THE LIMITS OF CONSCIENTIOUS OBJECTION TO ABORTION IN THE DEVELOPING WORLD

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ABSTRACT

The South African Choice on Termination of Pregnancy Act 92 of 1996 gives women the right to voluntary abortion on request. The reality factor, however, is that five years later there are still more ‘technically illegal’ abortions than legal ones. Amongst other factors, one of the main obstacles to access to this constitutionally enshrined human right is the right to conscientious objection/refusal. Although the right to conscientious objection is also a basic human right, the case of refusal to provide abortion services on conscientious objection grounds should not be seen as absolute and inalienable, at least in the developing world. In the developed world, where referral to another service provider is for the most part accessible, a conscientious objector to abortion does not really put the abortion seeker’s life at risk. The same cannot be said in developing countries even when abortion is decriminalised. This is because referral procedures are fraught with major obstacles. Therefore, it is argued that the right to conscientious objection to abortion should be limited by the circumstances in which the request for abortion arises.

INTRODUCTION

The legalisation of voluntary abortion raises the ethical problem of the right to conscientious refusal. In turn, conscientious refusal raises the problem of the moral obligation of health care providers to assist women to obtain a right sanctioned by the law. At first glance, this might appear as a non-issue in most developing countries with liberal abortion laws and readily available and accessible abortion services. In these conditions, the duty of the conscientious objector to abortion is to refer the
woman to a non-objecting colleague or institution. In developing countries with liberal abortion laws, however, the right to abortion is often limited by various local constraints: education, information, accessibility of health care facilities, social stigma, and last but not least, conscientious refusal. In such cases, whereas the law ensures the right to abortion, access to abortion is limited by the mentioned reality factors.

In order to meet the two conflicting rights, two alternatives may be considered: 1) limiting the right to conscientious objection; or 2) recruiting and employing non-objecting personnel to staff the facilities designated by the state. The first option involves a strong restriction on individual rights; the second does not. However, what the first option does in developing countries is to put women’s health and lives in peril. The second option is fraught with practical problems.

Therefore, we have to consider the two following questions. To what extent is the exercise of different ‘free’ choices dependent on the local reality factor of infrastructure? Which choice is morally more binding: to avoid ‘innocent’ deaths by refusing to participate in abortion, or to prevent the potential death of a pregnant woman?

CONSCIENTIOUS OBJECTION

In its broadest sense, conscientious objection is to object in principle to a legally required or permitted practice. The issue of moral obligations of laws has been a matter of controversy from times immemorial. In the *Crito*, Plato explored the question. Closer to us, Martin Luther King invited civil disobedience in his ‘Letter from Birmingham City Jail.’ This was followed by widespread conscientious objection during the Vietnam War and later the Gulf War.

Conscientious objection finds its roots in Biblical principles and in classical natural law theory. The Bible teaches that God

institutes human authority. In case of conflict, His commands take precedence and ought to be obeyed. The religious version of the natural law theory, associated with Aquinas and the subsequent scholastic tradition, is an offshoot of the Biblical teaching: the natural law is the expression of God’s will for the creation. The secular version, as first promoted by Hugo Grotius, sees the natural law as an objective set of principles that can be discovered by reason.4

There is a wide range of situations where conscientious objection to the law or to the state is involved. One of the most popular has always been the problem of the ‘just war’ and the objection to the bearing of arms where a compulsory draft law does exist. As an alternative to bearing arms, conscientious objectors in some countries have been given the choice of a ‘national service’ which entails a lengthier civilian service.5 More recently, since the legalisation of abortion in a large number of countries, conscientious objection to abortion has come to the fore. The question is whether conscientious objection is an inalienable and unlimited right, or whether it should be limited in certain circumstances. Can the question be answered affirmatively without compromising personal rights and integrity?

In the context of military obligations, Bertha6 argues that, from a Hobbesian perspective, the fact that the state has spent enormous amounts of money in the training (of soldiers) puts duties to fulfil a contract. Therefore, conscientious objection is not tenable, and, he argues, a government should be very conservative in granting conscientious objection statuses. Following Bertha’s line of thinking one could equally (arguably) say that, in a Hobbesian perspective, the state has spent enormous amounts of money to train doctors. Hence, in this view, their right to conscientious objection should be limited.

One should make a distinction between conscientious objection against war and bearing weapons, and conscientious objection in medicine. In the former, having a person refuse to carry a weapon and/or to take part in combat does not directly affect the life of a fellow human being. The latter, however, does. In medicine, abortion is an exception to the general obligation to treat all categories within the limits of one’s competence.7

5 Bertha, *op. cit.* note 3.
6 Ibid.
(Another exception to the duty of assistance is the request for physician-assisted suicide.)

**Guidelines for a doctor’s conscience**

According to the *Declaration of Lisbon on the Rights of the Patient*, adopted by the 34th World Medical Assembly (1981), a physician should always act according to his or her conscience and always in the best interest of the patient.\(^8\) The *Declaration of Lisbon*’s intent was to place emphasis on the medical profession’s independence from legislations and governments. As a rule, the legalisation of abortion aims at providing abortion seekers the lawful opportunity for voluntary abortion in proper and safe medical conditions. Also as a rule, the abortion laws equally protect the professional’s independence to provide or to deny the service. The refusal, however, puts a legal obligation on the professional to refer the woman to an abortion service provider. Hence, abortion laws are in keeping with the spirit of the *Declaration of Lisbon*.

**Limits to conscientious objection in medicine**

According to Christie & Hoffmaster, ‘a physician’s role is to subordinate moral beliefs to moral obligations, for the ultimate commitment is to the patient even if that necessitates the violation of one’s moral views’.\(^9\) In Wicclair’s view:

> Appeals to conscience can have a significant moral weight even when physicians have conscience-based objections to practices which are endorsed by established norms of medical ethics. However, since other values and interests, such as patient autonomy, dignity, and well-being, are also at stake, it is unwarranted to give physicians more or less blanket permission to withdraw from patient care in such cases.\(^10\)

It does not follow, however, from the legalisation of abortion that it is endorsed by established norms of medical ethics. The old

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adage that what is legal is not always moral (and vice versa) also applies to the abortion debate. Christie & Hoffmaster remind us:

A physician cannot ignore the problem [of a request deemed immoral]. He or she must choose between some degree of complicity and rejection . . . and should back off when there is genuine value conflict.¹¹

It seems impossible to be at the same time an accomplice and to retreat when a conflict of values arises. Complicity is to be a partner in a ‘wrongdoing’; to back off is to refuse such partnership. To back off is to keep one’s hands clean; to compromise is to make one’s hands dirty. To back off is to keep one’s integrity, regardless of the consequences affecting others. To back off is to hide behind conscientious objection, whatever may happen to the victim of a back street abortion. To compromise is to accept the *aporia* of responsibility, to use Jacques Derrida’s vocabulary.¹² *Aporia* (from the Greek *pora*, path; and the *alpha privativum*, absence, lack) means the lack of a path to follow; it also means a question. Is there an answer? Is there a path to follow? Is moral purity and self-integrity the answer? As Murphy writes: ‘If moral purity means never choosing anything which one will have to regard as in some sense wrong and regret for all one’s days, the moral purity may be impossible in a complex world.’¹³

One of the mainstream moral theories of medical ethics is the so-called ‘principlism’, based on the principles of autonomy, beneficence, non-maleficence, and justice. But, as pointed out by Pellegrino:

The most radical reorientation in the Hippocratic tradition is that, in the last 25 years, autonomy has superseded beneficence . . . Autonomy as a moral guide has its limitations. Moral minimalism (contractualism) minimises the obligation of beneficence . . . To be beneficent, respect for the patient’s values and choices is essential.¹⁴

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If the practice of medical ethics leans too much on the contract between patient and physician, a conscientious objector has every right to refuse to be part of that contract, to be an ‘accomplice’ in a request deemed immoral. In that case, however, the duty to respect a patient’s request/choice is negated. In *Abortion and Moral Theory*, Sumner writes: ‘It is in general preferable not to require doctors and nurses to perform tasks that deeply offend their moral principles, at least as long as others are willing to meet patients’ needs’. In other words, the right to conscientious objection is limited by the circumstances within which it arises. The reasons for this are:

Any institution that is publicly funded is obliged to provide a suitable wide range of public services. Individual persons may opt out of performing abortions without thereby rendering abortions unavailable, but if the entire hospitals do so, substantial numbers of women may have no meaningful access to the service.

*Individual limits to conscientious objection to abortion*

The *British Abortion Act* (1967: section 4[2]) states that conscientious objection is inapplicable when the continuation of pregnancy poses a serious danger to life, or health, physical or mental. The *European Code of Medical Ethics* (1987: art.18) states: ‘It is ethical for a doctor, by reason of his own beliefs, to refuse to intervene in the process of termination of pregnancy, and to suggest consultation of other doctors.’ The *Medical Termination of Pregnancy Act N7* (1995) of Guyana precludes conscientious objection where women’s lives are at risk. The *Committee on the Elimination of Discrimination against Women* (CEDAW) of the United Nations (1999: art. 12 §11) states that it is the government’s duty to ensure access to care that some physicians conscientiously object to providing. This implies that governments must ensure the availability of non-objecting physicians who are prepared to render the service. Swedish law provides no

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17 Ibid.
19 Quoted in Cook and Dickens, *op. cit.* note 16.
20 Ibid.
right of conscientious objection and imposes a contractual obligation to assist in the termination of a pregnancy. \(^{21}\) The South African *Choice on Termination of Pregnancy Act 92* (1996: section 10) makes provision for penalties for obstructing the law:

Any person who prevents the lawful termination of pregnancy or obstructs access to a facility for the termination of pregnancy, shall be guilty of an offence and liable on conviction to a fine or to imprisonment for a period not exceeding 10 years.\(^{22}\)

The shortcomings of this section of the act is, first, that it seems to address only the physical obstruction to the access to an abortion service facility and not the health hazards (i.e. the morbidity) and life threats (i.e. the mortality) caused by conscientious objectors who willingly neglect women undergoing a termination of pregnancy. Second, it does not mention the right to conscientious objection or the lack thereof (or limits to conscientious objection).

Still, in the South African context, the health portfolio committee indicated in parliament its concern about the preventable death of women from botched illegal abortions. The minister of health’s response was: ‘Health care workers should place their duty before their beliefs.’ At the same session, the chief director for maternal & child health services stated: ‘Health care workers should not use their beliefs to deny people access to services.’\(^{23}\)

**Institutional limits to conscientious objection**

Abortion is a personal choice, as it is emphasised in the title of the South African Act: *choice on termination of pregnancy*. Whose choice is it? The woman’s, the lawmaker’s, the physician’s, the nurse’s? Is the choice guaranteed? What hampers the making of the choice? Is it a choice limited by the local circumstances? On one view (call it the personal choice to be anti-choice, to refuse the right to choose to others), the right to conscientious objection is inalienable and unrestricted.\(^{24}\) To be morally free:


\(^{23}\) Bateman, *op. cit.* note 1.

flawless, this view will have to ‘justify’ the 600 000 annual deaths from ‘unsafe’ abortion globally.\textsuperscript{25} On the other view (call it pro-choice), one has the moral obligation to prevent these avoidable deaths. To be morally flawless, this view should have to ‘justify’ the 50 million abortions that are induced annually worldwide.\textsuperscript{26} The irony is that, whatever the choice, both stances lead to a dead end and end in death. In the end, it is a matter of choice between the woman’s or the unborn’s life. Therefore, the lawmaker’s perspective on abortion boils down to a public health matter rather than an ethical one.

The points made by Sumner are important for three reasons. First, he emphasises that conscientious objection, where applicable, is an individual right but not an institutional right. Second, he insists on the fact that even private health facilities, by virtue of the fact that they provide services to the public under the auspices of governmental agencies ‘cannot refuse ethically or legally a service unless they provide a reasonable access to such services through other facilities.’\textsuperscript{27} And finally, he notes that ‘public hospitals must guarantee that at least some of their medical staff will perform abortions, or will refer to others who do.’\textsuperscript{28}

GLOBAL VIEW ON ABORTION

In an ideal world, one should wish that all pregnancies would be planned and welcome, and that contraception would eliminate the need for voluntary abortion. Currently, however, half of all pregnancies in developed countries are still unplanned, and half of the unintended ones are terminated.\textsuperscript{29} On the other hand, the increase in involuntary infertility is addressed by reproductive technologies that result in supernumerary embryos and multiple pregnancies. The former poses the ethical problem of the ‘disposal’ of tens of thousands of unclaimed or unwanted embryos, not to mention the ethics of cloning. The latter poses the problem of fetal ‘reduction.’ For all these reasons, contraception on its own is unlikely, in the foreseeable future, to eliminate the need for abortion. Thus, the reality of abortion (in its broadest sense) is likely to stay with us for a while, whether we like it or not.

\textsuperscript{25} Varkey et al., 2000, \textit{op. cit.} note 2.
\textsuperscript{27} Sumner, \textit{op. cit.} note 15.
\textsuperscript{28} Ibid.
\textsuperscript{29} Schenker and Cain, \textit{op. cit.} note 26.

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In the developing world, the need for ‘safe’ abortion results from different socio-economic factors and circumstances. For a host of reasons – culture, education, poverty, tradition, sexism, gender bias, etc. contraception has not yet made a significant impact on the need for abortion. Therefore, in an attempt to curb the morbidity and mortality from ‘unsafe’ abortions, the procedure has been legalised in more than 100 countries worldwide.

**Arguments pro and con abortion**

A common, but arguably simplistic, view on abortion is limited to the two antipodean but straightforward stances: pro-choice/pro-life (anti-choice). The former rests its case on the premise that women have the right to dispose of their own bodies; neither rights nor moral standing are granted to the unborn. The latter rests its case on the inalienable right to life of the unborn; no right is granted to the woman.

As Benjamin writes, ‘the main strength of the absolute pro-choice is the philosophical limitation of the absolute pro-life stance – that is, its inability to provide a plausible secular justification of the absolute sanctity of life.’ While Benjamin has a point, it does, however, not follow from the weakness of the pro-life argument that the pro-choice counter-argument is valid. The real philosophical conundrum arising from the dispute is, according to Oddie, ‘the extraordinary difficulty of achieving some kind of rational consensus on the moral status of the unborn.’ The same difficulty applies to the pro-choice argument. As pointed out by Chervenak & McCullough, ‘there is no clearly convincing moral argument that the woman’s life is more important than that of the fetus.’

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30 Gender Bias: Perspectives from the Developing World. Available at: http://.advocatesforyouth.org/publications/factsheets/fsgender.htm
There is a third argument on the morality of abortion that focuses on public health and demographic concerns. In Western Europe, abortion is regulated as a public health need with the medical profession as its gatekeepers. Access to abortion is legal when the physician decides that it is indicated on health and/or socio-economic grounds. In North America, abortion is part of an individual’s right to bodily integrity, privacy, or autonomy, which cannot be infringed by the state except to protect conflicting rights.\textsuperscript{35} South Africa’s \textit{Choice on Termination of Pregnancy Act} addresses abortion as a matter of social equity and justice, rather than on health grounds (but includes medical indications).\textsuperscript{36} It declares that the law was enacted ‘recognising the values of human dignity, the achievement of equality, security of the person, non-racialism and non-sexism and the advancement of human rights and freedom.’\textsuperscript{37} Making abortion strictly a matter of women’s rights leaves little, if any, room for conscientious objection. Moreover, as mentioned earlier, the act makes provision for indictment in case the access to this human right is obstructed. What, then, are the ‘justifications’ of the public health stances on abortion?

\textit{The ‘reality factor’}

A global survey of the situation of abortion in the year 2000 shows that 60\% of humanity lives in countries where voluntary abortion – that is, abortion on demand – is legal. This represents more than 100 countries; 28 of them are in Europe, and only two in Africa (Tunisia and South Africa). In the remaining 39\%, 14\% permit abortion only to protect a woman’s physical health, and 21\% only to save a woman’s life. In 4\% of countries, abortion is still absolutely prohibited (e.g. Ireland).\textsuperscript{38} There are globally 50 million induced abortions each year.\textsuperscript{39} According to the World Health Organization, it is estimated that there are 20 million ‘unsafe’ abortions globally each year, and that 600,000 women die each year from the complications of ‘unsafe’ abortions. Most ‘unsafe’ abortions happen in the developing world.\textsuperscript{40} Indeed, abortion is not only an ethical issue; it is a very serious health matter. Why is that?

\textsuperscript{35} Berer, \textit{op. cit.} note 2.
\textsuperscript{36} Government Gazette, \textit{op. cit.} note 22.
\textsuperscript{37} Berer, \textit{op. cit.} note 2.
\textsuperscript{38} Benagiano and Pera, \textit{op. cit.} note 31.
\textsuperscript{39} Schenker and Cain, \textit{op. cit.} note 26.
\textsuperscript{40} Varkey et al., 2000, \textit{op. cit.} note 2.
Many factors affect the rates of abortion. What is clear is that the legal prohibition of abortion is no deterrent. On the contrary, there is ample evidence showing that the legalisation of abortion does result in a significant decrease in abortion rates. It is equally clear that the decriminalisation of abortion leads to a significant drop in morbidity and mortality from ‘unsafe’ abortion procedures. Education, availability of and easy access to contraception, and the availability of proper health care have all contributed to the decrease in abortion rates in the developed world.\(^\text{41}\) Hence, from a strict public health point of view, there is a need to legalise abortion. But that does not solve the issue of conscientious objection/refusal.

In the developing world, however, things are different. I wish to limit the discussion to the South African reality. At the time of the enactment of the act, in February 1997, the national department of health designated 246 public and 138 private facilities to provide legal abortion services. Since then, around 50,000 legal abortions are performed annually. An equal number (and most likely even more) of ‘unsafe’ – that is, ‘technically illegal’ (as they are performed outside of the designated facilities) – abortions are performed. The South African particular also indicates that 30% of avoidable maternal deaths result from ‘unsafe’ abortions. The 1997 confidential enquiries into maternal deaths revealed that 575 deaths resulted from pregnancy-related sepsis or incomplete (that is, ‘unsafe’) abortions.\(^\text{42}\) In 1998, the same enquiries showed that 60.5% of early pregnancy deaths and 38.8% of deaths from pregnancy-related sepsis were due to ‘unsafe’ abortions.\(^\text{43}\)

Why is it that, in spite of the legalisation of abortion, more women still do resort to unsafe practices instead of safe ones? Ignorance of the law, unavailability of the services (for whatever reason), taboos and stigmatisation undoubtedly play a role.\(^\text{44}\) A recent survey has shown that only 53% of all South African women were aware of the Act, and that 61% of rural women were totally unaware of the availability of legal abortion. It also showed that, in rural communities, 58% of women are unable to negotiate for protected sex.\(^\text{45}\) In addition, I would argue that,

\(^{41}\) Benagiano and Pera, \textit{op. cit.} note 31.
\(^{44}\) Berer, \textit{op. cit.} note 2.
in South Africa, appeal to conscientious objection by health care providers in state-run facilities is a major contributor to the high number of ‘unsafe’ abortions. It is known that only 28% of the designated facilities are effectively on-line, and that 95% of them are in cities and towns.\textsuperscript{46} This leaves almost half of the female population (that is, those living in rural areas) with little or no access to a constitutional right. The designated facilities that do not provide the service invoke the right to conscientious objection.\textsuperscript{47} The state does not prosecute those who provide ‘technically illegal’ abortion because ‘unsafe’ abortions have become ‘safe’ or ‘safer’ (that is, the medically induced abortions have much less morbidity and mortality than the ‘surgically-induced’ ones).

Much has been said about the limits of conscientious abortion as it relates to where a health care provider starts involving or withdrawing him or herself. In Britain, for instance, the \textit{Janaway vs Salford Health Authority} was about a doctor’s secretary who refused to type the referral letter for an abortion on grounds of conscientious objection.\textsuperscript{48} The British Medical Association regards the situation as similar to that in France, Italy and Norway: doctors are not legally required to authorise or to perform abortions, but are obliged to be involved in pre-operative care and referral.\textsuperscript{49} In Denmark and the Netherlands, one can conscientiously object to being involved in pre-operative care, but there is nonetheless a legal obligation to refer the woman seeking an abortion to another colleague.\textsuperscript{50} It could, however, be argued that the current situation with ‘medical’ abortion differs from the traditional ‘surgical’ abortion. In other words, in most cases abortion is induced by the oral intake and/or the vaginal application of a drug that induces uterine contractions. The drug is self-administered by the woman. The role of the health care provider is to prescribe the drug and to hand it over to the woman seeking an abortion. The real active role player in the induction of the process is the woman herself. A staunch conscientious objector could also argue that the janitor who sweeps the operating theatre floor after the evacuation of retained products of conception has the right to conscientious objection and to refuse to sweep the floor. Where does participation start and end?

\textsuperscript{46} Varkey et al., 1999, \textit{op. cit.} note 2.
\textsuperscript{47} Bateman, \textit{op. cit.} note 1.
\textsuperscript{48} Saunders, \textit{op. cit.} note 21.
\textsuperscript{50} Saunders, \textit{op. cit.} note 21.
In developing countries with liberal abortion laws, an unlimited right to conscientious objection not only denies women a constitutional right, but also puts their health and life at risk. The local circumstances do not ensure access to a legitimate and legal request. Therefore, the right to conscientious objection to abortion is not absolute. The only way to protect the conscientious objectors’ right would be to staff the designated facilities with non-objecting health care providers.

CONCLUSION

Where abortion is decriminalised, women’s right to abortion often conflicts with health care providers’ right to conscientious objection. One has to keep in mind that the right to conscientious objection is an individual right and not an institutional right. Health facilities, private and public, have the moral duty to ensure that women seeking abortion are provided the service they are entitled to by the law. Although it is not clear where the right to conscientious objection starts and ends, the duty to refer is both a moral and legal obligation that can easily be fulfilled in developed countries. In developing countries, however, often the local circumstances do not ensure access to safe abortion. Therefore, the right to conscientious objection should be balanced against the health hazards resulting from ‘unsafe’ practices. It could also be said that the state that passed abortion laws simultaneously has the duty to ensure access to safe abortion to all women seeking an abortion. In South Africa, 72% of the designated state-run facilities claim conscientious refusal. Therefore, more than half of abortions are still ‘unsafe.’ Since conscientious objection is not an institutional right, the state has the moral and legal duty to enforce the law in the institution it has designated. This places a limit to conscientious objection. Moral purity is difficult in a complex world.

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