

# **How details matter morally in the debate on conscientious objection:**

## **The case of Norway**

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Ever since Norway's liberal abortion law allowing abortion on demand in the first trimester was passed in 1978, some Norwegian general practitioners (GPs) have refused to refer for abortion. This practice became the focus of an intense public debate in 2012-14. In this chapter I recount the legal, political and clinical developments with an international readership in mind, emphasising features of the Norwegian practices and debate which may inform the international bioethics debate on conscientious objection.

In Norway all abortions are carried out in public hospitals and paid for by the state. A referral is not formally required, yet it is customary for patients seeking abortion to be referred from their GPs, especially outside of the major cities. Norwegian GPs most often have responsibility for a subset of the municipality's population, typically 800 to 1500 patients, for whom they are the "fastlege" (allocated

GP; literally, "permanent doctor"), being obligated to provide health services including referrals. Patients are free to change their allocated GP. Norway's 1978 abortion law accommodated hospital employees – doctors, nurses and midwives – who conscientiously object to performing or participating in abortion. No provision was made, however, for GPs who object to referrals. Yet, some GPs refused to refer for abortion, a practice that garnered little attention in the ensuing decades, sporadically however being acknowledged in documents from the health authorities.<sup>1</sup> In 2011, however, the Ministry of Health and Care Services issued a circular stating that GPs had no right to conscientious objection, neither in the case of abortion referrals nor in any other situation.

This development launched a heated and protracted public debate. In the population a majority appeared to be opposed to toleration of conscientious objection for GPs,[1] yet in 2013 the (new) government proposed a formal reintroduction of toleration for conscientious objection to abortion referrals, a development for which the Christian democrat party (Kristelig Folkeparti) was the driving force. In the consultation process the proposal was welcomed by some, yet the overall picture was one of strong opposition, including dismissive consultation responses from many private citizens. The opposition to the government proposal reached its zenith in March 8 Women's Day parades in which more than 10,000 people took to the streets in Oslo alone, with protests against toleration for conscientious objection being the main parole. The government retracted its proposal, deciding instead that no conscientious refusals on the part of GPs should henceforth be tolerated, yet doing

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<sup>1</sup> The exact extent of this practice is unknown, but approximately 20 GPs who objected to abortion referrals and/or other practices were named in the public debate. (In total, Norway had 4,387 GPs as of 2014.)

away with the GP's duty to refer for abortions. GPs are now obligated to perform the consultations with women seeking abortion, providing information and performing a clinical examination and laboratory tests yet are exempt from the very act of referral if they so wish. Patients may proceed directly to hospital without a formal referral.

The public debate raised issues of freedom of conscience and the limits of toleration, issues that are general and not limited to abortion practices. Recognizing that these topics ought to be assessed on a principled level, as part of the political solution a governmental committee (of which the present author is member) was set up and tasked with producing an official green paper on freedom of conscience and conscientious objection in the workplace, including but not limited to the health sector. The committee's report is due September 2016.

The government's new policy was welcomed in many quarters but not all. Although the abortion conundrum might have been solved, the policy did away with toleration for the GP's conscientious objection to any other practices. Some GPs then faced a choice to either alter their practices, leave their jobs or choose a line of confrontation. The GP Katarzyna Jachimowicz was fired by the municipality for refusing to insert intrauterine devices (IUDs). At the time of writing she has given notice of an impending lawsuit against the municipality, invoking the right to conscientious objection under § 9 of the European Convention of Human Rights and stating that she is prepared to take the case to Strasbourg if necessary.<sup>2</sup>

These recent developments which have briefly been recounted here highlight several topics of interest to the international debate on conscientious objection in law, bioethics and public health. Two such topics will be discussed here: Firstly, I will

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<sup>2</sup> <http://www.nrk.no/telemark/oppsagt-reservasjonslege-i-telemark-saksoker-kommunen-1.12844713>

argue that the details of how conscientious objection is carried out in practice may be quite pivotal for a moral assessment; secondly, a concern often voiced in the Norwegian debate was whether conscientious objection practices involve an unacceptable moral signal or an unacceptable moral condemnation of women seeking abortion. If so, conscientious objection may seem to be ethically unjustifiable. I introduce and briefly discuss this concern.

### **Details matter morally**

In the verdict of some commentators, the dilemma of conscientious objection was not a difficult one: Conscientious objection impedes access to safe and medically accepted services to which the patient has a legal right. Because the health services exist for the sake of the patient, then in the balancing of the health professional's freedom of conscience on the one hand and the patient's right to health services on the other, the latter clearly must win out.

Arguably, however, this is a too simplistic view of the dilemma. When one looks into the details of how conscientious refusals to refer for abortion actually took place in practice, it might be argued that the stated dilemma dissolves: for at least some of the actual refusal practices, the patient's right to health services is not impeded in any significant way, or so I will argue.

An interview study with seven GPs with a conscientious objection to abortion referrals identified three typical practices which might be representative for Norwegian GP conscientious objectors.[2] These three practices had in common that the GP had arranged for one or more willing colleagues to take over the work of writing and submitting the referral letters. The first group of objecting GPs ensured that whenever the patient gave the reason for the consultation to the office's secretary,

their appointment would be made not with the refusing GP but with the GP's colleague. In this way the objecting GP would not be involved in direct contact with the patient seeking abortion. The second group would rather interrupt the consultation whenever the issue of abortion referral came up, explaining their inability to refer and requesting the secretary to schedule an appointment with the colleague at the earliest opportunity. The third group performed the full consultation but left for the colleague to perform the paperwork including the referral itself.

The argument I want to make is that an assessment of the moral acceptability of conscientious objection practices should be made based on insight into details such as these about what actions refusal practices actually consist of and what consequences they actually have. In this case it could be argued that the first practice – scheduling the consultation with the colleague from the outset – is preferable, because it avoids unnecessary consultations and waiting time; of the three alternatives this appears to be the most smooth practice from the patient's perspective. For the patient, the second and third variants both involve an extra consultation and being told by their GP that the GP morally disapproves of the course of action the patient has decided upon or is contemplating. These consequences may be perceived as burdens.

Concrete details of refusal practices, then, might be morally important. Only by having a detailed account of refusal practices will one be able to answer morally important or decisive questions such as: Does conscientious refusal impede access to the health services in question? Does it lead to increased waiting time, travel distance or expenses? And, considering the concrete way the health professional communicates the conscientious refusal, does it lead to an experience of moral condemnation on the part of the patient?

In my own estimation the first of the three alternative refusal scenarios is clearly the preferable one. If authorities were to tolerate refusals, then perhaps practices in line with this first alternative ought to be mandated when the field was regulated.

However, on neither of the three scenarios the patient's access to services is impeded. Thus, an examination of the details of the refusal practices arguably shows that it is misleading to construe the case as one of a *conflict* between the health professional's freedom of conscience and the patient's right to health services, or even as a *balancing* of the two: both these interests are very important yet both can be protected and neither needs to be compromised in this concrete case.

### **Refusal practices as self-contradictory?**

Another way in which details matter morally is when providing a coherent rationale for conscientious objection. As shown, the Norwegian GP objectors considered it as required of them that they at least preserve the patient's interests through providing for consultations with a colleague who was willing to refer. This, however, left them open to a charge of ethical inconsistency, a charge made by several in the Norwegian debate: If they were unwilling to *refer for abortion* because this would amount to morally unacceptable complicity in abortion, how then could they accept to *refer to a colleague* who then performed the actual referral for abortion? If the one referral is illicit, how can the other be licit? This is an important charge that the GPs cannot dismiss, but that they can, however, answer.

The GP's response could go along two lines, which I will here merely sketch. First, our examination of actual refusal practices shows that at least for the first of the three alternative practices, what actually takes place is quite different from a referral

for abortion.[3] Here, the GP merely ensures that a system is in place for routing patients seeking abortion to a colleague. The actions involved on the part of the objecting GP are different from those involved in constructing and submitting a written referral letter. One possible philosophical interpretation of this difference is provided by the distinction between formal (intentional) and material (non-intentional) cooperation found in natural law ethics:[4] Whereas regular abortion referrals constitute formal cooperation in abortion, the practices outlined here arguably constitute (mere) material cooperation. This is a morally relevant difference between abortion referrals and the acts involved in establishing a system for the colleague assuming responsibility for the patients. However, the two other alternative refusal practices outlined above are more difficult to differentiate from referrals for abortion; the answer sketched here might not be available to proponents of these practices.

Second, although outsiders could perceive both the writing of the referral letter and the provision of a colleague's consultation as "referrals", the existential qualities of the two sets of actions might be very different for the GPs. As a case in point, when asked why she started to object to abortion referrals, one GP related that "I am into spiritual counselling, I pray a little for people. I often place the hand that I write with on those I pray for. And then at one time it became clear that – I cannot sign this death sentence [i.e. the referral letter] with the same hand that I use to bless".[2] For this GP, then, the very act of writing and signing a referral letter took on a moral and symbolic significance that she did not perceive in the alternative arrangements she undertook to ensure that the patient was seen by a colleague.

**What does society's toleration signal?**

In the Norwegian debate a frequent argument was made that society ought not to tolerate conscientious objection because this would signal a kind of assent to the objectors' moral opposition to abortion. The fear was that such a concession could then be exploited by critics of abortion in future attempts to restrict abortion practices. A related, second argument was that the objecting GP's explaining his or her refusal to provide a referral could be experienced by the patient as an indirect moral condemnation.

Against the first argument it could be argued that by toleration society does not intend to signal assent to the objector's moral view. Rather, toleration springs from the recognition that a modern liberal democracy houses a plurality of moral and religious worldviews and moral convictions that may be strongly held and integral to the person's moral identity.[5] A policy of toleration implies the *acknowledgment* that the moral view in question occurs in society and that it is not contrary to democratic values and in that sense is acceptable. A liberal democracy should protect the moral integrity of those citizens who belong to a "moral minority" also.[6] This is likely, however, to imply toleration for certain moral attitudes that other citizens might find repugnant and morally deficient.

Arguably, the second argument has more going for it. The physician-patient relationship is a morally charged relationship,[7] and the GP is in a position of power vis-à-vis the patient. A patient seeking abortion might be particularly vulnerable. In this situation it is arguably unprofessional and unacceptable for the GP to convey his/her reasons for conscientious refusal in a way that can cause an experience of moral condemnation. The GP should take pains to be maximally sensitive to how such communication takes place. However, as citizens of a pluralist society we cannot expect or demand to be shielded from exposure to moral viewpoints that differ from

our own in our interaction with fellow citizens. Again, the potential for experiencing moral condemnation is an argument for preferring the first of the alternative refusal practices, wherein the patient is seen by the objecting GP's colleague directly.

### **Concluding remarks**

This brief discussion of recent developments concerning conscientious objection in Norway has highlighted some topics that have been central in the Norwegian public debate. These topics have been shaped by the legal and clinical context of Norwegian healthcare services, and the Norwegian political-ideological context in which opposition to abortion on demand is a marginal phenomenon. The contention underlying the chapter is that on the topic of conscientious objection there is something to learn from other countries' regulation, practices and debates. The international bioethics debate on the principled and normative aspects of conscientious objection should be informed by different accounts of actual objection practices worldwide.

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