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Research Article

Ethical Posture of the Physician Objecting to Legal Abortion

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Abstract

Objectives: This study aimed to evaluate the profile and ethical posture of physicians objecting to legal abortion.

Methods: A cross-sectional study was conducted with 97 physicians from a legal abortion reference unit. Objection to legal abortion was the dependent variable; socio-demographic data, time since graduation, graduation, and religious beliefs were the independent variables. Ethical posture was assessed based on whether the physicians agreed to explain the reasons for objection, advised on the procedure's legality, and referred patients to another professional. Data were analyzed using the χ^2 test and t-test with a 5% significance level.

Results: Of the physicians, 19.6% objected to abortion in cases of sexual violence and risk of maternal death, and 16.5% objected in cases of anencephaly. Older age, being married, higher educational level, longer time since graduation, high religiosity, and being a fervent practitioner were predictors of refusal to perform abortion in cases of violence. Fervent practitioners objected more often to the risk of death cases; physicians with a longer time since graduation, fervent practitioners, and those with high religious motivation objected more to anencephaly cases. Of the physicians, 35.1% did not explain the reason for objecting, 14.4% did not advise the patient, 27.8% did not refer to the patient and 71.1% did not perform the procedure even in the absence of a non-objector.

Conclusion: Being very religious and a fervent practitioner were predictors of refusal to perform legal abortion. A reasonable proportion of physicians demonstrated ethical ignorance.

Keywords: *Legal Abortion; Reproductive Rights; Women's Health; Conscience; Ethics*

Introduction

Conscientious objection can be defined as the refusal to comply with a regulation that goes against an individual's moral, religious, or ethical principles [1]. It is guaranteed by the International Covenant on Civil and Political Rights [2]. The exercise of the specialty of gynecology and obstetrics exposes the professional to conscientious objection situations regarding reproductive medicine procedures, such as abortion, contraception, and infertility [3]. Abortion as a practice is discouraged worldwide and the procedure is refused by practitioners [4]. Despite being a growing topic of discussion in bioethics, studies on the subject are limited, and little is known about the prevalence of objecting physicians.

The allegation of conscientious objection regarding legal abortion brings about important issues for women who need this procedure as well as the health system as a whole [5]. It is often considered an obstacle that goes against international human rights covenants, thereby negatively influencing the quality of sexual and reproductive healthcare [6].

Health professionals may oppose certain treatments, even those supported by law, for moral, religious, philosophical, or ethical reasons [7,8]. Conscientious objection is the most frequent reason for physicians refusing to perform a legal abortion [9]. Some people have defended the right to refuse-being considered a manifestation of autonomy and freedom of thought-and a guarantee of their professional independence, identity, and consequently, conscience [10]. However, others regard this right as incompatible with medicine, representing a violation of scientific integrity, and exposing the patient to harm [11].

Recognizing that this individual right harms women who need to undergo the procedure, objection has been moderately dealt with. Unfortunately, the current legislation on conscientious objection differs regarding the rights they seek to guarantee: the right to quality reproductive healthcare, or that of the professional to plead conscientious objection. Some studies have focused on maintaining a sufficient number of non-objecting professionals, others have concentrated on women's right to be referred to professionals who perform the necessary procedures, and others on the definition of the objecting physician [12].

In Brazil, conscientious objection is regulated to limit refusal and protect the sexual and reproductive health of sexually victimized women [13]. However, several records of non-compliance by physicians confuse objection with opinion, making the refusal something selective [14]. The illegitimacy of refusal, backed by a lack of knowledge on the concept of objecting physicians, local legislation, and technical bases, are cited as aggravating factors [15]. This abuse of the right to refuse leads to inequality in reproductive health rights, distancing women from the scarce specialized legal abortion services owing to the existing stigma about the refusal to perform the procedure [10]. This obstacle leads to higher rates of unsafe abortions and increased maternal morbidity and mortality, especially in the most vulnerable groups [16].

Identifying and training objecting professionals on the appropriate ethical posture at the time of the alleged conscientious objection can guarantee their rights and minimize the detrimental effects the refusal may cause on them, the patient and the health system. This study assessed physicians' ethical knowledge of conscientious objection at a reference unit for legal abortion. Furthermore, the prevalence of objections and the profile of the objecting physician were investigated.

Methods

The study had a cross-sectional design. It was conducted between May 2021 and January 2022. It comprised 97 physicians from the clinical staff of a public maternity hospital that was a reference for legal abortion. Professionals were randomly selected. All physicians were invited to participate in the project, and those who agreed signed an informed consent form and responded to a self-administered, unidentified, and non-timed questionnaire. The completed questionnaires were deposited in a sealed box that was opened by the researcher after data collection was completed.

The following independent variables were considered: age, race (self-reported), sex, marital relationship, length of professional practice, graduation, religion, frequency of religious practice, degree of religiosity, and knowledge of conscientious objection in medical practice. Religiosity was graded according to Hoge's Intrinsic Religious Motivation Scale [17], based on whether the participants agreed with two statements: "I strive to maintain and follow my religious beliefs in all aspects of my life" and "my way of life is guided by my religion." Religiosity was classified as low if the physicians disagreed with both statements, moderate if they agreed with only one, and high if they agreed with both statements.

The dependent variables were objection to abortion in cases of pregnancy resulting from sexual violence, risk of maternal death, and anencephaly. The ethical knowledge analyzed regarding the attitude of the objecting physician included the following: the physician's

obligation to explain clearly the reason for their objection, their duty to advise the patient on the legality of the procedure they morally or religiously refused to perform, the need to refer the patient to another physician who would not deny the legal procedure requested, and if that were not possible, they would be obligated to perform it themselves. Statistical analysis was performed using the SPSS 14.0 software at a statistical significance previously defined as $p < 0.05$. Word and Excel for Windows® were used for the text and table processing, respectively. The data were analyzed by frequency and percentage distribution, and the χ^2 test and t-test were used for analysis. The study was approved by the Research Ethics Committee (Comitê de Ética em Pesquisa - CEP) of the Bahia School of Medicine and Public Health, Salvador, BA, Brazil, under CAAE No. 10866012.0.0000.5544 and Opinion No. 146.883. All the participants signed an informed consent form.

Results

In total, 104 physicians were invited to participate in the study. Of these, 97 agreed to participate, thus forming the sample. The mean patient age was 40 ± 12 years. Most participants were women (66%) and identified themselves as white (62.9%). Furthermore, 57% of physicians reported being in a marital relationship, 55.7% had a specialist title, and 47.4% had more than 10 years of professional practice. Regarding religion, 81.45% reported following religion, 56.7% did not usually attend religious services, and 44.3% were classified as having low religiosity according to Hoge's scale. Refusal to perform an abortion in cases of pregnancy resulting from sexual violence and the risk of maternal death was reported by 19.6% of the sample. Moreover, 16.5% of the physicians objected to abortion in cases of anencephaly (Table 1).

Characteristic	n/N (%)
Age	40 ± 12 years
Women	64/97 (66)
White	61/97 (62.9)
Marital relationship	56/97 (57.7)
Instruction level	
Graduation	34/97 (35.1)
Specialist	54/97 (55.7)
Postgraduate studies	9/97 (9.3)
Time since graduation	
< 5 years	22/97 (22.7)
Between 5 - 10 years	29/97 (29.9)
> 10 years	46/97 (47.4)
Follows a religion	79/97 (81.4)
Attends religious services	
Never	55/97 (56.7)
Once a month	30/97 (30.9)
≥ Twice a month	12/97 (12.4)
Hoge's scale	
Low religiosity	43/97 (44.3)
Moderate religiosity	27/97 (27.8)
High religiosity	27/97 (27.8)
Objectors to abortion in situations of:	
Sexual violence	19/97 (19.6)
Maternal life risk	19/97 (19.6)
Anencephaly	16/97 (16.5)

Table 1: *Participants' sociodemographic and religious characteristics.*

Abbreviations: n = Number of Physicians, N= Total Sample.

Of the physicians who objected to abortion in the case of a pregnancy resulting from sexual violence, a greater association was observed with those who were older (p = 0.008) and in a marital relationship (p = 0.009). A higher educational level (p = 0.041), longer time since graduation (p = 0.002), being a fervent practitioner (p = 0.047), and having a high degree of religiosity were predictors (p = 0.002) (Table 2).

Predictor	Sexual violence n/N (%) p-value	Risk of maternal death n/N (%) p-value	Fetus Anencephaly n/N (%) p-value
Age	46.32 ± 10.94 p = 0.008**	41.53 ± 12.09 p = 0.538**	43.69 ± 10.56 p = 0.169**
Women	13/64 (20.3) p = 0.802*	16/64 (25.0) p = 0.061*	12/64 (18.8) p = 0.405*
White	10/61 (16.4) p = 0.302*	13/61 (21.3) p = 0.578*	10/61 (16.4) p = 0.972*
In a marital relationship	16/56 (28.6) p = 0.009*	11/56 (19.6) p = 0.987*	11/56 (19.6) p = 0.329*
Graduation level			
Graduation	2/34 (5.9)	6/34 (17.6)	4/34 (11.8)
Specialist	15/54 (27.8)	11/54 (20.4)	11/54 (20.4)
Postgraduate studies	2/9 (22.2) p = 0.041*	2/9 (22.2) p = 0.931*	1/9 (14.3) p = 0.514*
Time since graduation			
< 5 years	1/22 (4.5)	4/22 (18.2)	3/22 (13.6)
Between 5 - 10 years	2/29 (6.9)	3/29 (10.3)	1/29 (3.4)
> 10 years	16/46 (34.8) p = 0.002*	12/46 (26.1) p = 0.242*	12/46 (26.1) p = 0.034*
Follows a religion	16/79 (20.3) p = 0.729*	17/79 (21.5) p = 0.315*	12/79 (15.2) p = 0.468*
Attends religious services			
Never	6/55 (10.9)	8/55 (14.5)	7/55 (12.7)
Once a month	9/30 (30.0)	5/30 (16.7)	4/30 (13.3)
≥ Twice a month	4/12 (33.3) p = 0.047*	6/12 (50.0) p = 0.017*	5/12 (41.7) p = 0.043*
Hoge's scale			
Low religiosity	2/43 (4.7)	6/43 (14.0)	3/43 (7.0)
Moderate religiosity	7/27 (25.9)	8/27 (29.6)	8/27 (29.6)
High religiosity	10/27 (37.0) p = 0.002*	5/27 (18.5) p = 0.271*	5/27 (18.5) p = 0.043*

Table 2: *Predictors for objection to legal abortion.*

*Abbreviations: *: x^{2}; **: t-test; n = Number of Physicians; N = Total Sample.*

Of the sample, 48.5% reported never participating in discussions on conscientious objections. Furthermore, 31.5% did not agree that it would be ethical for the physician to describe clearly the reason for objection, and 14.4% of physicians did not comply with the professional's duty to provide information on the requested procedure's legality. The obligation to refer the patient to a professional who did not oppose the procedure and, if this is not possible, objection refusal was rejected by 71.1% of physicians (Table 3).

Ethical knowledge	Yes n/N (%)	No n/N (%)
Should the physician clearly explain the reason for objecting to perform a legal abortion to the patient?	63/97 (64.9)	34/97 (35.1)
Is the physician obliged to provide information on the procedure's legality?	83/97 (85.6)	14/97 (14.4)
Is the physician obliged to refer the patient to someone who does not oppose the requested procedure?	70/97 (72.2)	27/97 (27.8)
If there is no other physician available, should they perform the requested procedure?	28/97 (28.9)	69/97 (71.1)
Was conscientious objection addressed at some point in your training?	50/97 (51.5)	47/97 (48.5)

Table 3: *Ethical knowledge of physicians on conscientious objection.*

Abbreviations: n = Number of Physicians, N = Total Sample.

Discussion

Access to reproductive healthcare is obstructed by scarce resources allocated to health actions, lack of information, inadequate understanding of local legislation, and social, moral, and religious stigmas related to sexuality and abortion in several countries, but especially the poorest [18]. The illegitimacy of alleging conscientious objection has been related to disastrous consequences in countries with better resources, thus hindering free exercise of fundamental rights [19].

In this study, there were objections in the three circumstances of legal abortion, which were slightly lower in the event of anencephaly. A survey involving physicians working in legal abortion services reported the percentage of objectors to be three-fold higher than that reported in this study [20]. In a study that asked 1,174 medical students whether they agreed with legal abortion, half were against abortion in cases of pregnancy resulting from sexual violence, and a lower percentage in cases of risk of maternal death and anencephaly [21]. Abortion for any reason is refused by approximately 80% of gynecologists in Portugal and Italy. This calls for implementation of strategies to regularize objection without harming women and the health system in these countries [22].

Religiosity has been identified as the primary motivating factor for conscientious objections, especially abortion [23]. In the sample studied, following a religion was not related to a greater possibility of objection in the situations discussed. Refusal was significantly related to fervent practice and greater religious motivation, which is corroborated by other studies that sought to identify predictors of objection to legal abortions among medical students [24,25].

The objection must have a constant character, and not a changeable or moldable attitude, according to each circumstance [26]. This sample showed abortion objection selectivity through greater refusal in cases of pregnancy resulting from sexual violence among older physicians with more time in professional practice and higher educational levels. Older people are more prone to prejudice and social, moral and religious stigma related to pregnancy termination [27]. In this study, the lower objection to abortion of more fervent practitioners in cases of risk of death for women reflects refusal selectivity.

Conscientious objections are individual, exceptional, and based on ethical, moral and religious reasons that should be sincere and authentic [28]. Recognizing the physician's right to refuse certain reproductive health procedures for intimate reasons as well as the women's right to access quality medical care, it is imperative to develop appropriate legislation and define the ethical profile of the objecting physician. Entities such as the International Federation of Gynecology and Obstetrics (Federação Internacional de Ginecologia e Obstetrícia) and the World Health Organization recognized the right to object, but do not relieve the duty of care. The objecting physician must clearly explain the reasons for refusal, describe all appropriate procedures, including those they oppose, and take responsibility for the patient until the necessary procedure is performed [1,29]. This regulation has not been adequately respected in several countries, which has disastrous consequences for women's health, for they are prevented from exercising their fundamental rights [30].

This study revealed that a proportion of physicians working in a reference unit for legal abortion were unaware of the legislation on the subject. Not accepting the need to clearly state the reason for objecting demonstrates a discriminatory attitude and moral disapproval and exposes women to constraints that can discourage search for the necessary legal procedure. The refusal to provide information about the legality of abortion in this circumstance and referring women to non-objecting physicians can delay or even prevent the procedure, exposing women to greater risk.

More than 70% of the physicians in this sample were unaware of the duty to perform the procedure if there was no other physician available-they did not recognize the duty of care, or that the objection did not exempt them from any responsibility. Legally, the objecting physician is responsible for the patient until she undergoes an abortion. Lack of knowledge of the objector's ethical posture was also reported in other studies with medical students [21,24] and can be justified by the lack of approach to the topic in professional training, which was mentioned by almost half of the physicians in the sample.

Undue allegations and inadequate ethical posture regarding conscientious objection by certain medical professionals impair access to services, overload non-objectors, and leads to their stigmatization [12]. Currently, there is pressure to minimize the perimeter of conscientious objections, which, for some authors, is nothing more than a refusal to provide services that should not be allowed [31]. European countries, such as Bulgaria, Iceland, Finland, Sweden, and the Czech Republic, have already adopted this conduct [32]. In Italy, where numerous gynecologists and obstetricians are objectors and thus, significantly affect the health system; therefore, strategies have been proposed to protect women's reproductive rights. These include authorization to perform early abortions by non-specialist physicians, incentive funds and additional vacation time for non-objectors, with hospitals that perform abortions, including a percentage of objecting physicians in their clinical staff that do not affect care [33].

Facing a situation without proper ethical and legal understanding makes it harder for the professional to deal with the problem and makes him/her even more fragile. Lack of knowledge of regulatory frameworks and of ethical and humanistic education are predictors of inappropriate conduct in conscientious objections. Investing in professional training post graduation and providing scientific, ethical, and humanistic content are necessary, and are considered a significant challenge in medical education. The use of active methodologies involving discussions about real or fictitious clinical cases in small groups has been associated with greater comfort, safety, and ethics at the time of refusal, and even in identifying future objecting physicians, minimizing conflicts and risks for all involved [34]. Medical students must consider their moral and religious characteristics when defining a specialty to avoid the obligation to perform procedures they can oppose.

Limitation of the Study

This study had some limitations. The sample comprised physicians from only one health unit and was not probabilistic, although physicians were consecutively and randomly included. The strong religious, cultural, and legal influence of the subject may have prevented data generalization.

Conclusion

High religiosity and being a fervent practitioner were predictors of abortion refusal in the three circumstances evaluated. Refusal selectivity regarding abortion in cases of sexual violence was evidenced by greater objection by older physicians, those with a longer time since graduation, and those with higher educational levels. In the case of the clinical staff of a referral unit for legal abortion, the percentage of objecting physicians and the lack of knowledge of the correct posture at the time of refusal can harm patients seeking the service. Therefore, inappropriate conscientious objection violates the scientific integrity and autonomy of women, exposing objecting physicians to ethical and legal sanctions. Educational strategies are imperative to guarantee the right to conscientious objections, and to protect women who need the procedure.

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