisco who are disabled or chronically ill, including specialized care for those with chronic wounds, head trauma, stroke, spinal cord and orthopedic injuries, HIV/AIDS, and dementia.

12. In addition to these two hospitals, SFHN includes fourteen clinics throughout the community where patients can access health care services, including primary care, pediatric care, vaccinations, phlebotomy, asthma care, cardiology, HIV prevention and treatment services, dermatology, physicals, dental care, cancer care, family planning, and prenatal care.

13. The Maternal, Child and Adolescent Health ("MCAH") Section of SFDPH also offers a wide range of services to patients through SFHN. MCAH focuses on the most vulnerable children and families, filling what would otherwise be a serious public health gap. Its aim is to

1 reduce health disparities and improve health outcomes by strengthening the public health systems
2 and services that address the root causes of poor health.

3 14. Behavioral Health Services ("BHS") is also part of the comprehensive SFHN.
4 BHS operates the County Mental Health Plan and provides San Franciscans with a robust array of
5 services to address mental health and substance use disorder treatment needs. Treatment services
6 include: early intervention/prevention; outpatient treatment (including integrated medical and
7 behavioral health services); residential treatment; and crisis programs.

8 15. The Transitions Division of SFHN serves severely mentally ill individuals who
9 have multiple complex characteristics—including mental health issues, being medically
10 compromised, and those with cognitive impairments.

11 16. The Managed Care Section oversees the contracts under which the SFHN provides
12 medical and mental health care to members of managed care programs including those operated
13 by the San Francisco Health Plan, which is the government entity that administers the Medi-Cal
14 managed care plan for the City and County of San Francisco, and by private insurance plans.

15 17. SFHN is also the lead entity in the Whole Person Care Pilot designed by the State
16 of California to serve the multiple medical and mental health care needs of adults experiencing
17 homelessness and high users of multiple systems.

18 18. **Population Health Division**: SFDPH also includes a Population Health Division
19 ("PHD"). This division addresses public health concerns, including consumer safety, health
20 promotion and disease prevention, and the monitoring of threats to the public's health.

21 19. PHD consists of ten integrated branches that work together to assess and monitor
22 the health status of San Francisco and implement traditional and innovative public health
23 interventions. For example:

24 - Applied Research, Community Health Epidemiology, and Surveillance coordinates data
25 collection, processing, management, analysis and interpretation related to health and
26 morbidity in San Francisco.
27 - Bridge HIV is a global leader in HIV prevention, research, and education. Operating as a
28 clinical trials unit within SFDPH, Bridge HIV conducts innovative research that guides

global approaches in HIV prevention. The Department's contributions in the early fight against HIV/AIDS has made it a trusted and renowned resource for understanding HIV infection and disease.

- Community Health Equity and Promotion includes the core public health functions of informing, educating and supporting communities. Through the use of comprehensive approaches across the spectrum of prevention, the Branch plans, implements, and evaluates prioritized community initiatives, including promoting active living, preventing HIV, other sexually transmitted infections, viral hepatitis, and the effects of trauma.
- Disease Prevention and Control integrates core public health communicable disease functions, along with specialty care and treatment, and laboratory diagnostics. It is responsible for interacting with SFDPH health delivery systems in order to coordinate and maximize disease screening and other prevention activities in primary care and the hospitals.
- And Emergency Medical Services Agency ("EMS") manages and prepares for all types of medical emergencies in San Francisco. Among other things, they direct, plan, monitor, evaluate, and regulate the San Francisco EMS System in collaboration with system and community providers.

20. I am familiar with the new U.S. Department of Health and Human Services ("HHS") regulations entitled, "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority" (the "Final Rule").

21. The Final Rule puts SFDPH to an impossible choice.

22. If the Final Rule goes into effect and SFDPH is required to comply with it, SFDPH's mission to protect and promote health and well-being for *all* people in San Francisco will be undermined. Based on my years of experience in the public health field, including as a practicing physician, I expect that patients will delay seeking medical care based on fear of being discriminated against or mistreated in healthcare facilities. Delays in seeking care lead to worse individual and public health outcomes as well as higher costs to the healthcare system. In

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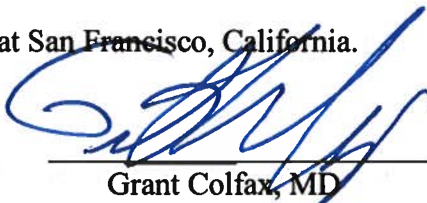
addition, If SFDPH cannot involuntarily transfer personnel who refuse to perform their job duties—like receptionists or schedulers who refuse to schedule patients for medically necessary services—our hospitals and clinics will not be able to function efficiently, significantly compromising patient care for everyone.

23. On the other hand, if SFDPH refuses to comply with the Final Rule and HHS terminates funding to SFDPH, the result would be catastrophic. Virtually all of the services and programs discussed above would be impacted. SFDPH would have to restructure the entire public health system with a drastic reduction in services. Hospital beds, behavioral health clinics, primary care clinics, and emergency services would all have to be significantly reduced. Hundreds of employees would likely lose their jobs. People in need of urgent and emergent health care might not be able to receive timely services, and could die as a result. In the event of an earthquake or other catastrophic event, the health and safety of the entire region could be compromised. In short, termination of all HHS funds would cause a loss of critical health care capacity for San Francisco and the region.

I declare under penalty of perjury that the foregoing is true and correct and that this declaration was executed on September 9, at San Francisco, California.



Grant Colfax, MD

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*CITY AND COUNTY OF SAN* FRANCISCO

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

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| CITY AND COUNTY OF SAN FRANCISCO,<br>Plaintiff,<br>vs.<br>ALEX M. AZAR II, et al.,<br>Defendants. | No. C 19-02405 WHA<br>*Related to*<br>No. C 19-02769 WHA<br>No. C 19-02916 WHA |
| STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,<br>Plaintiff,<br>vs.<br>ALEX M. AZAR, et al.,<br>Defendants. | **DECLARATION OF DR. CHRISTOPHER COLWELL IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT**<br><br>Date: October 30, 2019<br>Time: 8:00 AM<br>Courtroom: 12<br>Judge: Hon. William H. Alsup<br>Action Filed: 5/2/2019 |
| COUNTY OF SANTA CLARA et al,<br>Plaintiffs,<br>vs.<br>U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,<br>Defendants. | |

I, Dr. Christopher Colwell, declare as follows:

1. I have personal knowledge of the facts set forth in this declaration and, if called as a witness, could and would testify competently to the matters set forth below.

2. I am Chief of Emergency Medicine at Zuckerberg San Francisco General Hospital and Trauma Center ("ZSFG"). I have served in that position since July 1, 2016. In this capacity, I oversee all emergency service operations for the City and County of San Francisco ("San Francisco" or "City"), including the Emergency Department at ZSFG.

3. Prior to coming to ZSFG, I was chief of the Department of Emergency Medicine at Denver Health and professor and executive vice chair of the Department of Emergency Medicine at University of Colorado School of Medicine. I have been an emergency physician for 24 years and have published more than 100 manuscripts or book chapters in the areas of prehospital, emergency and trauma care. I received my Bachelor of Science degree from University of Michigan and my medical doctorate from Dartmouth Medical School. I completed residency training in emergency medicine at Denver Health where I served as chief resident. I am a fellow of the American College of Emergency Physicians.

4. ZSFG is the only trauma center in San Francisco. In addition, ZSFG is the provider of trauma care for the northern portion of San Mateo County and thus has a service area of 1.5 million people. It has the highest trauma center designation (Level 1) which increases a seriously injured patient's chances of survival by an estimated 20-25%. The ZSFG trauma team serves nearly 4,000 adults & children annually for traumatic injuries.

5. Pursuant to ZSFG Administrative Policy 5.15, if a staff member in the ZSFG Emergency Department requests not to participate in an aspect of patient care because doing so would conflict with the person's religious or moral beliefs, the Department will honor that request as long as it does not negatively affect the quality of patient care. Importantly, however, if the immediate nature of the patient's needs do not allow for a substitution of personnel, individuals are required to perform their duties unless and until other competent personnel can be provided.

6. If individuals could categorically refuse to assist with a critical procedure—and suffer no repercussions—patients would suffer.

7. Every day, patients present in the ZSFG emergency room with life threatening conditions. Many times every month, those conditions involve serious complications relating to pregnancy or a sexually transmitted disease/infection. A team member opting out of those patients' treatment would put their health—and even lives—at serious risk.

8. Within the last few weeks, I was personally involved in the treatment of a healthy young woman who had bled substantially into her abdomen due to an ectopic pregnancy. Her condition was critical. If a member of the team responsible for her care had opted out of her treatment for any reason, the woman would have died before other competent personnel could have been substituted in.

9. Similarly, I was involved in the treatment of a young woman who was septic and hypotensive due to pelvic inflammatory disease resulting from a sexually transmitted disease. The patient required immediate treatment. If a member of the team responsible for her care had opted out of her treatment for any reason, the woman might have died.

10. Put simply, emergency medical teams cannot do our jobs and save people's lives if there is an option for team members to opt-out of providing emergency care.

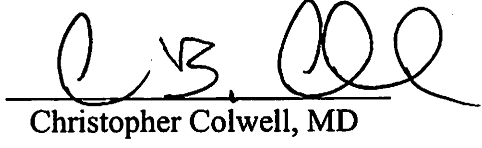
11. If San Francisco's Health and Human Services ("HHS") funding were terminated, the results for the healthcare system in San Francisco would be catastrophic.

12. Because the vast majority of its funding comes from HHS, the ZSFG Emergency Department would likely be forced to close within months. I believe it would reasonably take more than three years for another hospital to build the necessary infrastructure and obtain the required verifications to open a similar program.

13. In the interim, other local hospitals would not be able to cover the increase in demand for emergency care. Accordingly, there would be no place in the region for patients with severe trauma to be treated. Patient care for individuals with major injuries like gun-shot wounds, stab wounds, severe blunt trauma, traumatic car crash injuries, and traumatic brain injuries would be severely compromised and more of these individuals would die.

14. In addition, the ZSFG Emergency Department personnel treat a wide range of non-traumatic complaints for a predominantly underserved, urban population. ZSFG is the primary

1 provider of psychiatric emergency care in the City. Accordingly, closure of the Department
2 would mean that thousands of people would lose access to medical care and individuals suffering
3 psychiatric emergencies would have no place to be treated.
4
5 I declare under penalty of perjury that the foregoing is true and correct and that this
6 declaration was executed on September 9, at San Francisco, California.
7



8 Christopher Colwell, MD
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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CITY AND COUNTY OF SAN FRANCISCO,
Plaintiff,
vs.
ALEX M. AZAR II, et al.,
Defendants.

STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,
Plaintiff,
vs.
ALEX M. AZAR, et al.,
Defendants.

COUNTY OF SANTA CLARA et al,
Plaintiffs,
vs.
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,
Defendants.

No. C 19-02405 WHA
*Related to*
No. C 19-02769 WHA
No. C 19-02916 WHA

**DECLARATION OF DARREL CUMMINGS, CHIEF OF STAFF OF THE LOS ANGELES LGBT CENTER, IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT**

| | |
|---|---|
| Date: | October 30, 2019 |
| Time: | 8:00 AM |
| Courtroom: | 12 |
| Judge: | Hon. William H. Alsup |
| Action Filed: | 5/2/2019 |

1 I, Darrel Cummings, hereby state as follows:

2 1. I am currently the Chief of Staff of the Los Angeles LGBT Center ("the Center"), a not-
3 for-profit 501(c)(3) organization based in Los Angeles, California, that provides a variety of
4 services to members of the lesbian, gay, bisexual, and transgender ("LGBT") communities. I have
5 served in that capacity since 2003, and also previously served as Chief of Staff from 1993 through
6 1999. More broadly, I have been an advocate on LGBT issues since 1979. I submit this declaration
7 in support of Plaintiffs' Motion for Summary Judgment and in support of their opposition to
8 Defendants' Motion to Dismiss or, in the alternative, for Summary Judgment.

9 2. The Center was founded in 1969 and offers programs, services, and global advocacy
10 that span four broad categories: health, social services and housing, culture and education, and
11 leadership and advocacy. The mission of the Center is to fight bigotry and build a world where
12 LGBT people thrive as healthy, equal, and complete members of society. Today the Center's more
13 than 650 employees provide services for more LGBT people than any other organization in the
14 world, with about 500,000 client visits per year.

15 3. As the largest provider of services to LGBT people in the world, many of the Center's
16 patients tell us that they come to the Center seeking culturally competent healthcare due to being
17 denied care or discriminated against based on their real or perceived sexual orientation, gender
18 identity and HIV status. The Center's client population is disproportionately low-income and
19 experiences high rates of chronic physical and mental conditions, homelessness, unstable housing,
20 trauma and discrimination, and stigmatization in healthcare services. Many of these clients come
21 to the Center from different areas of California, other states, and even other nations to seek services
22 in a safe and affirming environment.

23 4. The Center is one of the nation's largest and most experienced providers of LGBT health
24 and mental healthcare. We accept a variety of health insurance plans, including Medi-Cal
25 (California's Medicaid program), Medicare, and most private insurance plans. We also provide
26 services to uninsured individuals. We work with these individuals to help them access insurance
27 through Covered California (California's Affordable Care Act "exchange"), and/or navigate other
28 medical- and drug-assistance programs. Where insurance is not available, our services are offered

on a sliding-scale basis, based on ability to pay. We pride ourselves on providing leading-edge healthcare, regardless of individuals' ability to pay.

5. The Center receives various forms of Health and Human Services funding, including Public Health Service Act funding. Approximately 80 percent of the Center's funding originates from the federal government, including, but not limited to, funding under the Ryan White Comprehensive AIDS Resources Emergency Act of 1990, direct funding from the Centers for Disease Control and Prevention, discounts under the 340B Drug Discount Program, and Medicaid and Medicare reimbursements. The Center also receives federal funding for research programs, and is currently a participant in multiple federally-funded studies, including through National Heart, Lung, and Blood Institute; National Institute of Allergy and Infectious Diseases; National Institute of Child Health and Human Development; the National Institutes of Health, National Institute of Drug Abuse, and the Patient-Centered Outcomes Research Institute. The Center is, therefore, subject to the substantive requirements of the Denial-of-Care Rule and has a reasonable fear that it could be at risk of sanction and loss of federal funding as a result of the Denial-of-Care Rule.

6. As a federally qualified health center, the Center is required to serve anyone on a nondiscriminatory basis who walks into its doors. The Denial-of-Care Rule's vague language makes it difficult for the Center to decipher how to proceed in light of contradictions between the Denial-of-Care Rule on the one hand and, on the other hand, nondiscrimination requirements, medical statutes, rules, standards of care, ethics requirements, and accreditation standards. The Denial-of-Care Rule invites chaos within the Center, will consume the Center's resources, and will make it more difficult for the Center to provide the same level of premier care to its patients. The Center cannot function in such an environment.

7. The Center provides a wide spectrum of healthcare services, including, but not limited to, HIV treatment, testing, and prevention care, as well as treatment for gender dysphoria and mental healthcare. The Center has medical providers who specialize in the care of transgender patients and who provide a full range of primary care services in addition to hormone therapy, pre- and post-surgical care, and trans-sensitive pap smears, pelvic exams, and prostate exams. The

1 Center's broad array of healthcare services are all under one roof, from counseling and therapy to
2 pharmaceutical and nutrition needs.

3 8. The Denial-of-Care Rule will worsen health disparities between the LGBT community
4 and other communities. With existing health and healthcare disparities in the LGBT community –
5 particularly the shortage of LGBT/HIV culturally competent providers – the Denial-of-Care Rule's
6 broad and vague language and invitation to providers to engage in discrimination will further
7 exacerbate existing barriers to healthcare and result in negative community health outcomes.

8 9. For example, the Center's providers have observed patients arriving at the Center with
9 acute medical conditions that could have been avoided but-for the patients' reluctance to seek
10 routine and necessary medical care for fear of discrimination and being turned away. A shocking
11 number of LGBT patients fear going to a healthcare provider due to negative past experiences
12 directly related to their sexual orientation or gender identity. The Denial-of-Care Rule will
13 exacerbate those numbers as a result of increased discrimination and denials of healthcare
14 treatment. For similar reasons, LGBT people are less likely to have a primary care provider whom
15 they consider their personal doctor. That means that in times of need, LGBT people are more likely
16 to randomly select a healthcare provider with whom they do not have a relationship, and they are
17 at increased risk of finding a provider who is not LGBT-affirming. With an increase in refusals of
18 healthcare services as a result of the Denial-of-Care Rule, LGBT people will be far less likely to
19 receive the healthcare treatment that they need because, after being turned away, they are unlikely
20 to seek other care out of fear of repeated rejections.

21 10. This directly affects the Center because there will be an increase in community members
22 seeking referrals to LGBT-affirming services that the Center does not have sufficient resources to
23 provide, an increase in community members experiencing the trauma of discriminatory or
24 unwelcoming healthcare experiences, and worsened community health outcomes among the
25 population that the Center serves. Additionally, the Center will have to expend more resources on
26 its health promotion campaigns to ensure that LGBT patients access necessary preventative
27 screenings and testing (including for cancer, HIV and other STIs) given that the Denial-of-Care
28 Rule will change the healthcare landscape for the LGBT patient population.

1 11. For some patients that the Center serves, especially those who live in regions with
2 limited options for LGBT-affirming healthcare services, finding LGBT-inclusive healthcare
3 options is already a struggle. Additionally, for some medical specialties, there are only a handful
4 of healthcare providers in a patient's region who have the specialty necessary to treat the patient,
5 so a denial of care by even one provider could make it practically impossible for an LGBT patient
6 to receive the specific healthcare service sought. This is even more concerning in regions where
7 patients' only options are religiously-affiliated organizations that could claim religious or moral-
8 based objections to providing any and all care to LGBT patients as a result of the Denial-of-Care
9 Rule, in contradiction to medical ethics and standards of care.

10 12. The Denial-of-Care Rule's overly broad language invites increased discrimination
11 against LGBT people and people living with HIV at other healthcare centers, outside of the Center.
12 The Center's healthcare providers – particularly its counselors, psychiatrists and other behavioral-
13 health staff – have treated many patients who have experienced traumatic stigma and discrimination
14 based on sexual orientation, gender identity, HIV status, and/or other factors. The stories that
15 patients tell the Center's staff about their discriminatory experiences outside of the Center include:

16 a. One transgender patient was unable to find supportive mental-health housing
17 due to discriminatory experiences based on gender identity, which led to the
18 patient being homeless.

19 b. Another transgender patient, who developed profuse bleeding after surgery,
20 was denied treatment at an emergency room where they were told by an
21 emergency room doctor: "what do you want me to do about it?" They arrived
22 at the Center in distress three days later, having lost a significant amount of
23 blood.

24 c. A transgender patient needed to have a pelvic exam. The Center referred
25 him to a specialist who denied services to him because he was transgender.

26 d. Patients have stated that their physicians told them that they do not need HIV
27 testing because they are not engaging in same-sex sexual relationships. Not
28 only is that conclusion contrary to medical guidelines, but when patients

refuted assumptions about their sexual relationships, they were met with disapproval.

e. Patients have expressed concern about traveling outside of Los Angeles for business because if they are ever in need of emergency medical assistance, they will not know where to go to ensure that they will receive nondiscriminatory, proper healthcare services.

f. One patient recalled that when her late partner was in the hospital, she was there most of the time to care for her. There was a nurse who treated them kindly and appropriately until the nurse heard them refer to each other by "Honey." The look on the nurse's face changed and she treated the couple "like trash" after that. The patient remarked that allowing healthcare employees (everyone from those working in food service and housekeeping to physicians and nurses) to express their religious or moral views when providing care to patients results in placing LGBT patients in a "lesser-than" category of patients.

g. Patients residing at assisted-living facilities have described discrimination and denials of care when their sexual orientation, gender identities, and HIV statuses were revealed. Patients who are transgender have described having to hide their gender identities and transgender status once they are no longer able to care for themselves and are required to find assisted-living arrangements.

h. Patients have described being intentionally referred to by names and pronouns other than their preferred names while seeking healthcare services elsewhere.

i. A patient described being given his positive HIV results by way of his provider placing a lab printout on the counter then leaving for 10 minutes and letting the patient read it. The patient was not given any further information, and was instead told to go to our Center.

j. Patients have reported that their primary care physicians do not feel comfortable prescribing HIV preventatives, such as Truvada for PrEP, even when such medications are appropriate and should be provided according to current medical guidelines and standards of care. Patients also have reported that their physicians shame them for requesting PrEP medications and then deny them the medication, which is how they find their way to the Center. For example, when one patient asked his provider about Truvada, his physician questioned him as to why he needed it and proceeded to tell the patient that he would not need the medication if he were more careful. Another patient was denied PrEP altogether and lectured that he did not need PrEP unless he was having sex with sex workers.

k. Patients also have expressed reluctance to use their insurance for PrEP because they are afraid of having the drug documented on their insurance record. These patients fear that a history of using a medically necessary HIV preventative could be used against them in the future by making them targets for discrimination based on sexual orientation, gender identity and/or transgender status, and HIV status, given the current political climate and discrimination in the healthcare context.

l. A significant number of patients come to the Center's Sexual Health and Education Program for testing and sexual education rather than their primary care physicians because they do not feel comfortable talking about their sexual histories and choices out of fear of being treated negatively, judgmentally, and with bias and discrimination.

m. Multiple patients have stated that they come to the Center to be tested for sexually transmitted infections because the Center does rectal and throat swabs instead of only urine tests. Not all healthcare providers do all three forms of testing even though three-site testing provides the most accurate results for testing and treating sexually transmitted infections. This is

especially true for gay men. Someone could test negative for a sexually transmitted infection with a urine test, for example, but test positive with a rectal swab. Patients report that when they specifically asked their outside provider to do rectal swabs, they were judged. When patients are judged by their physicians and/or cannot be out to their physicians about their sexual orientation and/or gender identity out of fear of discrimination, LGBT patients cannot receive the healthcare services that they need, including prophylactic treatments, and may experience delays in medically necessary treatments, resulting in more acute, life-threatening conditions.

13. Many of the Center's patients and LGBT people in general have reported that they are not out to their other medical providers about their sexual orientation and/or gender identities out of fear of discrimination and denial of healthcare. The discriminatory mischaracterization of transgender-affirming care as "sterilization" in the preamble to the Denial-of-Care Rule will result in an increase in the examples of discrimination cited above. For many transgender individuals, gender confirmation surgery is a treatment for gender dysphoria and is not a surgery meant to affect reproduction, just as a hysterectomy on a cancer patient is not intended to affect procreation. While impacts on reproduction may be an incidental effect of some transgender-affirming care, such treatment is *not* "sterilization."

14. The Denial-of-Care Rule invites further discrimination justified by religious or moral beliefs against the Center's patients and puts the health of LGBT patients at risk. The Rule encourages LGBT patients to attempt to hide their LGBT identities when seeking healthcare services, especially from religiously-affiliated healthcare organizations, in order to avoid discrimination. When patients are unwilling to disclose their sexual orientation and/or gender identity to healthcare providers out of fear of discrimination and being refused treatment, their mental and physical health is critically compromised.

15. The Denial-of-Care Rule also adversely impacts the Center by necessitating the diversion and reallocation of resources in order to provide referrals to patients, including for patients that the Center does not have the resources to treat because of increased demand for the

Center's services as a result of the Rule. The Denial-of-Care Rule will cause an increased number of LGBT patients and patients living with HIV to seek the Center's assistance in finding LGBT-affirming healthcare providers. The Center will also have more difficulty finding LGBT-affirming healthcare providers, especially those with niche specialties, given that the Rule emboldens healthcare providers to refuse to treat LGBT patients.

16. The increase in referral requests requires the Center to allocate additional staff time to pre-screen service referrals to ensure that staff are sending patients to LGBT-affirming providers and not to providers who themselves or whose staff would cause additional harm to the Center's patients. As a result of the Denial-of-Care Rule, the Center may need to hire a case-manager to address the community's need for referrals to welcoming providers. The Center's staff and resources have already been spent engaging in advocacy, policy analysis, and services to address the ill-effects of the Denial-of-Care Rule. The Center will also have to divert resources away from other programming to conduct informational sessions about the Denial-of-Care Rule to answer patients' and staff members' questions about how the Rule will affect them and the services that the Center provides.

17. It will be increasingly difficult to determine whether job applicants will be unwilling to perform essential job functions, which is likely to undermine the Center's philosophy of fostering a diverse workforce. The Center's current recruiting process is developed to ascertain whether a job applicant will provide healthcare consistent with the Center's mission to establish a welcoming, nondiscriminatory environment for all patients and staff, without violating the law. Providing care in a non-discriminatory and inclusive manner, putting aside people's individual religious or moral beliefs, is a core part of the Center' job criteria for new applicants. If the Center can no longer inquire about whether an applicant will decide which patients to treat on the basis of religious principles that are inconsistent with the Center's mission, hiring managers will be in a complex position of trying to ascertain whether those job candidates might cause harm to patients while at the same time considering risks and requirements under the Denial-of-Care Rule. The Center cannot alter those job criteria without thwarting its mission.

18. Furthermore, if the Center is required to get the consent of religious or moral objectors to a proposed accommodation for their religious beliefs, the Center's operations will be negatively affected, resulting in potential delays in treatment, prevention, and other supportive health services to patients. Under the broad and vague language of the Denial-of-Care Rule, the Center will constantly fear the realistic possibility that any of its staff – from janitorial to cafeteria or security personnel – could discriminate against the Center's patients on the basis of religious beliefs, causing extreme harm to the Center's patients and mission. The Center will have no recourse to reassure its patients that the Center is a safe and affirming place for them to seek healthcare, which could cause irreparable damage to the Center's reputation. Likewise, implementation of the notice provision in the Denial-of-Care Rule that implicitly puts the onus on patients to request an LGBT-affirming healthcare provider who will not have a religious-based objection to treating such patients would result in immediate negative responses from clients and erode patient trust, further thwarting the Center's mission.

19. In short, the Denial-of-Care Rule makes it difficult, if not impossible, for the Center to continue providing the same level of social, mental, and physical healthcare to its patients. The Center's mission includes addressing the need for equity in healthcare for all of the Center's patients and the LGBT community generally. This mission will be frustrated by the Denial-of-Care Rule as there will be a decline in overall LGBT-patient health and public health at large.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct to the best of my knowledge.

Executed on September 4, 2019, in Los Angeles, California.

Darrel Cummings
Chief of Staff

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

| | |
|---|---|
| CITY AND COUNTY OF SAN FRANCISCO,<br>Plaintiff,<br>vs.<br>ALEX M. AZAR II, et al.,<br>Defendants. | No. C 19-02405 WHA<br>No. C 19-02769 WHA<br>No. C 19-02916 WHA |
| STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA,<br>Plaintiff,<br>vs.<br>ALEX M. AZAR, et al.,<br>Defendants. | **DECLARATION OF DR. ELEANOR DREY IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF THEIR OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, FOR SUMMARY JUDGMENT**<br><br>Date: October 30, 2019<br>Time: 8:00 AM<br>Courtroom: 12<br>Judge: Hon. William H. Alsup<br>Action Filed: 5/2/2019 |
| COUNTY OF SANTA CLARA et al,<br>Plaintiffs,<br>vs.<br>U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,<br>Defendants. | |

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I, Dr. Eleanor Drey, declare:

1. I am a resident of the State of California. I am over the age of 18 and have personal knowledge of all the facts stated herein. If called as a witness, I could and would testify competently to all the matters set forth below.

2. I earned my medical degree at Harvard Medical School. I also completed my residency in Obstetrics, Gynecology and Reproductive Sciences and a fellowship in Family Planning Clinical Care and Research at the University of California, San Francisco School of Medicine. I am licensed to practice medicine in the State of California. I am a Professor in the Department of Obstetrics, Gynecology & Reproductive Sciences at the University of California, San Francisco. My areas of interest include risk factors associated with delayed presentation for abortion, and I have published several articles on this topic, as well as other topics related to reproductive health.

3. I am currently the Medical Director of the Zuckerberg San Francisco General Hospital ("ZSFG") Women's Options Center ("Center"). I have served in this role since 2003. Before that, I served as Acting Medical Director from 2002-2003. In addition, I currently am serving as the Acting Chief of the ZSFG Obstetrics and Gynecology division.

4. The mission of the ZSFG Women's Options Center is to offer high quality, sensitive and confidential abortion services.

5. We provide both first- and second-trimester abortion care, including medication abortion, and have on-site ultrasound and interpretation services. Highly trained counselors provide individual counseling before procedures and are present to offer emotional support during abortions. We offer intravenous ("IV") sedation for first- and second-trimester abortion procedures. Because we are located within a trauma hospital, we have the resources to care safely for the most medically high-risk patients. Our experienced licensed nursing staff are present during and after all phases of procedures to provide the highest quality of care and support. Patients are offered contraceptive counseling, with all birth control methods available during their visit.

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6. The women who come to the Center for care disproportionately tend to be vulnerable individuals who have less ability to navigate complex medical systems. Many already have suffered significant setbacks in their attempts to access care before they get to our Center. Many patients come to us because they have no other option for obtaining the medical care they need. Some have limited options because of financial constraints or medical comorbidities. Others have limited options because of the nature of the care they require—the Center is one of very few providers in the area that will provide abortions up to 24 weeks and is equipped to handle medically complicated procedures.

7. I am familiar with the rule "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority," RIN 0945-AA10, issued by the U.S. Department of Health and Human Services (the Rule), published in the Federal Register on May 21, 2019.

8. The Rule creates a broad exemption to opt out of any healthcare service based on a moral or religious ground (right granted to medical provider but also to anyone with an articulable connection to the provision of that service, including helping to make arrangements for that service). Specific potentially relevant scenarios are included in the Rule: abortion, certain vaccinations if there is an "aborted fetal tissue" connection (such as rubella, Hepatitis A, varicella, or "chickenpox"), contraception, and gender transition/gender dysphoria (counseling, administering hormone prescriptions, etc.), tubal ligations, hysterectomies, and physician-assisted dying. There does not appear to be any exception provided for emergency situations under the Rule.

9. There are a number of ways that the Rule could negatively impact people's ability to receive evidence-based care. If a potential patient hoped to get an abortion or contraception or any of the other services touched upon by the Rule and a telephone receptionist or operator refused to refer the individual for those services, then the individual would be left without access or honest information. A health care institution would have no way to track how many and which patients were being denied services. The negative impact on access and health could be significant. For example, decreased access to contraception could lead to more undesired

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pregnancies, which are associated with worse maternal and child outcomes. Decreased access to abortions also has been shown to result in later abortions, which involve more risk than early abortions, which have virtually no risks or adverse health consequences.

10. If call operators or receptionists refuse to direct patients to our Center or to schedule appointments for women seeking abortions, we need to be able to transfer those individuals—involuntarily if necessary—to another position or to an area where these refusals would be less likely to occur. If those individuals cannot be transferred, patients and potential patients would, at best, be delayed in accessing care. This is highly problematic because abortion is a time-sensitive procedure; abortion's medical risks and costs increase with any delay, along with patient distress at having to delay receiving care. At worst, some patients would not be able to obtain safe abortion care at all. In such instances, I have seen women be forced to carry unwanted pregnancies to term. Tragically, I also have seen women in these circumstances take desperate measures such as throwing themselves in front of moving traffic or having their partners beat them in the abdomen to try to self-induce termination of their pregnancies.

11. The Rule also would make it difficult to work safely as a team if some of the team members were unwilling to participate. Inadequate communication and limited health care provision also could compromise safety, leading to worse patient outcomes if some staff were not communicating openly and thoroughly to others about all of the patient care that was being provided.

12. In addition, patients might not know what health care they were being restricted from receiving. For example, if a patient wanted palliative care but had a provider who insisted on aggressive resuscitation, the patient and their family would be unlikely to know about the limits to end-of-life care before being admitted to the hospital.

13. Moreover, the Rule would make it financially unsustainable to provide many services. We would be prohibited from transferring employees within a facility to another area where refusals would be less likely to occur and could have insufficient participating staff to meet the needs of our patients. For example, we could have a nurse working in our unit who refused to

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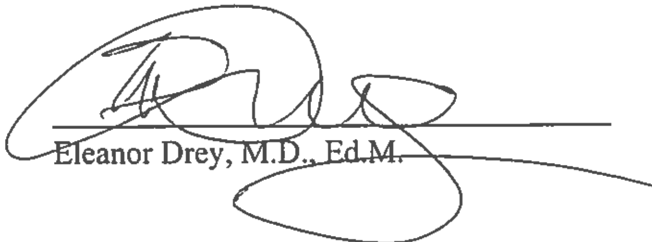
care for patients having abortions. In a setting where there are mandated nursing ratios, you then either would have to limit the number of patients seen in order the accommodate the non-participant, or you would have to hire a replacement nurse because one was refusing to care for patients. Either of these options would be financially prohibitive.

I declare under penalty of perjury under the laws of the United States and the State of California that the foregoing is true and correct to the best of my knowledge.

Executed on Sept. 11th, 2019 in San Francisco, California.



Eleanor Drey, M.D., Ed.M.