Conscientious objection to abortion provision in Bogota, Colombia: religion, respect, and referral

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Background

Each year, an estimated 68,000 women die from unsafe abortions (Grimes et al., 2006), and eight million experience complications requiring medical attention, though only five million receive care (Johnson, Kismödi, Dragoman, & Temmerman, 2013). When women have access to safe and legal abortion services, the vast majority of abortion-related morbidity and mortality is eliminated, while the overall incidence of abortion remains approximately equal (Grimes et al., 2006). Criminalization severely restricts women's access to safe services, but even after abortion is decriminalized, procedural, economic, informational, and cultural barriers continue to impede access to legal abortion services in many countries (Ashford, Sedgh, & Singh, 2012; Johnson et al., 2013). Some of these barriers emerge in the patient-provider relationship, including failure to refer and conscientious objection (International Sexual and Reproductive Health Law Programme, 2008).

Conscientious objection – in which healthcare professionals are exempted from providing or participating in abortion care on religious, moral or philosophical grounds – presents a particular litigious barrier to abortion services (Johnson et al., 2013). From a human rights perspective, there is a tension between protecting women's right to health and protecting health service providers' right to exercise individual moral conscience (Johnson et al., 2013). Conscientious objection has been identified as an important barrier to abortion access in Zambia (Koster-Oyekan, 1998), South Africa (Centre for Health Systems Research and Development, 2005; Harrison, Montgomery, Lurie, & Wilkinson, 2000), Poland (The Federation for Women and Family Planning, 1996), Mexico (Human Rights Watch, 2006), Canada (Shaw, 2006), Australia (Department of Health (Western Australia), 2002; Victorian Law Reform Commission, 2008), and India (Barge, 2004).

In Colombia, conscientious objection to abortion has been the object of debate in the wake of partial decriminalization of abortion. In 2006, the Colombian Constitutional Court ruled to partially decriminalize abortion in three circumstances: when the life or health of the mother is at risk, when a severe fetal malformation is identified, and when the pregnancy is the result of rape, incest, or forced insemination. The court made this ruling under a right to health and women's rights framework, acknowledging abortion access as a component of women's rights to health. This reflects a dramatic shift from treating abortion as a criminal act to treating it as a human right to be guaranteed by the state (R. J. Cook, Erdman, & Dickens, 2007).

In the years since the court's ruling, implementation has been inconsistent and many women continue to be denied abortion services across the country (Dalén, 2013). Fundamental disagreements about abortion remain, and key actors such as hospital administrators and physicians utilize varying interpretations of ethical, legal, and medical requirements as defined by the Court ruling (Amado, Calderon Garcia, Cristancho, Salas, & Hauzeur, 2010). In 2008, the Court issued a decision clarifying some of the legal duties of providers, hospitals, and healthcare systems with respect to abortion provision and conscientious objection. The Court defined conscientious objection as a right of individual human beings to refuse to perform abortions, given that they do so out of a "well-established religious conviction" (Colombian Constitutional Court, 2008). Institutions, such as hospitals, do not have the right to conscientiously object. According to the ruling, objecting physicians have a duty to refer, and institutions have a duty to ensure the availability of non-objecting physicians to whom patients can be referred (Rebecca J Cook, Olaya, & Dickens, 2009).

Very few studies have examined the ethical and/or religious influences on physician unwillingness to perform abortions after decriminalization. In order to promote broader implementation of abortion

decriminalization in Colombia, it is important to understand—from the objector's perspective—the experience of conscientious objection, and the complex factors that influence the way care providers interact with patients requesting abortions. Using a qualitative grounded theory approach, this study addressed the issue of conscientious objection from a public health and rights perspective, exploring the tension between respecting women's rights to heath while maintaining health service providers' right to exercise personal moral conscience.

Methods

Research setting and local support

The study was conducted during June and July of 2014 as part of an interdisciplinary investigation of barriers to access to safe and legal abortion in Bogotá, Colombia. A graduate student research team from Emory University worked in collaboration with a local advisor at the University of the Andes (OAB), and with partners at two Colombian reproductive health clinics.

Study population

Participants were recruited through a snowball sampling referral process and purposively selected to include a broad representation of self-identified conscientious objectors in Bogotá, Colombia. The study used a broader definition of conscientious objection than the Colombian law. Inclusion criteria encompassed any woman's healthcare provider who felt that her or his moral, ethical, or religious beliefs precluded her or him from being willing to perform or assist abortions in some or all situations. In total, 18 self-identified conscientious objectors participated, including 14 doctors, 3 nurses, and one medical student in her final year of residency. A majority (n=13) of participants were female. The participants ranged in age from 28 to 69 years old, and had between 1 and 33 years of experience providing health services to women. Half (n=9) of participants worked in public hospitals, 4 worked in private clinics, and 3 worked in hospitals affiliated with the Catholic Church.

Data collection

Using a semi-structured guide that evolved slightly throughout the research process, one female researcher from Emory University conducted in-depth interviews in a variety of settings. Most interviews were conducted in a hospital, clinic, or university office, one was conducted at the participant's home, and one was conducted at the researcher's apartment. All interviews were conducted in Spanish, and lasted between 30 and 120 minutes. Interviews focused on the ethical, moral, religious, and legal influences around referral for abortion and the provider-patient relationship.

The study design incorporated an iterative process which allowed for an expansion of the inclusion criteria to include nurses upon hearing from a participant that nurses were a key population who often self-identify as conscientious objectors, but do not have the legal right to refuse to assist with abortions. One of the authors (CEB) conducted interviews with women (n=18) who accessed abortion services, and also identified stigma and shaming by nurses as a common negative experience during the procedure. Thus, interviews with self-identified conscientious objector nurses focused on the experience of providing abortion despite religious, ethical, and/or moral objections.

As part of the multidisciplinary investigation, the authors also interviewed 11 key informants including local bioethicists, women's rights activists, attorneys, and clinic administrators. These interviews were less structured than the interviews conducted with objectors, and focused on the particular knowledge and experience of each interviewee.

Data analysis

All interviews were transcribed by a professional Colombian transcriptionist and checked for accuracy by a bilingual researcher in the US. Data were then entered into MAXQDA and are being analyzed using a Grounded Theory approach with an aim to identify salient themes and potentially a theory to illuminate paths towards relieving the tension between provider's religious beliefs and patient's rights to safe, legal health services.

Ethical considerations

Ethical approval to undertake this study was obtained from the Emory University Institutional Review Board, and the ethics committees of the University of the Andes and Profamilia in Bogotá, Colombia. All study participants provided oral informed consent prior to the interview process. Oral, rather than written, consent ensured that names were not recorded in any location, and provided peace of mind for interviewees to give answers that their superiors or co-workers may not like.

Results

Types of objection

Analysis of interviews is still in process, but several themes have begun to emerge. First, we have conceptualized our sample into three "types" of objectors, as follows:

- **Radical objectors** refuse or are very reluctant to refer, and object to most forms of birth control
- **Moderate objectors** usually or always refer patients and firmly support and promote birth control as a means to prevent abortion
- **Partial objectors** appeared in two main categories:
    - Those who object in cases of advanced gestational age (14 weeks and 22 weeks were independently given as the cut-points for "advanced")
    - Those who object depending on the circumstances of the pregnancy—e.g. only provides abortion when the fetus is non-viable

Nurses, who are not able to object under the conscience clause of the law, are in their own category as objectors who are still obligated to assist in abortions.

Religion (or not)

Seventeen participants identified as Catholic, and one as Evangelical Christian. Religion was a salient theme for many, but not all, interviewees, and many said that they feel God's presence in their work as healers. Despite demonstrating religiosity, objecting providers also discussed medical ethics as an underlying cause for objection, based on the belief that abortion is physically dangerous and harmful to women's mental health. Providers appeared to have been influenced by what they were taught in medical school as much, or more, than personal religious conviction. Providers explained that, in medical school, they were taught about induced abortion only in the context of how to address complications of unsafe, illegal abortions when they arrive in the emergency room. While providers expressed judgment towards women who seek abortions and several admitted that they always refuse to refer, many viewed referral as a way to save "one out of two" lives, by preventing women from seeking illegal and unsafe abortions on their own.

Respect

Key informant interviews with women's rights activists, lawyers, and healthcare providers in the capital city of Bogotá confirmed that provider objection is a salient barrier to access for women seeking abortion. Their concern does not relate to the existence of conscientious objection as a right reserved for physicians. Rather, key informants who support abortion rights were frustrated about the way conscientious objection is utilized in practice. One informant, for example, claimed that providers will sometimes "hide" their objection from the hospital, and then refuse to provide services when a patient is before them. Several informants expressed their discontent with providers who claim to object at a public hospital, but will perform the procedure at a private clinic, where it is more lucrative.

It's important to raise awareness, about those of us who defend the right to abortion, that we're not against conscientious objection. Rather, we're against the misuse of that objection when it leads to abuse of women.

Box 1: Quote from an attorney in Bogotá

None of the objectors interviewed discussed this kind of behavior, but many expressed their sense of religious or moral obligation to try to talk women out of getting an abortion. Often this came from a place of not believing that the women had properly thought out her options. Some objectors discussed their relationships with charities focused on support of unwed mothers and adoption services, and how they try to connect their patients to these charities as an alternative to abortion.

I try to make them see that it is possible to continue with their pregnancy.

Box 2: Quote from a conscientious objector in Bogotá

Some objectors, particularly moderate objectors, discussed the importance of respect for women's decisions, and quickly getting them to a provider who would be willing to perform the procedure. One interviewee, for example, spoke about the joy she gets from supporting the patients that she refers after the abortion is complete. She said she seeks to provide a non-judgmental space for spiritual and emotional healing as part of a holistic medical practice.

Referral

Key informants who support abortion rights discussed refusals to refer as a common, but egregious, violation of women's rights. While some objectors admitted that they never or very rarely refer their patients, the vast majority could at least delineate a protocol that they are expected to follow, and several expressed a sense of comfort in their ability to refer, a sense of security in the knowledge that their patients will be given the care they have requested.

If a woman isn't referred, she will perform her abortion in another way, possibly one that isn't safe.

Box 3: Quote from a conscientious objector in Bogotá

Among very religious interviewees, the topic of culpability and sin came up with respect to referral. One interviewee went so far as to say that if he were to refer, he would be a murderer because "someone signs, someone executes the order, and someone dies because of it." Another interviewee, who refers patients following the protocol of the public hospital where he works, wrestled actively with the concept of sin in relation to referral throughout the interview.

Discussion

- The aim of this study was to identify avenues for intervention that would ease the burden of conscientious objection as a barrier to safe, legal abortion while preserving the religious liberty of care providers. It is hoped that the process of analysis will allow meaningful themes to emerge that will shed light on this poorly understood phenomenon.
- Keeping in mind that most physicians in Bogotá attended medical school while induced abortion was still illegal, it is not entirely surprising that they internalized the message that abortion is dangerous. Providers' focus on what they learned in medical school and their medical, rather than religious, ethical reasoning during many interviews might point to a route for intervention focused on continuing medical education and revision of the medical school curriculum.
- This study had several limitations.
    - The observed focus on a science/medical paradigm may have been an artifact of participants' perceptions of the interviewer—a young, female graduate student from the United States.
    - The broad definition for "conscientious objection" may make it difficult to compare results to other studies.
    - The researchers spent only two months in country, and discovered the significance of nurses' perspective too late. From the small amount of data that was collected, it appears that this would be a very interesting and important area for further research.

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